WEBVTT

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Thank you for joining today's program will begin shortly.

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Hello, welcome to today's webinar. My name is Mario and I'll be in the background answering any technical questions. They experienced difficulties during this session, please type your question into the q amp a section, and a producer will respond will

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be holding the q amp a session during today's webinar, we encourage you to submit written questions at any time is the q amp a panel located at the bottom of the zoom webinar viewer, please type your questions in the text field and click Send.

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Should you wish to be closed captioning during this program, please click cc at the bottom of your zoom window to enable or hide subtitles.

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During today's event, all participants remain in listen only mode, without light to get started we hope you enjoy today's presentation.

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And now like to introduce your first speaker for today. My Louis IDD and TPI section chief division of mental health developmental disabilities and substance abuse services by the floor.

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Thank you my.

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Again, welcome to today's presentation the talent care management, 105 webinar where we will be focusing on the delivery of tailor care management. Next slide.

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Okay, this is our fifth webinar, and I'm series, and this session, like I mentioned will focus on the delivery of tailored care management.

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This schedule training will be recorded and will be posted on our website, so no worries there. The you'll see that our previous sessions are also we're also recorded and you will be able to find those webinars also on our website, which will be shown

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on the next slide.

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Okay.

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Alright, so time permitting, we will have a q amp a session at the end of our, our presentation, and like Mario said please do not hold your questions to the end, we do have the feature where you can ask your questions and type those in in the question

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box that is typically located in that lower right hand corner of your screen so please use that.

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If for some reason after we part of part ways this afternoon, you think of questions. No worries, you will be able to submit questions to us using the email that is posted on the slide the Medicaid, that Taylor Karen man Schmidt at DHHS that nc.gov web

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web address. And also, as I mentioned, just a slide ago that today's training webinar will be recorded and you will be able to find that on our managed care.

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I Taylor care management web web page, along with this recording and our previous recorded sessions.

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Alright, so today your presenters are myself, my Lewis, I am the audience.

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Section Chief with the division of mental health developmental disabilities and substance abuse services. You'll also hear from Gwen sharar, who's the Senior Program Manager for special programs with NC Medicaid, and Dr.

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Keith McCoy, our Deputy Chief Medical Officer for behavior health and add Community Systems.

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All right. Next slide. So today's agenda is as follows. We'll do a quick recap of tailored care management, the model will talk about the delivery of care management care team requirements, and then again have opportunity for question and answer.

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Right.

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So, next slide.

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So quick recap of what is tailored care management, of course.

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I'll tell all tailored plan members are eligible to receive tailored care management and, including those individuals who are enrolled in the 1915 see innovation event TBI waivers individuals who are in the groups that are delayed or excluded from managed

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care at this time, who would otherwise be eligible for the tailored plan will also be able to have access to tailor care management.

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All right. And then, Taylor clan members will be assigned to a care management entity, using three approaches. We have the.

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The tailored care management entity or prep or Care Management Agency, the CMA advanced medical home, plus or H plus and then there's also the plan based care management.

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The department has noted that we do believe that the care, care management should be provider base and that's what we would like to see to them within the AMH pushes or the CMS to that maximum maximum extent possible.

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So, I'm just want to share that and remind you that. And then of course, under the Taylor care management.

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Members will have one care manager who will be equipped to manage all things and then that they need, including that physical health behavior health, add pharmacy, long term support cetera so that's begin that overview of the model, and that care management,

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that whole person care approach that we have been talking about over the last few sessions.

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All right. Next slide.

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Right. And on this slide again this is just the review of the tailored care management process. So this slide is here to remind us that there's an enrollment process, part of the process assignment engagement and in today's portion of the process that

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we will be talking about is related to the actual delivery of the Taylor care management process. So with that said, I would like to turn it over to Dr.

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McCoy to kick us out with the details around the delivery of this of the service.

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Thank you, Maya.

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Right, can go on to the next slide.

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I think these are Gwen's, we're going to we're going to have him do this next one and then I'll follow up.

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Yeah, these are these are my slides.

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So, the be 10 care management process, sort of starts with the Comprehensive Assessment and the care management comprehensive assessment is a person centered assessment of a member's healthcare needs functional and functional accessibility need strength

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support goals and other characteristics that will inform the care plan, or, or individual support plan ISP.

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And, ultimately their treatment.

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A Comprehensive assessment must be completed for all assigned members.

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The care management comprehensive assessment.

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Any for any organizations that are providing Taylor care management, they must begin to comprehensive assessment within 30 days of tailored plan enrollment.

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They must complete the Comprehensive Assessment within the following timeframe for members identified as high acuity within 60 days of chain of plan of enrollment from members identified as medium to low acuity within 90 days of tailored plan enrollment.

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And for organizations, providing Taylor cared management, they must implement tools and the tools and methodologies, developed by the tailor plans to conduct the care management comprehensive assessment.

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And so we know that in the beginning and and undoubtedly ongoing, there's going to be, you're going to have some members that you're going to have hot, a hard time getting ahold of or or getting up with, or you may make contact with them.

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Initially, it may not be able to get a hold of him, you know, again, you know so member engagement is is going to be, in some cases, different that difficult.

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So organizations provider, providing tailored care management let's make this efforts to complete the care management comprehensive assessment in person in a location that meets the members needs in limited circumstances, a care management assessment

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may be completed by a technology conferencing tools, ie audio video or web.

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The results of the care manager comprehensive assessment must be shared with the appropriate providers, or, or entities.

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Primary Care behavioral health providers to inform

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here and for treatment planning with the members consent.

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So let's look at the, what the share management comprehensive assessment lists include.

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They must include an assessment of a minimum set of domains immediate care needs current service providers across all need available informal caregiver or social support functional needs accessibility needs drinks and gold physical health conditions including

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dental physical, intellectual or development developmental disability.

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Developmental Disabilities.

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Organizations providing Taylor care management must complete reassessment at least annually. and when members circumstances change, and needs change, including after triggering event.

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had, you know, significant life events. All those things would may cause a nice need to reassess.

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The care plans and individual support plans or ISP are informed by the results of the care manager comprehensive assessment and other data.

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Organizations providing Taylor care measures must develop an initial care plan for each member with behavioral health needs. And or an ISP for each member with an ID or TBI need the care plan, or ISP requirements, they must include a minimum set of domains,

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including the names and contact information of key providers. Those people who are on the care team, family members and others chosen by the member to be involved in the planning and service delivery.

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They must include measurable goals and strategies to improve self management and planning skills strategies to increase in social interaction employment and community integration, social education and other services needed by the number for the care plans

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and ISP must be individualized person centered and develop.

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Using a collaborative approach, including the member and family participation.

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So I just want to recap that the the care plans are to be developed with all those key members, including the provider and their family. Next slide please.

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care plans an individual support plan must be documented and stored and made available to the member and the appropriate representative, including the tier, the care team members, the care plan is p requirements must incorporate data, including the results

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of the care manager comprehensive assessment claims analysis and restoring any available medical records screening and our level of peer

to don't termination tools such as the locus or catalog is similar to the requirements for the care manager comprehensive

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assessment organizations providing Taylor care management, let's update their care plans, and I FPS at least annually. And when the members circumstances change, including after triggering events, such as inpatient hospitalization.

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So, I will now turn it over to Dr McCoy's to talk a little bit more about ongoing care management, and care coordination.

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I think when. So, when is gone through some of the real core work that has to be done through tailored care management and ensuring that there are really good comprehensive assessments that are done in the context of a care team, and a whole person.

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Person Centered way. And that, that, that care plan is used to drive many of the next steps that are included in ongoing care management, including care coordination.

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So through organized care coordination and members needs and preferences are known, and communicated to the right people at the right time, assuring appropriate and effective care.

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So this is in part translating the items that are in that care plan and making sure that those items those goals, the sub parts to each of those goals get done in a timely appropriate manner consistent with that plan.

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So, care coordination requirements include ensuring that the member has an ongoing source of care that coordination occurs across different settings of care.

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So you think about a primary care physician, a behavioral health provider, a physical therapist.

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So that care needs to be coordinated in a coherent way coordination of services, such as helping with appointments, and wellness reminders, social services appointments coordinations and referrals and following up on referrals and working with the members

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providers to help coordinate resources during any crisis event, assistant scheduling and preparing members for appointments.

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That includes helping to arrange transportation which may include non emergency medical transportation, and then providing referral information and assistance in obtaining and maintaining community.

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That's just cut off for us.

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So I don't know what it says below that, but we will go to the next slide.

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All right so organizations providing tailored care management will be responsible for LinkedIn members to services that help address unmet health related resource needs, including providing referral information and assistance, that is inclusive of filling

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out applications for services listed below needed.

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So when you think about community based and social support services you think about disability benefits nutrition food income housing, transportation, employment, education, financial literacy of assistance, linkages with child welfare services but those

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are involved, after school programs Rehabilitative Services domestic violence services legal services services for the Justice involve population so this is really quite extensive.

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When thinking through in a whole person way what someone needs in order to be able to be well have the connections and resources that they need to not just survive but thrive in their community setting health related services may include Food and Nutrition

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Services TANF resources, childcare subsidies, low income energy assistance, able now accounts WIC program. And then also additional resources related to maybe specialty services that are associated with some of the some of which may be Medicaid, some

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of which may not be Medicaid like state funded services around supported employment, vocational rehab. Other things that support community inclusion, like volunteer opportunities, and other types of activities that promote community inclusion.

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So, in addition to care coordination health promotion is an important aspect of ongoing care management. So organizations providing tailored career management will engage members with or at risk for chronic conditions or other emerging health problems

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through providing health promotion activities. So the definition of health promotion is the education engagement with members to promote good health. Proactive management of chronic conditions, early identification of risk factors and ensuring appropriate

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screening occurs for emerging or high risk health problems. So some of these services interventions may include providing education on a members chronic condition, that helps them manage it more effectively.

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Teaching self management skills and sharing self help recovery resources, providing education on common environmental risk factors such as exposure to second and third hand tobacco smoke, conducting medication reviews, and regimen compliance and promoting

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wellness and prevention programs and we'll talk a little bit more about medication reviews in a moment. Next slide.

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In addition to the supports that we've already mentioned, there are additional assistance that can take into account and individual or entire family support needs so edgy thinking about someone not just as an individual, but in their context where caregivers,

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or other significant important individuals in members life may need some help with education and self management and self advocacy and wellness connection to prevention programs, connecting the member caregivers and family members to education or other

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training activities that will help them to function develop social and adaptive skills and navigate the service system also related to services that will help support and maintain employment success in school, or other forms of community integration,

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not providing information to the member and family members around the supports that we outlined in the previous slide, as well as other paid supports like peer support services respite services, helping them understand their rights protections and responsibilities,

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assisting them with file grievances, or complaints and seeing that through to resolution, helping them with advanced directives which can

include psychiatric advanced directives and helping them understand a guardianship alternatives and options.

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In addition for high risk pregnant women.

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It's important to inquire about broader family needs and offering guidance on family planning and helping to make sure that there's a safe plan of care for the pregnancy period that as well as the postpartum period.

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ongoing care management is something that doesn't really have a time limitation.

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It is something that needs to be available 24 hours a day seven days a week, should something significant happened like a physical health, or behavioral health emergency.

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So organizations providing tailored campaign management must be able to 24 seven share information about care plans about psychiatric Advanced Directives coordinate care to help the member find the appropriate setting during urgent and emerging events.

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In addition to that, similar to what we were just discussing about thinking about the family system as a whole, for behavioral health needs tailored care management resources must be consistent with system of care principles, such that they promote family

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driven, and you've guided service delivery and have a knowledge of the child welfare, the school and juvenile justice systems. Next slide.

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I'm going care management includes continuous monitoring. So once you've got your plan once you've done education once you've connected people to resources, it's important to see one or those resources, achieving the goals that you're hoping they would

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have the connection actually been made, as the service been delivered in the way that it was supposed to, so that there can be a feedback loop, to see if care plans needs to be updated.

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Or if additional coordination of care needs to occur. So organizations providing tailored can manage continuous monitoring of progress of the

goals identified in the care plan and the ISP through face to face and collateral contacts and routine care team

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and this includes supporting and members, adherence to prescribe treatment regimens, and wellness activities. medication monitoring is also important and that includes regular medication reconciliation conducted by an appropriate care team member, so

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not everybody is skilled or trained to do that sort of work and support of medication adherence. So this is a role that may be assumed for example by community pharmacists through a CIA in

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an addition, making sure that routine assessments and screenings and exams are done and tracked by the Members healthcare team. So that includes making sure that annual physical exam or well child visits the next slide.

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So, there are various different acuity levels that we have outlines high, moderate and low and we have assigned associated contacts, based on that acuity tear tailored care management entities must meet the minimum contact requirements for members according

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to their acuity tier. And we as the department will be sending information about the members acuity tier two tailored plans, which will share that information with CIOs and and its pluses contacts that are not required to be in person maybe telephonic

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through to a real time video and audio conferencing, or telehealth. So for example, a member with high behavioral health needs. We've set the target at for medical care manager to member contacts per month with at least one person, one on one in person

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during the month where that number has high acuity needs. And similarly for IDD or TBI for high. It has been set of three contacts per month, including two in person contacts, and one telephonic contact, and you can see what the other contact requirements

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are for members duly diagnosed with behavioral health condition and IDD or TBI. The tailored career management organization shall determine whether the contact requirements for behavioral health or add conditions apply based on what is clinically most

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important at that time.

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and Transitional Care Management is a really important part of tailored care management and I've helped them care management in general, when individuals are transitioning from one clinical setting to another such as an inpatient unit to a skilled nursing

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facility or two from the community into a residential type center or from, from a crisis setting into a non price of setting.

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That's a particularly important time for coordination of care for reassessing and updating the care plan or ISP. And for ensuring that the care team is fully aware of the transitional needs, and that the plan is being followed.

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And we will have a lot more to say about Transitional Care Management in a future webinar. next Friday November 5.

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All right, I'm handing this back to when.

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Thank you.

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So we want to now talk about care team requirements. Next slide please.

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organizations providing Taylor care management must establish a multidisciplinary care team for each member, the care team should include the member, the members care manager, and the following individuals, depending on the members need.

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So we just want to focus on the fact that all of these that I'm about to talk about are not required, but they are, they would be required if the member needs that person on their team.

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So you would have your supervising care manager, their primary care provider.

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Any behavioral health providers it to your TV I providers is applicable.

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Other specialist, nutritionist, pharmacists pharmacy ticks obstetrician gynecologist for pregnant women in Region transitional stat and transitions as, as applicable here manager estate extenders.

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next slide, other providers and individuals as, as determined by the care manager and a member,

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The aim is pause or CMA does not need to have all of the care team members on staff or embedded, but would need to have them, or they would need to have them as part of the care team.

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Various providers of various specialties may participate in care teams virtually from other settings.

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So I just want to talk up a little bit about some forthcoming guidance on the use of what we call care management extenders and Taylor care management, we've been getting a lot of questions from providers and other stakeholders about how community navigator

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peer support specialist and community health workers fit into the Taylor care management model.

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department recognizes that these experiences, individuals will play an important important role in Taylor care management care teams, and that they currently provide an important role

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for our members, and we are in the process, process of developing guidance to provide clarification on their roles.

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The department is committed to building a robust Taylor care management workforce that is live by care managers, and that would include care manager expanders as we call them, which would be the community navigators the Peer Support Specialist, and the

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community health workers, the forthcoming guidance will address the functions that these extenders can perform within the model.

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How extenders can help fulfill the number contact requirement.

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The training and supervision requirements for these extenders, and the qualifications needed to serve as an extender to inform this guidance the department will seek input from our tablet, our newly formed Taylor career management Technical Advisory Group.

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The department is also considering the extent to which care management extend or policies as well as other feedback. We have received will affect the Taylor care management right.

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So we're still working with our actuaries to determine if, use of, or how or to the extent that extenders would impact, right.

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Click clinical consultants we've also gotten a lot of questions about the use of about the requirement for clinical consultants.

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Organizations providing Taylor care management should develop relationships with clinical consultants to provide subject matter expert to the care team, so they could be a psychiatry psychiatry just depending on the population served a neuro psychologist

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or psychologist for CMA as a primary care physician appropriate for the population being served. To the extent that that the members PCP is not available for consultation.

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In order to meet the requirements AMH plus and CMA may employee or contract with consultants or do go through a CI no other partner.

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Clinical consultants should be available by phone to your staff within the AMH plus is our CMA to advise on complex issues on an ad hoc basis.

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And so we've gotten some, some questions about,

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about how to pay for these clinical consultants, and we want to share that the cost associated with clinical consultants are included in the Taylor care management rate.

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So, This is the end of our formal session.

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So now we're going to go through some questions and answers.

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And so we have Mandy lips lips them, who is one of our consultants who works closely with us and helps us with our has helped us tremendously with our tailor camp management design and implementation.

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So we're going to try to go through some, some questions.

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Thanks Gwen.

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Okay, I'm going to start with the following question for cheat.

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Will the care management comprehensive assessment, be in addition to the regular comprehensive clinical assessment or diagnostic assessment or will the care magical comprehensive assessment replace the CCA or da entirely to the CCNDA are different types

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of assessments than a care management assessment care management assessment is specific to needs that require care management, they would take into account items that are outlined in a CCA or diagnostic assessment, but the CCA and diagnostic assessment,

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our clinical assessments done by clinicians licensed clinicians, whereas the care management assessment is done by a care manager does not have to be a licensed clinician, and it doesn't include things like I'm diagnosing someone with this specific diagnosis

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and recommending this specific clinical or medical treatment that's more appropriate for a CCA or a diagnostic assessment. So the care management assessment is different from, but should take into account information provided to the CCA or a diagnostic

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assessment.

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Hey thanks Keith.

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Alright, the next question. And I think that it's for Glenn and other folks to jump in as well.

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Care Management can help prepare members for appointments and meetings like folks that in the presentation. Does this include things like IEP meetings VR employment meetings planning and other types of meetings.

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Yeah, I would say yes because the purpose of the finger care management is to address all their needs. So, if they and.

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And if there is an IP or if there are those types of services needed that they should be part of that care team, and so absolutely Taylor care management would help address those, those appointments or those situations.

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Hey thanks Graham.

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OK, the next question.

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I think is for Maya. Can you speak briefly on the distinction between the role and tasks of a care manager versus care coordinator within the tailored plan.

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So as we transition to the tailor plan, the care relevant care coordinator will not exist anymore we will actually have the table would have care management.

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And what happens with care management, it is a whole person approach so that care manager will be responsible for supporting not only with the behavior health means but also those physical health needs and supporting individuals being connected in both

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of those areas which is not something that the current care coordinator role does it's just focused on behavioral health.

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I've got enough folks in and out of my home. I'm just not really interested in this as a service. And when that is the case, the tailored plan is responsible for care coordination for all of their members.

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For those who are actively receiving tailored care management that care coordination work will be done by the tailored care manager and that care team as appropriate.

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But for those who don't engage in tailored care management, the basic care coordination functions that are required by all health plans in Medicaid, those will fall back to the tailor

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it Thanks Dr McClay.

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Okay, so the next question that we have here is around.

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If somebody is not able to reach the members of the care manager is not able to reach the member. How many times do we need to try and make contact with a member before they can be discharged.

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Dr MacLeod Would you be willing to take that one as well.

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Sure, so the RFA the tenant plan RFA does define and probably the provider manual as well, what best effort is, and that is at least three documented strategic follow up attendance, such as going to the members home, working with a known provider to meet

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the member and an appointment to contact number. If the first attempt is unsuccessful since that first attempt, and then three strategic follow up attempts are required.

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Thank you.

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Next question is also for you.

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Well care management agencies still be able to provide services like CST peer support and ih along with the carrot with care management or will tell her management replace these services. These services are part of our state plan and will continue to be part of our state.

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And we understand that there are some care management care coordination functions that happen in some of these more team based services, or services like like peer support it's, it's, it's important to know who's on first and to ensure that duplication

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is not occurring. So, if the intensive in home team is billing for the same functions as the care manager is managing, then that would be problematic.

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So you wouldn't want to say hey I spent, you know, two hours doing coordination of care work as the intensive in home provider, knowing that the care manager is doing that it's that exact same work that would not be appropriate so you got to make sure

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that the roles are well defined that you know who is doing what, and that there is not duplication of services, or duplication of functions, ultimately it is the Taylor plans responsibility to ensure that duplication is not occurring.

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And so that may be something that occurs when they are reviewing authorizations for services or other things, making sure that they're clear plans in there for appropriate division of services and non duplication.

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Thank you.

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We've gotten a few additional questions about whether people are able to opt out of Taylor career management, what happens I think that this was covered a little bit but it seems like it's worth reinforcing since there's been a number of new questions

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on that.

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Yeah, so tailored career management would have to be an opt out process, as opposed to an opt in. So if someone will be assigned, they can always raise their hand and say I don't want that.

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But people always have the opportunity to decline, a service and again if someone says no so say you engage them appropriately, you try to, you know, set up appointment that they're pretty consistent or their guardian is pretty consistent and saying this

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this is not something we're interested in, then that would be someone who's care coordination functions would fall back to the tailored plan outside of the Terry Taylor care management model, just under the routine universal requirements for care coordination

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that's required of all

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right.

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I think this is a good one for either Gwen or Maya, and the question is Will a care manager extender be able to provide or be able to be employed by the same agency as a teller care management provider.

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where they will be able to be employed by the same agency we're looking at the extender as as as an extension of the care manager.

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And we're looking at the extenders or how the extenders can provide some of those functions that be, that are required of the care manager, that would do two things.

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Help the care manager be able to

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provide services to a larger number of members.

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And also, you know, we've had a lot of questions about staffing.

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So, if you are using extenders, you may not need quite as many care managers, if some of the functions are going to be farmed out to the vendor so we're working on all of that guidance and that will be forthcoming.

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Dr McCord, do you have any other comments.

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Yeah, I think, I think this is a design decision that we are working through I don't think that there's any final decisions made on how this will work or exactly, you might be eligible for that but we certainly have gotten consistent feedback that extenders

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would be helpful to the process, it would be very helpful from a workforce standpoint, and ensuring that we get the maximum amount that we can out of this model for those who are in the tailor plans.

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So we appreciate that feedback but we are still in the design process for that and can't answer a lot of specific questions yet.

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So here's a question for Dr. McCoy, what are the primary functions of the supervising care manager.

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So supervisor overseas I think no more than eight care managers, as.

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Currently, and essentially they, they are a quality control aspects of making sure that care plans are really thorough, making sure that care teams are happening in appropriate ways, making sure that the care managers are given the resources and training

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that they need they're able to staff cases with folks, making sure they're able to get access to consultants, looking strategically at the case load helping to stratify and prioritize and inventions, making sure that after hours research resources are

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appropriate.

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So, so they really would be kind of glue in the background for the care managers to make sure that when a care manager for example may just not have expertise in an area where someone has a need outlined in a care plan, making sure that those connections

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happen for that care manager.

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So I think also the supervising care manager will have a row for coverage when care managers are out on.

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Thanks Dr clay. And I think the next question is also for you. The question is how many members would a Taylor care manager have on their caseload.

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We we're not setting caseload specific requirements.

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I think that depends on what the mix is from acuity steer team acuity tier standpoint, we do make some assumptions in developing our rates wet case loads might look like.

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But we are not setting strict requirements in this model.

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Thank you.

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We've gone through a lot of the questions. And there's one about how the department is going to be determining acuity care acuity tears. Dr MacLeod maybe you could also provide a little bit of information there.

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So, we have a draft model that we've worked on internally, it's based on a mix of static and dynamic factors that would have to do with my diagnosis and service utilization history, whether or not they're a child versus an adults may may affect how the

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points are done whether or not they're on the behavioral health or the IDD or co occurring, those things will factor into that but that is not a model at this point that is ready to be shared externally.

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And there's a follow up at the care manager of a mix acuity tears on their case loads.

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Yes, that's the intention of the model.

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And I know that somebody asked about the key assumptions that we're using the right setting processes, there's the guidance document that the status release that we can put into the chat to answer that question.

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I think one more.

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There's a question about whether the care manager is going to be responsible for making finding kongregate care residential placements.

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dR McGuire Maya maybe you could speak to that.

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So finding appropriate placement is within the scope of a care manager. That said, there may need to be significant collaboration with the tailor plan network department, those sorts of things so we would expect the tailored plan, especially where there

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are network adequacy or funding issues. For example, some of the residential settings are funded through state funds which are not entitlements. So navigating that may require pretty, pretty close collaboration with the tailored plan.

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So my here's a question for you, how will individuals receiving the innovations waiver factor into Taylor, or management, or will it be designated through the through the Taylor plan.

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So members who are on the innovation waiver the TBI waiver will be still assigned a tailored care manager, and though in the RFA, it does say that individuals who have a current care coordinator who meets the qualifications to be a care manager, that

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there would be those efforts to make sure that those individuals because they connect it with it.

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With that care manager, but they will receive Taylor care management, just like other members of Instamatic, who are in the tailor plan, and still be with have that care manager support with those additional needs or responsibilities that come with being

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a waiter or waitress service recipients so that bed HTTPS monitoring and things like that so that will still take place.

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It didn't require Am I missing anything I think that that interested that question. That's right and it would be up to the, to the member whether or not they wanted to stay with that individual so I really enjoy my relationship with my character they

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wouldn't force that on anybody. Right, became a care manager and, you know, fit is always important. Some, some matches just start matches that in great for some people and not for others so certainly want to keep choice at the forefront here.

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And I think what that I'm going to turn it to Maya for the wrap up. All right. Thanks, Mindy and thank you everyone for all of the questions that you shared and thank you for joining us.

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My Connect.

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One thing I do want to remind everyone of our newly created to tailor care management Technical Advisory Group.

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The inaugural meeting is going to be held today at 3pm.

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And so, we would like we were also going to put the link if anyone would like to,

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to attend. I will put the link in the chat.

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Thanks for that reminder going yes our inaugural meeting is today shortly after this.

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So again, thank you for all the questions that everyone shared as a reminder, this webinar is recorded and will be posted on our tailored care management website.

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And if you think of any additional questions. You may also email, the tailor it to your management email address to have those questions adjust.