Care Coordination Learning and Action Network
10/25/2016 / 12:00 – 1:00 p.m. CT

Good afternoon everyone and welcome to the introduction to improving coordination and medication safety. This event is being hosted CIMRO of Nebraska. Quality health Associates of North Dakota and the South Dakota foundation for medical care. We are known as the Great Plains quality innovation network. Hopefully you are able to see my screen. We would like to thank you for joining us today. We are recording this event and the recording any -- slides will be available on the Great Plains quality innovation website. You can see the website they are. As a reminder we ask you to utilize start to meet your line and start to unmute your line. We will be taking questions from all of our participants. In the meantime, we invite you to utilize that chat feature that is offered through this platform. You can find that chat feature at the top of your screen in the center. If you hover your mouse up there the ribbon will float down and you will see a chat box. If you click the checkbox, it will open up a chat somewhere on your screen perhaps over the slides so you may want to move it to the right or left. We would invite you to utilize this feature so you can instead of holding questions until the end and you forget them just go ahead and check them in. We do have Jackie who is monitoring our chat today and we will be checking in with her periodically. What you can expect from us during the course of this event and future events moving forward because this is a multi-month event is recently the Great Plains quality innovation that were conducted and environmental scan and we ask to hear from you. What opportunities you wanted to be able to learn from one another. And we heard you. We have created this series of events to encourage peer to peer learning not just across each of our individual states but across the entire region we want to talk to you with community experience and what is happening in your communities to address these issues of medication safety, care -- care coronation and chronic disease management. At some point we may invite you to be part of the larger conversation as you will be hearing later today as we learn from the community and what it is they are doing. We want to create deeper partnerships with you and we hope this structure that we've put together will accommodate that. This is not a reason and learn scenario. Our land structure includes webinars such as the one today where we will be talking about different aspects of care coordination, medication safety and chronic disease management. Additionally, we will have topic specific coaching calls. Where you all will utilize your expertise collectively and our expertise to the presenters who are on the line today to talk about what it is you are doing. The Bears you are facing, potential solutions and opportunities to learn from other communities in other settings about what they are doing and how they are successful and how they -- that may translate to you. We will be meeting on the fourth Tuesday of every month October through June with the exception of December. In December will be meeting the third Tuesday of the month to accommodate the travel and holiday schedule. We will be meeting at the same time from noon to one central time. We hope this is a convenient time for you. All of the webinars will be recorded. The topic specific coaching calls will not be recorded. Without further ado I would like to dive in and introduce Paula. Paula, we heard from a provider from North Dakota on our care coordination environmental and they express the wanting to utilize the [Indiscernible] to provide patient care. During the course of your time when you were talking to us about promoting effective communication to improve care coordination we hope you will discuss how a community can provide coordinated care.

Thank you Vanessa. That is a great question. I'm going to address that shortly. First we can have the next slide. Just a reminder of the goals for care coordination. We want to reduce hospital admission and readmission by July and readmission by July 2019 and we want to increase community tenure by 10% by July 2019 as evidence of the number of nights that Medicare beneficiaries spend at home. We want to reduce the prevalence of adverse drug events, emergency department visits, observation stays, hospital it admission or avoidable hospital readmissions that are a result of the care transition process. In order to improve care coordination we do establish partnerships. This partnership should include hospital, scaled and long-term care universities, physicians, pharmacists and other community stakeholders. Because we do want to improve the communication. We also want to develop partnerships with patients and families to improve readiness for transitions. To improve chronic disease self-management and to reduce medication harm. Next flight. Briefly I want to share some data from 2015 which is the 30 day readmission to all locations in the Great Plains Quinn. In the Great Plains Quinn we have a 30 day readmission rate of 15.84% and across the nation our rate is 18 point 18.3%. Also we have hospital discharges by location across the Great Plains Quinn and you can see the number of discharges that we had and then the percentages to home, a facility, home health or hospice. Also we have 30 day readmission by discharge locations. You can see that across the Great Plains Quinn we have 15% that were at home and work readmitted within 30 days 16.5% to the skill and 19 to the skill and 19.8% to home health and 1.8% to hospice. When we consider care coordination and patient care transitions from one healthcare

setting to another or to home with no services, we need to consider what are my patients or residents risk for readmission. If a patient has been readmitted to the hospital within the last 30 days that is a risk. Also if they have had a hospitalization within the last [Indiscernible] within the past 12 months they are at risk for readmission. So many of our medic care patients that we see have multiple morbid conditions as you know. That includes things such as CHF, diabetes, renal failure, cancer and dementia. Also we have pneumonia, sepsis and psychoses that are risk factors. This is shown in some of the data that we have from the Great Plains Quinn. Then of course there is polypharmacy and with polypharmacy's there isn't increased risk of adverse drug events and falls with or without a fracture which may be related to a medication adverse drug event. There is also surgical complications. We are not done. There may be other risk factors to consider. Communication with the patient and family and the next provider may not be ideal. It may not be complete and it may not be timely. The communications that is lacking can be a risk factor. If the next provider does not have all of the information that they need to properly care for the patient or the resident, this is a cause for risk. The transition to the next setting if it is incomplete for example, if there is no nurse to nurse call there are therapy orders -- I'm sorry, the patient or resident came for therapy but there are no borders. They have a room but there are no orders. They have pain medication but you don't know when they got there last -- pain medication. Many times the discharge summary is not available when they are transferred to you or within 24 to 48 hours. It's important they have a follow-up clinic visit within that 5 to 7 day time. After they have discharged from the hospital. We also are concerned if there is no documentation about advance care planning. You may be wondering about the mental status of your patient or resident. Their social situation and whether or not the patient is at risk for readmission. The medication risk is important and if it is not complete such as it doesn't have any indication or diagnosis for each of the medications, if there is dosage but you don't know what it is, if you don't know when to discharge the antibiotic if there are admission, those are all issues that need to be dealt with related to medications. There may have been changes in the patient's conditions prior to transfer or perhaps their condition was not communicated to you when he changed in a timely manner. The patient and family may not be on the same page so advance directives could be an issue or a challenge for the next provider and sometimes the patient and the families simply do not communicate what their preferences are. There also could be an issue with resources not being available in the next provider setting. These are all factors that need to be considered when we are talking about your risk for readmission. Now I want to answer the question. Improving communication both internal and external is extremely important. One of the tools that we have is the Internet tools. These are all tools that are free. The tools include things such as the aspire to offer communication, the stop and watch and the capability list and we do now have capability list for not only nursing homes but also for assistant living and home health agencies. The capabilities list can be extremely important for communicating with the emergency department or communicating with the patient physician or communicating with the provider that's going to be on call over the weekend. Multidisciplinary met vacation -- medication is a must to have with the most accurate medication was possible. At discharge the patient and family need to have a reconciled dedication list and be knowledgeable about those medications. Teach back is an evidence-based tool and should be and always event for patients and family education. Patients and families and providers do need to know about what is there advanced care plan. I know this physician can be -- this discussion can be difficult but must be done and the patient wishes should be shared with the family and all of the healthcare providers. One thing that is not on this list is root cause analysis for readmission and 80 visits. There is a root cause analysis tool is called AQI tool which is on the interact and this is a valuable tool for taking a look at what happens when you send a patient back for admission or two and ED visit. Jackie, I wanted to check with you, are there any questions in the chapter?

There are not. Jamie with the Great Plains Quinn asked a question for the providers how are you working to improve care coronation in your community. If you would like to respond, you can use the chat feature to do so.

Great. With that I would like to introduce Jamie sticks. He will talk about medication safety and I do have a question for you Jamie. A provider from Nebraska commented that medication reconciliation is a large undertaking and requires much coordination and it has been a struggle to implement a successful program. What are some of the key elements of medication safety?

Thank you. That is a good question that I will touch on near the end of this webinar. We will be able to spend more time during our upcoming coaching calls and learning session in January discussing dedication [Indiscernible]. As we move on to the next slide we can see the issue regarding medication safety nationally. I have a variety of statistics out on this slide and none of them are that good unfortunately. We all know that medication safety and drug advance are an issue. It's the second highest priority area. Look at some of these national statistics regarding polypharmacy. The

impact and drug events and the three specific drug classes that we have on the flight as well. As a result of some of the statistics the Department of Health and human services released the national action plan for adverse drug event prevention in the fall of 2014 focusing on three high risk medication classes. Anticoagulants, diabetic agents and opioids. Let's try and drill this down a little bit more regionally to look at the states within the Great Plains Quinn. This slide looks at the risk for drug events and shows that over 20% of our Medicare population is at high risk for adverse drug events. In this case we define high risk as a Medicare beneficiary being on three or more medications of which at least one is from the three high risk medication classes. This is just risk. How does this impact care? The next slide demonstrates that the answer to that question is considerable. This slide looks at all cause admissions and readmissions for both the overall Medicaid -- Medicare population and those are the bars on the left side of each graph versus those falling into the high risk medication categories. High risk medication consumers are 1.5 to 4 times more likely to have a hospital admission or readmission compared to the overall Medicare population. These numbers demonstrate how much this population is at risk and contributes to our overall admission and readmission rates. Finally, let's take this one step further looking at this analysis that tries to identify adverse drug events that result in a hospital admission. With this analysis it looks that diagnosis codes likely associated with the symptoms or outcomes of an adverse drug event. So for anticoagulant it's looking for codes related to a bleed for diabetic agents hypoglycemia and opioids we're looking at [Indiscernible] depression, falls and things like that. As you can see there are variations in the amount of adverse drug events per 1000 high risk medication consumers. While the rates of adverse drug events from the diabetic agents and opioids is much lower all when we go back and compare the Great Plains network states with the national averages and where we are ranked with the other states in the country, we struggle a lot with the opioid adverse drug events compared to our peers. We have a higher rate in that medication group. What are we doing about this? Our aim is to improve medication safety to reduce adverse drug events by implementing practices that a line with the national action plan for adverse drug event prevention. Our goal is to see a reduction in incidents drug events by 35% by March 2018 and we are also looking to see a reduction in those all cause admissions and readmissions for those high-risk medications consumers. How are we going to accomplish this? Much of our approach to this is similar to what Paula has described during the care coordination part where our approach is to engage community petitioners and work on multi-diced -- disciplinary solutions to improve medication safety practices across organizations and communities. To get back to Paula's questions when she introduce this topic, here are some medication safety interventions currently occurring in communities throughout the Great Plains Quinn. Many efforts involve medication reconciliation of which we will look at briefly a little bit later. Other examples include including medication adherence through medication adherence programs such as that synchronization, medication packaging, looking at chronic disease management, engaging consumers and families in practices and working with our provider partners to implement improved communication technique such as teach back. Screening for adverse drug events, working with providers to make sure we are looking to identify adverse drug events, utilizing both our health information technology and also in our approach to communicating with our patients. We also have had our environmental scans and finally looking at implementing nationally recognized best practices and medication guidelines for both the high risk classes including the recent CDC guidelines for pain management. We refer to the care coronation medication safety environmental scans earlier in this talk and as we introduce each of these subject areas some valuable insight was identified from the scans. The first scan that we completed with the adverse drug event medicine -- medication environmental scan last year. The result of this scan has helped us to understand current practices involving adverse drug events screening. We had broad responses from practice settings to our scan and found that a majority track adverse drug event with varying use of standardized screening tools. A lot of the drug events that were tracked looking at the results from our scan were focused more on medication errors than an adverse reaction but still some very enlightening data was shared in that environmental scan. Then we also had our care coordination scan which was provided earlier this year and we collected your responses earlier this year. I'm not going to go through all of these but there were great examples of success challenges and lessons learned related to medication safety that we will look forward to addressing in the medication safety webinar and our coal -- coaching calls. The result of these are mental scans are also available on the Great Plains quality innovation network website he could feel free to further review the results there. Finally I want to highlight the work that has been going on within our communities around medication reconciliation. On the environmental scan med rec was a big area focus in many communities with many different provider settings. I want to take a minute to highlight the work of one community in North Dakota who through their collaboration, transparency and data sharing have made improvements regarding med rec throughout the community. This collaborative consisted of skilled nursing facilities and area hospitals that implemented a series of interventions both communitywide and internally within their facilities to improve med rec that has resulted in some of the improvements seen here. With decreasing trend line on the number of clarifications needed as residents transferred between the nursing homes and the hospitals. Not only does

this show the value of their collaborative work together but it also points out the value of the data collection and a quality improvement efforts. All of this data is data that is collected by the partners of this collaborative and without this collecting and transparency and sharing of data a lot of these interventions and improvements would not have occurred and the outcomes would have been unknown. What can we look forward to the course of the next nine months as we work through this learning and action network specifically related to medication safety. What we can look forward to is the sharing of experiences. We heard that in these environmental scans that you want to hear from your peers and learn some of the best practices and challenges. We will look for coaching opportunities, we also hope to spread some of the successes that you have seen in your communities through others and if you are struggling within your community you can incorporate some of the work that has been done elsewhere. Finally we will look to share the development of tools to screen for adverse drug events. Your active participation in this land is what will make this successful. Thank you for your time and I will do a quick check with Jackie to see if there are any questions. I encourage everyone to use the chat function if you have questions or comments you would like to share.

Jamie, we do not have any questions or comments at this time.

Thank you Jackie. Now I would like to turn it back over to Vanessa who started us off. Vanessa is from the Kansas foundation for medical care and she will be discussing chronic disease morbidities. Vanessa, on our environmental scan one provider made a suggestion that all of us agree with that that was the importance of assessing the patient's families need and preferences. Part of getting the needs and preferences for the family relate to successful management of the chronic disease.

That is a great question. It's one that we will explore today as well as during our coaching calls. For those of you who elect to join the chronic disease portion of our upcoming land series. This month we have our coaching calls and I would advise you to join us if you are interested and explained that issue in greater detail than we have time for today. In order for us to talk about chronic disease management and relate that back to our work and the healthcare field as well as the question that Jamie asked regarding the importance of comprehensive assessing needs and preferences and how that impacts is it's important that we have a definition of what health is. This definition comes from the world health organization and it has been unchanged since 1948. What's great about this example -- this definition is that you will notice if you things. First is the complete absence of outward healthcare. There is evidence that suggests that 60% of what influences our health status and our ability to maintain or improve or sustain has nothing to do with healthcare. 60% of it happens outside of any healthcare setting. That is important because a lot has changed in our world since 1948. The other thing I want to point out about this definition is that the state of complete etc. is really about individuals assessment of their own physical, mental and social well-being. Not necessarily just our doctors or our nurses definition. Again all of these things are important because these distinctions is important because a lot has changed since 1948. The first one is obvious. In the United States we are not getting younger. That is the most important difference between the world of yesterday and the world of today. 150 years ago we did not have airplane or spaceflight or nuclear weapons or the network. All of these things have changed but the number one change is our life span. We used to live to be 35 or 40 years old on average in the United States but now we live to be 80. Think about that for a minute, we now get to lives and many of the reasons we are able to live longer can be attributed to public health, advancement, medical advancement and improvements and other things which is great but again it means we are not getting younger. The first wave of the baby boomers turned 65 in 2011 and this generation spans 1946 to 1964. This includes 72.5 million Americans and an additional 6.3 million immigrants. This is resulting in I'm president at growth in the number of proportion of older adults and two factors. Longer lifespans and baby booming generation will combine to the double relation of Americans age 65 and older during the next 25 years to more than 72 million. By 2030, older adults will account for 20% of the US population. I want to pause for a moment and point out that in 1970 less than 10% of our population was 65 or older. This is important especially in states like Kansas where we are on the leading edge of the United States and aging overall population age because we are rural and many of our counterparts Nebraska, South Dakota, North Dakota are also rural states. This means we need to be thinking about innovative ways that we can address chronic care management. This is important because we are living longer does not necessarily mean that we are any healthier. I want to point out that currently 80% or more of the United States adults and kids do not meet physical activity guidelines. If we use a obesity rates as a placeholder for activity levels here's what a map looks like we compare states with the city rate of 25% or more. In 1970 there were zero states that had adult obesity prevalence rate of 25% or more. In 1990 it was still zero states. When we jumped to 2007 the number of states was 32. If we look at 2015 data, it is now 44 states. That is frightening and it is similar trends for children. We are getting older

and are not as active and what is something that contributes to our obesity in addition to our physical activity rate it is how we eat. A lot has changed in the American household since the leave it to beaver days. We used to cook more and from scratch. Now we eat out or used buying time strategies for cooking were we by partially completed meals. We also increased as an nation our grazing and snacking habits which means we are eating more prepackaged foods. 80% of American diets do not meet USDA healthy eating guidelines. These things are important because at the beginning of the 20th century and the Representative was a leading cause of death. Now it is chronic conditions. In 2012 about half of US adults 117 million had one or more chronic health condition. One in four head to our more chronic conditions. This is staggering when we start to think about how this impacts the elderly. By 2030 By 2036 out of every 10 Americans 65 and older will be managing more than one chronic disease. We are in the healthcare field so what are the biggest culprits of chronic condition development and/or advancement? It is lack of physical activity and poor nutrition. Those are two and the other two are tobacco and alcohol use. I want to pause and think about that for a moment because none of those things are related to healthcare. They are related to that larger concept of health that we talked about further. If you elect to join the coaching calls to discuss chronic care management some of the things that we are going to explore is ways we can improve not only our care to vote -- delivery strategies to address chronic care management but also our community strategies where we are thinking outside the traditional healthcare box and looking at ways we can engage our communities, healthcare -- consumers as well as their families and caregivers in support that help them outside the healthcare setting. That is important because 60% of what influences our house has more to do how we spend our time outside of the doctor's office. Our job in the chronic care management group is going to be to support your individual and personal community journeys related to the plan study act that you will be creating around improving chronic care management. We are going to be working to develop frameworks so you can make and sustain these games after the course of our nine month land event -- LAN event. To return to Jamie's question that he asked earlier, how is accessing the needs and preferences of patients and families relate to successful management of the chronic disease? If we can figure out ways to engage health consumers as well as their families to understand how they live then we can develop interventions that help these individuals achieve success in managing the chronic condition and not just a medication that may be associated with the chronic condition but dietary changes. Lifestyle changes to help them be successful so that weight when they come to see us perhaps they are coming to talk to us about something successful that is going on in their life. With that, I want to do a check in with Jackie and see if we have anything in the chat that we need to talk about at the moment.

We do not Vanessa.

Okay. Where we will do now is we are going to move on and I'm going to introduce Linda. Linda when responding to our environmental scan made a comment that care coordination takes a village. You've got a special guest with you today and we would like to hear from you all about how his work is exemplifying that philosophy.

Thank you Vanessa. Good afternoon. Could you pull up the website that we will be working with. It's my privilege to introduce Tony with right at home. He has been an engaged member of [Indiscernible] coalition for the last five years in Sioux Falls South Dakota. As many of you are aware the goal of the community coalition is to work together to identify interventions that will bring synergy to our goals in reducing hospital readmission, admission and adverse drug events. Tony saw a need in the Sioux Falls area for additional source to beneficiaries and family engagement and step up to the plate. Tony is involved other members of the coalition and brought a unique opportunity to the community. Here is Tony to explain.

Thank you Linda. Just a little bit of background of who I am and what I'm doing. I own an in-home care business in Sioux Falls and because of that we get phone calls on a daily basis of someone calling and saying, mom has fallen or mom has gotten out of the hospital or I don't know if there's a nursing home available. Questions post up every day. Because we are not involved in that part of their life, I had to try and find some way to answer the question for them. What evolved from that was this eldercare channel that you see in front of you. There are 13 different categories within this site. I will run through them quickly. There's adult day care and home care, home health care, medical equipment, independent living, assisted living, nursing homes, elder care, hospice, how to pay for care, other care physicians within this area and eldercare consultants and the community services at the bottom. The driving force of why I created this was try to help an answer those calls that I was getting and provide a resource for those people to go to and find information that they seek. My goal is to create a one-stop shop with all of the area resources that involve anything elderly. Vanessa can you drill into the community services page and maybe again on the Better Business Bureau at the

top. Under each of these categories there are subcategories. As of right now we have 88 people that are involved in this site that has some sort of content out there to try to help answer questions. My goal is that each one of these people to create a short video with them between three and eight minutes each to let them explain in their own words what it is that they can do for the elderly population. In this example, you see Jesse Smit from the Better Business Bureau and she and I talked about how small businesses and large businesses are involved in the elderly and then she dials down into fraud. The BBV gets a lot of questions about fried especially in the summer time for people living alone whether it be tele-marketers or someone stopping by their home. The pretense of this is that Jesse gets to say this in her own words and it gives her a warmer introduction to the population that is viewing this versus going to her website. There are other things that go along with this, on that I do not charge anything for anyone to be a part of this site. There are no contracts. It's all about free visibility and getting information in the public eye. Below are video you can see some scripting that Jesse has provided about the best -- Better Business Bureau and how it effects the elderly and at the top of the screen there is also some links to her social media -- you'll see her Facebook and twitter and LinkedIn. The other one you see is www.that is a link to the Better Business Bureau website here in Sioux Falls. By creating those links we are improving this website search engine optimization both on this website as well as the people that are creating -- having involvement in this website as it directs traffic back to their own site and Google smiles upon that because they know we are active in this community and in the health Cal -- healthcare realm as well as finding them up on a Google page. I don't know if I have a whole lot other than to answer the question that was posed that it takes a village. It truly does. You can see going through this website all the people that are involved in that. If you think about any of your loved ones in the healthcare field and the elderly that I am focused on, it takes their doctors, their nurses, social workers and it takes their children that should be involved in their care and trying to figure out what the need and what their questions are. I'm hoping by producing this that it's a small step in trying to put this information at their fingertips so they can be better informed about what their choices are in and around the Sioux Falls area. With that I will check in with Jackie and see if there are any questions of any kind.

There is not any questions.

Then I will turn it back over Vanessa. If anyone has questions and has not reached out on this form, please feel free to give me a call or email me. I would be happy to visit about any of this.

Back to you Vanessa.

Thank you Linda and Tony. It's great that you are able to share your experience not only with us but also with those listening on the phone. Before we move on to questions and answers, I would like to remind everyone that there is a lot of ways that you can lead in action today. You can sign up for the learning and action network which includes a great deal more than the topics that we are talking about today because our quality innovation network works across a broad range of topics from the hospital setting to others and you can sign up for notifications about all of the learning and action network events that take place across the Great Plains quality innovation network at the website you see there. We would also invite you to view the website resources around care coordination and medication safety that are part of the Great Plains quality innovation network especially as you are thinking about how it is that you as a community and your community can be internal to your organization or it can be a more broad-based multi-stakeholder and multidisciplinary group that includes other external to your organization from around your community. View those resources and begin to think about what journey it is that you would like to undertake over the course of the next nine months as part of this event experience. At this point before we talk about our next event which is coming up on November 22 and we want contact information for each of the states I would like to invite our operator to commute our lines and remind that you can unlike your line by using start to -- start to on your phone and have any questions about the LAN experience in general or talk about what it is you are looking forward to.

All lines are now live.

Thank you.

Jackie, while we are waiting for someone to muster up the courage to ask something live on the phone, I noticed in the chat there was a question about when or if the slides and recording will be available. The answer for everyone yes it

will be available on our website. We will send an email out to all participants with the link to that information as soon as the information is posted on the website.

It sounds like we do not have -- go ahead.

If we are focused at our facility on improving our quality measures, are there things on the Great Plains site -- we're focusing on are moderate to severe pain, are there things available that can help me with that?

And waiting to see if anyone from the panelists want to speak up.

What setting are you an?

We are a skilled rehab facility with long-term care residence. We get our quality indicators and [Indiscernible] and there are certain things we flag on. [Indiscerbible - background noise] we have to make improvements just as other people the way they are doing it I hate to write plans of action if there's something out there already.

We have resources in a few different areas that can help with that. Our medication safety page will have some pain management resources and also our improving quality in nursing homecare page also has resources on paying [Indiscernible] as well as your process.

Thank you.

This is Tammy and I was going to let you know there's a quality measure video series that is excellent on the website. If you go to the nursing home page you can find it there.

Falls is always something where working on. That's where I would need a valid source to go to. Thank you.

You are welcome.

Paula, I was going to ask if you could talk more about the tour -- [Indiscernible] and where folks are interested learning more maybe able to find that information or links on our webpage.

If you go to our website the care coordination website there is a link to the intractable. I'm going to give you the link where you can go to to find the interact tools. It is interact2.net and I will take you to the Internet site and when you go there you will find there are tools for not only nursing homes but also for assisted living and a home health. As I said you can go to our website and the care ordination page and that will give you a link to the interact tools.

Thank you Paula. For those of you that are interested in learning more about interact and how you may be able to utilize interact not only within your facility or settings but across your community, I would invite you to consider joining the rehospitalization portion for the coaching calls that way you can explore and here from communities and other providers that are using that tool and learn more about their experience. Same thing for the individual that was talking about medication issues. I'm sorry I did not catch your name. You may want to explore that [Indiscernible] portion of our LAN topic specific coaching calls. You can also look at because it sounded like there may be some communication issues going on, you can join anyone of the coaching calls that would be of interest to you to discover how it is that you can drive change within your community. Are there any other questions that are out there? All right, to be respectful of everyone's time because everyone likes to leave early and no one likes to stay late, what we will do now is going to pull back up our slide and I'm going to encourage you to take a quick look and reach out to the individual in your state if you want to learn more about this specific event series. If you want to engage in conversations about construction of your community and looking at what your [Indiscernible] cycle may look like over the course of next nine months related to your community and your specific issues that you are looking to drive forward, please feel free to reach out to anyone of us. You can reach out to the person who is specific to me if you are in Kansas or Sally, we are part of the same team and we are excited to learn from you about what is working in your community and how it is that you are making change. We will be coming back together again on November 22. We will meet from 12 to one central time and we will be in a big group to kick off this idea of care coordination and learn

more about how care coordination can drive meaningful and sustainable change. One of the things that we heard from you loud and clear is you want to hear from communities who have experience in these particular areas so we will invite a great claims quality innovation network community that we are working with to share their experience around the particular idea of care coordination as it relates to hospitalization. With all of that in mind, I would like to say thank you all very much for joining us today. Again we would invite you to go and visit the Great Plains website to learn more about how you can be involved and explore specific tools, find additional contact information and at this point if there are no other questions, I'm going to open up a poll and I would encourage you to take a moment before you leave to answer the questions because your feedback helps us to better. Thank you everyone for being with us today and thank you to Tony and Sally who was not able to talk and Jamie and Jackie and Paula and Linda and all of you for being generous with your time. We look forward to seeing you on November 22.

[Event Concluded]