Laurie: The Quality Insights Quality Innovation Network Team welcomes you to today's webinar: IMPACT Act of 2014 - Understanding the Changes to Post-Acute Care. My name is [Laurie Fink 00:00:16] and I'm a Communication Specialist for the Improving Care Coordination in Quality Initiative.

Before we get started, I would like to take a moment to review a few housekeeping items. First, all participant lines have been muted and will remain in a listen only mode during the presentation. There will be a question-and-answer session following the presentation. If you have any questions that come to mind during the session, please feel free to type them in the Q&A box or the Chat box, which can be found on the right-hand side of your screen, and we will address all these questions at the end of the formal presentation.

Please note that this webinar is being recorded, and the recording will be posted on the Quality Insights website later today. You should have already received a copy of the slide deck via email this morning. If for some reason you did not, the presentation slides are also posted on the Quality Insights website at www.qualityinsights-qin.org. Both resources can be found under the Events tag as an Archived Event.

Now before I introduce our speaker, we'd like to get a feel for who all is joining us today on the call, so we're going to do a quick polling question and you will see it posted on the right hand of your screen asking, "What setting are you from?" So I'm going to go ahead and open that poll and if you could please type your answer in there, select either home health, skilled disability, inpatient rehab, or long-term care hospital, and we'll get a feel for who all is on the call today.

All right. Great. It looks like we have almost everybody logging their answers in. I'll go ahead and close the call, and those results will post in about 15 seconds. While we wait for those responses, I'll go ahead and introduce you to today's presenter, Linda Anderson.

Ms. Anderson is the founder and principal of Anderson Elder Law in Media, Pennsylvania. The firm is dedicated to aiding individuals and families to navigate the legal, financial and medical issues related to elder law, estate planning, and long-term care and special needs planning. Ms. Anderson has over 25 years of experience in the elder law field and is a certified elder law attorney as confirmed by the National Elder Law Foundation and authorized by the Pennsylvania Supreme Court. She is an accredited attorney with the Department of Veteran Affairs as well as a member of the Life of Care Planning Law Firms Association and the National Academy of Elder Law Attorneys. She has been recognized as a Pennsylvania "Super Lawyer" in the field of elder law since 2014 and as one of the Top 50 Women Lawyers in Pennsylvania since 2007.

Now, without further ado, I will hand things over to Linda.

Linda: Thank you. Hi everybody. I'm going to just suggest that the first slide ... Before we joined and brought the group in, I wanted to just share a little bit of what I was talking to Carolyn [Hahn 00:03:40] about, which is my point of view as an elder law attorney. When I do my legal work, I'm not representing healthcare providers. I'm representing the families that are your patients, and my clients are using the services of post-acute care providers. For me this is just a very interesting development where I feel like we may have shared areas of concern and that it's really important for me as an elder law attorney to understand as much as I can. As much as the transition is going to affect you, it's likely going to affect my clients as well.

So just a little bit more about what my background is in terms of why I'm interested in this. I know some of you are actually in states outside of Pennsylvania, and if you ever need an elder law attorney in those states, I would refer you to a website, NELF(National Elder Law Foundation).org where you can find a list of elder law attorneys state by state.

With that, we're going to start the conversation about IMPACT Act of 2014. First, I just have to comment about what an amazing acronym this is. You just have to wonder if there's somebody sitting in Congress whose entire job is to figure out, "How do we make legislation have a catchy name that fits the bill content perfectly?" But when you think about IMPACT, the Improving Medicare Post-Acute Care Transformation Act, it really does fit the bill incredibly well.

What's amazing about this legislation beyond the incredible, amazing acronym is the unbelievable speed with which it was actually introduced and then passed. The slide says, "Signed into law December 6." It's actually October 6. When you think about how this legislation went from being introduced in June and signed in October, it had to have bipartisan and bicameral effort, which means that both Democrats and Republicans were on the same page and both the House and the Senate were on the same page simultaneously with a stated goal of actually changing what's going to happen with post-acute care and Medicaid funding. This is actually very big news and very, very quick moving with an incredible amount of momentum behind it. We're going to go over some of the elements that you all are going to have to be dealing with as post-acute care providers.

When we think about this incredible, fast-moving legislation that had bipartisan support, you have to wonder, "Where did the issue come from? What was the problem that's going to be solved?" It was interesting. Prior to the passage, there was the House Ways & Means and the Senate Finance committees. They were soliciting feedback from stakeholders about PAC reform. The response from the

committees was that the real issue here was that we needed a standardized post-acute assessment data tool.

Laurie: I think we might have lost Linda Anderson. Her phone line must have dropped. Let's give her a minute to call back in and get back on track for the presentation. I apologize for that. I'm not sure exactly what happened, but we'll give her a minute to see if she can rejoin the call. Thanks for your patience.

Linda: Am I back on?

Laurie: There she is. Yes.

Linda: There I am.

Laurie: Thought we'd lost you there for a minute.

Linda: Yeah. The call just dropped, and I was busy talking. Okay. Let me jump right back where I was. We're back on the slide IMPACT Act of 2014 and we're talking about, "What is it that's the real motivation behind this incredibly big shift in PAC funding?" What's interesting is that there was actually an Institute of Medicine and IOM report that was issued in 2013, and the IOM is an independent nonprofit think tank, it's an arm of the National Academy of Science, so there wasn't any partisan point of view.

But what was interesting is that the report concluded that there were incredible variations in healthcare spending depending where you lived in the country, that Medicare payments, depending on where you were, were actually going to be very different. When they looked to see what was actually going on when you unbundle the Medicare payments, where was the source of the variation between the areas of the country? What you can see from the slide is that 73% of the variation relates to the post-acute care. Saying it another way, if the regional variation that PAC's spending didn't exist, the Medicare spending variations would fall by 73%.

With that information, the whole incentive to really address ... Whether it's a standardized tool or whether it's a payment system, but the idea of actually evaluating PAC funding and Medicare became a very hot button. The recommendation from the House Ways & Means Committee and the Senate Finance Committee was they needed to incentivize the clinical and financial integration of healthcare delivery systems and encourage care coordination, real-time sharing of data and tracking of service use and health outcomes and distribution of provider payments.

Well, for somebody who is representing the families, I can only tell you that this sounds very confusing. The bottom line, the take-away message of IMPACT is that there's going to be a standardized post-acute care assessment tool and we're also moving to a unified PAC payment system. The two things, where we're going, are related to those tools and the payment system. So we're going to talk a little bit about those items.

When you think about the assessment tool and the way the assessments happen right now, you all understand that post-acute care occurs in four different types of settings. If you look at this table here, we've got the HHA for the Home Healthcare Agencies, we have SNF for the SNIFs, we have IRF for the Inpatient Rehabilitative Facilities, and we have LTCH for Long-Term Acute Care Hospitals. When you look at the very first line across there you can see what the assessment tool is labeled for that particular provider or that level of care on the continuum. What you can see is that every single column has a different type of data assessment tool. One of the things that presumably is going to happen is that we're going to have assessment tools that are going to look for the very same data so that you can have separate assessment tools but that the information collected is uniform information that's reported in a way that not only is collected but can be interpreted across the levels of continue of care for all the acute care providers.

When you look at the chart, I think it's also helpful to keep this chart in mind when we talk about other areas, but you can see there that there are going to be three different areas of assessment. When we're collecting data among the different levels of care or the different providers, there's going to be a way to communicate about Patient Assessment Data. The idea is that there'll be at least five points where there will be common data collection among the different levels. For Quality Measures, again there's going to be five points so we're going to agree as to these five points and potentially more that everyone's going to measure the same five things in the same way so that we can exchange data as to those points. The final category is the Resource Use Measures, and for that, there are three points.

As you start to understand the chart, you can see at the very top, we start with four different labels of how we're collecting the data and we're looking to standardize those four different approaches as to five points, five points and three points for the three different categories.

The other thing that you can see on the chart is that there are different starting dates for this reporting. I think what's interesting is if you look at the column for the SNIFs, the IRFs, and the LTCH Long-Term Acute Care Hospitals, you can see that those dates in the last three categories actually align. For some interesting issue, I'm not quite sure what, under the Home Health Agencies you can see that

the deadlines are always just a few months beyond the deadlines for the other categories.

Again, we're talking about the IMPACT Act recognizing that post-acute care occurs in these four areas, recognizing that these four providers are all busy trying to measure the data currently, but we're now going to say we want to do something different. And the difference is that we're going to ask for particular data in each of the three categories.

For the first one, for the Patient Assessment Data, there will be at least five points where we're going to be looking for a standardized interoperable data required. The first category or the first data point would be Functional Status, the second one would be Cognitive Function and Mental Status, the third area would be Special Services, Treatments and Interventions Required, number four would be Medical Conditions, and number five would be Impairments. With those five points, the idea would be to be among those post-acute care providers to be able to compare what's going on in terms of that Patient Assessment Data no matter where the services are provided. One of the interesting things about this data collection is that there are going to be other categories as suggested by the Secretary of Health and Human Services, and the idea is that we're going to be working among these four categories of data tools with a goal of eliminating overlapping and duplicative data.

With this data, one of the other stated goals is alignment of this Patient Assessment Data with claims data so that we can see not only what the utilization is for the patient assessment but, "How does it actually relate to the claims data and how their things are paid?" The deadline for that alignment is in 2018. Again, from my consumer point of view, what I was looking to see and find in the reading was, "How does this relate to the consumer choice?" "How is this data going to be used?" One of the interesting comments was the data is not to be used to require Medicare beneficiaries to be provided PAC care by a specific type of provider. At least initially as we're rolling out this program, the idea is that we're not supposed to be using and relying on the data to determine what type of person's going to be getting care at a particular level.

The other comment that I'd add is if we're going to have Patient Assessment Data, when is it going to be measured? At this point, it's going to be at a minimum of the time of admission and discharge, but again, as the Secretary of HHS rolls out additional rules, there may be other times for analysis.

When you look at the chart, you can see there's a timeline for reporting the data. Again, we're looking at October 1, 2018, 2016, except for the Home Health Agencies, which do have a few more months.

The second category of measurement is going to be the Quality Measurement, and again we're looking for five points of data that would be in the standardized interoperable format so all the providers can exchange data. Under those five points, we're looking for again Functional Status, Skin Integrity, Medication Reconciliation, which I guess would be medical errors, Major Falls, and in the Patient Information and Preference when a patient transitions from hospital to another PAC provider. These five data points are going to be the Quality Measurement; at least these five points and again there may be others. You can see from the chart when the reporting begins for that and you can see again the Home Health Agencies do have a couple extra months for their reporting.

The third area is going to be the Resource Use Measurements. There are three points of data for this one: Total Medicare Spending Per Beneficiary, Discharge to Community, Hospitalization Rates of Potentially Preventable Readmissions. What's interesting about this is that even though we're talking about this last, the timeline for reporting this data is actually the first deadline which will be October 1, 2016. I think it's pretty safe to say that changes are coming no matter what type of PAC provider you are and that we're slowly moving into the beginning of some of the reporting periods.

Let's continue talking about rolling out. Now what's interesting about this chart is this is not a chart based on the IMPACT Act, but this is a chart that was actually produced as part of the Congressional committee meetings that I referred to earlier. I think what's very interesting to me about the chart is that really where this intended legislation was going and what it was going to achieve was already pretty well defined. You can really see at the very end of it, it refers to the Prospective Payment System and it refers before that to different data points and different reports. The idea is that IMPACT Act was something that was very well developed and when it was enacted, there wasn't much change between how it was developed and what we actually saw within the few months when it was enacted.

When you think about the IMPACT Act of 2014 and you think about this timeline, the analogy I think that's helpful is to understand that there are really two trains.

Laurie: Looks like we lost Linda again. She must have some bad storms moving through her area today. Let's give her a minute so she can dial back in. Sorry again for the pause here. If you'll hold on for just a minute, hopefully she'll dial back in. Thanks.

Hi. Carolyn [Hahn 24:01]. Are you still on the line? Maybe you could ... if there's anything you would want to add right now, till we wait for Linda to join the call, about the Impact Act?

Carolyn: Laurie? This is Carolyn with the office. I think she's having some problems with her connection.

Laurie: Okay.

Carolyn: Can you have her call back in?

Laurie: Sure.

Carolyn: Hold on a minute. Hold on, Laurie. Can you have her ... Tell her to call back in. Yes. That's correct. Yes.

Yep. That's my cell phone. Okay.

Laurie: So Carolyn, she's calling back in?

Carolyn: Yes. She's going to call back in.

Laurie: Okay. Was there anything you wanted to add about the IMPACT Act while we're waiting on behalf of the 25:02.2]?

Carolyn: Not really. Give the presentation. I apologize for the connection. There seems to be a problem.

Laurie: Yep. Got to love modern technology, huh?

Carolyn: Yeah.

Laurie: Hello? Hi, Linda, you're back.

Linda: Yeah. I ...

Laurie: Okay. Good.

Linda: ... don't know how long I was off, but okay. So where was I when I got cut off again?

Laurie: We're still on slide number five, the Timeline of Major Deliverables in the IMPACT Act.

Linda: Okay. In terms of the timeline the two trains leaving the stations ... Did I get cut off before or after that?

Laurie: On the train, you might just want to restart on that slide.

Linda: Okay. All right. We're looking at a chart that talks about the timeline of the implementation of IMPACT Act of 2014. What's interesting about this slide and this chart is that it's not actually from the IMPACT Act of 2014. It was actually developed by the committee work of Congress prior to the enactment of the legislation. I think what's interesting about the timeline is that it's clear that IMPACT Act was really very well developed in terms of the intention to have a prospective payment system. You can see that at the end. Then you can see the timeline with the different ... What's actually going to occur in terms of the data collection and the reports.

Just to sort of walk ourselves through the implementation of IMPACT, again, one of the first deadlines that's going to be coming up would be the June 30, 2016, which relates to a prospective payment system study. In terms of IMPACT Act of 2014 there are two trains leaving the station.

Train number one has really very little to do with the data assessment tool. It has to do with changing to a prospective payment system. When the legislation was passed, it was a stated goal to make sure that we're establishing a payment system that establishes payment rates according to the individual characteristics instead of where the treatment's actually received and that there's a recognition that some of the regulations are going to be needed to be changed and that there has to be from the study an analysis of the impact of recommended payment systems on cost sharing, on access to care, and on choice of setting. The study also should include a projection of the reduction for Medicare spending. We're not looking to spend more on Medicare. The study's actually looking to see how it'll be reduced. The IMPACT Act of 2014 has again a timeline for train number one which relates to the prospective payment system.

The second train that's leaving relates to all of the data collection and analysis that we just reviewed. Just to recap the first deadline that we're going to be looking toward, it would be the October 1, 2016 where the Resource Use Measure and some of the Quality Measurements reporting actually begins. Once we get the data there's going to be confidential feedback to the PAC providers that will be provided October 1, 2017. Then again for the home health agencies, they do get their data a few months later after the confidential data to the PAC providers. A year later there'll be the public reporting of the PAC provider data so that it actually gets rolled out a little bit later. It's important to note that as the PAC providers, there's going to be a penalty if there's a failure to report the data, there'll be a reduction in the market basket price of 2%. My understanding is that the reductions are not cumulative and limited to that fiscal year.

It's very interesting to see the trains have left the station and like any trains, there's a tremendous amount of momentum that's going behind this work.

Switching gears to ... Again, within the IMPACT Act but something completely different that relates to Medicare.gov, the website for CMS, and a portion of that website has the 5-star Nursing Home Compare rating. What was interesting about the IMPACT Act is that under the Affordable Care Act, there were some changes that were legislated to improve the 5-star rating for nursing homes, but there was actually no funding actually provided with Affordable Care Act. What IMPACT Act actually did is actually provide the funding for those changes.

At this point, just to bring everybody to the same area of understanding, when you look at the Nursing Home Compare, there are three domains where each skilled nursing facility is actually going to be measured. One is the health survey, the second would be the nurse staffing, and the third would be the quality measures. Those three domains are then combined for a composite scale for another rated measurement so that when you look at Medicare.gov, there will be a 5-star rating on those four areas - the composite scale and those other three.

Where the issue came around this area was around in October of 2014 when the White House and CMS announced the plans to improve the website in five distinct different ways. If you look at the slide, we're talking about, "What are the five areas of improvement that we can look to see on our Nursing Home Compare?" The first one relates to the Nationwide Focused Survey Inspections. What does that actually relate to? Well, what was interesting is that up until the Affordable Care Act and now with the IMPACT Act, much of the staffing data that is used to rate the nurse staffing portion of the 5-star ratings is based on data that's provided by the skilled nursing facility.

That approach, CMS had been criticized for relying on data that's self-reported data and, in fact, in August of 2014 the New York Times report had an article that two out of three of the 50 facilities that were on the watch list as special focus facilities had actually achieved 4- and 5-star ratings on staffing and quality measures based on self-reporting data that evidently they felt was not actually accurate. So as I said, the IMPACT Act did provide the funding for a quarterly electronic reporting system and the idea is that the table records from the SNIF are now going to be used to actually determine the nursing staffing data, which will give us actual data as compared with self-reported data.

The status for this change is at the pilot testing is happening in fiscal year 2015 and it should be rolled out nationwide by fiscal year end for 2016. When you think about the IMPACT Act of 2014 and the Nursing Home Compare, part of what CMS is doing is really allowing the staffing to be payroll-based reporting instead of self reporting.

The other change ... One of the things that is occurring is the additional quality measures. As of January of 2015, one of the changes that's already being measured is the use of antipsychotic drugs within SNIFs. More quality measures are coming under that category as well. Other potential areas could be resident rehospitalization and discharge to community. We're looking to see additional quality measures so that when you look at that portion of the rating, we have more information.

Another area of improvement is going to be how the states relate to this federal website. At this point there's absolutely no sharing of the data, so this legislation calls for the states to maintain their websites and to submit timely and usable data that can be onto the federal website, too. The idea is that we're going to have one portal so that we'll be able to see a bigger, more complete picture of the quality of the different SNIFs in our area based on this website. In terms of the IMPACT Act of 2014, we've got the Nursing Home Compare, which is the other area.

IMPACT Act of 2014 also had a major development that relates to Hospice. Hospice not so long ago was more mom-and-pop providers but has now turned into a very important part of our healthcare delivery industry. IMPACT Act of 2014 passed hospice integrity provisions as part of the legislation. Again, the issue that was being addressed related to some reports that the Office of Inspector General had found back in 2007. It was determined that as hospice providers, they're getting much less oversight than all the other categories of Medicare providers. Then after 2007 the OIG did another updated report and noted that these survey frequencies hadn't really changed since 2005 and that, in fact, in at least two states more than a quarter of the hospice providers hadn't been surveyed within the last six years.

In an effort to address this issue, the IMPACT Act of 2014 has a survey requirement that the hospice providers be surveyed no less frequently than once every 36 months. This change has been rolled out as of April of this year. What's interesting is that it has a 10-year horizon so that we're going to have, as of September 30, 2025, a sunset provision for the survey. There was money set aside as part of the IMPACT Act to provide for the additional costs and additional surveys. How those surveys get done, CMS will have contracts with the local survey agencies or other approved accreditation agencies within the state. That funding is guaranteed $70 million for the next 10 years. I guess the decision will be at the end of the 10 years whether or not the continuing surveying and funding actually is needed.

With the additional surveys, there are a couple other things that were changed under the hospice part of IMPACT 2014. One of the changes is to ensure the hospice agencies' compliance with beneficiary rights that are in the Medicare

Conditions of Participation. There's a new rule that does require that the hospice notice include language in the Hospice Election Statement where the Medicare participant has the option of making sure they have identified an attending physician and that it has been chosen by the patient or an authorized representative. The recommendation from again my point of view, the consumer point of view, is that we're making sure that hospice patients are choosing a trusted physician who may not be associated with the hospice provider just so that you have a doctor with broader concerns and perhaps a longer history with the patient.

The other part of the IMPACT Act for hospice providers is that the Act is going to change a possible trigger for medical review of certain patients' care. The issue that was being addressed here again relates to the Affordable Care Act, did require a medical review of hospice stays exceeding 180 days for hospices with an unusually large share of long-stay patients, but because of the drafting error, even when the Healthcare Reform was passed, it didn't permit CMS to actually implement the change.

Now with IMPACT Act of 2014, we do have the ability for CMS to roll out this. Once a certain threshold is met by the hospice program where a certain percentage of the patients have a length of stay that's over 180 days or more, that a medical review process will be triggered. The idea is that if there is a hospice provider where many, many, many of the people are there over a certain amount of time, the idea is that, "Are these people actually being certified for hospice correctly?" and there'll be a medical review to make that determination.

Another change that relates to hospice is the Act also aligns the hospice reimbursement and the hospice aggregate financial cap to a common inflationary index. I don't know a lot about this because it's not in my practice area, but my understanding is that since hospice actually began, the hospice reimbursement and the aggregate financial cap were actually set by two different economic indices. Now at this point, it means that the cap has been adjusted so that the IMPACT Act aligns the inflation for both the hospital aggregate cap or the hospice reimbursement. That, again, is for the next 10 years. At the end of 10 years, when we have our sunset, I guess it's possible that there'll be a misalignment now of the hospital reimbursement in the hospital financial cap.

In terms of the IMPACT Act of 2014, I think it's safe to say that the timelines are very well defined. The goals are very well defined. I think if I were a PAC provider, I'm looking at an incredible amount of data collection and reporting, I'm looking at a change in my payment system, and all of these things are coming within a very short amount of time. As a consumer point of view, I feel like

there's shared areas of concern and I think it'll be very interesting to see how this gets rolled out.

With that, if there are any questions?

Laurie: If anybody has any questions, please feel free to post them in the Chat box or the Q&A box found on the right of your screen. I will read those to Linda. I did want to let you know from our first poll question just to get a feel for who all was on the call today, we have 15 attendees from the home health field, 52 from skilled facilities, 4 from inpatient rehab facilities, 2 from long-term care hospitals. Those were the attendees that submitted their responses. We have a nice mix today on the call.

Linda: That's a great mix.

Laurie: Okay. We've gotten a couple questions coming in now, Linda. The first question asked: Can you review the two five points and three points?

Linda: Yes. Okay. Let me make sure I get to the right slide. Okay. We're talking about the three new categories of data collection. The way that it has been defined within the IMPACT Act is under these three major categories: Patient Assessment Data, Quality Measures and the Resource Use Measures. At this point we know that there are at least five points of data for patient assessment. There could be more as this develops. For Quality Measures we know there are five points, and for the Resource Use Measures there are going to be three points. When you think about those three points or those five points, I can go over those different elements, but I think what's more important to know is that they may not be the sum total of all of the points.

For the Patient Assessment Data, the five points include the Functional Status. Cognitive Functional and Mental Status is number two. Number three is Special Services Treatments and Interventions Required. Number four is Medical Conditions. Number five is Impairments. The idea is that when you think about Patient Assessment Data, there will be at least five points that PAC providers - no matter what type of PAC provider - will be able to exchange data in an interoperable and standardized format where everybody's reporting it in the very same way.

Similarly, with the Quality Measurement, the five points would be the Functional Status, Skin Integrity, Medication Reconciliation, Major Falls, and Patient Health Information. Again, those five areas will be the standard in interoperable data for the Quality Measures.

For the Resource Use Measurement, the three points that we have as of right now would be the Total Medicare Spending for Beneficiaries, Discharge to Community, and Hospitalization Rates of Potentially Preventable Readmissions.

Laurie: Okay, Linda. We had another question. It asks that: The timeline under the LTCH is different but you mentioned it would be the same. Is that a typo on the slide or is that correct?

Linda: Under the LTCH.

Laurie: The timeline under LTCH is different but you mentioned it would be the same. Is that correct?

Linda: No. It's [46:24.5] slide. On the LTCH, the five points, that's actually correct. This slide is correct.

Laurie: Another question asks: Will you be discussing the slide referring to POA changes?

Linda: Yeah. If I had time, I was going to throw that in, but in Pennsylvania - this is state specific - there has been an incredible piece of legislation passed that relates to financial powers of attorney. Many healthcare providers have been contacting me saying, "Do I need to do something different?" The bottom line is for our Pennsylvania practitioners is that if you're looking at a patient or a representative and they have a power of attorney that's pure medical power of attorney or healthcare power of attorney or a living will advanced directive, the financial power of attorney statute doesn't have anything to do with those documents that are purely medical. If you have a combination document, then you are going to have a review based on the new statute.

So for Pennsylvania practitioners, if you have more questions, feel free to email me and I can send you an article about the Pennsylvania power of attorney statutes. For other states, just know that you have similar legislation that talks about how you get your surrogate decision makers for financial and medical and often those are two different statutes.

Laurie: Okay, great, Linda. There's no other questions yet, but we'll pause and then if it sees anybody else has anything else they'd want to ask you on this topic.

All right. It looks like there's no more questions coming in, so at this point I'd like to thank everyone for joining us today. If you do have any additional questions, we encourage you to reach out to your local Quality Insights Care Coordination team member. Please note that we will post the presentation slides and the recording of today's session on our website, and you will be able to access them at www.qualityinsights-qin.org and they'll be found under the Events tab as an

Archived Event. There will be a very brief evaluation at the close of this session. If you would, please take a minute to complete it. Your input really does help us plan for our future programs. With that, I'd like to thank you again for taking time out of your day to join us for the session. Have a great day.