Transcript for Q4CY19 *Partial Hospitalization Program (PHP) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

August 26, 2020

Hello, everyone, I would like to welcome you all today to this review of the *PHP PEPPER*, the PEPPER for Partial Hospitalization Programs my name is Amy Barnaby and I work for RELI Group, Inc. RELI is contracted with the Centers for Medicare & Medicaid Services, or CMS, to develop, produce and disseminate the PEPPERs.

For those of you who might be interested in live captioning of today's session you can access that captioning by clicking on the link that is in the QA panel, it's the very first question listed, that is where you will find that link.

Today I'm going to be focusing our discussion on the most recent release of the PEPPER for Partial Hospitalization Programs which is the version Q4CY19, CY or calendar year 2019. In this release, we don't have any revisions to the target areas. There have been no target areas that have been retired and no new target areas. So we are going to have mainly a high-level review of the PEPPER and then we will also talk about the other resources would be available to you.

If you are familiar with PEPPER and the PEPPER program, there might not be a lot of new information covered today, but if this is your first experience with PEPPER, I think we are going to all find it is a nice orientation to the program. If after today's session you still have questions about PEPPER or if you are new to PEPPER and you feel that you need any additional training resources, I would encourage you to access the recorded training sessions that we have available on the PHP "Training & Resources" page at PEPPER.CBRPEPPER.org. These have been put together in shorter segments that allow you to pick and choose the information that you are most interested in, so feel free to access those recorded training sessions again on our PEPPER website.

Let's start at the very beginning. What is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. And essentially the PEPPER is a comparative data report, again, summarizing those claims, focusing on areas that have been identified as high risk for improper Medicare payment, primarily in terms of whether the claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. In the PEPPER world we call those target areas.

The PEPPER summarizes your Medicare claim data statistics and then it compares them with aggregate Medicare data for other providers in the nation, in your Administrative Medicare Contractor or MAC jurisdiction and then also in your state. And these comparisons are the first step in identifying where you might be at a higher risk for improper Medicare payments, which really simply means your billing practices look different from the majority of other providers in that comparison group. I do want to stress the PEPPER cannot identify improper payments, but it can give you a heads up if your statistics look unusual.

Looking at the history of the PEPPER, we can see that the PEPPER was originally developed in 2003, so it

has been around for a number of years. TMF Health Quality Institute developed the PEPPER and it was originally for short term acute care hospitals and then a couple of years later for long term acute care hospitals. TMF began distributing the PEPPERs to all the providers in the nation in 2010 and then along the way it the developed PEPPERs for other types, as you can see, the Partial Hospitalization PEPPER has been available since 2012.

Now, beginning in 2018, CMS combined the comparative billing report, or CBR, and the PEPPER programs into one contract. For those of you who haven't heard of the Comparative Billing Report Program, CBR summarized Medicare Part B program data for areas that have been identified as prone to improper payment in the Medicare Part B areas. Now both of those programs have been combined into one contract, the RELI group and its partners, TMF and CGS began producing CBRs and PEPPERs so now we are focusing on producing the reports on this wide range of providers.

Why are providers receiving PEPPERs? Well, CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste and abuse. CMS has a number of strategies to meet this goal, such as provider education and early detection through medical review, which might be completed by the Medicare Administrator Contractors, the recovery auditors or other contracting groups. Also, CMS looks at data analysis. The provision of PEPPER to providers supports these strategies and the PEPPER is considered to be an educational tool that can help providers identify where they could be at a higher risk for improper Medicare payment. So that those providers can then be proactive and monitor and take any measures that they find necessary. I'd also like to mention that the OIG, the Office of the Inspector General, encourages providers to have a compliance program in place to help protect their operations from fraud and abuse. An important piece of a compliance program is conducting regular audits to make sure bills for Medicare services are correctly documented and billed and those services are reasonable and necessary. The PEPPER supports that auditing and monitoring component of the internal compliance program.

Let's move on now and focus specifically on the *PHP PEPPER*. The version Q4CY19 summarizes statistics for three calendar years, calendar years 2017, 2018, and 2019. Now, for those of you familiar with PEPPER, you know that each time our team produces a PEPPER, we refresh the statistics — we refresh the statistics for all of the target areas and for all of the time periods in the PEPPER. What that means is, if you looking at the newest PEPPER and comparing it to last year's release, you could see some slight changes in the numerator and denominator counts, perhaps in some of the 80th percentile numbers for the comparison groups and so on. And that would be due to the reflection of those refreshed statistics which may include revised claims that were submitted over the last 12 months, late claims, claim adjustments, those type of things. So, just keep that in mind when you are looking at your PEPPER and of course remember that the oldest calendar year rolls off as the new one with is added on.

I do want to talk now a little bit about episodes of care, because the PHP summarizes statistics based on episodes of care that are identified for each of the PHPs. Essentially, an episode of care represents an episode of treatment for an individual beneficiary. We do know that a beneficiary could receive PHP services for a varying length of time which could be from one day to several months. So, this episode is created for the entire course of treatment. To identify these episodes, we obtain all of the claims that have been submitted a provider for a beneficiary and we sort them from the earliest claim from date to

the latest. And there cannot be any gap or break in service of more than seven days between one claim and the next. If there is a gap between one claim through date and the next claims date, that is eight days or more, then we consider that to be a break in service and so the first episode would be ending and then a new episode begins. We do summarize all of the statistics in that episode in the time period, which would be the calendar year in which it ends, that's the through date. So, whenever that through date falls, that's the calendar year in which that episode statistics are going to be reported. We do look at the claims for one year prior to each time period so that we can evaluate those longer episodes of care.

I've included an example here to give you a better understanding of how we create these episodes. This is an example of claims that have been submitted from one partial hospitalization program for one beneficiary, just to show you to episode creation process. You can see that in the first column, these are all for the same beneficiary, beneficiary A, and we have numbered these claims submitted by the PHP in the second column so you can see that this PHP submitted 11 claims for this beneficiary over the span of about ten months. The next two columns represent the from and the through date, followed by the gap in days between those claims. And then the next column identifies which episode it falls in. And the last column identifies the length of stay for that episode of care. So, you can see here that the first four claims are combined to form one episode, because there was not a gap of eight or more days between any of those claims. However, there was a gap of 95 days between claims 4 and 5. So, claim 5 represents the beginning of a new episode for this beneficiary. The first episode ends January 20th, 2018. That would be counted in calendar year 2018, even though it started in calendar year 2017. The second episode of care ends August 26, 2018, and so those statistics for the entire episode would also be counted in calendar year 2018.

Let's talk now about the improper payment risks that are pertinent to partial hospitalization programs. PHPs are reimbursed on a per diem basis under the outpatient perspective payment system, OPPS, for care that they provide to Medicare beneficiaries, there are four separate PHP Ambulatory Payment classifications, or APC, payment rates. There are two for level one service, three services per day. There is one for community health centers, one with is for hospital-based PHP. And there are 2 APCs for the level 2, which is four or more services per day. One is for CMCs and one is for hospital-based programs. These target areas were developed or identified based on a review of the PHP reimbursement methodology. We also reviewed issues identified by other regulatory agencies such as the OIG and we also consulted with CMS subject matter experts to identify those potential vulnerable areas. We looked at national claims data to help support our assessment. We do look at these target areas, the existing target areas on an annual basis to ensure that there are still sufficient claims that have been submitted and that would be pertinent and useful information for the partial hospitalization programs. Those of you who are familiar with PEPPER may notice we have retired some target areas over time and added new ones, so over time the target areas can change. For this release, though, we have not implemented any revisions.

This is an OIG report that was released a number of years ago. This reviews questionable billing by community mental health acceptance of responsibilities and includes nine questionable billing characteristics. The report can be found at the link on the slide. We do have two target areas in the *PHP*

PEPPER related to the OIG findings in this article — or excuse me this report. The report is focused on the PHPs administered through community health centers, but it would probably be applicable to all PHPs. So, if you haven't had a chance to look this report over it might be a good read even though it is a few years dated.

Now, in the PEPPER we summarize these statistics for the target areas. The target areas are areas that have been identified, again, as potentially at risk. We structure these as a ratio with a numerator, including those episodes that are potentially problematic. The denominator is a larger reference group and we report these numbers as a percent so that when you look at your PEPPER you are going to see your statistics reported as the target area percent. So, let's review the current *PHP PEPPER* target areas.

There are four target areas that are still in the PEPPER. I will review each of them briefly here. The first one is *Group Therapy*. We all know group therapy is less costly to provide than individual therapy, so this target area is looking at the financial incentive for PHP to provide group therapy when individual therapy might be more appropriate for the beneficiary. Here we are looking at the proportion of all of the episodes where the beneficiary received only group therapy, in other words, only if the beneficiary received any individual therapy then their episode is not going to be included or counted in this target area. The beneficiary would have received no individual therapy during the entire episode in order to be included and counted in the numerator with this target area.

The *No Individual Psychotherapy* target area similarly identifies the episode where the beneficiary did not receive any individual psychotherapy during that episode. We have had some feedback from some of the PHPs regarding the fact that the provision of individual psychotherapy is not a Medicare requirement and that is true. PHP is in lieu of inpatient psychiatric hospitalization, but as we coordinated with CMS we have learned that there is a general expectation that PHPs provide some amount of individual psychotherapy as well as a range of services during that Medicare beneficiary's course of treatment. Of course, everything being focused on what that beneficiary needs.

The next target area looks at episodes that have 60 days plus of service. Again, as I membered, there is not a limit on the length of time that a beneficiary could receive PHP, so there is the risk that there might be services continued beyond the point where they are necessary or advantageous for the beneficiary. So, the *PHP PEPPER* is identifying here the beneficiary to receive greater than 60 days of service, and we are counting the actual days of service in this target area, not the difference between the from and the through date. This is one of those that was identified in the OIG study that was mentioned a couple of slides ago, along with the group therapy issue.

In the last target area is looking at *30-Day Readmissions*. Reducing readmission, of course, a continuing focus is TMF, readmission can be an indication of incomplete care, premature discharge, inadequate patient discharge instructions or patient noncompliance. So, we do include this readmission measure that looks at the proportion of beneficiaries who are readmitted either to the same or to another PHP within 30 days of the last date of their episode.

Now, aside from the target areas in your PEPPER that you will see calculated using the numerator and the denominator definitions for each of those target areas, we also calculate percentiles. And percentiles helps us identify how different our statistics look from the majority of other providers in the

comparison group. We calculate percentiles by taking the target area percent for a given target area. So, let's say we are looking at a *Group Therapy* and we take the target area percent for all of the PHPs in one of the comparison groups, let's say the nation. All of the PHPs in the nation, we take their target area percent and we sort them from highest to lowest. To identify the 80th percentile which is an important point in that distribution, we identify the point below which 80 percent of those target area percents fall. And that point in the distribution is called the 80th percentile.

Now why is that 80th percentile important? Well, in the PEPPER we use the 80th percentile to identify what we call outliers in the PEPPER. These are providers whose target area percent is either at or above the national 80th percentile. So, if your target area percent is greater than that point where we have identified the 80th percentile, then in the PEPPER you are going to see your statistics identified in red bolt font. That's the visual queue your statistics look different from most of the other providers in that comparison group. And I want you to keep the image of this of the ladder in mind as we walk through this sample PEPPER here in just a moment, because I think it's a great visual that explains that 80th percentile.

The other thing you will notice in your PEPPER is that we have these statistics of the comparisons for three groups. The first one is national, of course that is all of the PHPs in the nation. And we use the national 80th percentile to identify outliers. We will also use the MAC jurisdiction group which is compared to all of the PHPs that submit their claims to the same Medicare Administrative Contractor. And then we also have the state comparison group which is the smallest.

I am going to turn, actually presentation over to Kim Hrehor at this time. She has a sample PEPPER we are going to walk through as a nice demonstration and review.

Thank you again, again, this is Kim Hrehor. I am with the RELO Group and I am going to walk through a sample PEPPER for partial hospitalization program.

Now PEPPER, they look a little bit different to those of you who are familiar to using the PEPPER but all of the data and the information that you are used to seeing is still included within the PEPPER. So we are going walk through this real quick and show you how things have been rearranged a bit. Now for those of you who are new to the PEPPER I do want to just mention that the PEPPER is distributed electronically. It is a Microsoft Excel workbook and you will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you open your PEPPER, it is going to first show you this tab called the purpose page, and you will notice that now we have the CMS logo included on the PEPPER, on the very first page, along with our PEPPER logo. On row 11, you are going to see your six digit CMS certification number, your CCN, or provider number, along with your care provider's name. On row 12, it is going to identify for you the most recent calendar year that is summarized within with this release of the PEPPER.

The next tab is the definitions tab, and here is where you can find the complete numerator and denominator definitions for each of the target areas in the PEPPER. You will also notice that throughout the PEPPER we have removed any hyperlinks that we used to have to different worksheets within the PEPPER or to our website. The reason for these, the removal of the hyperlinks, was to ensure that PEPPERs are compliant with 508 acceptability guidelines. That means folks that have hearing or seeing

disabilities will be able to utilize the PEPPER using their specialized accessibility software.

The next worksheet is called compare targets report, and as always, this report I like to refer to as the heart of the PEPPER. It is the only place within the PEPPER that you are going to see your statistics for all of the target areas all in one view. Now it does summarize only the most recent calendar year of statistics, and here in looking at the statistics through the fourth quarter of calendar year 2019, you will also notice that this report looks much more compact than it has in years past. And that is because we have removed the descriptions from the target area I guess you can say definitions. Now we just have the target area names listed here. We still will show you the numerator count, which is the number of episodes that meet the numerator definition. The denominator definition is not included on this report. However, it will be included on the target area reports as in the past.

Now the reason this report is so helpful is because, again, does show you everything on one worksheet and it also helps you understand how your statistics compare to those three comparison groups that Annie mentioned just a little bit earlier. So, you remember that when Annie walked through target area definitions, there was a numerator and a denominator definition. For the *Group Therapy* target area, we have 43 episodes that meet the numerator definition.

When we compare that to the denominator definition, which is not included here, we can calculate our target area percent of 37.7 percent.

Now, most of you can probably calculate your own target area percent using your own claims data, but the value of the PEPPER comes in when you are able to understand how your target area percent compares to that of other PHPs in the nation and the Medicare Administrative Contractor jurisdiction or in the state. And so that is where these percentiles come in handy.

So, when we look at our target area percent of 37.7 and thinking about that ladder image that Annie just showed us a couple of slides ago, those target area percents for all of the PHPs in the nation are sorted from highest to lowest. Our target area percent of 37.7 is at the national 10.3 percentile. That means that it is pretty far down there towards the bottom end of that ladder, only 10.3 percent of all the PHPs in the nation have a lower target area percent than we do. Now if we were at or above the 80th percentile for nation then we would see our target area percent here displayed in red bold font as a visual queue to help that stand out to us. But for this target area, this PHP is on the low end of the scale, and so probably doesn't have much to be concerned with.

Now normally here we would see the jurisdiction percentile but you will see both jurisdiction and the state percentile cells are empty for this particular PHP. And what that signifies is that there are fewer than 11 PHPs in the jurisdiction that have sufficient data to calculate statistics for this target area. And when that occurs, we do not calculate percentile for the jurisdiction and then similarly, when there are fewer than 11 PHPs in the state with reportable data, we do not calculate the state percentiles. So, in those instances you will see blank cells.

This last column here shows us the total amount of Medicare reimbursement, that our PHP received for these numerator episodes.

So, this can be really handy in helping you identify, first of all for these target areas, how does your

target area percent compare to those for the nation, the jurisdiction and the state? And then how much Medicare reimbursement might be involved with those particular target areas? The other thing I will point out is you will see here this PHP only has three target areas listed on the report. The fourth target area is not included. And that would be because this provider does not have sufficient data to generate statistics for calendar year 2019. So, if there are not sufficient statistics or sufficient episodes for statistics generation then we are not going to see it included on the compare targets report.

One other thing I am going to point out is that this is the only place within your PEPPER that you are going to see your exact percentiles. On the target area report you will see how your target area percent compares to that 80th the percentile that line in the sand that Annie just covered, but here you will see your exact percentile for calendar year 2019.

So, let's take a look at some of the target area reports. The first thing you are going to notice when you click on the report target area, report tab, is that the graph which used to be at the top of the report has been moved to the bottom of the report. And, again, this was made primarily so that we can be compliant, again, with those 508 acceptability guidelines. But the information that you are used to seeing, even though it has been rearranged a little bit is still available. So in this target area of *Group Therapy*, we do see your PHP statistics for calendar year 2017, calendar year 2018, and calendar year 2019. We have added this row here for outlier status that will identify whether or not you are an outlier for this particular target area and time period, so we can see that this PHP is not an outlier for any of these target areas or time periods. Next you are going to see your target area percent and these are the values that are going to be graphed. As the blue bars here in your target area report. That hasn't changed. Again, it has just been rearranged a little bit. The target count is the numerator, and then the denominator count, of course, those are the episode that qualifies for denominator definition. We also include the average length of stay for the numerator episodes as well as for the denominator episodes, the average amount of Medicare reimbursement for the numerator episodes and then the total amount of Medicare reimbursement for those numerator episodes. And all of this information was previously included in the PEPPER. Below that, as before, is the comparative data table, which identifies for us the target area percent that is at the 80th percentile for the nation and for jurisdiction and for the state. Again, for these three calendar years, and these are the values that are graphed as the red lines in the graph here below. The solid red line is the national 80th percentile. The dashed red line is the jurisdiction 80th percentile. The dotted red line is the State 80th percentile. And since we were not able to calculate jurisdiction and state percentiles for these two target areas, you will notice they are not displayed here.

What is nice about the graph is that it just gives us a nice way to evaluate our target area statistics, whether they have changed over time, how close we are to that 80th percentile. You can see here we are below the 80th percentile but we are getting kind of close. And one thing that popped out to me was, as I was looking through this sample PEPPER, is that there has been a fairly significant decrease in the target area percent for *Group Therapy* for this PHP. And I always encourage people to think about what factors might be leading into any significant increases or decreases that they see in their PEPPER statistics. There could be changes in patient population, in referral sources, maybe there have been staffing changes within the organization and you are now providing different types or different levels of

services than you were before. There could be changes in coding or billing staff. There are a lot of different factors that play into what you are seeing in your PEPPER. So, if you look in your PEPPER and you see increases or decreases and something doesn't quite look right to you, I would encourage you to gather some folks within your organization together to examine the numbers, perhaps pull a few medical records, compare those to the claims and see if there is anything that you need to be concerned with or if what is reflected in your PEPPER is what you expect to see.

We still include the suggested interventions below the graph. The suggested interventions, which are also included in the PEPPER user's guide are very general statements. If you were an outlier for this target area, what might you think about looking at? What could be some of the concerns involved with that outcome? So, they are provided there as guidance for you, but certainly not meant to be set in stone.

Also, as you look through your PEPPER, this new format, everything is going to look bigger, so all of the fonts have been enlarged, and things are going to look a little bit different but trust me, everything is still there.

So, each of these target areas have a tab, that is within your PEPPER and you are going to see the same type of information available. Here this provider also had a significant decrease for the *No Individual Psychotherapy* target area.

At times, if there is not sufficient data for calculation of statistics, you might find that your report is completely empty. There are no blue bars here on the graph and the data table would tell you there is no data. That occurs, again, if there are fewer than 11 episodes that meet the numerator or denominator definition.

All right. And then lastly, we have a couple of supplemental reports within the *PHP PEPPER* that don't have any bearing on outlier status for your organization, but they are just provided for comparison use for supplemental information. The top diagnoses tab shows you the top diagnoses, the top CCS or Clinical Classification Software, diagnosis categories for the most recent calendar year. It will show you the up to 10 categories. You will notice now that we no longer have blank rows, this PHP only has sufficient data to calculate numbers for these three categories. We will show you the total number of episodes for each of those categories in the calendar year. The proportion of episodes for each Clinical Classification Software category for — as compared to total episodes of, and then your average length of stay for each of those categories.

The nationwide tab provides the same type of information, but it is aggregated at the national level, so it is going to include all of the PHPs in the nation you will see the top 10 categories, along with the total number of episodes, proportion of episodes to total and then the national average length of stay. Some of you might find this type of comparative information helpful in your normal operations.

So, that is a quick review of a sample PEPPER. I am going to go ahead and turn the presentation back over to Annie. And we will continue.

All right. That was wonderful. Thank you, Kim.

So, after that wonderful review of the sample PEPPER, let's talk now about what the PEPPER means to

you. We got a lot of information, again, from Kim in the sample review but we do often get at times questions from providers do they have to use their PEPPER? Are they expected to take action or make some change based on their PEPPER? We have had several questions from PHP providers as to what we expect them to change. And in reality, the providers are not expected to make any changes. There is no requirement to use your PEPPER. There is no expected response for whatever your PEPPER statistics show. The main thing that we want to point out is the PEPPER is really a road map that can help you identify when you might be at a higher risk for improper payments. It is a free report that is made available to you by CMS. Remember, also, there are a lot of other federal contracts that are looking through Medicare claims data databases in an effort to identify providers that could benefit from perhaps educational outreach, perhaps a medical record review or some other focused intervention. So, it is helpful to know your statistics look different from other providers and to know that just because they look different doesn't mean you are doing anything wrong. And that way when you are looking at your PEPPER data, if something doesn't look quite right in your mind you have that opportunity to dig a little bit and see if there is something going on that might need your attention.

Sorry about that — alright, there we go. As you may know, PEPPERs are distributed annually in electronic format. There are two distribution methods used for PEPPER distribution and the method depends on whether the PHP is a unit of a short term acute care hospital or inpatient psychiatric facility, or a freestanding community mental health center.

Because PEPPER does contain hospital specific sensitive data, we cannot send it through e mail. Most providers are going to be receiving their PEPPERs through QualityNet, because most of the PHPs that receive a PEPPER are a unit of either a short term acute care hospital for an IPF. QualityNet is a secure distribution system developed by CMS for the reporting of hospital quality data. The hospital's QualityNet administrator can download the PEPPER and that person is usually involved in the hospital submission of quality data. If there isn't a QualityNet administrator at your hospital IPF, we advise you to contact the QualityNet Help Desk and they can assist you. In addition to the hospital's QualityNet administrators, those that have a basic user account can also receive the PEPPER. The file is available for 60 days from the date that it is uploaded into the QualityNet system, and if you for some reason have not downloaded your PEPPER we would encourage you to do so because after those 60 days the file will be moved out of the QualityNet system but we can upload that file again — you will just need to contact us through Help Desk and make that request.

The community help center PHPs are going to get their PEPPERs through the PEPPER resources portal. You'll click on the PEPPER distribution, get your PEPPER link, there are some instructions there to access the portal, and each release is going to be available for approximately two years. So, if you didn't get last year's PEPPER you are still in luck and can still get last year's PEPPER through the portal.

You will need a couple of pieces of information to access your PEPPER. You will need your six-digit CMS certification number as well as either a patient control number or a medical record number from a claim or a traditional fee for service Medicare beneficiary that received services during the last three months of 2019.

Before I move on I also want to mention if you are trying to get your PEPPER through PEPPER resources portal and if you are struggling to do so, the last thing we want you to do is to be frustrated and give up.

Please contact our Help Desk. We have a great team and they can help you access your PEPPER, so don't let that frustration get the best of you.

Once you get your PEPPER, if you do see you have some red numbers here and there, the first thing we want you to do is to remember, do not panic. Remember that just because you are an outlier, again, it doesn't mean there is any compliance issues that exist, it doesn't mean you are doing anything wrong, but let the PEPPER open up a review of why you may have been an outlier. Do those statistics in your PEPPER reflect what you expect to see given your operations, your patient population, your referral sources, the staff that you have on board, your healthcare environment? There are a lot of factors that can make your statistics look different from others. Just think about that. If you feel that something looks unusual, you can — we always encourage providers to run some samples and look at the documentation in the medical record, compare that with what was submitted on the claim. Was everything coded and billed appropriately based on the documentation in the medical record? Ultimately you just want to make sure you are following the best practices even if you are not an outlier in PEPPER.

Every year we do put together aggregate data on the target area as well as the top diagnoses. These are updated on the data page at PEPPER.CBRPEPPER.org and these have been posted and made available for the PHP so you will find the calendar year 2019 data there now.

Other resources that you will find on the website include the User's Guide. There is a spreadsheet out there that identifies the total number of PHPs and each mass jurisdiction in total and by state and of course those recorded PEPPER training sessions that we mentioned earlier in the webinar. And a sample PEPPER, also if you are interested.

If you a find you need further assistance please contact us through our Help Desk, which is on the website. There is a form that you will submit and a member of our team will contact you promptly. Just remember to not seek information from other associations or other organizations. Our team is the official source for information on PEPPER and we want to make sure that you are getting the right answer and the guidance you need.

Here is a screen shot of our website home page. You see the partial hospitalization program and the blue arrow pointing. It is in the middle bottom part of the screen. This is where you can access the user guide, the training and resources, as well as the link to that distribution page.

We are going to take some questions now and we will answer any questions that have been submitted through the Q&A panel, and as we conclude the webinar, please take a moment after we conclude the QA and provide us feedback to let us know if this webinar has been helpful to you and we really appreciate any feedback you can give us to improve future sessions.