Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System Final Rule
Presentation Transcript

Speakers

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Karen VanBourgondien: Hello, everyone. My name is Karen VanBourgondien. I am with the Outpatient Quality Reporting Support Contractor. Thank you for joining us today as CMS discusses the finalized proposals in the calendar year 2025 OPPS/ASC final rule as it relates to the [Hospital] OQR and REH Quality Reporting Programs.

Our speakers today are Kimberly Go and Dr. Anita Bhatia. Kimberly is the Program Lead for the Hospital Outpatient Quality Reporting Program. She joined CMS' Center for Clinical Standards and Quality in late 2022 and previously worked in the Center for Medicare where she gained experience in rulemaking and policy development for the Medicare hospital payment policy. Anita is the CMS Program Lead for the Rural Emergency Hospital Quality Reporting Program. Dr. Anita Bhatia plays a crucial role in development of the proposed and final rulings, and her contributions to the rulings are essential to the continued success of these programs.

The objectives for today are here on the slide. We will show you where to locate the rule in the *Federal Register*. Kim will discuss the three health equity measures that pertain to both the Hospital OQR and the REH Quality Reporting Programs, as well as the finalized proposals specific to the Hospital OQR Program. Anita will discuss then finalized proposals as they relate to the REH Quality Reporting Program.

If you did not download the slides from our website at QualityReportingCenter.com, you can just simply download them now by clicking on the icon on the right side of your menu.

Here we have the direct link to the final rule in the *Federal Register.* We do recommend you read the rule we are just summarizing today. So, if you have time to access the final rule for a more complete understanding of the finalized action, that might provide more clarity. Without any further delay, let me turn things over to Kim to discuss the finalized proposals that pertain to both the Hospital OQR and the REHQR Programs. Kim?

Kimberly Go: Thank you, Karen. Under the Biden-Harris administration, CMS committed to advancing health equity through our quality reporting programs. According to the CMS Framework for Health Equity, addressing health and healthcare disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities.

To support this framework and address significant disparities in health outcomes, we proposed the addition of three measures centered on health equity: the Hospital Commitment to Health Equity measure, or HCHE; the Screening for Social Drivers of Health, or SDOH, measure; and the Screen Positive Rate for SDOH, or Social Drivers of Health, measure. In adopting these measures in the Hospital OQR and REHQR programs, CMS is aligning with other Medicare quality reporting programs with the goal of ensuring equitable care across health care settings to the greatest extent possible. These measures will incentivize quality reporting entities to collect and utilize data to identify critical equity gaps, implement plans to address said gaps, and ensure that resources are dedicated towards health equity initiatives.

First, the Hospital Commitment to Health Equity, or HCHE, measure, which assesses a hospital or REH's commitment to health equity using five attestation domains, which you see listed here. We proposed that mandatory reporting for this measure would begin with the calendar year 2025 reporting period for the calendar year 2027 payment determination. More details on these domains and the elements within can be found in the final rule.

The HCHE measure is calculated on points achieved in the five domains. The numerator captures the total number of domains to which the hospital or REH can attest affirmatively, up to a maximum of five domains. The denominator consists of a total of five points; that is one point per domain. A hospital or REH will only receive a point for a domain if it attested Yes to all of the elements within that domain.

We will not accept an attestation whereby a hospital or REH attests Yes to some, but not all, of the elements; in the event a hospital or REH is not able to attest Yes to one or more elements within a domain, they will respond No.

Social Drivers of Health, or SDOH, is an umbrella term that refers to community-level factors that impact health and well-being. Health-related social needs, or HRSNs, are social and economic needs that affect an individual's ability to maintain their health and well-being. We selected five evidence-based domains to screen for HRSNs, which are noted here on the slide. These domains will be used for both the Screening for SDOH and Screen Positive Rate for SDOH measures, and their descriptions can be found in the final rule.

The Screening for SDOH measure assesses the total number of patients aged 18 years or older that were screened for social risk factors, specifically the five HRSNs we just discussed on the date of service. Voluntary reporting will begin in the calendar year 2025 reporting period followed by mandatory reporting beginning with the calendar year 2026 reporting period for the calendar year 2028 payment determination.

The Screening for SDOH measure is calculated as a percentage equal to the numerator over the denominator. The numerator is defined as the number of patients aged 18 years or older who are screened for all five HRSNs on the date of admission. The denominator is defined as the total number of patients who are admitted to a hospital outpatient department or REH, as applicable, and who are 18 years or older. The measure excludes patients who opt out of screening or are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

Hospitals and REHs will use a self-selected screening tool for data collection to reduce burden and in recognition of the fact that some healthcare facilities may already be screening their patients for HRSNs.

We refer readers to evidence-based resources like the SIREN website for screening tool options as well as the Accountable Health Communities, or AHC Model, screening tool on CMS.gov. In alignment with the Hospital IQR Program, hospitals could confirm the current status of any previously reported HRSNs in another care setting and inquire about others not previously reported, in lieu of re-screening a patient within the reporting period.

Hospitals will aggregate data they collect for the numerator and the denominator and submit to CMS. They will not be required to submit patient-level data. We require aggregate data because we believe patient-level reporting is unnecessary and would cause undue burden due to the transfer of large quantities of data. However, in the future, we may consider requiring the reporting of patient-level information. We believe that starting with voluntary reporting, followed by mandatory reporting, will provide a transition period for healthcare facilities to select and integrate screening tools into their clinical workflow processes.

Our third proposed health equity measure is the Screen Positive Rate for SDOH measure. The Screen Positive Rate for SDOH is a process measure that provides information on the percentage of patients receiving care at a hospital who were 18 years or older on the date of service, who were screened for all five HRSNs and who screened positive for one or more of those HRSNs. As with the Screening for SDOH measure, we proposed to adopt this measure beginning with voluntary reporting for the calendar year 2025 reporting period followed by mandatory reporting beginning with the calendar year 2026 reporting period for the calendar year 2028 payment determination. As with the Screening for SDOH measure, this has been finalized as proposed. Please note that this measure is not intended for comparison of screen positive rates of HRSNs between healthcare facilities but is rather to provide transparency in the delivery of care and actionable information to healthcare facilities on the unmet needs of their patients.

The results of the Screen Positive Rate for SDOH measure are calculated and reported as five separate rates, one for each HRSN.

The numerator is defined as the number of patients receiving care at a hospital who are 18 years or older on the date of admission, who were screened for all five HRSNs, and who screened positive for having a need in one or more of those HRSNs. The denominator is defined as the number of patients receiving care at the hospital who are 18 years or older on the date of admission and are screened for all five HRSNs during their care. This measure has the same exclusions as the SDOH Screening measure, those who opt out of screening or those who are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

The Screen Positive Rate for SDOH measure does require hospitals to collect patient-level data on their patients' SDOH screening results. However, consistent with the Screening for SDOH measure, we are adopting the Screen Positive Rate for SDOH measure as an aggregate measure. As such, hospitals will be required to submit aggregated data representing the total numerator results for each of the five screening areas and the total number of patients screened for each of the five HRSNs.

For all three health equity measures, HCHE, Screening for SDOH, and Screen Positive Rate for SDOH, the reporting period for each measure will be January 1 through December 31 of the year two years prior to the applicable payment determination year. Hospitals will be required to submit the data required for each of these three measures annually using a CMS-approved, web-based, data collection tool available within the HQR system starting January 1 through and including May 15 in the year prior to the applicable payment determination year. Hospitals will be able to enter, review, and correct data during the submission period.

For additional information on how to apply and report these screenings, we refer readers to the Hospital IQR Program's FAQ document regarding this measure in the Hospital IQR Program, available on the Quality Reporting Center website. We will develop a similar Frequently Asked Questions document for the Hospital OQR, REHQR, and ASCQR Programs as part of providing educational and training materials,

This document will be conveyed through routine communication channels. The measure specifications can be found on the QualityNet website, and the direct link is here on the slide.

Karen VanBourgondien: Kim, can we pause here for a moment and talk a little bit about the equity measures that you just discussed before we move on?

Kimberly Go: Sure. I think that would be a great idea.

Karen VanBourgondien: Okay. Perfect. Kim, there were some commenters who recommended CMS either include voluntary reporting or delay mandatory reporting for the Hospital Commitment to Health Equity measure to allow facilities adequate time to expand health equity improvement initiatives and create, build, and deploy processes, or even phase in measure domains incrementally. Some even suggested that by delaying mandatory reporting that would provide CMS with more time to better define each domain and to continue to evolve and potentially respecify the measure to reduce burden on providers. Can you maybe shed some light on CMS's perspective on some of those comments?

Kimberly Go: Sure. So, we received a lot of great feedback and recommendations about the HCHE measure. Although we do appreciate concerns about the timing of mandatory reporting, we believe health equity is a pressing issue which deserves serious focus and rapid action. That said, the HCHE measure assess the capacity and commitment of facilities regarding health equity and helps them identify potential gap areas on this topic to improve quality of care. Again, reporting for the HCHE measure will be mandatory beginning with the calendar year 2025 reporting period for the calendar year 2027 payment determination. So, hospitals and REHs will still have more than a year before the submission deadline of May 15, 2026. That is the remainder of calendar year 2024 and all of calendar year 2025 to address any potential barriers to positive attestations.

Karen VanBourgondien: Okay. Thank you, Kim. Here is a question we have been getting about the Screening for SDOH measure: The facility screens the patient for all five Health-Related Social Needs. What happens if the patient answers some questions, but refuses to answer others? Are they then excluded from the denominator?

Kimberly Go: Yes, that is correct. If the patient or their authorized representative declines to answer one or more questions related to an HRSN, the patient is excluded from the denominator of the Screening for Social Drivers of Health measure and the Screen Positive Rate for SDOH measure.

Karen VanBourgondien: Okay. Thank you, Kim. With that, I am going to hand it back over to you to carry on with the presentation. Thanks for pausing, Kim.

Kimberly Go: Sure, thank you, Karen. So, we are going to turn our attention to program updates that are specific to the Hospital OQR Program. I highly recommend you read the rule for details for a more complete understanding of these updates. Last year, we finalized an immediate measure suspension policy for the REHQR Program in lieu of the immediate measure removal policy. The REHQR Program's immediate measure suspension policy provides that, in cases where we believe that a measure raises patient safety concerns, we will suspend the measure's use in the program instead of immediately removing the measure until its potential removal undergoes the standard rulemaking process. In this year's rulemaking cycle, we finalized the same policy for the Hospital OQR Program.

Specifically, we modified the current immediate measure removal policy in the Hospital OQR Program, so that it is more appropriately referred to as immediate measure suspension policy beginning with calendar year 2025. Under this immediate measure suspension policy, in cases where there is evidence that the collection and reporting of a measure raises potential patient safety concerns, we will suspend the measure from the program until potential removal can be proposed through the standard rulemaking process.

We will notify hospitals and the public of the decision through standard communication channels, including program-specific Listservs and program guidance currently housed on a CMS-designated website. We will address the suspension and propose removal in the next feasible rulemaking cycle.

In the calendar year 2025 OPPS/ASC final rule, we also adopted a new measure that is specific to the Hospital OQR [Program] measure set.

This measure is the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure. This will be referred to as the Information Transfer PRO-PM to begin with voluntary reporting for the calendar year 2026 reporting period followed by mandatory reporting beginning with the calendar year 2027 reporting period for the calendar year 2029 payment determination. Recent studies have shown that compared to inpatient settings, outpatient settings are associated with worse patient understanding and lower patient activation. That is an individual's understanding, competence, and willingness to participate in care decisions during their recovery, which indicates an area for quality-of-care improvement. Research also indicates that information that is simpler to read and more complete has been associated with fewer follow-up calls to providers as well as less frequent hospital readmissions.

So, the Information Transfer PRO-PM assesses the level of clear, personalized recovery information given to patients aged 18-years or older who have had surgery or a procedure at a hospital. The measure reports the average score of a patient's ratings on a three-domain, nine-item survey to evaluate the clarity of the clinical information patients are given before, during, and after an outpatient surgery or procedure. The three domains are Patient Needs, Medications, and Daily Activities. The Patient Needs domain assesses whether the recovery information considered a patient's health needs and personal circumstances. The Medications domain examines the clarity of medication information provided, including guidance on taking new medications, potential side effects, and discontinuing medication.

The Daily Activities domain assesses the clarity of guidelines around diet, physical activity, returning to work, and driving. Results from the survey provide hospitals with patient-reported outcome data designed to assess and improve communication efforts and reduce risk of patient harm if the patient does not fully understand the recovery information.

The Information Transfer PRO-PM will be calculated based on patient-reported outcome data, hereafter referred to as PRO data, collected by hospitals directly or through their authorized third-party vendors through a web-based survey instrument distributed to patients or their caregivers. The survey will be administered not less than two days post-procedure and no later than seven days post-procedure or surgery. Additionally, there is a 65-day window for patient response and a minimum random sample size of 300 completed surveys to ensure the reliability of the measure. Hospitals unable to collect 300 completed surveys will not be able to perform random sampling and will be required to submit data on survey responses from all completed surveys received.

Because the intent of the measure is to encourage hospitals to provide individualized recovery instructions regardless of the patient's unique characteristics, there is no need for risk-adjustment. The measure numerator is the sum of all individual scores a hospital receives from eligible respondents, which could be patients or caregivers. Each individual score is calculated for each respondent by taking the sum of items for which the respondent gave the most positive response, Yes or Very Clear, and dividing by the number of items the respondent deemed applicable to their procedure or surgery. Applicable items are calculated by subtracting the sum of items for which the respondent selected Does Not Apply from the total number of survey items. The measure denominator is the total number of patients 18 years or older who had a procedure or surgery in a hospital, left the hospital alive, and responded to the survey. Only fully completed surveys are included in the measure calculation.

Hospitals must use the HQR system for data submission for any PRO–PM that we adopt for the Hospital OQR Program measure set.

Hospitals may choose to directly submit their PRO-PM data to CMS using the HQR system or utilize a third-party entity, such as a vendor or registry, to submit their data using the HQR system. The HQR system allows for data submission using multiple file formats, such as CSV or XML, as well as manual data entry, giving hospitals additional flexibility in data submission. The reporting period for each measure will be January 1 through December 31, two years prior to the applicable payment determination year. Data will be submitted annually via the HQR system starting January 1 through May 15 the following year or one year prior to the appliable payment determination year. This is the same submission format used for the web-based measures in this program.

Karen VanBourgondien: So, Kim, let's pause here a minute and address some comments and have some discussion. Regarding the finalized immediate measure suspension policy that you discussed, once a measure is suspended, are facilities still penalized for non-compliance with the requirements for the suspended measure in the subsequent payment determination year?

Kimberly Go: Karen, that is a great question. Under the immediate measure suspension policy, once the measure is suspended, data collection and reporting would cease until permanent action is determined in a subsequent rulemaking cycle, so the next feasible rulemaking cycle. Hospitals and REHs would not be penalized for non-compliance with the suspended measure as the requirement to collect and report data would not be in effect.

Karen VanBourgondien: Okay. That makes sense. Thank you, Kim. There were some commenters who expressed concerns with CMS' proposal to adopt the Information Transfer PRO-PM due to burden on the hospital outpatient departments to implement the measure. They felt the challenge of integrating surveys into provider workflows, and hospitals are already facing staffing challenges and resource constraints. The burden of implementing this measure, they felt, is greater than CMS indicated in the rule, and it does not account for a facility's time spent strategizing, reviewing, and updating policies, building technology, training staff, etc. to implement processes for this new measure.

Can you shed some light on CMS's perspective on some of those comments?

Kimberly Go: Of course. First, let me-say that PRO-PMs provide an important opportunity for patient-reported outcomes to inform clinical decision making, and it also benefits patients by engaging them in discussions about potential outcomes. The testing of the Information Transfer PRO-PM by the measure developer included interviews of clinicians, nurses, quality improvement officers, and data administrators in hospital outpatient departments. This has indicated that the increased burden on hospital outpatient departments would be minimal because the data would be collected and reported electronically by administrative staff and quality officers engaged in data sharing activities outside of clinical workflow before being integrated into a clinical information system. Additionally, to provide more flexibility, we are not requiring hospital outpatient departments to collect that in a standardized way. Hospital outpatient departments may use a variety of data collection and storage approaches. We encourage hospital outpatient departments to use the processes best suited to them.

Karen VanBourgondien: Thank you, Kim. Some other concerns regarding the new Information Transfer PRO-PM were an additional patient survey for patients who would respond with patient survey fatigue. They noted that this would lead to low participation rates, especially with the addition of the new equity measures as well. What is CMS' perspective on that particular type of comment?

Kimberly Go: Again, that is a great question. We intend to evaluate responses rates associated with the Information Transfer PRO-PM along with other surveys and continue to consider ways to reduce patient survey fatigue. As it stands, we estimate that each patient would require an average of six minutes to complete the nine-item survey for the Information Transfer PRO-PM, so, an average of six minutes for this particular survey.

Karen VanBourgondien: Very good. Thank you, Kim. One more question about the Information Transfer PRO-PM, some commenters were concerned about the measure's minimum random sample of 300 completed surveys which is inconsistent with minimum responses outlined in measure specifications and whether or not all questions had to be completed on the survey. Can you respond to that as well?

Kimberly Go: Of course. I will start with the second question, whether or not all questions have to responded on the survey**.** The answer is yes, all questions on the survey need to be completed to meet the 300-survey minimum. Partially completed surveys should not be counted towards the 300-survey minimum. As for the first question, we intend to update the measure specifications manual to reflect the minimum random sample size of 300 completed surveys. The reason for the minimum sample size of 300 is to provide sufficient data for improved reliability. Does that answer the question, Karen?

Karen VanBourgondien: Yes, Kim. Thank you so much. In light of time, I think we should probably move along with the presentation. So, I am just going to hand it back over to you, Kim.

Kimberly Go: Sure. Thank you, Karen. So, moving onto measure removals. In the calendar year 2025 OPPS/ASC final rule, we selected two measures for removal from the Hospital OQR Program measure set.

These measures are the MRI Lumbar Spine for Low Back Pain and the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measures with removal effective with the calendar year 2025 reporting period for calendar year 2027 payment determination. Evidence has shown that these measures do not drive improvements in patient care, nor do they result in better patient outcomes.

Next, we also have two administrative updates for the Hospital OQR Program.

First, beginning with the calendar year 2025 reporting period for calendar year 2027 payment determination, a hospital using EHR technology certified to the ONC health IT certification criteria will be required to have its EHR technology certified to all eCQMs that are available to report under the Hospital OQR Program. This will align the Hospital OQR Program's eCQM certification requirements with the Hospital IQR Program and Medicare Promoting Interoperability Program clinical quality measure electronic submission requirements for eligible hospitals. Additionally, hospitals will be required to use the most recent version of the eCQM electronic measure specifications for the designated reporting period available on the Electronic Clinical Quality Improvement Resource Center website. We generally update the measure specifications on an annual basis to align with current clinical guidelines and code systems.

We also finalized that data for the Median Time from Emergency Department Arrival to Emergency Department Departure for Discharged ED Patients-Psychiatric/Mental Health Patient stratification will be publicly available on the Care Compare site beginning in calendar year 2025. This includes data that were previously published on data.medicare.gov. Since the data required for public reporting are already collected and submitted by participating hospitals, we believe that publicly reporting this stratification will not create additional burden.

Just as a reminder, this is a view of the newly finalized measures, which are also available in the final rule. Again, we encourage reading the final rule for a more complete understanding of our finalized proposals.

Again, these are the newly finalized measures, part two of two.

Karen VanBourgondien: Okay, Kim, thank you. Let's pause here again and talk a little bit about some of the comments that CMS received. Some commenters did not really support removing the MRI Lumbar Spine for Low Back Pain measure from the measure set, noting that four additional ICD-10-CM codes that describe "discogenic back pain" were issued. Can you elaborate on CMS' perspective?

Kimberly Go: Yes, we do recognize that there are now four additional ICD-10-CM codes that describe "discogenic back pain." These additional diagnosis codes do not reflect a new condition but allow practitioners more specificity in coding conditions already captured by the measure. So, we don't believe the additional ICD-10 codes would have substantively expanded the measure cohort.

Karen VanBourgondien: Okay, thank you, Kim. Some hospitals are asking about the benefit of reporting the Median Time for Discharged ED Patients - Psychiatric/ Mental Health data on Care Compare. Are you able to elaborate on that as well?

Kimberly Go: Of course; by publicly reporting these data on the Care Compare tool, we are aiming to increase transparency around behavioral health patients and highlight areas where resources and processes may need to be strengthened. These data will be informative for patients as well as researchers, policymakers, and hospital staff as they attempt to address health disparities and improve the timeliness of care for mental health patients.

Karen VanBourgondien: Thank you, Kim. So, I think we should move on with the presentation.

Kimberly Go: Yes, so I think that's it for the Hospital OQR Program. I will now turn it over to my colleague, Anita Bhatia, for the REHQR Program updates. Thank you very much.

Anita Bhatia: Thank you, Kim. In addition to the three health equity measures that Kim discussed, there are only two other proposal we have in this rulemaking cycle for the Rural Emergency Hospital Quality Reporting Program.

We proposed to modify the reporting period for the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure from one year to two years beginning with the calendar year 2027 program determination. We have monitored and evaluated the reporting patterns of hospitals that have converted to REH status.

We have found that, under the Hospital OQR Program, a limited number of current Rural Emergency Hospitals were able to publicly report on this measure as specified based on case threshold minimums. This modification to extend the data reporting period will address low case thresholds as we have a statutory obligation to consider ways to account for low case volumes and to publicly report on quality-of-care metrics for Rural Emergency Hospitals. On the slide, you can see an example of this new extended reporting period. For the calendar year 2027 program determination, the reporting period will comprise data from calendar years 2024 and 2025. That is encounters from January 1, 2024, through December 31, 2025. We have finalized this modification from one year to two years for the reporting period beginning with the calendar year 2027 program determination, as proposed.

Our next proposal for discussion is our data submission policy proposal. In the calendar year 2025 OPPS/ASC proposed rule, we noted that it was necessary to specify when a hospital that converts to REH status is required to begin reporting data to the Rural Emergency Hospital Quality Reporting Program. Thus, we proposed that a Rural Emergency Hospital must begin submitting data to the Rural Emergency Hospital Quality Reporting Program on the first day of the quarter following the date that a hospital has been designated as converted to a Rural Emergency Hospital. After consideration of the public comments we received for this proposal, we finalized the data submission policy following conversion to Rural Emergency Hospital status as proposed.

Here on the slide is a view of finalized measures for the program, and this is included in the final rule. Additional details of our finalized measure proposals are available in the available final rule.

Karen VanBourgondien: Anita, I have a couple of questions here, if you wouldn't mind helping to answer. Here's a question, Anita. It seems like for the most part commenters supported the proposal to extend the reporting period for the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure.

They feel that finalizing the policy would allow a broader range of hospitals to reliably report the measure, provide consumers with ratings for a greater number of facilities, enhance the reliability of the measure results due to having a larger sample size, provide hospitals with a more accurate and comprehensive understanding of performance trends over time, allow for improved data analysis and better-informed decisions regarding patient care, and reduce the pressure on hospitals to gather and report data within a shorter window thereby supporting more sustainable and effective reporting practices. Is that generally what CMS received for comments?

Anita Bhatia: Yes, Karen, all of that is true; this was a very popular proposal. Thank you to all the commenters for their support.

Karen VanBourgondien: Great. Anita. Just to reiterate, when a hospital does convert to an REH, can you go over again when they are required to begin reporting data.

Anita Bhatia: Sure, Karen. An REH must begin submitting data to the Rural Emergency Hospital Quality Reporting Program on the first day of the quarter following the date that a hospital has been designated as converted to an REH. We do have that information along with an example on slide 41.

Karen VanBourgondien: Okay Perfect. Okay. I think that's all the time we have. Anita and Kim, thank you both for joining us today and talking about CMS' finalized proposals. We did cover a lot of information today. Before we leave, let me mention a few important program reminders. To stay in the know, if you will, make sure you have subscribed to the Email Updates service on the QualityNet website home page. This is clearly marked, and it says Subscribe to Email Updates right on the home page. I think it's on the left side of your screen. We will put a link in the chat box. This is a no-cost email distribution. You will receive emails on important program information, webinars, deadlines, and a whole lot more. It's really a must-do.

You can easily sign up, again on the QualityNet home page. It's just a really easy way to stay in touch with what you need to know to be successful in your reporting. You will also need to keep your passwords active for both NHSN and HQR. You must log in every 60 days to keep your passwords active. When you log in, you do not have to perform any specific tasks; you just need to log in. You do not want your account dismantled because you did not log in. There is nothing worse than going to submit your data, only to find out that your account has been deactivated. This is especially problematic if you wait to the last minute to enter your data. Believe me, this does happen, and this is why we are mentioning this to you. Please keep your passwords active by logging in every 60 days. If you need any program assistance, please reach out to us, the Support Team. We are always here to help. Our number is here, right on the top, on the slide here. We also have other resources here available to you. Thanks again for joining us. Enjoy the rest of your day. See you next time.