Transcript for Q4FY18 Critical Access Hospital PEPPER Review
May 15, 2019

Okay. I think we will go ahead and get started. I would like to welcome all of you to today's review of the Critical Access Hospital PEPPER. My name is Kim Hrehor and I work for the RELI Group who is contracted with the Centers for Medicare and Medicaid services or CMS to develop, produce and disseminate the PEPPERs. For those who are interested in live captioning of today's session, you can access the captioning by clicking on the link in the first question in the Q&A panel. Today I will be focusing on the Critical Access Hospital PEPPER, the most recent PEPPER for Critical Access Hospitals.

Today I am going to be focusing on the PEPPER for Critical Access Hospitals, the newest release which is version Q4FY18. In this release of the PEPPER, we don't have any revisions to the target areas that we will need to discuss so it is mainly going to be refresher, a high-level review. I will also be covering some of the other resources that you will find on the website which include the national and state level data as well as the peer group bar charts.

During the session today I am also going to have a sample — a review of a sample PEPPER. Now, if after today's session you find that you still have some questions about the PEPPER, perhaps PEPPER is something that is new to you and you feel like you need a little bit more detailed information, we do have available on the PEPPER website in the Critical Access Hospital training and resources section, the recorded training sessions that can help flush out all the details about the PEPPER. We will be reviewing percent--percentiles, all the target areas that are in the critical access PEPPER in greater detail. There is a sample pepper that will be reviewed in greater detail. Feel free to access that if you feel that you need a little bit more detailed information.

So what is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Reports. And essentially the PEPPER is a comparative report that summarizes one hospital's Medicare claims data statistics for areas that might be at risk for improper Medicare payment. Primarily in terms of whether the claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. Now, in the PEPPER we call these target areas. The PEPPER summarizes your Medicare claim data statistics for each of these areas and then it compares your statistics with aggregate Medicare data for other hospitals in three different comparison groups: all hospitals in the nation, all hospitals in your Medicare or MAC jurisdiction and then in your state. And these comparisons are the first step in identifying where you might be at a higher risk for improper payments which really just means that your billing practices look

different from the majority of other hospitals in the comparison group.

I do want to stress that the Critical Access Hospital PEPPER cannot identify the presence of improper payment. But it can let you know or can alert you if your statistics do look different so then you can decide if there is something that might be concerning that you need to take a closer look at.

So many of you might know that the PEPPER has been around for a number of years. It was originally developed back in 2003 for short-term acute care and a couple of years later for long term acute care hospitals. Back then it was made available by the quality improvement organizations. Then in 2010, TMF health quality institute began distributing PEPPERS to all hospitals in the nation under a new contract with CMS and over the next few years different types of PEPPERs were created for different provider types. You can see the critical access PEPPER is one of PEPPERs that has been around for a longer amount of time. We developed the critical access hospital PEPPER back in 2011. Then in 2018, CMS combined the comparative billing reports and the PEPPER programs into one contract. And so this means that there are now comparative reports for a wide range of providers that are being produced by the RELI Group with the PEPPER focusing on the Part A claims data, the Comparative Billing Reports or CBRs focusing on the Part B data. RELI Group is contracted through program integrity, provider compliance group, and our team includes TMF as well as CGS. We are going to be continuing to produce the PEPPERs along again with TMF and CGS.

For most of you this change should be pretty transparent. You might notice a few formatting changes to the PEPPER. We do have a new website. But our team is committed to continuing the production of the PEPPER and the support that the provider community has become accustomed to.

Why does CMS feel that the provision of PEPPERs to a number of providers supports their agency goals? Well, CMS is mandated by law to protect the Medicare trust fund from fraud, waste and abuse and they employ a number of strategies to meet this goal such as provider education and early detection through medical review, which may be conducted by the Medicare Administrative Contractors, the recovery auditors, or other contractors within the federal umbrella, as well as data analysis activities. The provision of PEPPERs to providers supports these strategies. CMS considers the PEPPER to be an educational tool that can help hospitals identify where they could be at a higher risk for improper Medicare payments so then they can be proactive and monitor and take any preventive measures if necessary.

I should also mention that the Office of Inspector General or OIG encourages providers to have a compliance program in place to help protect their operations from fraud and abuse. An important piece of a compliance program is conducting regular audits to ensure that charges for Medicare services are correctly documented and billed and that those services are

reasonable and necessary. So the PEPPER supports that auditing and monitoring component of a solid compliance program.

Let's move on now to focus more closely on the PEPPER, more specifically the newest PEPPER version Q4FY18 for critical access hospitals which is was released on April the fifth of this year.

With each release of the PEPPER, we are summarizing the statistics for discharges that occur in the most recent three federal fiscal years so this release includes or summarizes both data for fiscal years 2016, 2017, and 2018. And you will notice that the version number Q4FY18 really just indicates that the statistics are through the fourth quarter of fiscal year 2018.

And just as a reminder, the federal fiscal year starts October the first and runs through September thirtieth of following year. Each time we release a new version of the PEPPER we refresh all the statistics. So that means we go to the claims warehouse, download all of the claims data for all of the target areas and all of time periods and so what you are looking at in your PEPPER are the most current data that we have at the time that data was pulled. Usually two to three months before the report has been distributed.

So if you are looking at your PEPPER, your newer PEPPER and comparing with it last year's PEPPER, there is a good chance you will notice some differences in the numerator or denominator counts, which would be the result of late claims being submitted, or perhaps some adjusted claims-any revisions or resubmitted claims. Those would all be taken into account and so the statistics are going to be reflecting those claims as they were at the time the data were downloaded.

And each time we release a PEPPER the oldest fiscal year is rolling off as we add that more recent, the newest fiscal year on.

All right. Now, would I like to talk a little bit about the improper payment risks that are pertinent to Critical Access Hospitals. Because Critical Access Hospitals do treat many of the same types of patients and provide most of the same services as short-term acute care hospitals, most of you will notice that the Critical Access Hospital PEPPER includes many of those same target areas as the short term acute care hospital does. Probably the target areas that are most different would be the ones that are more related to procedures.

The main difference with the Critical Access Hospitals versus the short-term hospitals is that the Critical Access Hospital reimbursement is based on cost rather than prospectively through the inpatient perspective patient system, DRG model. Critical Access Hospitals do have a shorter length of stay, of course they are limited to having an overall average length of stay of 96 hours. All of that being said, Critical Access Hospitals are at risk for medically unnecessary admissions and although DRG coding errors don't impact reimbursement, correct coding is still important which is why we have continued to include these target areas in the Critical Access Hospital

PEPPER.

I would also like to just mention that the comprehensive error rate testing or CERT contractor, every year they review a sampling of claims from a wide array of providers that bill Medicare, Part A, Part B, Part C. And every year they release a report that identifies the projected improper payment rate and the dollars in error. The most recent report is the 2018 Medicare improper fee for service payments report. And for Critical Access Hospitals, they found a 6.1 percent error rate with a projected $386.6 million in error. It is a neat report that comes out every year. I can say that these numbers, the error rate and the dollars are lower than they were a couple of years ago. So I think that is a good thing for the Critical Access Hospital community. If you are interested in looking at this report, you can find it on the CMS website, CMS.hhs.gov/cert or CERT.

So let me talk a little bit about the target areas. In the PEPPER all of our target areas are constructed as a ratio where we have a numerator which are the discharges that are potentially identified as potentially problematic. Those that might be miscoded or admitted unnecessarily. The denominator is a larger reference group that contains the numerator. So we are able to calculate a target area percent using the numerator and denominator definition that you will find for each of the target areas in the PEPPER.

Because we have a lot of target areas in the Critical Access Hospital PEPPER, I am not going to list out the definitions for all of them. But I do want to just point out that the PEPPER does include target areas that are concerned with both the potential for improper coding, whether that is over-coding or under-coding, as well as the potential for unnecessary admission. The first few target areas listed on this slide starting with stroke intracranial hemorrhage and running through the single CC or MCC target area, this first group of target areas are focused on those coding-related issues. And so when you are looking in your PEPPER, you are going to see that we identify not only high outliers which indicates the potential for over-coding but also low outliers which could indicate the potential for under-coding. So be mindful of that as you look through your PEPPER. The remaining target areas there are again more focused on admission necessity and all of these target areas with the exception of the swing-bed transfers target area, that is the second bullet on the second column on the right, are also included in the PEPPER for short-term acute care hospitals.

The swing-bed transfer target area is specific to Critical Access Hospitals and we are looking at this target area at the percent of three and four day stays that are transferred to a swing-bed unit. Many Critical Access Hospitals have swing-bed units and at the time we add this target area, it was to fulfill a CMS request that we look at this as another way to monitor the three day stays which qualify for a SNF or swing-bed admission.

Now, I have included just to give you a feeling for how these target areas are constructed, I

have given you an example of the numerator and denominator. So for each of the target areas, you will find that we have these definitions. So here this is septicemia. The numerator is the count of discharges for the septicemia DRGs 870, 871 and 872. And in the denominator we have a larger group of DRGs which includes a simple pneumonia which are DRG 193, 194, 195. Respiratory system diagnoses with ventilator support, that is the DRG 207 and 208. And then the urinary tract infections 689 and 690. These additional DRGs in the denominator are the DRGs to which septicemia DRGs are frequently changed. If a reviewer is reviewing reports for the septicemia DRGs and they change it, many times it is changed to one of these other DRGs in the denominator.

I just wanted to give you all an example of how they structured. Most of you can calculate your statistics for your target areas using your own internal claims data. But as we will talk in just a moment, the value of the PEPPER is being able to compare your statistics with others in those three comparison groups.

So in the PEPPER you will see your percent value for all of the target areas. But we also calculate percentiles in the PEPPER. The percentile is a way that can help give you context as to how your target area percent will compare to the target area percents for other Critical Access Hospitals in any of those comparison groups. So what we do when we calculate percentiles is we take the target area percent for all of the Critical Access Hospitals, let's just say all of the Critical Access Hospitals in the nation for septicemia and for fiscal year 2018. We sort those target area percent from highest to lowest.

So as you look on the slide here, I have an example of a ladder. And there are target area percents that are associated with those rungs there on the ladder, they are sorted from highest to lowest. The next step is we identify the point below which 80 percent of the hospitals target area percents falls. And that point is identified as the 80th percentile. In the PEPPER, we use the 80th percentile as that boundary, as that line in the sand for identifying the providers whose statistics look different from most of the other hospitals. So really what that means is your target area percent is in the top 20 percent of all the other hospitals in the comparison group. In the PEPPER you will find that your target area percent will be identified in red bold font if you are at or above the national 80th percentile.

Now, for those coding-focused target areas we also identify the low outliers which would be those hospitals whose target area percent is at or below the 20th percentile. The 20th percentile is that point in the distribution below which 20 percent of the hospitals percent value fall. And so that means that you are on the opposite end of that distribution and have the potential perhaps for undercoding. You can see how the percentiles can give you some context, can help you understand how your hospital is comparing to the other hospitals in the nation, jurisdiction or state, and it can give you a feeling for whether your statistics look different or not. And then

that can help guide your next steps based on what you feel perhaps should be following.

This is the point during my presentation where I like to share a sample PEPPER. So I am going to a sample PEPPER now. And this is a sample Critical Access hospital PEPPER that you're seeing on your screen. The PEPPER is distributed as a Microsoft Excel workbook. And you will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you first open your PEPPER, it opens up to this tab called the purpose tab. You will see your hospital's CMS certification number here. Next to it will be your hospital's name. This row will identify the most recent quarter of statistics, summarized in that PEPPER. So this is through the fourth quarter of fiscal year 2018.

Scrolling down just a little bit, again here is the version number and then this is your jurisdiction. The MAC jurisdiction comparison group. You will see your MAC's name identified here on row 22 in your PEPPER. If you are not certain which Medicare administrative contractor your hospital submits its claims to then it would be identified here. And the jurisdiction comparison group is made up of all of the other Critical Access Hospitals that submit their claims to the same MAC for Medicare reimbursement.

Within the PEPPER we also have a definition tab that give us that complete numerator and denominator definition for all of the target areas in the PEPPER.

This might be handy if you are looking at a particular report and you are thinking, well, what is this numerator value represent? What does this denominator value represent? You can click to the definitions tab and see the entire definition here.

The next report is the compare targets report. And this is a nice report. I like to call it the heart of the PEPPER. It is the only place within your PEPPER that you are able to see your hospital's statistics for the target areas all on one page. Just a couple of caveats. It does include only the target areas for which your hospital has sufficient volume to generate statistics. So it is possible you may not see all of the target areas on this report and it is only for the most recent fiscal year. So this is for the four quarters ending the fourth quarter of fiscal year 2018.

Let me briefly review the information that you will find here. Here will be the target area, a name, a brief description of the numerator and denominator. This will be your numerator count. Your number of target discharges. When we compare the numerator with the denominator, which is not on this report, we can calculate our target area percent. This hospital has a target area percent, for this target area, of 100 percent. That places them at the jurisdiction — I am sorry, at the national 100 percentile. The percentile, and I want you to think about to the ladder example, the percentile tells us that 100 percent or all of the hospitals in the nation have a lower target area percent than we do. So thinking about that distribution on the ladder, highest to lowest, we are at the very top of that ladder.

Similarly for the jurisdiction we are at the 100 percentile within the hospitals in the jurisdiction. Now, the state percentile cell is empty and it will occur if there are fewer than 11 hospitals in the state that have sufficient data to generate statistics. In that instance, the state percentile is not going to be calculated and so you will see a blank cell there.

The sum of payments column identifies the amount of Medicare reimbursement that the hospital received for these numerator discharges. These 33 discharges for stroke intracranial hemorrhage resulted in over $186,000 of reimbursement for the hospital.

I want to go to the next example here, respiratory infections. We have 13 discharges in the numerator when compared to the denominator, our target area percent is 27.7. Now, our national percentile here is 70.3. So we think about that distribution in the ladder. Our target area percent places us at the 70.3 national percentile so 70.3 percent of all the hospitals, the Critical Access Hospitals in the nation, have a lower target area percent than we do. So we are roughly — we are about in the top, you know, maybe close to half-- a third of the way down. Not quite, in the distribution of percent from highest to lowest, we are still towards the top end of the ladder but you will noticed we are not above the 80th percentile. Our target area percent is not identified as an outlier because we are not at the 80th percentile or higher. We also don't have percentile for the MAC jurisdiction comparison group and it is possible that occurs when there are small volumes of hospitals in the MAC--in the jurisdiction comparison group and they don't have sufficient data to report statistics. But you can see that for some of these target areas, we do have percentiles calculated for nation and jurisdiction and state. So really a lot just depends on the volume of hospitals and also the volume of claims for some of these target areas. Here is an example of where a hospital is a low outlier, for the single CC or MCC target area, they are at the 8.1 national percentile. So 8.1 percent of all hospitals in the nation have a lower target area percent. We are almost at the very bottom of that distribution of target area percent. So we are identified here in green italics. Even lower when we are looking at a comparing our hospital to the jurisdiction hospitals 5.6 jurisdiction percentile and then the 12.5 state percentile. One other comment-this is the only place in the PEPPER that you will see your exact percentile values, only on the compare targets report.

So now let's take a look at a few target areas for each of the target areas, there is a report in the PEPPER. We do have our statistics graphically displayed here for the hospital. So these blue bars identify the hospital's target area percent over the most recent three federal fiscal years. What is nice about this is that you can see how your target area percent might be changing over time if it is. And you can also see how your target area percent is approaching the 80th percentile for nation, which is the solid red line. Jurisdiction which is the dashed red line. And state is the dotted red line. You can see we don't have state 80th percentile for the most recent couple of years. And then for the coding focus target areas, we also include the 20th percentile trend line for nation, jurisdiction, and state.

Now, this hospital went from being just above the 20th percentile a couple of years ago to being over the 80th percentile. Now, whether that might represent a change in their patient population or coding practices is something that they would need to perhaps look into if that is something that they were questioning.

Below the graph is a data table that will show you your target area percent over the three years. Your numerator count or denominator count. Your average length of stay for the numerator discharges. Your average length of stay for the denominator discharges. The average amount of Medicare reimbursement for the numerator discharges and the total amount of Medicare reimbursement for the numerator discharges.

Then below that we see the target area percent that is at the 80th percentile for nation, jurisdiction and state. And then the 20th percentile for the coding focus target areas for nation, jurisdiction and state.

And these are the values that are represented by these red and green lines up here in the graph.

One other thing before I move on, all of our target area reports include at the very bottom what we call suggested intervention. Suggested interventions for high outliers and for low outliers. These are some very general statements that help you interpret what it might mean if you are a high outlier or a low outlier. And what might be the next step if you were looking to sample some records, what might you take a look at. These suggested interventions are also included in the PEPPER user's guide. We have included them here, just as a nice reference.

So each of these target area reports are formatted in the same way. You will see in the PEPPER instances where there appear to be missing data, whether there is no bar in the graph or no data in the data table. This is going to occur when the numerator or denominator count is less than eleven. We cannot calculate the statistics for the provider if the numerator count is less than 11. So it is really not anything to be concerned with. It just means you have really low volume and we cannot calculate those data.

Simple pneumonia—I'm just going to walk through some of these really just to give you a feeling for how these look. One thing I like to suggest is consider looking at your medical CRGs with CC or MCC and surgical DRGs with CC or MCC in tandem. Occasionally I am looking at PEPPERs and I see one hospital that is a high outlier for medical and a low outlier for surgical or it might be vice versa. To me that could indicate certainly a difference in patient population for the medical versus the surgical patients. It could also be something about the way that the physicians document in the medical record. Are you capturing those complications and co-morbidities in order to justify the coding for CCs and MCCs? It could just be something to

take a look at if you are noticing that you are high in one of these areas and low in the other, just keep that in mind.

Now, some of you may find that you have no data at all for some of these target areas and again, that certainly is possible. This hospital may not have a swing-bed. And they may not be transferring any patients to their swing-bed or to others. And so if you have low volume, it certainly is possible that there will not be statistics reported for any of the time periods.

As we are getting to the last few target areas here in the PEPPER, I do want to point out that is a supplemental report that we include that identifies for your hospital the top DRGs for the most recent fiscal year. We will identify for you the DRG number, description, the total number of discharges for that DRG in the fiscal year, the proportion of discharges for each DRG to total and then your hospital's average length of stay for that DRG.

This report will include up to 20 DRGs as long as there are 11 discharges in that fiscal year. And we have some summary rows for the top DRGs and for all of your DRGs. There is a similar report that summarizes information at the jurisdiction level. So this is going to show you for all of the hospitals in your jurisdiction the same information, the DRG, the total discharges, the proportion of discharges to total. And then the jurisdiction and the national average length of stay for those DRGs. Okay. That was a quick walk through of a sample PEPPER. I will go back to the my presentation and we will continue on.

So sometimes hospitals or other providers will ask me what does this PEPPER mean to me? Do I have to use it? Do I have to take any action in response to what I see in my PEPPER? And the short answer to those questions is no. You are not required to access your PEPPER. You are not required to take any action to do any reporting or anything like that to — in response to what you see in your PEPPER.

I do like the remind folks that the PEPPER is—can be a roadmap that will help you identify areas that you could be under focused by other auditors. As we probably are all aware, there are a number of contractors that have access to all of the Medicare claims data that are submitted and they might be looking through those claims data to identify hospitals that could benefit from some educational intervention, perhaps some focused review or some other activities. So I think the value of the PEPPER is that it can give you that heads up, it can let you know when your statistics look different and you can decide if what you are seeing in your PEPPER is what you expect, or, if there is something that makes you a little uncomfortable and you feel like you perhaps should take a closer look maybe, discuss with others within your organization and decide if there is something there that you need to work on.

Again, it is a free report that is made available by CMS and would I encourage you to use it. How do you obtain your PEPPER. This year for the Critical Access hospitals we have a new

distribution method. CMS has asked us to make the Critical Access Hospital PEPPER available through our portal which is how a good number of other providers access their PEPPER. So now instead of using QualityNet, all of the critical access hospital PEPPERs are available through the PEPPER portal. I know this is a new thing for a lot of you. So if you haven't been through it, it is really not very daunting. You don't need to register or anything. Just go to our website. There is a link that you will click on. The PEPPER distribution, get your PEPPER. There are instructions there. You will access the portal.

What is nice about the portal is that we do have the most recent two releases of PEPPER that are available there. So if you didn't pull your PEPPER last year, it is there for you to access now. As a reminder, we can't send those PEPPERs through e-mail. I did want to mention actually that even though there are Critical Access Hospitals that have inpatient psychiatric and inpatient rehab units, those are — those IPF and IRF PEPPERs are also available through the portal. And I get this question quite frequently, why isn't there is a skilled nursing facility or a NF PEPPER available for Critical Access Hospitals? The swing-bed of Critical Access Hospitals are not reimbursed through the SNF PPS. We don't have the information available to generate PEPPERs for those swing-bed units. Now IPF and IRF units of Critical Access Hospitals, those are reimbursed through the respective PPS payment systems and that is why we are not able to produce PEPPERs for those units. But they are not available for SNF or swing-bed of Critical Access Hospitals.

So what you will need to access your PEPPER is your six digit CMS certification number and the validation code. The validation code for Critical Access Hospitals to access their PEPPER was sent by e-mail to the Critical Access Hospitals' QualityNet administrator. Now, we have heard from some Critical Access Hospitals that perhaps that e-mail was not received or it could have been that there were some changes in personnel. So if you haven't received the message that has your unique validation code, you can contact us through the help desk and we can coordinate with you so that you can obtain your PEPPER. It is probably also a good idea just to make sure that your QualityNet administrator is updated within the QualityNet system. There is a very good chance that we are going to utilize the QualityNet administrator e-mail address as that point of contact who receives the validation code moving forward. So just keep that in mind.

And there was a question that was submitted prior to today's session about multihospital systems and whether one person can access the PEPPER for all of those hospitals, those Critical Access Hospitals? The short answer is yes. If you have that validation code, you should be able to obtain the Critical Access Hospitals PEPPER for all of those facilities--or hospitals rather. And as a matter of fact, a number of people can access the PEPPER from the portal within an organization if they have the necessary information, they have the certification number and if they have the validation code, the PEPPER can be accessed multiple times by multiple people

within the hospital.

Once you do have your PEPPER let's say you see a lot of red and a lot of green. What should you not do? Don't panic. Just because you are an outlier doesn't mean that any compliance issues exist, doesn't mean you are doing anything wrong. But again, think about why you might be an outlier. Some of those things that we talked about, your statistics reflect what you know about your organization--could there be some differences there? Maybe you have some staffing changes. Maybe you went through a documentation improvement program and are capturing more CCs or MCCs or whatever. There can be a lot of things that can affect the way your statistics look in the PEPPER so just keep all of that in mind. The most important thing is just to ensure that you are following the best practices even if you are not an outlier.

After every release of the PEPPER, we produce national level and state level data and that is available on the PEPPER website, on the data page. This is aggregate information for each of the target areas as well as for the top DRGs. These are updated following each report release, and the fiscal year 2018 reports are out there on the website now.

A few years ago we also began producing — I think Critical Access Hospitals, this might just be the second one. Peer group reports. Peer group graphs. And these peer group bar charts will allow hospitals to compare their PEPPER statistics to a smaller subset that they might consider to be their peers. For each of the target areas, what we do is identify the 20th, the 50th and the 80th national percentile for Critical Access Hospitals in three different categories. We look at size, which is based on number of discharges. We look at location, which is urban versus rural. And we look at ownership type, for profit or physician owned. Nonprofit or church owned and government.

We do update these bar charts annually. There are a couple of difference documents that explain how we put these together. There is a file that identifies each hospital with their ownership type, location and size. And if you don't agree with that information, just know that we obtain those variables from the Provider of Services file which is maintained by CMS so please coordinate with CMS to have your information updated if that is necessary.

And this is just an example of a peer group bar chart. The top blue graph I know it is really small. But that one is focused on size. And so we are looking at the smallest, the middle and the largest one-third of Critical Access Hospitals. We can see how the 80th, the 50th, the 20th percentile may vary for each of those subgroups.

In this instance the smallest one-third of hospitals, which is the lightest blue bar, they have the greatest percentile values as compared to the other two subgroups.

The middle graph, the pink is location. We don't see very much difference for this target area for urban versus rural. And then the bottom is ownership type where we have those three

bars, the darkest one there is the for-profit and that is the one that looks to have a slightly higher 80th and 50th percentile than the other two groups.

We do have a number of resources available on the website. Of course there is the user's guide. There is a spreadsheet that identifies the number of hospitals in each jurisdiction in total and then by state. Of course those recorded PEPPER training sessions. There is a sample PEPPER out there and there is a document that notes out the history of target area changes and the expected impact on those statistics.

At any time if you need help with your PEPPER, whether you need help obtaining your PEPPER or if you have a question about the statistics in your PEPPER, visit our help desk which is on the website. There is a little form that you will complete and member of our team will promptly assist you. We do ask that you do not contact other organizations for assistance with PEPPER. We are the official source of information and want to make sure that you get the right answer.

This is a quick look at our homepage. PEPPER.CBRPEPPER.org. You can see the Critical Access Hospital resources are easily available from the homepage. We have links to the user's guide, to the training and resources page and to the PEPPER distribution page.