Care Delivery Implementation

Mikhail N. Kosiborod, MD, FACC, FAHA

Executive Director, Cardiometabolic Center Alliance

Saint Luke's Mid America Heart Institute

Professor of Medicine, University of Missouri—Kansas City

Kansas City, Missouri

Melissa Magwire RN MSN CDCES

Perspectives on Team-Based Care, Care Coordination, Practical Tips, Patient/Staff Education

Team Based Care Coordination: A Necessary Approach for Prevention and Chronic Disease Management

DR. MICHAEL BLAHA: Welcome to the next section of the course on Foundations of Cardiometabolic Health, our certification course. This next section is an important section about how we bring together teams to deliver comprehensive care in the cardiometabolic health space because it's so important to think about this as a comprehensive discipline rather than separate disciplines of diabetes and heart disease, etc. I'll start off in this first section kind of the fundamentals of team-based care. Then we'll switch to a section on how team-based care can improve the quality of care and outcomes in cardiometabolic disease. For this section joining us would be Melissa Magwire, Mikhail Kosiborod, who have great experience with this at St. Luke's, anyway within their experience and expertise. Let me just introduce our speakers, Melissa.

MS. MELISSA MAGWIRE: Thanks Dr. Blaha, I'm really excited to be involved in this section. Melissa Magwire, I'm a 30-year tenured master's prepared diabetes nurse educator. I work as a clinician alongside Dr. Kosiborod in the St. Luke's Haverty Cardiometabolic Center of Excellence. And I'm also the Program Director of the Cardiometabolic Center Alliance.

DR. MIKHAIL KOSIBOROD: It's really great to be with you. I'm Mikhail Kosiborod. I'm a cardiologist at St. Luke's - - Heart Institute. I spent most of my career in the cardiometabolic space both of a clinical investigator and also now the Director of the Haverty Cardiometabolic Center of Excellence at St. Luke's - Heart Institute and also the Executive Director of the Cardiometabolic Center Alliance.

Ms. MAGWIRE: We're going to start off with team-based care coordination and really looking at why this is a necessary approach to not only prevention but also chronic disease management.

MS. MAGWIRE: A few chronic disease facts just to get us started. We know that chronic disease is defined as having at least one condition lasting at least 12 months or longer that requires ongoing attention and/or really limits the activities of daily living. We also know unfortunately this is the leading cause of death and disability in the United States. And of course, we all know that this is a leading driver of cost in health care utilization in the United States.

Let's start things off with a little bit of a question, test your knowledge of what you feel like chronic disease state is currently in the United States.

MS. MAGWIRE: The first question is, what do you think the percentage of adults in the US is that have at least one chronic disease? Is it A. 25%, B. 60%, C. 35%, or D. 50%? We'll give you a second to answer that.

MS. MAGWIRE: Okay. The answer for number is actually 60%, so again 60% of people living in the United States currently have at least one chronic disease. Let's take this a step

further and see what you think the percentage of patients or adults in the United States that have at least two chronic diseases are, would that be A. 25%, B. 15%, C. 40%, or D. 35%? We'll give you a second to answer. Okay, while the number is a little bit less, it is C which is 40%, that's still a huge portion of patient population in the United States. It really kind of paints the picture for why this is such a needed and urgent topic to be discussed in.

MS. MAGWIRE: Another thing that really sets the stage for care coordination is the realization like understanding that as a patient, it's really a very crowded landscape. Just talking as an example someone who's living with type 2 diabetes, ASCVD, and chronic kidney disease, which we know are very common comorbid conditions for folks to be living with. Think about that from a patient perspective and understand that the patient not only has their family members we're trying to help but they may be seeing a nephrologist and a nephrologist nurse practitioner, a general cardiologist, perhaps a heart failure cardiologist, the healthcare team there which could be their nurses and heart failure nurse specialist like APPs and physician assistants. They're probably also seeing their primary care physician who may also have providers such as nurse practitioners and PAs even a PharmD. Then they're seeing an endocrinologist for their diabetes and a nurse practitioner, diabetes education and care specialist, and a dietitian. Oh, and then we also need to add in some of the other care providers that we see on the periphery like ophthalmologists, dentists, podiatrists, and pharmacists. Just looking at the screen, you can really tell that as a patient dealing with one or two or three chronic comorbid conditions, there are a lot of people that are playing into this care plan. And you can understand why really having somebody coordinate this is really necessary.

MS. MAGWIRE: The care coordination model was really created due to the prevalence and cost of chronic disease. It was really sort of an indication of the fee-for-service delivery model that we're currently living in although we are taking steps to change to that to more value-based. Again this is another reason why care coordination is really that more important as we move forward. But the evidence really revealed that care coordination was leading to improved outcomes and potential cost savings. And so back in 2015, Medicare began to actually offer care coordination reimbursement codes for aspects of care coordination. Because multiple studies and abstracts have shown that there was some room to move the needle in cost and outcomes if we did a better job with care coordination. Medicare and other payors felt that a way to entice providers into really changing the care model was to provide these fees and these codes in reimbursement. However, within about the initial 15 months of these fees being available for reimbursement, only about 5% of the codes have been really used. There was only an update of about 5% in care coordination. And so what that really did was lay the groundwork and fundamentals for more education on this. And to really build care coordination and put it out there as sort of pinnacle of how we want to develop models of care.

MS. MAGWIRE: And so at that time, in the advent of this quadruple aim or this coordinated approach, I'm going to take a few minutes to go through what some of these different aspects of this quadruple aim are and how you can apply those to practice. We'll see this later on when Dr. Kosiborod delivers his piece of this lecture series and how to put it into practice.

We'll start at the top left hand talking about health outcomes. Really what was found across the board is we studied this care coordinated approach was that communication techniques and education coupled with the interventions that really influence health outcomes and the need for interventions and consultations. Health outcomes could be in fact really improved or impacted by how we were communicating as a team amongst each other but also how were communicating to our patients and our patients' families. That communication piece became key.

Then moving down to the patient experience, we saw that a positive patient experience really improved outcomes as well also provider experience, and the cost. While we typically historically thought of the patient experience as the outcomes, did we keep the patient well? Did we improve their health? There was more to it about the experience. Did the patient walk away from the experience feeling comfortable, feeling that they had a say in their care?

Then we move over to the provider experience. We saw that patient satisfaction was actually a driver in the provider experience. When our patients felt better about the care that they're receiving and express more positive outcomes, that way as providers we felt more invested as well. And it was the leading factor in improving the experience for the provider. It gave them a sense of comfort when actually communicating with their patients and family members. And so this provider experience didn't just speak to burn out but it also further impacted how we deliver care and how we spoke to our patients and their caregivers, thus truly coordinating that whole piece.

And then finally the cost of care. When you start talking to payors, providers, and healthcare administrations about developing a new model of care and coordination of care, maybe adding in some more layers, one of the first things that come to mind is how is this going to impact the visit? Is this going to lengthen the visit? Is this going to call for the need for more staff? And ultimately is this going to cost more? Well, what we found in looking at all of these studies in care coordination was that actually, it was fairly neutral in a short term. Studies suggested that there was a minimal impact on the visit length and very positive impact on patient satisfaction, perceived patient number of unmet needs and concerns as well. By really coordinating the care, the impact on cost for this new model was neutral.

MS. MAGWIRE: How do you go about building an effective team for care coordination? There's a few fundamental elements for success in coordinating team approach. Those would be a defined scope, rationale, and key partnerships, effective information exchange, trained and available workforce, evaluating the improvement of care coordination, and then the all-important and very encompassing patient and family engagement. In the next section, we'll discuss a few of these.

Scope, Rationale, and Key Partnerships- Patient-Centered, Coordinated, Comprehensive Model of Care Delivery

MS. MAGWIRE: Moving on to scope, rationale, and key partnerships that are needed for

care coordination. When you look at what a patient-centered, coordinated, comprehensive model for delivery entails, we have to look at all the different aspects. Of course, the big driving aspect that you'll see in here repeated throughout this section of the course is that the patient needs to be in the middle of the care coordination. There's multiple topics that surround the patient such as care coordination such as access to medications and care, the experience, satisfaction, the education, the outcomes, and of course the quality of life. But in the periphery we need to not forget and not exclude the fact that we have these comprehensive treatment plans. What are the key support staff and personnel needed? We need to make sure that we understand that we develop this model with the key sense to the transition to value-based care environment, remembering that the payors and clinicians also have a say on this as well.

MS. MAGWIRE: When looking to build this model of care and putting it in the cardiometabolic realm, who are some of the essential cardiometabolic team members? Of course the patient is the middle, the cardiometabolic patient. But then looking at that core care team for cardiometabolic team, is it a physician, a nurse practitioner, a physician assistant. And then you see over to the right-hand side this care coordinator which is the hallmark or caveat to a model we're going to expand on later. But really looking at that care team coordinator, be that a diabetes nurse educator, clinical pharmacist, registered nurse, a dietician, but then also not forgetting our key elements or our partners making that overall care, the podiatrist, the ophthalmologist, those types of therapists. And then other collaborating specialists such as our endocrinologists, cardiologists, or primary care nephrologists, really looking at this global sense and building a team that's all-inclusive but then having someone such as a care coordinator really helps drive the ship and keep things moving forward.

Trained and Available Workforce

MS. MAGWIRE: A trained and available workforce. One of the caveats or hallmarks of what you need to do before you decide what your team is going to consist of is what team members do you need? What is that patient journey going to look like? It's a little hard to put together a team when you don't really know where you're going on this journey and what the end result is going to be.

And so this is an example of what we use locally in our Center of Excellence at the Haverty Cardiometabolic Center of Excellence. What we wanted our care pathway or journey for the cardiometabolic patient to look like. We sat down with a simple exercise of mapping out all the key variables that we felt were really important for care collaboration and this team-based approach. And then we started to plug in who the team members should be. We started as early on how to we get that referral to the center to what happens pre-appointment, what's the communication that needs to happen to the patient or with the patient prior to the appointment, setting up the stage and expectations and coordination, maybe even introducing the patient to their care coordinating team for this journey prior to even being seen in the clinic.

And then upon arrival to the clinic, what are the steps? Who can fill that in? Who can help provide the education for the patient? What are the necessary things we need to do before the provider or care team even gets into the room? What happens during the rooming process? What are the key elements? What are the expectations again there that we need to set forth for the patient and the family members? Then finally a really good comprehensive review of the patient history with the patient, getting the patient's concerns and needs right out in the forefront so that our care team has an idea of what they're going into for this appointment. And then the team visit which is really the hallmark for this collaborative approach in this specific model, and the provider assessment, education and expectations. In the very bottom, you'll see one of probably the most important of this care collaborative approach is that care team communication to wrap up the visit and moving forward. You can look at this and see that there's multiple, multiple parts and pieces to this and many players, but really having an idea of what your journey needs to look like so that you can plug in the appropriate team members.

MS. MAGWIRE: Moving on to that train and available workforce. Throughout this, you'll see the term effective information exchange or communication. We all like to think that we communicate everyday with our peers and our patients but what we've seen from a traditional care model, care coordination really takes a consorted conscious effort to make sure we're coordinating it in a very comprehensive manner, this communication that needs to happen.

Once you've identified your patient journey, you need to identify your team members and their comfort level or knowledge. You may find that you have some folks that are out the door, out the gate, ready to go in this collaborative model and others that maybe need a little bit more training. One of the things we did locally was to identify our experts, pull from within. Who are our folks who want to take the ball and run with it and those that needed a little bit more training? And then provide learning opportunities. And then I think one of the most important things of care collaboration you'll hear over and over again and see in the literature is the need for daily care team huddles. This traditionally started in-patient safety huddles were mandated. But there's no reason why they shouldn't actually occur in the outpatient space as well. We found this exceedingly important to this care collaboration, so really getting an idea and scope of the patient's needs before the start of the day, before the start of the clinic, so you can anticipate those needs really make a lot of time in that patient appointment to be really effective care delivery. Start with that daily team huddle to identify any needs you might have and anticipate and share that to the care team.

Patient and Family Engagement

MS. MAGWIRE: Next is patient and family engagement. We know to have any sort of hope to have adherence to a treatment plan and positive outcomes and positive patient satisfaction, we really need to make sure that we involve the patient and their family members or support system from the very onset.

MS. MAGWIRE: No talk or lecture regarding patient engagement would really be completely

without really looking at determinants of health. We know that in the background we may have been doing this all along but this has really taken on an important need and we now have some coding and documentation needs that we need to all be speaking to when it comes to social determinants of health. There's a very valid reason for that. And so part of the element for successful engagement of patient is to really make sure that we're communicating in a way that is meaningful to the patient. We can't do that unless we identify some of those barriers or constraints that our patients may have.

I found this really interesting. This comes from the Robert Woods Foundation which really looks at some of the key makeup of things that might be a barrier for our patient or things that need to be considered when we're developing a patient coordinated plan. That's the fact that about 20% of what we need to be thinking about or what is impacting patient care is their actual access to care and their quality of care. But then we also have their health behaviors. This makes up about 30% of that. Do they use tobacco? Are they able to be adherent to a diet? Do they use alcohol? Any of those risks, those modifiable behaviors, but you need to have that screening in place that talks about that. When you're talking about the diet and adherence and things like that, having that conversation with patients to understand do they have affordability or access to healthy foods, do they live in a food desert, do they now have the ability to get fresh fruits and vegetables? Can they not exercise because of the safety of their surroundings?

And that goes into the next section which is that physical environment. Is there environmental issues? Are they having safety concerns within their environment? And then finally about 40% of it is their socioeconomic factors which plays into a whole host of issue that need to really be addressed during these appointments. What's their education level? What is their health literacy level, their income status? Do they need help with patient assistance programs for medication access? It's all well and good to come up with a treatment plan and a coordinated path of care. But if we haven't taken these social determinants of health into consideration, our patients and ultimately healthcare in general cannot be successful. Really making sure that we put this in that care coordination plays right out of the gate and that we're not only screening for this but we're educating the entire care team on what our patient's needs are.

MS. MAGWIRE: Another good example of an attribute for successful coordinating patient care plan is one that really looks at the overarching goal of constructing a care plan that patients can successfully follow. I made reference a minute ago to the fact that we have all the tools that at our armamentarium right now. We have medications now that we know can make huge impacts in patient outcomes. But if our patients can't access them or don't understand the need for them or have educational barriers that are keeping them from being adherent, the best care plan in the world is not going to make an impact in overall outcomes.

The AHA is a great example of one of their ways to manage cardiometabolic risk in people living with type 2 diabetes. And they put a couple of different decision key points to remember in place. That's to assess the patient, the social determinants of health, the need like we just spoke of. Acknowledge why we need to build this and acknowledge what some of the patient's barriers might be, to assist in overcoming those barriers. To really pull in

the family, the entire care team, and that patient's support system into the decision-making. And you'll hear the term joint decision making a lot when talking about care coordination. And then review, review, review, and monitor the plan and revise the plan if needed. While these sound like very common-sense approaches, unfortunately, we don't see these always applied unless there's a consensus effort in this care coordinated model to build this within the patient journey. Keeping those steps in mind is really going to take you further down that care coordination journey with the patient.

Education and Improvement Of Care Coordination Care Team Education

MS. MAGWIRE: Education and improvement of care coordination. We've talked a little bit about educating our patients, but we also know that we need to educate our team. And so one of the things that we have found most beneficial I mean looking at this new care delivery model is the consistency of messaging and education across the board. If you think back to one of the previous sections in this talk, we talked about how many different care providers that a patient may see or their family members may see when they have this chronic disease, comprehensive disease management program. We want to ensure that were giving consistent education messaging across the board for what are the needs for these medication regimens. What are the needs and the reasons behind some of the behavioral changes that we're asking the patients to make? And then also I think the key or caveat to the care coordinated model is really empowering the non-physician staff to keep things moving forward. We all know as the population in the United States continues to grow, it's fast outpacing the number of providers who are available to give the care that we need to and we need to lean heavily on our non-physician staff to really coordinate this care. This model speaks very well to that that you can use nurses, diabetic nurse educators, dieticians, pharmacists, and nurse practitioners to really keep the momentum going.

But that really entails or requires a really comprehensive team. Having care team goals and strategic planning in place, building on that team, optimizing the workflow, really working at what the end goals, what are the things we're looking to measure? And then also providing that consistent messaging and those tips and tools that our practitioners need, therapy selection pathways, treatment protocols, practical considerations. We know how to prescribe the drugs, but what are the steps that anyone on that care team can help remind a patient to keep them adherent and on the right path to having a good outcome and a decrease in some of these comorbid conditions. Really making sure that not only do we ask our staff to give care but we give them the protocols and practical tips and consistent messaging behind the scenes, so there are patients who feel like they're getting a seamless specific message no matter who they're talking about in the care team.

And then one of the other things we need to look at for care team coordination in this model is how do we measure success.

MS. MAGWIRE: This is an example of something that we use locally and across several institutions that are part of the alliance that you'll hear a little bit more about the healthcare consortiums in general that are looking at is registries and ways to actually measure outcomes. Understanding that these are multifactorial from the easy things that

we think of immediately like biometrics, are we pushing the needle in risk factors such as A1c control and eGFR and LDL cholesterol to are we using guideline-directed medical therapy at a level of which we should be because we know they have proven outcomes and proven indications. Are we using RAS blockades and GLP-1 receptor, SGLT-2 inhibitors for the appropriate patients for the appropriate reasons?

But also including in the clinician and patient engagement, medication adherence questions, self-management education questions, patient-reported outcomes, that patient satisfaction that we spoke to earlier on that's a key or a real hallmark to successful care coordination. Then looking even further out and building that scope into this value-based health economics. Are we making an impact on ED utilization, medication safety, decreases in hypoglycemia ER visits, readmissions after heart failure? And then finally those hard clinical outcomes that will take a little longer to measure but things such as MACE, heart failure, diabetic kidney disease progression. Making sure that our model of care has a way to measure its success and perhaps look for ways to continually improve the type of care that we're giving and the experience that we're delivering to our patients.

MS. MAGWIRE: And another way of thinking about this even more globally is looking at how this care coordination not only impacts the patient but also the program that you put into place and overall the health system and the cost-effectiveness of them because all three of these things actually need to be considered. But of course, we start at the patient level because that's really who this is aimed at, which is to improve the outcomes of our patients. This is an example of a patient that's been seen in a cardiometabolic center of excellence and we see first of all are they on guideline-directed medical therapy such as an SGLT-2 or GLP-1? Are they on ACE or an ARB? Are they on lipid-lowering drugs? All those things that we're looking to measure in guideline-directed medical therapy and standards of care that we should be adhering to.

And then did we move a needle on their A1c, on their blood pressure, on their weight, BMI? Did they improve the diabetes distress score of their KCCQ score? And how does that then follow through or flow into overall our program outcomes? For example, here are some things that we're looking to measure here locally and across the alliance in general. What proportion of patients had an A1c greater than 9%? And maybe we set the mark that we want to see that improve by 20% over 12 months. Do we want to look at the impact on LDL cholesterol and have that improve by 20%? Do we want to look at the proportion of patients who are on optimal guideline-directed medical therapy and improve that by 20%? So really setting those overall program goals on top of patient goals. And then finally looking at the health system in general. Did we make an impact on emergency department visits and utilization on in-patient utilization? New events and complications, overall star rating improvements with some of our ACO and HEDIS metrics. Did we make any improvements on that? And then finally that total cost of care. Really kind of wrapping it up to look at how this coordinated care and really setting the foundation can not only make major impacts and end roads on patient outcomes but also program outcomes and larger yet health system outcomes and decrease in utilization and decrease in cost. With that, I'd like to thank you.

Panel Discussion

MS. MAGWIRE: Okay. We've discussed a little bit about the foundations of care coordination and the importance of that. before we move on to Dr. Kosiborod's lecture which is really going to take that care coordination piece in those fundamentals and give you some real-life examples of how we implement it here at St. Luke's. I'd be really interested to hear some thoughts from Dr. Michael Blaha on this. Dr. Blaha, I know you're a firm proponent in care coordination, but we'd love to get a couple of your key takeaways from the importance of really applying this to not just the cardiometabolic care model but to care in general, so maybe give me a couple of pearls of wisdom you have on how you've worked with care coordination at your center.

DR. BLAHA: Yeah, I mean your talk was so perfect and so important in medicine in 2022. What got me thinking, you've talked about chronic disease which is where we're at with cardiometabolic disease. But we're also at that junction of where acute care turns into chronic care. I think about the patients who just had a myocardial infarction or just had their first heart failure episode and they're going to transition to the outpatient setting. And I think about outpatient who just had a myocardial infarction, traditionally they would've left the hospital, maybe seen a cardiologist, maybe there's a referral to an endocrinologist. They'd see a primary care doctor too. And it might not be so clear the roles that each of those is going to play in the care of myocardial infarction. In other words, the cardiologist might talk about - - platelet therapy. He doesn't think that obesity and glucose management is part of that domain knowing the endocrinologist might be talking about those issues. The endocrinologist might spend a lot of time on self-efficacy and home monitoring and card counting and not really get into GLP-1 or SGLT-2 management because they think that might be what the cardiologist and the primary care might try to figure out where they fit in all these too. That transition from acute care to chronic care after a heart failure episode or after myocardial episode is really where I think this is so important. That's where we failed a little bit I think mostly in the past.

It's clear when you look at some of the data why the cardiologist for example says sometimes or they don't use an SGLT-2 inhibitor or a GLP-1, they say, I don't know enough about the drugs. That's sort of not my domain. I don't want to step on anyone's toes. It's not really for me to manage glucose. Well that's a very old fashioned viewpoint. And now we realize that we need to be a team and we need to have communication. The model that you set out is definitely the way of the future. What do you think about something? I think that these patients who like I said who just had their first myocardial infarction just had a stent and they don't know where to go. They're going to say, who's my doctor? Who's in charge of this? They may not see the connection between the risk factors in the event in the way that we want them to see it.

MS. MAGWIRE: I think that's brilliant. That's exactly why this care approach is needed. We see that constantly in clinic. I can tell you having been in practice for 27 years before coming to this care coordinating model here at St. Luke's, we would get frustrated. We wouldn't see the outcomes that we thought we should be getting. We were doing everything we could but we felt very disconnected. To your point, once patients were seen within this new program that we have, I can't tell you how many times a patient said to me, why didn't somebody put this altogether for me before. It's not disparaging and either healthcare providers. But it was that lack of ownership that the patient was even feeling.

They were confused. Who do I go to for this? I think this really clear path or trajectory that you're talking about setting the patient up from day one even as acute is something that's really, really, really necessary. How do you feel we get past this feeling of, well, that's really not my place or they probably need to be on this agent but that's not for me to start? I know that's a huge question to tackle in just a few minutes. But what do you think some of our initial steps are too kind of get past that inertia of picking it up and running with it because you're part of the overall care team.

DR. BLAHA: I think to me it adds some points but of course the entire of the care team, everyone has to be on the same page. If for example a cardiology practice, a cardiologist decides to say, well, I'm going to get involved with prescribing SGLT-2 and GLP-1s but the nursing staff or the MAs or everyone in the office doesn't know much about those drugs, it's going to be hard to pull that off when the call comes in and says I got a question about this new medication or the pharmacy is related to that clinic doesn't have experience with that medication, it doesn't work well. Everything has to be an alignment across the entire clinic. Of course, that's the concept of the cardiometabolic even in these clinics that are emerging in this space.

I know that the nurse in our center, once she became very familiar with the GLP-1 receptor agonist, it works so much better when we give you the teaching in the office or take the question about dosing or side effects. And you have to be ready to do that. I think the point you made about the team has to be much larger in terms of construe than just the prescriber or the nurse manager in the clinic. It has to be everybody including the trainees and they're going to have to be familiar with that medicine. I think this is a big part of it because when someone says this isn't my space or I don't know how to do it, they're not really saying I don't know the data but they're saying I don't actually know how to do this in real life. I don't know how to take that phone call. I don't know how to do the dose titration. I don't know who's going to help me. This is so important because, yeah, the patient like you said, what's to say who's my physician taking care of this problem or sometimes I've said to my patient before let's talk about this medication like a GLP-1 or SGLT-2 and say, well, I didn't think you manage diabetes here. You know what I mean, those kinds of things. Just to your point, I think it takes the entirety of the team and right down the list even for the front desk, everyone has to understand what we're trying to accomplish. But that's my impression. What do you think about? What are the barriers that you?

MS. MAGWIRE: No, I agree wholeheartedly. It's that consistent messaging from everyone from the front desk to all the providers, and then that consistent messaging not only to the patient but peer-to-peer. And what we found is that if we actually verbalize and communicate the messaging and the treatment plan of course to the patient and their caregiver to our other providers and our partners as to why we're doing what we're doing, it was sort of an interesting learning curve where we found in those practitioners we're providing that messaging back to the patient and the patient felt like they were getting a seamless care delivery. To your point Dr. Blaha, it's very important that that communication is from day one all the way through and it's consistent across the board, so thanks for your input on that.

DR. BLAHA: Yeah. Of course. I'll close one more thought about that because I think what you said is so right by communicating why you're prescribing these things too. Earlier in the days, for example, SGLT-2 and GLP-1 as a cardiologist getting involved in this, it was a little awkward at first. Sometimes you would say am I stepping on someone's toes. The primary care would say, well, I'm not so sure that we need to do that. But then you clearly articulate we're doing this for cardioprotection or renal protection and you start to see practice has changed around you. You know what I mean as I see what you're trying to accomplish. And of course, then the patient will come to you with a better understanding of how diabetes and how kidney disease, all these things wrap into the coronary artery disease or heart failure that patient might have. And then you communicate that and you can change people's practice around you too if they see the rationale for what you're doing. Anyway, a great section Melissa on care coordination. It's so important. And thank you so much for having this discussion.

MS. MAGWIRE: Thank you.