Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

Improving Behavioral Health Outcomes Through Measurement-Based Care

Presentation Transcript

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The IPFQR Program's outreach and education methods occasionally facilitate the presentation of material and opinion that are not necessarily those of CMS. This is one such webinar wherein the content is provided by the National Committee for Quality Assurance, or NCQA. This presentation is provided for potential interest and general educational value for the IPFQR Program's participants. And the presentation does not directly concern the operation of the program nor program participant performance. The material and opinions that are included in this webinar are those of the NCQA, not necessarily those of CMS.

Hello everyone and welcome to today's Inpatient Psychiatric Facility Quality Reporting Program webinar titled *Improving Behavioral Health Outcomes Through Measurement-based Care*. My name is Evette Robinson and I am the Project Lead with the VIQR Support Contractor for the IPFQR Program. It is my pleasure to introduce our guest speakers for today's webinar, Dr. Sarah Hudson Scholle and Dr. Junqing Liu. Dr. Sarah Hudson Scholle is Vice President for Research and Analysis at the National Committee for Quality Assurance, or NCQA. She has been with the NCQA for over 15 years where she leads research on new opportunities from measuring quality of care and models of care to improve outcomes. She has led projects to develop performance measures related to depression, antipsychotic medication management, and care for people with serious mental illness, and is a consultant to HSAG on the development of measures for IPF. Prior to joining the NCQA, Dr. Scholle

was an associate professor and conducted mental health services research at the University of Pittsburgh Department of Psychiatry. Dr. Scholle received her Master in Public Health from Yale University and Doctorate in Public Health from the Johns Hopkins University School of Hygiene and Public Health. Dr. Junqing Liu is the Research Scientist in the Performance Measurement Department at NCQA. She has been with NCQA for over six years where she serves as a project director and researcher on several federally-funded child and adult behavioral health measurement projects. Prior to joining NCQA, Dr. Liu was a research assistant professor at the University of Maryland School of Social Work and conducted evaluations of federally-funded research, projects on the implementation of evidence-based practices, and child welfare systems in six states. Dr. Liu received her PhD and her Master in Social Work from State University of New York, Albany. Before we proceed with today's webinar, I want to remind those in attendance that the slides for this presentation were posted to the *Quality Reporting Center* website at *www.QualityReportingCenter.com* prior to the event. If you did not receive the slides beforehand, you can download them from the Quality Reporting Center website. On the bottom of the home page, you will see a list of upcoming events. Click on the link for this event and you will find a link to the presentation slides available for download at the bottom of the page. As previously mentioned, 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* website at a later date.

During today's presentation, we will discuss the current state of behavioral health quality measurements in general and not specific to the IPFQR Program, as well as new approaches to measurement for behavioral health and improving care for addiction.

By the end of this presentation, participants will be able to perform the following tasks: discuss trends in the quality of behavioral healthcare, as well as measurement approaches focusing on outcomes and the need to

overcome data challenges, and finally, review a measurement framework for improving addiction care.

Now I will turn the presentation over to our first speaker, Dr. Sarah Hudson Scholle.

Dr. Sarah Hudson Scholle: Hello, I'm Sarah Hudson Scholle from NCQA and I'm delighted to be here and have this opportunity to talk with you about the work that we do at NCQA to try to promote quality in mental health and addictions care. Some of you may be familiar with NCQA, but just as a refresher, we are a not-for-profit healthcare organization in Washington, DC. Since 1990, we have been focused on improving quality of healthcare and we do that by measuring quality, by working with organizations to make that information publicly available, and working with consumers, employers, federal government, state government and providers in facilities to try to improve the quality of care.

One of our main methods of doing this is the Healthcare Effectiveness Data and Information Set, which we call HEDIS®. HEDIS is a set of performance measures that are specified for health plans to report on the quality of care across a range of clinical issues: effectiveness of care, access to care, and patient experiences. These measures are used in many states and in federal programs and some of these measures have been adapted for reporting by other entities, including providers and a few have been adapted for hospital reporting.

Today we're going to focus on the work that we've done with health plans and invite you and the inpatient psychiatric facility world to listen with us and help us learn about how what we've been doing might be relevant to your work. So, we have been reporting measures of quality for mental health and substance use since the beginning of HEDIS reporting and it's a little bit disappointing to see what we find. Overall, we see lower quality of care on behavioral health measures compared to other chronic conditions. This slide, for example, shows that the average performance rate for mental health measures and substance use measures, compared to

measures for diabetes or cardiovascular disease, is much lower across all kinds of health plans, commercial plans, plans that serve Medicaid and Medicare populations.

So, we know that there are a number of challenges to improving behavioral healthcare. Some of these challenges have to do with our information and our ways to identify and provide treatment. Some have to do with the lack of coordination across different kinds of providers between hospitals and outpatient, between general medical care and mental health and substance use care. Some relates to the lack of interest in mental health and substance use quality from organizations that could really put some focus on these issues, and I think fundamentally, there's a concern about whether the quality measures are strongly enough related to outcomes of care.

An example that's specific to mental illness is a HEDIS measure that looks at whether people who've been discharged from hospital for mental illness, whether they have a follow-up visit with a mental health specialist within 30 days after discharge. What we can see is that, over time, the line is pretty much flat which tells you that, over time, we haven't seen much improvement. If we look at the performance rates, we can see that 25 to 40 percent of people who've been discharged from a hospital for mental illness don't receive a visit with a specialist within 30 days. This, I think, epitomizes the kinds of concerns about coordination of care follow-up and connections.

Recently, this measure has been adapted for reporting by inpatient psychiatric facilities and, here again, we see a similar challenge of lower rates of performance than we'd really like to see for a very needy population.

So, given these patterns of care, what should we do to address these concerns? Well, at NCQA, we're working to try to think about what's the role of different kinds of organizations at different levels of the healthcare system to work in and work towards improving care, and so this advance of having inpatient psych facilities work on the same issues as health

plans, we think is a good approach. In other measures, we're also looking at what's the role of individual practices in healthcare systems to help encourage improvement. So, we think that's a good sign.

We also think we need to be thinking about the measurement approaches that we're using and looking for ways to improve the measures to make them more relevant to consumers and the organizations that purchase healthcare to make them more tangible and relevant to healthcare providers and organizations who are being evaluated by these measures.

I want to give you an example of where we're headed. We've been looking at the quality of care for people with depression for a number of years. I've been with NCQA now for over ten years and this is one of the areas that I started to work on when I came, and it's taken us a while to really figure out how we could bring a focus on outcomes and to depression. And I wanted to show you this slide to help you understand where we see challenges along the way. So, we know the evidence for measurement-based care. We know that using standardized tools to promote care, to assess symptoms, to follow patients over time, to see if they're improving and, if they're not, to react to that care is a well-established practice and has a substantial amount of evidence across depression, anxiety, and a number of mental health conditions. But this is what we found in a recent study where we looked at individuals who had a PHQ-9 score that was over the threshold of, I believe it's over, 10, and we looked to see what happened to those individuals over time. And what we found is that by six months, only about less than a quarter of those individuals actually had a follow-up assessment. And then when we looked at those who were assessed to see what happened to them, we found that only about 20 percent of them actually had evidence that they remitted. Another 20 percent had evidence that they responded, that there was a reduction of about 50 percent in their score. And then we have 60 percent of those patients who got a follow-up assessment who actually did not have a response. The critical piece in measurement-based care is whether the assessment happens and there's an adjustment to treatment, and here we see that, even when people were not responding, their symptoms were not

improving to that threshold. Three quarters did not have some kind of change in treatment that would recognize. So, I think people in the field call this clinical inertia, this feeling of there's not… the information that could be used from the PHQ, first of all, is not being captured and it's not being dealt with in a clinical [way]. You know, it's not influencing care.

We know that it can because studies like the Collaborative Care Model have shown that this kind of proactive monitoring in a system that has care coordination, care management, regular case load review, can lead to better treatment adherence, improvements in depression outcomes, improvement in quality of life. So, this has been the focus. We are thinking, when we look at our measurement approach, we need to be thinking more about, "How do we get to that improvement and outcome and what are the steps along the way that will get us there?"

That's why our focus today is on thinking about what are the structures and processes that should be in place to support improved depression care and other mental healthcare. How can we measure processes of care in a limited way where it's going to lead to direct improvements and outcomes? How do we capture information about outcomes? So, I'd like to tell you some more about what we're doing in depression and how we're changing our approach to measuring the quality of care.

So, first of all, structures. We believe that structures build the foundation for high-quality care. An example of the kinds of structures we're looking for organizations to develop to improve care for mental health and substance use, is our distinction in behavioral health integration that we've just recently released. This is focused on primary care practices who do a large portion of the mental healthcare in this country. And the purpose of this program is to encourage primary care practices to take a comprehensive approach to thinking about how did they integrate focus on mental health and substance use care in their practice. So, that includes thinking about are they - do they have the right people in their team either onsite, in their practice, or through coordination and ongoing arrangements with behavioral health providers who work offsite to provide integrated care for patients. We think about the data-sharing

capacity. Are they using a data system that allows for a single-care record for an individual that will capture information about their medical care and their mental healthcare? Maybe not all the details of the mental healthcare, but enough to allow for integrated care. We're looking for the implementation of evidence-based care following guidelines for medication and psychosocial treatment and using standardized tools to assess symptoms over time. And finally, we encourage organizations to think about quality improvement as part of their normal work, that they're measuring their performance and monitoring it and improving it over time. So, we've just released this. We developed this in collaboration with states that are looking for greater capacity to address mental health and substance use issues in the primary care setting and, certainly, these are capacities that would be relevant to mental health and substance use providers as well.

Here's more detail about these competencies that include behavioral health expertise, evidence-based protocols, ways to share information across the providers treating the patient, and ways to use quality measurement to improve. In our performance measures, we've added a new focus on outcomes in measures for HEDIS for health plans. And we've done this in a structured way, where we first started in 2016 asking health plans to report on the use of the PHQ-9 to monitor depression symptoms for adolescents and adults. We then added a measure that looked at depression remission and response. So, our thinking here was a start with a focus on let's use a standardized tool. Let's focus on whether people are getting better. We looked at whether we could have a measure that looked at treatment adjustment and we found that it was very complex to get from the medical record. So, we thought we'll just focus on this outcome. And then we added a depression screening measure in 2018. And the reason we did that is because we wanted to try to get our system in order before opening up and looking for new cases because the evidence tells us depression screening can happen and, when it does, it can be comprehensive, but the follow-up may not happen and often does not. And so that's why we thought this order - this trajectory of measure, made sense.

All of these measures are voluntary-reporting measures for health plans and they're based on clinical data because we need to see the results of the PHQ assessment in order to determine the performance of the measure. And here's a few more details about that. These measures apply to adolescents and to adults, all adults of all ages. They're focused on people with major depression or dysthymia. And we look - this is a brief description of the measures. We have very detailed specifications and, if you're interested in those, we can point you to them. These measures are all adapted from existing provider-level measures that were developed by the Minnesota Community Measurement program and are NQF endorsed.

So, one of the things that is guiding our focus on outcome measures is thinking about how can this information that we want to use for quality reporting be relevant to clinical care? Because we don't want quality measurement to be something that's added on, on top of everything else. We want it to be useful. And, as we've been thinking about the importance of getting information directly from patients and families about symptoms and functioning and other aspects of the impact of health conditions, we've been thinking carefully about who is giving the information and who can use it. Our mantra is measure once. Use the data for multiple purposes. So, when we think about the use of a PHQ-9 in a clinical setting. We think the patient gets that information and can see, over time, how they're doing. They might be able to understand what are the triggers and be able to understand when they're moving into a challenging problem or see their improvement. A clinician and care team can use the information to guide decision making, and to inform shared decision-making. This is where we see that treatment adjustment based on symptom improvement or lack of symptom improvement. For the QI team and for a healthcare system, this information can be used to track their population to understand performance, to benchmark over time, and to determine maybe we need additional behavioral health services. Are we using medications appropriately? What else could we do? What other kind of support might our patients and clinicians need? For researchers, this information might be important to help determine what might be new evidence for care, and we see payers, purchasers, governments, employers wanting better

information about the impact of care. Are people back to their daily functioning, back to work? And are they feeling better, really?

Now, as we think about this focus on outcomes, we have a big challenge. It's about how do we share the data across the different individuals that might have a real purpose in using it. We want the data sharing to be patient-centered. Actually, we want patients to be aware and understanding of how their data are shared. We want the information to be useful and available to the clinicians and care teams that can use this for decision making and, for that sharing to happen, we need a structured electronic format. And that's part of what is really revolutionary about this set of depression measures for health plans because it's requiring health plans to work with healthcare systems and providers to share this information, not so much in a potentially identifiable way, but really to share it for the improvement of care. And we think health plans have a role in organizing and supporting this data sharing, because health plans are responsible for developing provider networks, ensuring coordination across mental health and general medical care. And so, we believe that adding health plan responsibility for these measurement approaches, for these care approaches, can help to support the providers and facilities that are serving patients directly. Now, I'd like to turn it over to my colleague, Junqing Liu, to speak about how we think this approach of focusing on outcomes could be used to improve addiction care.

Junqing Liu: Thanks, Sarah. Next, I'm going to talk about substance abuse treatment quality measurement. We know that substance abuse is common and costly. The opioid misuse epidemic has escalated the need for access to effective treatment.

So, one question we hear often from payers as well as providers and consumers is how the payers and consumers can identify high-performing providers. You may have heard in the news about private equity investment in addiction treatment centers. This is concerning to payers and consumers because such centers often lack connections with the communities. Patients tend to relapse after going back to the communities.

Substance abuse treatment measures have been in HEDIS for a decade. This measure captures patients who have two visits within 44 days of their initial substance abuse service visits. As we can see, the performance of this measure has hovered around 40 percent over the decade and is declining, especially in recent years. So, this is concerning given the substance abuse and opioid overuse epidemic.

So, we believe that measurement-based care is a crucial component in improving the quality of addiction care. This is also aligned with the value-based payment reform of healthcare. We think future addiction measurement should prioritize outcomes and we need a suite of measures of quality given the complex healthcare needs of this population. A recent healthcare blog discussed using cascades of care framework, used to combat the HIV-AIDS crisis to address the opioid epidemic, and it calls for a closer look at quality measures. So, we propose this suite of addiction measures. Measures in the dark blue exist. Measures in the light blue can be adapted, and the measures in the red are new concepts and we're looking for opportunities to develop them. So, for the measures in the dark blue, they are currently in HEDIS for health plan reporting. For instance, the two measures at the bottom are also in Medicaid, which is of the course, reported by the state. These measures in the dark blue focus on treatment and the screening of alcohol and address substance abuse treatment. So, the measures in the light blue exist for the general population. They can be adapted for the addiction population because we know that the addiction population also have comorbidity, mental health, and physical health condition. So, we are thinking about, for instance, we can adapt the depression screening and the monitoring measures for the addiction population. So, for the measures in the red, these are the outcome measures. We heard from stakeholders that these outcomes are very important for the addiction population, whether they are recovering, whether they, uh, have stable housing, etc. So, some of these outcome measures use healthcare data. Others may use incurred data that come from another service sector. So, we need to be very creative in working with stakeholders in this field to address the data source issue for reporting quality measures like these.

In the next few slides, I'm going to talk about a few existing measures on substance use that are currently reported by health plans to NCQA. So, the first measure here is Unhealthy Alcohol Use Screening and Follow-Up. This measure was adapted from the American Medical Association's provider-level measure Unhealthy Alcohol Use and Brief Counseling. So, this is a measure newly introduced into HEDIS, 2018. So, this measure is for all adults, and the numerator looks for screening for unhealthy alcohol use using a standardized tool. The tools include AUDIT, AUDIT-C, and NIAAA's single question. It also looks at follow-up care for those who are screened positive. Follow-ups should occur within 60 days of a positive screening. The bottom in this box here shows the type of follow-up care. The first of four bullets are the same as AMA's provider-level measures. So, we try to harmonize. The last bullet: documentation of receiving other alcohol misuse treatment. Those are the claims codes that have been used for other NCQA substance use measures.

So, the next measure, this is the measure that you saw the performance has been declining a few slides ago. So, this is the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. It's a measure that is a long-standing measure, and we made a revision of the specification for HEDIS 2018. This is the latest specification. So, the measure denominator is for adolescents and adults with a new diagnosis of substance abuse with service in inpatient, outpatient, ED, or detoxification setting. So, that's quite broad, the denominator. A numerator looks for an initiation rate that's a visit for substance use care within 14 days of the initial diagnosis and the engagement rate, which looks for another two visits within 34 days after the initiation visit. The type of substance abuse or AOD, alcohol and other drug, dependence treatment here includes inpatient, outpatient, intensive outpatient treatment. We usually have a care setting associated with some procedure codes of services. Those may be psychotherapy, medication assisted treatment. It will also allow telehealth services for this measure.

So, the next slide, these are the outcome measures we want to talk a bit more for the addiction population. As I mentioned, these we heard from

stakeholders are important. We want to look into whether the addiction population are recovering from substance abuse, whether they are employed, have stable housing, and whether they are involved in the criminal justice system, as well as the mortality. So, we want to definitely learn from stakeholders like states and health plans, healthcare systems, who are exploring or doing something to capture outcome measures like these from various data sources.

So, substance abuse treatment, we just talked about, is addressing one side of the addiction problem. The other side of the problem is appropriate pain management to reduce the risk of addiction to pain medications. So, this is the pain management measure framework we have thought about. It starts from use of non-opioid, non-pharmacotherapy, all the way to use monitoring, tapering, and the cessation of opioid therapy as applicable. So, the red rows of arrows at the bottom are indicating the measures that we are introducing into HEDIS for health plan reporting. So, the first red arrow is pointing at a measure that's the risk of chronic opioid use. This is for patients with a new episode of opioid use who are dispensed opioids for 45 days out of 90 days of treatment. This is going to add to the upstream prevention of preventing potential chronic use for patients who are newly using opioids. So, this measure is adapted from the Minnesota State Department of Health measure. The second red arrow is pointing at two measures that are adapted from Pharmacy Quality Alliance measures. These measures were introduced into HEDIS last year. So, the first is use of opioids at high dosage. That's defined as 120 mg morphine-equivalent dosage during the treatment period. The second is use of opioids from multiple providers that's defined as four or more prescribers and four or more pharmacies. These measures are also used in a CMS over-utilization monitoring system. In the future, we explore more measure concepts for introducing into HEDIS that will address further upstream measure concepts, such as using non-opioid and non-pharmacotherapy for chronic pain. So, that's our thinking of addressing the other side of preventing addiction.

So, the main take-away from this webinar is that one: We think that improving quality of behavior healthcare requires action at multiple levels from providers to payers, such as health plans. There's also a desire from the field focusing on outcome measures for mental health and for substance abuse populations. As Sarah mentioned, we have depression outcome measures and we are exploring some addiction outcome measures. So, we have a draft framework of addiction measurement and we think these measures will help to drive improvement in care quality and reduce risks. We are looking forward to opportunities to develop some of the new measures in the framework. That's my part of the presentation. We'll turn back to the moderator for questions and discussion.

Debra Price: Well, thank you, Junqing and Sarah. This is Debra Price and we have time for about three questions. Then we're going to get back with Evette. Okay, so the first question is: Do you see tele-psych being a resource and/or alternative that could improve quality for remote areas and areas that lack providers? This might be for Junqing.

Junqing Liu: Thanks for the question. So, this is Junqing. That's a great question. We know that there is a lack of providers for mental health and substance abuse populations. The telehealth interventions have been supported by research evidence that they are as effective as in-person visits, especially the video conferencing and telephone visit modalities. So, we recognize that telehealth offers an opportunity to increase access to care and, also, it's supported by research evidence. Thus, we actually added telehealth modalities that are supported by research evidence in the HEDIS behavior health measures in the 2018 publication. So, now the measures, such as substance abuse treatment and follow-up after hospitalization for mental illness, they all count telehealth services.

Debra Price: Well, thank you very much for that Junqing. Another one, I think this would be for you as well. When you are talking about 30-day follow-up being low, are you addressing scheduled appointments or actually coming to the follow-up visit? And how is noncompliance accounted for? Kind of a two-part question there.

Junqing Liu: Sure. So, the follow-up after hospitalization for mental illness measure, it counts actual visits. We have the visit codes defined. It needed to be a visit with a mental health practitioner. So, a scheduled appointment or referral, they do not count. Only the actual visit counts, as I mentioned. In the first question, telehealth visits, actual visits, also counts. So, for patients who may not show up at the visits, I assume that's what noncompliance means. They would not be picked up in the numerator of this measure. So, for a health plan double measures that are reported through HEDIS, we do not count patient refusal, for example, in an exclusion of measure. We know that is the case with some provider-level measures.

Debra Price: Okay, thank you.

Dr. Sarah Hudson Scholle: This is Sarah. I'd just like to jump in. Why wouldn't we handle that? Why wouldn't we allow the scheduling? We're really trying to understand whether people get that recommended care, and we understand that people that have trouble getting to appointments or aren't ready for appointments that that's going to be a problem across different communities and different provider facilities. The performance measure is really trying to encourage everyone to do the best, the most they can to get people into care. So, we want the measure to focus on whether people receive the recommended services, and it really encourages organizations to work hard to reach out to people who are going to have the most trouble getting into those visits.

Debra Price: Thank you for adding that Sarah. We have one - we have time for one more question and you can decide who will answer this one. It's, do outcomes for OADA (AODA) include improvements in functioning and not just days of abstinence? Junqing or Sarah?

Dr. Sarah Hudson Scholle: I'll go ahead. I put my phone on mute. We think that they should, and the challenge is really being able to measure either days of abstinence or functioning. What we hear from consumers and employers and others is that they really want to understand are people getting back to work, going

to school, doing what is part of their usual daily life. Are they functioning well? We also want to know that they're not experiencing negative issues such as being in jail or being homeless. So, in the work that we're doing to think about where we should go in the future for addiction treatment measures, this is where we want to focus on both: Did they get treatment and is their functioning improving?

Debra Price: Thanks Sarah. Junqing, do you have anything to add?

Junqing Liu: Yes. Just to say, that's definitely what we are exploring. The outcomes include functioning and symptoms. So, as I mentioned during the presentation, the data source is a challenge for capturing some of the functioning outcomes, but we also hear there are healthcare systems, especially in a few states, that are looking at a database that covers services that are provided in healthcare as well as other social service sectors. They are able to track the outcomes like housing, criminal justice involvement for mental health, and the substance abuse populations. So, we look forward to opportunities to explore those outcome measures with systems and organizations who may be interested and have some capacity in exploring that.

Debra Price: Thank you. Thanks to both of our guest speakers today, and now I'm going to pass the ball back to Evette Robinson.

Evette Robinson: I would like to thank our guest speakers for presenting today's topic, *Improving Behavioral Health Outcomes Through Measurement-based Care*. In the next few slides, I will review some helpful resources pertaining to the IPFQR Program.

This slide lists the acronyms that were referenced during today's presentation.

This slide contains a hyperlink to CMS's Meaningful Measure Framework page located at *CMS.gov*. This page provides information and resources that pertain to CMS's new comprehensive initiative, Meaningful Measures, which was launched in 2017 and identified high priority areas for quality measurements and improvement. Its purpose is to improve

outcomes for patients, their families, and providers while also reducing burden on clinicians and providers. We hope that you will find it helpful and informative resource.

CMS recommends that IPFs refer to the most recent IPFQR Program Manual for information pertaining to the IPFQR Program. The manual is located on the *QualityNet* and *Quality Reporting Center* websites and contains information about program requirements, measures for the Fiscal Year 2019 payment determination year, as well as links to helpful optional paper tools pertinent to the data submission process. You can access the manual by clicking on either of the links on this slide.

You can click on the title of the table on this slide to access the IPFQR Program resources page on the *QualityNet* website. Additional active links on this slide are available for you to send us your questions about the IPFQR Program. We encourage you to use the Q&A tool in particular because it provides the best means by which we can track questions and answers. It also delivers our responses directly to your email inbox. Additionally, this is 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. We recommend that you sign up for the IPFQR Program ListServe if you've not already done so, so that you can receive communications that we send out to the IPFQR community pertaining to webinars, program updates, and other announcements.

On this slide, we have a few upcoming educational webinar events listed, and we, again, ask that you monitor your emails to ensure that you receive information regarding these webinars via the IPFQR Program ListServe. This concludes the content portion of todays' webinar titled *Improving Behavioral Health Outcomes Through Measurement-Based Care.* I will now turn the presentation over to Deb Price who will describe the continuing education process for today's event.

Debra Price: Thank you, Evette. Today's webinar has been approved for one continuing education (CE) credit by the boards listed on this slide. We now have an online CE certificate process and you can get your certificate two different

times. Right now. if you have time at the end of our presentation, a survey will automatically pop up. Take the survey and at the end you will be taken to your certificate. If you don't have time, tomorrow a survey, or within 48 hours anyway, another survey will be sent to your registration and you can get your certificate that way. If you're in a room with other people and only one of you registered, then tomorrow, when you get the second survey, please send that to the other people in your room so they can also get the certificate.

Okay, if you do not immediately receive a response when you register for your certificate, that means that something is going on with your computer. You might have a firewall that's blocking our link. If that's the case, please go back to the link that we have that's called the New User link, and on that link, you would take and put your personal email. like Yahoo or Gmail or what have you. Use a personal email because firewalls never get up with personal emails.

This is what the survey will look like in a minute as soon as I finish out these slides. You notice on the bottom right hand corner, the little gray Done button. You press the Done button when you are finished, and this is the page that opens. There are two links on this page. The first one is the New User link. That's the one you're going to click on if you have had any problems getting certificates, or if you've never attended and received certificates before.

The second link is the Existing User link that you click on if you haven't had any problems. This is where the New User will take you. You have a first name, last name. We're asking you to put your personal email like Gmail or yahoo and then give us your personal phone number.

This is what the Existing User link takes you to. Your user name on the top box is your complete email address including what's after the @ sign. Then, of course, use the password that you signed up with. If you forgot your password, put your cursor into the box and you'll be prompted how to start a new password.

Now we'd like to thank everyone for attending our webinar. If we didn't get to your question or if you asked questions after our two speakers were done, we will get to those questions and they will be posted at our website, which is *QualityReportingCenter.com*. Please enjoy the rest of your day. Good bye.