Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Where's My Report?
Everything You Want to Know About the FY 2021 Hospital VBP Program Percentage Payment Summary Report

Presentation Transcript

Speaker

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Bethany Bunch: Hello and thank you for tuning into the Hospital Value-Based Purchasing Program On Demand webinar focused on the fiscal year 2021 Hospital VBP Program Percentage Payment Summary Report. My name is Bethany Bunch, and I am the Hospital VBP Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your virtual host for the webinar and today's speaker.

This event will provide an overview of the fiscal year 2021 Hospital VBP Program Percentage Payment Summary Report, including a discussion of the background of the report, hospital eligibility, how to download the report, the measures and domains included in the Hospital VBP Program, the scoring methodology, and the data within the reports.

At the end of the event, participants should be able to identify the way hospitals will be evaluated within each domain and measure, recall the Hospital VBP Program eligibility requirements, interpret the scoring methodology used in the Hospital VBP Program, and locate the Total Performance Score and value-based incentive payment percentage on the PPSR.

If you have questions during the webinar, you may submit them to the following email address, WebinarQuestions@hsag.com. When sending questions, please use the webinar title in the subject line. The webinar title is *Where's My Report? Everything You Want to Know About the FY 2021 Hospital VBP Program Percentage Payment Summary Report*. In the email body, please include your question, and, if your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible.

If you have questions unrelated to the current webinar topic, we recommend searching for the topic in the *QualityNet* Inpatient Q&A tool. If you do not find a similar topic, feel free to use the tool to submit a new question.

On today's webinar, we are going to review a high level of many aspects of the FY 2021 Hospital VBP Program. We will touch on some of the calculations, but we won't be diving too deep into them. For those that would like the deeper dive into the calculations, we recommend watching the *What's My Payment On Demand?* webinar on the Quality Reporting Center website.

Here is a list of acronyms that I may reference on today's webinar.

Our presentation will start with the background and framework of the program.

The Hospital Value-Based Purchasing Program is required by Congress under Section 1886(o) of the Social Security Act. The Hospital VBP Program was first adopted for fiscal year 2013, and CMS has used this program to adjust payments for every fiscal year subsequent. The Hospital Value-Based Purchasing Program was the first national inpatient pay-for-performance program in which hospitals are paid for the services based on the quality of care rather than the quantity of services provided. The Hospital VBP Program pays for care that rewards better value, improved patient outcomes, innovation, and cost efficiency over volume of services.

The Hospital Value-Based Purchasing Program is an estimated budget-neutral program and is funded through a percentage reduction from participating hospitals' DRG payments. Incentive payments will be redistributed based on the hospital's Total Performance Score in comparison to the distribution of all hospital Total Performance Scores and the total estimated DRG payments. Please note that withholds and incentive payments are not made in a lump sum but through each eligible Medicare claim made to CMS. The funding from the fiscal year 2021 program will come from a 2.00 percent withhold from participating hospitals' base operating DRG payment amount. CMS anticipates the total value-based incentive payment will total $1.9 billion in fiscal year 2021. For those of you that are new to the Hospital VBP Program, I hope the graphic on this slide helps you understand the funding process. On each claim, your hospital will have a reduction of 2.00 percent of the DRG

amount. Then, based on how your hospital performed in the program, your hospital will earn value-based incentive payments, which can be as low as 0 percent if your hospital received a Total Performance Score of 0 to more than that 2.00 percent, which would result in a hospital receiving an overall positive payment adjustment due to the Hospital VBP Program. The graphic shows a hospital earning value-based incentive payments of 3.00 percent. So, when you withhold 2.00 percent, but then gain 3.00 percent, you are netting a positive adjustment of 1.00 percent on each claim. If your hospital was to earn back less than 2.00 percent, let's say your hospital earned a value-based incentive payment of 1.50 percent, you would have a net reduction of 0.50 percent on each claim. Your value-based incentive payment percent is displayed on the Percentage Payment Summary Report for you to review. We generally are asked each year, "What is the highest value-based incentive payment percentage that can be gained each year?" There isn't a set value each fiscal year, and it ultimately depends on the distribution of scores and the base operating DRG payments in that fiscal year. However, I can tell you that last year, in fiscal year 2020, the highest value-based percentage was around 4.90 percent, which resulted in a net increase of around 2.90 percent after the initial 2.00 percent reduction to fund the program.

The Hospital VBP Program adjusts payments for approximately 3,000 hospitals each fiscal year. The program applies to subsection (d) hospitals which are short-term acute care hospitals paid under the inpatient prospective payment system in 50 states and the District of Columbia. If your hospital is a subsection (d) hospital, your payments will be adjusted unless one of the exclusion reasons listed on this slide applies. Those exclusion reasons include hospitals that are subject to payment reductions under the Hospital IQR Program, hospitals that were cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients, hospitals that had three out of the four domains calculated, hospitals with an approved extraordinary circumstance exception, and hospitals located in the state of Maryland. If your hospital is excluded from the program, your report will state "Hospital VBP Ineligible" on the first page. Additionally, data for your

hospital will not be publicly reported in the Hospital VBP Program tables on the *Hospital Compare* website or its successor website. Excluded hospitals will not have their payments adjusted, which includes not being subject to the 2.00 percent withhold and the opportunity to receive incentive payments. I just want to reiterate because this is one of the most common questions from excluded hospitals. Hospitals that are excluded for any of the reasons listed on this slide will not have their payments reduced by 2.00 percent, and they will not have the opportunity to receive incentive payments.

This slide provides a timeline of the Hospital VBP Program. We are currently at the box with the You Are Here stamp. CMS released the fiscal year 2021 Percentage Payment Summary Reports to hospitals on July 31. Following the release of that report, hospitals have a 30-day period to review the reports and the scoring calculations and request a correction. If you are submitting a review and correction request, the request is due by August 31 at 11:59 p.m. Prior to the performance report release, the Baseline Measures Reports for fiscal year 2021 were released in March of 2019. The Baseline Measures Reports provide the baseline period rates and performance standards to assist hospitals in setting targets in the performance period. In April 2020, CMS released the mortality and complication measure HSRs, and, in May 2020, CMS released the MSPB HSRs. Following the release of each of those reports, hospitals had a 30-day period to review and request correction of the calculations of these specific measures. Looking ahead, payment adjustments for fiscal year 2021 will begin on October 1, 2020, and continue through September 30 of 2021. In the fall of 2020, CMS will post Table 16B to the CMS.gov website, which is a table that contains each eligible hospital's payment adjustment factor. We anticipate, in January 2021, CMS will update the *Hospital Compare* or its successor website with the fiscal year 2021 scoring results for the Hospital VBP Program.

For the FY 2021 Hospital VBP Program, there are three measure updates from the FY 2020 program year. The 30-day mortality measure for COPD was added to the Clinical Outcomes domain beginning in FY 2021.

Additionally, the 30-day mortality measure for pneumonia was updated to use an expanded cohort in FY 2021. This is the same expanded cohort that has been used for a few years now in the Hospital IQR Program and reported on the main pages of *Hospital Compare*; however, due to regulations CMS didn't start using the expanded cohort in the Hospital VBP Program until FY 2021. The last measure update for FY 2021 was the removal of the PC-01 measure from the Safety domain.

In a press release dated March 22, 2020, and a guidance memo issued March 27, 2020, CMS announced that it was excepting all hospitals from CMS's HAI and HCAHPS Survey data submission requirements for Q4 2019, Q1 2020, and Q2 2020 because of the COVID-19 public health emergency. Data submissions for Q4 2019 for those measures are relevant for the FY 2021 Hospital VBP Program. Although discharges and care delivery for Q4 2019 were not impacted by COVID-19, CMS excepted hospitals from reporting requirements because the submission deadline for the quarter was scheduled while hospitals were impacted by the public health emergency. CMS excepted hospitals to assist health care providers while they directed their resources toward caring for their patients and ensuring the health and safety and staff.

It is important to note that this memo excepted hospitals from CMS's submission requirements for the fourth quarter but did not exclude the use of data from the quarter. If data from fourth quarter 2019 was submitted by the submission deadline, it was used in the scoring calculations for the Hospital VBP Program. If a hospital did not submit data for Q4 2019, their FY 2021 Hospital VBP Program measure results for the HAI measures and HCAHPS Survey dimensions rely on a performance period of January 1, 2019, to September 30, 2019.

The next set of slides will show the steps for running your Percentage Payment Summary Report.

CMS made the Percentage Payment Summary Report available Friday, July 31. Reports are available to run through the new *Hospital Quality Reporting*, or *HQR, QualityNet Secure Portal*. In order to access the new

HQR portal, you must use your new HARP ID, password, and two-factor authentication. If you have not established your HARP ID yet, you can still do so by logging into the old *QualityNet Secure Portal* and following the prompts that will be displayed to establish your HARP ID and link your *QualityNet* accounts. I would also like to note that you will need to run the Percentage Payment Summary Report, and it will not be available in the *QualityNet* Secure File Transfer inbox, like the claims-based measure HSRs or the HAC Reduction Program reports that were recently sent to hospitals.

To run your report, first go to the *QualityNet HQR Secure Portal* at hqr.cms.gov/hqrng/login. Enter your HARP ID and password and select Login. Select the method to receive your two factor authentication code. Once you've received your code, enter the code in the box and select Continue.

Review the terms and conditions, and select Accept to accept the terms and conditions. You will need to scroll to the bottom of the terms and conditions in order for the Accept button to become active.

Once the *HQR Secure Portal* is displayed, select My Reports on the top-left navigation menu.

The rest of the steps should be similar to running a report in the older *QualityNet Secure Portal*. Select Run Reports under the I'd Like To menu of options.

Under Report Program, select Inpatient. Under Report Category, select Hospital Value-Based Purchasing – Feedback Reports. Select View Reports.

The two Hospital VBP Program reports should now be displayed. To run the Percentage Payment Summary Report, select the Value-Based Percentage Summary Report link.

Select your parameters for the report. For the FY 2021 Percentage Payment Summary Report, select FY 2021 under Select Reporting Period. Then, click the Run Report button.

You will receive a Report Submitted confirmation. From this screen, select Search Reports.

Your report will be ready to download when the status at the left of the report is a green checkmark. Once it's ready to download, select the green download arrow button in the action menu to download your report.

When the prompt displays to open or save the report, you can click either.

This slide displays the summary of steps to assist you in running your report from the new *HQR QualityNet Secure Portal*. If you have any questions relating to running the report or establishing your new HARP ID, please contact the *QualityNet* Help Desk by e-mailing them at qnetsupport@hcqis.org.

I will now touch on the domains and measures used to evaluate hospitals in the Hospital VBP Program.

This slide displays the four domains hospitals will be evaluated on in the fiscal year 2021 Hospital VBP Program. Each domain is weighted equally at 25 percent of the Total Performance Score. The Clinical Outcomes domain contains the 30-day mortality measures for AMI, COPD, heart failure, and pneumonia. The Hip-Knee Complication measure is also included in the Clinical Outcomes domain. The 30-day mortality measure for COPD is new to the Hospital VBP Program in FY 2021. The Person and Community Engagement domain contains the HCAHPS Survey dimensions. The Safety domain contains the five CDC healthcare-associated infection measures. Please note the PC-01 measure was removed from the Hospital VBP Program Safety domain beginning in this year, FY 2021. The Efficiency and Cost Reduction domain contains the Medicare Spending per Beneficiary measure.

The Hospital VBP Program is unique in that it allows hospitals to earn improvement, which is scored based on how a hospital improved in their own performance from the baseline period to the performance period, in addition to the opportunity for achievement, which is scored based on how a hospital compares versus all other hospitals in the country. We have two periods listed on this slide, baseline and performance, in order to calculate both of those scores. The HCAHPS Survey, HAI measures, and MSPB measure are calendar year measures and utilize a performance period of calendar year 2019 and a baseline period of calendar year 2017. The mortality measures and complication measure use multi-year baseline and performance periods that are listed on this slide.

When we were covering the eligibility of the program, we discussed a hospital being excluded if they had fewer than three domain scores calculated. So, in order to cover the minimum data requirement for the Hospital VBP Program, I would like to start there, which is the last row in the table on this slide. In order to have at least three domains calculated, a hospital would have to meet the minimum data requirements within each of those domain. For the Clinical Outcomes domain, a hospital must have at least two of the five measures scored, requiring a minimum of 25 cases in each of the measures. For the Person and Community Engagement domain, a minimum of 100 HCAHPS Surveys are required to receive a score. In the Safety domain, a minimum of two measure scores is required, with each measure having a requirement of at least 1.00 predicted infection as calculated by the CDC. For the Efficiency and Cost Reduction domain, a minimum of 25 episodes of care is required.

Like I mentioned a few slides back, hospitals have the opportunity to receive improvement and achievement points on their Percentage Payment Summary Report based upon their measure rates during the baseline period and performance period relative to the performance standards. The performance standards consist of the achievement threshold and benchmarks for all measures and the floor, which is only applicable for the Person and Community Engagement domain. The achievement threshold is calculated as the median, or the 50th percentile, of all hospital rates

measured during the baseline period. The benchmark is a mean of the top decile, which is the average of the top 10 percent during the baseline period. The floor is used in calculating the HCAHPS consistency score and is the rate of the lowest performing hospital during the baseline period.

The measures displayed on this slide will have a higher benchmark value than an achievement threshold because higher rates demonstrate better quality in the measure. The measures that this description is applicable for are the 30-day mortality measures in the Clinical Outcomes domain and the HCAHPS dimensions. A quick reminder: The mortality measures use survival rates in the Hospital VBP Program.

The measures displayed on this slide will have a higher achievement threshold value than the benchmark because lower rates demonstrate better quality in the measure. The measures that this description is applicable for are the complication measure, the healthcare-associated infections in the Safety domain, and the Medicare Spending per Beneficiary (MSPB) measure in the Efficiency and Cost Reduction domain. Please note, the MSPB measure uses data during the performance period instead of the baseline period to calculate performance standards. The performance standards for the MSPB measure will be listed on your hospital's Percentage Payment Summary Report.

This slide displays the performance standards used in the fiscal year 2021 program. These performance standards, with the exception of the MSPB measure, were included in your baseline measures report and will also be displayed on your hospital's Percentage Payment Summary Report.

There are three values calculated for every measure: achievement points, improvement points, and a measure score. We will cover achievement points first. Achievement points are awarded by comparing your hospital's rates on a measure during the performance period with all other hospitals. So, how does CMS compare you to all hospitals? The answer is through the use of performance standards of the achievement threshold and the benchmark that we just discussed. To recap, the achievement threshold was the median of all hospital performance, and the benchmark is the

mean of the top 10 percent. You can determine how many achievement points your hospital will receive by reviewing these three scenarios. Is your hospital's performance period rate at or better than the benchmark value? If yes, your hospital will get the maximum of 10 achievement points. Is your hospital's rate worse than the achievement threshold? If that answer is yes, your hospital would receive 0 achievement points. Is your hospital's rate at or better than the achievement threshold, the median value, but not quite at that benchmark? Then, your hospital would receive 1 to 9 achievement points based on the achievement point formula.

Improvement points are unique to the Hospital VBP Program in relation to CMS' other inpatient pay-for-performance programs, such as the HAC Reduction Program and the Hospital Readmissions Reduction Program. Not only can hospitals be evaluated based on their current performance in comparison to all other hospitals, but they can earn points by improving from the baseline period. CMS may award hospitals improvement points if the hospitals' performance period rate is better than their own baseline period rate. The maximum point value for improvement points is 9 points. If your hospital's performance period rate is better than the benchmark and also better than your own baseline period rate, you will receive a maximum of 9 improvement points. If your hospital's performance period rate is worse than or equal to the baseline period rate, you will receive 0 improvement points because no improvement in the rates were actually realized. If your hospital's performance period rate is in between the baseline period rate and the benchmark, your hospital will receive 0 to 9 improvement points based on the improvement point formula. If you would like to see examples of the achievement and improvement point calculations and all of the subsequent domain scores, Total Performance Scores, and payment adjustment calculations, please watch the *What's my Payment?* On Demand webinar available on the Quality Reporting Center website.

We will now move into a brief overview of reviewing and reading your reports.

The Percentage Payment Summary Report has five pages. The first page is a summary of your hospital's scores and the payment adjustment information. The first section contains your hospital's Total Performance Score, the state average, and the national average. The domain scoring section contains each domain's unweighted score, domain weight, and weighted score.

The payment summary section contains five values. The Base Operating DRG Payment Amount (Reduction) will display "2%" for all eligible hospitals because that is the amount that is withheld for fiscal year 2021. The Value-Based Incentive Payment Percentage is the incentive percentage a hospital will receive without taking into account the 2.00-percent withhold. The net change in payment amount is the Value-Based Incentive Payment Percentage minus the 2.00-percent withhold. If this value is positive, your hospital will receive an overall increase in payments due to the Hospital VBP Program. The payment adjustment factor is the number that you can multiply against a DRG to determine what you will be paid for that DRG based on the program. The last value is the Exchange Function Slope. This value is the same for each hospital and is used to calculate the hospital's payment adjustments that we just covered. Please note that the slope displayed on this slide is not the slope that will be used in fiscal year 2021.

If your hospital is excluded from the program, the first page will display the reason for your hospital's exclusion in the middle of the page, which is displayed on this slide in the yellow highlighting. In addition, your hospital's Total Performance Score and payment adjustment fields will display "Hospital VBP Ineligible."

The second page of the report is the Clinical Outcomes Detail Report. This page will contain the measure-level results, such as the number of eligible discharges and the baseline and performance period rates.

In addition, the Clinical Outcomes Detail Report will display the performance standards, improvement points, achievement points, and the measure score. At the bottom of the table, there is a summary of the domain results, which includes the number of measures receiving a measure score, the unweighted domain score, and the weighted domain score.

The third page will display results for the HCAHPS Survey, including the baseline and performance period rate.

In addition, the performance standards, improvement points, achievement points, and dimension scores will also be displayed. Under the table, the domain summary is displayed, including the HCAHPS base and consistency scores; the unweighted and weighted domain scores; and the number of surveys completed. In addition, there will be a footnote displayed that states which dimension was used to calculate your hospital's lowest dimension rate, which is used in the consistency score calculations.

The fourth page of the report displays the measure results for the Safety domain, including the baseline and performance period totals for each measure. The Number of Observed Infections are the actual number of infections your hospital reported during that specific measurement period. The number of predicted infections are calculated by the CDC based on the data that your hospital submitted and other national values. The Standardized Infection Ratio is the ratio of the number of observed infections and number of predicted infections.

The right side of the table displays the performance standards and point calculations.

The summary beneath the table includes the number of measures the hospital was scored in, the unweighted domain score, and the weighted domain score.

The last pages of the report display the information for the MSPB measure within the Efficiency and Cost Reduction domain, including the baseline period totals, performance period totals, performance standards, scoring, and the domain summary.

This slide displays select values from the report and the precision for those values. For example, the 30-day mortality measures have a baseline and performance period rate that is displayed six places to the right of the decimal on the Percentage Payment Summary Report. I would like to highlight the asterisk on the HCAHPS baseline and performance period rate. Please note that these values have a displayed precision of two places in the baseline period and four places in the performance period to the right of the decimal. However, a greater precision of those rates is used to calculate the improvement and achievement point values than is displayed on the report. If you have any questions regarding the calculations on your report, please feel free to ask your questions through the Inpatient Q&A tool found on *QualityNet*.

Now, we're going to move into reviewing your data.

Hospitals may review their data used in CMS programs in two different stages. The first stage is considered a patient-level data review stage in which hospitals ensure their underlying data or claims are accurate either prior to the submission deadline, the claims pull date, or during the HCAHPS review and correction period. The second stage of review is the scoring and eligibility review. During the second stage, hospitals can ensure that the data reviewed during phase one is properly displayed on the report, and the scoring, such as improvement points, measure scores, or domain scores were calculated correctly based on the already finalized measure result. Corrections or modifications to the underlying data are not allowed during a stage two review. Examples of stage two reviews include the *Hospital Compare* preview report, the Hospital VBP Program review and correction period, and the claims-based measures review and correction period.

For CDC NHSN measures, the stage one review also allows hospitals to use the approximate 4.5 months after the quarterly reporting period ends to submit and review the data into NHSN. Corrections or modifications to the data after the quarterly submission deadline will not be reflected in CMS reports or programs, although the data can still be entered or modified into NHSN.

For the HCAHPS Survey stage one review, CMS allows hospitals to have a seven-day period after the submission deadline to access and review the HCAHPS data in a review and corrections report. Please note that new data are not accepted into the warehouse during the review and correction period, just modifications to the existing data. After the quarterly HCAHPS review and correction period, no changes can be made to the underlying HCAHPS data.

Now, that we have covered the stage one items, we will discuss the details of stage two. The stage two for the claims-based measures includes 30 days to review and correct scores based on a hospital's claims included in a Hospital-Specific Report, or HSR. If a hospital suspects a calculation error on the report, a request for review and a possibility for correction can be submitted during this 30-day window. Requests for submission of new or corrected claims to the underlying data are not allowed. We do recommend contacting your MAC, or your Medicare Administrative Contractor, if you identify an error in the underlying claims data, so the claims are correct during the next claims pull.

Another stage two review is the review and correction period for the Percentage Payment Summary Report. After the release of the report, hospitals will have 30 days to review and request correction of the calculation of scores for each measure, domain, and Total Performance Score. Requests for correction of underlying data, such as your baseline or performance period rates, are not allowed during this period and should have already been addressed during a stage one review for each of the measure types.

Some best practices for reviewing your data during stage one include having a second person review submitted data for errors, creating a plan for spot checking or sampling the data submitted for errors, reviewing the data a vendor submits for accuracy before submission or prior to the submission deadline, and performing routine coding audits to ensure claims are being coded and billed correctly.

The benefits of having correct data include having usable data quickly that can assist you in your quality improvement initiatives at the hospital. Also, having accurate data ensures the hospital is assigned a payment adjustment factor that correlates to the hospital's actual performance. For public reporting, having accurate data can help organizations focus on quality improvement priorities and assist consumers with how well a hospital is performing.

So, now that we understand when the underlying data should be reviewed versus the review of a hospital's score and eligibility, let's move on to the process to submit a Percentage Payment Summary Report review and correction request if your hospital identifies a potential scoring error.

Hospitals may review and request recalculation of scores for each measure, domain, and Total Performance Score. Hospitals have 30 days after the Percentage Payment Summary Reports are released to request this review. If you would like to submit a request, please submit the completed review and correction form through one of the methods listed on this slide. If emailing the form, please ensure that you are not submitting PII or PHI, since this is not a secured method. If you are submitting a request, please have it submitted by August 31 at 11:59 p.m. for CMS consideration.

The review and correction form is posted on *QualityNet*. This page describes where to find the form if you would like access it.

When completing the form, please make sure you are providing the following information: the date of the review and corrections request; the hospital CCN, or CMS Certification Number; the hospital contact information; the reason or reasons for the request; and a detailed description for the reasons identified.

Next, we will review the appeals process.

A hospital may appeal the calculation of their scores through an appeal only after receiving an adverse determination from CMS following a request for review and correction. Hospitals will have 30 days in order to request an appeal after receiving the review and correction decision. If your hospital did not submit a review and correction request, you waive your eligibility to submit an appeal request. To submit an appeal, you would follow the same process on sending a completed appeal form.

To access the appeals form, please use the steps listed on this slide to access the form on *QualityNet*.

When completing the appeals form, please include the information provided on this slide, including the date of your hospital's review and correction request.

The topics listed on this slide are the appealable items during the appeals period, including the calculation of scores, incorrect domain weights applied, or if your hospital's open/closed status was incorrectly specified.

The following resources are available to you.

If you have questions or would like to learn more about the Hospital VBP Program, I would recommend checking out the resources listed on this slide. We provide educational events and webinars such as these throughout the year and then store the recordings and slides to watch On Demand on the Quality Reporting Center website. Please feel free to check out the website if you want to learn more about the baseline measures reports, the claims-based measure Hospital-Specific Reports, and any proposed or finalized changes that were announced in the IPPS proposed and final rules. If you

want to have quick references to the measures used or the performance standards in the Hospital VBP Program for a fiscal year, we have those easily accessible on the Hospital VBP Program pages on *QualityNet.* If you would like a tutorial video of the resources available for the Hospital VBP Program, the Quality Reporting Center website has an On Demand webinar that walks through all of the *QualityNet* pages for the Hospital VBP Program, the resource documents, how to run reports, and how to ask and check status on questions in the Q&A tool. If you have any additional questions, you can reference the Frequently Asked Questions in the Inpatient Q&A tool on *QualityNet*, and, if your question is not answered, submit a question through the same tool.

The resources available on this slide can be found by clicking on the link in the slide. Specifically, as you are reviewing your report and you have questions, please reference the How to Read Your Report Help Guide. If you need assistance in calculating your values on the report, the Scoring Quick Reference Guide is a nice, handy cheat sheet to use.

Because this was an On Demand only event, we tried to address some of the frequently asked questions during the presentation. If you have additional questions regarding the webinar, please follow the instructions on the next slide.

You may submit webinar questions to the following email address, WebinarQuestions@hsag.com. When sending questions, please use the webinar title in the subject line. In the email body, please include your question, and, if your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible.

We appreciate hearing your feedback as we determine what education to provide in the future. Please help shape our education to your needs by completing this quick survey. Thank you and have a great day!