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>> ROARA MICHAEL: Good afternoon everyone and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled how to get your EHR to match reality for UDS measures on depression. My name is Roara Michael, CIHS associate and your moderator for today's webinar. As you may know, the SAMHSA-HRSA CIHS promotes the development of integrative and primary behavioral health including mental health and substance abuse services to better address the needs of mental health and substance abuse conditions. Behavioral health and primary care provider settings. In addition to national webinars to help providers integrate care, the center is continually posting practical tools and resources to the CIHS website. Providing direct phone consultations to providers and stakeholder groups. And directly working with SAMHSA primary and behavioral healthcare integrative use. And, HRSA funded safety net settings.

Before we get started a couple of housekeeping items, to demo the presentation slides please click on the bottom left of the screen. The slides are also available on the CIHS National Council website, located on the tabs about us\webinars. Today's presentation slides will be automatically synchronized with the audio so you will not have to flip any slides to follow along. Listen to the audio through your computer speakers but please ensure that they are on and the volume is up. You may submit questions to the speaker at any time during the presentation by typing a question into the "ask a question" box in the lower left portion of your player. Finally, if you need technical assistance please click on the question mark button in the upper right corner of your player to deal with the frequently asked questions and contact info if tech support if needed.

The views, opinions, and contents expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, or the US Department of Health and Human Services. Now I'll pass it off to Nick to introduce today's learning objectives. Nick.

>> NICK SZUBIAK: This is Nick Szubiak from the Center for Integrated Health Solutions and your task leader and I want to welcome you all for being here this afternoon. I just what to go over our learning objectives and the areas that we're going to be covering today is tips and guidance to improve electronic health record workflows, data entry, and reports for depression screening and follow-up intervention. Key lessons learned from one provider on how changing utilization of the EHR improved outcomes. And strategies for sharing data with the team to improve benchmarking and quality. Now I would like to introduce today's speakers. And to start off with Adrian Bishop, Adrian is the director of eHealth and Organizational Development at Advocates for Human Potential. Adrian has worked with federally qualified health centers for over 12 years. His specialties include health IT, payment reform, change management, workflow design and strategy alignment. Adrian is a UDS

reviewer and part of the high-tech project. A HRSA NGA to support health centers and their full optimization of their EHR's and related health IT systems.

Ellen Radis is the senior program manager at Advocates for Human Potential and is the current director of the UDS project where she oversees the team of the developing of the UDS manual, training activities, and data analysis. She is also the conservator to the high-tech project which collaborates with HCPN's, and NCA's and the whole EHR's as IT systems. She has over 25 years of experience training in behavioral health and Health Center settings. Ellen started her career in behavioral health working in behavioral health and clinical programs.

And finally Belinda Stiles, Belinda has a Master of Arts degree from the University of Chicago School of Social Services Administration and a bachelor of social work degree from the University of Cincinnati. Belinda is an independently licensed social worker that has supervisory designation and currently serves as the behavioral health manager for Five Rivers Health Centers. She has served adolescents and adults as a behavioral health provider and SQA for mental health and substance abuse related issues. She also supports community and mental health by providing individual, couples and family counseling for those struggling with anxiety, depression, school related behavior issues, substance abuse, grief and loss, life transitions, trauma, gender orientation and sexuality, and HIV/AIDS. So please join me in a warm welcome to our presenters and now I'm going to hand it off to Ellen.

>> ELLEN RADIS: Thanks Nick, welcome everybody, we're about to get started on the webinar how to get your EHR to match reality for UDS measurement and UDS measures on depression. Here's our agenda today, the topics we'll be covering. 1st, Adrian will be covering the electronic health data, the big picture from both clinical and systems perspectives and then relate how looking at the big picture affects our everyday work. Then we will look at the depression screening data lifecycle, a logic model to frame our discussion. After that, we'll talk to Belinda Stiles from Five Rivers Health Centers in Dayton, Ohio about her experiences implementing and integrating behavioral health care systems. She will tell us about the systems and the workflows that support a civic account improving depression screening rates. Next, we'll discuss the depression screening measure including strategies for working with your UDS reviewer and validating your data. After the presentation there will be time for questions, now I'll hand over presentation to Adrian.

>> ADRIAN BISHOP: Thank you for joining us today. I want to introduce this webinar starting with the foundation of how we are managed through the UDS discussion screening measures. For this presentation we're looking at the presentation screen from a primary care perspective. This is a two-way street, a behavioral health environment, next slide. Bear with me a second. Alexander is a national thought leader on integration and I just want to read the last sentence because I really do think that allows patients to feel that for almost any problem they have come to the right place. The focus has got to be tuned in to make a patient feel comfortable and confident with his or her care.

So the big picture, the electronic health data is really critical, having your staff not spending most of their time working on the EHR and that includes leadership and operations, billing, etc. Many years ago, electronic health information was used primarily to document the patient care providers, now IT is used much more practically here to recall patients when they are [indiscernible] and share

information between providers. Next slide. Things even change more when we look at the data we operate in now, we submit data to these registries, the health information exchanges, managed care more efficiently and effectively, so while this webinar focuses on the internal use of data, especially the way we document depression screening, we want to keep the big picture in mind and need to collect new data prospectively and importance as times goes on.

So why is health data important? Summary, we use it to manage patients' care internally and externally and operate efficiently and effectively. This becomes even more important [indiscernible] environment. Not only data that we can trust, that is the focus of this webinar today.

>> FEMALE VOICE: Overall, our goal is to increase the number of health center patients who are screened for depression and have a follow-up plan documented if the screening is positive. Here you can see in 2014 the 1st year this measure was in place 38.8 percent of patients met the clinical measure standard and were screened for clinical depression. The following year the UDS rate increased to 50.6 percent. This data shows a significant increase from the 1st year which is expected as health centers have had the measure implemented for the entire year in 2015 and started working on process improvements as a result of understanding their 2014 data. We do not yet have the data from 2016 as we're just concluding the review process this week, this year's data will be available later this summer.

This graph shows the power of data, the 1st set of bars shows that in 1999 the hypertension rate in the US population was 29 percent and percent of those patients who controlled hypertension was 30 percent. The next shot of data shows the hypertension prevalence is still 29 percent, but the percentage of patients with controlled hypertension has doubled to 62 percent. The data helps us identify hypertension patients which then supports better treatment and monitoring of the conditions resulting in more patients being in control of their disease and hypertension awareness and management is improved. As with the hypertension data, data resulting from the depression screening measures helps us to identify those patients who are experiencing depression. Hopefully early in the conditions progression and then offering treatment and referrals to help these patients address their depression and increase their quality of life. Adrian.

>> ADRIAN BISHOP: So I would like to introduce you all to the data lifecycle. This is a model that we're going to be using throughout the presentation. It starts off with data definition. And ends up with substantive use. We're going to go through this by segment. I want to make the point here that data and effective use of data has a number of interdependencies, and we're going to go into more detail with each one as we go around. So 1st of all, back to the little bit – the substantive use segment, substantive means actual meaning, in other words data we can trust. All of the uses that we talked about in the previous slides fall into this category of substantive use, inventive care for healthy patients, disease management to chronic patients. [indiscernible]. There is one more point that I think I ought to make, they call this the lifecycle for another reason, clinical data lifecycle and beyond. This is the most important use of data that there is. Next slide. So we're going to start talking about data definition, we're going to spend a little bit longer on the data definition segment then the rest of them.

So data definition, if we're going to collect data and use data we need to understand the rules of data. Different kinds of critical data are stored in the EHR in different slide forms and formats. To collect data on the wrong form or format is going to be unrecoverable and unusable. Also when we collect data we need to associate it with the appropriate attributes. Why is this collected? Who it was that collected it? What services were collected? What purpose for the diagnosis or test was this for? Likewise, when we want to report data we need to understand in terms of the numerator, denominator, exclusions if there are any. If we don't fully understand the data that we are collecting and reporting, and these terms that are required for the detailing, it's never going to be usable. There is no point in training our staff of EHR to collect [indiscernible] as a result of the trustworthy data. Next slide.

All EHR's are certified. I'm going to talk a little bit more about this later on, we're going to certify the EHR with 3 basic types of reports available. There's the certified reports and these are primarily CMS electronic clinical quality measures eCQMs and these reports have been built into the EHR by the vendor using nationally agreed electronically specified data definitions certification requirements. Other vendor developed reports as well things like Million Hearts, UDS reports, and while these are specified they are not specified at the level of detail and they may not be electronically specified at all. Compliance to these reports is not a CHR certificate of requirement. Last of all, we have the ability to write our own customized reports. These reports are viewed for many purposes, they may be rightly specified and differ based on the person developing the report. So really we have this hierarchy of reporting and reports, certified reports, noncertified, and the unique customized reports. UDS measures from 2016 were aligned in most places with quality measures, we could align them with eCQMs that way we are aligning the UDS measures with nationally certified electronically specified. The reporting ability of EHR may be supported by other pieces of equipment, things like data warehouses and other reporting tools and there is no doubt that these can add a lot of data functionality, we've got to remember that the EHR data itself is the EHR data source [indiscernible] no matter what other system we are using, data originates from the EHR so the EHR we've got to make sure is accurate really before we do anything else with it. Next slide.

We just mentioned eCQMs, electronic clinical quality measures and these are the heart of any service wide system, the ability to report clinical data is concerned. ECQMs are specified by CMS and each measure is [indiscernible] manages the measure and updates the measure. 64 eCQMs currently for eligible providers, going to be calling these eligible clinicians in 2017. The E means electronically specified, in other words the EHR vendors can specify electronics certification and import them into our systems. That means that all certified EHR's regardless of vendors should be able to report these accurately and consistently. So these eCQMs that are part of the ONC EHR certification requirements are updated annually, so those updates normally happen in the summer so every year we need to make sure that firstly we understand the changes and how they impact our work, and secondly we have incorporated any changes into the EHR models. Okay, the link at the bottom of the slide is the eCQMs library and this is where we find all of the details of these eCQMs. So in summary, any certified should be able to report these accurately as long as the data is in the correct place and the correct format. Next slide.

So the reason we are here, eCQMs CMS2v5, preventive care and screening, screening for clinical depression and follow-up plan. Okay, so this is a UDS measure, it can be found on table 6B section

M, line 21. The measure is [indiscernible] eCQMs and the number of patients age 12 years or older with at least one medical condition during the measurement period. The numerator is the number of patients screened for clinical depression on the date of the visit using an age-appropriate standardized tool and if screened positive for depression for whom a follow-up plan is documented on the date of the positive screen and possible solutions. Lastly, the data could more be more detailed. 12 years or older, that means the patients have got to be 12 at the beginning of the measurement year or turn 12 during the measurement year. And what is an age-appropriate standardized tool? What screen tools point to that category and how do we use them? And the follow-up plan, how this applies to the follow-up plan and how we document it. So we get a lot more detail and we're never going to be able to figure out our EHR effectively, never going to set up workflows of data. Let's talk a little bit about how we get the information that we need. So let's say that we need to know more about what constitutes a follow-up plan. Next slide.

The table here is taken from 1 of the UDS fact sheets that support the UDS manual. And you'll see it's highlighted, you will also get the same information from going to the UDS manual and you'll find the same links there. So we're looking at the link associated with CMS2v5, screening of depression and follow-up plan. Click on the link and see where it takes us.

This is the eCQMs resource Center, this is the one stop shop to report clinical quality improvement. And this is where we are going to find all of the data definitions basically for eCQMs. On the slide above, you'll see a screenshot, and this is where we find the summary data definition of the measurements that we are talking about. It doesn't really give us any more information than the UDS manual; in fact, this is where we got the test from but if we were to scroll down, scroll down at the bottom of the page we'll find a data definition section. If we click on the specification links. Next one.

Okay, we're going to come up with what constitutes a follow-up plan. So a list of items that is a follow-up plan, additional evaluation for depression. We have a suicide risk assessment which is referred to practitioners who are qualified to treat depression. Other interventions of follow-up plans and diagnosis of treatment of depression. So all of these are constituents for a follow-up plan. Again, we can click on these and get further information to find out exactly what we are allowed to use. So let's say that we're additional evaluation for depression. Let's delve down into it and see what we find. There is a list here that talks about the follow-up plan. But there is a reason for picking an evaluation for depression. In 2016 using the initial screening and [indiscernible] as the follow-up, most EHR's – arguable whether or not this is allowed on the basis of the initial screening tools only. So we've got a bit of confusion in here so chose the latter viewpoint, supported by clinical best practice. This will be changed accordingly to allow the practice of using the PHQ 9 as the follow-up of the PHQ 2. And you can see by drilling down like this we can come up with a whole list of what is allowable for a follow-up plan. On the left-hand of each one you will see a code and if we want to know even more about any of the items under this description we can pick on that snowman code and go down even further into the detail. So this way we can find all of the details that we're going to need to configure our system and manage our workload and train our staff. This sounds really complicated. But realistically, once you've got the hang of it it only takes a couple of minutes. Click on the link, move forward, and you'll get the details that you want and of course you can do this with any of the 64 eCQMs and in fact you're going to have to do this with the eCQMs that are part of the UDS reporting requirements in 2017.

Okay, next one please.

>> ELLEN RADIS: The details of the measure really digging in like Adrian demonstrated is important because these details can better – help you better understand the measured criteria. Based on this knowledge you and your team can create workflows that are customized to your setting. For instance, you can determine which variety of clinical screening tools work for your providers and population. Which of the follow-up tools or activities work for your unique settings and meet the needs of your patients. The details of the measure provides you with those choices which may enable you to customize workflows to your health center. Drilling down will help fully understanding the measure and also provide better and more informed insight into your data.

>> ADRIAN BISHOP: Thank you, Ellen. Now let's talk a little bit more about your electronic health records. So we talked about certification, we talked about certified EHR's. This is worthwhile going into more detail about that. 90 percent, or over 90 percent nationally are on certified EHR's. Or certified electronic health records, CEHRT's, if you see CEHRT, you know it's certified. Certified is being able to store data in defined structured format. Defined the functionality and security requirement. Able to share data with other EHR's securely and able to report data including eCQMs. Also being certified EHR's are also certified as meeting the requirements of CMS and meaningful use and most of you can attest to this over the last few years. Meaningful use has two objectives, the 1st is to increase adoption and use the technology effectively in the provided environment and that's what we've been concentrated on. The 2nd and perhaps even more important requirement was to establish a set of better standards to enable EHR's to be consistent compliance requirements that allow EHR's to report and share data. So in other words, from one EHR vendor should be able to store, report, and share from another vendor. In other words, the main reason for meaningful use is alignment of the EHR's between the vendors and alignment with the national specifications. And to some extent that's going to be important over the next few years, 1400 [indiscernible] 90 percent of the top vendors now.

And, moving on. We talked about EHR, let's talk about integrating the EHR, we're talking about integration. So we're talking about and EHR that can share patient data across programs. To do that is going to have to have a master patient index or unique patient identifier so that the same patient is only in the system once regardless of what program they are a part of. It's also going to have common practice management capabilities. So in other words demographics,race, ethnicity, SOGI, scheduling, insurances check-in, check-out, revenue cycle management is all going to be consistent in one place in this system. Also going to share clinical data between programs, obviously this is going to be within the limits of CFR 42 part 2. The ability to share data across programs that allows us to at any one time we can manage one patient across programs and see which services are working across integrated systems. So really it supports the precept of "One Patient" and whatever programs or services that patient is taking advantage of. Okay, next slide.

When we started with this presentation we talked about the number of people and spent a lot of our daily work in EHR. Because of that, when it comes time to update that EHR this is a team effort where all of the IT, clinical leadership, operations, finance, quality improvement, data analysts and lots of other people. Set up an EHR committee for each of these functions and all major decisions

are made collective by this activity and shared with everybody. Where we see EHR's are better by one group or one function then we seem to have problems with the organization. Next slide.

So clinical work. At this point we're going to talk about the workflows, I would like to introduce the depression screening data. So I'm going to introduce Belinda and she has been very sophisticated in [indiscernible] to manage the depression screening follow-up process.

>> FEMALE VOICE: Thank you, Adrian. Adrian and I would like to welcome Belinda Stiles, from the Five Rivers Health Centers in Dayton,Ohio. We are both UDS reviewers and have spent the last 6 weeks working with health centers to finalize their UDS reports. As I was reviewing the 5 Rivers report I saw significant change in the depression screening rates, improving from 45 percent in 2015 to 96 percent this year. When there is a significant change in UDS data from one year to another, reviewers ask us to explain the change. So I reached out and met Belinda and thought that you would like to hear from her as well. We're going to interview her or have a conversation with Belinda about our work and the workflows that she utilizes at 5 Rivers. We've included a series of slides that go over the material that Belinda is going to talk about. We are not going to really go slide by slide during this presentation, we're just going to have a conversation. The next slide. Well, I want to have the slide while we are speaking with Belinda is their improvement, 5 Rivers and improvement between 2015 and 2016, you can see it has been pretty significant. So welcome, Belinda.

>> BELINDA STYLES: Good afternoon, hey everybody.

>> ROARA MICHAEL: Thanks for joining us. I think the 1st question we have is if you could tell us a little bit about Five Rivers Health Centers and your behavioral healthcare program there.

>> BELINDA STYLES: Absolutely, so Five Rivers Health Centers, a combination of health centers, we are serving about 20,000+ patients per year, and our collection of health centers include family practice health centers, center for women's pediatrics, our medical surgical health center, homeless clinic, dental services, and a pharmacy. Our medical staff is comprised of nurse practitioners, physician assistants, a dietitian, OB's, midwives, we also have a psychiatrist, and wonderful students from Wright State University School of Medicine and pharmacy students from a variety of pharmacy schools in our state. Our behavioral health team is comprised of social workers, professional counselors, chemical dependency counselors and case managers.

>> ROARA MICHAEL: Great, thanks. Since we are focusing on how to leverage your EHR to support clinical decision-making, can you tell us about the system that 5 Rivers uses and how they are supporting your clinical services?

>> BELINDA STYLES: Absolutely. We are currently using ethics which is an EHR which is also used by some of our major hospitals here which is a beautiful thing as we are able to share some information and to follow up on other services and treatments that patients are receiving when they are in our hospital system. So within that system, what we've done is we've built templates and what we like to call smart phrases that help us to document the services that we are providing and the behavioral health team in the medical chart. So we talk about integration and we're talking about a

shared system, the patient does show up one time in this chart, you're able to – the medical provider's able to charge in the system and as well as the behavioral health provider.

>> ROARA MICHAEL: That's great. You mentioned that you have several different sites, do all of the sites use the same platform?

>> BELINDA STYLES: Yes, we all use the same template.

>> ROARA MICHAEL: Great, great, nice to know. Again, since we are trying to talk about the depression screening measure, and the use of the EHR, can you tell us about some of the workflows or how you develop some of the workflows for your depression screening at 5 Rivers?

>> BELINDA STYLES: Absolutely, I'm sure like many other health centers on the line we've been through a variety of changes in how to get this right or get this in a way that's efficient and effective. And so, the one thing I can say is trial and error is the name of the game. And we've definitely gone from having people fill things out in lobbies and tradition and back to the next provider and who gets it? And where is it filed? And all of those beautiful things, but currently what we've done in the midst of trying all of those things is that we've built a PHQ-9 into our electronic health record. What that looks like is not only is this screening tool there and available to see and have the information inputted, we really inputted into our process. So when the medical assistant is calling the patient back and getting all of their vitals and all of that information, 1 of the vitals that they're getting is asking them about their emotional health and so that PHQ-2, those initial 2 questions are asked and if those are positive we are automatically going into the PHQ-9, and once that happens if that's also positive, we room the patient and immediately notify the medical provider and a behavioral health provider so we can do our best to address that during that appointment.

>>ROARA MICHAEL: I know that when we spoke earlier, you talked about huddles and how the behavioral health providers and the primary care providers sort of communicated each day, can you tell us a little bit about that?

>> BELINDA STYLES: Absolutely. Again, trial and error is the name of the game and really each side is laid out differently and unique in many ways and so 1 of our smaller health centers, our homeless clinic, we have a larger behavioral healthcare team and a smaller medical team. And the beauty of that is that every morning they are able to move through the patient's that are scheduled for the day, and they are talking about patients chronicle medical issues, mental health and substance abuse history, medication refills and specific behavioral concerns. At that point in time, the medical team is reminded of what they are focusing on and the behavioral health team has sort of a game plan of patients that they are planning to see. We also make an effort to see any new patients, so we are always going in with aid and introduction and talk about the services that we provide. So that happens at our smaller health center. At our larger health centers where we may have a smaller behavioral health team and far more providers, 10, 12, maybe 14 providers the behavioral health providers are doing their own review of patients but also talking about the medical providers about what review they've done, who they would like to see, and how we are planning to see them. 1 of the other beautiful things which you did not exactly ask about in this moment, but having a layout that allows us all to be on the same floor together, so you'll find your behavioral health providers on the

medical floor so even if we haven't pre-gamed to see a certain patient, if the medical provider comes out of a room and says I've got some concerns, they can right then and there talk to the behavioral health provider and they may go into the room together or they may have already done sort of a warm handoff to the behavioral health provider.

>> ROARA MICHAEL: Thanks, that sounds great. As we mentioned at the beginning of the introduction, 5 Rivers increased the depression screening score significantly between 2015 and 2016, can you tell us a little bit about how you achieved this?

>> BELINDA STYLES: Absolutely, Adrian talked quite a bit about drilling down on definitions and so that's something that we did. So we have reviewed the workflow and the work the providers are doing and the expectations and the collection of the data. We really drill down on the definitions and what we found is that in our practice we were already providing the follow-up in the same visit. So in that clinical belief that the PHQ-2 is not a precursor for the PHQ-9, that it really triggers each other in that same moment and instead of waiting to address that, we wanted to make sure that we were doing our best to address that in the same visit. So addressing that has meant for us dialogue with the medical provider, communication about what we are hearing and we are understanding and the behavioral health provider might be talking about coping skills and supportive resources, the medical provider may start a medication. Or, maybe the patient will receive support from our case manager being connected to housing, food, or dealing with social and community-based needs that they may have while they're there for that appointment. So as we better understood the definition and looked more closely at what we were actually doing we found that our follow-ups were not delayed but right in that moment in time.

>> ROARA MICHAEL: Great, thanks. What do you think the biggest benefits to conducting the depression screening and other screening are for your populations and maybe talk to us about what some of the challenges have been as well?

>> BELINDA STYLES: I think one of the benefits is quality patient care. The research and the experience tells us that patients who show up to their medical appointment and they will pour out their hearts to the medical provider without question and a lot of that can be hard to manage in one visit and what I think we're all doing, health centers on the line included, is we are wanting to meet the patient where they are and speak to those needs, so when a patient comes in and they are talking about having issues with sleep and their body aches and pains, we also know that that can be very much connected to their thought process and their emotional health. You know, when the behavioral health provider goes in and the patient says hey, I have lost a loved one. Now there are financial and legal things that feel overwhelming and pressing that might be connected, obviously, to how they scored on the depression screening. What their physical responses are to that, so it's a beautiful opportunity to really connect the mind and body which we know play off of each other so much. And how we function in this world, so it's a great opportunity to really meet the patient's needs and for them to feel heard and for us to improve our quality of care that we offer in our health centers. You asked me another question, challenges.

>> ROARA MICHAEL: Yes, basically about challenges, with integrating the depression measures into your EHR and your workflows, what have been some of those challenges for you?

>> BELINDA STYLES: I would say 1 of our major challenges would be having the technical piece. We have a beautiful electronic health record that we use that is correct into our major hospital so those are beautiful things, at the same time we really have come to learn what our EHR is capable of and so using those available but also meeting the challenges of going. Billing templates. Building systems that are connected, they communicate well. So really building out some of the things that help make the work more efficient and effective, so for example our PHQ-9 is in the electronic health record and you can find it in sort of a worksheet area, but also in there with other evidence-based tools that we use for screening patients. So it was in there at one point and we were using it there but we found that it was more useful and more efficient in our process if we included in the intake portion, intake template versus just having it in the system. So again, it's the idea that trial and error and really figuring out best place, the best way to put it in there, if it connects us in being able to be pulled out for data purposes. So it's a lot of trial and error in that way.

>> ROARA MICHAEL: Great. One of the things that we have chatted about over the past few weeks is that these systems work really well when you plan them out and everything goes as planned, 1 of the things we brought up yesterday was what happens when things don't go as planned? Or things get really busy? Does that affect the documentation, or your processes related to the depression screening? And keeping that integrated into your processes?

>> BELINDA STYLES: So like everybody else when things go wrong we're running around like crazy. And so again the beauty of the PHQ-9 piece is that it's built into our intake, has to be asked, it can't be skipped. The tricky part is if we have 20 or so positive screenings at the same time, if we are servicing many patients in our Health Center that they – it's going to be harder for our behavioral health providers to get around to all of those people, and so the goal is to meet people in that appointment, but we are also leaning very heavily on our medical providers to help us understand what they're saying in the room and dependent on what they are seeing in the room and the severity of the depression symptoms that are present, who needs to be seen and who can we follow-up with? So the screening continues to happen based on how it's built in. And the documentation is there. The medical providers again will notify us and we'll do our very best to reach out to patients within the following few days of their scores asking them what's going on, how can we be of support? We may talk to the medical provider about bringing the patient back sooner to discuss this further, so we – we are like everyone else and running around and making sure that we are doing our best to prioritize the needs of patients. But also realistically knowing that we cannot always do that to every single person who comes in. So we do – we try to do follow-up phone calls, schedule appointments for patients to come back sooner, connect them to community-based resources in a very timely fashion.

>> ROARA MICHAEL: Great, thanks. If you could sort of talk about what lessons learned, talk about to the audience what lessons have you learned about this process that you would sort of wrap up and, you know, just tell us about some of your lessons learned. Sorry, I didn't phrase that very well.

>> BELINDA STYLES: No worries, no worries. Lessons learned. Slow down. [CHUCKLING] Give yourself some time to create a game plan which will always be sort of your 1st, 2nd, or 3rd draft. Spend some time in that game plan before you make changes. 1 of the things that I really appreciate about working at 5 Rivers and our overall agency flow is that all opinions are included. So your staff

is the most valuable part of developing your workflow. So really talking from the front door to the back door about what they're saying, about what patients are concerned about or speaking of, and really using all of those pieces to help create a workflow that is also sort of efficient and effective and expect to continue to change it. You won't do this 1 time and it's done. You will always be figuring out how to improve, how to make it more efficient and effective for your staff and effective and efficient for your patients. So continuing the fight, support each other as a team and as a staff as you are doing this, and also —

>> ROARA MICHAEL: Thanks so much Belinda.
        Adrian, do you have any other questions? Have I at left anything out here?

>> ADRIAN BISHOP: Fabulous job, I am hoping there will be some questions that will come to us that we can answer as well.

>>ROARA MICHAEL: That was great, thanks again Belinda for taking the time out of your very busy day, obviously, to tell us about your experiences at Five Rivers. And now I'm going to hand the presentation back over to Adrian, running through the slides that we prepared with the information that Belinda just talk to us about. And here we go, Adrian.

>> ADRIAN BISHOP: A little bit about data capture, how it captures very much follows from what Belinda has been talking about. So thank you so much Belinda for the practical messages that you've given around the workflows. Effective capture, data capture means the correct person will put the correct data in the correct form in the correct place and that's all we are really trying to do. It sounds easy, but bear in mind this has got to be done consistently. We all know how busy we all are, and this has to be done consistently when you have staff changes or staff absences. This can be done consistently when we are busy and not busy. We all know just how crazy a clinical department can be. So data capture is often defined by protocol, who puts the data in and where do they put it, how do they put it in and at what point in the workflows they put it in. This has got to be a formal process, to operate despite the boundaries that you know you're all going to be facing in a busy workload and busy days. What we've also got to be very, very careful of is not to expand the data capture until it becomes burdensome. What I am trying to say here is that as time goes on every year, we are asked to collect more data, report more data, do more things with the data, and if we're not careful even well configured EHR workflows expands and expands and expands to a point where it becomes burdensome on those who are doing it. So part of the role of the EHR committee is not only to look at what we need to do and how we need to do it but to make sure that we are not overwhelming already busy staff with data collection requirements. Otherwise, data consistency.

The other thing I want to talk about is exceptions also can be managed. Most information is put directly into the EHR either by the clinical environment or electronically things like from local hospitals and rounds. These paper documents get faxed into the SQHC, so they might be like Belinda was saying the PHQ-2 and PHQ-9 that have been part of the data collection process. When this happens, we have to manage these exceptions formally. The data on paper has got to be converted into electronic data by somebody. Who is going to do that? Who is responsible? So the bottom line of the data cycle is setting up formal processes and being very clear about who puts what data in, when,

and why, but most of all it has got to operate when the barriers are there. The more data, staff changes, staff absences, busy times, etc. Okay. Next slide please.

>> ROARA MICHAEL: Whoops, I skipped ahead there. Excuse me here.

>> ADRIAN BISHOP: So a little bit about validation and onto the process of validation in a little bit more detail. Sorry? Ellen? Data validation is the process of ensuring that an EHR operates on clean and correct data. It is a constant process. Good data needs continuous movement management. And validation. Lots of different things we can do to ensure that data is correctly managed, peer review's, we understand trends and identified outliers. We compared data from multiple sources. We can even compare it by manually sampling. We compared data to state and national benchmarks. But the bottom line is that wherever we find an issue, 1st of all we've got to spot it and secondly we've got to formally correct it and we have got to correct it from the perspective of systemic action rather than individual action so there is no point in correcting individual data points. What else could that impact? The person that made the 1st mistake, are they making other mistakes in the system? We have got to look at it from a formal corrective action viewpoint. Bad data [indiscernible] the system and if we let that happen we can't pull it back out again. Talk about UDS data. Those UDS reviewers and because we talked about many, many FDHC's and how they use their UDS data, some you QSC's use that data very effectively for improvement. They run their data every 3 months and we need to talk to people about running data every month. Run the data once a year. So I will leave you with the question which 1 of those do you think has the best data? Realistically, it's going to be the formal ones. Okay, next slide.

>> ELLEN RADIS: Thanks, thanks Adrian. As Adrian was just talking about data validation, I wanted to sort of bring that together and you typically get sort of 1 of 3 outcomes around data validation. Once you do the process of validating your data, the issues will relate to one of these 3 categories. Numerators are the number of patients who meet the measurement criteria. In this case, talking about depression those are the patients over 12 who have at least one medical visit, screened for depression, and if the screening is positive a follow-up plan is documented. If the validation issues are related to the numerator, your report is not finding evidence of compliance in your records. The denominator or universe for the depression measure is all of those patients over 12 with at least one medical visit. If there are 2 nominator validation issues you may want to ask if the report is including everyone; who should or should not be part of that universe? Is it missing exclusions or required time frames? And the last category of sort of grouping these issues would be clinical issues. And that would be that the service was not provided or provided at the wrong time or with the wrong patient.

This slide shows some of the validation issues we just spoke about. As you can see the root causes apply to different causes of validation problems. For example, if you identified either a numerator or denominator issue you may want to look at your EHR programming configuration. Work with your team to ensure that the report is pulling the right data, or all of the necessary data to support the measure. For example, is the report taking into account exclusions? Is it pulling depression diagnostic data from all possible places in the record? Or, you might need to look at structured data, is the data being entered in the right place and in the right format? 1 of the most common issues with the depression screening measure, and I just saw it today in a UDS report,, is that the follow-up is

being documented as pretext. And not using a specific checkbox. So they are, that's the case then the report of the EHR is not going to pick up that information. If you identified clinical issues, you may want to look at your workflows, the policies, procedures including workforce development and staff training which is another issue I think we can't stress enough is that you may have all of these processes and procedures in place, but when a new person comes you need to take the time and effort to make sure that people are trained and understand what their expectations are around augmentation and communication within your different workflows. A bit later in the presentation, I'll go into more details about validation and provide information on an easy to use validation tool.

Now, we're going to talk about the UDS depression screening measure and present some of the national data, as well as some of the details about validating and reporting your UDS measured data for this measure. This 1st slide shows the depression screening measure, how the depression screening measure compares to other similar UDS clinical measures. Specifically, those that address screening and follow-up activities. You can see here the measures are listed from those with the lowest rates to those with the highest, with a range of 38 percent for colorectal cancer screening to 82 percent for the tobacco use screening and cessation interventions. The depression measure is about 50 percent. These other screening measures are structured similarly to the depression measure, you may want to look at your success with these other measures to inform you about how to implement the depression measure in your Health Center. The next 2 slides including this 1, show the depression screening measure by various Health Center populations and characteristics. The 1st table shows depression screening rates by rural and urban health centers, homeless and agricultural workers. As you can see, all are very close to 50 percent with a little variation – a range of only 49 through 51 percent. This table shows the depression screening rates by Health Center size. And again, there is little variation. This time I only saw a slightly larger range between 48 and 53 percent. These data show that there does not seem to be any significant constraints related to the depression screening measure based on Health Center size, location, or related to specific populations such as homeless or agricultural workers.

Now we're going to spend some few minutes specifically on UDS reporting of the screening for clinical depression and follow-up plan. This measure, as was mentioned earlier, is reported on table 60, line 21. And column A you will enter your universal denominator, all patients aged 12 years and older, 12 years before the measurement period that had at least one medical visit. If you are using your EHR and not a sample, the number in column B should be the same as the number in column A. If you are using a scientifically drawn sample of 70 patients the number in the column A will be 70. You also have the option of using the 80 percent rule or a number equal to or greater than 80 percent of all patients who fit the criteria, or a value of no less than 80 percent of the universe reported in column A. Oh, this thing – excuse me, we've skipped ahead here a little bit here. Sorry about that.

You can find out more information about using a sample or the 80 percent rule in the UDS manual. When determining the universe or denominator you must consider the following exclusions which of course are available in even more detail in the eCQMs manual that Adrian described earlier. Patients who refuse to participate, who are in urgent or emergent situations. Patients whose functional capacity or motivation to improve impacts the accuracy of the result. Patients with an active diagnosis for depression or a diagnosis of bipolar disorder. And patients who are in ongoing treatment for depression. So you always have to remember these as often as reviewers sees – were

these exclusions taken into consideration when the universal denominator was determined? To complete entering your data for this measure in column C goes patients on the date of the visit using an age-appropriate standardized tool and if screened positive for depression, a follow-up plan is documented on the date of the positive screen. Always remember to include all of those patients that were positive and had follow-up plan documented in the record. Oftentimes, this is another issue we see as reviewers, if there is a low rate [indiscernible] of screens, remember you have to count everyone, those with positive screens as well as those without.   [indiscernible] are currently using the PHQ-2 print an initial screening tool for depression and then administer the PHQ-9 as evidence of a follow-up plan. But next year neither will be allowable as document and follow-up activities. You are encouraged to write an immediate intervention such as Belinda described rather than just doing another assessment. More information on these changes will be discussed in the change webinar as scheduled on May 9th.

And now, we included these couple slides that we thought would be helpful but also very much on our mind as we are concluding the review of the UDS review system, the UDS reviews process this week, we're seeing a lot of the [indiscernible] as a result of that data entry and these are a couple of the common report issues that we're seeing. So for those of you, you know that there are edits that come up when the system is questioning your data, 1 of the most common edits for the depression screening and other clinical measures is your unit in. In this case, the system is questioning your universe or denominator, the system bases this [indiscernible] and on your estimated number of patients over 12. When you see this edit, you should look into your data to make sure you are including all medical patients over 12 from all of your sites. Are you including all of those patients over 12 with at least one medical visit? Are you excluding those patients with a current diagnosis of depression? And are you excluding patients currently in treatment for depression?

As a reviewer regarding compliance to the measure and not specifics about how the denominator or universe was determined and this is more information for the reviewers the other edit message that you will typically see in relation to the depression screening measure and the other clinical measures is compliance between last year and this year. Or, if your compliance rate is 0 to ensure that you're not just counting positive screens which can result in lower compliance rate, you may want to look at your workflows and ensure that your data is mapping properly. At this point, you really should validate your data. Auditing your data. You validate if it is an accurate reflection of your work and activities.

The health information technology, evaluation, and quality center are a high-tech center that have created a validating your data tool. This particular high-tech tool is a structure processor data and is a great tool for validating your depression screening data. The next several slides review some of the potential issues that can be revealed with a formal data validation process outlined in this tool. Here are some of those issues. Your report, your validation read, spend different systems at different sites, or not following pulling the follow-up information. The pulling information from that pulling noncompliant values? Is your report pulling patients who refused screening and counting them as compliant? Or, again not pulling patients who have a follow-up plan? Other potential data issues include documentation in the wrong location spoken about earlier, in this case the report will not pull that info. And if you also are not used you also need to service, the assessment of the follow-up was

provided. Was the service provided and not being pulled by the report, or were these services not provided as expected?

Other issues revealed through the data validation process issues. Is your report including patients who should be excluded such as those diagnosed with depression, or currently in treatment for depression? What if the services are incomplete, but the report is only pulling screening information or follow-ups, but not both. That tool at the high-tech tool website describes detailed instructions for validating your data, and addressing your data issues, Adrian.

>> ADRIAN BISHOP: Okay, so now we come to the substantive use session of the data lifecycle. This is certainly the most important segment of the cycle. As I said, at the beginning of the presentation, substantive use data needs to be accurate and meaningful enough to be useful. In this presentation, we tried painting a picture that shows multiple interdependencies the have to be controlled to make sure that the data is accurate and meaningful. [indiscernible] That is so true when it comes to data. The data is not absolutely accurate, it's not going to be relied on. Only you know if it's accurate. If the data you reported in 2016 requires improvement I hope the data lifecycle helps as well as the practical points that Belinda provided.   Remember if your current process follows the PHQ-2 with a PHQ-9 you may have to develop new workload in 2017. Bear in mind that data availability and accuracy is critical; the life and well-being of the patient may well depend on it. So thank you for your time, and Nick, I think that we've got some time for quite a few interesting questions that have been compiled during the presentation.

>> ELLEN RADIS: Just before we do that I want to talk about some resources that can maybe help you some of the information that we've talked about. The next 2 slides show some of the additional resources that you can access to support your health centers, data collection, analyzing and reporting your clinical data. On the slide, there's resources related to to the UDS depression screening measure, on the CIHS website, your go to resource for behavioral health integration. Here are specific links for screening tools, health information technology, developing and implementing workflows, confidentiality, and integrated care models. We also want to recommend that you check out the high-tech center website; as I mentioned earlier the data validation tool is 1 of the many tools on this website. High-tech supports health centers in the use of health records to collect accurate clinical data and to use this data to support positive health outcomes for health center patients. There are several resource sets on the website for the following topics. Health IT enabled quality improvement, which is where the data validation tool lives. EHR selection and implementation. Health information exchanges. QIT/HIT workforce development. Value based payment. Privacy and security. Electronic patient engagement. And population health management. And thank you and before we hand this back over to you Nick, Adrian and I really wanted to thank you and Belinda for allowing us to share her time and for her to share her experience with us. I think that really helped bring some life to this presentation. Thanks and back over to you Nick.

>> NICK SZUBIAK: Great, thanks everybody. The chatbox has been very active with a lot of questions, and so I am going to try and summarize some of the questions for you all to talk to us a little bit about, so let's go ahead and get started. 1 of the questions that came up in a lot of different forms was really about the numerator and denominator. So I am wondering if we might be willing to kind of revisit again the numerator and denominator definition?

>> ELLEN RADIS: Sure, basically your denominator or your universe is going to be all of the patients over 12 years old who had at least one medical visit, that is your denominator and that is the universe. It is an often referred to as the universe in your UDS reporting. So that is your denominator. Your numerator —

>> ADRIAN BISHOP: Ellen, can I ask a question around those denominators?

>> ELLEN RADIS: Sure.

>> ADRIAN BISHOP: Sorry to interrupt you and then around the denominator how often should that denominator be screened?

>> ELLEN RADIS: Oh, how often should the screening be? I believe that the requirement and – Adrian, is it once a year that they're supposed to be screen?

>> ADRIAN BISHOP: Yes, that's right.

>> ELLEN RADIS: Go-ahead, Adrian.

>> ADRIAN BISHOP: When I look at this question now and it is a really interesting question, the question is the Numerator plus all the patients positive screen for the follow-up plan or is it all patients that have screened positive or negative plus those with a positive screen? Obviously, the 2nd would cause some double counting so it is the former. I think the point to make here is that realistically, the only way you'd ever know the answer to that is to do the drill down we said. If you just read the numerator and denominator, even off of the ECQI site, it's never going to give you the details that you need to configure your workflows with. So like we talked about earlier on around the age range, again we said was it 12 during the year? Was it 12 before the year? Again, the only way you would ever know the answer to that is to drill down into those specifications and then get it from there. So all of these questions that really talk about, you know, kind of the nuances in the working, realistically the only way to answer them is to do like we said, follow that link, drill it down, look in the specs and that's where you see the absolute, definitive answers to these questions.   Whether it's this measure or 1 of the many other measures that realistically they are arguable, never really told you exactly what you got to do.

>> ELLEN RADIS: But we can tell folks by having done some digging into this ourselves that we know that in terms of the age range that the patient has to be 12 before the beginning of the measurement period. Correct, Adrian?

>> ADRIAN BISHOP: That's correct, yes, but again the only way you'd know that is by drilling down into the measures like we talked about. So Nick, does that kind of answer the question there?

>> NICK SZUBIAK: Yeah, I think so. And the great thing is just as a reminder to everybody, we're going to be sending out a recording of the webinar and all of the webinar slides are going to be available and so folks are going to be able to look at the numerator and denominator and look at

those slides to kind of compare and see what they are measuring in their health center, so we have that as a resource as well. I just thought I'd switch gears a little bit and ask Belinda a question, if that's okay?

>> BELINDA STYLES: Sure.

>> NICK SZUBIAK: And so were just getting to the question, and so Belinda, does Five Rivers use specific technical assistance resources, so any other external supports, to improve your depression screening measures?

>> BELINDA STYLES: So for sure we are working with our ethic technical team. I know that our administrators, higher above myself, are spending time with sort of our other administrative bodies to again drill down the definitions and make sure we are understanding what these things mean and discussing with them what our services are looking like. So that we are all on the same page. So I do know that those discussions do happen.

>> NICK SZUBIAK: Great. As a follow-up, Belinda, because you mentioned ethics, there were many questions in the chatbox wondering if you were willing to share some of your templates around I guess how you are documenting and using ethics to really improve your UDS measures?

>> BELINDA STYLES: Sure, I'm sure that will probably be in a group or some other form other than here. Absolutely, we are constantly improving that, so yes.

>> NICK SZUBIAK: Great, so maybe you and I can work off-line a little bit about how we might make some of that support accessible to some of the other folks on this webinar, I think there was a high interest around that, so we can talk a little bit about that.   And then one last question, Belinda for you, we were wondering what are some of the quantitative data that you track and report on and I guess that question is around depression screening and whether you are kind of communicating those data points to your staff?

>> BELINDA STYLES: So yeah, so we are as a new behavioral health team, we are doing quarterly meetings, of course we're reviewing all sorts of things. We are talking about patients positive screens. A positive PHQ-2 automatically leads us to do a PHQ-9, so PHQ-9's that are 10 and above definitely bring in our behavioral health providers and we're talking about how many people are screening positive. How many people we're able to see in that visit and we are working on following up with those patients. We are talking about those pieces and we are constantly working together as a team to use a variety of ways beyond just the conversation of coping skills but as we live in this beautiful age of technology talking about things that support patient well-being, so we are continuously looking at what we have, what more we want to know and how we believe that information is going to impact our workflow and clinical practice.

>> NICK SZUBIAK: Great, thank you, thank you so much. And maybe this question goes back to Adrian and Ellen, the question is for 2017 aren't we supposed to be using CMS2v6? So I think that connects to the specifications.

>> BELINDA STYLES: That's right.

>> ADRIAN BISHOP: The answer is yes, of course. We talked throughout this presentation around v5 because that was obviously the 2016 requirement but we are closing out the 2016 cycle at the moment. But the 2017 and we did say that every year these do get updated so the 2017.   The person that asked the question is absolutely right. We are on version 6. The good news is the changes are fairly little. The reason we haven't got into that is that there is a UDS process, Ellen can talk about, about communicating those changes and we have the change webinar coming up and the UDS manual wording that is going to have to change as we go forward a little bit. If you are talking about 2017 workflows, it is the version 6 that we'll be looking at, follow that link, but make sure you take a look at the version 6 and version 5 if you want to be definitive.   Ellen, do you want to talk about the way that we're going to communicate the changes?

>> BELINDA STYLES: Yes, well, the changes are going to be the UDS has a changes webinar scheduled for May 9th at 1 o'clock, which will be going out over the HRSA Announcements. I believe relatively shortly. But, I think what Adrian said is also true, there is very little changes, very few changes, and some changes in the terminology I believe from clinical depression to depression, I forget what way goes.   Another thing you can do that we didn't go into detail in the presentation is if you go into the eCQMs, you'll see there is a compare function, so that you can compare version 5 to version 6 and it will point out what the differences are. But they are mostly around nomenclature. There is nothing I believe, Adrian, that we found significant in terms of major changes in the measure this year.

>> ADRIAN BISHOP: The denominator and numerator and exclusions, that's right.

>> BELINDA STYLES: Those are going to be the same.

>> ADRIAN BISHOP: That's a great point and a great question, we should have mentioned that.

>> NICK SZUBIAK: Great, thanks so much guys for that. And we have a few more minutes for maybe a couple of more questions. This question sounds like a simple question, but I think it's a little bit more complex so I'm going to ask it to you. What level of staff completes the PHQ-9?

>> BELINDA STYLES: So with our PHQ-2 and PHQ-9 built into our input for patients. I'm probably going to address a few different questions if that's okay in the midst of answering this. With it being built in the MA is asking the questions from the electronic health records.   So we built in an actual screening tool in the medical assistant is asking those questions. So as a part of involving the behavioral health provider, the behavioral health provider is going to review that with the patient so kind of going over again how they answered their questions, making sure that it is correct and sort of what they meant by those questions, so the MA is doing the initial question asking. The behavioral health provider is going to do some follow-up. I also saw 1 of the questions was how often is that PHQ done? It's annually done, it's done every year, but we've created the freedom for the behavioral health providers to reassess if there are changes in a person's treatment. So if in January they come in and they fill out the PHQ-9 with the MA and see the behavioral health provider and they are referred out for long-term counseling, when they come back in 3 months possibly for their next

medical appointment. We may re-administer as a behavioral health team that PHQ-9 to see if that talk therapy is helpful.   Or if the medical provider has started an antidepressant. And we want to use the PHQ-9 to see how maybe that antidepressant is helping. So we do it annually as an organization, but there is room if there are changes in treatment to reassess using that tool.

>>NICK SZUBIAK: Great, thanks so much for taking that question on Belinda, and a few of the others that you'd seen that are close to that question as well. Another question for the group, there was some question around what score on the PHQ-2 triggers a follow-up? And so folks were kind of asking if we screened positive on a PHQ-2, what is that number, what does that look like? And, if a PHQ-9 screened positive what number indicates a follow-up or not?

>> BELINDA STYLES: For the PHQ-2, it's really a yes or no.   If you are saying yes to one or both of those questions, we're going to do a full PHQ-9. And so for the PHQ-9 to be screened or to be identified as positive, it's going to be a score of 10 or higher. But we also are paying attention to the suicidality questions, so that also is going to be a highlight.

>> NICK SZUBIAK: Great, thanks so much Belinda for that. And one of the other questions, there were a few questions around writing down policy and protocols and I know Ellen and Adrian spoke to this already but I think it is important enough for us to talk about again. There are some questions about the importance.   Is it important to have a written protocol on how to capture data?

>> BELINDA STYLES: Yes.

>>ADRIAN BISHOP: Yes, the short answer is very much so. It's got to be directed from the top, at the end of the day, it is a job of clinical leadership to really define the what and how to document it in the EHR system.   And the only way to make sure that happens consistently is through written protocols. And part of the job if you like of the HR committee is to agree to those protocols and make sure they are configured in a user-friendly way in the EHR.   So the answer is definitely yes. If we don't write the protocol, it becomes a free-for-all, I'm afraid.   We end up with non-consistent data.

>> NICK SZUBIAK: Great. And I'll ask this question from my old stomping grounds in Hawaii, they are asking why are there report issues when SQHC's are using certified EHR's? Does that mean that the vendors are not building the reports correctly?

>> ADRIAN BISHOP: No, in general, the reports are defined and specified, but very often what is the problem is the mapping of the data to the report. So for the report to pull effectively it's got to know where the data is pulling from and what form it's pulling from. So if the data is in the wrong place or in the wrong form, and bear in mind in the EHR there are often multiple places to put the same data, and if all of those places are not mapped to the report then you can end up with all or some of that data not being reported effectively.   So I don't think so much that it tends to be a reporting problem, it tends to be a mapping of the data to the report problem. Again, that is part of the vendor's responsibility, but at the end of the day it's getting the right data into the right form in the right place. If you do that consistently, the chances are it's going to pull an accurate report.

>> NICK SZUBIAK: Adrian, thanks so much for that answer.

>>ELLEN RADIS: I was just going to say even if the report is pulling the correct data, you may still find data issues. Data issues with data entry, or inconsistent, in the wrong format or the wrong place like Adrian said. So even if it's mapped properly or perfectly it's still worth validating your data because you still may identify some of those other issues.

>> NICK SZUBIAK: Well, great. A big mahalo to Ellen, Adrian, and Belinda. Thank you so much for joining us today. And being with us. I'm going to hand it over to Roara to go ahead and close us out for the afternoon.

>> ROARA MICHAEL: All right, so thank you all for joining.   Once again a recording and transcription of this webinar will be available on the CIHS website. Once you exit the webinar you will be asked to complete a short survey, your input is important to us and influences the development of future CIHS webinars. So again, I'd like to extend a huge thank you to our presenters for joining us on today's webinar. Thank you all for joining us and please stay tuned for more webinars in the near future. Have a great afternoon.

>> NICK SZUBIAK: Thank you, all of you.

>> ROARA MICHAEL: Thank you.

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