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Navigating CMS's 2025 eCQM Validation Changes

Preparing for the New Accuracy-Focused Validation Process

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Presenters

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CE Credits Available!

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CMS Validation

Verification that data submitted by hospitals can be reproduced by a trained abstractor using a standardized protocol.

01

Accountability

Holds hospitals accountable for the accuracy of data.

02

Data Integrity

Ensures data integrity and compliance with CMS standards.

03

Public Reporting

Supports public reporting of data and ensures consumers are provided with accurate and complete information that reflects the quality of care provided at the hospital.

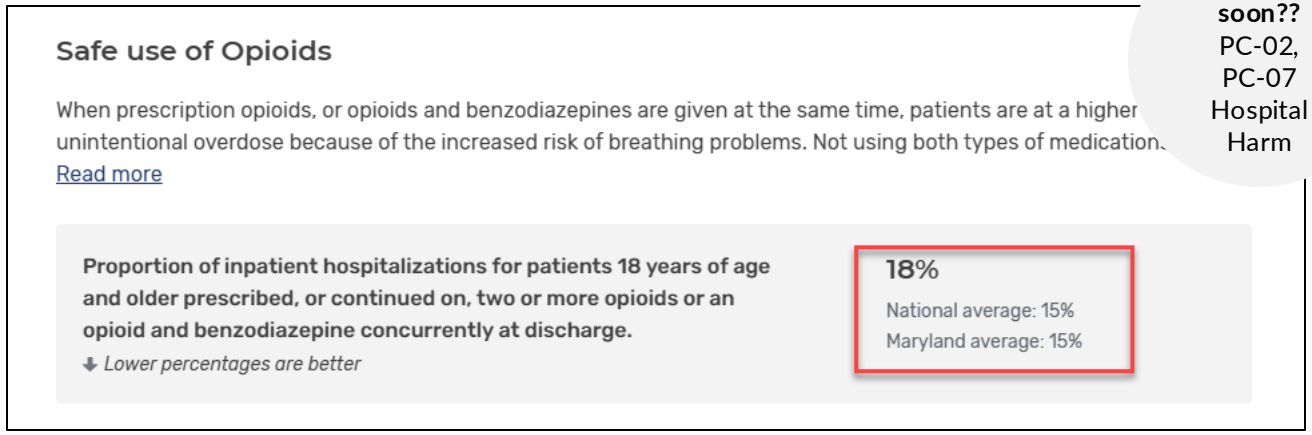
04

Policy

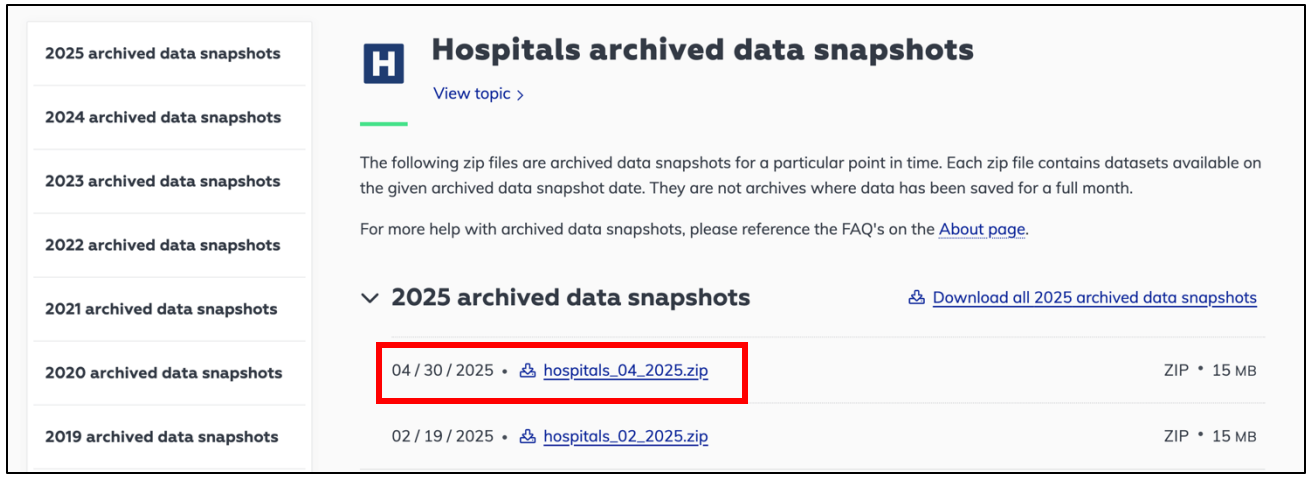
Policy requires it.

Public Reporting of eCQMs

Care Compare, Star Ratings, Data Downloads



Coming soon??
PC-02,
PC-07
Hospital Harm



National eCQM Results Posted on Care Compare

All eCQMs updated every October

National and state rates only calculated on required eCQMs

To Access eCQM Published Results:

- Visit Archived Data Snapshots page
  eCQM Download | Provider Data Catalog
- Download the most recent update
- Results are found in two files:
- Timely_and_Effective_Care-Hospital.csv
- Maternal_Health-Hospital.csv

CMS Validation Timeline

2013

CMS finalizes validation of chart-abstracted measures for the Hospital IQR Program, effective Fiscal Year (FY) 2015.

2018

CMS finalizes validation of eCQMs, requiring selected hospitals to submit at least 75% of sampled medical records timely and completely. Records are validated for completeness only, not data accuracy.

2021

CMS aligns validation scoring processes, combining the scores for chart-abstracted measures and eCQMs. Requires 100% of the sampled eCQM medical records to be submitted. eCQM validation carries a weight of 0%.

2024

Annual selection of up to 200 randomly selected hospitals and up to 200 hospitals using targeting criteria to participate in both eCQM and chart-abstracted validation.

2025

CMS finalizes eCQM validation scoring based on the accuracy of data beginning with CY 2025, affecting the FY 2028 payment determination. Requires hospitals to achieve a minimum passing score of 75% to pass validation

What's at Risk for Audit Failure?

How does CMS calculate the IQR penalty?

- Each year hospitals receive an increased Market Basket Rate for services to Medicare. This amount is offset by a negative Productivity Adjustment (PA).
- Under the IQR program, hospitals that do not meet all requirements will receive a 25% reduction to their Annual Payment Update (APU) (Market Basket Rate-of-Increase).
- These reductions are applied to the annual reimbursement amount that hospitals receive for claims billed to Medicare.

	Est. FY 2026 Medicare Revenue	Est. FY 2026 Medicare Revenue with +3.2% APU Increase & - 0.8% PA (i.e., 2.4% increase)	Est. Lost Revenue
IQR Failure (25% Decrease APU and -PA = +1.6%)	$100,000,000	$102,400,000	($800,000)

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Agenda

01. Intro to eCQM Validation
02. Historical Context
03. Impact on Payment
04. New Validation Requirements for CY 2025
05. Validation Process
06. Data Management Best Practices
07. Preparation Tips

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eCQM Validation: Pre-CY2025

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History of eCQM Validation

- Required to provide medical records for eight cases (randomly selected) per quarter per calendar year
- Clinical Data Abstraction Center (CDAC) validated for “completeness” = Cases reviewed to confirm all requested records were provided
- Hospitals passed validation by submitting all requested cases
- If unable to submit all cases, eCQM validation carried zero weight in scoring

History of eCQM Validation

Even though it didn't impact validation results, CMS abstracted for accuracy anyway

The abstractor reviewed the data elements from the submitted medical records to determine measure outcome based on the eCQM specification. That outcome was then compared to the measure data and results from the eCQM QRDA files.

This served two purposes:

- Allowed CMS to provide confidential feedback to hospitals highlighting areas for improvement ahead of mandatory validation based on accuracy.
- Gave CMS insight into how well hospitals were managing data accuracy.

Hospitals were not penalized if the auditor abstracted results didn't match the eCQM results.

History of eCQM Validation

A Case for eCQM Accuracy Validation

- Accuracy of data is determined by calculating an agreement rate: **how often the eCQM data submitted in QRDA files matches the medical record data reviewed by CMS during the validation process.**

- eCQM agreement rates have steadily improved over the years since CMS started validating eCQM and for the last several years, hospitals selected have had consistently high agreement rates.

  - ✓ The **overall agreement rate** across all measures was about **90%.**
  - ✓ On the low end of agreement rates was STK-3, Anticoagulation Therapy for Atrial Fibrillation/Flutter. The average agreement rate was **~84%.**
  - ✓ At **94%,** the measure with the highest average agreement rate was STK-5, Antithrombotic Therapy by the End of Hospital Day Two.
  - ✓ The low end of the average accuracy is well above a passing threshold of **75%.**

- This is the primary reason CMS decided it was time to move from completeness to accuracy and hold hospitals accountable for their eCQM data.

eCQM Validation: Starting CY2025

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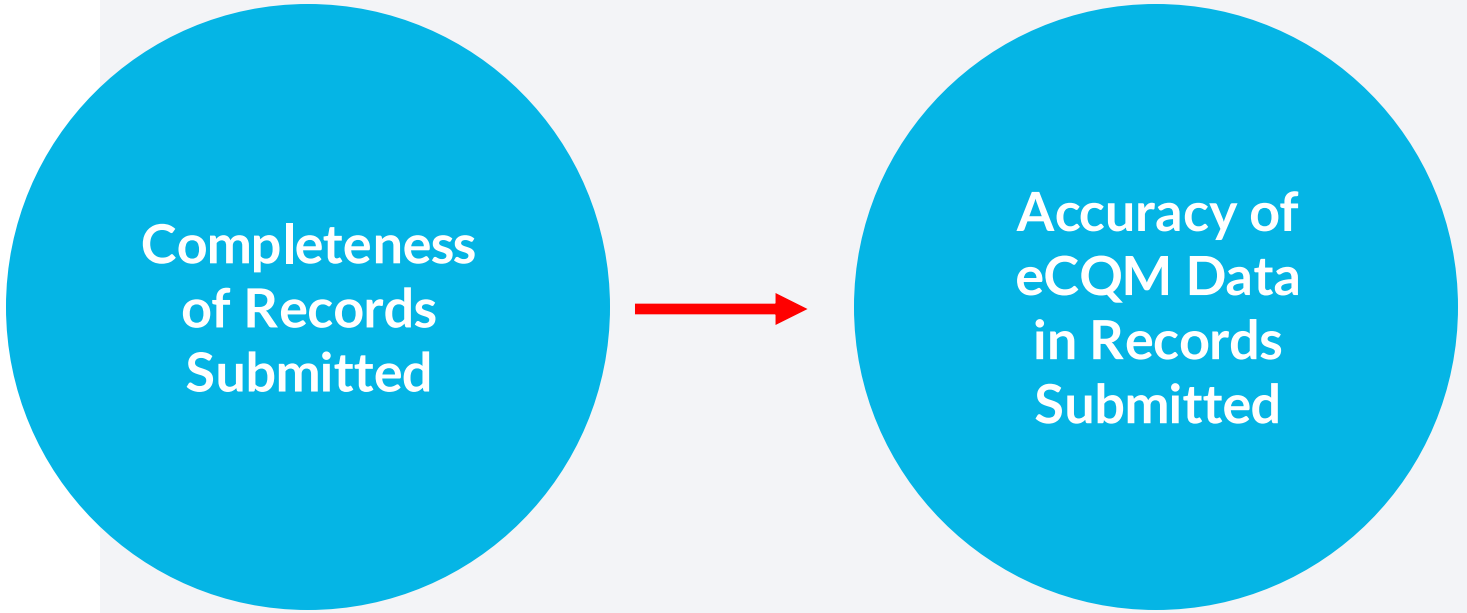
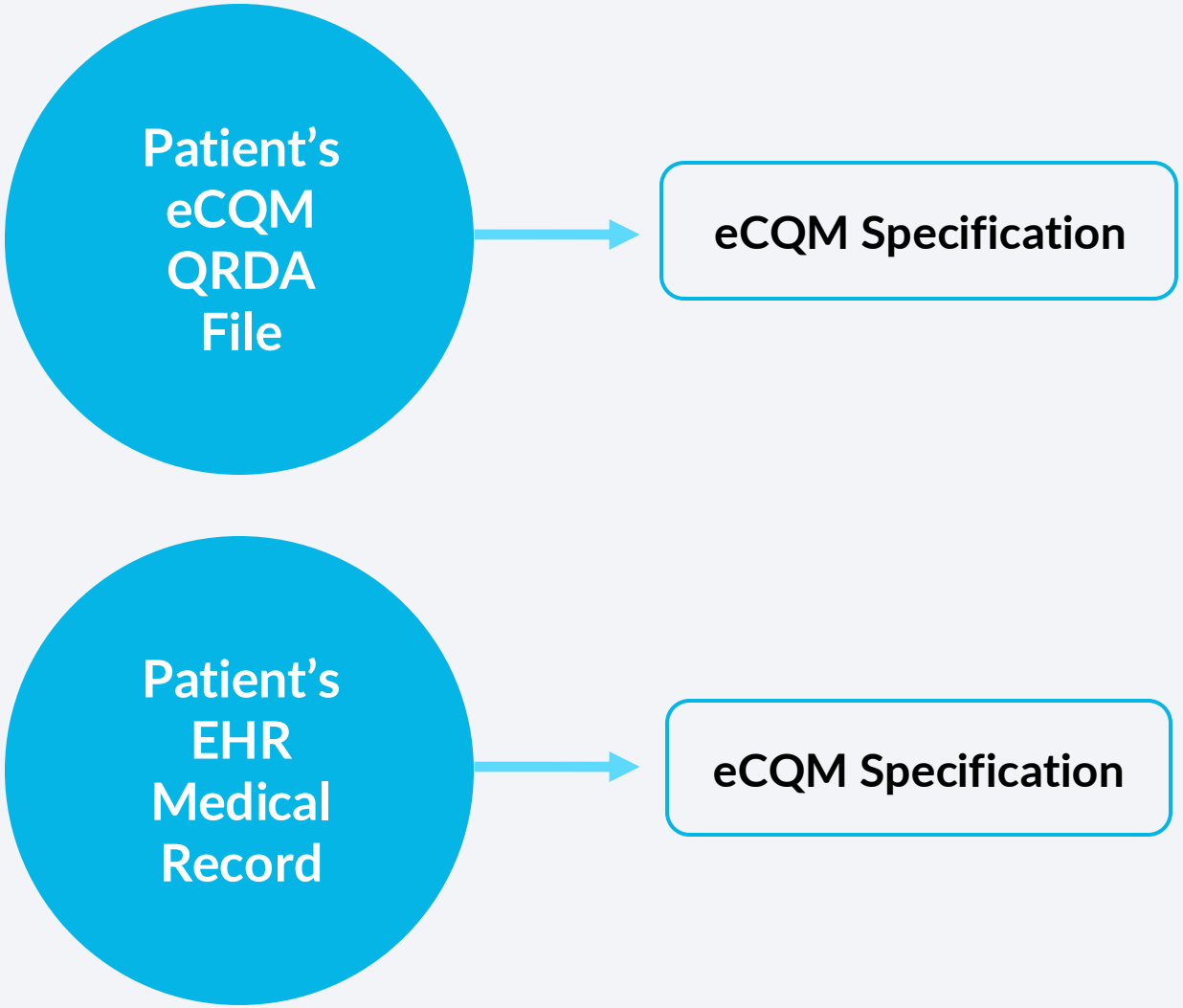
eCQM Validation

CY 2025 Data
FY 2028 Payment Determination



eCQM Validation



eCQM Validation Process: Old vs. New

Validation Process Description	Quarters of Data Required for Validation	Scoring
Current Validation Scoring for the FY 2025 – FY 2027 Payment Determinations (87 FR 49308 through 49310)		
COMBINED Process (Chart-Abstracted Measures and eCQM Validation): up to 200 Random Hospitals + up to 200 Targeted Hospitals	1Q 2022 – 4Q 2022	Chart-Abstracted Measures: at least 75% validation score (weighted at 100%) And eCQMs: Successful submission of 100% of requested medical records
Update to eCQM Validation Scoring for the FY 2028 Payment Determination and Subsequent Years		
Up to 200 Random Hospitals + up to 200 Targeted Hospitals selected for both Chart-Abstracted Measures and eCQM Validation	1Q 2025 – 4Q 2025	Chart-Abstracted Measures: at least 75% validation score And eCQMs: at least 75% validation score

New eCQM Validation Process

- Data collection starting 1/1/2025
- 200 randomly selected hospitals and 200 selected using targeting criteria ~June 2025
- CMS will request medical records for 8 randomly sampled cases per quarter - **validated based on the eCQMs the patients qualified for**.
- Two separate validation scores: eCQMs + abstracted measures.
- eCQM scoring methodology aligns with chart-abstracted.
- Chart abstracted score must be ≥75% and eCQM score must be ≥75%.
- Fail validation if either score is below 75% - won't receive full APU and included in the targeted sample the following year.
- Missing medical records are treated as mismatches and count against the agreement rate.

CY 2025 eCQM Validation: Calculating the Score

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Resources

A detailed FY 2028 Confidence Interval document will be published to the inpatient data validation resources page of QualityNet when FY 2028 (CY 2025) selected hospitals are notified of their selection. We anticipate this selection notification to occur sometime in June 2025.

https://qualitynet.cms.gov/inpatient/data-management/data-validation/resources

Data Validation Overview

IP_FY27_Val_Webinar_Random

Scoring Methodology

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Calculating the eCQM Validation Score

Eligibility

Medical record must contain sufficient information to determine measure eligibility and/or outcome.

Validation

Validation is based on the measure outcome and is not scored at the data element level.

Outcome

If CDAC abstraction doesn't produce the same outcome as the eCQM outcome, then the case is considered a mismatch.

From: validation@telligen.com <validation@telligen.com>
Sent: Monday, April 21, 2025 11:43 AM
To: Kristen Beatson <kbeatson@medisolv.com>
Cc: validation@telligen.com
Subject: RE: [External] Validation Scoring

CMS verifies that eCQM data submitted to the HQR Secure Portal in QRDA format align with measure specifications as it relates to the patient's medical record.
When validating cases, the CDAC reviews data found in both discrete and non-discrete fields in the medical records submitted as PDF files.
If information found in the PDF medical record does not align with data in the QRDA, it could result in mismatches.

Individual elements are not validated in and of themselves, but rather validation occurs at the outcome level; selected cases are scored as either a 0/1 or 1/1.

Thanks,
Hospital Quality Reporting (HQR) Validation Support Contractor
validation@telligen.com

From: Kristen Beatson <kbeatson@medisolv.com>
Sent: Monday, April 21, 2025 10:56 AM
To: validation@telligen.com
Subject: RE: [External] Validation Scoring

Fantastic, that is so helpful. So to confirm, in essence, a mismatch (0/1) would occur if:

1. A patient qualified as a fall out / is failing VTE 1 based on the data in the QRDA file submission.
2. The same patient is excluded from VTE 1 based on an exclusion data element that is found in the PDF (during CDAC review) that was not present in the QRDA file.

Thanks again for your time today.

From: validation@telligen.com <validation@telligen.com>
Sent: Monday, April 21, 2025 1:26 PM
To: Kristen Beatson <kbeatson@medisolv.com>
Cc: validation@telligen.com
Subject: RE: [External] Validation Scoring

Yes, the scenario you have outlined below is a good explanation of what would create an outcome level mismatch for CMS eCQM data validation.

Thanks,
Hospital Quality Reporting (HQR) Validation Support Contractor
validation@telligen.com

Calculating the eCQM Validation Score

QRDA Submission to HQR eCQMs Results

- Hospital tracking CMS 506 throughout 2025 reporting year.
- Patient X qualifies for the Numerator based on 2 Opioids at discharge.
- Hospital submits CMS 506 to HQR per IQR eCQM requirements.
- Reviews eCQM results on HQR post submission to make sure populations are the same as the reports they've been tracking.

Medical Record CDAC Abstracted eCQM Results

- Hospital selected for validation
- Receives list of medical records to submit and Patient X is on the list.
- Hospital submits all records.
- CDAC abstracts Patient X for CMS 506 and finds documentation of an intervention for drug addiction therapy using methadone in a note.
- Patient X qualifies for the Exclusion based on treatment for Opioid Use Disorder.

Mismatch impacting agreement score.

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Calculating the eCQM Validation Score

Scoring Methodology

Calculate an overall agreement rate ‘p’ between the hospital reported results and CDAC adjudicated results.

↓

Calculate the sampling variance v(p)

↓

Calculate the final score as the upper bound of the 90% two-sided confidence interval as follows:

$Hospital\ Final\ Score = p + 1.645 \times \sqrt{v(p)}$

Calculating the eCQM Validation Score

- Step 1 – Four (4) CMS506 cases are validated out of 100 possible cases eligible for validation (frame count). Of the 4 cases, 2 matched for an agreement rate of 50%.
- Step 2 - Using the agreement rate (50%), sample size (4), and frame count (100), the variance is calculated.
- Step 3 - The upper bound of the two-tailed 90% confidence interval is then calculated. The result indicates that we are 90% confident that the true agreement rate is at most 96.5%, the highest score possible considering variance and uncertainty.

Step 1: Calculate CMS506 Agreement Rate

p = agreement rate

m = total number of matches (1= match & 0=no match)

n = number of cases validated

Calculated as → p = m/n = 2/4 = **0.5 = 50%**

Episode of Care	Measure	Match	Cases Validated
A	CMS506	1	1
B	CMS506	0	1
C	CMS506	1	1
D	CMS506	0	1
Total		**m=2**	**n=4**

Step 2: Calculate the Variance for CMS506 Agreement Rate

v(p) = variance

N = total number of CMS506 cases eligible for validation (frame count)

$$v(p) = \frac{p(1-p)}{n-1} \times \frac{N-n}{N}$$

Calculated as → $v(p) = \frac{0.5 \times (1 - 0.5)}{4 - 1} \times \frac{100 - 4}{100}$ = **0.08**

Step 3: Calculate the Final Hospital Score (upper bound)

$$Hospital\ Final\ Score = p + 1.645 \times \sqrt{v(p)}$$

The square root of 0.08 = 0.283

Final calculation:

= 0.5 + 1.645 x 0.283 = **96.5%**

Calculating the eCQM Validation Score

All measure results will be included in the initial agreement rate calculation and the scoring methodology will be applied as a whole.

Episode of Care	Measure	Match	Cases Validated
A	CMS506	1	1
B	CMS506	0	1
C	CMS506	1	1
D	CMS506	0	1
E	PC-02	1	1
F	PC-02	1	1
Total		m=4	n=6

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Preparing for Validation: eCQM Data Management

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The new eCQM validation policy sets a high standard for data accuracy.

Hospitals eCQM data must meet the 75% agreement rate.

To do this, hospitals need to implement well-defined processes for managing eCQM data, ensuring that it is accurate, complete, and meets the validation requirements.

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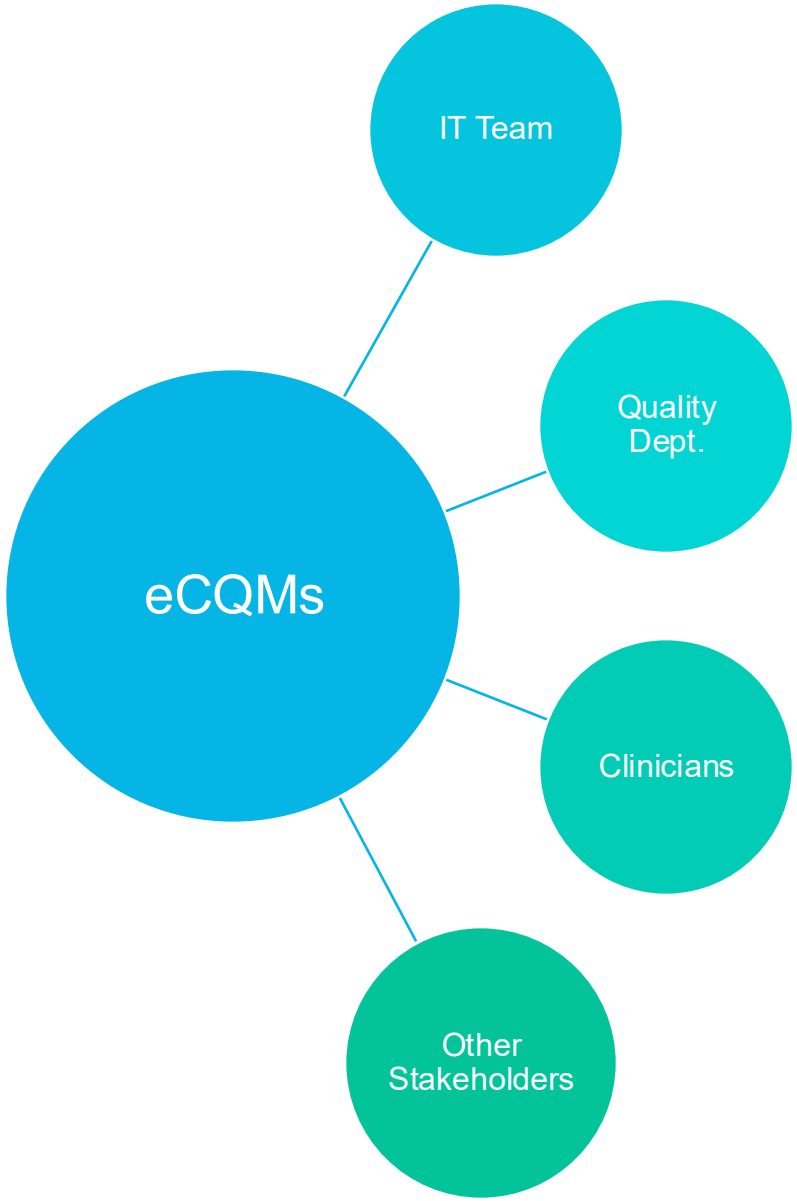
eCQM Data Management

Data Management is Key!

- Successful eCQM data validation requires a structured data management plan to ensure the accuracy and integrity of your data. Helps healthcare organizations maintain accurate and usable patient records and ensures that the information meets regulatory requirements.
  - Organizing and handling of data
  - Ensuring data is collected, stored, processed, and used effectively
  - Applying relevant codes
  - Safely storing it in a database
  - Ensuring it is in the correct format for various uses such as generating regulatory files like QRDA I
  - Keeping track of where the information came from within the EHR system to ensure accuracy and compliance.

eCQM Data Management Plan

- eCQM data management team: representatives from both the IT and Quality teams must be involved.
- Collaborate on data management processes
- Determine Ownership
- eCQM data capture, accuracy, completeness, mapping, storage, and QRDA file components.



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eCQM Data Management Plan

Education

- Educate team members. Make sure all stakeholders understand the basics of eCQMs, the significance of failing an audit, and are committed to your data management goals.
- Identify and share resources

eCQM Data Management Plan

Track your eCQM data

Develop a system for tracking your eCQM data capture processes that can be used as a central resource for eCQM management and for audit prep.

- Identify the eCQMs being tracked and submitted by your hospital every year.
- Document each data element included in each measure.
- Review EHR documentation process for each data element:
  - ✓ Identify where in the EHR the data element is/could be documented
  - ✓ Who documents
  - ✓ Structured vs Unstructured vs Paper
  - ✓ EHR identifiers
  - ✓ Mapping

CMS 506: Data Management Tracking

	Data Elements	EHR Data Capture	Primary "Documenter"	Relevant Unit/Location	EHR IDs	Mapping	Code Type	Notes
Exclusions	Cancer Related Pain						ICD SNOMED	
	Sickle Cell Disease	Coding Problem List Nursing doc. ? Progress Notes ? H&P	Physicians + Nursing	All *Check hem.	ABC.1234	Complete in prob list, coding, nursing.	ICD SNOMED	Review nursing doc; review notes
	Opioid Use Disorder Diagnosis	? In paper in ED	?	?	?	?	ICD SNOMED	New data element – do we have this completed?
	Treatment for Opioid Use Disorder (Home Med or Med Order AND Intervention)						RXNORM SNOMED (both required)	
	Hospice or Palliative Care						SNOMED	
	Acute Care Hospital, Hospice Care Referral or Admission, Expired, Left AMA						SNOMED	

eCQM Data Management Plan

Be aware of and plan for other changes that might impact your eCQM data.

01

EHR and other vendor software updates + migrations

02

Mapping & formulary vendor updates

03

Documentation – new, updates, changes

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eCQM Data Management Plan

Frequency + Timelines

Agree on and commit to timelines for eCQM data review and frequency of review. How often will you meet as a team? How will you communicate gaps, status, dependencies? — it is imperative your review processes align with:

1. **Annual regulatory updates** - know when new measures are added, and when specifications and codes are updated
2. The eCQM reporting period start and end date
3. Submission window open & close
4. Specific submission plans and timing
5. Validation selection timing

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CMS 506 v7: Safe Use of Opioids – Concurrent Prescribing (2025)

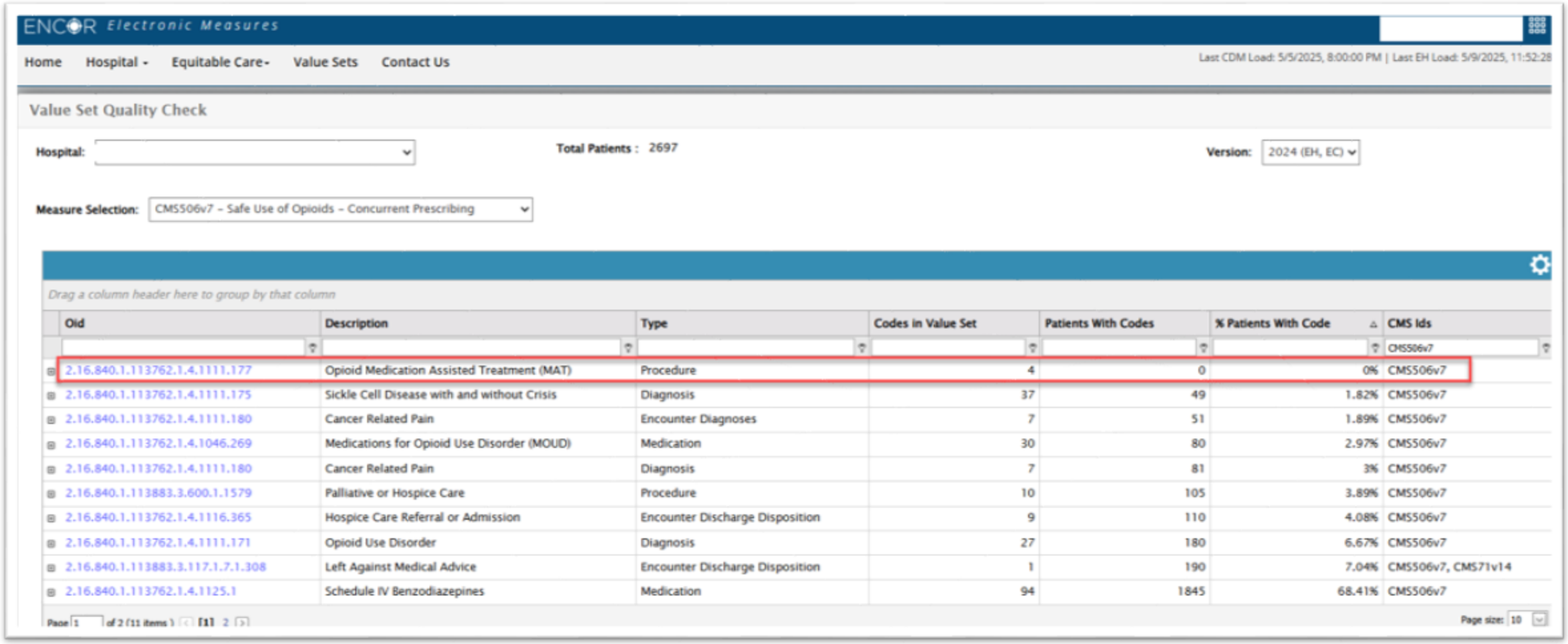
Measure Changes:

- IP and Numerator updated to include Schedule **IV** Opioids (in addition to Schedule II and III)
- Length of Stay ≤120 days removed as an initial population qualifier
- Exclusions:
  - Replaced 'All Primary and Secondary Cancer' with 'Cancer Related Pain'
  - Added ordered or active medication for opioid use disorder + "opioid medication assisted treatment (MAT)" intervention. Med needs to start or have an author date during the MAT intervention and need to start or have an author date time during the measurement period. Requires new mapping and data capture for intervention performed "MAT".
  - Added sickle cell disease
  - Added left against medical advice
- Many changes to values sets / codes. Review mapped documentation to confirm codes are current.

Measure Value Sets:

OID	Description
2.16.840.1.113762.1.4.1111.180	Cancer Related Pain
2.16.840.1.113883.3.117.1.7.1.87	Discharge To Acute Care Facility
2.16.840.1.113883.3.117.1.7.1.292	Emergency Department Visit
2.16.840.1.113883.3.666.5.307	Encounter Inpatient
2.16.840.1.114222.4.11.837	Ethnicity
2.16.840.1.113762.1.4.1116.365	Hospice Care Referral or Admission
2.16.840.1.113883.3.117.1.7.1.308	Left Against Medical Advice
2.16.840.1.113762.1.4.1046.269	Medications for Opioid Use Disorder (MOUD) (RxNorm)
2.16.840.1.113762.1.4.1111.143	Observation Services
2.16.840.1.113762.1.4.1	ONC Administrative Sex
2.16.840.1.113762.1.4.1111.177	Opioid Medication Assisted Treatment (MAT) (SNOMED/CPT)
2.16.840.1.113762.1.4.1111.171	Opioid Use Disorder (ICD10/SNOMED)
2.16.840.1.113883.3.600.1.1579	Palliative or Hospice Care
2.16.840.1.113883.3.117.1.7.1.309	Patient Expired
2.16.840.1.114222.4.11.3591	Payer Type
2.16.840.1.114222.4.11.836	Race
2.16.840.1.113762.1.4.1046.241	Schedule II, III and IV Opioid Medications
2.16.840.1.113762.1.4.1125.1	Schedule IV Benzodiazepines
2.16.840.1.113762.1.4.1111.175	Sickle Cell Disease with and without Crisis

- Value Sets:
  - Replaced All Primary and Secondary Cancer (2.16.840.1.113762.1.4.1111.161) with value set Cancer Related Pain (2.16.840.1.113762.1.4.1111.180)
  - Replaced Schedule II & III Opioid Medications (2.16.840.1.113762.1.4.1111.165) with value set Schedule II, III and **IV** Opioid Medications (2.16.840.1.113762.1.4.1046.241)
  - Added Left Against Medical Advice (2.16.840.1.113883.3.117.1.7.1.308)
  - Added Opioid Use Disorder (2.16.840.1.113762.1.4.1111.171)
  - Added Medications for Opioid Use Disorder (MOUD) (2.16.840.1.113762.1.4.1046.269)
  - Added Opioid Medication Assisted Treatment (MAT) (2.16.840.1.113762.1.4.1111.177)
  - Added Sickle Cell Disease with and without Crisis (2.16.840.1.113762.1.4.1111.175)
  - Added RxNorm 2383946 (Remimazolam) to Schedule IV Benzodiazepines (2.16.840.1.113762.1.4.1125.1)



CMS 506: Safe Use of Opioids Concurrent Prescribing

IP / Denominator

- Inpatient Encounter
- ≥ 18 years of age
- At least One New or Continuing Opioid or Benzodiazepine at Discharge

Numerator

- Two or more concurrent opioids at discharge

OR

- Concurrent opioid and benzodiazepine at Discharge

Exclusions

- Cancer Related Pain
- Sickle Cell Disease
- Opioid Use Disorder Diagnosis
- Opioid Use Disorder Treatment (Home Med or Med Order AND Intervention)
- Palliative or Hospice Care
- Discharge to Acute Care Hospital
- Hospice Care Referral or Admission
- Expired
- Left Against Medical Advice

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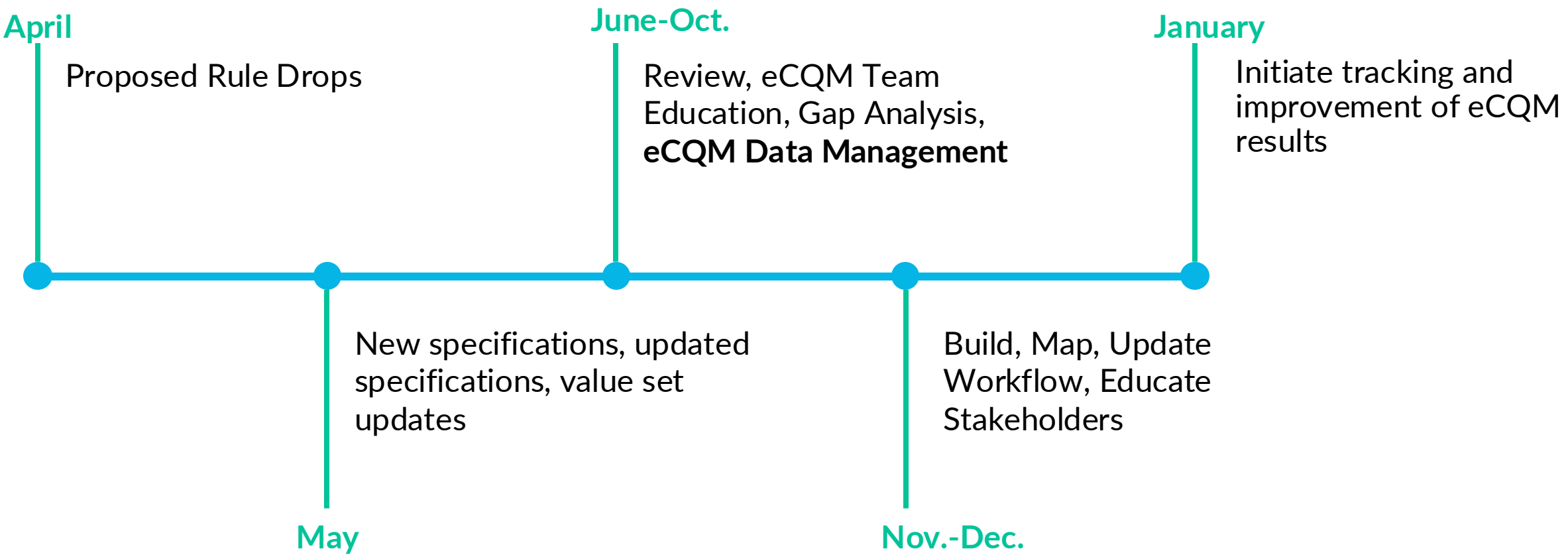
Annual eCQM Cycle



eCQM Data Management Plan

Reference previous audits

E	F	G	H	I	J	K	L	M
Program	Payment Year	Included Quarters	Confidence Interval Upper Bound	Confidence Interval Lower Bound	Overall Yearly Estimated Reliability	Validation Sample Size	Total Case Population	Met eCQM Medical Record Submission Requirement
	2025	1Q 2022 - 4Q 2022	98%	83%	91%	32	180	Y

X	Y	Z	AA	AB	AC	AD	AE	AF
Origina	Validat	Original Outcome - Denominator Exclusion	Validated Outcome - Denominator Exclusion	Original Outcome - Numerator	Validated Outcome - Numerator	Origina	Validat	Result
Met	Met	No Exclusions	No Exclusions	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match
Met	Met	Excluded	Excluded	Not Met	Not Met			Match

AF	AG
Result	Element Name
Mismatch	Emergency Department discharge date
Mismatch	Departure date from Emergency Department
Mismatch	Transfer from a hospital setting
Mismatch	Emergency Department encounter leading to this admission
Mismatch	Departure time from Emergency Department
Mismatch	Inpatient Encounter admission date
Mismatch	Admit to Inpatient date
Mismatch	Admit to Inpatient time
Mismatch	Inpatient Encounter admission time
Mismatch	Inpatient Encounter <= 120 days
Mismatch	Inpatient Encounter discharge date
Mismatch	Emergency Department discharge time
Mismatch	Emergency Department admission date
Mismatch	Inpatient Encounter discharge time
Mismatch	Principal diagnosis of Psychiatric/Mental Health Patient
Mismatch	Admit to Inpatient
Mismatch	Emergency Department admission time
Mismatch	Inpatient Encounter discharge time
Mismatch	Arrival time to Observation Services
Mismatch	Comfort Measures Time
Mismatch	Departure time from Emergency Department
Mismatch	Principal diagnosis during Inpatient Encounter
Mismatch	Observation Services
Mismatch	Comfort Measures Ordered or Performed
Mismatch	Statin prescribed at discharge
Mismatch	Inpatient Encounter discharge date
Mismatch	Inpatient Encounter admission date
Mismatch	Emergency Department encounter leading to this admission
Mismatch	Departure date from Emergency Department
Mismatch	Comfort Measures Date
Mismatch	Time of LDL-c laboratory test result <70

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eCQM Data Management Plan

Understand high risk for failure:

- Documentation in unstructured field that does not “make it” to a structured field.
- Data elements that are not mapped – won’t be in the QRDA file but will be in the medical record.
- Data manipulation -- Changes to QRDA file to meet requirements or to submit without error.

Consider

- Use EHR reports
- Scan EHR database
- Conduct your own audit or…

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eCQM Optimization & CMS Audit Preparation Services

Clean Data. Better Results. No Surprises.

Regulatory Confidence

Better Measure Results

Operational Efficiency

Team alignment

Audit Readiness

Project Deliverables

Training Materials	Current State Assessment Report	Gap & Audit Risk Analysis	Action Plan	Strategic Plan
Week 4	*Week 6*	*Week 8*	*Week 10*	*Week 12*
Educational evaluation and two team-specific sessions – Quality team and IT team.	Evaluation of current eCQM workflows, data capture and mapping. A review of known gaps & barriers to measure compliance.	Database analytics Detailed eCQM gap analysis and audit risk report. One and a half hour session to review results and discuss next steps.	Detailed plan of action to address gaps & improve results. Mapping support. Audit risk mitigation. Working session including team communication and improvement planning.	A tailored strategic plan that details an eCQM management process and audit readiness plan. A roadmap of future eCQM requirements. Audit assistance if selected.

OPTIONAL: MEDISOLV MOCK AUDIT

Medisolv will conduct a mock audit using a sample of eCQM cases. You'll receive the results of the survey with identified mismatches to improve performance.

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Professional Development (CE Credits!)

1 CPHQ CE Credit

Directions for claiming credits:

https://nahq.org/claiming-cphq-ce/

- Log in to NAHQ.ORG and navigate to **My Learning**
- **Launch** this Learning Lab program
- Ensure you click on each item listed; hint: look for a **green check mark** next to the item
- Complete the **Webinar Evaluation**
- Access a Certification of Completion in the **Transcripts** tab

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