PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

National Healthcare Safety Network (NHSN) Central Line-associated Bloodstream Infection (CLABSI) and Catheter-associated Urinary Tract Infection (CAUTI) Updates for the PCHQR Program

Presentation Transcript

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Lisa Vinson: Good afternoon and thank you for joining today's educational event entitled *National Healthcare Safety Network Central Line-associated Bloodstream Infection and Catheter-associated Urinary Tract Infection Updates for the PCHQR Program*. My name is Lisa Vinson, and I am the PCHQR Program Lead for the PPS-exempt Cancer Hospital Quality Reporting, or PCHQR, Program with the Inpatient Values, Incentive, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be the moderator for today's event. As the title indicates, today's presentation will focus on the modified CLABSI and CAUTI measures as they relate to the PCHQR Program. I would like to emphasize that the specific content for today's webinar is only applicable to the participants in the PCHQR Program related to participation and reporting in CMS quality reporting programs. Please be sure to refer to information regarding both measures provided by the support contractor for your program. In addition to this, we felt that this topic and the information provided today will be beneficial to the PCHs since both CLABSI and CAUTI measures were refined and finalized for inclusion in the PCHQR Program. We also received feedback that information pertaining to these measure refinements would help the PCHs gain a better understanding of these measure updates. If you have a question as we go along through today's presentation, please type your question in the chat window. At the end of this event, we will have a question-and-answer session. For our speakers to best answer your question, we ask that, at the beginning of your question, please reference the slide number along with your question in the chat window. Questions that are not addressed during this question-and-answer session will be posted to *QualityNet* and Quality Reporting Center web sites at a later date. Furthermore, the slides for today's event were posted on QualityReportingCenter.com prior to the event. The transcript and recording of today's event will be posted on the same web site and *QualityNet* in the near future as well. Lastly, please be sure to remain in the event until the very end in order to complete the event survey which also contains the links for continuing education, or CE, credits.

If are you not able to stay on until the end of the event, you will receive an email with links to the survey and CE credit to the email address you provided during registration within the next 24 hours. Next slide, please.

Today's materials were created in collaboration with members of the Centers for Disease Control and Prevention, or CDC, team, namely Maggie Dudeck and Prachi Patel. Maggie is the lead for the National Health Care Safety Network Methods and Analytics team, and Prachi is a scientific data analyst. Maggie and Prachi will lead the discussion regarding the CLABSI and CAUTI measure updates as it pertains to the PCHQR Program. Next slide, please.

As a reminder, we do not recognize the raised-hand feature in the Chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the Chat tool. All questions received via the Chat tool during this webinar that pertain to this webinar topic will be reviewed, and a question-and-answer summary document will be made available at a later date. To maximize the usefulness of the question-and- answer summary document, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions again will be addressed in the summary document to be published at a later date. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool or during the question-and-answer session, nor in the question-and- answer summary document for the webinar. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool. You can access the Q&A tool using the link on this slide. There you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question to us via the Q&A tool which, again, you can access at the link on the slide. Later in today's presentation, I will review how to submit inquiries via the *QualityNet* Q&A tool. As stated earlier, there will be a moderated question-and- answer session at the end of this presentation.

So, please, be sure to enter your questions in the Chat window as the presenters move through the slides. We look forward to addressing as many

of your questions related to this webinar topic as time allows.
Next slide, please.

Here is a list of acronyms you may hear during today's presentation. These are quite familiar to participants in the program and regular attendees of our events. Acronyms you may hear and see include ACH, for acute care hospital; CDC, for Centers for Disease Control and Prevention; CAUTI, for Catheter-associated Urinary Tract Infection; CLABSI, for Central Line-associated Bloodstream Infection; NHSN, for National Healthcare Safety Network, and SIR, for Standardized Infection Ratio. Next slide, please.

The purpose of this presentation is to provide updates regarding NHSN CLABSI and CAUTI in the PCHQR program. Next slide, please.

There are several objectives we hope participants are able to achieve at the culmination of today's event. These include understanding the purpose and approach for measure re-baselining, along with factors used in SIR calculations; summarizing the CDC risk-adjustment methods and re-baselining analysis of CLABSI and CAUTI data; interpreting the PCHQR Program CLABSI and CAUTI SIRs; and producing CLABSI and CAUTI SIRS within the NHSN application. Next slide, please.

Before we delve deeper into our topic for today, I would like to provide a few background points regarding both CAUTI and CLABSI measures in the PCHQR Program. First, both measures were adopted into the PCHQR Program in the FY 2013 IPPS/LTCH PPS Final Rule, effective for the FY 2014 program year. Of note, CAUTI and CLABSI were the first two healthcare-associated infections, or HAI, measures finalized for inclusion in the PCHQR Program. Other HAIs were finalized for inclusion in subsequent final rule publications. Second, the refined versions of CAUTI and CLABSI, which will be discussed further today, were recently finalized for inclusion in the PCHQR Program in the FY 2021 IPPS/LTCH PPS Final Rule, effective for the FY 2023 program year, which was published in September. This year's final rule indicated that data collection of these refined measures will begin in calendar year 2021, and public reporting is tentatively scheduled to begin in the fall of calendar year 2022. Hyperlinks

to the final publications can be found on the PCHQR Program pages of the *QualityNet* and Quality Reporting Center web sites. The VIQR support contractor team is currently in the process of updating various pages on both sites to ensure the most up to date information is available. I would now like to turn the presentation over to our first speaker. Maggie, the floor is yours.

Maggie Dudeck: Thank you, Lisa. Thank you so much for inviting myself as well as my colleague, Prachi Patel, to present today on the CAUTI and CLABSI measures for the CMS PCHQR Program. Thank you for joining us this afternoon. I'm going to give a brief background and overview of the CAUTI and CLABSI measures, specifically with how we assessed cancer hospitals for these two measures. Prachi will go into more details behind the risk adjustment as well as how you can use the NHSN application and analysis tools to obtain your SIRs.

So, the CDC re-baseline is a term that we have used for a few years to basically describe our process for determining not just a new baseline year, but also assess and employ new risk models for calculating our Standardized Infection Ratios, or SIRS. I know many of you may already be familiar with SIRs, but, if you are new to this, the SIRs are a risk-adjusted measure, and it allows for scalability. So, essentially, what that means is that you can obtain a SIR for your CLABSI data at an individual-unit level, scaled all the way up to your entire hospital, for all units in your hospital. At the national-level, we then can scale it up at all different kinds of levels, including state level and the national level. With the SIR it does require a static baseline from which progress can be measured. When we look at data from 2019, we use the 2015 data as our baseline and our starting point. So, we can say for any particular HAI in 2019 how much progress has been made since 2015. For example, we can say if we have seen a 50 percent reduction in CLABSI since 2015.

Our most recent baseline year was 2015, and we concluded our rebaseline analysis in 2016. This resulted in nearly 200 new HAI risk models that use

the 2015 data, and we have been doing this to generate SIRs for 2015 data and forward.

To give you a very brief overview of the risk adjustment, it was performed at the national level, and we use data from all facilities that reported to NHSN for the HAI data. So that included a number of facility types like acute care hospitals, critical access hospitals. We looked at the data that we felt could help us explain and would be appropriate for risk adjusting for each particular HAI. Not all of the data elements that we analyzed were found to be statistically significant. We only ended up using those factors that were found to be statistically significant. In addition, significant factors do differ with each HAI and/or setting that is being analyzed. So, when we look at laboratory-identified event data, the risk factors for that are different than what we see for Central Line-associated Bloodstream Infections.

When it comes to the cancer hospital data and NHSN, it is important to note that, of more than 3600 acute care hospitals that we have, 17 of them at the time of our re-baseline were enrolled as cancer hospitals. Of those 17, 11 are considered PPS-exempt Cancer Hospitals. All inpatient units that are reported by cancer hospitals are oncology hospitals, so all of the cancer hospital data that we have within NHSN report for only oncology-type units. Whereas, for general acute care hospitals, they obviously have a large number of non-oncology type units for which they can report. It is important to note that all of the cancer hospital data are included in our NHSN acute care hospital risk models. So, what this means is that we do not have separate models for cancer hospitals alone. They are included with our acute care hospital population.

We did assess a hospital's enrollment status as a cancer hospital as a potential risk factor. This helped us to answer the question: "Was designation of cancer hospital a significant predictor of the HAI outcome that was being measured?" Our CDC results did produce a consistent finding when we performed this analysis.

That is, that designation of the cancer hospital was not a significant predictor of device-associated healthcare associated infections. The

same result emerged when we limited to just the 11 PPS-exempt Cancer Hospital subset.

For the Central Line-associated Bloodstream Infection, or CLABSI, model, all cancer hospitals are included in the reference group, and Prachi will explain what that means as part of her presentation. The PPS- exempt Cancer Hospital subset contributed to 1.6 percent of all central line days reported in 2015 in our acute care hospital group. So, the reason I bring this up is because it is not simply enough for us to just measure how many hospitals contributed out of the total. We are also keenly interested in on the device days because device days contribute to not just the risk, but also the amount of precision and the measurement of that type of HAI. With the CAUTI model, it is slightly different. Cancer hospitals are included with general acute care hospitals as a risk group, which means they are not part of a reference group. There is some elevated risk, but they are included with the acute care hospitals in that elevated risk. In both of the CLABSI and CAUTI models, oncology locations were considered significant risk factors. The risk in the measurement of the SIRs, for your particular population, is being driven by the types of patient care units for which you are performing your surveillance and where your patients are residing. So, with that, I would like to turn it over to my colleague Prachi Patel for a more detailed look at these measures.

Prachi Patel: Thank you, Maggie. Good afternoon, everybody. Thank you for joining today's presentation. My name is Prachi Patel, and I am a member of the Methods and Analytics Team within NHSN. As mentioned earlier, I will review the NHSN risk adjustment for CLABSI and CAUTI.

I will then review the SIRs and the tables within NHSN and interpret that information. So, let us begin. Next slide.

As a review, the SIR, or Standardized Infection Ratio, is a summary statistic that compares the number of HAIs that were reported to the number of HAIs that were predicted based on our referent time period, which is 2015. The SIR is your number of observed HAIs divided by your expected number of HAIs. The expected number is derived from the HAI-

specific model. We'll go over the CLABSI and CAUTI model in the next couple slides, but NHSN does calculate the information within the application. Next slide.

Let us do a quick interpretation of the SIR. So, if you have a SIR of 1, this indicates that the number of infections reported would be the same given the US baseline data. Greater than 1 would be more infections were reported than predicted given the baseline data. If you have a SIR of 1.25, then 25 percent more infections [occurred] than what was predicted. Less than 1 would be fewer infections were reported than what would be predicted given the baseline data. So, if there was a SIR of .50, then 50 percent fewer infections occurred than what was predicted. Next slide.

So, what is the basis for using SIRs and not rates? The SIR allows users to summarize data by more than a single stratum, such as location or procedure category, and it is adjusted for differences in the incidence of infection among that strata. So, unlike the rates, when you use the SIR this allows for summarization, while in rates, they are only comparable across that single strata such as location or facility type. Also, the SIR permits comparisons between the number of infections experienced by facility or group or state to the number of infections that were predicted to have occurred based on national data. Next slide.

So, I'm going the start by introducing the General Negative Binomial Regression Model, which is used for CLABSI and CAUTI. On the next couple slides we will go over factors included in the model and how to calculate your number predicted. More information regarding that can be found in A Guide to the SIR, which I have linked in this slide. It provides a more detailed look and explanation for items within the model and for the different HAI types.

I would highly recommend that when you have time to please look at the SIR. The majority of information in that guide can answer questions that you have regarding different models. Next slide.

So, what is included within the acute care hospital model for CLABSI and CAUTI? So, we have CDC location, which means hospital unit type and how it is mapped within NHSN. Is it mapped as a medical ward, or surgical ICU ward? [We have] facility type, how your facility registered at NHSN, such as general acute care or oncology hospital. Medical school affiliation and bed size are factors that are derived from the annual survey. The annual survey is released in the beginning of each year, and this would identify if your facility is a major teaching hospital and how many beds are within your facility. Next slide.

So here is a list of the parameter estimates for the CLABSI model. Parameter estimates reflect the nature of the relationship between that variable and the risk of HAI. In the case of these categorical variables, the risk of HAI in an individual category is compared to risk of HAI in the referent category. If you have a positive parameter estimate, that indicates that the risk of HAI in that category is higher when compared to risk of HAI in the referent category. If you have a negative parameter estimate, that indicates that the HAI risk in that category is lower when compared to the HAI risk in the referent category. I would like to point out the stars indicate where oncology units are being included in the CLABSI parameter estimates for CDC location. Next slide.

So, these are the other factors included in the CLABSI model. We have the Medical School Affiliation category, the Facility Type category, and the Facility Bed Size. Next slide.

Let us take a look at an example of calculating your number predicted. We have a 115-bed oncology hospital. They're a graduate teaching facility. They're reporting for a medical oncology critical care unit. That unit had 220 central line days for September 2020. So, let us try our hand at calculating the number predicted for this hospital, for that unit. Next slide.

From our example criteria from the previous slide, I created a model for entering in the parameter estimates to calculate the number predicted for this unit. So, what I have done is included all of the perimeter estimates on the left and, in the parenthesis next to each parameter estimate, the 1

indicates that the risk factor is present, and 0 indicates that it is not. So, since we want to calculate the number predicted for a Medical Oncology Critical Care unit, I would go ahead and enter in a 1 next to that parameter estimate of .3257 as indicated by that arrow. This screen shot is from the SIR guide that I mentioned earlier in my presentation. It will provide a more detailed look at the model and where different locations are categorized in which parameter estimate bucket. For the Medical Oncology Critical Care, it is included in all adult critical care units. Next slide.

Next, we will take factors from the annual survey. Since this is a 115-bed facility and it is a graduate teaching facility, those parameter estimates are indicated with a 1. So, the .1494 and .1160, you can see there is a 1 added there. So now that we filled out our model with all the pertinent risk factors, we can start our calculation. You would take your intercept, which is the -7.6325 and then would you add .3257 for your location. Then add .1494 for your medical school affiliation. Then would you add .1160 for your bed size Once you get that value, which is -.7, sorry, -7.0414, we would take the exponent of that number. Once you do that in your calculator, you get a value of .008749. So, this is the part of the model that you bring in your central line days or catheter associated days like Maggie mentioned. This is where that portion of the model is taking into account the device usage. So, what you would do is when you have the exponent number of .80008749, you multiply it by 220 central line days for that unit month. So, once you multiply that, that is when you will get your number predicted of .192 for that unit month. Next slide.

So, we have done all that work, and I know it cannot be expected to do that for every unit, every month, to get your information. It is helpful that NHSN does that for you. Now, that you have that information, how do you interpret it? Let us look at an interpretation of an SIR with an actual SIR table as pulled from NHSN. As you can see, this facility reported six CLABSIs, or infection counts, for critical care units during the first quarter of 2020. This is your observed number of CLABSIs. The overall SIR for this facility during that time period was 3.498. This indicates that the facility observed more infections than what was predicted, so the number

predicted for the first quarter was 1.715. Please keep in mind that a SIR will only be calculated if the number of predicted infections is greater than 1. So, for a previous example when we calculated it on our own, we had .192. That is not greater than 1. So, you will not have a SIR calculated for that time period. Next slide.

How would we interpret our P value? The SIR p-value is a statistical measure that tells you if your observed number of infections is significantly different from what was predicted. So, a p-value less than .05 indicates the number of observed is statistically significant from the number predicted. For both of these quarters, the p-value is below .05, so it is statistically different from your number predicted. Next slide.

How would you interpret the SIR confidence interval? If the confidence interval includes a value of 1, then the SIR is not significant. For example, i the lower bound is less than 1, and the upper bound is greater than 1, then the SIR is not significant. The visual to your right provides a graphical representation of what would be considered statistically significant and not statistically significant. As you can see, the red includes a value of 1, so is not statistically significant. However, the greens are outside of that 1 valu so you know that those are statistically significant. Next slide.

So, running your reports in NHSN, before you go into NHSN and start running your SIR reports, please remember to generate your data sets. Only data that are included within the time period boxes will be in the report. We receive a lot of questions asking why certain months are excluded from the reports, and that's because within the beginning time period and ending time period they have not included that specific month or quarter of data.

So, it is very important that as you add in information or you are removing events, or adding an event, then you enter the correct time period for what you wish to analyze. A lot of our issues can be resolved by just reviewing this screen before running any reports. Next slide.

So currently in NHSN, we have device-associated module reports. The SIRs are currently available. These reports will include data for 2015 forward, so if you were to navigate to any of the reports within the device-associated module, you will be able to run your SIRs for data for 2015 and forward. Next slide.

So, what is coming for hospitals participating in the PCHQR Program? There will be new CLABSI and CAUTI CMS SIR reports. They will replace the rate tables that are highlighted in the screen shot. They will be available beginning in 2021. These reports will only include data for 2021 Q1 moving forward. Unlike the device-associated modules I showed in the previous slide, those will have data moving 2015 forward to current, but these new SIR reports for the CMS PCHQR Program will only have data for 2021 Q1 moving forward. Also, please keep in mind the data submitted to CMS will be aggregate CCN-level data. If you are already within one CCN, it will be for that CCN-level data, not only for your individual org-ID. This is not applicable to everybody, but as a reminder. Next slide.

So, that is it for me. Here is a list of some analysis resources that are helpful to answer any questions that you may have during the analysis of your data within NHSN. If it is beyond what is in these reference guides, we highly encourage you to please reach out to NHSN@CDC.gov, and one of our many subject-matter experts will be happy to talk with you and help you through any issues that you may be having with your analysis data. Thank you very much, and we will move on to the next speaker.

Lisa Vinson: Thank you, Prachi. Thank you, Maggie, for that valuable information provided regarding the updated CAUTI and CLABSI measures.

So now we are ready to begin our question-and-answer session. Just as a reminder, if you do have a question, if you could please place it in the Ask a Question box. That way, we will be able to view that question and present it to the audience, and our subject-matter experts on the line can address those at this time. We will give you just a few seconds to do that if you

have not done so already. So, one question I see is: Are PCH SIR data only at the facility level, or is it available at the individual-unit level, as well?

Maggie Dudeck: Hi, this is Maggie. Prachi, did you want to take that one?

Prachi Patel: No, you can see your unit-level SIR data within the reports in NHSN. It will provide that information, and you can also see it at a facility level. There are different tiers as to how the SIR report is produced. You will be able to see it at the facility level, location type level, and then by your unit level. So, there is different tiers, and we do have training documents that will help you look at these different SIR reports.

Lisa Vinson: Okay. Thank you, Prachi. Second question, "Can you describe ARMS versus SIRs, and why are they not used or useful for the PCHs?"

Maggie Dudeck: Hi, this is Maggie. I'll go ahead and answer that. So, ARM stands for Adjusted Ranking Metric. It is a type of metric that recently became available within the NHSN application, I think within the past year. It is available at an overall level. Right now, I think it's for acute care hospitals and does combine data for a long period of time, like for a year combined. So, we do not look at the ARMS at a quarterly level. I think the wonderful thing about the Adjusted Ranking Metric is that it does help to adjust, particularly for those facilities that have a low volume of let us say central line days and maybe they cannot obtain the SIR. It is something that can be used in the future for a composite metric or for quality measurement and public reporting. However, from a prevention standpoint and from an individual facilities standpoint in trying to track progress of their HAI data over time, even at the quarterly level, the usability of the ARM has not really been practiced yet. So, I think there is still a lot more work to be done on that aspect. So, for individual facility use, I think the ARM can provide some measurement of where you may stand among the nation during that particular point in time, but the SIR is really rich in information because you can scale it down to your individual unit level and understand where your HAIs are occurring and how much device days you have within each of your units and how that shifts throughout the year. If you have any

additional questions about the Adjusted Ranking Metric, please feel free to email our NHSN team at NHSN@CDC.gov.

Lisa Vinson: Thank you, Maggie. I would just like to revisit one of the questions that appears to may have been already answered, just so that everyone that is attending is able to see the answer for this or just to know the answer to this because I believe this question has come up before. The question states: "Can you share who the 17 cancer hospitals are, the 6 others than the PCHs?" Maggie or Prachi, can you address that question?

Maggie Dudeck: Sure. This is Maggie. I'm happy to address it. So, for those on the line who are enrolled in NHSN and using NHSN, when your facility signed up, you signed some of them electronically, what is called an Agreement to Participate and Consent. That agreement to participate and consent is an agreement between you and CDC and what we do is CDC outlines this is how the data will be used, this is how data will be shared. In that, it gives us the ability to share data with CMS for those data that are part of a CMS program. There are some other stated purposes in there. Wrapped all up in that is an Assurance of Confidentiality, and there is also some other legal type language in there as it relates to the Public Health Service Act. So, we take that agreement very seriously, and we take the confidentiality of your facility and your facility's data very seriously. With that, we are not allowed to share information that would be outside of those stated purposes and our Assurance of Confidentiality, which means we are not able to share your data or information on everybody who contributed to a particular subset, especially being the small number of facilities that are in there.

We do not share that with just anybody who asks. So, we take it very seriously, and we do have our stated purposes and Assurance of Confidentiality on the NHSN web site if you are interested in seeing what is stated on there.

Lisa Vinson: Thank you, Maggie. One other question: "To be clear from Maggie's comments, do the 17 cancer hospitals report only oncology units?"

Maggie Dudeck: Yes. This is Maggie. So, sometimes we get questions on whether or not our cancer hospital data or a designation of a cancer hospital includes hospitals that are, and I am blanking on the name, but that have like a cancer center designation, I think, from NIH. I apologize if I completely messed up what that designation is called, but we know there are much larger of facilities that fall into that. The cancer hospital designation within NHSN really serves as a point of we are solely a cancer hospital rather than an academic facility that may have a separate cancer center or specialized cancer set of wards that they service. This is really meant to be largely, we service oncology population and so, therefore, their opportunity to report data in to NHSN is based solely on these are the types of oncology units that we have for our patient population, and we don't have other sorts of just general medical wards or general maternity wards. We have some special units specific to that population.

Lisa Vinson: Thank you, Maggie. Next question: "Are PCH SIRs comparable to ACH oncology SIRs? It seems like PCH patients may be more acute or risky than patients at ACH facilities, and [I am] curious if the model fully adjusts for those differences."

Prachi Patel: Hi, this is Prachi. I will take a stab at this. Maggie, if you would like to finish it off or add other information. So, the model takes in to account your CDC location as it is mapped. So, your patient acuity for the model is gathered from your CDC location and then your facility type is taken into account later on into the model. So that's how the patient acuity is incorporated into the model. Maggie, did you have anything else you wanted to add?

Maggie Dudeck: I think you have covered it well. I think I would just add to wrap into that is that, you know, part of our analysis earlier on to assess cancer hospitals separately included this additional designation of as a facility type in addition to controlling for the types of units. Do we see any sort of significant difference? We did not see any of that difference back when we were looking at the 2015 data. Now, eventually there will come a time and, no, I don't know when it is, but there will come a time where we will need on reassess and develop new models for future SIRs and we will assess this

factor again. So, it is something that we will continue to look at and consider but based on the data that we had and what had been reported, there was no significant difference.

Lisa Vinson: Okay. Thank you, Maggie and Prachi. Looks like this will conclude our question-and-answer session at this time. We thank those who submitted your questions. Again, if your question was not addressed, a question- and-answer summary document will be available at a later date on *QualityNet* and Quality Reporting Center web sites. Next slide, please.

Before we close today's event, I would like to provide a brief overview on submitting questions via the *QualityNet* question-and-answer tool. Next slide, please.

Displayed on this slide is how you can access the PCHQR Program question-and-answer tool via the *QualityNet* home page. You will access this tool by selecting the Help drop down link as indicated by the red box and then selecting the PPS-exempt Cancer Hospitals link to start the process. Next slide, please.

Now, you are at the *QualityNet* question-and-answer tool landing page. After you select the Ask a Question link as shown by the red box on the slide, you will be taken to a page where you will need to complete your personal information. Then, you will be asked to enter details regarding the inquiry you are submitting. On this page, you are also able to browse program articles, and search to see if your question may have been previously addressed and posted for viewing. Next slide, please.

Here is where you will submit your inquiry. Be sure to complete the required fields. Once this is complete, you will need to select Submit a Question as denoted by the red box on the slide and this will submit your inquiry.

We encourage you to utilize this tool to ask any program-related questions you may have, and you may also query the system to see

if the topic you are inquiring about has already been addressed. Next slide, please.

As indicated on this slide, today's educational event has been approved for continuing education, or CE, credit by the boards listed. If you need additional information or assistance obtaining these credits, please utilize the CE credit link listed on this slide. Next slide, please.

In closing, we would like to thank you for your time and attention during today's presentation. Also, a special thank you to our guest speakers, Maggie and Prachi. We hope that the information provided today was beneficial to you as a PCHQR Program participant. Please remember, if you are able, to remain in the event to complete the event survey and retrieve the links for CE credit. Thank you and enjoy the remainder of your day.