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NAADAC

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MEASUREMENT BASED CARE: AN ESSENTIAL COMPONENT OF
HIGH-QUALITY BEHAVIORAL HEALTHCARE

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>>: The broadcast is now starting. All attendees are in listen only mode.

>>: Hello, everyone, welcome to today's webinar on measurement based care, presented by Julia Finken. My name is Samson, and I'm the director of Training and Professional Development. I would like to introduce to you NAADAC's training and professional development content manager, Jessie O'Brien. She will be the facilitator for this training experience. Jessie.

>>: Hello, everyone. My name is Jessie O'Brien. I joined the NAADAC team in June after a ten-year run working for an agency in New York that specialized in the treatment of substance disorders. I'm a credentialed alcohol and substance abuse director and I'm thrilled to continue my career with the NAADAC team and all of you. It's a pleasure to be here today. The permanent home page for NAADAC webinars is [www NAADAC.org webinars](http://www.NAADAC.org/webinars). Make sure to bookmark this page so you can stay up to date. Closed captioning is provided by caption access. Please check your most recent confirmation e-mail or our Q and A for the link to use closed captioning.

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automatically muted to prevent background noise. If you have trouble hearing the presenter for any reason, consider switching to a telephone line using the audio option which is next to the orange arrow in your Go To Webinar control panel. You can use that orange arrow any time to minimize or maximize the control panel. If you have any questions for the presenter, type them into the questions box. We'll gather the question and I will pose questions to the presenter during our webinar. Any questions we will not get to, we will collect from the presenter and post the questions and answers on our website. Without further ado, let me introduce you to today's presenter, Julia Finken. Julia is the executive director of behavioral health care. In this role she leads strategy and growth for the behavioral health care accreditation group. Julia has over 30 years of leadership experience in the health care industry, including behavioral health care, home care, acute care, and ambulatory care setting. Julia has extensive development in business development, marketing management, sales management, strategy, finance, and cuing, education and performance event. She has dedicated her care in health care to maximize operational and cost efficiencies. She received her master's degree at the University of California Irvine and a minor in business and economics at California State University. She is a certified professional and health care quality and American society for quality certified black belt. NAADAC is delighted to presented to you by this expert. Julia, if you're ready, I'll hand this over to you.

>>JULIA FINKEN: Thank you every one for taking the time today to join us to talk about measurement based case. We are going to talk about the impact on improving outcomes for individuals with health care needs. We'll discuss the criteria needed for implementing for measurement based care and we'll highlight the practical applications for the use of data collected from standardized instrument. Measurement based care is an important tool for

improving quality and treatment of care treatment of services, and we want to make sure that you are learning about the potential impact and how to implement measurement based care an important step in this process. So it's my pleasure to have you all start or continue your journey toward improved outcomes by joining me here today. The joint commission started our journey on measurement based care in 2018. So before that time we always evaluated whether organizations set the outcomes of care for the individuals that they serve, however, we didn't require organizations to use tacit, reliable measurement based instruments to do so. We did let them select their own process and tools for measuring their outcomes. So in 2017, prior to modernizing our standard about outcome measurement, we -- it was a 36 most frequently scored behavioral health care standard. It was scored on 8% of all of our surveys. We wondered why. We wanted to change the standard. It should be obvious from the scoring data that we were really doing little to move the industry forward towards measurement based care. So there was growing evidence of scientific and literature of the benefit for using objective data to measure individual progress over the course of care. And then using that information to make better treatment decisions. So these benefits we saw through the literature search had across treatment modalities, settings, and it helped identify cases and populations that cost the most in terms of time and resources.

So when the joint commission makes a change to a standard, we take a very systematic approach to doing that. We base it on research and input from experts in the field. We did complete an extensive literature search. We engaged efforts in measurement based care in addiction medicine and mental health and children services to help us make this change. We went ahead and publicly posted all of the standards that we had drafted in order to get feedback from all of our stakeholders. Then we conducted learning visits, pilot visits and field review. We started that process in

2016, and we were really happily surprised that we received over all resounding support for the development and implementation of a requirement to use measurement based care that came from providers, from pairs, from regulators. We had a lot of support across the field. We knew this was a big change for everyone, so we gave the field a year to prepare for implementation, and during that time we gave a lot of support via phone calls. So we took phone calls from all types of organizations. We put on webinars. We developed a portal of instruments that organizations could select from if they chose to. We did a lot of educational presentations at conferences and other venues. So in January of 2018, we made the changes to the standard, and here are the key elements that we changed. What we first required that organizations must use a standardized tool or instrument. Secondly, we said that they needed to gather and analyze data from these instruments and use it throughout the course of care to inform the objectives and the goals of the individual plans for care. And then finally we said the organization need to aggregate all of the data across all of the individuals that they serve and use that information to improve services that they provided to their entire population. So here's what happened. We went from 8% of our organization with findings in the standard to 47% and we viewed that actually as a good thing because it meant that we have opportunity to really drive this change. It took organizations awhile to fully and effectively implement measurement based care. So 2018 was really a year that education and coaching from our survey. And the organizations had 60 days following the survey to submit to us evidence that they had selected and implemented a tool.

>>: Thank you, Julia. I'm going to launch the poll, and you can choose your answer to is your organization currently using a standardized instrument for measurement based care? As a reminder, you can send in questions to the presenter in the questions box. We are going to have a live Q and A and ask the

presenter your question in the order in which they are received. I see lots of answers coming in. I'm going to give about five more seconds before I close the poll. Thanks everyone. I have closed the poll. I'm going to share the results and then turn this back over to the presenter.

>>JULIA FINKEN: This is great to see that 59% of you are already using a standardized instrument for measurement based care. Hopefully today if you are running into any issues with implementation or using your data, you'll walk away today with some good information on that. For those of you who aren't using a tool yet, this is your day to really start thinking about it. Hopefully I'm going to approximately provide you with a lot of resources for you to start on that journey. And you'll hear about some other organization's experience with using measurement based care and the powerful impact it has had on improving outcomes and I hope that will be a motivator for you to start moving forward. So what is measurement based care. It really starts with typically a client rated instrument, and the instrument is then scored, and then it represents the progress that is being made by the reporter. The main purpose is to really stimulate conversation between the clinician and the client. And this is where we see the staff get excited. So if you are having difficulty getting your tools implemented, if you can get some super users moving on it and start to provide their peers with feedback on how powerful it is to help them to guide their conversations with their clients and help their clients to progress toward better outcomes, the better your implementation process will go. There's many ways that these tools can be administered, so some organizations it's a barrier for them because they think this is going to be very expensive or complicated or require a lot of system changes on their electronic records. It doesn't have to be that way. A lot of these can be done with paper and pencil and plotted out in a short period of time. But there is the availability of more sophisticated

systems where a client may come in and enter and score their survey on a tablet. It will then calculate out their data, either through a data center or directly, they go directly to the provider, and then the provider has immediate feedback to them to provide to the client about progress and collaboration between the clinician and the -- in terms of discussing progress or lack thereof. Have an opportunity to talk about what they can change that can positively impact the final outcome of care. When measurement based care is implemented, it's implemented in different ways for different populations or services or settings. So beings for example, if you are a substance abuse disorder organization who has residential facilities, you are going to be administering this tool over a set period of time in most cases. You are going to determine the frequency. There is an opportunity in these cases for more frequent measurement because the individual is right there on a daily basis. If you compare that to an outpatient setting where you may have the potential for even a longer period of data collection, so that frequency may be less often that you might need to employ some type of remote capability for completing surveys but it also gives you the opportunity to change the scheduling of appointments based on the feedback from the survey. It's important for us to talk about what type of instrument we're going to meet a requirement for measurement based care. First of all, the instrument needs to be reliable. So it needs to give the same results on successive trials as a repeated measure. It also needs to be valid, meaning that it's relevant and meaningful for you. And it's sensitive to change so that it detects the change that the measure is intended to detect. You want to make sure that it's able to be used on multiple occasions with the same subject, and make sure that the tool can differentiate between those that need treatment and services and those that do not. So there's a lot of really useful and important quality measures, but not every good measure meets a requirement for measurement

based outcome. Measures like looking at whether your organization or your individual service providers are following clinical practice guidelines is more of a process measure. So it's not an outcome measure. Perception of care questionnaire or looking at some type of compliance of treatment or looking at an outcome after the completion of a service really wouldn't meet the criteria of measurement based care. Measurement based care is the ability to measure and then use the data objectively throughout the course of care to impact the final outcome of care. So we know that selecting a standardized instrument is one of probably the largest obstacles for organizations. So in doing that we wanted to really help our providers, our accredited providers but also just the industry at large to identify some appropriate instruments to be utilized for behavioral health care. So in doing that there is a website address here, we developed a landing page in the portal. We have about 64 instruments on that listing right now. We don't endorse any of these instruments, but we have vetted them to make sure they meet the criteria for a measurement based instrument. This is very small but I wanted to point out that our instrument listing, we go into quite a bit of detail about the instrument so you can make an informed decision on whether it's something you are interested in pursuing. We do give you the developers contact information so you can reach out directly to the developer if you have questions about the use of the instrument. We designate the reporter, so whether it's a self report or direct provider report or an independent provider and then we go into some depth in describing the instrument. What is the primary purpose of the instrument, what population does it apply to, is it good for substance abuse disorder, is it good for mental health, is it good for a combination or dual diagnoses. We talk about the population, is it good for adults, children, or could it be used for both. And then also the different setting. So this particular instrument could be used really in a myriad

of care settings, including outpatient, residential, and inpatient. Most of the tools take on average about five minutes to complete by the reporter and so this tool is a five minute tool and it takes about one minute to be scored. So you can see that it can go very quickly which sometimes is a clinician is it going to add or take away time from their time with the client but it's very minimal time spent. It also will tell if you there is any benchmark data available and whether psycho metric testing has been done on the instrument and whether that testing has been done on published materials. It will tell you if there are different administration options. This particular instrument can be done with paper and pencil. It can be done electronically and also on the mobile app. The publications that support the use of this measure are listed below as well. There's lots of other resources as I said. We are not prescriptive on what instrument is used, as long as it meets the criteria. NIH has a listing of instruments and in their listing there are 34 that meet the measurement based criteria. Also, the Kennedy forum has a lot of really good instruments as well. Those are available for the public at large too.

>>: All right. I'm going to go ahead and launch today's second poll. You can go ahead and choose your answer. For those organizes not using a standardized instrument for measurement based care, what has been your greatest barrier for getting started. If you have any questions, please feel free to put them in the questions box, in the Go To Webinar panel and we will answer those toward the end of the webinar in our live Q and A. Great. I see results coming in. I'm going to give it a about five more seconds. All right. Thanks, everyone. I have closed the poll. I'm going to go ahead and share the results and I will turn this back over to you, Julia.

>>JULIA FINKEN: Thank you. So, yes, at this point in time it's not surprising to see that implementation challenges come out as the highest concern and there are some key things that we are going

to talk about to help you with implementation. But really the most important thing is for your service delivery people, clinicians or nonclinicians who are using the instrument to see very early on and very quickly the value that they can derive and how it can help them interact with the clients that they serve and it gives them really objective data instead of trying to figuring out why a client is not progressing. And a lot of the tools also do come with some decision support. So it can help you to take different selections in terms of how you are going to change your plan for care of treatment and services in order to get that client back on track. We'll talk about that in just a moment.

The other point of implementation, it needs to feel practical for the individuals working in your organization on a day-to-day basis. So here are some of the steps you can take to make sure that happens. So first of all, when our surveyors go out and talk to organizations, they emphasize a few things. The first step is making sure that the leaders really understand the instrument and select an instrument that's really very appropriate for the population that the organization serves. That's going to increase the value and optimize the value to your clinicians and the clients because it's going to improve the outcomes that matter the most to them. So we do -- we'll ask the leaders why did you select the particular instrument, and then we'll talk to them about how did you go about implementing the instrument. Some of the things that tend to be key for a successful implementation is again the selection of the right instrument but also what education and training did you provide to staff, and how did you roll it out. So was everybody involved, did you have a pilot group before you tried to roll it out? How do you monitor the staff are using the instrument and how do you provide them support for using the instrument and interpreting the data? So helping them to make it useful and practical for them on a daily basis for every client. And then, you know,

for your supervisors, how are they tracking the instrument administration by the clinician and then how are they working would those that are not using the instrument regularly to help them to understand how to use the instrument and to get the most benefit from its use. In order to do that, we used what's called a tracer methodology and we'll take a select number of clients and we'll trace their course of care from beginning to end. That's a really good tool for organizations to use as well. You can do some record review and make sure that there's evidence in the record that the instrument is being used. You can make sure that when the instrument is being used that there's notes in the progress note to make sure that the instrument is being discussed with the client by the clinician. If clients are filling out these forms and they never receive any feedback and not involved in any followup with the instrument, then your compliance is going to be much, much lower from a client perspective will obviously flow through the entire measurement based care program. So it's important that the clients do understand how the instrument is going to be used to help monitor their progress and to help them collaborate on getting the best possible outcome. And then also again the clinician should be able to describe how they used the data, what they learned from the data, how they interact with the client around the data, and then how the supervisors use the data to work with their team members.

So let's look at some examples. This is an example of a tool that scored on a zero to 100 scale. One hundred is good. Zero is bad. Whenever you are looking at an instrument, you want to know the clinical cutoff. In other words, if somebody falls above this clinical cutoff, then they are really not in need of treatment. If they are below the clinical cutoff, then you know they are a good candidate for service. Many of the controls do have an upper and lower control limit. Above the upper limit, there is not a need for service. Below that limit, the lower control limit, we

know that there are some treatment failures going on. So we start by plotting their initial score. You can see this individual's initial score is around 44 on a scale of 100. And then most of the instruments we can calculate a projected rate of improvement. So in other words, if everything were to go as planned, this individual would progress along this line in an upward manner. Now we know that -- if we look at a client, we know there's some variability, that clients don't fall on a straight line of progression, so there are ups and downs. But it's staying within those upper and lower control limits, so we know this client is moving in a positive direction. So this is a great opportunity to have a conversation with a client and reinforce what they are doing because it is having the positive impact that both the clinician and the client are looking for. In this second example, this client you can see is not following the projected course of progress. In fact they are deteriorating. So this is a great alert to know that this client is at risk for treatment failure. So this is a really important time for the clinician and the client to put their heads together and look at the treatment plan and say what is working and what is not working and make some revisions. And then as care is continued, you can start to see if there's any positive changes. We can look to see if the client -- if the deterioration would start to turn around and progress in an upward manner.

So just to summarize, using the data for an individual client, you are going to analyze and deliver the data to the client as objective feedback and then discuss it with them and use it to inform any changes and goals and objectives or to inform that you are on the right track and to not make any changes. And then it's a high alert situation if you start to see deterioration. So when I talk to clinicians, they, you know, probably the most positive thing they say about the use of measurement based care is that it early on lets them know if the therapy is working or it's not working, and they can make those changes quickly. So

then the other use we talked about is the organizational use of data. So this is really helpful in that it allows the organization to aggregate all the data and to identify quality improvement opportunities. They can incorporate that in their performance improvement. If they see overall for an entire population of individuals are not progressing at a steady rate, they can look at where in the course of care where it's failing and what they can do for the treatment planning for the whole population to avoid this happening in the future. So it's really powerful in helping clients but also supervisors can use this to look at how individual clinicians are performing or how a whole team or a whole location is performing. Here's an example of aggregating the data for one client record. So we see how this client progresses. Look at the power if we graphically displayed the progression of 19 clients using 19 records. These could be the clients of a single clinician or it could be a specific unit or diagnostic group or patient population. But when we are aggregating the data and graphing it, we are finding a way to summarize the information. Just by looking at the graph, we can see that a majority of the clients are trending right along that trend line that we have some clients that are out of that upper control limit potentially, and we've got some clients that are showing deterioration. So if we put all of this data in a chart, we can look at the pre and post scores and we can tabulate the difference between. So how much they've progressed throughout the course of care or how much they've declined across the course of care. And then we can develop a score card. So we can learn from those total clients that the main number of times that we have contact with a client is 7.4 times, but most frequently we are will go contact with clients three times. We can calculate that the average change is 21.4 points of change over the course, the entire course of care, and the average change per contact, so every time we see that client, they progress in the positive direction by about 4 points. So if we know

that reliable change on this particular instrument is 15 points on this 0 to 100 scale, we can look at the average number of contacts there is to achieve reliable change. And for this data it's 3.9 contacts. So then what we can do is take this and say how is what this team, let's say, at a specific location performing compared to another team. And then those two teams can compare their results and start talking about leading practices. So if one organization that is taking, you know, ten contacts on average to make a 21.4 change and the other is taking the 7.4, they can start to discuss what are the leading practices in the treatment that the higher performing team is doing that this other team can start to adopt.

So again, we can use it to -- on an organizational basis to evaluate individual providers, to identify quality improvement opportunities, to assess the impact of quality improvement initiatives. So once you've identified where you can improve, then you can circle back and use this data to keep monitoring if actually the interventions you've put in place have actually improved the quality of what you're doing. And then you can also demonstrate the effectiveness of your program to serve as stakeholders, whether that's clients, payers, regulators, it's all available to them.

And when we looked recently, the end of 2019, at how our organizations were performing, there were about 33% that still had not selected a tool, but then we saw the majority were selecting tools, they had implemented, and they needed some support in terms of their implementation. So our surveyors had a chance to do some education and also provide some feedback and education around how to use the data in aggregate to improve the performance of the entire organization. So our organizations are progressing. For those of you that are still trying to select a tool, I just brought some of the most frequently used tools. I don't think a lot of these were surprise you. PH Q-9, COWS, BAM, GAD-7 were the most frequently used tools. But lots of

tools are being used, a huge range of instruments. So, you know, it's not one size fits all. So we asked our surveyors, what were the examples that organizations, that they were serving they felt added the most values from using measurement based care, and one of the top findings was that the using the tools they thought resulted in really great discussions with clients. And they were able to really individualize the plan for care treatment services to support client identified goals and they found it to be very powerful. The other -- probably the second most important use and value that the clinicians found was that using it as part of a high alert system. And that was to identify treatment failures early and to make necessary changes to get these clients back on track. So we worked with a couple of organizations a few months back to garner some information about how they had gone about selecting, implementing, and using the data for measurement based care. These were organizations that were, you know, really robustly using measurement based care. So I've summarized what we learned from these organizations recently. So the first question we asked them is what is the process they used to select their instrument? So we talked to Shawna Granato from Addiction Campuses, what she had to say what she found really powerful was integrating the compliance program and using a lot of research and experts to cull what tools they were thinking about down to a manageable few. And then they brought that information to every location and every team and really just engaged them in the decision making process. So everyone was involved in selecting the tool. And then they wanted to make sure that the tool could be incorporated into their electronic medical record. And then they kept everybody engaged in the process through weekly calls to make sure that they remained supportive and engaged in what they were doing. We also talked to Antoinette from Sierra Tucson, she said that they tried the measurement based care into their overall mission and treatment philosophy and that allowed them to choose

the instrument based on what their staff and clients valued most and that was quality of life. They were able to find instruments in the public domain that met all the criteria. So that was a real plus for them in terms of a cost savings. We then asked what process did you use to implement measurement based care?

Shawna said that what they found most important was that they built trust with clients and staff regarding what the purpose was as being to improve outcome. They then decreased the amount of change by integrating the tool right into their current work flow. So that got staff on board. They adjusted their electronic medical record to support the use of the tool and the data so it allowed staff to not take extra steps and extra works. And then they did a lot of coaching in order to embed the tool in practice and to demonstrate the benefits to all of the staff and the clients.

Antoinette talked a lot about how they wove the measurement based care into the patient treatment experience. They assured all their clients that the findings from the tool and the progress would be shared with them by their clinician. So they found that these discussions enabled them to really get buy in and engagement from both staff and clinicians. And then in order to take that even a step further, they developed some really easy to interpret graphs, very colorful graphs that clients can easily understand and see whether they were progressing or not. And then finally in terms of how data, we asked them how have you used your data. For Maeve O'Neil who is with BH Force, she said they used it to increase the client value. So they were able to look at an aggregate, what services seemed to work really well, what services did they need to add to enhance their program. They ended up adding a Yoga meditation and wrote to their program. And they were able to adjust their schedules and curriculum better to meet the client needs. And they also were thrilled to find out that they could use the aggregated measurement based care data to get into networks with pair payers and win appeals with insurance companies.

Antoinette felt what was powerful was the development and use of a client report card. And that they were better able to evaluate program fidelity to see what was working and what was not. One of the main things they implemented was to better understand the AMA behavior and they were able to use the data to help them come up with interventions to prevent these occurrences. And they felt that they used the data well to also improve the treatment team effectiveness by specific conditions. They also used it for utilization review for managed care decision making regarding the length of stay.

>>: All right. It's time for our last poll which we will do quickly here. You can go ahead and choose your answer for what steps will your organization take in the next 90 days related to measurement based care? Last reminder, if you have any questions, put them in the Go To Webinar questions box and we will get to them at the end. Although, I know time is of the essence. I see lots of answers coming in. I'm going to give another five seconds count down here. I'll close the poll and share the results. And return this back over to you, Julia.

>>JULIA FINKEN: This is great. We've got an even mix, including nothing. So I'm hoping the nothing are the people who have all of this in place and it's just working really well for you. But I'm glad to see the organizations are going to select an instrument and then work on implementation. So with that, I just want to summarize by saying that we know that successful implementation of measurement based care, it isn't easy. It really does require changing the culture of your organization and having a lot of patience while you are doing that. But we strongly believe at the joint commission that the results are well worth the journey. We hope you will continue or start on this journey today. If you need any help, if you have any questions, I have put contact information for my team members. We can answer your questions or direct you to someone who can. Our department health care quality

and evaluation helps many, many people select tools and troubleshoot implementation and learn to use data. Please avail yourself of that resource. And with that, I want to thank you for listening here today and see if there are any questions.

>>: Awesome. Thank you so much, Julia. It looks like we have time for a few questions. So I'm going to roll right into those. The first question is from Christian. If you are a clinician working with someone who has a co-occurring disorder, one being a thought disorder, does the clinician or the client complete the assessment. The client's perception may be very different from the clinician and not necessarily reality based.

>>JULIA FINKEN: So typically you would still, if they are capable, have the client complete the instrument, because it gives you the basis for where the clinician's perception is different from the client's and it opens up that discussion, and it does help them to formulate how you are going to move forward, what needs to be changed in the plan of care to bring some of that in alignment or modify the goals and objectives. You can -- some organizations choose to have a significant other, family member, somebody else also involved in completing the instrument, and sometimes that can be helpful as well.

>>: Awesome. Those are great ideas. Very helpful response. The second question here is from Ashland asking what does EP1 and EP2 stand for?

>>JULIA FINKEN: Thank you. I should have clarified that. So the joint commission standards are broken up into what we call elements of performance which is kind of a checklist of what needs to be done in order to bring that standard in compliance. So EP1 is just element of performance 1. EP2 is element of performance 2. It's just our standard language.

>>: Thank you for that clarification. Last question. Debby asks do you provide or suggest any trainings on the evidence based tools that you endorse on your website.

>>JULIA FINKEN: So we don't -- we don't endorse specific tools, we just provide tools that we vetted that meet our requirement. But you are open to select any tool that you want. We do general training. Frequently throughout the year we do webinars, we have trainings at conferences. But if you need some individualized help, you can, as I said, work with our department of health care quality, and they will help you to select an instrument that would fit your organization. They can talk to you about implementation and give you some tips on that as well as walk you through how to utilize your data.

>>: Wonderful. Thank you so much, Julia. Just a reminder, everyone, that immediately following this live event you will find the online CE quiz link on the exact same website you used to register. You can see it right here. That means everything you need to know is right up here at the top at this website. Instructions are highlighted on the slide. You can find the user friendly online quiz and also in our control panel as a reminder. Here's the schedule for our upcoming webinars. Please tune in if you can as there are interesting topics with great presenters. On July 29th, our cultural humility series continues, on August 5th, we have increasing effective clinical supervision for substance abuse. Lots of great presentations coming up. I also recommend that you bookmark this page seen here on this screen for our cultural humility series so you can stay up to date on this series. Additionally please visit our Covid-19 resources page. The website is also here on the slide. They have provided to you six excellent free webinars presented by leading experts in the field. Currently NAADAC is also offering two specialty online training series, the first series clinical supervision in the addiction profession. You can find this on the site at the bottom of the slide. The second series is addiction treatment in military and veteran culture. This series is presented by Wayne, a retired combat vet. To find out more about this visit the website at

the bottom of this slide. Lastly, here's a quick reminder of the benefits of NAADAC membership. You have access over 145CEs. You will receive our magazine advances in addiction and recovery. We offer in person seminars throughout the U.S. and also included in membership is independent study courses, conferences, and certificate programs. Thank you so much for joining. Please note that a short survey will pop up at the end this have webinar. We care about what you think so please take time to give us your feedback, share any notes with the presenter and tell us how we can improve. Your feedback is important to us. Thank you again for participating in this webinar. Julia thank you for your expertise and support in the field. I encourage you to take time to learn how NAADAC helps others stay connected. That is the end. We will see you guys soon. Thanks so much. (End of lecture.)