# Building a Stronger Chronic Care Management Program: Maximizing Impact In-House

Savvy Jane – Montana CCM Cohort Finale Presentation

# Homework Review From Last Time

1. **Select 5 patients** from your active CCM panel, and work each patient **start to finish**
    a. Submit your reflection or bring to next discussion:
        i. What parts of the workflow ran smoothly?
        ii. Where did you lose time or run into roadblocks?
        iii. What steps could you standardize or batch for future efficiency?
2. **Email us directly with your biggest challenge**. We can provide organization-specific support tailored to your circumstances.
3. **Continue monitoring**:
    a. Your total Medicare/MAP patient population and how many of these patients visit your clinic monthly.
    b. Your total CCM enrolled patients and how that number is trending over time

# Why Keeping CCM In-House Matters

### Quality & Access

CCM drives measurable improvements in patient outcomes and creates consistent touchpoints for your highest-risk population.

### Financial Sustainability

In-house CCM generates reliable recurring revenue while improving quality metrics that impact value-based contracts.

### Control & Ownership

Keeping CCM in-house means you retain full visibility into patient data, relationships, and long-term program value.

Outsourcing can dilute the patient-provider relationship and hand over valuable data ownership to third parties. When you build CCM internally, you're investing in your clinic's future.

# The Case for In-House CCM

## What You Keep

- Direct patient relationships
- Complete data ownership
- Workflow integration
- Quality improvement visibility
- Team continuity and accountability
- Revenue retention

## What You Risk Losing

- Patient trust and connection
- Clinical insights and trends
- Control over care quality
- Long-term program ROI
- Staff engagement and ownership
- Community reputation

# Step 1: Identify Your Target Population

Before you can build a successful CCM program, you need to know exactly who you're serving. Start by conducting a thorough review of your clinic census to identify all Medicare and Medicare Advantage patients. This population represents your CCM opportunity base—the foundation upon which your entire program will be built.

Understanding your denominator is essential for setting realistic goals, forecasting staffing needs, and tracking your program's growth trajectory over time.

# Setting Your Enrollment Goals

**1,000**

**Eligible Medicare Patients**

Your baseline population from census review

**600-700**

**Target Enrollment**

Realistic goal for active CCM participation

**150-200**

**Patients Per Care Manager**

Industry benchmark for sustainable caseload

These ratios help you determine how many care managers you'll need to hire and what your revenue potential looks like. For example, a clinic with 1,000 Medicare patients should aim to enroll 600–700 patients and will need approximately 3–4 full-time care managers to support them effectively.

# Why Identifying the Population Matters

### Measure Success

You can't track progress without knowing your starting point. Your eligible population is the denominator that makes all your metrics meaningful.

### Gauge Program Strength

Understanding penetration rates helps you assess whether you're reaching enough of your eligible population or leaving opportunity on the table.

### Forecast Staffing Needs

Knowing your target enrollment allows you to hire the right number of care managers at the right time—avoiding both understaffing and overstaffing.

### Track Growth & Attrition

Monthly monitoring of enrollment against your eligible population reveals trends, helps you refine outreach, and keeps your program sustainable.

# Step 2: Build a Strong Enrollment Process

A well-designed enrollment workflow is the engine that drives consistent CCM growth. The key is to create a seamless, multi-touch approach that introduces CCM naturally throughout the patient visit. When enrollment is everyone's responsibility—from the front desk to the provider—you create multiple opportunities to engage patients without overwhelming them.

The most successful clinics prepare for enrollment before the patient even walks through the door.

# The Three-Touch Enrollment System

01

## Care Manager Preparation

Reviews tomorrow's schedule and prepares consent forms for eligible patients. Flags high-priority candidates based on recent hospitalizations or chronic condition complexity.

02

## Front Desk Introduction

Delivers a simple one-liner during check-in: "Dr. Smith participates in the chronic care management program. If you qualify, our care manager will call you to explain the details."

03

## Clinical Team Follow-Up

If patient declines, the nurse or MA provides more information about benefits. If still hesitant, the provider gives a brief, high-level explanation during the visit.

This layered approach respects the patient's autonomy while ensuring they receive enough information to make an informed decision.

# Front Desk Script: Keep It Simple

> **"Dr. Smith participates in the chronic care management program. If you qualify, our care manager will call you to explain the details."**

This single sentence accomplishes three things: it normalizes CCM participation, it positions the program as a standard part of care, and it sets the expectation for follow-up without requiring the front desk staff to become CCM experts.

The beauty of this approach is its simplicity. Front desk staff don't need to explain benefits or answer detailed questions—they simply plant the seed. The care manager handles the rest.

# Provider Talking Points

### Keeps patients healthier, happier, and independent longer

Regular check-ins and proactive care prevent small issues from becoming major health crises.

### Reduces hospitalizations and urgent care visits

Early intervention and medication management help patients avoid emergency situations.

### Helps patients manage medications and save money

Care managers identify cost-saving opportunities and ensure proper medication adherence.

### Supports patients in staying in their homes

By managing chronic conditions effectively, CCM helps patients maintain independence and avoid long-term care facilities.

# Step 3: Define the Workflow

Once enrollment is flowing, the real work begins. A strong CCM workflow balances clinic-driven enrollment with care manager-led case management. The clinic team focuses on identifying and consenting eligible patients, while care managers provide the deep, ongoing support that defines quality chronic care management.

Consistency is everything. Establish clear expectations for how care managers engage with patients each month.

# Monthly Care Management Workflow

### Start of Month

Care manager proactively calls each enrolled patient. No waiting for patients to reach out—you lead the engagement.

### Daily Outreach

Goal: 10–15 patient conversations per day. Document all touchpoints in the EHR for continuity and billing.

### Case Management

Address medication adherence, care gaps, appointment follow-up, and social determinants of health.

### Team Coordination

Loop in providers, behavioral health, and referral coordinators as needed for comprehensive care.

# Managing Attrition

## Why Patients Leave CCM

- Move out of area or to assisted living
- Transition to hospice care
- Begin home health services
- 
- Pass away
- Choose to disenroll

## Your Response Strategy

- Expect monthly turnover—it's normal
- Maintain a rolling enrollment list
- Build pipeline refill into weekly workflow
- Track attrition patterns to anticipate needs
- Celebrate the care you provided, even when patients transition

Attrition isn't failure—it's a natural part of caring for a medically complex population. The key is to continuously enroll new patients so your caseload remains stable and sustainable.

# Step 4: Create a Team-Based Care Model

CCM is not a solo sport. The most successful programs recognize that chronic care management works best when it's woven into the fabric of the entire care team. Every role—from referral coordinators to behavioral health consultants—plays a part in supporting patients with complex chronic conditions.

When everyone owns a piece of CCM, patients receive more coordinated, comprehensive, and compassionate care.

# Your CCM Dream Team

### Referral Coordinators

Track specialist appointments and ensure patients follow through with recommended care.

### Nurses & MAs

Provide clinical triage, medication reconciliation, and education during patient touchpoints.

### CHWs & Social Workers

Address social determinants of health, connect patients to community resources, and reduce barriers to care.

### Chronic Care Managers

Lead monthly outreach, care planning, and coordination across the continuum.

### Behavioral Health Consultants

Support patients with depression, anxiety, and behavioral health conditions that complicate chronic disease management.

### Nurse Practitioners & Providers

Oversee care plans, adjust treatment protocols, and maintain clinical oversight of the CCM program.

# Team-based care = best care

# Communication is Key

### Shared Goals

Every team member understands the clinic's CCM targets and how their role contributes to program success.

### Shared Data

Enrollment lists, care gaps, and patient progress are visible to the entire care team through your EHR.

### Shared Accountability

CCM outcomes are a team metric, not just a care manager metric. Everyone celebrates wins and problem-solves challenges together.

Integrate CCM communication directly into your EHR workflows. Use daily huddles or shared dashboards to keep the team aligned. When everyone knows who's enrolled in CCM, coordination happens naturally and patients feel the difference.

# Tools for Team Alignment

## Daily Huddles

Start each day with a quick team standup to review:

- High-risk CCM patients on today's schedule
- Recent hospital discharges needing follow-up
- New enrollments and consent opportunities

## EHR Integration

Make CCM enrollment visible at every touchpoint:

- Flag CCM patients in the schedule
- Use care plan templates for consistency
- Document all touchpoints in a shared note type
- Create reports to track enrollment and time spent

# Measuring Success

What gets measured gets managed. To ensure your CCM program is delivering value—for patients, for the clinic, and for the community—you need to track the right metrics consistently. These measures will help you make data-driven decisions about staffing, workflows, and program improvements.

Build monthly reporting into your care manager's workflow so you always have a clear picture of program health.

# Key Metrics to Track

1

### Enrollment Rates vs. Eligible Population

What percentage of your Medicare patients are actively enrolled? Are you hitting your 60–70% target?

2

### Monthly Attrition and New Enrollments

How many patients are leaving the program each month? Are you enrolling enough new patients to maintain or grow your caseload?

3

### Reduction in ED/Hospital Visits

Are CCM patients experiencing fewer emergency department visits and hospitalizations compared to non-enrolled patients?

4

### Patient Satisfaction and Medication Adherence

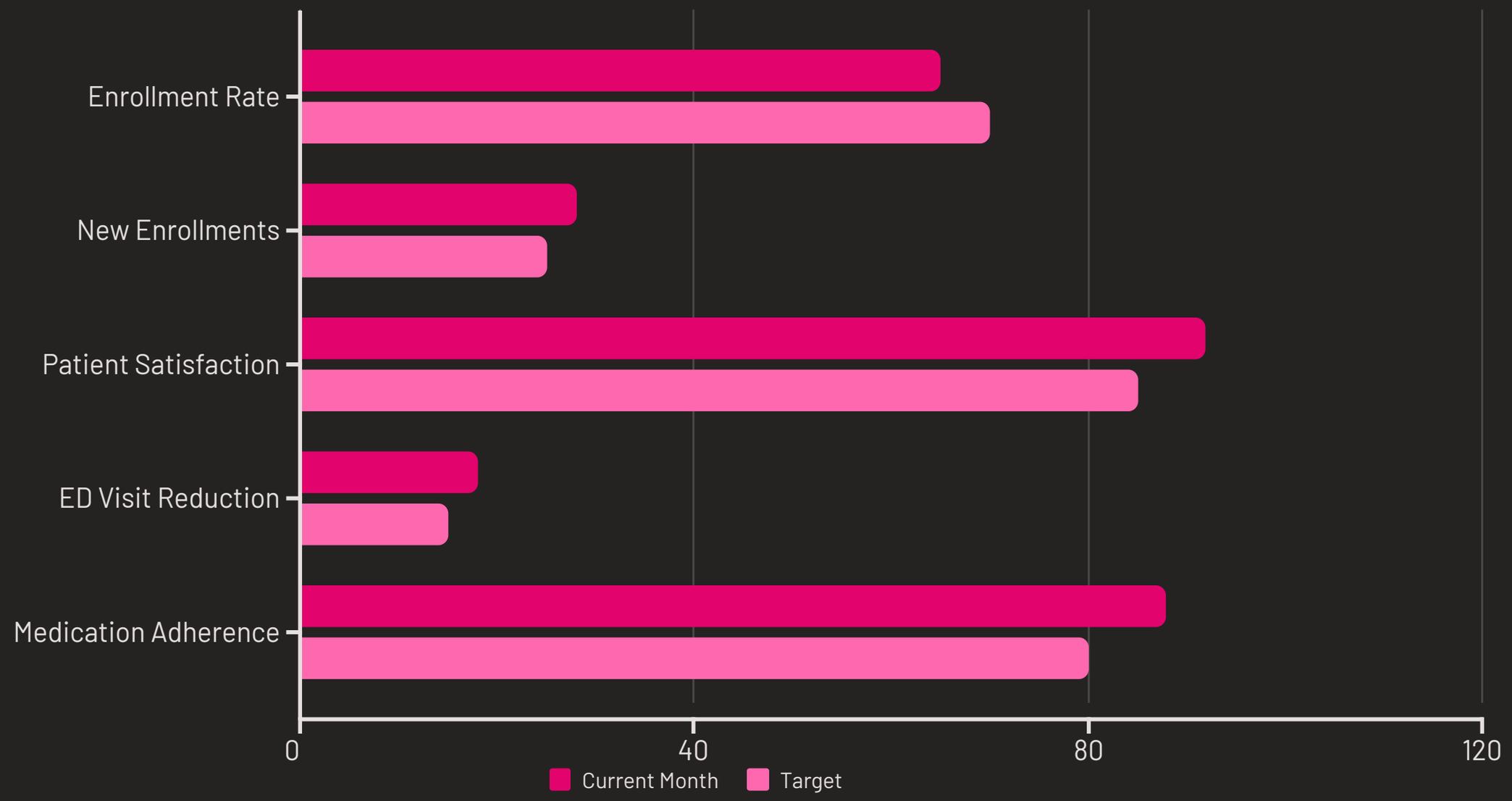
Do patients report feeling more supported? Are they taking their medications as prescribed?

5

### ROI for the Clinic

What's the financial impact? Consider both CCM revenue and quality incentive payments from value-based contracts.

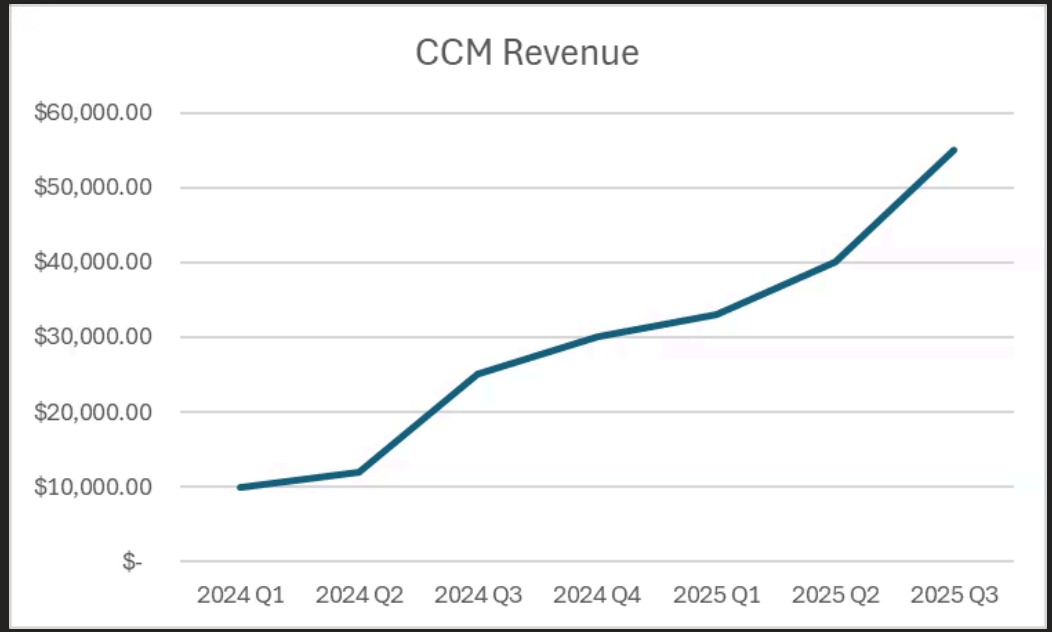
# Sample CCM Program Dashboard




A simple dashboard like this helps you spot trends quickly and celebrate progress with your team.

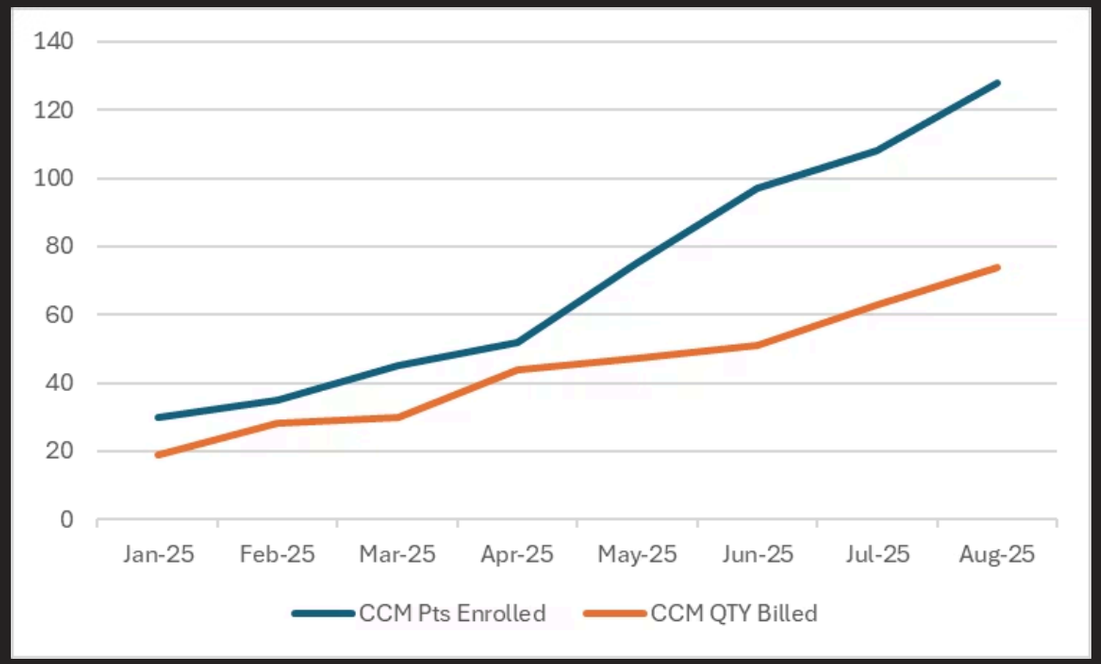
# Data-Driven Growth and ROI

Measuring your program's performance isn't just about compliance; it's about proving and accelerating your return on investment. By consistently tracking key metrics, you can identify areas for improvement, optimize resource allocation, and demonstrate the tangible financial benefits of your in-house CCM program.




This chart illustrates how a well-managed in-house CCM program can generate substantial revenue growth over time. Consistent enrollment, efficient workflows, and proactive care management translate directly into increased billing opportunities and a healthier bottom line for your practice.

# Analytics to Support Strategic Staffing: When to Expand Your CCM Team




A critical indicator for your Chronic Care Management (CCM) program's sustainability and growth is the balance between enrolled patients and your team's capacity to bill for their care. If the number of enrolled patients consistently exceeds those you can effectively manage and bill for each month, it signals an immediate need to reassess your staffing levels.

### Recognize the Tipping Point

When enrolled patients outnumber billable patients, it's a clear sign your current CCM staff is stretched too thin, potentially leading to burnout and missed revenue.

### Maximize Revenue & Care Quality

Hiring additional Chronic Care Managers ensures you can deliver high-quality care to all enrolled patients and capture all eligible billing opportunities, optimizing your program's financial health.

### Plan for Growth

Proactively evaluate staffing needs based on enrollment trends to maintain efficiency, improve patient outcomes, and scale your CCM program effectively.

# Maximize Your Potential: Harnessing EHR for CCM Success

Your EHR isn't just a record-keeping tool; it's a powerful asset for elevating your Chronic Care Management program. By leveraging its built-in reporting capabilities, you can transform raw data into actionable insights, driving both patient health and practice prosperity.

### Optimize Care Delivery

Gain clear insights into patient engagement and program effectiveness, allowing you to refine care plans and improve patient outcomes.

### Maximize Reimbursement

Easily track time spent and services rendered, ensuring accurate billing and maximizing your practice's financial return on CCM.

### Drive Strategic Growth

Identify growth opportunities and areas for improvement, enabling data-driven decisions to expand your CCM program's reach and impact.

Ready to unlock the full potential of your EHR for CCM? Here's how to start:

### Explore Your EHR Capabilities

Dive into your EHR's reporting section. Many systems have dedicated CCM dashboards or customizable reports that provide valuable performance metrics.

### Connect with Internal Experts

If you're new to EHR reporting, reach out to colleagues or internal IT support. There's often someone within your organization who can guide you through the process.

### Utilize Training & Resources

Many EHR vendors offer comprehensive online training, webinars, and educational materials specifically on utilizing their reporting tools for CCM. Take advantage of these!

### Regularly Review Reports

Make it a habit to regularly review your CCM performance reports. Consistent monitoring is key to continuous improvement and demonstrating your program's undeniable value.

# Sustainability Through In-House Ownership

When you build CCM in-house, you're not just creating a program—you're investing in your clinic's long-term sustainability and your community's health. In-house ownership means you control the data, the workflows, and the relationships that matter most. You build local capacity, strengthen continuity of care, and position your clinic as a trusted partner in patients' health journeys.

Your care managers become community experts, not call center representatives reading from scripts.

# What In-House Ownership Delivers

### Better Outcomes

When care managers are embedded in your clinic, they understand your patient population deeply and can tailor interventions to individual needs and community context.

### Stronger Patient Trust

Patients trust staff they recognize. In-house care managers are part of the care team, not outsiders, which leads to higher engagement and better adherence.

### Financial Stability

CCM revenue stays in your clinic, supporting salaries, infrastructure, and program growth. You also improve quality metrics that unlock value-based payment bonuses.

# The Outsourcing Trade-Off

## What You Give Up

Outsourcing CCM may seem convenient, but it comes with hidden costs:

- Patient data leaves your system
- Care coordination becomes harder
- You lose insight into patient trends
- Revenue is split with vendors
- Patients may feel disconnected from your clinic

When a third party manages your patients' chronic conditions, you lose the feedback loop that helps you improve care across your entire practice.

# Five Key Takeaways

01

## Identify Your Eligible Population

Know your denominator. Review your census and set realistic enrollment goals based on your Medicare population.

02

## Standardize Your Enrollment Workflow

Create a seamless three-touch system that introduces CCM naturally throughout the patient visit.

03

## Empower Care Managers

Give your care managers the tools, training, and support they need to lead with compassion and consistency.

04

## Keep CCM In-House

Retain control over data, workflows, and patient relationships to maximize outcomes and long-term value.

05

## Engage the Entire Team

CCM is everyone's responsibility. Team-based care delivers the best results for patients and clinics.

# Quick Reference: CCM Program Checklist

## Getting Started

- Run census report for Medicare patients
- Set enrollment targets (60–70%)
- Calculate care manager staffing needs
- Develop consent forms and scripts
- Train front desk, clinical, and provider teams

## Monthly Operations

- Proactive outreach at start of month
- Document all touchpoints in EHR
- Track enrollment and attrition
- Hold team huddles for coordination
- Review metrics and adjust workflows

# Common Challenges & Solutions

### Challenge: Low Enrollment Rates

**Solution:** Audit your workflow. Are all team members using the scripts? Is the provider reinforcing CCM value? Consider offering same-day enrollment conversations.

### Challenge: High Care Manager Burnout

**Solution:** Check caseload ratios. Ensure care managers aren't exceeding 200 patients. Build in administrative time for documentation and coordination.

### Challenge: Inconsistent Documentation

**Solution:** Create EHR templates and establish clear documentation standards. Review sample notes in team meetings to ensure quality and compliance.

### Challenge: Rapid Attrition

**Solution:** Analyze why patients are leaving. Are you enrolling patients who are too sick or about to transition to home health? Refine your targeting criteria.

# Resources to Support Your Journey

## National Organizations

- CMS Chronic Care Management resources and billing guidelines
- AAFP CCM toolkit and best practices
- HRSA guidance for health centers
- National Association of Community Health Centers CCM resources

## Internal Tools

- Enrollment script templates
- Care manager training modules
- Monthly reporting dashboards
- Patient education materials
- EHR documentation templates

Don't reinvent the wheel. Leverage existing resources and adapt them to fit your clinic's unique culture and patient population.

# Closing: Taking Ownership

> **"When we take ownership of CCM, we take ownership of our patients' health."**

Building a strong in-house CCM program isn't easy, but it's worth it. When you invest in your team, your workflows, and your patients' long-term wellbeing, you create a foundation for sustainable, high-quality primary care. Thank you for your commitment to this work.

## Open Discussion

What questions do you have? What challenges are you facing? Let's learn from each other and strengthen our programs together.

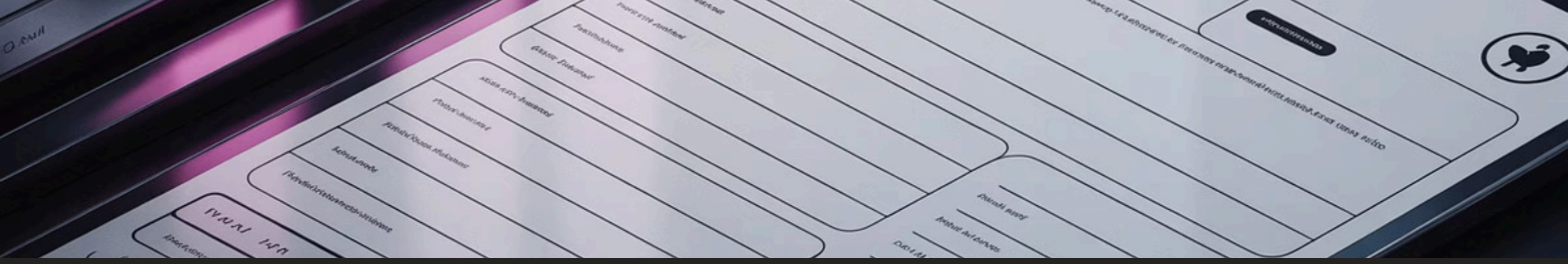
# Comprehensive Care Plan

A comprehensive care plan is a patient-centered, electronic document developed, revised, and monitored to guide the management of chronic conditions. It is based on a thorough assessment of the patient's physical, mental, cognitive, psychosocial, functional, and environmental factors, alongside an inventory of available resources and support systems. This plan ensures that patient health goals, concerns, and preferences are central to every aspect of their treatment journey.

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Ongoing revision and monitoring (per code descriptors)
- Cognitive and functional assessments
- Symptom management strategies
- Planned interventions
- Medical management protocols
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners
- Periodic review schedule

**Plan Availability and Distribution**

The comprehensive care plan must be made available promptly both within and outside the billing practice. Patients and their caregivers should receive a copy of the care plan when necessary.



# Patient Centered Care Plan

## Patient Information

Patient name: DOB

Last Medicare Wellness Exam

Patient Pharmacy:

Current Chronic Conditions:

**Current diagnosis list pulls in here**

## Patient Goals & Concerns

Patient Goal: (PCMH requirement)

Patient Concerns/ Barriers to Care:

Plan to Achieve Care Plan Goals:

Provider Guide Goals:

## Appointments & Support

Lab/ Clinic Appointments Due

Resources and Support: (Besides your health care team who would you turn to for health-related problems (family, friends, spiritual support, neighbor.)

Other providers involved in Care/ Specialists/ Counselors/ DME suppliers:

## Preventive Screenings/ Immunizations

### Immunizations Due now:

- **Flu**
- **Zoster**
- **Pneumovax 23**

## Treatment Goals/Targets

These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100, BP<150/90, weight of 150 pounds, 7 hours of uninterrupted sleep, average pain level of 5, ability to walk to my mailbox daily):

Diet:

Exercise:

Safety

Smoking

Future appointments planned:

Current Medication List:

**Med list should pull in from EMR here**

Please review your medication list and report any changes.

Your Chronic Care manager is:

# The Power of a Patient-Centered, Provider-Guided Care Plan

## Why the Care Plan Matters

### Foundation of CCM

The care plan is the foundation of Chronic Care Management (CCM).

### Patient-Centered & Provider-Guided

It must be patient-centered and provider-guided, reflecting the patient's goals, needs, and preferences.

### Adaptable & Dynamic

The plan can be updated or revised anytime as patient conditions, medications, or goals change.

# Meeting CCM Requirements

A compliant care plan must:

### Identify & Address Conditions

Identify and address all chronic conditions.

### Set Patient-Centered Goals

Include patient-centered goals and measurable outcomes.

### Outline Interventions

Outline interventions, responsible team members, and follow-up timelines.

### Ensure Patient Accessibility

Be accessible in the patient portal.

Providers should sign and acknowledge the care plan, reinforcing its importance during visits.

# Beyond the Portal: Meeting Patients Where They Are

### Seniors and Technology Barriers

Many seniors struggle with technology and portal access, making digital-only solutions challenging.

### Physical Delivery is Key

Best practice: Always mail or hand-deliver a physical copy of the care plan.

### In-Person Review Recommended

Review the care plan in person—ideally before or after a provider appointment.

### Enhance Engagement & Compliance

When patients review the care plan in a clinical setting, they tend to take it more seriously, improving engagement.

# Team Access and Communication

The care plan should be visible to the entire care team:

**Providers**

**Nurses and MAs**

**Care Managers**

**Social Workers / Behavioral Health staff**

Ensures coordinated communication and consistent messaging across the care team

# The Patient as a Partner

### Encourage active participation

Encourage patients to carry their care plan to all outside appointments.

### Comprehensive information

The plan contains the most up-to-date medication list, provider contact information, and active goals and interventions.

### Reduced burden

Sharing this with specialists reduces duplicate tests, repeat labs, and unnecessary costs.

### Improved outcomes

This approach saves time, reduces confusion, and builds trust.

# CCM Billing Basics

## Understanding the fundamentals of Chronic Care Management (CCM) billing is essential for successful program implementation and appropriate reimbursement.

### Key CPT Codes

99490: At least 20 minutes of clinical staff time directed by a physician/NPP, per calendar month.

99439: For additional time (often used by RHCs/FQHCs or for complex patients).

### Time Requirement

A minimum of 20 minutes of non-face-to-face clinical staff time must be spent per patient per calendar month to qualify for CCM services.

### Meticulous Documentation

Accurate and comprehensive documentation is paramount. It must clearly reflect all time spent, services rendered, and patient interactions to support billing claims.

# CPT Code 99490: The Core of CCM Billing

## CPT 99490 is the foundational billing code for Chronic Care Management, enabling providers to be reimbursed for crucial non-face-to-face care coordination services.

### Primary CCM Service

This code covers the essential non-face-to-face care management services provided to patients with multiple chronic conditions.

### Time Requirement

Requires at least **20 minutes** of clinical staff time per patient per calendar month, directed by a physician or other qualified healthcare professional.

### Core Components

Includes establishing and revising a comprehensive care plan, providing 24/7 access to urgent care needs, and facilitating care coordination.

### Reimbursement

Typical reimbursement rates range from **$40-$60 per patient per month**, varying by geographic location and payer.

Eligible professionals for billing include Physicians, Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists.

# CPT Code 99439: Extending Chronic Care Management

**Add-on code for non-complex Chronic Care Management (CCM) services that covers each additional 20 minutes of clinical staff time per calendar month, beyond the initial 20 minutes.**

# CCM Billing Best Practices & Compliance

Adhering to best practices and strict compliance guidelines is crucial for successful Chronic Care Management (CCM) billing and avoiding audits.

### Obtain Explicit Consent

Verbal or written consent must be obtained from the patient each calendar month before initiating CCM services. Document this consent thoroughly in the patient's record.

### Meticulous Documentation

All services, communications, and time spent must be accurately recorded. This includes date, time, activity performed, who performed the service, and a clear link to the patient's care plan goals.

### Accurate Time Tracking

Ensure precise tracking of non-face-to-face clinical staff time for each code (e.g., 20+ minutes for 99490, additional 30 minutes for 99491). Time must be clinically directed and justifiable.

### Avoid Common Pitfalls

Beware of insufficient documentation, billing for less than the minimum time, missing monthly consent, and incorrect code usage (e.g., billing add-on codes without the base code).

# What's Next? Your Journey Continues!

Congratulations on successfully completing the CCM cohort! This is an exciting new chapter, and we're here to ensure you feel confident and supported as you implement your new skills. Here's how you can continue to thrive and stay connected:

## Immediate Next Steps

### Review & Reflect

Revisit your course materials and notes. Identify the top 3-5 key takeaways you want to implement first.

### Set Actionable Goals

Define specific, measurable, achievable, relevant, and time-bound (SMART) goals for applying what you've learned.

### Apply Your Knowledge

Start integrating new strategies and tools into your daily work. Don't aim for perfection, aim for progress!

### Seek Feedback

Share your progress with a trusted colleague or cohort member and ask for their constructive feedback.

## Ongoing Support Resources

### Cohort Resource Hub: CCM Improvement Cohort | Montana Performance Improvement Network

This site provides continued access to course materials, templates, and bonus guides.

### Mentorship Opportunities

Explore opportunities to connect with mentors for personalized guidance and support on your implementation journey.

### Future Workshops & Webinars

Stay updated by attending workshops and webinars that will help deepen your expertise.

### Internet Resources: Home - Centers for Medicare & Medicaid Services | CMS

CMS provides comprehensive guidance and toolkits to help strengthen your CCM program.

## Suggested Implementation Timeline

1. **Weeks 1-4: Initial Application**
   Focus on implementing 1-2 core strategies. Establish new routines and identify immediate areas for improvement.
2. **Months 1-3: Evaluate & Adjust**
   Measure the initial impact of your changes. Refine your approach based on results and feedback received.
3. **Months 3-6: Deeper Integration**
   Fully embed new practices into your workflow. Share successes and lessons learned with your team or organization.
4. **Beyond 6 Months: Continuous Growth**
   Explore advanced topics, seek leadership roles, and mentor others to drive sustained, impactful change.

## Stay Connected

Your cohort is a powerful network! Continue to leverage these relationships:

- **Cohort Group:** Keep in touch with your fellow cohort members through your established communication channels (e.g., LinkedIn group, Slack workspace).

We are excited to see the impact you will make. Keep pushing forward!

# Complete Your Cohort Journey: Share Your Impact

**1. Complete Final Reporting Tasks**

To help us capture the full statewide impact of our collective efforts, please complete the following final reporting tasks:

- ✅ Submit your final tracking data for **Medicare/Medicare Advantage patient counts** and **Chronic Care Management (CCM) enrollments**.
- ✅ Share **1–2 success stories** or standout patient experiences that highlight your achievements.
- ✅ Provide **team reflections or quotes** on what changed, what worked well, and what challenges you still faced.
- ✅ We'll share the comprehensive **final Impact Summary** with all cohort participants.

# Questions and Open Discussion

Please do not hesitate to reach out with any questions. Feel free to email us directly if you have any questions or would like additional information:

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