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Good morning everyone. My electronic devices show me it is 11:00. We're going to get started to save time for interaction at the end of this section. I want to thank you for attending Mountain Pacific first quote reporting learning and action network. We appreciate the value of your time and are excited to try this new format to bring you timely updates and what is happening with the various quality improvement programs and initiatives as well as taking time to hear from you on your successes and lessons learned, barriers and turtles. I'm Sharon Phelps. This event is a joint effort of two departments not Pacific. -- Mountain Pacific. The health County services and the quality improvement organization department. This event is meant to be an overview and will not go into the same depth as we do with our regular webinars. Was quite yet some of the highlights and tell you what's important for you to know now to help you along the way. We'll continue doing hour full-length webinars in the coming months.

This event is being recorded and will be available on our website empty QHS.com within a week or two. The slides are available for download right now and if you click on the file button on the top left corner of your screen then click on save and then click document it should save the entire slide deck. When we get this posted on the website it should have a transcript and a recording as well. All phone lines have been placed on mute until we are ready for the sharing portion of the call. We encourage all of you to put your phones on mute to minimize background noise when we are doing the sharing portion and you are not speaking. For your convenience we have included a list of acronyms at the end of the slide deck to help you with any acronyms that are being used by CMS. It seems like there are new ones all the time and want to make sure everyone understands what we mean when we use a given acronym.

The first item on the agenda is to review the purpose of LAN. Some of you might be familiar with LAN and perhaps have participated in the inspection prevention or nursing home LAN is supported by Mountain Pacific. In general a LAN is a group that comes together to implement change and spread evidence-based practices from peer-to-peer learning and solution sharing to improve care delivery and outcomes. LAN use the concept of all teach all learn. We have two mingles with our LAN. The first is for this LAN to be dynamic and responsive to your needs and what you need. To help you comply with the PQRS and other quality programs and free to share your knowledge wisdom and experience is to help you with your peers. We'll your expert so what you do and often you know things about how to make quality happen in your facilities better than we do. Another main purpose of the LAN is to share with you updates from CMS on all things quality related. We're starting with the position quality reporting system as this is a complex program which will be undergoing dramatic changes as the Medicare act and reauthorization known as MACRA is put in place. For example we received notice yesterday the proposed rule for 2017 has been released and is open for comment until June 27 until June 27, 2016. Unfortunately it came in too late for us to review all 962 pages before today's session. We will be working with summarize the import proposals by hour may session.

Let's talk about the logistics. Everyone has a time schedule so we selected a date and time for the first event. We want to hear from you to get a sense of when might be the best time for most of you to attend the monthly LAN. When this event is over you will be brought to a survey monkey page developed an evaluation. In the evaluation you will find a few questions on the best day of the week and time for a LAN. We appreciate you completing that information and will let you know when the main LAN will be held as soon as possible. We encourage you to give us agenda items if you have an item which you additional information. We have a few potential topics listed in the survey monkey evaluation so we you have the opportunity to prioritize each item to receive attention in May and June and will add the new released proposed rule to that list as well.

We want to encourage you will make it to the sharing section to be shy and share your knowledge and wisdom and experience. You can help solve someone else's issues today.

Before we get into the next slide we want to do some polling questions. First did you report PQRS measures in 2015? And if yes what methods did you use to report? If you used multiple methods for different providers please select all that apply. Jennifer from WebEx thank you for posting those. Was will be up for about 45 seconds. Please hit the submit button and then we will see what the results look like when the time is up. While we wait I'm going to go on to the next slide. This is a review. We want to touch a little bit on payment adjustments. There are two types of payment adjustments. One for the PQRS program which is a negative a -2% if you don't report PQRS at the physician level. Then there is also another payment adjustment for the value-based modifier incentive program. Was that the payment adjustment program to happen two years after the performance year. This provides a you're in the middle for submission and calculation of benchmarks for each measure and for each group electively. Currently in 2016 you are receiving upward neutral or downward payment adjustments on Medicare part B physician fee schedule payments for all eligible professionals who were subjected to PQRS and to build under your tax ID number in 2014. The data used to send in for 2015 will be determined payment adjustments in 2017. And the data used in -- use of it for 2016 will affect your payments in 2018. 2018 payment here is the last year under the current PQRS incentive program. CMS is proposing the 2017 will be the performance year for payment adjustments in the merit-based incentive payment system also known as minutes. Let's -- Mets came to us from the -- I did a quick review of the proposed rule yesterday and they have included language that states 2017 will be the first performance year.

Let's look at the poll results. It looks like of the people that responded 10 of 11 did report PQRS and one did not. We had quite a range of reporting methods. Five people reported group and nine people did individual reporting. No one did a qualified data registry nor did they do claims. Thank you for that information. That's an interesting spread.

I want to review this value-based modifier table for just a minute. This is for 2016. If you look at table number two or groups of 100 or more eligible nationals at the bottom of the slide you will see the downward adjustment are straight -1 or -2%. The upward adjustment are not a straight percent but are either one or two times and adjustment factor. The value-based modifier program was designed to be budget neutral so one of the calculations CMS does is to add up all the money taken from those getting negative adjustments and that gets split among those who get upward adjustments. The adjustment factor for the upward adjustments for 2016 was 15.92%.

For those providers who got the two times the adjustment factor they are seeing almost 32% positive adjustment on all of their Medicare physician fee schedule payments for 2016. You can see one that is such a big factor this year. There was over 13,000 groups with 10 or more and of that over 5000 failed to meet the minimum reporting requirements and 59 received a decrease based on low performance. Over 8000 remained unchanged or neutral. The money that was taken from the negative adjustments on the groups that I just -- that's report or received a decrease was divided up among the 128 groups that had high performance. The bottom line is that high performers were well rewarded for their efforts this year. Each year that adjustment factor will change based on the number of groups failing to meet minimum reporting requirements and groups receiving a decrease based on performance. Here is Montana and Wyoming numbers. This is the total number of Tran for these attacks ID number to determine what a group is. That is their definition of a group. What we can find was of those groups for the groups with 10 or more EPC cannot satisfy PQRS reporting there was 21 in Montana and 18 in Wyoming. Bear in mind these are groups of 10 or more EPA's. We don't have the numbers for those that have nine or less. For 2014. We also do not know if we have anybody in the top tier of one or 28 who got additional positive payments.

Now let's take a look forward based on the 2016 of what things will look like in 2018. You can look at this slide. Based on what your group looks like. First please note providers who are subjected to value modifiers. That's different grouping of providers the nose subjected to PQRS. Of this group includes positions, PA, nurse practitioners clinical nurse specialist certified registered nurse anesthetist. Including -- important thing to note is that if you do not participate in PQRS you automatically get the penalty of 2% if your group is nine or less or a solo practitioner and 4% if it's a group with 10 or more eligible professionals. That's a big deal because dad and on to your PQRS adjustments of 2%. For those with groups of nine or less that would be a total hit of -4%. And for those with troops of 10 or more that would be a hit of minus -6%. That is just for not reporting. If you do report and to participate it is a quality tier which comes from your cost and quality composite scores in the Q are you -- QRUR. You can upward adjustment are no adjustment and a downward adjustment. Based on performance.

This reiterates that point. Groups and solo practitioners are subjected to upward, neutral, or downward adjustments derived from the quality tearing methodology. The only exception to this is groups consisting of only nonphysician eligible providers and solo practitioners who are nonphysician eligible providers. That's the physician assistant nurse practitioner, clinical nurse specialist and cRNA. If a group only has those with no positions then they are not subjected to the downward adjustment however if you do not report, you will get the downward adjustment. You still need to report to be able to not get being negative adjustments. Also value modifiers can be waived if at least one EP built for PFS items and services under the group TIN and one of the items listed. Pioneer is your model, comprehensive primary care initiative, or other similar Innovation Center models. If you're participating in one of those please make sure you speak with your support staff for that model to determine whether or not the value modifier is waived for you.

We're going to have another polling question. First we're going to talk about remittances by code. Will be like to know is have you reviewed the remittances to see if you're being penalized? And is your hospital tracking the total cost of penalties by specific code? Jennifer please post the

polling question. Thank you. While this is going we're going to move on to the next slide. We talked about the adjustments. How do you know if your claim have been adjusted? The answer to that is CARC and RARC codes. Claim adjustment reason code and if that something that is a new terminology to you talk with your billing department because they understand this. When they get remittances back from Medicare they will have these codes on their that explain why something might have been adjusted or perhaps even denied. The first code is the claims adjusted reason code and that is code number 237 which is the legislative regulatory penalty and you will see that when a positive or negative adjustment is applied. Next we have the remittance advice remarks code. We have listed those here so that you have these for reference. If this is new to you if you have not been tracking these you can look at your claim to see if these are appearing on your claim. This can also help you understand which charges are getting adjusted and that can help assist you in determining which measures to monitor and report for 2016. The billing systems also can allow you to map those codes so you can then see the total financial impact for your facility. It's get electronic remittances you might want to check with your billing department if they can set it up so you can then see the total dollar value for an adjustment for PQRS, value modifier or for the EHR incentive program.

We had our poll results back. We have one person who is tracking. It looks like the PQRS and GHR codes and maybe 2 are tracking the modifiers. I cannot see which is which. Thank you for filling those out. And now I'm going to turn the session over to Sara Lee from Health Technology Services and she will talk about what is new in 2016.

Thank you Sharon and thank you all for joining us we hope you have some good discussion. There are some changes for 2016 PQRS. One of them is the Jeh Pro -- GPRO reporting method is changing. There's one additional option for reporting and that is called the qualified clinical data registry. That is different in the qualified registry. In that you can go outside with the qualified medical data registry you can go outside the specific measures for PQRS. And go to some of the polity measures that you report. There are specific organizations that are certified and qualified physical data registry means you have to speak with them if you're interested in that option. Again I think we've set this several times. The value modifier 4% penalty for 10 or more and 2% for 2-9. Or solo practitioners. Remember the new group are part of that value modifier now. There are new measures in 2016. 281 measures are in the PQRS measure which means any of them you choose to report of nine measures and 18 measures are in the GPRO Web. There are 23 cost-cutting measures. There are new groups for we call measure groups and they can be done by into the reporting and those are multiple chronic conditions cardiovascular prevention and diabetic retinopathy. There are no groups that you can look at to see if any of you Pacific riders would qualify for that. There are measures that were retired or groups that were retired and that would be because they were not representative of the quality for those particular specialists. Or maybe they're implemented already in the clinical practices that's a good one to measure for improvement purposes. Make sure that you look at the latest measure list for whatever mechanism you decide you're going to report.

And the CAHPS survey requirements you to pay attention to those also. The next slide I've put together a chart on the think this is an easier way to see what your options are for reporting it is the individual option and then your groups are 2-24 or 25-99 or 100+. The difference for the group size when you get up to 25 have the option of doing the web interface reporting. Another

thing to note is for groups of 100 more the CAHPS survey is mandatory. You must do if your group TIN size is over 100. There's a moment if you click on CMS website there's information on the survey and a list of the vendors that you can contact and discuss about their cost and what they do.

I did want to point out this is time if you decide if you want to do GPRO reporting in 2016. The deadline is June 30. It is open now it opened April 1. A couple of prose. If you successfully report GPRO reporting it will cover all providers in your group TIN. As if you are successful it will protect you from any PQRs or value modifier penalty. That will be for the entire group that is in your facility in 2018. We're talking about 26 and reporting that will affect your 2018 payments. As far as the registry reporting you can report nine measures over three domains and not all your providers have to be represented in those measures. There might be a specialist that does not -- that I measures the makeup pick a specialist and doesn't have any beneficiaries under that. That is okay if that is what claims show or what you are data shows.

Some important items to pay attention to. They're not necessarily gone but they may not be for everyone but your group practice must contract with a seamless certified vendor and then you bear the capture admin cost if you're 100 more. You cannot get out of that if you use GPRO reporting. I think with a providers you probably will do that but you do have to bear the cost of that certainly. -- The survey. You must register the group between April 1 and June 30 and you have to include your method. There are many thinking -- a lot of thinking to do and analyzing to decide what you want to do and you are committed to that. I've heard it's difficult to get out of doing GPRO and the method you choose after the June 30 date. You can on click you're going to do it and decide you're going to but after June 30 you cannot make changes.

Measures may not be applicable to all providers. In a group as I said a specialist that might not be applicable. It could impact position compared to what they do is report one number and it might not have a big of an impact but might not show a particular impact and how what they are doing. Because they take a group number.

Amber is going to take over and discuss the QRUR.

The midyear QRUR are out and if you have not seen your QRUR you probably need to talk to your CFO who has probably been the one who is received the report out of the ED I am. Identity management system. Make sure you tell that person to add you as a defining user -- defined user she can access is reports when you wish. It's also important to download the entire supplemental appendix as well because that would give you additional information about where your patients are attributed to are going outside of your system. This is especially important for critical access hospitals and those primary care providers that do a lot of outside referrals because the cost of care that occur outside of your four walls are also attributed to you. On practitioners should have received a notice about the QRUR being available. This does not actually say what your payment is going to be. Your value-based payment -- this is just for informational purposes only. It's basically a check we want to make sure the information that is in the QRUR is correct so you have time to make adjustments. Many people are finding they have way more MPI numbers society with the practice then what is actually in reality. I think that is a good way of keeping track of things. They also will try to more frequently in the coming years.

Here is some links for you to click on. There are tons of resources out there. The language can be a little bit confusing and if you have particular question we are happy -- we are planning on doing an entire webinar regarding the QRUR. If you have specific questions please let us know what those are and we can go into more depth about that.

Here are again -- we are giving you lots of links. Were always available to help but most of our information also comes from the federally available resources on the CMS website.

And now it's what kinds of questions do you have? We spent a lot of time on these websites scouring for answers to your questions. Feel free to try to ask you something we have to go research because that's how we learn. You can use the chat box and let us know what kinds of successes you had and we will have some further discussion questions which Chevron will lead but we really do want to hear from you of what barriers you have and what hurdles you facing. So we can have our education be more specific to it needs a.

Amber I'm going to unmuted the line. It looks like we have our first question in the chat box. In regards to group reporting what percentage of the group has to have data? Sarah do you want to take that one?

I can take that one. I have seen no percentage of what the group -- if you are doing GPRO reporting you are taking everything for everybody within an organization that is eligible. And you are finding that numerators and denominators of those measure you choose. You to take a compilation of all the information. There's not a minimum. There would be for one measure but you could have five of your 10 providers that can report on a particular measure if you are talking about doing individual reporting for a group you have to be over 50% of your providers have to report PQRS so you do not get the value modifier penalty for your group.

If you have more questions Valerie put them in or you can give me a call.

The next question comes from Julie. Can aside facility report GPRO we have providers and site providers.

Here's what I can tell you about doing GPRO. Group reporting looks at all of the providers in the group. You get to pick which measures -- nine over three domains unless you use EHR which is a little different. But when you do those measures once you are -- what you're looking for is the results for that measure not necessarily the results for each provider. You are looking at a group level. You might have specialist in the group who may not have contributed towards those measures. But they go on as part of the group we need to the group reporting. That's one of the strengths of using group reporting as an option. Serried you have anything to add?

No. The answer is yes but you can do GPRO reporting and it's just how you pick those measures. The method you're going to do or your mechanism in and how you would take those measures that we depend upon which ones your reporting on.

The next question comes from Sherry. When reporting as a group are required to report the only one -- via only one method?

As far as I know yes you can only put you are doing one method as a group. You do not get multiple choices when you register to report as a group. You have to put the method you're using.

Take you all for the questions. Do we have anyone who wants to get on the conference line and ask a question?

Here's a question from Debbie. For our express urgent care office we've reported on one full-time provider. For 2016 with a be beneficial to report GPRO? We have one full-time. Debbie my question would be do you have other part-time providers? At this point in time there is no low-volume threshold for PQRS reporting. So if you have a provider let's say worked 25% of the time then if you do not report PQRS on them then they would get the penalty. And if you only report on one out of four providers you do not need that 50% rule that Sarah mentioned. So yes it could be beneficial for you to report GPRO.

Next question. How to the payment adjustments follow traveling stats? That's an interesting question. We were having a discussion among the HTS and QIO staff about that. We have been chattering about that in the last couple of days. I think it's important to look at which payment adjustment you're looking at and how you are going to the stat. If you are local staff are covering for a permanent divider for less than 60 days you can build that [Indiscernible] under your permit provider data and so it's that goes court to permit provider. However if you have a [Indiscernible] to fill a hole if your billing under their NPI number then you have to look at how those penalties are assessed. Sarah did you want to say something?

You are not hearing me but that's exactly what you said. The [Indiscernible] you might run into some cases if they are work for specific company in the that's how they are billed or could be different even. But they will -- if they work with you in 2016 and the capture them as a TIN and NPI if they are still with your organization in 2018 as a [Indiscernible] middle under their NPI and your TIN then you get penalties. There is also a look at what is happening two years later. This that factor involved as well.

Will you receive a payment adjustment if they worked in a facility two years ago were they did not report? For PQRS in the value modifier what that is looking at is the TIN NPI combination. If you have a provider in 2016 that say they're going to work for you for three months. To help cover an opening. And but they have never been to your facility before then there is no record of your TIN with their NPI. You will not get that PQRS -2% penalty because it goes by the TIN , NPI combination.

Again I urge you to get with your billing department and look at the claims that you are getting that either do or do not have those remittances by adjustment code. That can help you fine-tune which of your providers are getting penalties and which are not. And it helps you understand the situation at your clinic when you can see the actual penalty that you are getting. Unfortunately there's nothing you can do about 2016 -- 2015 based on the data that you have some time left in

2016 to get a sense of who is getting a penalty and what are they getting the penalty on and what does it look like. That may also help you understand what measures can you be looking at. Don't be afraid to go down to the billing office or wherever they are located and have them show you some claims to see if you get an idea of what it looks like.

We encourage you to put more questions into the chat box. But we have a few discussion questions would like to hear from you on. The first question of using the PQRS and 2015 which method did you select? Why did you pick that one? And you can go ahead and put your answers into the chat box so people can see it. What method you pick in 2015 will use the same method in 2016? And why or why not? Why are you picking a selected method to submit? We think it's important for people to understand.

This is MJ. I'm going to jump in on this one. I think there are several affiliates from the links clinic for listening in. Those of us on the links clinic utilize Turner as electronic health record. What influenced our decision was we said here we will help you as we were floundering and Willie is the same method in 2016? That is still up for grabs. At least in my facility. It would make sense to continue to use the same thing but there are some concerns about at least in my mind do they really have all of the quality stuff built? It supposed to be done by the end of June but we all know what is supposed to be means.

I have a question for you. Am I correct in understanding that right now you cannot necessarily see the quality measures and see what the results are for 2016?

For PQRS? That would be 100% correct.

Okay. It's hard then to determine which measures the want to work on and try to improve because you have not been able to look at those measures and have not been able to do the data validation the show that whatever the results you are getting matches with what you're documentation looks like.

Correct.

I can understand your concern and that is complicates -- that combo kits trying to decide are we doing -- what method are using if we have to submit -- commit to that by the end of June.

We have a regional affiliate meeting that told us that 32 of the 64 are built. But no one has seen reports. I don't have access in my facility to look at any clinical quality data reports. Even for Meaningful Use.

Deal of anyone in your facility does? -- Do you know if anyone in your facility does?

Many of those crossover and that might be a good place to start. Perhaps someone in your IT department might have those.

We do however he has is resigning and will be leaving May 20. If you are not the billing clinic employee you do not have access to that information.

That is a challenge.

Yes. And I will say please know that we do have a contract billing clinic Jeremy is trying his best but he has 18 affiliates he's trying to help and so it's not easy.

That is one of the -- your comments are important. One of the things I think we would like to do at Mount Pacific is really -- Mountain Pacific through the a 62 page proposed rule for MACRA and comment based on the challenges and the hurdles that are faced by rural settings. And I know in the short review I was able to do yesterday there is some language in there about rural health clinics. Critical access hospitals and they really do want to hear from folks out there as to what hurdles you are facing. Not being able to get your hands on the quality data on an ongoing method really hampers any type of effective quality improvement program which is what they are after. I think CMS along their power has some ability to influence what EHR do and what products they will put out in relationship to quality. Some of the initial language the first 50 pages is pretty interesting. These are very important comments for us to hear about the difficulties you're having.

Thank you for that. Let's go to the next question. But if you have more information like that we do want to hear about it as we get information together to comment.

The next questions who in your facility has access to the EIDM? Were they able to get access to the QRUR? Have been able to look at that and have you used the information for any purpose? We like to hear from you on those items.

Sometimes we find someone might have access but the person who really needs to see the information does not have access.

I will jump in. This is been. We have two people access to the EIDM which is me the quality coordinator and our quality director as well. We also have one person was a security official who does the approvals. But they don't access anything. We were both able to access QRUR. We actually dug into the report and used it to provide some tentative information to our providers about how we're doing with quality. We have made some use of it although not knowing where exactly the data is coming from we are hesitant to take a lot on it. But we have provided the information to our providers and try to use it to give them a midyear picture of how we're doing. As far as what would like to learn about it I like to be able to dig into it more and understand where the data is coming from and be able to rely on the data more heavily.

Thank you for that information. I think our experience has been some people have looked at it. It is a large report and it is confusing. We will be looking at doing a webinar on the QRUR and trying to help extract what information is helpful and what can you do with it. How can you use it. Thank you for the feedback.

One of the other things that is going to be interesting to QRUR is I think when you see where your patients are receiving care outside of your formal -- four walls there might be places on their that you have never actually had a referral relationship. Patients are independent creatures

and they can go where they wish. But I think it's a great opportunity to look at where your patients are going outside of your organization and have a conversation with those patients about how important it is their primary care facilities all talk to each other. Besides just a marketing aspect this is also a continuity of care issue. Really understanding what your patients needs are.

The next question have you selected your quality measures for 2016? What factors influenced the selection of those measures?

We've heard from MJ they don't even have the report to look at which measures the -- make the most sense for them. They are still waiting for access. I know there are a few others on the call that have -- affiliates that running into the same issue. What about everyone else? Do you have a good handle on what you are doing for 2016? Or are still trying to get your hands on data? Will be part of an ACL. They don't know what those are. Looking at 2016 data based on 2015 measures. That is good. Measures are selected at the site facility. That's great to hear. All right. We have quite a range. Some people are picking those and some are not some looking what they've done previously summer looking at what will be defined by the ACL. Let me ask a question. What is new to me is that your measures being defined by the ACL that you don't know what they are yet. I thought those ACO measures were out there but I might be mistaken.

It's more that I think we have not had the conversation yet. We haven't gotten to that point with the ACL. Rather than they are not available. We just have not recovered from reporting to this year yet.

I'm sorry it was that painful you are still recovering.

We've been shortstaffed and just have not gotten to that point yet. We're still in the formative stages of the ACL and we're just not there yet.

One step at a time.

Yes. The earlier we can get providers on board with the measures the better we're going to come out.

Here is the last question. And and we will wrapped up. Does your EHR provide a dashboard to monitor your PQRS measures? If they do how often are you monitoring those results? If you don't have a dashboard what are you doing to get a handle on what those results look like? I have one person responded privately that yes they have a dashboard and are tracking on a dashboard. And at least two facilities are clinic affiliates and are not able to track. A registry supported by the EHR they can monitor. Mary you hit -- you found the source but. Hospital-based provider. That's a conversation that we have trying to have with electronic health record vendors whenever we went into them. Many -- many of the dashboards are set up nicely for industry practices and they work well for that but when it comes to hospital-based providers what is built into the hospital system are the inpatient quality reporting measures and not necessarily the PQRS measures. I certainly feel your pain on that one because it's not near as simple to get the data the hospital-based provider. We've had conversations with those vendors to say is it as simple as of report that is the inpatient you can adjust to report to get that? That would be -- that's a really

good point I think to put in comments on the proposal rule that we need to improve the capabilities to track PQRS measures for hospital-based providers. That's a great point. We understand Julie's pain as well where they don't have an EHR and everything is done manually. That is a huge gap -- a huge jump to get all that done. These comments from you are very important. We will get a printout of all of these and this will help inform the comments we can provide in all of our interactions with CMS and vendors. Because the goal is not to spend your whole life getting at the data but being able to use the data to improve results and improve patient care. Everyone shares in that goal.

I mentioned at the beginning in the survey at the end of this session we have some questions for what your preferences are for the education that we will do in the me LAN. One is how does Petrus interact with other quality reporting special situations? Such as NRACO. PCMH are private insurance. Critical access hospitals and RHC. We get many questions on those. Another option is how to use QRUR to improve care. Another one is looking at the actual documents from CMS about that give the workflow for individual measures there are some handy tools out. Another aspect of PQRS is public reporting on the physician compare website. With like to hear from you of which of those you think are important and you want to hear more about.

The last two pages are our acronym list. If you downloaded the slide deck or Figo out to our website we should let everyone know after we get the recording back from quality net. We will let you know when it's posted. Unless anyone has additional questions thank you very much for joining us. We hope this was valuable for you and certainly was valuable for us to get a sense of the hurdles you are running into and think about how we can help you overcome those barriers. Sarah or Amber do have anything else to add?

I think that about covers it.

I'm good. Any feedback on these those that we like to talk about on the next LAN would be appreciated. We are helping you out if we can and we do some research ahead of time.

Thank you. Have a great day.

Thank you. [Event Concluded]
