Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

Measure Dry Run
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility

Presentation Transcript

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Evette Robinson: Hello everyone and welcome to today's Inpatient Psychiatric Facility Quality Reporting Program webinar. My name is Evette Robinson and I am the Project Lead with the bigger support contractor for the IPFQR Program. Before we begin today's webinar, I would like to remind those in attendance that the slides for this presentation were posted to the Quality Reporting Center web site prior to the event. If you did not receive the slides beforehand, please go to the Quality Reporting Center web site at www.qualityreportingcenter.com, on the right side of the homepage you will find a list of upcoming events. Click on the link for this event, scroll down to the bottom of the page, and there you will find the presentation slides available for download. This session is being recorded and the slides, transcript, webinar recording and questions and answers from this presentation will be posted on the *QualityNet* and Quality Reporting Center web site at a later date. At this time, I would like to introduce our guest speakers for today's event: Dr. Reena Duseja and Megan Keenan.

Dr. Reena Duseja is the Director of the Division of Quality Measurement in the Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality at the Centers for Medicare and Medicaid Services. She oversees measure development and analysis for a variety of CMS quality recording and value-based purchasing programs. She received her medical degree from George Washington Medical School, trained in emergency medicine, and also holds a Masters in Science in Health Economics from the Wharton School of Healthcare Economics and Management at the University of Pennsylvania.

Megan Keenan is a health services researcher with expertise in quality measure development and project management. She leads the contract responsible for the development, maintenance and implementation of quality measures for the CMS IPFQR Program. She holds a master degree in health policy and administration from the Yale School of Public Health. Please note that we do not recognize the raised hand feature in the chat tool during webinars. Instead, you may submit any questions that are related to the topic of this webinar to us via the chat tool. The measure developer will respond to questions during this webinar. Questions to

which the measure developer cannot respond during the webinar will be reviewed and documented in a Q&A transcript which will be available again at a later date.

If you have a question that is not related to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool, which you can access using the link on this slide. Now, without further ado, I will turn the presentation over to our first speaker, Dr. Duseja.

Reena Duseja: Thank you, Evette. So, I'm on slide 7. CMS developed a 30-day all-cause unplanned readmission measure for the inpatient psychiatric facility setting. To introduce the measure in the setting, CMS is conducting what we call a measure dry run which will run from October 17 of 2017 through November 14 of 2017. The purpose of the dry run is to educate facilities about the measure specifications and familiarize them with how the measure results will be publicly reported, which starts in December of 2018. It's important to note that the measure results shared with facilities during the dry run will not be publicly reported.

On slide 8, I have the purpose of the presentation and so during this presentation the participants will learn how the IPF readmission measure will be used in the Inpatient Psychiatric Facility Quality Reporting Program, how the measure is specified and calculated, and how to interpret your facility's results. The dry run results are calculated using Medicare fee-for-service data from September of 2014 through August of 2016. At the conclusion of this presentation, the measure developer will be available to respond to your questions. Submit it through the chat tool on the measure specifications or the interpretation of facility results. As a reminder, please do not include any patient identifying or protected health information in your questions.

Slide 9 describes the background of this measure. CMS prioritized the development of an IPF readmission measure because the IPF patient population is not included in our other readmission measures. Readmissions among psychiatric Medicare patients admitted to IPF settings are relatively common. They occur after approximately one in five

discharges. Now, while we recognize that not all readmissions are avoidable, and they can result from examples like natural disease progression or necessary planned follow-up care, there still exists wide variation in the readmission rates across facilities and it indicates that there is room for improvement in this setting. As you can see from this slide, there's a variation across facilities and it persists even after adjustment for differences in the type of patients treated by each facility, and this range is anywhere from 11% to 34%. Currently, many facilities have limited access to information on their patients after they leave their facility. Some may only be able to track the readmissions that come back to their own facility or to their partner organizations, and this also hinders quality improvement efforts to reduce readmissions.

Slide 10 describes the goal of this measure. The goal of the IPF readmission measure will provide facilities with complete information on readmissions for their Medicare patient population to help inform readmission reduction efforts. Literature was identified during the development of the measure that provides examples of effective readmission reduction strategies. Now, these include administering evidenced-based treatments for the patient's condition, connecting patients to post-discharge services and follow-up care, performing medication reconciliation to reduce medication errors, and communicating with the patient care providers about the treatment plan, and educating the patient about their treatment during the discharge process. Now, additional strategies in the supporting literature will be provided in the measure technical report. However, we also recognize that not all readmission reduction strategies are appropriate for each facility or, maybe, even for each patient, so we encourage facilities to develop interventions that best meet the needs of their patient population.

Slide 11 describes the intended use of the measure in our IPFQR Program. So, given the existing gap areas of potential to improve patient outcomes in this setting, CMS added this measure to the Inpatient Psychiatric Facility Quality Reporting Program in the federal rule which was published on August 22, 2016. This program is pay-for-reporting, so

facility performance of the measure is not considered when determining the payment updates. The measure is calculated by CMS using Medicare claims data, so facilities are not required to abstract or submit additional data. As noted earlier, the measure will be publicly reported on *Hospital Compare* in the table with the other IPFQR measures and that will start in December of 2018. Finally, this measure has received endorsement from the National Quality Forum in 2016 and we will be updating that annually. With that I will hand it over to Megan Kennan, who will provide an overview of the measure specifications and information on how to interpret your facility results.

Megan Keenan: Great, thank you. The specifications were developed by clinical and measure development experts at the University of Florida and Health Services Advisory Group. The team aligned the measure structure with the hospital-wide readmission measure currently in use in the hospital setting. That measure does not include psychiatric patients, but is similar in that it is not specific to a single condition. Once fully developed and adapted to the IPF patient population, the IPF readmission measure was reviewed and approved by a technical expert panel, consisting of 17 participants representing clinicians, patients, measure development experts, and organizations that focus on improving care for psychiatric patients. The final measure was then released for public comment in 2016 and subsequently updated in 2017 to include ICD-10 codes. The measure development team will update the measure annually to ensure that current code sets are applied, it's aligned with related measures, and it addresses recommendations from stakeholders.

The criteria for the measure population outline the types of patients who are eligible to be assessed by this measure. The unit of measurement for the measure population is called an index admission. Given that this measure specified for the IPF setting, it is limited to patients with principal psychiatric diagnoses who are admitted to either a freestanding IPF or an IPF unit within a larger facility. The measure does not include psychiatric patients admitted to other acute care settings. The measure does include admissions during a two-year performance period to ensure that most

facilities have enough cases in their measure population for a reliable measure score. The patients must be enrolled in Medicare Parts A and B during the admissions, prior to admission, and at least one month after discharge because the claims data are used to identify all eligible patients, readmission outcomes, and patient risk factors. It's worth nothing that severe mental illness can qualify as a disability, so about two-thirds of patients in this Medicare population are under age 65. Therefore, the measure includes patients age 18 or older at admission. Finally, to be eligible for the initial patient population, patients must be discharged alive because patients who expire during the admission could not be readmitted following that stay. Once the initial measure population is identified, exclusions are applied to further refine the eligible population. Patients who leave against medical advice are excluded because the facility may not have had an opportunity to provide complete discharge care, so it may not be fair to hold them accountable for readmissions following those discharges. Patients with unreliable data are excluded. Unreliable data include admissions with discharge status of deceased, but where the patient has subsequent admissions or where the death date is prior to the admission date. Transfers for appropriate medical care are not considered readmissions. Therefore, patients who are transferred are excluded from the measure entirely because the intervening admission could influence readmission rates and it would not be fair to hold the original admitting facility accountable for care that was potentially provided by another facility. Finally, patients who are readmitted within two days of discharge from the IPF are excluded because readmission to the same IPF in that timeframe is considered an interrupted stay by CMS billing policy and, therefore, that claim is bundled with the claims for the index admission. This means that readmission within two days of discharge are only visible in the claims data if the patient is not readmitted to the same IPF. This combines measure results, so all patients are excluded. Next, we'll discuss the readmission outcome. This measure, like other existing readmission measures, evaluates readmissions for any cause. This encourages consideration of both physical and psychiatric conditions. It also allows IPF's to implement a broader range of quality improvement initiatives. It's particularly important, in this patient population, because patients with

psychiatric illness have a greater likelihood of dying prematurely from preventable or treatable co-morbid medical conditions. Additionally, the relationship between the diagnosis at admission to the IPF' and a diagnosis of their readmission is complex. For example, a patient discharged with schizophrenia could be readmitted with a hip fracture due to a fall from side effects and prescribed medications that were not adequately reconciled. However, it is worth noting that the top five most common diagnoses of readmissions are, in fact, related to psychiatric illnesses. The measure does not include readmissions and the outcome for planned procedures. The approach to identifying and removing planned readmissions is aligned with the hospital-wide readmission mentioned earlier in the presentation. Plan readmissions are relatively rare in the patient population, at around 2% of all either planned or unplanned readmissions. The measure looks for readmissions in the 30-days following discharge from the IPF, which is consistent with existing readmission measures and supporting literature. The outcome is binary, so each index admission can either have an outcome of readmitted or not readmitted. Therefore, only one readmission is counted in the measure rate for each index admission. One final note on the outcome: If the first readmission as a planned readmission, the measure stops looking for additional readmissions so that the IPF of the index admission is not held accountable for outcomes that may have resulted from the intervening planned readmission.

The measure rate is risk-adjusted because patients may have different risks of readmission that are unrelated to the quality of care provided by the IPF that treated them during the index admission. As you can see here, the measure is only trying to assess differences in IPF performance; therefore, the measure adjusts for the types of patients or case mix treated by each facility. Risk factors must be patient characteristics and not characteristics of the IPF, they must be present at the start of care, and not reflective of care provided during the index admission. They must be related to the outcome both conceptually and empirically and, finally, they must be reliably collected and available on national datasets.

The risk model should contain as few risk factors as possible to improve the strength of the association between the risk factors and the readmissions. Therefore, the measure development team combined variables with similar clinical presentation and risk of readmissions and removed variables with weak associations from the model.

The final risk model includes four types of patient risk factors: demographics for age and gender, the principal discharge diagnosis of the index admission, psychiatric and non-psychiatric co-morbidities present during the index admission and the year prior to index admission, and finally, other psychiatric specific risk factors related to having a history of leaving inpatient settings against medical advice or history of suicide attempts or self-harm.

Next, we will discuss the measure dry run in more detail and walk through an example of an IPF-Specific Report to provide information on how to interpret your facility's results. Note that the data shown on subsequent slides are for demonstration purposes only and do not reflect an actual facility's results or actual national level data. If you have not done so prior to this call, we encourage you to download your IPF-Specific Report and review your results prior to November 14, 2017. The measure developer will be available through that date to provide support if you have any questions on your report. You can send all questions to PQM@HSAG.com. As a reminder, measure dry run results will not be publicly reported. The purpose of the dry run is to familiarize facilities with the measure and a type of information that will eventually be publicly reported in the future.

To download your IPF-Specific Report, log into your *QualityNet Secure Portal* and open your AutoRoute_inbox. Once there, you will see a zip file that contains your IPF-Specific Report Excel file and a PDF measure information and user guide. The user guide will help with interpretation of the IPF-Specific Report. Highlight that file and click "Download." Facilities without active CMS Certification Numbers or without any eligible cases in the measure population between September 20, 2014, and August 2016, will not receive an IPF-Specific Report file.

If you do not see a file in your AutoRoute_inbox and do not believe your facility falls into either of those two categories, please contact PQM@HSAG.com.

Once you have downloaded your IPF-Specific Report, you'll notice that it consists of six worksheets listed here. On the subsequent slides, we'll describe each in more detail. First, open Worksheet 1 to review the summary. This includes your IPF name, CMS Certification Number and state. If you notice discrepancies in any of your facility information, please contact PQM@HSAG.com before continuing to review your IPF-Specific Report. As a reminder, please do not email your IPF-Specific Report because it includes personally identifiable information and protected health information. We ask that you also take care not to include this information in your questions. Worksheet 2 contains your facility's performance relative to the national readmission rate. This is the information that would be publicly reported during a reporting year. However, as we mentioned earlier, the measure dry run results in this report will not be publicly reported because this is not a reporting year for this measure. Measure scores are presented as risks standardized readmission rates or RSRRs, seen here next to the red arrow. Confidence intervals are calculated around each RSRR to determine whether the score is statistically different from the National Readmission Rate, seen here next to the blue arrow. If the National Readmission Rate falls between the lower and upper limit of the confidence interval, the facility's performance is considered no different than the national rate. In this example, the facility performance was no different from the national readmission rate because its confidence interval expands from 14% to 24.8% and includes the national readmission rate of 20.9%. The performance category is shown in the row next to the orange arrow. Below that, in Table 2, this worksheet also provides an overview of how other facilities nationwide and within your state perform relative to the national readmission rate. Here, lower readmission rates indicate better performance, so facilities that perform better than the national rate have confidence intervals completely below the national rate and facilities that perform worse than the national rate have confidence intervals completely above the national

rate. In this example, you can see that most facilities nationwide perform no different than the national readmission rate. However, within this facility state, there's a much higher proportion of facilities that perform worse than the national rate. Finally, you'll notice rows for the number of facilities with fewer than five cases in their measure population between September 2014 and August 2016. This is too few cases to obtain a performance category relative to the national rate. In this example, there are 72 facilities nationwide that have fewer than 25 cases during the measurement period and were not assigned a performance category. The remaining information on Worksheets 3 through 6 of the IPF-Specific Report will not be publicly reported during the reporting year. This information will be provided to facilities to further inform quality improvement activities. Worksheet 3 is intended to provide more information on how the RSRR is calculated and how it relates to the RSRR of other IPFs nationally. Table 3 provides more information on how your RSRR was calculated. First, your observed readmission rate next to the blue arrow is calculated by dividing the number of unplanned readmissions by the total number of index admissions in the blue circle. In this example, the observed readmission rate is 16.1%. Next, risk adjustment is applied to obtain the facilities Standardized Risk Ratio relative to the national readmission rate, which has a Standardized Risk Ratio of one. In this example, the facility's Standardized Risk Ratio is less than one because it is better than the national readmission rate. If the facility's rate was worse than then national readmission rate, it would have a Standardized Risk Ratio greater than one. Next, the Standardized Risk Ratio in the yellow circle is multiplied by the national readmission rate in the other yellow circle to obtain the Risk Standardized Readmission Rate or RSRR, next to the yellow arrow. The same is done to obtain the confidence interval for the RSRR. Tables 4 and 5 show how your facility's observed and risk-adjusted readmission rates compare to other facilities with at least 25 eligible index admissions. In this example, the facility is in the 25th percentile for RSRRs, which indicates that their RSRR is lower or better than 75% of facilities.

Worksheet 4 helps facilities better understand their readmissions compared to facilities nationwide. Table 6 shows total number of readmissions in the row with the blue circle. In this example, the facility has 49 index admissions that were followed by an unplanned readmission. Among those readmissions, 12 returned to their facility and 37 were readmitted to another facility, as indicated by the rows with the red circles. Prior to this measure, this facility may only have been aware of the 12 readmissions to their own facility, but with this report they can see the additional three quarters of readmissions that are occurring at other facilities. This report further breaks down the 37 readmissions to the other facilities with the rows with the yellow circles by showing that 21 were to other IPFs and 16 were to acute care hospitals. The percentages in the rows beneath the red and yellow circles show the percentage of overall readmissions. In this example, the facility has a higher percentage of readmissions to other IPFs than other facilities on average. This information may lead this facility to reach out to other IPFs in their area to better coordinate care.

Table 7 and Worksheet 4 provide more information on readmissions at the patient level compared to patients nationwide. In this example, you can see that the facility has 305 index admissions, but only 271 patients because some patients may have had multiple index admissions between September 2014 and August 2016. In the next rows, you can see that the facility had 49 readmissions in the outcome, but only 45 patients because, again, patients may have had multiple index admissions that were followed by a readmission during the performance period. This table further breakdown the readmissions by showing how many patients were only readmitted once and how many patients were readmitted multiple times during the performance period. In this example, the facility had three patients who were readmitted multiple times in the performance period, which accounts for much smaller percentage of patients with multiple readmissions than is observed nationwide. When interpreted with the information on the previous worksheet, with the RSRR percentile, this could indicate that the facility is doing a better job than other facilities on average at preventing readmissions. However, it could also indicate that

the patients treated by this facility have lower risks for readmission, independent of the facility quality. Regardless, this facility can use the information in this table to find patients with multiple readmissions and a discharge level worksheet to target readmission reduction interventions to patients that are at highest risk of readmission.

Tables 8 and 9 and Worksheet 4 provide information on most common diagnoses of index admissions and their specific readmission rates. Table 8 provides this information for your facility and Table 9 provides national information for comparison. In this example, the facility can see that they treat a higher proportion of patients with psychosis than many facilities nationwide, as indicated by the blue circles. You can also see that patients with psychosis have lower readmission rates at this facility than patients with psychosis nationwide. However, the facility can also see that their patients with drug disorders have higher readmission rates than patients with drug disorders nationwide, as indicated by the red circles. They can use this information to target readmission reduction strategies for patients with drug disorders. Finally, these tables show how many patients are readmitted for the same diagnosis as the index admission in the last column. As noted earlier in the presentation, the relationship between the principal diagnosis of the index admission and diagnosis of the readmission is complex. Few patients are readmitted for the exact same condition; however, this does not mean that readmissions for other causes are unrelated to care provided during the index admission. Information on readmissions for the same condition is provided here because particularly high rates would indicate that patients are relapsing frequently, which would highlight areas for targeted quality improvement. In this example, the facility does not have any particularly high rates of readmission for the same condition, as they are all well under 5%.

Tables 10 and 11 and Worksheet 4 provide information on the most common diagnoses of readmissions, with their counts and percentages of all readmissions. Table 10 provides this information for your facility and Table 11 provides national information for comparison. In this example, the facility has a higher percentage of patients readmitted for psychosis

than patients nationwide. When considering this information in the context of the information in Tables 8 and 9, this could be due to the fact that this facility treats a higher percentage of patients with psychosis than facilities nationwide. This facility could use his information to perhaps target readmission reduction strategies towards patients with psychosis to bring down their overall readmission rates. In general, when reviewing these tables, facilities can look for any top diagnoses that differ from the top diagnoses nationwide or percentages that are much higher than observed nationwide to identify areas for quality improvement.

Worksheet 5 shows how your facilities case mix of patients compares to patients nationwide. As you can see, risk factors are broken down by the higher-level categories presented earlier. The example in this slide is truncated, but your table should include the demographic, principal discharge diagnosis, co-morbidity, and history of risk factors. To interpret this information, let's look at the risk factor for gender. This table indicates that approximately 52% of this facility's 305 index admissions were from male patients. This facility has a slightly higher percentage of male patients than is observed nationwide, which is only around 49% male patients. Looking next to age in this example, this facility has a slightly younger population than is observed nationwide. Continuing to move down in the principal discharge diagnosis section, you'll notice that some cells have the letters "NQ", instead of a percent. This indicates that none of the 305 index admissions had the principal discharge diagnosis indicated by that row. An interesting observation in this example is that the facility did not treat any patients with a principal discharge diagnosis of dementia, but approximately 14% of index admissions to IPFs nationwide were for dementia. This again will help facilities better understand their patient population for targeted readmission reduction interventions.

Finally, Table 13 and Worksheet 6 provide discharge level data on each eligible index admission included in the measure population at your facility. Each row represents an individual index admission and an ID number. In an example we have been discussing, the facility would have

index admissions with ID numbers one through 305, because they had 305 eligible index admissions in their measure population. The next column includes your provider ID, which should be the same for all index admissions to your facility. Please email PQM@HSAG.com if you identify any rows with provider IDs in Column B that are not for your facility. The next four columns provide the beneficiary ID number, medical record number, admission date, and discharge date, so that you can identify the cases in your medical records if you want to obtain additional information for quality improvement efforts. The next few columns provide the ICD-9 or ICD-10 code and higher-level condition category of the principal discharge diagnosis. Facilities can sort the table by this information to compare similar index admissions. The next column indicates whether an unplanned readmission occurred in the 30 days following discharge from your facility. So, you will see a "Yes" if there was a readmission and a "No" if there was not a readmission. Facilities can start by this column to group all index submissions that were followed by a readmission. The remaining columns provide additional information on the readmissions that occurred including the readmission date, discharge date, ICD-9 or -10 code, and higher-level condition category for the principal diagnosis, whether the readmission occurred at your facility or another provider, whether the readmission was to an IPF, and the provider ID of the readmitting facility. This information can be used in the context of information provided on previous worksheets to identify areas for quality improvement and specific types of patients who may require more targeted readmission reduction interventions. This information also allows facilities to identify other facilities in their area where patients are being readmitted to improve coordination of care.

Now that we have fully reviewed the IPF-Specific Report, you can find additional dry run resources like a dry run fact sheet, the full measure technical report, and answers to frequently-asked questions on the inpatient psychiatric facilities measures page on *QualityNet*. As a reminder, this information was provided to familiarize facilities with the IPF readmission measure.

This measure will not be publicly reported this year. Public reporting for this measure will begin in December of 2018 using a performance period from July 2015 through June 2017. Now, we will open it up for questions.

Evette Robinson: All right, so we're going to take a look at some of the questions that we've received so far through the chat tool and we'll respond to those. So, Megan, did you want to begin with our first question today?

Megan Keenan: Sure, thank you, Evette. So, our first question that we received was a question about whether the numbers in the presentation were real. No, these numbers were just for illustration. For the actual national numbers, please refer to your IPF-Specific Reports. So, our second question that we received was how we identify IPFs for inclusion in the measure. So, we identify IPFs using their CMS Certification Number for participating IPFs. The next question we received is whether or not the measure is based on abstracted data. No, this measure is calculated from Medicare administrative claims data. Facilities will not be required to collect or submit any data for the measure calculations. The next question we got in was related to how facilities would know where their patients were readmitted to. So, the last tab of the IPF-Specific Report, the Excel file, contains information on each readmission. So, the provider ID of the readmitting facility is in Column Q and there's a link at the bottom of that file to search for provider ID. The next few questions deal with transfers. So, the first one was how we identify transfers. So, for this measure, like a lot of the other readmission measures, transfer is considered if an admission occurs on the day of discharge or the day following discharge from the index admissions. The measure does not use discharge status codes to identify transfers. In the next transfer question, they ask if their patient was discharged from their facility and transferred to a medical unit, would that count as a readmission. So, that would not count as a readmission as long as the transfer occurs again on the day of discharge or the day following discharge from the index submission. When a transfer occurs, the index admission is excluded from the measure altogether, so that the readmission is not counted and the facility is not held accountable

for outcomes that may have resulted from care that was provided during the intervening admission. The next question here asks if patients are readmitted for medical reasons, would that count in the readmission outcomes. So, here this is a little bit different. The answer to this would be yes, as long as it was not a transfer because the measure assesses unplanned readmissions for any cause, either psychiatric or medical. The next question is asking, and actually there were a few, if facilities could receive more time to review their report. So, we will go ahead and extend the measure dry run to allow additional time for facilities to submit questions and we'll send out a communication with the revised end date after this call. I think that was our last question here.

Evette Robinson: All right. Well, thank you so much again for reviewing those questions and answers. I think at this point we can get back to the tail end of our presentation for today.

Megan Keenan: If your question was not answered during today's call or if you have additional questions after reviewing your IPF-Specific Report, please send your questions to PQM@HSAG.com through November 14. As a reminder, please do not email your IPF-Specific Report, or include patient identifiers, or other protected health information in your questions. This concludes my portion of today's webinar, I will turn the presentation back over to Evette Robinson.

Evette Robinson: Thank you, Megan. In the next few slides I will briefly review helpful resources pertaining to the IPFQR Program. CMS recommends that IPFs refer to the IPFQR Program manual for information pertaining to the program. This manual is located on the *QualityNet* and *Quality Reporting Center* web sites. It contains information about program requirements, measures, and various tools pertinent to the program. An updated version of the manual and associated paper tools will be published before the end of this year and the availability of these materials will be announced via the IPFQR Program ListServe.

You can click on the title of the table on this slide to access the IPFQR Program resources page on the *QualityNet* web site. Additional active

links on this slide are available for you to send us your questions about the IPFQR Program. In particular, we encourage you to use the Q&A tool because it provides the best means by which we can track questions and answers and also delivers our responses directly to your email inbox. When submitting a question to us via the Q&A tool, we do ask that you provide the six-digit CCN for your facility for tracking purposes. This tool is also a great way for you to let us know what types of questions and topics you would like for us to address in future webinars. In addition, we recommend that you sign up for the IPFQR Program ListServe, if you have not already, so that you can receive communications that we send out to the IPFQR community pertaining to webinars, program updates, and other announcements. You can sign up to be added to the ListServe or to receive those notifications on the *QualityNet* ListServe registration page.

Here is a list of upcoming educational webinar events that we have planned for the remainder of this year. Again, we encourage you to monitor your emails to ensure that you receive information regarding the date, time, and content for these webinars via the IPFQR Program ListServe. At this time, I will turn the presentation over to Deb Price, who will describe the continuing education credit process for this event.

Deb Price: Thank you very much. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider and, as such, all nurses report their own credits to their boards using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credit.

We now have an online CE certificate process. You can receive your CE certificate two ways. The first way is if you registered for the webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk, please pass the survey to them.

After completion of the survey, you'll notice at the bottom right hand corner a little gray box that says “Done.” You will click the “Done” box and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk. Please use your personal email for this separate registration, so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificate from entering your computer.

If you do not immediately receive a response to the email that you signed up with for the Learning Management Center, that means you have a firewall up that's blocking the link into your computer. Please go back to the new user link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your new user link, just wait 48 hours because, remember, you're going to be getting another link and another survey sent to you within 48 hours.

Okay, this is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click “Done” at the bottom of the page when you are finished. This is what pops up after you click “Done” on the survey. If you have already attended our webinar and received CEs, click “Existing User.” However, if this is your first webinar for credit, click “New User.”

This is what the new user screen looks like. Please register a personal email like Yahoo, or Gmail, or AT&T since these accounts are typically not blocked by hospital firewalls. Remember, your password since you will be using it for all of our events. You notice you have a first name, a last name, and the personal email and we're asking for a phone number in case we have some kind of backside issues and we need to get in contact with you.

This is what the existing user slide looks like. Use your complete email address as your user ID and, of course, the password that you registered with. Again, the user ID is the complete email address including what is after the @ sign. Thank you for taking this time with me.