

Scott and White Health Plan Brown Bag Webinar

November 3, 2017



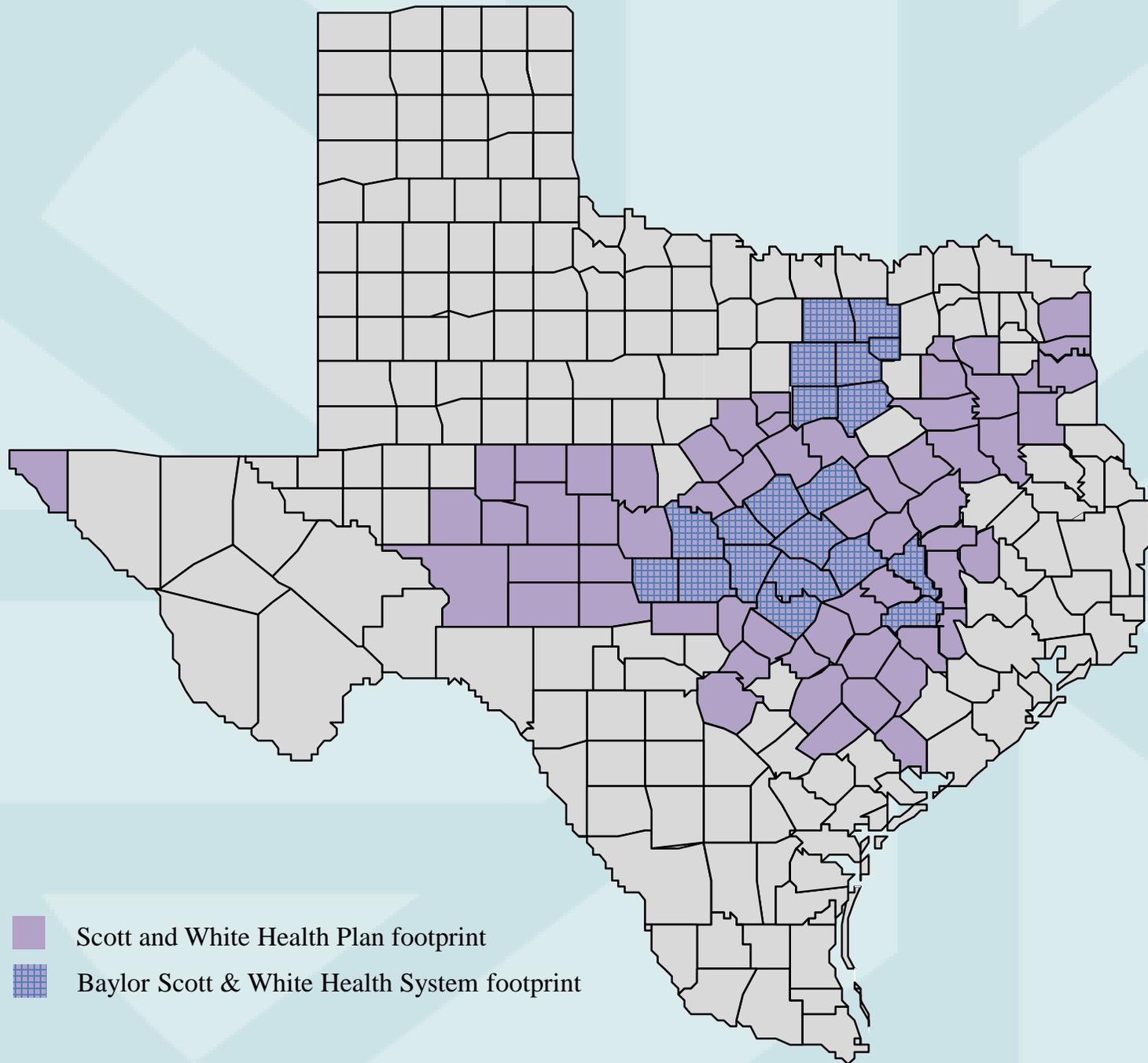
Scott & White
HEALTH PLAN



Scott & White Health Plan was established in 1982 to support the residents and physicians of Central Texas.

Today we serve 250,000 members in 80 counties across Texas through 130 Hospitals and over 17,000 Providers.

Serving Commercial, Medicare and Medicaid Populations.



Provider Relations

- Currently 9 full-time staff members
 - Includes manager plus eight PR Representatives that serve as liaisons for providers in the network to assist with addressing questions and issues.
- Phone Number
 - (800) 321-7947, ext. 203064 or (254)298-3064
- Fax Number
 - (254) 298-3044
- Email Address
 - SWHPPProviderRelationsDepartment@sw.org

Agenda

- Medicare Plans for 2018
- Health Services Division
- Quality Improvement
- Pharmacy Short-Acting Opioid Program
- Baylor Scott & White Quality Alliance
- SWHP Provider Portal



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Medicare Plans for 2018



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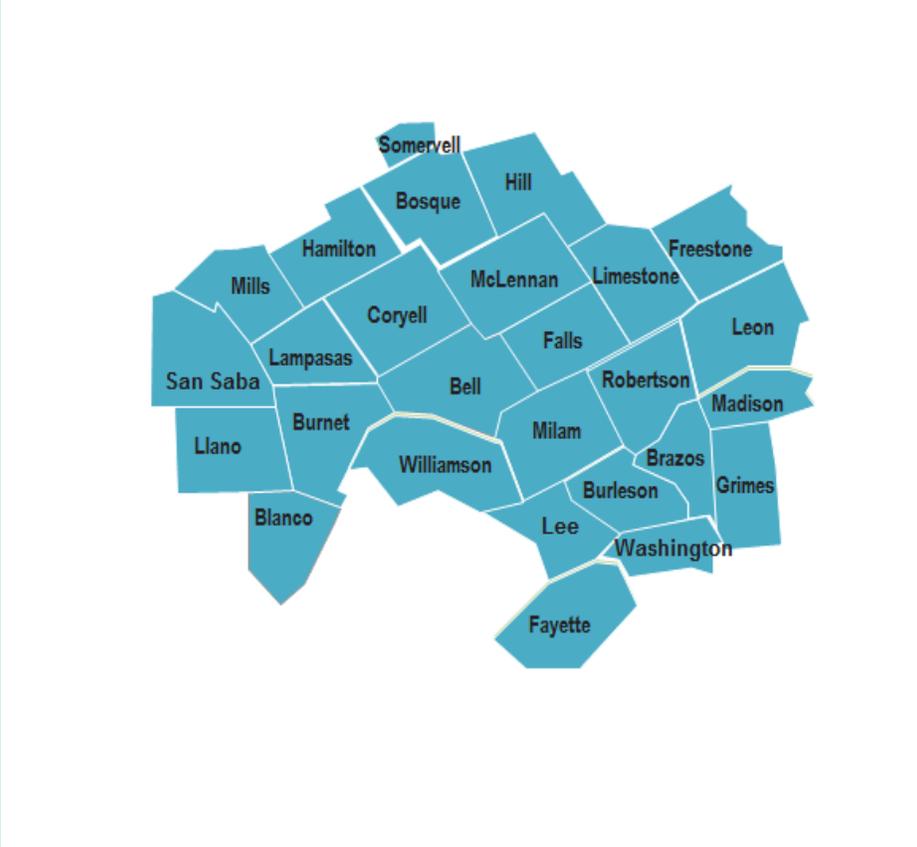
Medicare plans for 2018

- Three networks under Medicare Advantage
 - Vital Traditions (North Texas)
 - SeniorCare Advantage HMO (Central Texas)
 - SeniorCare Advantage PPO (Central and North Texas)
- Current Medicare Advantage providers will be part of the three networks regardless of whether the provider is in Central Texas or North Texas.
 - Detailed benefit information for each plan is located on our website
<http://medicare.swhp.org/en-us/>.
- Current SeniorCare Cost HMO plan will still exist in 2018. Members will be covered. More information to come regarding this transition for 2019.

Vital Traditions HMO Service Area



SeniorCare Advantage HMO Service Area



New Customer Service phone number for all Medicare:

1-866-334-3141

Health Services Division



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Who is Health Services?

UTILIZATION MANAGEMENT (UM)

- Intake Support
- Licensed Nurses (RN/LVN)
 - Prospective Review
 - Concurrent Review
 - Retrospective Review

Key departments and positions directly accountable for UM decisions, systems, and processes include:

- Chief Medical Officer
- Medical Directors
- Registered Nurses
- Licensed Vocational Nurses
- Administrative Intake Support

CASE MANAGEMENT / DISEASE MANAGEMENT

- Care Navigators
- Case Managers
- Social Workers

Utilization Management Program

Hours of Operation and Communication Services

Members and Practitioners who seek information about the UM process and/or the authorization of care by SWHP/ICSW, have access to Medical Directors, UM Managers, and UM Nurses daily business hours.

During normal business hours Health Services Department (HSD) and Evolent (Medicaid Medical Management) have local and toll-free phone lines to provide direct access to the respective divisions and to staff members who handle UM-related issues.

Designated UM/MD staff also provide “On-call” coverage 24/7 as needed to provide information, coverage determinations, and discharge planning.

What is Utilization Management?

Utilization Management in managed care means **“how often specific services are being used.”**

Utilization Management involves coordinating **how much** or **how long care is given** for each patient, as well as the **level of care**.

Our goal is to ensure care is delivered in the **most cost-effective manner** at the **right level**.

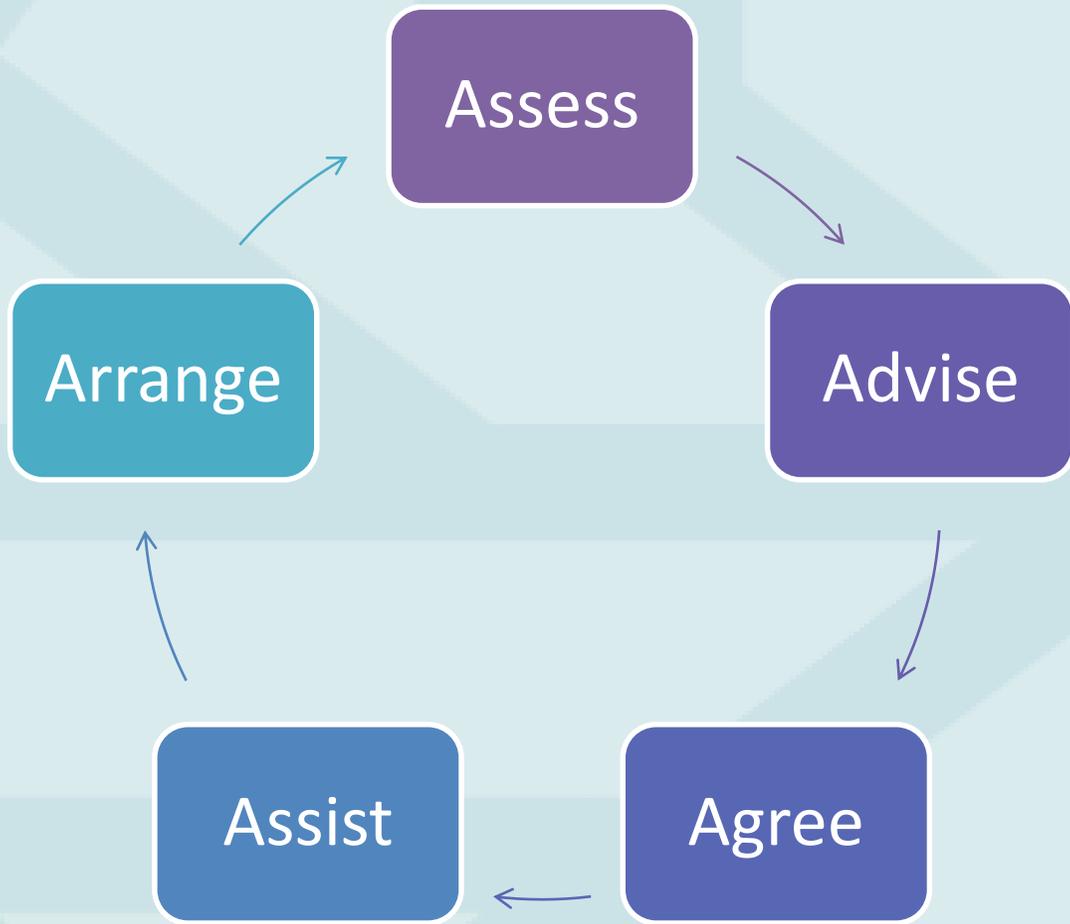
Tools utilized includes:

- Authorization requirements to assess and approve services before they are rendered.
- Concurrent review for ongoing assessment of continuing care needs.
- Discharge planning for smooth transition of care needs.

Preauthorizations

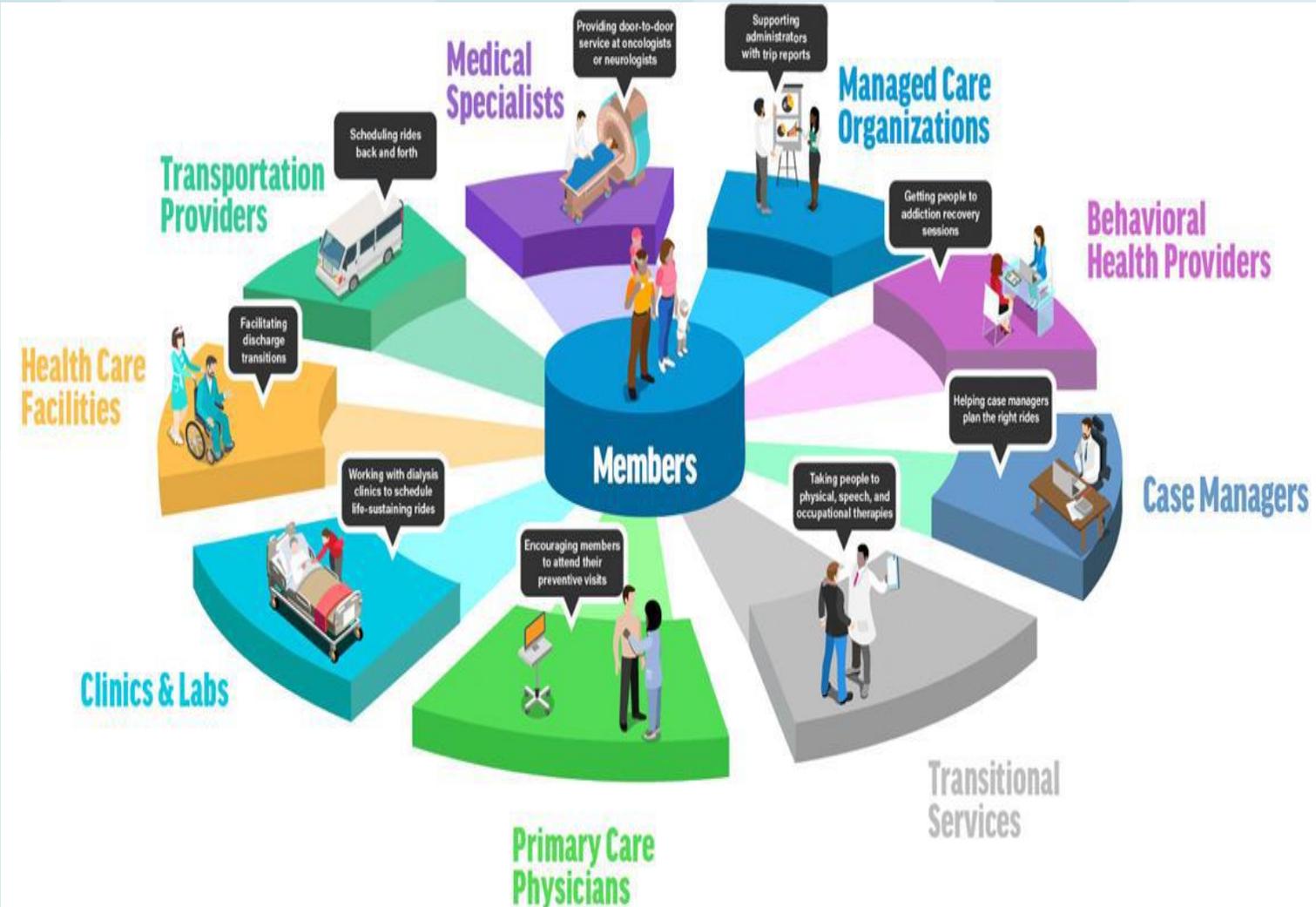
- Multiple lines of business
 - ASO
 - Commercial
 - Medicaid
 - Medicare
- Expedited versus Standard/Routine Reviews
- Admission Notifications
- Clinical decision making
 - Documentation
 - Clinical coding (Diagnosis and Procedures)

Case Management Assessment and Care Plans



Process of identifying the Member's condition/needs, abilities and preferences, which leads to the development of a plan of care.

Alignment



- Case Managers work to align all the moving parts
- Puts the plan into action with the Member

Provider Quality Updates



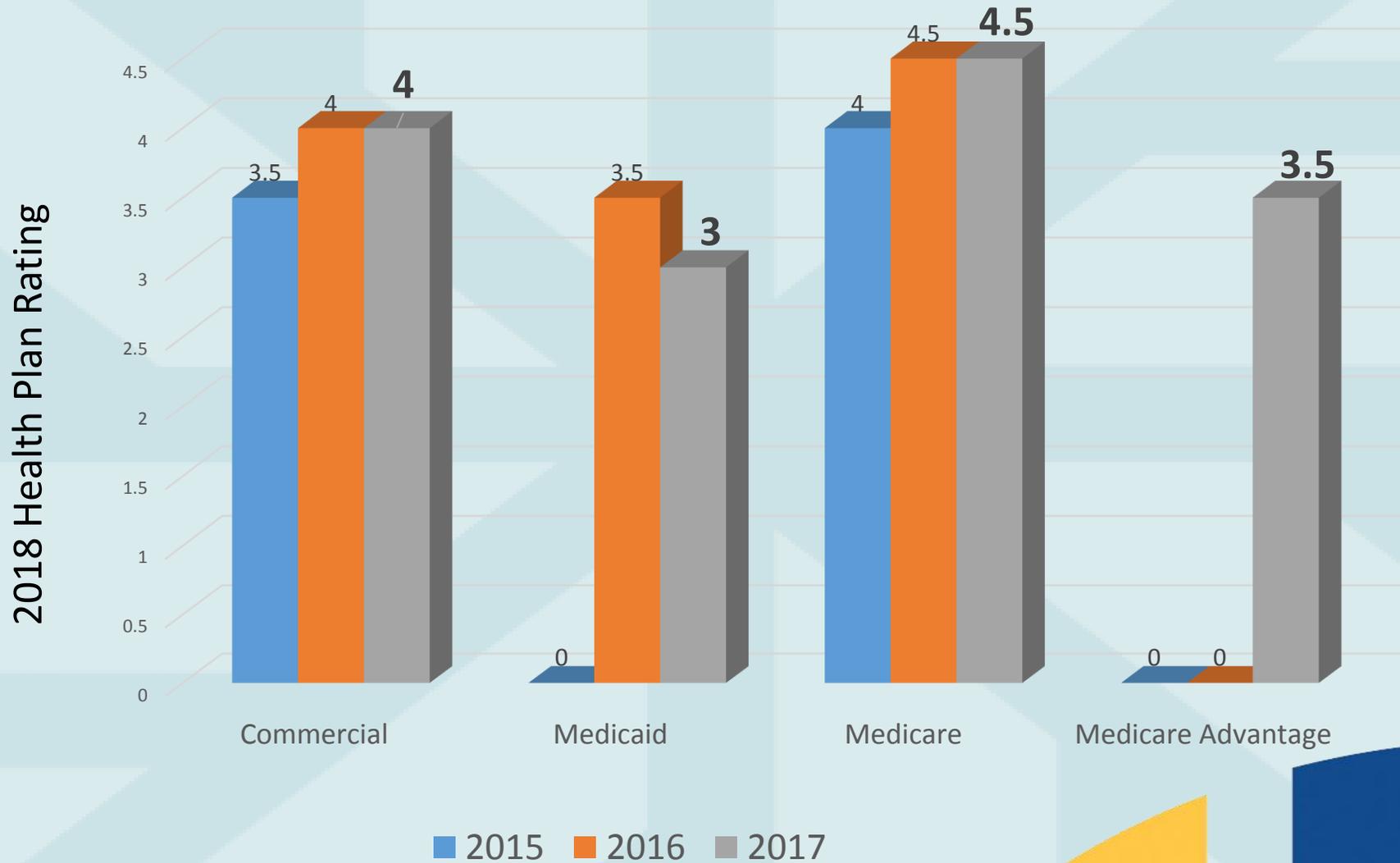
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SWHP's Quality Objectives

SWHP aligns with the broader Baylor Scott & White Health (BSWH) quality strategy of shifting from a volume mindset to one of value. SWHP seeks:

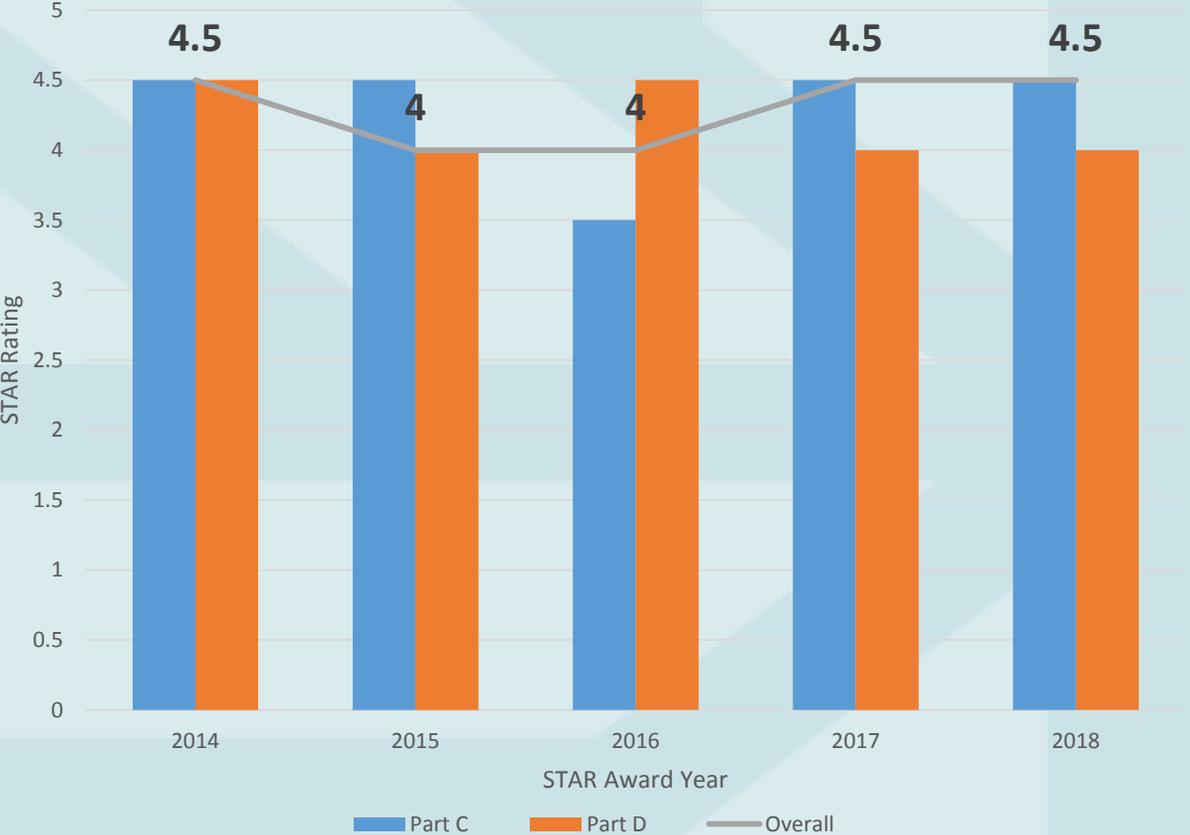
- **Healthier Members:**
Improve the health of our members by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.
- **Better Care:**
Improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe.
- **Smarter Spending:**
Reduce the cost of quality health care for individuals, families, and employer groups.
- **Customer Service:**
Improve the member experience with efficient access to health care.

NCQA Ratings Review



2018 Medicare Star Ratings

SeniorCare: Five Year STAR Trends



Vital Traditions: Three Year STAR Trend



Source: Health Plan Management System (HPMS)

Appointment Availability Requirement

To ensure members receive care in a timely manner, PCPs, specialist and BH providers must maintain appointment availability.

Appointment Availability Requirements



To ensure members receive care in a timely manner, Primary Care Providers (PCPs), specialty providers, and behavioral health providers must maintain the following appointment availability and after-hour access standards.

Appointment and Access Standards

Standard name	Scott & White Health Plan requirement
Urgent Care	Within 24 hours
	Commercial: 21 calendar days
Routine Care	Medicaid: 14 calendar days
	Medicare: 30 calendar days
Prenatal Care—initial visit	Within 14 days
High risk & New member 3rd Trimester	Within 5 days or immediately if emergency exists
Preventative Care Adult (21 and Over)	Commercial and Medicaid: 90 days
	Medicare: 30 days
Preventative Health Care (6 months—20 years)	Within 60 days
Newborn	Within 14 days
Behavioral Health	
Behavioral health, nonlife-threatening emergency care	Within 6 hours
Urgent Care	Within 24 hours
Initial Outpatient Behavioral Health Care (prescriber/non-prescriber)	10 business days, Medicaid: 14 days
Routine Behavioral Health (prescriber/non-prescriber)	14 days
Specialty Care	
Urgent Care	24 Hours
	Commercial and Medicaid: 21 calendar days,
Routine Care	Medicare: 30 calendar days



Scott & White Health Plan is dedicated to arranging timely access to care for our members.

- Standards are audited yearly.
- Clinics found to be non-compliant with standard availability will be contacted to make them aware of the findings.

After-Hours Access Requirements

To ensure continuous 24-hour coverage after normal business hours:

- One of the following must apply
 - Office telephone answered by an answering service
 - Office telephone answered by a recording*
 - Office telephone transferred to another location

*Recorded message should not direct the member to call another number.

After-hour access requirements for PCPs	
 <p>To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for member contact after normal business hours.</p>	
<p>One of the following must apply:</p> <ul style="list-style-type: none">• Have the office telephone answered by an answering service that can contact the PCP. All calls answered by an answering service must be returned within 30 minutes.• Have the office telephone answered after normal business hours by a recording. The recorded message should direct the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the call at the second number.• Have the office telephone transferred after hours to another location where someone will answer the telephone. The person answering the calls must be able to contact the PCP to return the call within 30 minutes.	<p>The following are not acceptable:</p> <ul style="list-style-type: none">• Answering the office telephone only during office hours• Answering the office telephone after hours with a recording telling members to leave a message.• Answering the office telephone after hours with a recording directing members to go to the ER for needed services.• Returning after-hours calls outside of a 30-minute time frame. 
 <p>Scott & White HEALTH PLAN PART OF BAYLOR SCOTT & WHITE HEALTH</p>	
<p>If you have questions, contact your Provider Relations representative.</p>	

Pharmacy



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Short-Acting Opioid Program

New to Therapy

- Definition: Less than 2 short-acting opioid AND no long-acting opioid prescriptions within last 120 days
- Maximum dose per day: 49 morphine milligram equivalents (MME)
- Maximum day supply per prescription: 7
- Maximum number of prescriptions per 60 days: 2

Treatment-Experienced

- Definition: Two or more short-acting OR any long-acting opioid prescriptions within last 120 days
- Maximum dose per day: 90 MME
- Maximum number of prescriptions per 60 days: 2

Exceptions

- Palliative/hospice care patients
- Cancer pain

Program Roll-out

- Implementation date: February 1, 2018
- Communications:
 - Prescriber outreach
 - Member outreach
 - Pharmacy outreach
 - Messaging to pharmacy at point of sale
 - Ability to override program at point of sale, as appropriate

Baylor Scott & White Quality Alliance

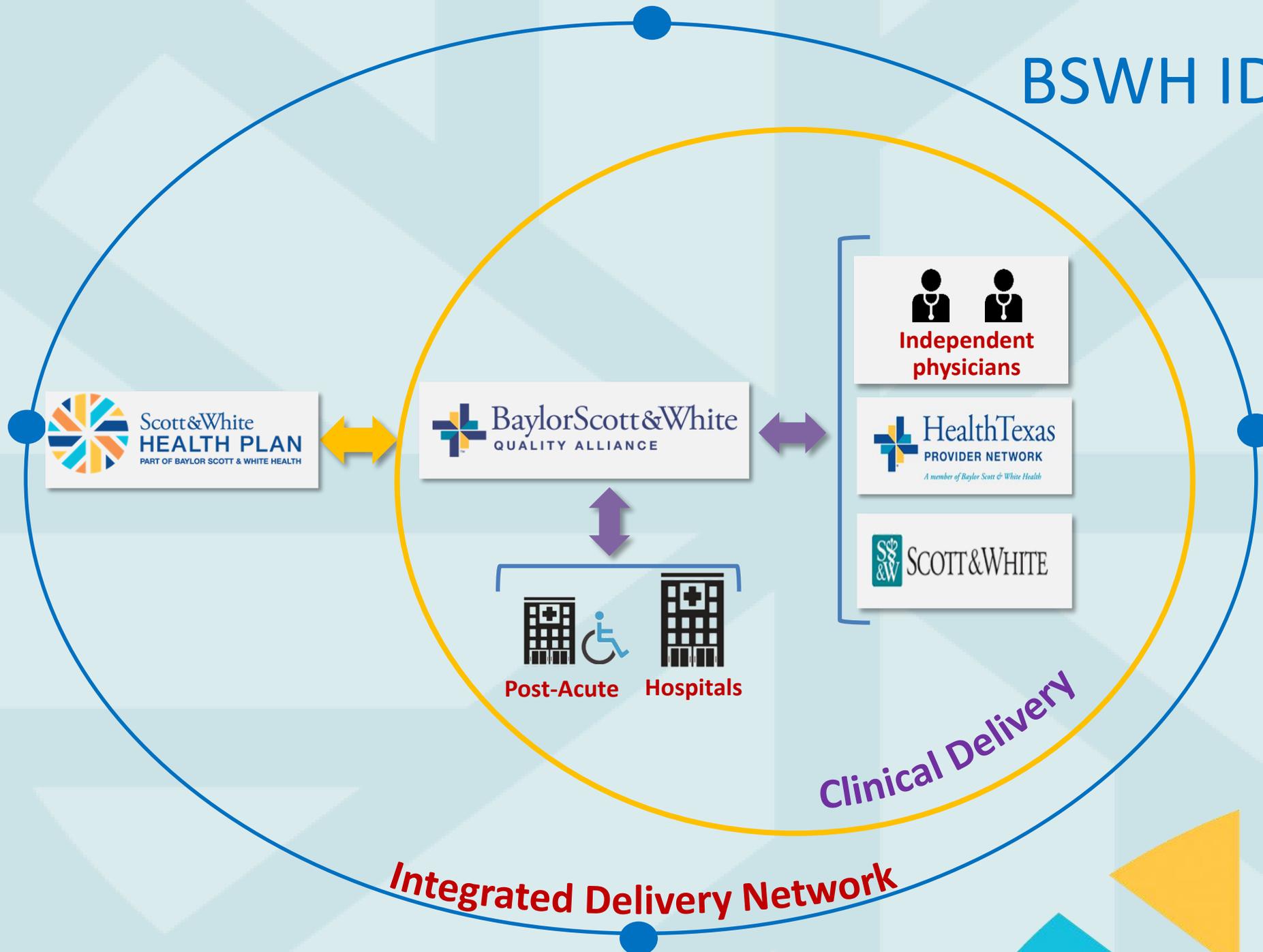
BSWQA Mission Statement



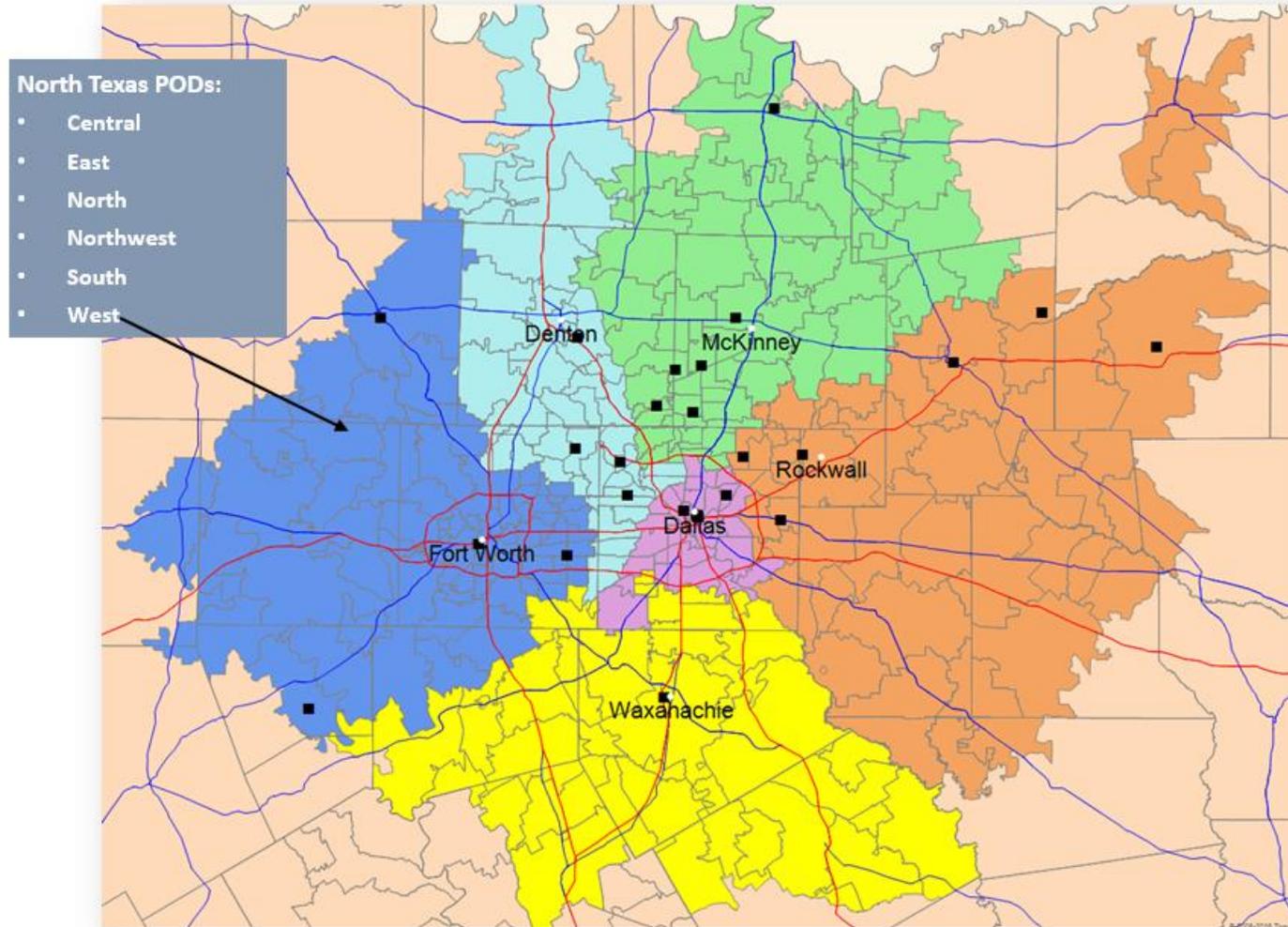
“Why we exist as an organization”

Baylor Scott & White Quality Alliance’s mission is to achieve the highest quality and most cost-effective care possible for the patients that we serve through clinical integration...

BSWH IDN Structure



Network Field Advisor Coverage



SWHP Provider Portal



SWHP Provider Portal

- SWHP has improved 270/271 connections with Availity, Recondo, and Experian
- Providers can access the SWHP Provider Portal at:
<https://portal.swhp.org/ProviderPortal/#/login>
- Provider Portal can be utilized for the following:
 - Check Member Eligibility & Benefits
 - Check Claims & Payment Status
 - **Improved Feature** - Look up Codes to Determine Prior Authorization Requirements
 - View Explanation of Claim Denial Codes
 - Look-Up Reimbursement Rates by Code
 - Submit Case Management Referral Forms
 - **New Feature** - Submit Prior Authorization Request Forms
 - **New Feature** - Register as a Group Provider
 - Add Additional Provider to an Existing Registration
(using individual NPI's)

SWHP Provider Portal



Provider log in

Access provider portal

 Save Email[Forgot Password?](#)

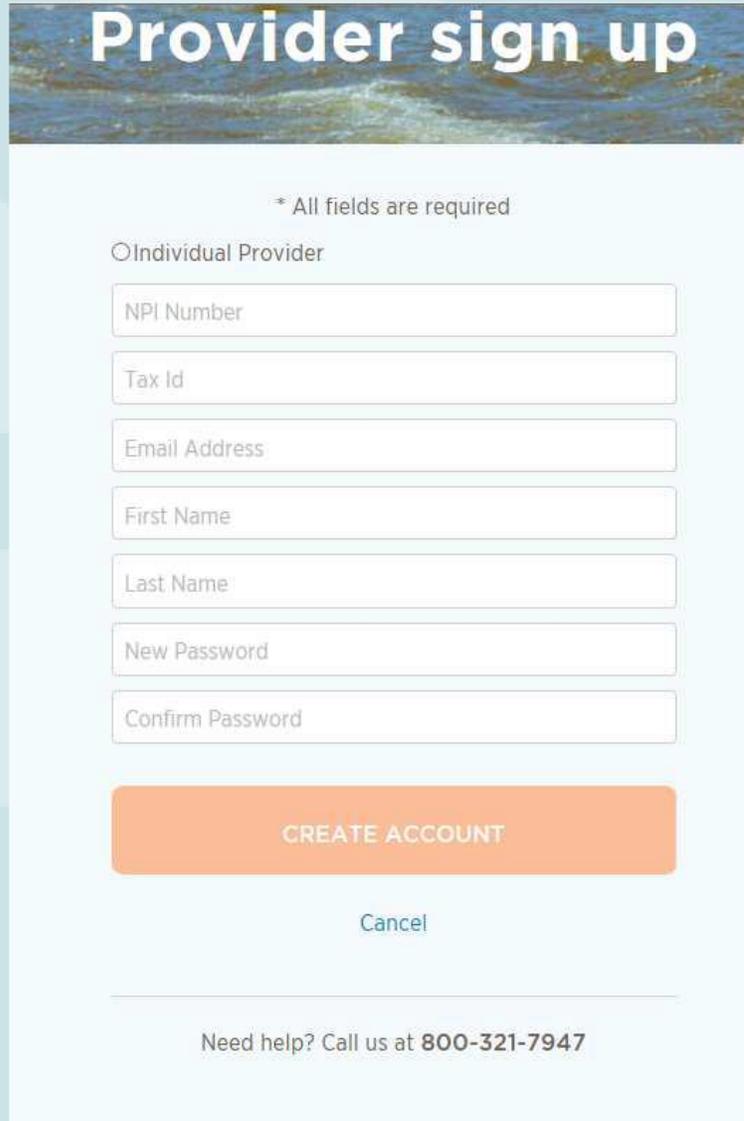
LOG IN

Don't have an account? [Sign Up Now](#)

Need help? Call us at [800-321-7947](tel:800-321-7947)®

Your privacy is safe with us. To see how we protect your information check out our [Privacy Policy](#).

Provider Sign-Up



The screenshot shows a web form titled "Provider sign up" with a blue header. Below the header, a note states "* All fields are required". The form is for an "Individual Provider" and includes the following input fields: NPI Number, Tax Id, Email Address, First Name, Last Name, New Password, and Confirm Password. At the bottom of the form, there is an orange "CREATE ACCOUNT" button and a blue "Cancel" link. A footer note reads "Need help? Call us at 800-321-7947".

* All fields are required

Individual Provider

NPI Number

Tax Id

Email Address

First Name

Last Name

New Password

Confirm Password

CREATE ACCOUNT

Cancel

Need help? Call us at 800-321-7947

- Fill in all fields, and click on **Create Account**. *Note that all fields are required.*
- If the Tax ID and/or NPI entered matches SWHP's information, your registration will be automatically approved, and you will have immediate access.
- If the Tax ID and/or NPI entered does not match SWHP's information, your account will not be automatically approved, and you will need to call the number listed at the bottom of the screen for assistance.

Forgotten Password or Locked Account

Provider log in

Access provider portal

Email Address

Password

Save Email

Forgot Password?

LOG IN

Don't have an account? [Sign Up Now](#)

Need help? Call us at **800-321-7947**

Your privacy is safe with us. To see how we protect your information check out our [Privacy Policy](#).

Forgot Password

Please enter your email address

Email Address

RESET

[Back to log in page](#)

Need help? Call us at **800-321-7947**

Your privacy is safe with us. To see how we protect your information check out our [Privacy Policy](#).

Forgotten Password or Locked Account

What should I do if I forgot my password?

- To reset your password, click on **Forgot Password**.
- Enter your email address that you used to register for the portal, then click **Reset**. A new password will be sent to the email address we have on file for you. (*If you do not see an email from us, be sure to check your spam folder.*)

What should I do if I am locked out of my account?

- If you have been locked out, it is usually because you had too many unsuccessful login attempts. To unlock your account, please contact the SWHP Provider Relations Department:

Phone: 800-321-7947, ext. 203064 or 254-298-3064 and select option 1

Email: SWHPPROVIDERRELATIONSDEPARTMENT@BSWHealth.org

Include your name, Tax ID, NPI, username/email address, and phone number in your email

Accessing the Provider Portal

Go to: <https://portal.swhp.org/ProviderPortal/#/login>

Below is a screen shot of many of the tools available within the portal to assist you with your administrative processes.

Powerful Online Tools



ELIGIBILITY AND BENEFITS

CHECK MEMBER ELIGIBILITY
AND BENEFITS.

CHECK ELIGIBILITY
AND BENEFITS



CLAIMS

SEARCH FOR YOUR CLAIMS
AND CHECK CLAIM STATUS.

SEARCH CLAIMS



FEE LOOK UP

LOOK UP FOR REIMBURSEMENT
OF PROCEDURES AND SUPPLIES.

FEE LOOK UP



PRE-AUTH CHECK

CHECK TO SEE IF A PROCEDURE
REQUIRES PRE-AUTHORIZATION.

PRE-AUTH CHECK

Member Eligibility/Benefits

- Select **Member Search** on the dashboard and the *Members Search Criteria* page will display
- Enter at least 2 fields in the search criteria
- Click **Search** to display the results

Home **Member Search** Provider Claims Look Up Tools Online Forms Log Out

Member Search Criteria

* Must enter at least 2 fields in search criteria

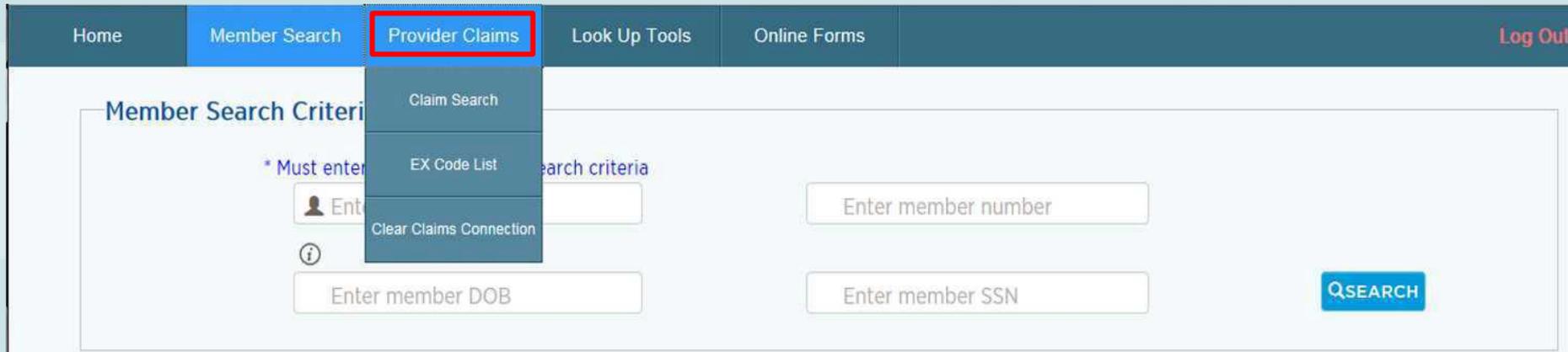
<input type="text" value=""/>	Enter member number
<input type="text" value=""/>	Enter member SSN

Enter member DOB

QSEARCH

Check Claim Status

- Select **Claim Search** listed under **Provider Claims** on the dashboard and the *Claim Search Criteria* page will display
- Enter the required information in the search criteria
- Click **Search** to display the results



The screenshot displays a web application dashboard with a navigation bar at the top. The navigation bar includes links for Home, Member Search, Provider Claims (highlighted with a red box), Look Up Tools, and Online Forms. A Log Out link is located in the top right corner. Below the navigation bar, a dropdown menu is open under Provider Claims, showing options for Claim Search (highlighted with a red box), EX Code List, and Clear Claims Connection. The main content area shows the 'Member Search Criteria' page, which includes a form with the following elements:

- A red asterisk and the text '* Must enter' followed by 'search criteria'.
- An input field with a person icon and the text 'Enter member number'.
- An input field with the text 'Enter member SSN'.
- An input field with the text 'Enter member DOB'.
- A blue button labeled 'SEARCH'.

Check Claim Status

- After you obtain your claim search results, you can click on the 12-digit alphanumeric number listed under the **Claim No.** column to see *Claim Detail Information*.

The screenshot shows a table with columns: Visit Date, Member, Claim No., and Type. A row is visible with Visit Date 07/30/2015 and Claim No. 1508070F5472. A red box highlights the Claim No. cell, and a blue arrow points from it to a pop-up window titled 'Claim Detail Information'. The pop-up window has tabs for 'Claim Snapshot', 'Service Details', and 'Payment Information'. The 'Claim Snapshot' tab is active, showing fields for DATE OF VISIT (07/30/2015), CLAIM NO., and MEMBER. Below this is a table of financial details:

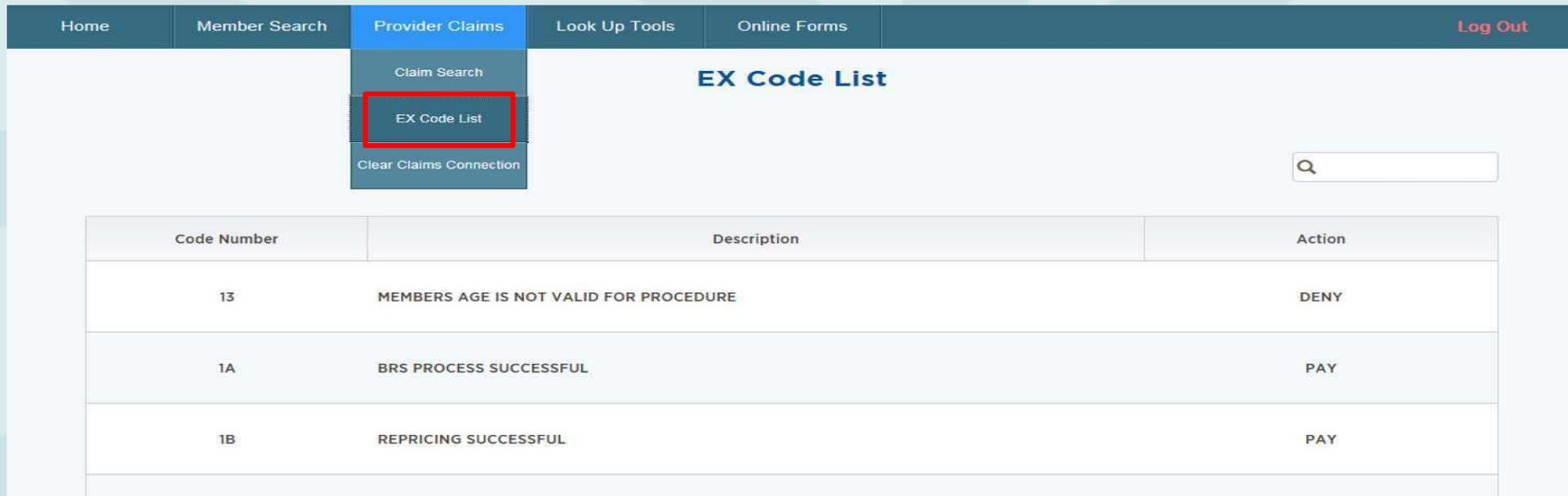
Claim Snapshot	
DATE OF VISIT	07/30/2015
CLAIM NO.	
MEMBER	
PROVIDER	
AMOUNT BILLED	\$1413.00
- PLAN ALLOWED	\$605.32
- PLAN DISCOUNT	\$0.00
- PLAN PAID	\$605.32
PATIENT RESPONSIBILITY	\$0.00
COPAY	\$0.00
COINSURANCE	\$0.00
DEDUCTIBLE	\$0.00
PATIENT MAY OWE	\$0.00

If you cannot find a specific claim, it may be due to one of the following reasons:

- SWHP has not received the claim.
- There may be an issue with the claims clearinghouse.
- The claim is billed with a Provider Number/NPI that you don't have approval to view.
- The claims clearinghouse did not send the claim to us.

Check Denial Codes

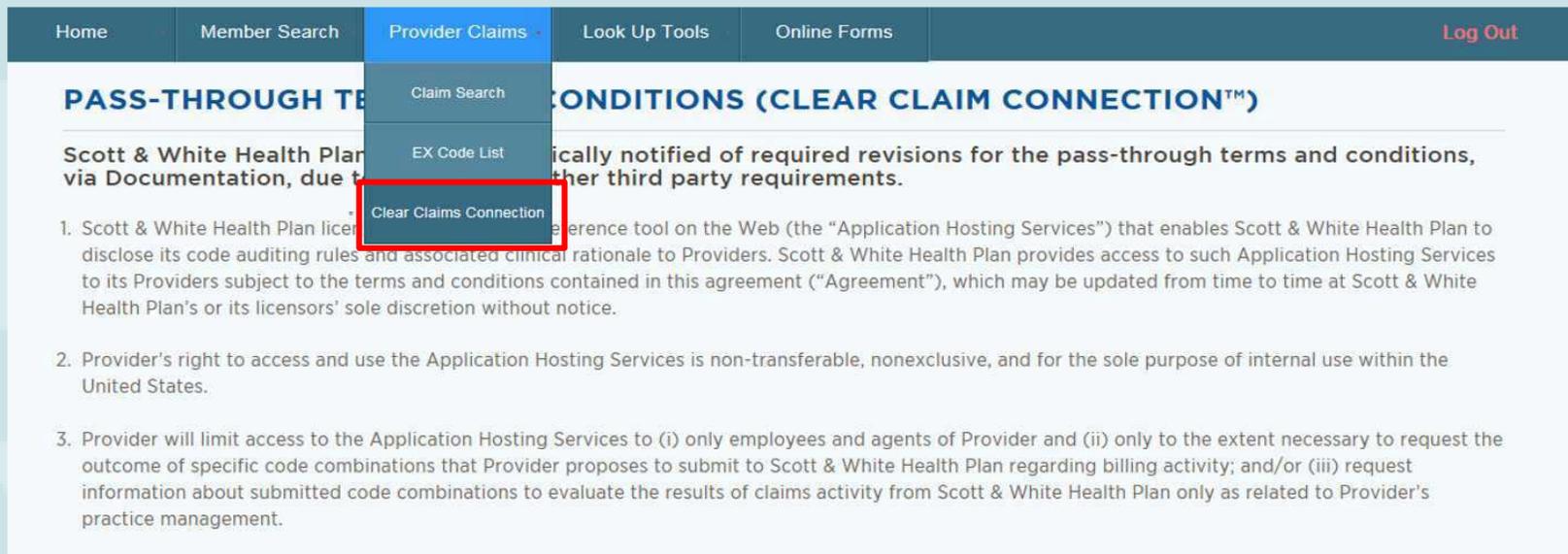
- The *EX Code List* is a catalog of all claim denial codes and their definitions
- Select **EX Code List** under **Provider Claims** on the dashboard and the *EX Code List* page will display



Code Number	Description	Action
13	MEMBERS AGE IS NOT VALID FOR PROCEDURE	DENY
1A	BRS PROCESS SUCCESSFUL	PAY
1B	REPRICING SUCCESSFUL	PAY

Clear Claim Connection

- Allows you to access the appropriate coding and supporting edit clarifications for services before claims are submitted
- Determine the appropriate code or code combination representing the service for accurate billing purposes
- Access the edit clarifications on a denied claim for billed services after an Explanation of Payment (EOP) has been received from the payer organization



The screenshot displays a web application interface with a dark teal navigation bar at the top. The navigation bar contains the following items: Home, Member Search, Provider Claims (with a dropdown arrow), Look Up Tools, Online Forms, and Log Out. A dropdown menu is open under 'Provider Claims', showing three options: Claim Search, EX Code List, and Clear Claims Connection. The 'Clear Claims Connection' option is highlighted with a red rectangular box. Below the navigation bar, the main content area features a heading 'PASS-THROUGH TERMS AND CONDITIONS (CLEAR CLAIM CONNECTION™)' and a paragraph of text: 'Scott & White Health Plan is hereby notified of required revisions for the pass-through terms and conditions, via Documentation, due to other third party requirements.' Below this text is a numbered list of three items:

1. Scott & White Health Plan licenses and provides access to its Application Hosting Services reference tool on the Web (the "Application Hosting Services") that enables Scott & White Health Plan to disclose its code auditing rules and associated clinical rationale to Providers. Scott & White Health Plan provides access to such Application Hosting Services to its Providers subject to the terms and conditions contained in this agreement ("Agreement"), which may be updated from time to time at Scott & White Health Plan's or its licensors' sole discretion without notice.
2. Provider's right to access and use the Application Hosting Services is non-transferable, nonexclusive, and for the sole purpose of internal use within the United States.
3. Provider will limit access to the Application Hosting Services to (i) only employees and agents of Provider and (ii) only to the extent necessary to request the outcome of specific code combinations that Provider proposes to submit to Scott & White Health Plan regarding billing activity; and/or (iii) request information about submitted code combinations to evaluate the results of claims activity from Scott & White Health Plan only as related to Provider's practice management.

Fee Lookup

- The *Fee Look Up* tool makes it very easy to get reimbursement estimates for procedure codes
- The *Fee Look Up* tool is updated on a quarterly basis
- Select **Fee Look Up** listed under **Look Up Tools** on the dashboard and the *Fee Look Up Criteria* page will display
- To use the tool, follow these easy steps:
 - Select the appropriate **Region** from the drop-down.
 - Select the appropriate **Medicare Locality** from the drop-down.
 - Enter a **Procedure Code** in the designated field.
 - Select the appropriate **Modifier(s)** from the drop-down (*if applicable*).
- Click **Look Up** to display results.

Home Member Search Provider Claims **Look Up Tools** Online Forms Log Out

Fee Schedule Look Up: Complete of Business and Current Year Contracts ONLY

Valid ONLY For Pre-Auth Code Look Up Effective July 1, 2017 - September 30, 2017 [Instructions](#)

Fee Look Up Criteria

----- Select a Region -----

----- Select a Medicare Locality -----

----- Select Modifier 1 -----

----- Select Modifier 2 -----

LOOK UP

Fee Lookup

- Additional Tips:
 - You can look up 7 procedure codes at a time using the button located next to the **Procedure Code** field. 
 - A link to the *Instructions* on how to use the tool are located to the right above the *Fee Look Up Criteria* box.

Fee Schedule Look Up: Commercial Line of Business and Current Year Contracts ONLY

Valid ONLY For Dates of Service July 1, 2017 - September 30, 2017

[Instructions](#)

Fee Look Up Criteria



LOOK UP

Pre-Auth Code Lookup

- Medical services, procedures, supplies, and drugs that require prior authorization must be medically necessary and meet SWHP coverage criteria.
- A prior authorization is needed if you plan to refer a member outside of the SWHP network.
- You can view the SWHP Prior Authorization Lists online at:
 - Medical: <http://swhp.org/en-us/prov/auth-referral/medical>
 - Medications: <http://swhp.org/en-us/prov/auth-referral/medications>
- If you have questions regarding prior authorization requests, please call our Health Services Division at 888-316-7947 or 254-298-3088.

Pre-Auth Code Lookup

- To help you determine the codes that require a prior authorization, you can use the **Pre-Auth Code Look Up** tool in the provider portal.
- Select **Pre-Auth Code Look Up** listed under **Look Up Tools** on the dashboard and the *Pre-Authorization Code Look Up* page will display.
- To use the tool, follow these easy steps:
 - Enter a valid **Procedure (CPT) Code** in the designated field.
 - Click **Look Up** to display the results.

The screenshot shows a navigation bar with the following items: Home, Member Search, Provider Claims, Look Up Tools (highlighted in blue), and Online Forms. Below the navigation bar, there is a menu with 'Fee Look Up' and 'Pre-Auth Code Look Up' (highlighted with a red box). A disclaimer is visible: 'DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Tool. However, this does NOT guarantee that the payment of claims is dependent on eligibility, covered benefits, provider contracts, coding and billing practices.' Below the disclaimer is a yellow box with text: 'Prior Authorization is required for ALL SERVICES to be provided by NON-CONTRACTED Providers (except for use of out-of-network benefits in PPO and POS Products, unless required by the Prior Authorization List)'. The main content area is titled 'Pre-Authorization Code Look Up' and contains a text input field with the placeholder text '*Enter a code and press "Look Up" to see if it requires pre-authorization' and a blue button labeled 'LOOK UP'.

Case Management Referral Form

- If a member needs medical case management, behavioral case management, or a transplant, you can complete the *Case Management Referral Form* in the provider portal.
- Select **HSD Referral Form** from the Online Forms tab on the dashboard to access the *Case Management Referral Form*.



The screenshot displays the provider portal dashboard with a navigation bar at the top. The 'Online Forms' tab is selected and highlighted in blue. Below the navigation bar, the 'Case Management Referral Form' is prominently displayed in large blue text. A red rectangular box highlights the 'HSD Referral Form' button, which is also highlighted in blue. Below this button is a 'PA Online Form' button. A disclaimer text reads: 'Please do NOT use this form to request prior authorization (PA) for medical services, please fax the required PA form and fax cover sheet to 1-800-626-3042 or call 1-888-316-7947.' Below the disclaimer is a note: '*Indicates required field.' The 'Requester Information' section is visible at the bottom, with a label 'Name of Requester' and a red asterisk indicating a required field.

Home Member Search Provider Claims Look Up Tools Online Forms Log Out

Case Management Referral Form

HSD Referral Form

PA Online Form

Please do NOT use this form to request prior authorization (PA) for medical services, please fax the required PA form and fax cover sheet to 1-800-626-3042 or call 1-888-316-7947.

*Indicates required field.

Requester Information

Name of Requester*

Prior Authorization Request Form

- *Prior Authorization Request Form* can be submitted electronically.
- Select **PA Online Form** from the Online Forms tab.
- After reading the instructions, scroll down and acknowledge that you have read and the form will be displayed.
- Once the form is completed, it can be submitted electronically.



The screenshot shows a web portal interface. At the top, there is a navigation bar with links: Home, Member Search, Provider Claims, Look Up Tools, Online Forms, and Log Out. Below the navigation bar, there is a dropdown menu for 'Online Forms' with two options: 'HSD Referral Form' and 'PA Online Form'. The 'PA Online Form' option is highlighted with a red rectangular box. Below the navigation bar, the main content area displays the title 'Medical Authorization Form' in large blue text, followed by the subtitle 'PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES'. Below the subtitle, there is a scrollable text box containing instructions. The instructions include: 'Please read all instruction below before completing this form. (scroll to the bottom to accept)', 'Please send this request to the issuer from whom you are seeking authorization. Do not send this form to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.', 'Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.', and 'In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.' At the bottom of the scrollable text box, there is a URL: 's://portal.swhp.org/ProviderPortal/#/medicalAuth' followed by the text 'request authorization by fax or mail when an issuer requires prior authorization of a health care service. An Issuer may also provide an'.

Survey Monkey

- Please complete the survey monkey by clicking the link below or copying and pasting to your browser.
- Your feedback will be anonymous.
- Your input will help us serve you better with future presentations.
- The survey will be open until 8 a.m., Nov. 6, 2017

<https://www.surveymonkey.com/r/JFN2JRR>