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Welcome to the "Root Cause Analysis: A Building Block for Performance Improvement." I'm Ellen your operator for today's call. At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session. Please note that this conference is being recorded. I will now turn the call over.

This is Lake Superior Quality Innovation Network. Welcome to "Root Cause Analysis: A Building Block for Performance Improvement." This webinar is intended for providers working with quality innovation networks in Alaska, Colorado, Hawaii?

Illinois, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Wisconsin, and Wyoming. All lines will be muted during this webinar. At the end of the webinar, there be a short time for questions. And you may also ask questions in chat. Our featured guest speaker is Kathie Nichols. Kathie provides leadership for safety initiatives in Minnesota insurancing homes as part of the Lake Superior Quality Innovation Network under the direction of the Centers for Medicare and Medicaid services. Through this works, she helps identify evidence-based practices and healthcare processes and systems and works with nursing home staff to adapt and adopt these practices to improve quality of life and quality of care for persons living in the nursing home. Kathie was part of cms's QAPI national demonstration project and has provided technical assistance to participating nursing homes as they integrated QAPI into their organization. Kathie has extensive experience in acute and long-term care including 20 years as a director of nursing. She is a certified rehabbation registered nurse and has used rehabilitation principles in supporting persons across the continuum of care. She is a current member and past board member of the Minnesota chapter of the association of rehabilitation nurses. I will now turn the presentation over to you, Kathie.

Thank you, Christie. It's my privilege to speak with you today on "Root Cause Analysis: A Building Block for Performance Improvement."

Thank you, we have the slide moved ahead. Hello, everyone of the greetings from the Lake Superior Quality Innovation Network for LSQIN representing the Medicare and Medicaid services Quality Improvement Organization program. Stratis Health is based in Minnesota and Metta star in Wisconsin. We're very pleased to be with you today. Today, our objectives are to explore how root cause analysis can be used as part of the performance improvement process within QAPI. We will identify the steps and processes involved in RCA and introduce you to the RCA toolkit for long-term care.

Root cause analysis or RCA is a process aimed at identifying the root causes of problems or events, the practice of RCA based on the belief that problems are best solved by attempting to address, correct or eliminate root causes as opposed to merely addressing the immediately obvious symptoms. By directing corrective actions or interventions of root causes, it's more likely that the problem will be prevented from recurring. RCA is typically used as a reactive method of identifying an event revealing the problems involved in solving them. Most often, analysis is done after an event has occurred. Understanding RCA and why events occur may make it useful as a pro-active method to anticipate problems and recognize safety risks. Root cause analysis is not a single sharply defined methodology. There are many different tools, processes and philosophies for confirming root cause analysis. However, it's also possible to define several general processes for performing RCA.

Why is RCA valuable? By being engaged as part of a team, staff are able to understand why events occur and help in identifying solutions. Understanding why events occur helps staff identify risks. Identifying risks helps promote safety and prevention. RCA helps staff analyze situations and their causes avoiding a quick fix that doesn't prevent recurrence or doesn't sustain changes. It promotes systems thinking and is a foundation for quality assurance and performance improvement. Root cause analysis leads to a desire to uncover the facts and the underlying story that led to the event. Understanding why the event occurred leads to a non-punitive sometimes called a just culture approach to improvement.

There are two approaches when events occur and the first approach looks at who was to blame and where the error occurred. This approach expects that our staff will always be perfect in their work performance. When an error happens, we blame the individual and either discipline or retrain, focusing on compliance with policies and procedures. But -- what if it happens again? What if someone else does the same thing? What if it goes deeper than that? The other approach is to pick the right problem to start with. We look at why the systems or processes allowed an error to occur. We expect our staff to act professionally, but know they are human and will make mistakes. If our systems allow them to. Solutions result in changing the process, which might include training, changing the culture, or staffing.

The terms process and system get thrown around frequently in quality improvement and RCA. Here's a way to define an differentiate the terms. Process means the steps staff follow to do something or produce something. Processes in long-term care are often guided by policies and procedures. A system is the combination of processes, people, the culture and environment and equipment. An example of a system would be medication administration. Administering medications canning thought of as a system composed of many processes and impacted by the people involved. The environment and equipment. If we make a change in one part of the system, it likely would have impact on other aspects, as well.

Once we start identifying our processes and systems, we are starting to perform systems thinking. In order to do this, we need to believe that the parts of a system can be best understood through how they relate to each other rather than in isolation. And it requires critical thinking -- excuse me -- critical thinking skills to analyze, synthesize and evaluate information. This doesn't come naturally but requires practice. Systems thinking and critical thinking are key tools in QAPI.

Although common quality improvement tools are helpful in RCA, the most important tools are listed here. They are critical thinking skills, a nonjudgmental attitude, the desire to understand why, and a belief that we can always do better.

One aspect of the RCA process that's important to understand is the use of the term "errors." Our natural response is to assume this means a mistake that someone made. However, that's not what is meant in the RCA process. In the RCA process, the term error refers to anything that happened that was not intended. But it does not imply that the error was the fault of the individual. For example, in RCA, if someone forgets to do something, that is not considered the fault of the individual but, instead, it's viewed as an outcome of the interface between that individual and the system in which they're working. The RCA process also assumes that if we can learn enough about the system, we can predictor.

Reporter: And then prevent them -- we can predict errors and then prevent them. The process looks for two types of errors, active errors, which occur at the point of interface between humans and a complex system, and latent errors, or the hidden problems within healthcare systems that contribute to adverse or unwanted events.

The concept of having a non-punitive culture in healthcare is that people make errors all the time not because they're incompetent or uncaring or careless but, rather, because of the complicated systems they work in, which really make it difficult not to make a mistake. Because there are so many ways to go astray, it's not appropriate for people to be punished when they make mistakes and, yet, that's exactly what we've always done in the past. When people particularly nurses make a medication error, they are a disciplined. But what we're saying now is that's not appropriate. Nor is it effective in terms of reducing the odds of the next mistake or another medication error. We also shouldn't punish people who report their mistakes but, rather, we should look upon mistakes as evidence, clues if you will, of a faulty system and create an environment where people feel comfortable about reporting errors and discussing ways to change the system. In a kind of a non-punitive he environment -- that county of a non-punitive environment is essential if we want to identify mistakes and risks. A very important concept in human factors is that human errors actually is predictable. And the expected rate of error can be measured. This table shows the probability of error in a few situations. Reading labels is something we're generally good at. And the probability of error is low. But it's not zero. Three out of 1,000 times we read a label will make a mistake. While this sounds very low, it can actually represent a fair number of errors since this is a very common task in a nursing home. The next someone a bit more common. -- the next one is a bit more common. 3 times in 100 is an error in self checking. So while checking your work is good, it's far from foolproof. The next is especially interesting as often we tend to do second checks as a way to prevent errors. However, this is not effective as we know that one out of 10 errors will not be detected with a second check. That's why double-checks are not considered to be a strong corrective action and likely waste staff time and energy with little benefit. The final example is the probability of error in situations where we're working quickly in a high stress situation. In this case, the probability of error is 25%. Therefore, even though the situation may not occur frequently, it's important that our systems and processes support us in preventing error while under stress.

To avoid blaming the individual and creating a non-punitive culture, we must focus our attention on our processes and systems including procedures, equipment, and work environment, our communication systems, and education and training. We have to be open to changing any or all of these elements to prevent errors or unwanted resident outcome.

Instead of looking at an unintended outcome or event involving an individual from the outside, we need to try to understand why they did what they did. By doing this, we avoid hindsight bias. Hindsight, or looking back, is always 20/20. Understand why their actions made sense at the time. This helps us understand that the quality of decisions are not determined by the outcome but, instead, the use of the information available at the time. It helps us realize that information for decision-making doesn't come all at once. Each new piece of information and the order in which it arrives to us can alter the choices we make. It helps us see how all potential outcomes can't be realized along the way. We haven't fully understood an event or problem if we don't see the individual's actions as reasonable. The point of a human error investigation in RCA is to understand why people did what they did, not to judge them for what they did not do.

Being aware of these human factors is relevant to RCA because it teaches us to avoid relying on memory and pushing staff to be more vigilant and instead makes use of protocols and checklists. Simplifying processes by taking out extra steps where we could potentially make an error. Standardizing procedures to reduce unintended variations or staff doing it differently every time. And using constraints and forcing functions that force us to do certain steps. For example, my car won't lock until the lights are turned off.

We have already talked about these points. So we'll move on to these ideas supporting the goal of RCA which is to determine why something happened, understand why people did what they did, and prevent it from happening again. The steps in the RCA process are listed here. Identify the event. Select the team. Describe the event, where did the breakdowns occur, identify all factors involved, identify the root causes and contributing factors, create change by designing and implementing process and system changes to eliminate the root cause, measure to determine the results. Within each of these steps, the team will use basic quality improvement tools such as creating a timeline, flow charting the current process to identify where breakdowns occurred, creating a cause and effect diagram or Fishbone to Grupo tension root causes and contributing factors into categories. Brainstorming corrective actions. Using PDSA to test and implement changes. Developing process and outcome measures to determine impact. And identifying ongoing measurement to determine if the change is sustained over time rather than reverting to the old way of doing things.

Approximately 5 years ago Stratis Health and the Minnesota Department of Health did statewide training and offered resource and training on root cause analysis for nursing homes. As a follow-up it was found that nursing homes really needed more practice in how to conduct root cause analysis to be effective with process. Last year, the Minnesota Department of Health approached Stratis Health to create a root cause analysis toolkit to assist nursing homes in this process. Federal civil money penalties were used to fund the project. We first did an extensive search for tools and materials and what was currently out there. To our surprise, we found that there were resources for hospital systems doing root cause analysis but very little that applied to root cause analysis in the nursing home setting. We also found that quality improvement methodology was referred to in root cause analysis but the available resources didn't do a good job of incorporating RCA into a process that was part of quality or performance improvement. With the pending QAPI regulations for long-term care, we wanted to assure that RCA was understood as part of QAPI. What I want to spend the rest of our time today is showing you the RCA toolkit for long-term care. It can be found at the website on the screen and I'll give you the address again towards the end of my talk. I wish that I had enough control over the technology used today to show you the website live. I was worried about internet connectivity and delays. So I'll walk you through the steps and some of the tools and hope that you'll take the time to explore the site on your own.

This is what the website looks like. On the first page are two videos one is a 16-minute video giving a general overview of root cause analysis, and some of the theory about a non-punitive culture I have already discussed. This video can educate a team prior to starting an RCA process. The second video is three minutes in length and shows you how to navigate the website. On the lower half of the page, you will see a home button and 7 steps we have identified as the RCA process. These include identifying the event, selecting the team, describing the event, identifying all the factors, identifying the root cause, changing and measuring, and communicating and sustaining. You can navigate by clicking on the steps in the diagram or using the list on the left side. We're now going to explore what's available for each step in the toolkit.

The root cause analysis is a problem solving method or process for conducting an investigation into an incident, failure, an actual or potential problem or concern. Events that can be investigated using the RCA process can be identified from many sources such as incident reports, individual family and staff feedback, surveys from regulatory agencies, and unexpected occurrence that led to an individual or staff harm, or a repeating problem. Under the first step or identifying the event, is a document listing these things to consider. RCA should also be considered for events that could have potential for serious or negative outcomes such as a close call or near miss. Throughout the toolkit all these situation will be referred to as events even though they come from a variety of sources. Other sources and examples for RCA include an adverse or sentinel event is an unexpected occurrence involving serious injury or death of an individual. For example, an individual falls resulting in a serious head injury requiring hospitalization. A near miss unacceptable risk or chronic failure example is the wrong medication dose is found repeatedly in a medication CART. Recurring complaints example is a family member complains that it took 30 minutes for his mother's call light to be answered and another family member reports that staff didn't appear for 15 minutes after turning on the call light.

A repeating event example would be 75% of all falls occur between 6 and 8 p.m. Or anytime a performance gap is identified, for example, a plan of care wasn't followed. RCA is also not necessary for every concern, incident or problem that arises. Some situations can be managed and resolved quickly. They are unlikely to recur based on unique circumstances. Negative consequences may be minor. Or nonexistent. And there's no pattern of a previous similar event or trend. RCA takes time and requires resources to be done well. The events I have described are best for this type of in-depth problem solving. RCA is a different process than managing an incident and implementing immediate action to correct the situation. RCA occurs after the immediate action is resolved and involved individuals and staff are safe and immediate communication has taken place with families or others involved, and now it's time for a team to really figure out what happened.

In the toolkit is a story used as an example from a nursing home. Within the toolkit you have access to a step-by-step process, instructions and a variety of worksheets and other tools to complete an RCA. This story or case study is used as an example and all the forms are completed using this example. So you get a blank copy as well as a completed copy. We know that some of you learn best by having a reference of how it was done to refer to. Let me share part of the story with you. Mary, 82 is admitted to the unit at white pine rehabilitation and care center in the hospital for rehabilitation following a left total hip replacement. She had fallen at her apartment and fractured her hip. Prior to her fall Mary lived independently. Mary is a widow with three children. All children live over 500 miles from Mary. As one of her daughters has taken time off to come and assist her mother as she recuperates from her surgery. Mary's physician writes an order for physical therapy evaluation. The physical therapist completes Mary's initial evaluation following her admission to the nursing home. The therapist recommends twice daily PT for Mary and explains the therapy plan to Mary and her daughter. The therapist emphasizes that recovery from the hip replacement will occur faster if Mary is diligent about participating in PT. Following the appointment, the therapist sends the therapy recommendation to the physician for an order and asks the therapy assistant to schedule Mary for twice daily therapy appointments. What occurs next is a series of events. Mary misses several therapy appointments during her first week in the nursing home. The first time it's because Mary has an early appointment and is still sleeping when the nursing assistant enters her room. The nursing assistant doesn't know about the scheduled appointment and lets Mary sleep resultings in her not being ready in time for the appointment the therapy can't be rescheduled for later in the day as the therapy schedule is full. The next time Mary misses an appointment, she slept poorly during the night due to hip pain. By the time she receives medication, it's early morning. Again, when another assistant comes to wake her she finds her groggy and decides to let her sleep. Mary misses another therapy appointment. This leads to a string of conversations with Mary being upset, her daughter being upset as therapy isn't happening as planned, the administrator being upset as this is a recurring problem in the facility, and missing therapy appointments leads to dissatisfied residents and families as well as affecting the financial status of the organization. Staff are upset as they are the cause link between what they believe is person centered or person directed care and the schedule for therapy. Staff also complains about the lack of consistent therapy schedule and conflicts between the nursing and therapy departments. Okay. Does any of this sound familiar? This is the event that leads this nursing home to conduct a root cause analysis.

The second step is selecting the team. There is a document discussing what a non-punitive culture is for the team to review and a link to a webinar presented by a just culture expert. Also included is a document outlining considerations for selecting a facilitator and team members and gives recommendations such as the facility should not be someone directly involved with the event, the facilitator, and the team members may or may not be those directly involved with the event and the rationale behind those suggestions.

Once the team and facilitator are selected, we move to step 3, describing the event. Instructions are included on how to conduct an investigation interview and turning those findings into a timeline. A timeline worksheet is included as well as a timeline of the events surrounding Mary missing her therapy appointment. Here's the example of the timeline. I'll read you the first row so you get the idea. The date and time are documented. 7:00 on May 6th. Following interviews, it was found that during morning report with nurse and nursing assistant, it's unclear if the therapy scheduled is discussed or if Mary's therapy was discussed even though the schedule was posted at the nursing station and was accurate. This information was gathered from the nursing assistant, the nurse and observing the therapy schedule for that day. We also began to look at the team and decide whether or not there was a system or process breakdown occurring. Another example is given for the following day when Mary again misses her therapy appointment. Again, at 7:00, there's morning report with the nurses and nursing assistants. What they tell you is that they are not sure if the therapy schedule for the individual was discussed. The therapy schedule is posted at the nursing station and is correct. That night nurse shares that the -- Mary woke up with a complaint of pain at 5:00 and was given a pain med at that time. And it also shows who got the information. What we find out is that shortly after report starts it's cut short. The nurse has to complete paperwork for another individual that's being transferred to the hospital. This leads to not knowing whether or not your process and procedure is followed because there's been a disruption in routine. Just as an example.

Once the timeline is established and spots where the system or process broke down are identified, the team begins to analyze all the factors involved in the event this is where the team uses the critical and systems thinking skills. Included in this step are instructions and worksheets on how to create a flow chart, a Fishbone or cause and effect diagram, a five-wise process and instructions on how to facilitate brainstorming. Five whys. You may be familiar with many of these tools as they are common to root cause analysis. The team can choose to use any of these tools. And there's no reason to use them all. But depending on your situation and your team dynamics, you may find one easier to use than another. You're offered them all in a tool kilt and provided an example from our story about Mary as to how that team used the toolkit.

Here's an example of a completed flow chart showing the current process for scheduling therapy appointments for residents in the TCU starting with the resident being admitted to the TCU and how the nursing assistant knows their assigned resident has therapy that day. Again, this is the flow chart of how it works now, the current process. We have also given an example after analyzing the process and making changes for a better outcome, this is now the process the team has developed to improve that same process. This team completed a flow chart of how the process could work better.

Here's an example of a blank Fishbone diagram. Another tool to look at all the factors involved.

Here's an example of a completed five whys worksheet. You may be familiar with this process of asking questions to dig deeper. The instructions include some of the limitations of the five whys like starting with the wrong question or really not conducting enough analysis to get to the root cause. But the tool is included for you to try. The fifth step is to look at all the factors that you've identified in step 4 and identify which is the root cause. The tool kid has a worksheet to -- the toolkit has a worksheet to help with this step and a completed worksheet is provided.

After looking at all the possible factors this team identified the problem was the person missing two of six therapy appointments over three days. The root cause was identified as a lack of consistent communication regarding therapy times for residents. There were also some contributing factors identified and these are that the therapy appointments aren't always scheduled in the best interests of the individual. That current and accurate therapy schedules are not consistently communicated from the therapy department to the nursing staff. Rehabilitation goals and plans are not determined with the individual and family on admission. Not enough therapy, staff or equipment to meet all the residents's therapy needs. There was a problem with rescheduling therapy when the schedule was full. And nursing assistants feel rushed at the start of the shift and felt like there was not always enough time to check the therapy schedule. One of the key steps in separating the root cause from all the other factors involved is asking these two questions. Would the event have occurred if this cause had not been present? And will the problem recur if this cause is corrected or eliminated? Once you have identified the root cause, you should ask these two questions. And if no is the answer to both questions, the team can be reasonably sure they have found the root cause. If you answer yes to either question, the team needs to go back and do further analysis to discover what truly is the root cause.

We have often seen failure when a team identifies the root cause but doesn't take the necessary steps to eliminate the root cause. Step 6 is change and measure. Creating change is the implementation step to make changes to processes and systems within the organization. The team develops a goal, measures and identifies implementation steps and an action plan. The implementation steps are trials using the PDFA or plan due study act cycle. The same steps are used for any quality improvement initiative. Failures to take these steps will not address the root cause. Tools included in this section are worksheets on goal setting, developing measures, creating an action plan, and defining a PDSA cycle. There are also completed examples of each of these worksheets. There are also some references for the teams that may want further instruction. There's a webinar on the model for improvement and conducting PDSA cycles. And a booklet entitled measurement guide for long-term care which goes into detail on creating measures and gives many examples that come from long-term care settings.

I'll show you some examples of these tools from the toolkit. Here's an example from the goal setting worksheet using the smart formula. The first step be specific when setting a goal and this team's answer to what do we want to accomplish is reduce the percentage of missed therapy appointments on the transitional care neighborhood by a specific day. The baseline and target dates are also identified. Who will be involved and where will it take place is answered. Defining this information is helpful when communicating to other staff, residents, and family.

There are instructions and a worksheet to create a corrective action plan. It's noted that historically, this is the weakest link in the process and often teams turn to education or reminding staff to be more careful as actions. These actions are often not sustainable. There are elements to any action plan. It doesn't need to be complicated but needs to be able to easily explain what you intend to do. You it needs to be realistic. Will it work? Those closest to the process will know. You need to consider the impact of the changes. Who will be affected if we do this change? Anticipate some resistance. In fact, plan for it. Consider doing a pilot or a trial. It's easier for staff to accept a trial of a new change reason it have the change brought to them to implement. And the action plan must address the root cause. The action plan must be measurable. If you can't measure it, it isn't specific enough. The toolkit has a form for creating an action plan. It includes the goal, what are we trying to accomplish, what specific actions can we make to reach our goal? It defines who is responsible. When will the work be completed? And what can we measure to show the actions led to an improvement?

Actions should be aimed at changing systems and processes in a way that eliminates the risk of recurrence of the event. This isn't a quick fix. It must address the root cause. And the worksheet discusses choosing stronger actions and defines weaker ones like retraining staff. There's also an example of the corrective action plans every plan developed by the nursing home team. The goal is to reduce the percentage of missed therapy appointments in the neighborhood and the target is 10% or less per month. The actions that they are going to do is create a process for assuring the therapy schedule is current at the start of each shift. And they are going to use therapy scheduling software to have the schedule updated by 5 p.m. each day. The therapy assistant is responsible and a specific date will be picked. The measures the percentage of missed therapy appointments per month on the transitional care unit. And we'll know if we have made change when we have lowered that number. Another process action is for ensuring the therapy schedule is accessible. The health unit coordinator will attach copies of the therapy schedule to each nursing assistant's assignment sheets prior to the beginning of the morning and evening shifts and who is responsible there? The health unit coordinator on the TCU neighborhood and there will be a date that's completed. A measurement for this one might be just an audit to assure that these schedules are being put to the assignment sheets or checking in with staff and doing a survey of just seeing how it goes.

This is an example from the PDSA worksheet and describes what happened when the team implemented the changes on one unit. They did a small test of change and what they found out when they began to implement things is that their data indicated that of the eight therapy appointments this resident had scheduled from a certain date to a certain date, the resident missed two of these appointments. The two missed appointments were due to the resident not wanting to attend therapy due to complaints of pain. The missed appointments were not due to a communication error. The nursing assistants were aware of the therapy appointments. And they did report that the therapy schedule was attached to their assignment sheets. So we know that we have another factor to look at here. And that's that it's not due to the schedule change that all the missed appointments are there. But it's due to people not being medicated and feeling comfortable enough to attend their therapy sessions. Also, the process for retrieving the therapy schedule from the electronic health record went well. There was a question though about how this will work on the weekends when the health unit coordinator isn't available to print off the assignment worksheets prior to to the morning and evening shifts. So you can see that there were several details that still needed to be worked out.

The final step in the RCA toolkit is to communicate and sustain. In step 7, the team defines ways to assure the changes they have implemented are communicated and shared with residents, families and staff. Measures for ongoing monitoring can be developed through use of a Dashboard. Other tools assist with communication and sustainability. Most of these tools link to the QAPI tools for sustainability on the CMS website. For long-term care, we really couldn't find or create better tools. So there's instructions on how to develop a Dashboard and a template for sharing a success story.

This slide also shows part of a worksheet on developing a communication plan. It provides avenues to consider to share your story. It gives you example of in person channels of sharing during face-to-face meetings or lunch and learn events. It talks about sending a letter to the editor or doing a press release. Also considering other avenues where you put the information in some kind of print like a newsletter and a report or other meetings. And is there a wear to share through emails or eNews letters? Anyway, this is just one page of that worksheet to show that you it takes you through the process.

That's an awful lot of information. I hope that your there are in root cause analysis was strengthened. And you'll take time to explore the toolkit before conducting your next RCA. Root cause analysis takes time and effort to accomplish long lasting change. Having a team skilled in RCA and training your staff on the principles will help your organization develop a culture focused on quality and ongoing improvements. Our residents and staff are depending on us to adopt root cause analysis as a regular process within our organizations. To provide the highest quality of care and services to our residents is an ongoing process. And root cause analysis can be part of our process to assure better outcomes for residents and for staff.

I want to thank you for your attention. And now we'll have Ellen tell us how we can open up for questions.

Thank you. We will now begin the question-and-answer session. If you have a question, please press *1 on your touch-tone phone. If you wish to be removed from the queue, please press the pound sign or the hash key. If you are using a speaker phone, you may need to pick up the handset first before pressing the numbers. Once again, if you have a question, please press *1 on your touch-tone phone. Standing by for questions.

[Pause]

Once again, ladies and gentlemen, for any questions press star then 1. We do have a question it comes from Ann. Please go ahead.

Could you give me some information again as to where I can find the worksheets for the root cause analysis?

The worksheets are found within the toolkit. And if you can see your screen right now, there's the link to the toolkit. As you move through the toolkit to the various steps, those worksheets are all listed out as under each step of the process.

Okay. Thank you.

You're welcome.

Again, for any questions, press *1.

And we have no further questions at this time.

Okay. Thank you very much. And thank you, Kathie. We appreciate what you shared with us about the toolkit and RCA. And thank you to all the organizations that participated in this webinar. Please take a minute as we go off -- here's some polling questions and please take a minute to answer these to help us evaluate the effectiveness of this webinar. This concludes the webinar and have a really great afternoon.

Thank you, ladies and gentlemen. This concludes today's conference. Thank you for participating. You may now disconnect.

[Event Concluded]