



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2019 IPPS Proposed Rule Acute Care Hospital Quality Reporting Programs Overview Presentation Transcript

Speakers

Grace H. Snyder, JD, MPH

Program Lead, Hospital IQR Program and Hospital Value-Based Purchasing (VBP) Program
Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards and Quality (CCSQ), CMS

Elizabeth Bainger, DNP, RN, CPHQ

Program Lead, Hospital-Acquired Condition (HAC) Reduction Program
QMVIG, CCSQ, CMS

Joseph Clift, EdD, MPH, MS, PMP

Measures Lead, HAC Reduction Program, Division of Quality Measurement
QMVIG, CCSQ, CMS

Erin Patton, MPH, CHES

Program Lead, Hospital Readmissions Reduction Program (HRRP)
QMVIG, CCSQ, CMS

Moderator

Candace Jackson, RN

Project Lead, Hospital IQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

May 9, 2018

2 p.m. ET

DISCLAIMER: This transcript was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to this transcript change following the date of posting, this transcript will not necessarily reflect those changes; given that it will remain as an archived copy, it will not be updated.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included in the presentation are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the transcript and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Candace Jackson: Thank you everyone for joining today's presentation titled *Fiscal Year 2019 Inpatient Prospective Payment System Acute Care Hospital Quality Reporting Programs Overview*. I am Candace Jackson, the Project Lead for the Hospital Inpatient Quality Reporting Program with the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I would like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers, will be posted to the inpatient website www.QualityReportingCenter.com and to the *QualityNet* site at a later date. If you are registered for this event, a reminder email, as well as the slides, was sent out to your email about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website, again at www.QualityReportingCenter.com. If you have a question as we move through the webinar, please type your question into the chat window. We will not be using the Raised Hand feature for today's webinar. For presenters to best answer your questions, we request that you, at the beginning of your question, please type the slide number into the chat window. As time allows, we will have a short answer and question session at the conclusion of the webinar. A transcript of all questions that are not answered during the question and answer session at the end of the webinar will be posted to the www.QualityReportingCenter.com website at a later date.

I would now like to welcome and introduce our Centers for Medicare & Medicaid Services guest speakers for today: Grace Snyder, Program Lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program; Elizabeth Bainger, Program Lead for the Hospital-Acquired Condition Reduction Program; Joseph Clift, Measures Lead for the HAC Reduction Program; and Erin Patton, Program Lead for the Hospital Readmissions Reduction Program.

Today's presentation will provide participants with an overview of the Fiscal Year 2019 proposed changes for the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital-Acquired Condition Reduction Program, and the Hospital Readmissions Reduction Program, as addressed in the recently released inpatient prospective payment system proposed rule.

At the end of today's presentation, participants will be able to locate the Fiscal Year (2019) IPPS Proposed Rule, identify the proposed program changes, identify the time period, and submit public comments to CMS. Please note, that during this presentation, CMS will not be able to provide additional information, clarification, or guidance related to the proposed rule. CMS strongly encourages stakeholders to submit their comments or questions through the formal submission process which will be discussed later in the presentation.

This is just a list is the acronyms that we will use throughout the presentation. I would now like to turn the presentation over to Grace Snyder. Grace, the floor is yours.

Grace Snyder:

All right, thank you, Candace. In 2017, CMS launched its new Meaningful Measures initiative, which identifies high priority areas for quality measurement and improvement. While continuing to focus on value and quality, CMS is taking a new approach in quality measurements using our new Meaningful Measures framework. This framework puts patients at the center of everything we do, as it serves to focus on measures that are the most meaningful to patients and to the providers focused on their care. It takes into account opportunities to reduce paperwork and reporting burden on providers associated with quality measurements by helping us to evaluate the highest quality measurement and improvement opportunities that are most important to improving patient outcomes. Based on the growing number of quality measures in CMS programs and the burden associated with the reporting on these quality measures, CMS sought out and incorporated diverse stakeholder feedback to develop the Meaningful Measures initiative.

As seen in this slide, using the Meaningful Measures framework will help us refine the measure sets used in each of our programs, so that we use a smaller number of measures that are most meaningful and high impact, yet

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

least burdensome, well understood by external stakeholders, and aligned across other programs when possible. The framework is also helpful for identifying measurement gaps and then the development of new quality measures.

On this slide, we see our handy infographic associated with the framework. As you can see, it is based on four strategic goals which are found at the center of this slide. These four goals are Empowering Patients and Doctors, Improve CMS Customer Experience, Improve State Flexibility and Local Leadership, and Support Innovative Approaches. These four goals are aligned to 19 Meaningful Measures topics that can be found on the perimeter of this slide and are closely linked to six main quality priorities. These six priorities are Promote Effective Communication & Coordination of Care, Strengthen Person & Family Engagement as Partners in their Care, Make Care Safer by Reducing Harm Caused in the Delivery of Care, Promote Effective Prevention and Treatment of Chronic Diseases, Work with Communities to Promote Best Practices of Healthy Living, and Make Care Affordable. For example, the quality priority of Promote Effective Prevention and Treatment of Chronic Disease includes five Meaningful Measures areas, as you can see in the top right corner. By focusing on these Meaningful Measure areas and others, we can find where there are gaps in measurements in quality improvement and then look to our partnership with states and communities to improve health outcomes.

This slide gives some additional examples on what the Meaningful Measures areas are and what that area entails.

With the Meaningful Measures initiative, it is important to note that CMS does not intend to replace any existing programs, create new requirements, or mandate any new measures, but really intends to increase measure alignments across CMS programs. The initiative will allow clinicians and providers to focus on patients and improve quality of care instead of focusing on reporting and paperwork. Additionally, it is intended to capture the most impactful and highest priority quality improvement areas for all clinicians.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

The Meaningful Measures framework truly guides CMS in helping to reduce paperwork and reporting burden associated with quality measurements for clinicians and other providers, while also allowing for us to develop the most parsimonious and least burdensome measure sets that are focused on health outcomes and that are the most meaningful to patients and their providers. As CMS moves forward, we will be reaching out to stakeholders for continued further input to improve the framework and we'll be working across CMS to implement the framework.

I would now like to address the proposed changes related to the Hospital Inpatient Quality Reporting Program or the IQR Program.

At a high level, CMS is proposing to remove a total of 39 measures from the Hospital IQR Program over the next four Fiscal Years and ten measures from the Hospital VBP Program beginning with Fiscal Year 2021. We are not proposing to remove any measures from the Hospital-Acquired Condition Reduction Program or the Hospital Readmissions Reduction Program.

As part of the Meaningful Measures initiative, we are engaging in efforts to ensure that the Hospital IQR Program measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall cost associated with the program. We believe these costs are multifaceted and include not only the burden associated with reporting but also the costs associated with implementing and maintaining the program. When these costs outweigh the evidence supporting continued use of a measure, we believe it may be appropriate to remove the measure from the program. We are proposing that we would remove measures based on this factor on a case-by-case basis and are proposing to remove a number of measures from the Hospital IQR Program based on this new proposed removal factor.

For the chart-abstracted clinical process of care measures, we are proposing to remove the two emergency department throughput measures ED-1 and ED-1, as well as the patient influenza immunization measure, IMM-2 and VTE-6, Incidence of Potentially Preventable VTE measure.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

These chart-abstracted measures are manually extracted, and it is highly burdensome to providers to collect the data. In this proposed rule, we are proposing to remove the IMM-2 measure beginning with Calendar Year 2019 reporting, as it has been topped out for the past three years, and the cost associated with the measure outweighs the benefit of its continued use in the Hospital IQR Program, as performance on this measure is very high and unvarying, and so cost of maintaining the measure in the program would outweigh the burden of keeping the measure. Additionally, we are proposing to remove VTE-6 and ED-1 beginning with Calendar Year 2019 reporting and ED-2 beginning with Calendar Year 2020 reporting under the proposed removal factor that the cost associated with these measures outweigh the benefit of their continued use in the program.

In this proposed rule, we are proposing to remove two structural measures, Hospital Survey on Patient Safety Culture and Safe Surgery Checklist (Use) measure, both beginning with Calendar Year 2018 reporting for which the data need to be submitted in the spring of 2019 and would impact Fiscal Year 2020 payment determination. These proposed removals are based on our evaluation that the performance or improvements on the Patient Safety Culture measure would not result in better patient outcomes as it is a structural measure, and, for the Safe Surgery Checklist, that the cost of the measure outweighs the benefit of its continued use in the program.

Beginning with Calendar Year 2019 reporting, which would impact Fiscal Year 2021 payment determinations, we are proposing to remove the following five hospital-associated infection measures from the Hospital IQR Program, as they would be maintained in the Hospital-Acquired Condition Reduction Program. By removing these measures from the IQR Program, it would eliminate the use of duplicative measures that have been potentially confusing for providers when reviewing feedback reports and tracking different uses of the same measures in different programs and, therefore, we believe that maintaining these measures in both of the programs no longer aligns with our goal of not adding unnecessary complexity or cost in using quality measures across our program.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

We are also proposing to remove the Patient Safety Indicator 90 measure, or PSI 90 measure, beginning with the Fiscal Year 2020 payment determination, which would use a performance period of July 1, 2016, through June 30, 2018, under the proposed removal factor that the cost associated with the measure outweighs the benefit of its continued use in the program. Like the HAI measure, this measure is also currently used in the Hospital-Acquired Condition or HAC Reduction Program. Using the same measure in more than one program has been creating confusion on feedback reports in tracking the use of the measures in more than one program. We are also proposing to remove the following five listed mortality measures and the hip/knee complication measure from the IQR Program, as these measures are used in the Hospital Value-Based Purchasing Program or VBP Program. We continue to believe that all these measures provide important data on patient outcomes following inpatient hospitalization. However, what we are seeking to do is to reduce duplicative measures in these programs and so, by proposing to remove these measures from the IQR Program, we believe that it will help reduce complexity and burden and cost for providers.

We are also proposing to remove the following seven claims-based readmission measures from the IQR Program and this will be beginning with the Fiscal Year 2020 payment determination. We continue to believe that these measures provide important data on patient outcomes and care coordination following inpatient hospitalization, which is why we will maintain most of these measures in the Hospital Readmissions Reduction Program. We are proposing to remove these measures from the Hospital IQR Program based on our new proposed removal factor, that the cost outweighs the benefit of continued use in the program, as this would eliminate the development and release of duplicative CMS feedback reports and providers having to track the use of same measures in more than one program. I'd also like to note that for the stroke readmission measure, which is not used in the Readmissions Reduction Program, the data collected for this measure is also captured in the hospital-wide all cause readmission measure that is being maintained in the IQR Program. So, we believe that the cost associated with interpreting the requirements

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

for two measures with overlapping data points would outweigh the benefit to maintain the measure in the program. This would help reduce duplicative data and produce a more harmonized and streamlined measure set. Additionally, under the new proposed removal factor, that the costs outweigh the benefit of maintaining the measure in the program, we are proposing to remove the Medicare Spending per Beneficiary measure and the six listed clinical episode-based payment measures from the IQR Program beginning with the Fiscal Year 2020 payment determination. We continue to believe that the MSPB, or Medicare Spending per Beneficiary measure, provides important overall hospital payment data and resource use data and we'll continue to use this measure in the Hospital VBP Program.

For the six clinical episode-based payment measures, we believe that the measure data are already captured within the overall MSPB measure and we believe the costs associated with interpreting the requirements for multiple measures with overlapping data points would outweigh the benefit to beneficiaries and providers of the additional information provided by these measures.

With respect to the electronic clinical quality measures, or eQMs, we are proposing to reduce the number of eQMs in the Hospital IQR Program measure sets by proposing to remove seven of the eQMs. This would leave eight eQMs in the IQR eQM measure set. We are proposing to remove these measures beginning with the Calendar Year 2020 reporting period which would impact the Fiscal Year 2022 payment determination. We are proposing to remove these seven eQMs under the new proposed removal factor that the cost outweighs the benefit of keeping the measures in the program. We are proposing the removal of these measures in alignment with the Medicare and Medicaid Promoting Interoperability Program, previously known as the Medicare and Medicaid EHR Incentive Program. In selecting these eQMs to propose for removal, we considered the relative benefits and costs associated with each eQM in the measure and believe that the cost of keeping the measures outweighs the benefit of their continued use in the IQR Program.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

With respect to the reporting of eCQMs to the IQR Program, we had made proposals for the Calendar Year 2019 reporting period, which would impact the Fiscal Year 2021 payment determination. Essentially, we have proposed to maintain the current eCQM reporting requirement, which is to report on four of the available eCQMs for any one self-selected quarter from 2019, and the submission deadline would be February 28 of 2020.

In terms of technical requirements, we do want to note that, for the Calendar Year 2019 reporting period and future years, we will be requiring the use of certified EHR technology that is certified to the 2015 Edition. In addition, for the 2019 reporting period, we are proposing to require the use of measure specifications that are published in the 2018 eCQM annual update for 2019 reporting and any applicable addenda, and this can be found on the eCQI Resource Center, as well as the 2019 QRDA I Implementation Guide, also available on the eCQI Resource Center.

In addition to our various proposals on changing the IQR Program, we are also seeking public comment on the inclusion of two new measures to the Hospital IQR Program in the future, a claims-only hospital-wide mortality measure and a hybrid version of the same hospital-wide mortality measure that uses both EHR data and claims data, as well as another measure that would measure Hospital Harm - Opioid-Related Adverse Events and this is an eCQM. For the hospital-wide mortality measure, we are specifically seeking public comments about the service line division structure of the measure, as well as input on the measure testing approach, and how the measure results might be presented to the public. For the Opioid-Related Adverse Event measure, we are seeking public comment on whether to initially introduce this measure as voluntary, adopt the measure into the existing eCQM measure set, or to adopt the measure as mandatory for all hospitals, as well as we are seeking public comment on ways to address any potential unintended consequences in future implementation of this measure.

Additionally, we are reaching out to our stakeholders to continue to identify areas for improvement in the use and implementation of eCQMs

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

under a variety of CMS programs, including the Hospital IQR Program. Stakeholders have expressed support for increasing availability of new eCQMs, developing eCQMs that focus more on patient outcomes rather than care processes, and (creating eCQMs) that are higher impact and more meaningful. As part of this effort, we are committing to seek the public's feedback on exploring how eCQMs reduce the cost and information collection burden associated with quality measurements, as well as to help us identify barriers which may contribute to a lack of adequate development of eCQMs and limit their potential, and as such, we are seeking stakeholder feedback on ways that we could address the challenges that we currently face related to the use of eCQMs.

On this slide, there are several more questions and areas where we seek the public's input with respect to eCQMs.

Now, I would like to turn to proposals related to the Hospital Value-Based Purchasing Program, or VBP Program. In the proposed rule, we estimate that the total amount available for value-based incentive payments for Fiscal Year 2019 will be approximately \$1.9 billion. This reflects the statutory requirement that applicable percent withhold for Fiscal Year 2019 is two percent to be able to fund Hospital VBP Program payment adjustments.

Also, the proposed rule includes Table 16, which is a list of the Proxy Adjustment Factors by hospital CCN. In creating Table 16, we used the Total Performance Scores from the Fiscal (Year) 2018 Hospital VBP Program, which are the most recently available Total Performance scores. In the IPPS final rule, we will include Table 16A, which will be an updated set of Proxy Adjustment Factors. Then, later this fall, we will post, onto the *CMS.gov* website, Table 16B, which will be the actual final payment adjustment factors for Fiscal Year 2019. Table 16B will use the Total Performance Scores from the Fiscal Year 2019 Program Year.

With respect to the measures used in the Hospital VBP Program, we are proposing to remove a total of ten measures from the Hospital VBP Program, as they are listed on this slide. For the PC-01, CAUTI, CLABSI,

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

MRSA, CDI, and SSI measures, we are proposing to remove them beginning with the Fiscal Year 2021 Program Year, which would use Calendar Year 2019 reported data. For the claims-based measures, PSI 90, the AMI payment, heart failure payment, and pneumonia payment measures, we are proposing to remove them with the effective dates of the IPPS final rule which will be October 1, 2018, as these measures would not be used in the Hospital VBP Program until future years as finalized in prior rules.

Specifically, regarding the measures in the Hospital VBP Program Safety domain, we are proposing to remove the five hospital-associated infection measures, the PC-01 measure, and the PSI 90 measure. We are not proposing to add any new measures to the Safety domain. So, if our proposal to remove all the current measures in the Safety domain are finalized, then there would be no measures remaining in the Safety domain. So, in that situation, we are also proposing to remove the Safety domain altogether from the Hospital VBP Program beginning with the Fiscal Year 2021 Program Year. I would like to note that the five HAI measures and the PSI 90 measure will continue to be used in the Hospital-Acquired Condition Reduction Program or the HAC Reduction Program. We believe that the use of the safety measures in that program is the best place to focus on the safety aspect of care quality in thinking about all of our hospital quality payment programs as a whole. I would also like to note that the PC-01 measure will continue to be used in the Hospital IQR Program.

So, if our proposal to remove the safety measures from the Safety domain are finalized, as well as the removal of the Safety domain from the Hospital VBP Program, we are proposing to make changes to the Hospital VBP Program scoring methodology and, in particular, the domain weight for the remaining program domains. The current Clinical Care domain we're also proposing to rename as the Clinical Outcomes domain, and we are proposing to weight it as 50 percent of the hospital's Total Performance Score. We would also retain the same domain weights of 25

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

percent for each of the Efficiency and Cost Reduction domain and the Person and Community Engagement domain.

In terms of minimum data requirements to be able to calculate the Total Performance Score for each hospital, we are also proposing specific minimum case or survey requirements depending on the domain. For the Person and Community Engagement domain, we're proposing to require a minimum of 100 HCAHPS surveys. For the Efficiency and Cost Reduction domains, which uses the Medicare Spending per Beneficiary measure, we're proposing a minimum of 25 episodes of care. For the Clinical Outcomes domain, which contains the mortality and hip/knee complications measure, we are proposing a minimum of 25 cases to be able to calculate each of those measures and to be able to have at least two measure scores to calculate the Clinical Outcome domain score. To be able to calculate the Total Performance Score for each hospital, we would require scores for all three of the remaining domains.

So, to help summarize the measures that are included in the Hospital VBP Program for each Fiscal Program Year, this slide shows, for Fiscal Year 2019, what domains and the measures are included and will be used for the calculation of each hospital's Total Performance Score. For Fiscal Year 2019, there are no proposed changes from what we had previously finalized. So, there would be four domains, each weighted at 25 percent. This slide shows all of the measures that are used in each domain.

This slide also shows the baseline and performance periods for the measures used in the Fiscal Year 2019 program.

For Fiscal Year 2020, again there will be no changes to the program requirements or the domains or measures used in the program that's previously finalized. So, we would continue to have four domains each equally weighted at 25 percent, and this slide shows the measures that would be used to calculate each of the domains.

This slide shows the baseline and performance periods for the Fiscal Year 2020 program year.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Beginning with Fiscal Year 2021, this is when our proposal to remove measures and to reweight the domains would go into effect if finalized. We would have only three domains, with the Clinical Outcomes domain weighted at 50 percent, and the Efficiency and Cost Reduction domain and the Person and Community Engagement domain would each be, continue to be, weighted at 25 percent of Total Performance Score.

This slide shows what the baseline and performance periods for the measures used in the Fiscal Year 2021 Program Year would be, and again, as you will note, if our proposals are finalized, there would no longer be a Safety domain, as those measures that were in the Safety domain would continue to be used in the Hospital-Acquired Condition Reduction Program.

This slide shows what the domains and the measures would look like for Fiscal Year 2022 through Fiscal Year 2024.

This slide shows what the proposed measurement periods would be based on performance periods for each of the measures used in the Fiscal Year 2022 Program Year, and this is if our proposal to remove various measures are finalized.

This slide would be for Fiscal Year 2023.

This slide would be for Fiscal Year 2024.

Now I will turn things over to the Hospital-Acquired Condition Reduction Program. Thank you.

Elizabeth Bainger: Thank you, Grace. My name is Elizabeth Bainger and I am the Program and Policy Lead for the Hospital-Acquired Condition, or HAC Reduction Program, and I want to thank everyone for joining us today. I'm pleased to have this opportunity to talk with you about the recently published proposed rule as it relates to the HAC Reduction Program. I'm only going to provide a very high-level overview during this webinar because of time constraints. I expect that you'll have questions and want more details that I'm able to provide today, so I encourage you to read the rule for more

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

information. Remember, the proposed rule is your definitive source for information and I strongly recommend that you read it and please take the time to also comment during the public comment period.

As Grace previously described, the Meaningful Measures initiative is intended to provide for the most parsimonious and least burdensome measure sets. We've taken a holistic approach to evaluating the appropriateness of the HAC Reduction Program's current measures in the context of the measures used in other inpatient value-based purchasing programs. As the program's name conveys, among the quality reporting programs, the HAC Reduction Program is the flagship for patient safety. It focuses on reducing harm caused in the delivery of inpatient care; therefore, we have determined that all of the measures currently included in the program should be retained because these measures address a performance gap in patient safety by reducing harm caused in the delivery of care. We are not proposing to add or remove any measures from the HAC Reduction Program. However, in an effort to eliminate duplicative measures, and as already described in the webinar, the Hospital IQR and the HVBP Programs are proposing to remove the safety composite and HAI measures listed on this slide. I want to stress that all the HAC Reduction Program administrative policies that I will be discussing in this webinar, related specifically to the HAI measures, are contingent upon the Hospital IQR Program finalizing its proposal to remove NHSN HAI measures from its program.

In last year's rule, the HAC Reduction Program finalized a return to a 24-month data collection period. We continue to believe that using 24 months of data for the CMS PSI 90 and the NHSN HAI measures balances the program's needs against the burden posed on hospital data collection processes, and it allows for sufficient time to process the data for each measure and calculate the measure results. The applicable period for the Fiscal Year 2021 HAC Reduction Program for the CMS PSI 90 is the 24-month period from July 1, 2017, through June 30, 2019. The applicable period for the NHSN HAI measures is the 24-month period from January 1, 2018, through December 31, 2019.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Specifically, with respect to the HAI measure data, the HAC Reduction Program has historically relied on Hospital IQR Program processes for administrative support and, so, we must propose policies related to data collection requirements. We are proposing to adopt data collection processes for the HAC Reduction Program beginning with January 1, 2019 infection events. Reporting requirements, including reporting frequency and deadlines, will not change in the current Hospital IQR Program requirement. It's our intention that this change will be seamless from the hospital perspective. We're also proposing to adopt the Hospital IQR Program's exception policy to reporting and data submission requirements for the CAUTI, CLABSI, and colon and abdominal hysterectomy SSI measures. If a hospital does not have adequate locations or procedures, it should submit the Measure Exception Form to the HAC Reduction Program beginning on January 1, 2019. As has been the case under the Hospital IQR Program, hospitals seeking an exception must submit this form at least annually to be considered. We've provided the *QualityNet* link to the Measure Exception Form on the resource slide at the end of the HAC Reduction Program's part in this presentation.

Beginning in Fiscal Year 2019, the HAC Reduction Program intends to provide the same HAI measures quarterly reports that stakeholders are accustomed to under the Hospital IQR Program; however, some hospitals that elected not to participate in the Hospital IQR Program may be unfamiliar with these reports. They provide your facilities quarterly measure data, as well as facility, state-, and national-level results for the measures. To access your report, hospitals must register for a *QualityNet Secure Portal* account. Here's one area where you, the stakeholder, will see a difference with this changeover from Hospital IQR to the HAC Reduction Program. Hospitals will receive reports from both the HAC Reduction Program and the Hospital IQR Program for their respective measures. So, now you will receive multiple reports.

In the Fiscal Year 2014 final rule, we detailed the process for the submission, review, and collection of claims-based data and we are not proposing any changes. Hospitals are encouraged to review and correct

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

their claims data in compliance with the time limits in the Medicare Claims Processing Manual. So, with respect to the HAC Reduction Program, the deadline for Fiscal Year 2019 has already passed. The deadline for Fiscal Year 2020 will be this coming September, September of 2018.

The HAC Reduction Program previously addressed the submission review and correction of HAI data both in the Fiscal Year 2014 and Fiscal Year 2018 Final Rule and we are not proposing any changes to our policies. For the purposes of fulfilling CMS quality measure reporting requirements, each facility's data must be entered into NHSN no later than the four-and-a-half months after the end of the reporting quarter because CMS does not receive or use data entered into NHSN after that deadline. Hospitals are encouraged to submit data early in the submission schedule, not only to allow you sufficient time to identify errors and resubmit data before the quarterly submission deadline, but also because it gives you a chance to identify opportunities for continued improvement.

We are proposing all subsection (d) hospitals subject to the HAC Reduction Program be subject to validation. This is a bit of a change. Under the Hospital IQR Program, only hospitals with active Notices of Participation were included in the validation sample. Under the HAC Reduction Program, we are proposing that all subsection (d) hospitals subject to the program also be included in validation. In addition, hospitals must electronically acknowledge that the data they are submitting are accurate and complete to the best of their knowledge. Hospitals are required to complete and sign the Data Accuracy and Completeness Acknowledgement on an annual basis via the *QualityNet Secure Portal*. The initial HAC Reduction Program proposed DACA signing and completing period will be April 1 through May 15, 2020, for Calendar Year 2019 data.

The previous slide indicated that 200 hospitals will be targeted for validation. This is in keeping with the process under the Hospital IQR Program, but the Hospital IQR Program currently assesses the accuracy of eCQM data and of chart-abstracted data and that includes clinical

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

processes of care measures, as well as HAI measures. The HAC Reduction Program does not currently include eCQMs, and we don't include clinical process of care measures. So, the targeting criteria that we are proposing, while similar to what IQR had previously finalized, is a bit different. We are proposing the following targeting criteria for the HAC Reduction Program: any hospital that submits data to NHSN after the HAC Reduction Program data submission deadline has passed, any hospital that has not been previously randomly selected for validation in the past three years, any hospital that failed validation in the previous year, any hospital that passed validation in the previous year but had a two-tailed confidence interval that included 75 percent, and any hospital which failed to report to NHSN at least half of the actual HAI events as determined during the previous year's validation effort. So, let me focus on that fourth bullet for a minute, the one that talks about the confidence interval.

We will provide a two-tailed confidence interval using only HAI measures for the HAC Reduction Program. This will be posted to the *QualityNet* website. So, with regard to the validation confidence interval, at a high level, this is how the proposal will work. First, we will score hospitals based on an agreement rate between the hospital-reported infections compared to events identified as infections by a trained CMS extractor using a standardized protocol. Next, we will compute a confidence interval. Then, if the upper bound of this confidence interval is 75 percent or higher, the hospital will pass the HAC Reduction Program validation requirement, but, if the upper bound is below 75 percent, the hospital will fail the HAC Reduction Program validation requirement. In addition, we are proposing to penalize hospitals that failed the validation requirement by assigning the maximum Winsorized z-score only for the set of measures CMS validated. We believe this aligns with the current HAC Reduction Program of assigning the maximum Winsorized z-score if hospitals do not submit data to the NHSN for a given HAI measure. Within 30 days of the validation results being posted on the *QualityNet Secure Portal*, if a hospital has a question or needs further clarification on a particular outcome, then you may request an educational review. But, here's the difference between the current Hospital IQR (Program) policy

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

and the policy that we're proposing for the HAC Reduction Program. Under the IQR policy, educational reviews can only be requested for the first three validation quarters. We are proposing that hospitals can request educational reviews for all four validation quarters under the HAC Reduction Program. If an educational review is requested timely and that review indicates an error on the CMS side, then the corrected quarterly score will be used to compute the final confidence interval.

Currently, the HAC Reduction Program utilizes NHSN HAI data from two calendar years to calculate measure results. For example, Fiscal Year 2022 measure reporting quarters includes quarter one 2019 through quarter four 2020, and that's what you see in the first column of this table. We are proposing that the HAC Reduction Program's validation period include the four middle quarters in the HAC Reduction Program's performance period, that is third quarter through second quarter. You see those rows shaded in blue on the table. Because we need to select our validation sample, and because of the time needed to build the required infrastructure, we believe the earliest opportunity to seamlessly begin this work under the HAC Reduction Program is quarter three 2019. Therefore, we are proposing that the HAC Reduction Program begin validation of NHSN HAI measures with data beginning with July 2019 infection event data. All of these validation requirements are laid out in more detail in the proposed rule, so I strongly encourage you to read it for more information.

Now, I'd like you to recall that, back on slides 54 and 55, I talked about when you could submit and correct your underlying claims data or HAI data for use in the HAC Reduction Program. Using that data each year, CMS calculates your hospital's safety composite measure results and measure scores, your CLABSI, CAUTI, SSI, MRSA and C. diff measure scores, Domain 1 and 2 scores and your hospital's total HAC score. These scores are included in hospital-specific reports, or HSRs which are distributed via the *QualityNet Secure Portal* usually in August.

After the scores are calculated and the HSRs are distributed, you have 30 days to review and request recalculation of your hospital scores. We currently call this 30-day period the Review and Corrections Period. It's

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

an opportunity to submit questions about the calculation of your hospital scores and request correction of the calculation errors. CMS intends to rename this annual 30-day period as the Scoring Calculations Review and Corrections Period because we believe that the new name will more clearly convey both the intent and the limitation. The intent is to allow hospitals an opportunity to review and correct score calculations. The limitation is that it's a 30-day period that does not allow you an opportunity to correct underlying data. We are not proposing to change any of our policies surrounding this 30-day review period; we are simply changing the name to make it more clear. Now, I'm going to pass the discussion to Dr. Joe Clift, who is the Measures Lead for the HAC Reduction Program. Joe will talk about scoring methodologies that we've proposed in this year's rule. Thank you.

Dr. Joe Clift:

Thank you, Elizabeth. This proposal is intended to address the impact of disproportionate weighting at the measure level for the subset of hospitals with relatively few NHSN HAI measures. For hospitals with measure scores for all six program measures, the weight applied to the CMS PSI 90 composite safety measure and each HAI measure is almost the same, 15 and 17 percent respectively. However, for hospitals with a measure score for only one or two Domain 2 NHSN measures, that is low-volume hospitals in particular, a disproportionately large weight is applied to each Domain 2 measure. For example, under the current weighting methodology, hospitals reporting on a single NHSN HAI measure received 85 percent measure weight for that one measure. As part of our continual improvement efforts, we examined options to allow the scoring methodology to continue to fairly assess all hospitals. We present two options in this year's proposed rule. CMS prefers the Equal Measure Weights option, which involves removing domains and applying an equal weight to each measure for which a hospital has a measured score. However, we are seeking public comment on an additional approach applying a different weight to each domain depending on the number of members for which a hospital has a measure score. We're referring to this as the Variable Domain Weights.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Under the proposed Equal Measure Weight proposal, we will remove domains from the HAC Reduction Program and simply assign equal weight to each measure for which a hospital has a measure score. We will calculate each hospital's total HAC score as an equally-weighted average of the hospital's measure scores. The table here displays the weights applied to each measure under this approach. For example, as you can see in the table, hospitals with a CMS PSI 90 score and one NHSN measure, that is two measures in total, would have 50 percent weighting for each. A hospital with a CMS PSI 90 score and three NHSN measures, that is four measures in total, would have 25 percent weighting for each measure. All other aspects of the HAC Reduction Program scoring methodology would remain the same, including the calculation of measure scores as Winsorized z-scores, the determination of the 75th percentile total HAC score, and the determination of the worst-performing quartile. As stated before, CMS prefers this approach because it aligns with the original program design to apply a similar weight to each measure. Also, if we add or remove measures from the program in the future, we would not need to modify the weighting scheme under this approach. It is simple, clear, and easy to understand.

Under the alternative approach, called the Variable Domain Weights, the domains are retained; however, the weights applied to Domain 1 and Domain 2 depend on the number of measure scores a hospital has in each domain. Where hospitals have fewer than five NHSN measures, the weighting applied to Domain 1 and 2 changes, so hospitals that had fewer NHSN measures would have more weight applied to Domain 1 than hospitals that have more NHSN measures. Hospitals that have data for all five NHSN measures and a score for the CMS PSI 90 would have a total HAC score based on our current existing Domain 1 (15 percent) and Domain 2 (85 percent) weighting. Under this approach, should CMS propose to add or remove measures, that might impact the domain weighting depending on the measure type and number of measures. For example, if CMS were to add a new patient safety measure and a new infection measure, that would add an additional measure to each domain; thus, the domain weightings would need to be reevaluated.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Our priority is to adopt a policy that improves the scoring methodology and increases fairness for all hospitals. Those proposed approaches address stakeholders' concerns about the disproportionate weight applied to Domain 2 measures for low-volume hospitals. We've simulated results under each scoring approach using FY 2018 HAC Reduction Program data. We've compared the percentage of hospitals in the worst-performing quartile in Fiscal Year 2018 to the percentage that would be in the worst-performing quartile under each scoring approach. This table provides a high-level overview of the impact of these approaches on several key groups of hospitals. As you can see, using FY 2018 HAC Reduction Program data, for smaller hospitals, 100 or fewer beds, there would be 1.8 percent fewer hospitals in the worst-performing quartile under Equal Measure Weight as compared to current program scoring. For hospitals with only one NHSN measure, there would be 4.2 percent fewer hospitals in the worst-performing quartile under the Equal Measure Weights as compared to current program scoring. Again, CMS prefers the Equal Measure Weights approach because it reduces the percentage of low-volume hospitals in the worst-performing quartile in the simplest manner for hospitals while not greatly increasing the burden on other hospital groups. In addition, it allows greater flexibility with adding or removing measures from the program since each measure is equally weighted for which a hospital has a score.

Also, in this rule, we are inviting comment not only on the proposals discussed thus far, but we are also seeking comment on additional measures for future adoption in the HAC Reduction Program. We are specifically interested in stakeholder comments regarding the potential for the program's future adoption of electronic clinical quality measures, or eCQMs. These measures use data from electronic health records and other health information technology systems to measure healthcare quality. We are interested in adopting eCQMs because we support technology that reduces burden and allows clinicians to focus on providing high-quality healthcare for their patients. We believe eCQMs offer many benefits to clinicians and quality reporting and are an improvement over traditional quality measures because they leverage the EHR to generate chart-

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

abstracted data which is less resource-intensive and likely to produce fewer human errors than traditional chart abstraction.

So, I'll conclude my piece by providing you with some additional HAC Reduction Program resources. Please note that the last two links are for stakeholder questions. I want to thank you for your time and attention and I'll now pass the presentation to my colleague, Erin Patton, to talk about the readmissions program.

Erin Patton:

Thank you, Joe. Good afternoon. Today, I will be providing a high-level overview of the proposed rule for the Hospital Readmissions Reduction Program. Detailed information can be found in the published rule or at the resources provided at the end of my presentation.

On this slide, you will see a summary of the proposals for Fiscal Year 2019 which include establishing the applicable periods, codifying previously finalized definitions, and (providing) a brief overview of how the Hospital Readmissions Reduction Program has approached the Meaningful Measures initiative.

The Hospital Readmissions Reduction Program, or HRRP, includes six claims-based readmission measures that are listed here, including acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective primary total hip and total knee arthroplasty, and coronary artery bypass graft surgery. All six measures will remain for Fiscal Year 2019. Discharge diagnoses for each applicable condition are based on a list of specific ICD-9 or ICD-10 code sets.

The applicable periods for HRRP use three years of claims data. For Fiscal Year 2019, the dates are July 1, 2014, to June 30, 2017. Subsequent dates for Fiscal Year 2020 and Fiscal Year 2021 can be found on this slide.

The Fiscal Year 2019 rule codifies the following previously finalized definitions: dual-eligible, which is identified as a full-benefit dual patient, that is, Medicare fee-for-service and Medicare Advantage patients and data from the state Medicare Modernization Act, or MMA, file; the dual proportion definition, which is the number of dual-eligible among all

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Medicare fee-for-service and Medicare Advantage stays during the applicable period and, finally, the applicable period for dual eligibility, defined as the three-year measure performance period which will account for social risk factors in the excess readmission ratio. This is the same as the applicable period otherwise adopted for the program.

As was mentioned earlier in the webinar, program measures were reviewed to take a holistic approach to evaluating their appropriateness in the HRRP Program. The outline box around Promote Effective Communication and Coordination of Care notes that the readmissions measures fall under this domain and are appropriately included in HRRP; therefore, we have determined that all measures currently in the program will remain.

In addition to the Meaningful Measures initiative, CMS also continues to consider options to address equity and disparities in its Value-Based Purchasing Program. In response to the 21st Century Cures Act in the ASPE report, CMS finalized policy to compare cohorts of hospitals to each other based on their proportion of dual-eligible beneficiaries which, based on the ASPE report, was the greatest predictor of poor healthcare outcomes among social risk factors tested. It is our goal to improve health disparities by increasing transparency and the ability to compare disparities across hospitals.

CMS welcomes public comments on the Fiscal Year 2019 proposals for HRRP. This slide also contains more detailed resources on the Hospital Readmissions Reduction Program and resources on reducing hospital readmissions. Thank you for your time and attention today. I will hand it back over to Candace.

Candace Jackson: Thank you, Erin. In these next several slides, you will find a summary of the measures included in all of the Inpatient Quality Programs, which programs they are included in, and the fiscal years that they are applicable for.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

This slide provides you with a direct link to the Fiscal Year 2019 IPPS Proposed Rule and the pages for each of the specific programs.

Then, lastly, CMS is accepting comments on the Fiscal Year 2019 IPPS Proposed Rule until June 25, 2018. Comments can be submitted either electronically, by regular mail, by express or overnight mail, or by hand courier. Please note that you should review the proposed rule for specific instructions for each method and submit by only one method. CMS will respond to comments in the final rule which is scheduled to be issued August of 2019.

At this time, we will continue the webinar by going into our live question and answer (Q&A) session. I'd like to thank Elizabeth, Grace, Joe, and Erin for providing the information today. In addition to them, we also have from CMS Mahir Patel, Joann Fitzell, and Kristie Baus who will also be addressing some questions for us or responding to questions for us. We do have time for a short question and answer session. So, we'll start our first few questions with questions that came in in regard to *Hospital Compare* and Star Ratings that seem to be a topic of interest in the chat box. Our first question: Given that HCAHPS linear mean scores are used for both HCAHPS summary star scores and hospital overall star scores, does CMS anticipate modifying the VBP methodology from Top-Box to linear mean scores (which would meet the Meaningful Measures framework of measure alignment)?

Kristie Baus: Excuse me, Candace. This is Kristie. I don't know if I can answer the question about the VBP, whether that methodology will be changing in regard to the reporting of HCAHPS data and the removal of the pain question. So, maybe I didn't hear the question fully.

Candace Jackson: Would you like me to repeat it again? Otherwise, all questions will be responded to at a later date and that would give you time to research it.

Kristie Baus: Okay. That's fine. Thank you.

Candace Jackson: Okay. I do want to remind everyone that, as we noted in the beginning of the presentation, CMS will not be able to provide additional information,

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

clarification, or guidance related to the proposed rule. So, on some other questions, they may not be able to respond, or maybe they'll only be able to give a high-level overall response. With that being said, I'll try to continue with some *Hospital Compare* questions. The next question: If a measure is removed from IQR, such as CLABSI or CAUTI, is it still included in the *Hospital Compare* Star Rating and how often will it be updated on the *Hospital Compare* website?

Kristie Baus: So, this is Kristie Baus again. In regard to the Meaningful Measures work, our goal is to make the front-end website display as seamless as possible for our users and for the different audiences of the website. That said, we're still looking at different ways to make that happen and (we are) assessing the impact to the star ratings as we speak. So, more information to come on that.

Candace Jackson: Thank you, Kristie. Our next question: What date does reporting period 2019 correspond to?

Kristie Baus: Which measures? They do vary. Which program?

Candace Jackson: They did not say. They are not specific. In regards to the majority of the terms drafted in IQR measures, maybe not so much the claims-based, the reporting period of 2019 would mean that would include discharges from January 1, 2019 through December 31, 2019. I hope that at least answers the question. We have a similar question and that says, "So, what date do you stop abstracting ED-1?" Again, that measure is being removed beginning with reporting period 2019. So, the last discharges that would be included for ED-1 in the IQR Program would be December 31, 2018. Our next question: Will we use the *QualityNet Secure Portal* when the measures change from the IQR Program to the HAC Program (e.g., CAUTI, CLABSI, SSI, and MRSA)?

Elizabeth Bainger: Hi, this is Elizabeth Bainger. So, is the question about how to obtain the HSRs? If that's what the question is, yes, the hospital-specific reports will be available through the *QualityNet Secure Portal*.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Candace Jackson: I believe maybe, Elizabeth, that they're asking if they no longer submit IQR measures, maybe such as the chart-abstracted. Would they still use the *Secure Portal* to submit other measures? They've specifically asked for CAUTI, CLABSI. So, I believe that, even though it's going from IQR to HAC, they would still use NHSN as the mode to submit that data. Is that correct?

Elizabeth Bainger: Yes, that's correct. HAI measures, the healthcare-associated measures, are still submitted through CDC's NHSN site, not through the *Secure Portal*, but they will receive their hospital-specific reports through the *Secure Portal*.

Candace Jackson: Thank you, Elizabeth. Our next question: Will claims-based measures that are being removed from the IQR Program still be calculated on behalf of critical access hospitals that are ineligible to participate in VBP?

Kristie Baus: Hi, this is Kristie. The answer to that is, that is our intention, yes, to continue displaying data for those hospitals that are not applicable to the various payment programs.

Candace Jackson: Thank you, Kristie. A general question: When will the proposed changes have a final decision?

Kristie Baus: So, this is Kristie again. By statute, the final rule has to be published no later than August 1. So, it'll be around August 1 of this year when things will be finalized.

Candace Jackson: Thank you, Kristie. The next question: If measures are removed from the IQR Program, does it mean that it will delay the reports we receive from CMS that provide our performance detail?

Kristie Baus: The Meaningful Measures initiative should not impact the timeline of receiving your reports.

Candace Jackson: Thank you, Kristie. Our next question: Part of the Safety domain on slide 4, if we could go to slide 41, includes PC-01 for VBP. Is it included in the HAC Program mentioned under slide 51?

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Kristie Baus:** No.
- Candace Jackson:** Thank you. Our next question, and we have several questions in regard to the eCQM validation and validation in general: Will hospitals be selected for both chart-abstraction and eCQM validation?
- Mahir Patel:** Hi, this is Mahir. No. The way we have laid this out in the final rule is hospitals will be either selected for chart-abstracted or eCQMs and that was finalized last year.
- Candace Jackson:** Thank you. On that same note then, Mahir. Will IQR chart-abstracted measures still be included for inpatient validation or just HAI measures?
- Mahir Patel:** So, any measures that are part of IQR Program will be subject to validation.
- Candace Jackson:** Thank you, Mahir. The next question is still kind of related to validation: Did I interpret correctly that all hospitals will undergo validation for HAI as part of the HAC Reduction Program?
- Mahir Patel:** No. So, we will be selecting randomly, as Elizabeth mentioned, 400 hospitals from all of the subsection (d) hospitals. So, it'll be a random pool of 400 hospitals, and then, additionally, we will be selecting 200 targeted hospitals based on the targeting criteria that Elizabeth mentioned.
- Elizabeth Bainger:** Thank you. Hi, this is Elizabeth. Just to clarify, under the HAC Reduction Program, all subsection (d) hospitals are subject to validation. That does not mean that they will be chosen for validation as Mahir just described.
- Candace Jackson:** Thank you, Elizabeth. Our next question: What AHRQ version will be used for the Fiscal Year 19 and Fiscal Year 20 PSI data for the HAC Reduction Program?
- Dr. Joe Clift:** Hi, this is Joe. We're going to be using version 8.0, which is the recalibrated version, based on the fee-for-service population for FY 19.
- Candace Jackson:** Thank you, Joe. Our next question: On slide 35, we'd like to go to that slide, it lists AMI payment, heart failure payment, and pneumonia

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

payment on VBP measure listings removed for Fiscal Year 2021, but it only lists MSPB for Fiscal Year 2019 on slide 39. Please advise. Are separate payment measures part of Fiscal Year 2019 and Fiscal Year 2020?

Bethany Bunch: Hi, Candace. This is Bethany Bunch. I can answer that one. In previous rules, CMS had finalized that these two payment measures, AMI and heart failure payment, were supposed to be included starting in FY 2021. The current proposal is to remove those two measures from VBP and that proposal would be made effective immediately. However, they weren't supposed to be included originally until FY 2021. So, that's why you're seeing that designated on that previous slide, but, no, they would not be included in FY 19 or FY 2020 either.

Candace Jackson: Thank you, Bethany. One last question for today: For the Hospital Harm - Opioid-Related Adverse Events, would it only be for the inpatient population?

Kristie Baus: Is there anyone from CMS? I believe that might be in relation to...

Dr. Joe Clift: Hey, Candace. This is Joe. Can you repeat that question again, please?

Candace Jackson: Of course. For the Hospital Harm - Opioid-Related Adverse Events, do they only include the inpatient population?

Dr. Joe Clift: Yes. That is the eCQM harm measure and that only includes inpatients.

Candace Jackson: Thank you, Joe. Okay, that concludes our question-and-answer session for today. As we indicated earlier, all questions that have been submitted will be responded to and posted at a later date to our *Quality Reporting Center* website. I would again like to thank all of our speakers from the Centers for Medicare & Medicaid Services today. I will now turn the presentation over to Dr. Debra Price to go over the CEU process. Deb, the floor is yours.

Dr. Debra Price: Well, hello and thank you for allowing me time to go over these credits. Today's webinar has been approved for 1.5 continuing education credits

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

by the boards listed on this slide. We are now a nationally accredited nursing provider and, as such, all nurses report their own credits to the boards using the National Provider Number 16578.

We now have an online CE certificate process. You can receive your certificate two different ways. First way: If you registered for the webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. Second way: To receive your certificate, within 48 hours, your host will be sending out another survey link. If there are other people in the room that are listening to this event, this is the time that you can send the link to them.

If you do not immediately receive a response to the email that you signed up with in our Learning Management Center, you probably have a firewall that's blocking our automatic link. If that's the case, please go back and use a New User link and use your personal email, as well as your personal phone number.

This is what the survey will look like at the end of this event. It will pop up and will be sent to all attendees within 48 hours. At the bottom, you'll notice the little grey Done box. Click that and this is the page that's going to pop up. You notice that there are two links in this page, the New User link and Existing User link. If you've been getting certificates all along and haven't had any problems, please click on the Existing User link. If you have had problems, that's when we'd like you to use the New User link and input your personal email, as well as a personal phone number.

This is what the New User site will look like. You put in your first name, your last name, your personal email, and personal phone number.

This is what the Existing User slide will look like. Your User Name is your complete email address, including what's after the @ sign. Your password is whatever you used to sign up. If you forgot your password, it's okay. Just click in that box and you will be shown what to do next.

Now, I thank you for attending the webinar. I hope that you learned something. Please enjoy the rest of your day.