

# KootenaiCareNetwork

## Rural and Frontier ACO's: Can They Deliver on the National Promise for Quality Care and Cost Management?

NAACOS Panel Moderator:  
Patricia "Patt" Richesin, MBA/HA, FACMPE  
President  
Kootenai Care Network  
Kootenai Accountable Care

# The Panelists

## Patt Richesin

- Kootenai Accountable Care
- Idaho
- Regional Integrated ACO

## Yvonne Ketchum-Ward

- Community Health Center Network of Idaho
- Idaho
- Statewide FQHC ACO

## Michelle Coon

- West Virginia Health Network
- West Virginia
- Regional Integrated ACO

## Tom Gronniger

- Caravan Health
- Nationwide
- Community Hospital ACO
- Aggregation and Management

## Simeon Niles

- Centers for Medicare and Medicaid Innovation
- CHART Model

# The Populations

Rural

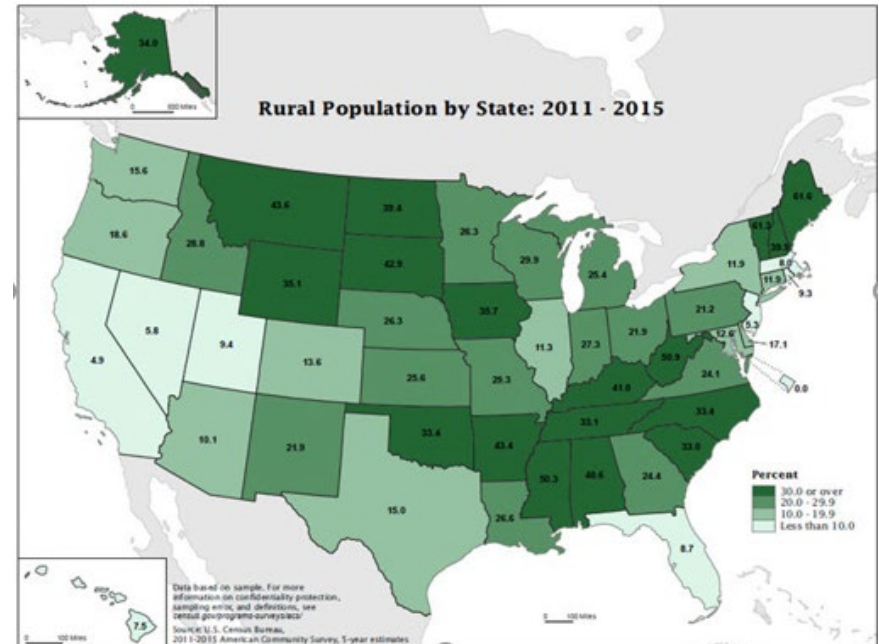
- According to the U.S. Census Bureau, in 2016, approximately **60 million Americans (19.3%) lived in a nonmetropolitan, or rural, area.**
- This figure included about 13 million children under 18 and 47 million adults.

Nonmetropolitan

- Although rural residents make up less than one-fifth of the U.S. population, **65% of the 3,142 U.S. counties are classified as nonmetropolitan (Meit, et al., 2014).**

Frontier

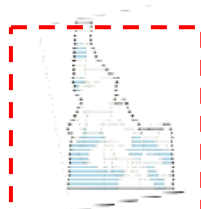
- This figure includes 445 “frontier” counties (U.S. Census Bureau, 2010) that have a **population density of fewer than 7 people per square mile.**



# Characteristics of Mountain West States



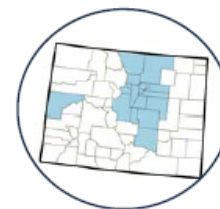
Utah



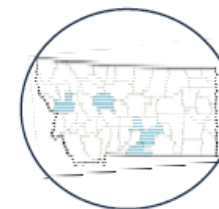
Idaho



Wyoming



Colorado



Montana

Average Population Density (# People/Sq. Mile for Rural Counties)

6.9

14.9

4.7

10.2

5.4

% Pop (Rural Counties)

11%

35%

70%

14%

65%

Avg. Sq Miles (Rural Counties)

3.1k

1.9k

4.3k

1.7k

2.7k

PCP/100k Population and State Rank (All Counties)

64.7 (49<sup>th</sup>)

73.1 (46<sup>th</sup>)

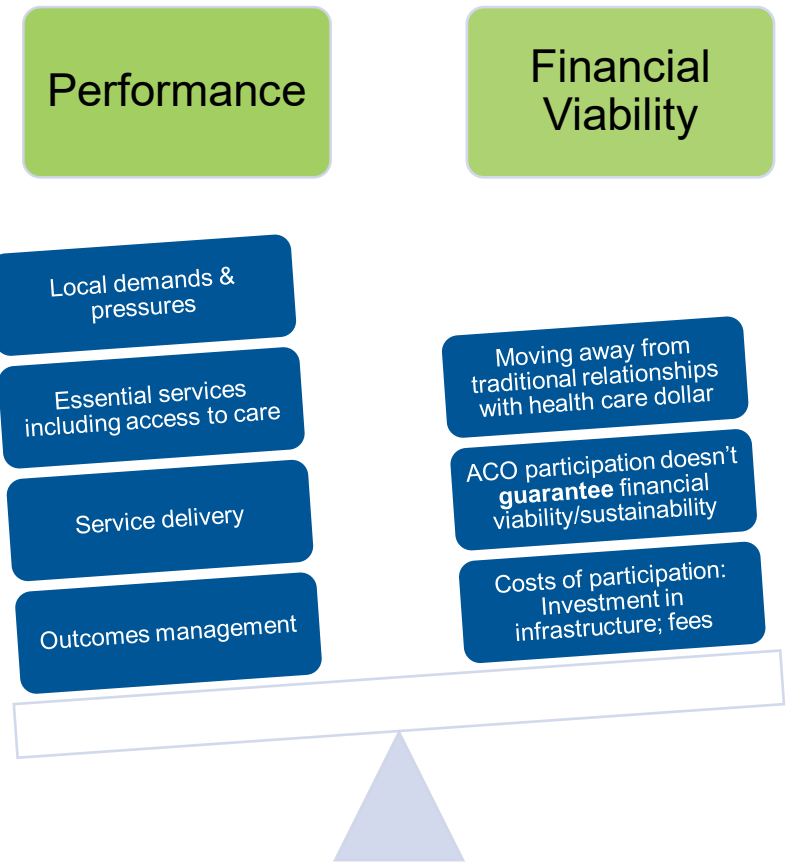
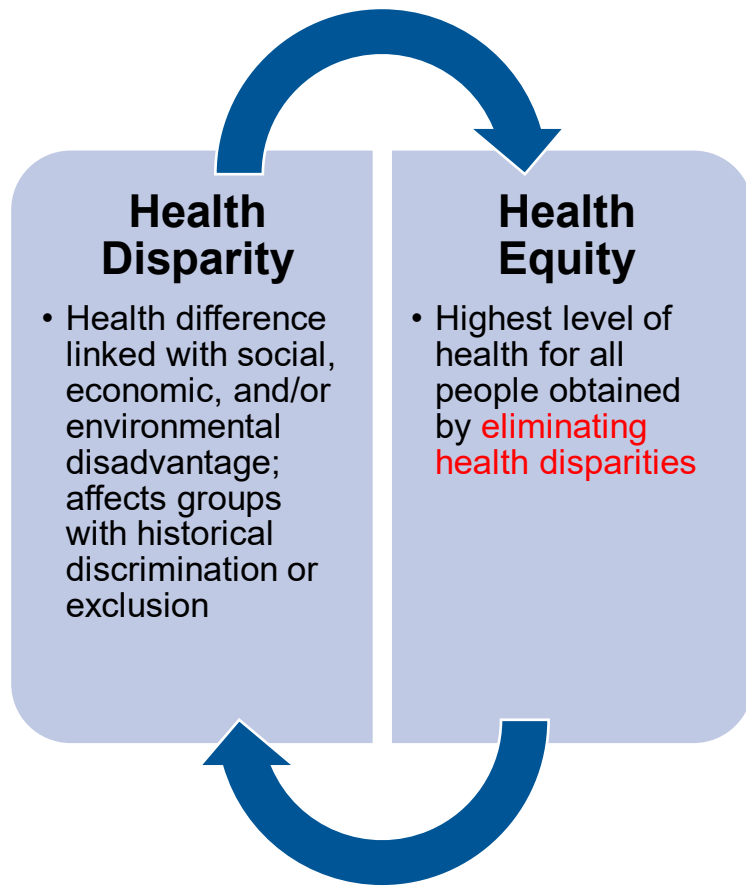
77.4 (43<sup>rd</sup>)

94.2 (21<sup>st</sup>)

86.6 (29<sup>th</sup>)

\*Expanded to 100 percent of the federal poverty level. Note: Data is 2017 or earlier if latest year available. PCP = primary care physician. Sources: Cragun, E. (2019 June 24). Pennsylvania Model and CMS Rural Initiatives. Presented at the 2019 Rural Health Convening, Midway, UT. Rural Health Information Hub. Centers for Disease Control and Prevention.

# The Rural Health Care Chasms



# Capacity for a Rural ACO to Influence Outcomes

There is no separate definition for a rural ACO within the CMS definition for accountable care organizations

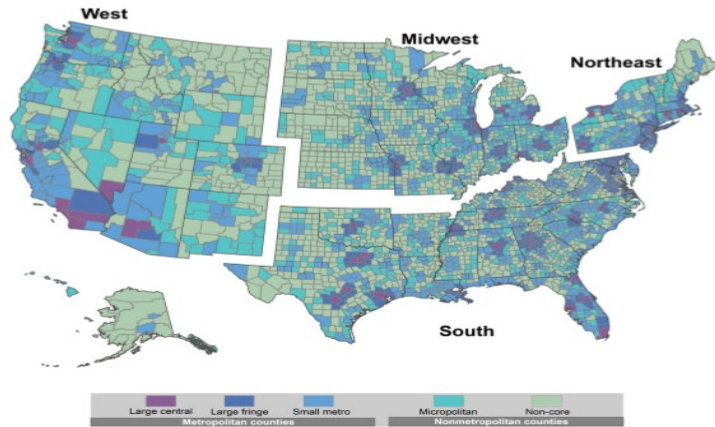
In 2018, the Centers for Medicare & Medicaid Services (CMS) reported that 1,517 prospective payment system (PPS) hospitals and 421 CAHs participated in 561 Medicare SSP ACOs.

However, a majority of 1,350 rural hospitals (including CAHs) have not yet participated in ACOs or other value-based payment model

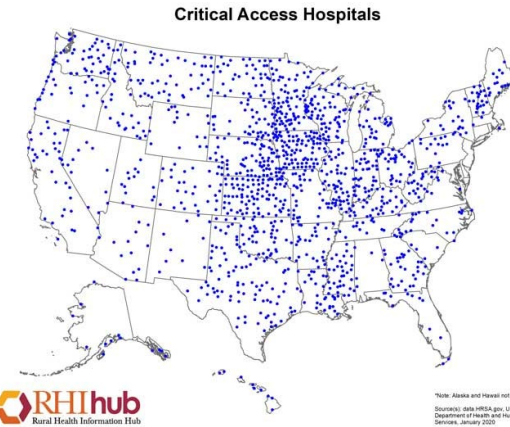
## Rural Participants, Providers, & Hospitals:

- Are essential to their communities and crucial to the care continuum
- Often lack key structures for value based agreements, including ACO's
  - Favorable finance & market conditions
  - Technology
  - Governance
  - Alignment
  - Transformation resources (care management, access to care, etc.)
  - Ability to financially bridge transformational demands (value based Initiatives)
- Are reliant on upstream colleagues for meeting quality, utilization, and cost of care outcomes
- Need to understand their role in advancing risk arrangements (Medicare ACO's & other value based arrangements)

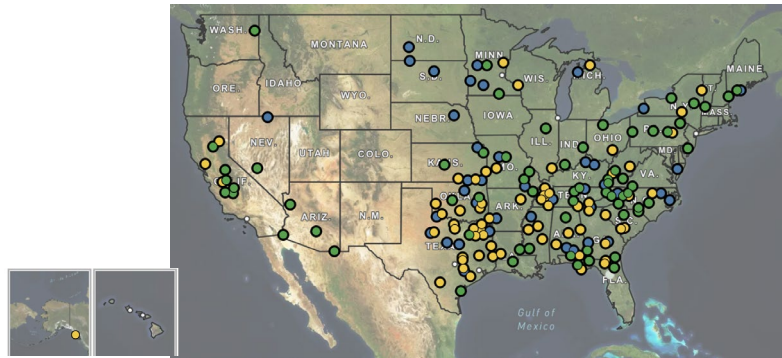
# Vulnerability of Rural Health



Population Density\*



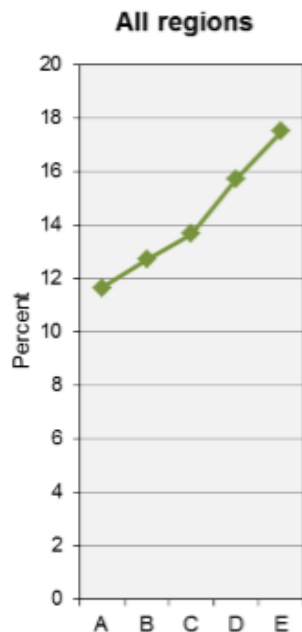
1,350 CAHS in U.S. (2019)



**174 CAH closures since 2005 (132 since 2010)**

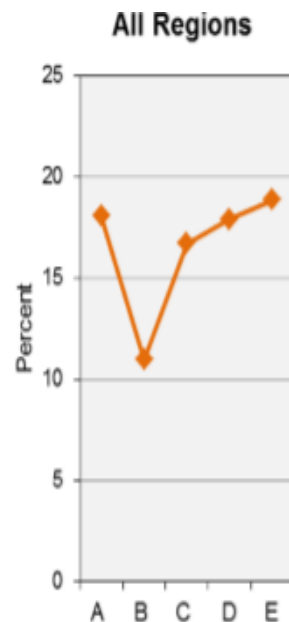
# Social Determinants and Access to Care By Urbanization (2010-2011)

Population 65 and over



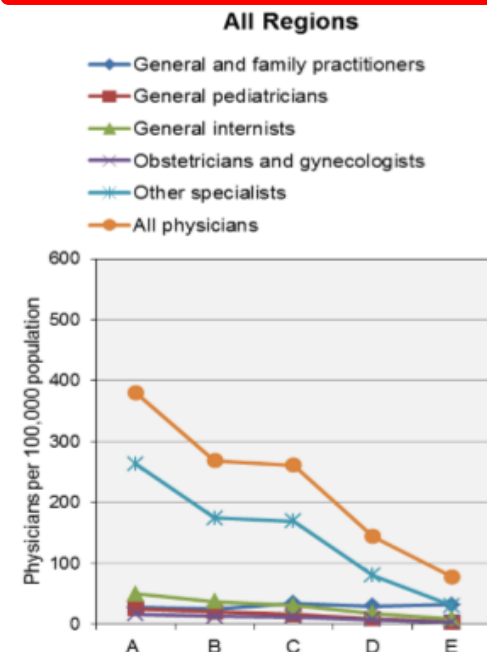
A	B	C	D	E
Large central	Large fringe	Small metro	Micropolitan	Non-core
Metropolitan counties			Nonmetropolitan counties	

Population in Poverty



A	B	C	D	E
Large central	Large fringe	Small metro	Micropolitan	Non-core
Metropolitan counties			Nonmetropolitan counties	

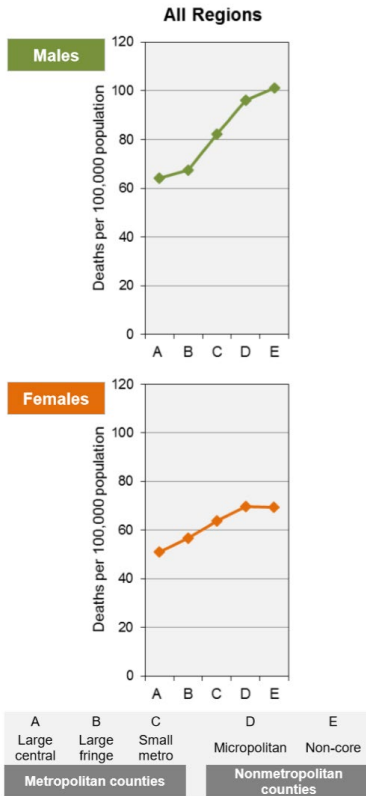
Active Physicians per 100,000 by specialty



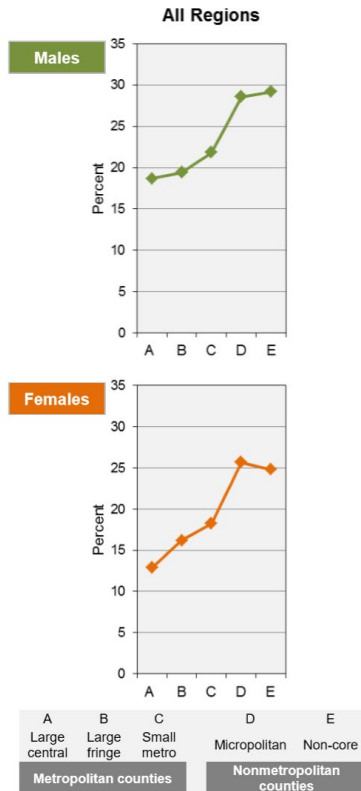
A	B	C	D	E
Large central	Large fringe	Small metro	Micropolitan	Non-core
Metropolitan counties			Nonmetropolitan counties	

# Illness Burden and Contributing Factors Varying Period 2006-2011 Per 100,000

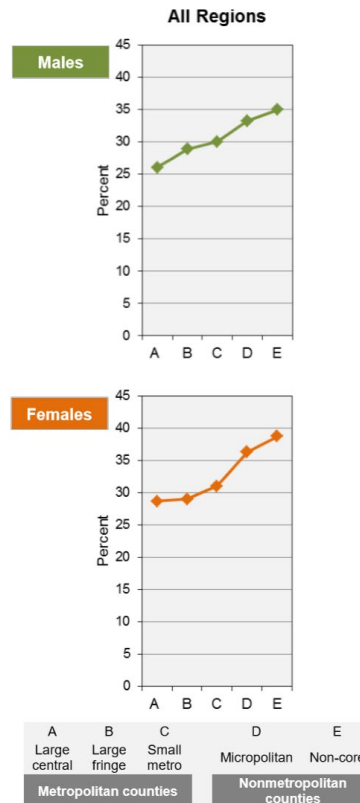
COPD



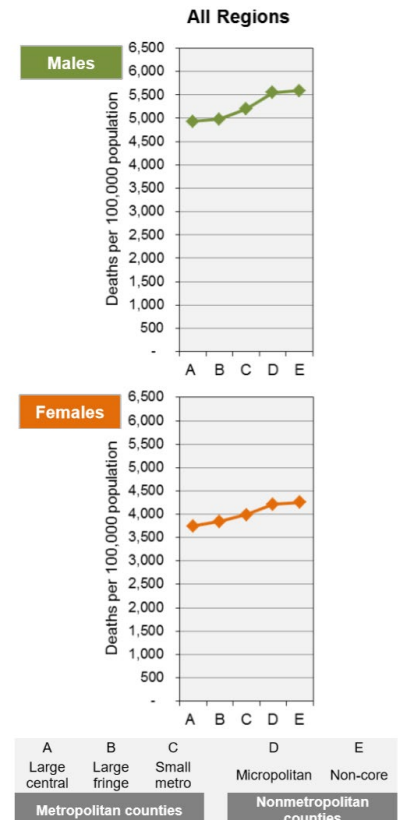
Smoking



Obesity



Death Rate 65+



# Rural ACOs: Same/Similar Competitive Influences as Urban/Suburban Colleagues

Retail	Episodic Bundled Payment	Health Plans	Direct Primary Practices	Telehealth	Disrupters / Private Equity
     	      	    	   	     	     

# Public Policy Influence (Examples)

- **Accountable Care Organization Accountable Investment Model (AIM -(2016)**

Full report September 2020; Overview, CMS September 2020

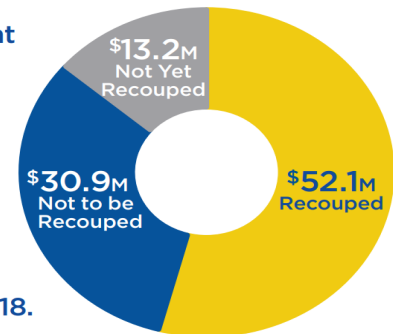
## Model Overview

The Accountable Care Organization (ACO) Investment Model (AIM) operated under the Shared Savings Program (SSP) from 2015 to 2018. AIM provided up-front payments to select ACOs to invest in infrastructure and staffing. It targeted:

- **New ACOs** to encourage their formation in rural or low ACO penetration areas (41 AIM Test 1 ACOs began in 2016).
- **Existing ACOs** that were small to encourage their continued participation and transition to two-sided financial risk (6 AIM Test 2 ACOs began in 2015 or 2016).

AIM ACOs received up-front payments for two years. These payments can be recouped from shared savings earned by AIM ACOs for up to six years.

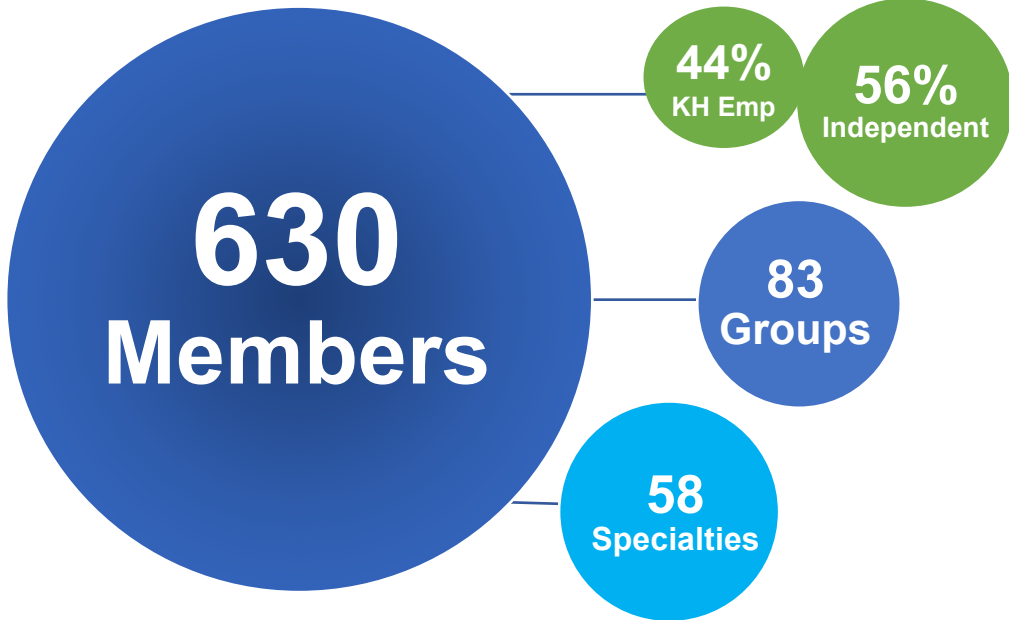
A total of \$96.2M in AIM payments were dispersed. So far, 54.2% of funds have been recouped through 2018.



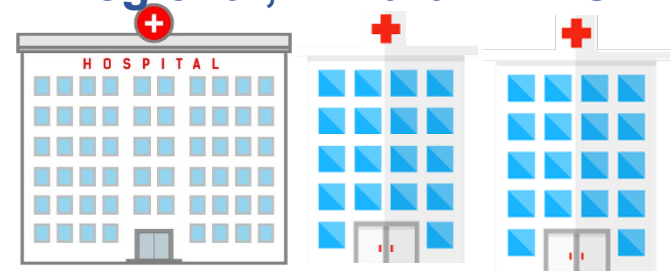
- **Rural Health Care Quality Improvement Act of 2016**
- **Rural ACO Improvement Act “Rural Glitch”**
- **CMMI transformation opportunities**
  - Pennsylvania Rural Health Model –global budget and rural transformation plan (example)
  - Community Health Access and Rural Transformation (CHART) Model

# Network by the Numbers

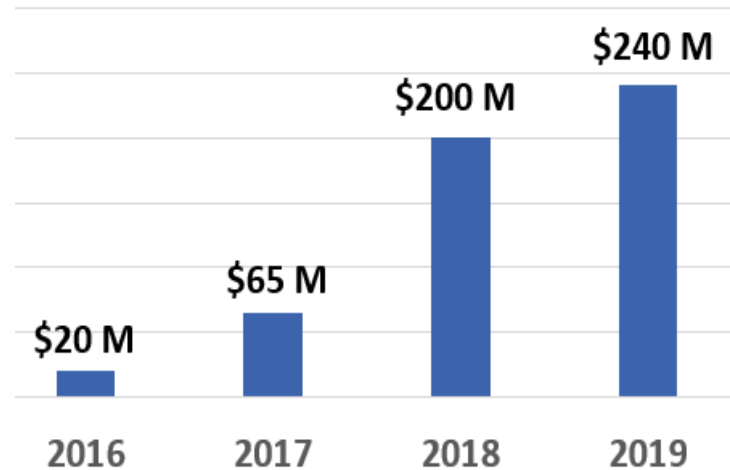
KootenaiCareNetwork



**3 Hospitals**  
1 Regional; 2 Rural CAHs\*



## Contracted Medical Spend



### LightBeam Population

#### Health Analytics

- 590,000+ Patient Files
- 62 Interfaces
- 22 EMRs
- 6 Health Plan Claim Feeds

### Health Plan Contracts

- Kootenai Health Employee Health Plan
- Blue Cross of Idaho QHP
- Pacific Source Medicare Advantage
- Blue Cross of Idaho Medicare Advantage
- Medicare Shared Savings Program ACO
- Blue Cross of Idaho Commercial

\* Rural CAHs new to network 2020; new to ACO 2021

## Kootenai Accountable Care

### Medicare Shared Savings Program PY 2018 and 2019

#### Improving Care (PY 2019)

MIPS Quality	96.06%
ACO Quality	96.75%

#### Chronic Care Management PY 2018

Impact	Difference (Per Month)
ER Visits	-11%
Acute Admits	-19%
Re-Admits	-30%

#### Transitional Care Management PY 2018

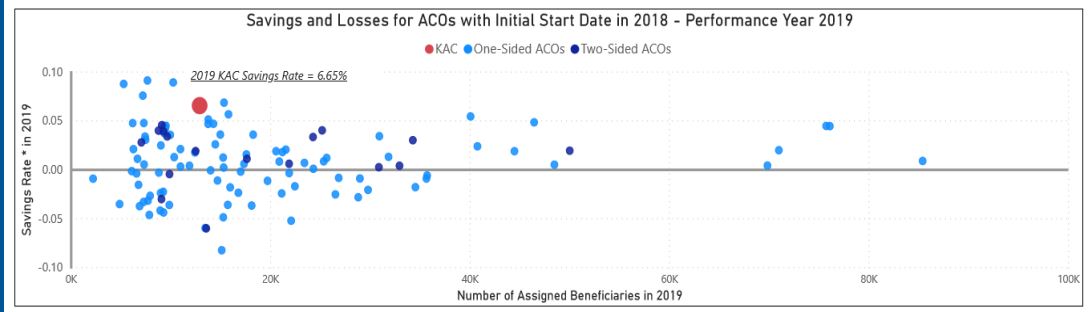
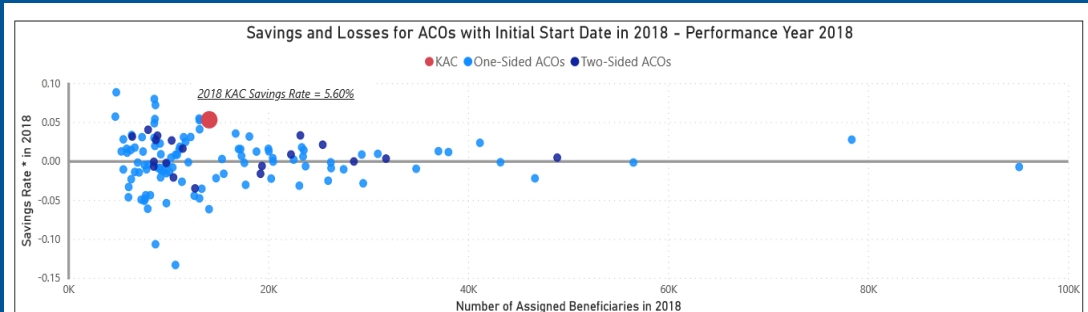


Compared to those that did not receive TCM, discharged patients that received TCM had an approximately

- 31% reduced risk of readmission
- 32% reduced risk of ED utilization

#### Achieving Savings

- ❑ Total KAC Savings in 2018 = \$7,061,252
- ❑ Total KAC Savings in 2019 = \$7,915,987
- ❑ Total KAC Savings for 2 years = \$14,977,239





CHCNI

Community Health Center Network of Idaho

Yvonne Ketchum-Ward –CEO

- ▶ To support and strengthen Idaho CHCs by collaborating with payers to improve the health status of patients and to offer CHC services as a network to health plans, employers, and the State of Idaho

## CHCNI MISSION STATEMENT

- ▶ Develop strong, healthy populations by evolving from a fee-for-service volume based model to a patient centered medical home model of care based on value and health outcomes through provider leadership and engagement.

**CHCNI VISION**

A series of several parallel white lines of varying lengths and positions, all slanted upwards from left to right, located in the bottom right corner of the slide.

- ▶ Community Health Center Network of Idaho, (“CHCNI”) was created on May 14, 2012 and currently consists of 14 Federally Qualified Community Health Centers (CHCs) located throughout Idaho.
- ▶ CHCNI was created to support and strengthen Idaho CHCs by bringing the CHCs together as a single organization. CHCs collaborates with payers to balance the payer mix, raise visibility and credibility, increase coordination between CHCs, strengthen their reputation as a hallmark of quality and cost efficiency/effectiveness and improve the health status of patients

WHO IS CHCNI?

- ▶ Statewide we have 91 clinic sites in 52 communities
- ▶ Served 202,700 patients in 2019
- ▶ 92% of our patients are below 200% of FPL
- ▶ 32% are uninsured – 58,000 adults
- ▶ 28% private insurance, 15% Medicare, 25% Medicaid


## WHO WE SERVE

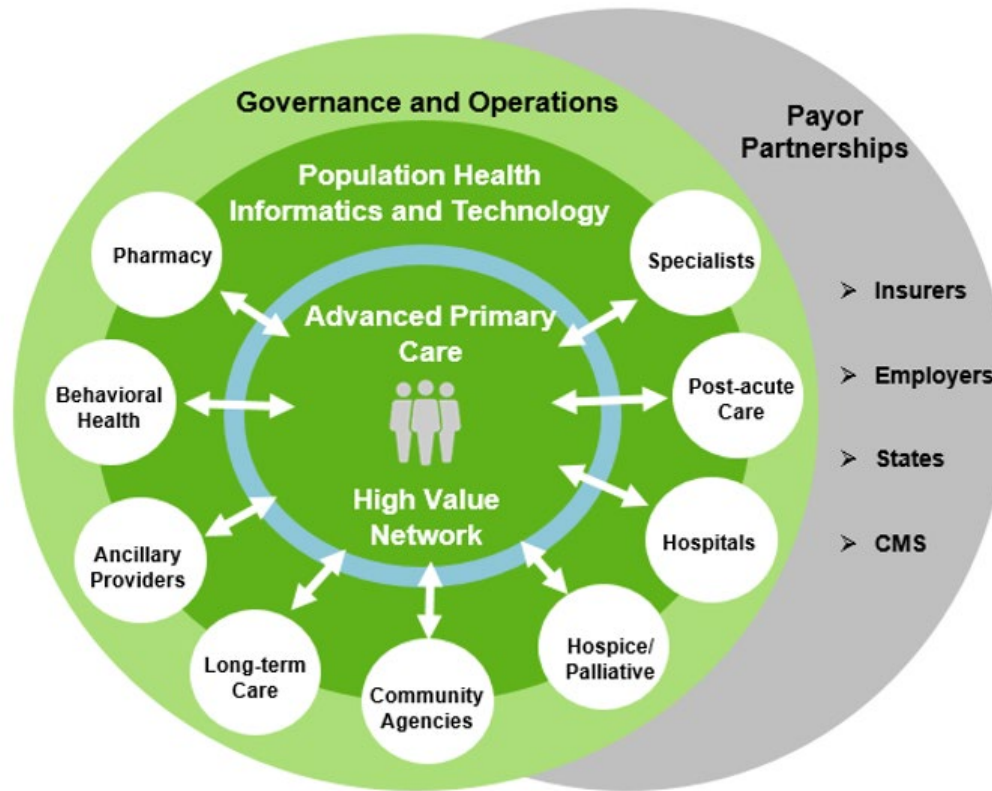


The logo for West Virginia Health Network features the text "WEST VIRGINIA" in white, "Health" in a large, bold, lime green font, and "NETWORK" in white. The text is enclosed in a white rectangular frame with rounded corners. A red dot is at the top-left corner, and a teal dot is at the bottom-right corner. The background is a solid grey color.

WEST VIRGINIA  
**Health**  
NETWORK

Michelle Coon, President of  
West Virginia Health Network

A network diagram consisting of several interconnected nodes and lines. The nodes are represented by small colored dots in various colors including red, teal, orange, purple, blue, and green. The lines are thin and grey, connecting the nodes in a complex web-like structure. The diagram is positioned in the lower right quadrant of the image.

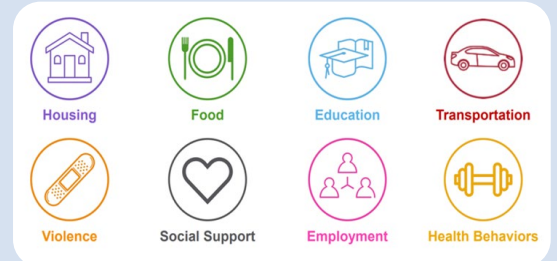




1300+	12	15	4	64,877
<b>Total Providers</b> <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Specialty Care</li> </ul>	<b>Hospitals</b> <ul style="list-style-type: none"> <li>• Tertiary</li> <li>• Acute</li> <li>• Critical Access</li> </ul>	<b>Post-Acute Partners</b> <ul style="list-style-type: none"> <li>• Skilled Nursing</li> <li>• Home Health</li> <li>• Hospice/ Palliative Care</li> </ul>	<b>Community Health Centers</b> <ul style="list-style-type: none"> <li>• Federally Quality Health Centers</li> <li>• Rural Health Centers</li> </ul>	<b>Total Lives</b> <ul style="list-style-type: none"> <li>• ACO- PFFS</li> <li>• Commercial</li> <li>• Medicare Advantage</li> <li>• Medicaid</li> </ul>



# Key Initiatives



Post  
Acute

ER  
Utilization

Care  
Management

\*SDoH

\*Chronic Conditions

Achieve  
the Quality  
Top 10



Manage  
Utilization  
& Costs

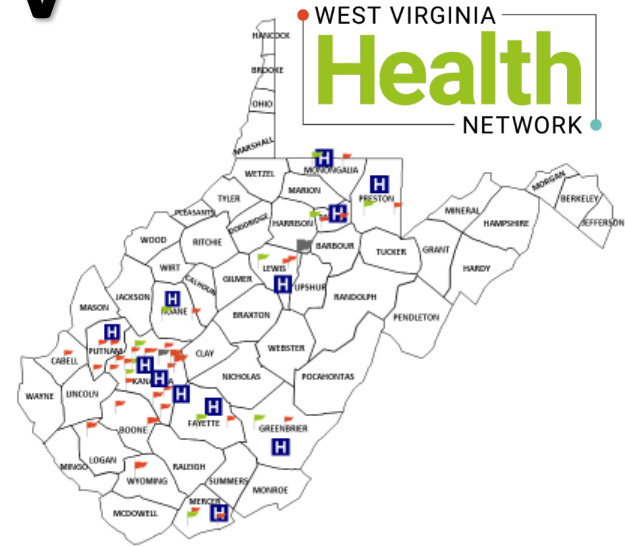


Accurately  
Represent  
the Health of  
Patients

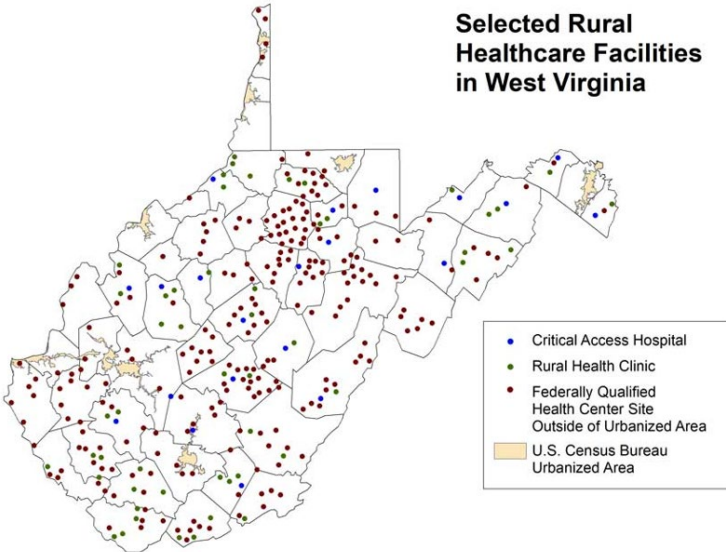


- ✓ Population Health Platform
- ✓ Predictive Analytics
- ✓ Telemedicine
- ✓ Remote Patient Monitoring

# Landscape of WV



**Selected Rural  
Healthcare Facilities  
in West Virginia**





**CARAVANHEALTH**<sup>®</sup>  
NOW THE NUMBERS WORK

# Caravan Health

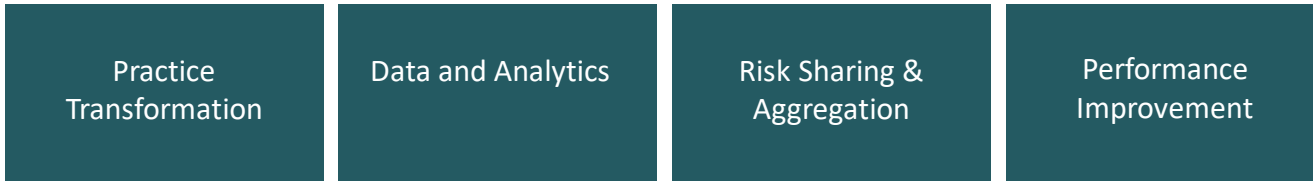
Tim Gronniger  
CEO

September 30, 2020



# About Caravan Health

*Helping Providers Navigate the Challenges of Value-Based Payments*



**170** employees

**>250** health systems

**585,000** attributed Medicare lives

**12** Collaborative Accountable Care Organizations ranging from

**5,000** to **165,000** attributed lives

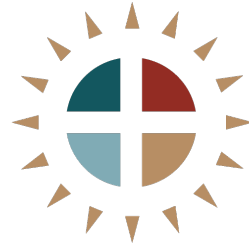
**CMS**

Contractor

**>26,000** clinicians



# Caravan Creates Results



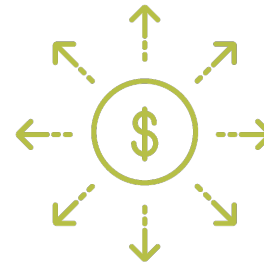
**95%**

Average  
MIPS Scores  
2019



**\$108M**

Total Shared  
Savings  
2015-2019



**70%**

Of clients received  
shared savings for  
2019

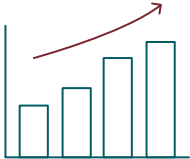


**\$191M**

Total Savings to  
Medicare  
2015-2019

# Care Transformation in Rural and Safety Net Settings

More problems than you can count...



 *Staffing shortages ...*

 *... Skills gap ...*

 *... Technology burnout...*

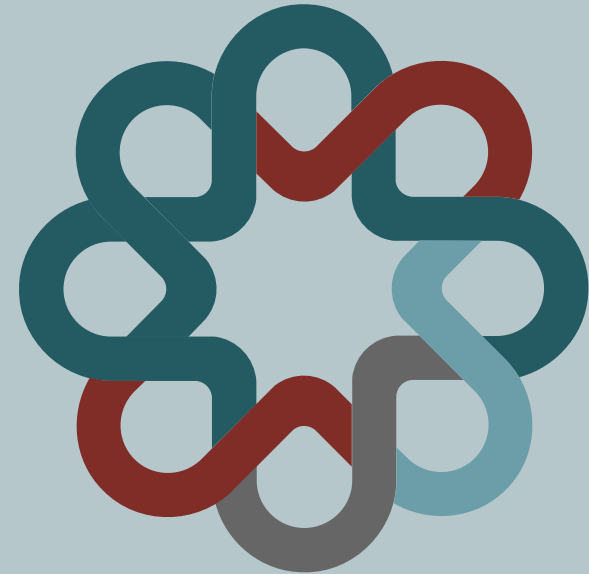
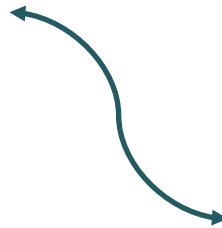
 *... Patients with low income and massive unmet social needs ...*

# What can be done?

Build and teach from the  
**“Business Case for  
Quality”**



Use new CMS-created codes for wellness services, non face-to-face care, and coordination to fund staff to do that work, taking work off of the plate of the physician



Team Based Care

# ACO Investment Model Saved Medicare \$382M Over Three Years



In year three, AIM ACOs saved **\$38.73 per beneficiary per month** with statistically significant reductions in spending.



Of **\$96.2 million** in up-front payments, more than half of the amount has already been recouped.



In all, **55.3%** of ACOs earned some shared savings and **59.6%** returned some or all of the AIM funds to CMS.

Caravan Health is proud to have sponsored *21 of the 41* small, rural ACOs in AIM, driving a significant part of the cost savings.

# Community Health Access and Rural Transformation Model

Near term opportunities

Long term opportunities

Questions

What to do next?

# Community Health Access and Rural Transformation (CHART) Model

## *Model Overview*

The Centers for Medicare & Medicaid Services (CMS)  
Innovation Center

# Introduction and Model Goals

The Community Health Access and Rural Transformation (CHART) Model is a voluntary model that will test whether **aligned financial incentives, operational & regulatory flexibility**, and **robust technical support** will help rural providers transform care on a broad scale to achieve the following goals:

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**Improve  
access to care  
in rural areas**

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**Improve quality  
of care and  
health outcomes  
for rural  
beneficiaries**

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**Increase adoption  
of alternative  
payment models  
(APMs) among  
rural providers**

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**Improve rural  
provider  
financial  
sustainability**

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# CHART Model Theory of Change

The CHART Model creates a pathway for providers, purchasers, and payers to invest collectively in improving access, quality, and the economics of rural health care delivery. The Model will drive change through **3 core elements**:

## UPFRONT FUNDING WITH VALUE-BASED PAYMENT

Provide seed money for upfront investment and introduce two value-based APM choices for planning in care redesign and care coordination:

1. Capitated payments to stabilize hospital financing and incent community-based, preventive care
2. Advance payments to accountable care organizations (ACOs) to improve care for rural beneficiaries

## OPERATIONAL FLEXIBILITIES

Relieve regulatory burden, emphasize high-value services, support providers in beneficiary care management, and catalyze care transformation

## TECHNICAL & LEARNING SYSTEM SUPPORT

Enable both payment and clinical transformation. The CHART Model's flexible funding provides for technical assistance and learning diffusion opportunities for transformation

# Participation Options

The CHART Model consists of two tracks for rural communities to implement APMs to improve access to high quality care and reduce costs.

**Cooperative Agreement Award Recipients of the Community Transformation Track may not participate in the ACO Transformation Track**



## Community Transformation Track

Communities receive **upfront funding**, **financial flexibilities** through a predictable capitated payment amount (CPA), and **operational flexibilities** through benefit enhancements and beneficiary engagement incentives.

This track builds on lessons learned from:

- *Maryland Total Cost of Care Model*
- *Pennsylvania Rural Health Model*



## ACO Transformation Track

Rural ACOs receive **advance shared savings payments** to participate in one-sided or two-sided risk arrangements in the Medicare Shared Savings Program (Shared Savings Program).

This track builds on lessons learned from:

- *ACO Investment Model (AIM)*

# Community Transformation Track





# Award Recipient Eligibility

CMS anticipates selecting up to 15 Award Recipients (**Lead Organizations**) for the Community Transformation Track.

Examples of entities eligible to apply to be a Lead Organization **include but are not limited to:**

State Medicaid Agencies (SMAs)

State Offices of Rural Health

Local Public Health Departments

Independent Practice Associations

Academic Medical Centers

Health Systems

Each Lead Organization must delineate the boundaries of its “Community,” which **must meet the following criteria:**

Encompass **either** (1) a single county or census tract; **or** (2) a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy’s grant program eligibility criterion.

Include **at least** 10,000 Medicare Fee-for-Service (FFS) beneficiaries with a primary residence located within the Community.



# Funding and Timeline

CMS will award cooperative agreements of up to \$5 million to each Lead Organization on behalf of their respective Community.

**During the Pre-Implementation Period**, each Lead Organization will work with community partners to develop a strategy to implement health care delivery system redesign.

**During each of the six Performance Periods**, Lead Organizations and Participant Hospitals will implement their Transformation Plan.

**All cooperative agreement funding is tied to performance requirements including but not limited to the following:**

Funding Amount	Performance Requirements
<b>Up to \$2 million for the Pre-Implementation Period</b>	Awarded upon selection into the Community Transformation Track and acceptance of the Terms & Conditions.
<b>Up to \$500,000 per Performance Period</b>	Awarded upon CMS approval of Transformation Plans and a sufficient amount of Participant Hospitals' revenue in a CPA arrangement in each Performance Period.



The Transformation Plan is a detailed description of the care delivery transformation that a Community will undergo. Lead organizations and community partners will **develop the plan** during the pre-implementation period, **implement the plan** during the performance periods, and **update the plan** annually.

## Transformation Plans require:

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### Assessment



An assessment of the existing state of the Community (assets and areas for improvement)

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### Strategy



A description of the service delivery and payment redesign strategy

***The CHART Model Team will review and provide feedback on all Transformation Plans on an annual basis.***

# Community Partners



Each Lead Organization will form an **Advisory Council**, recruit **Participant Hospitals**, engage the **SMA and Aligned Payers**, and develop and implement the Transformation Plan.

	Advisory Council	Participant Hospitals	SMA <sup>†</sup> & Aligned Payers
Responsibilities*	<ul style="list-style-type: none"> <li>• Represent the Community’s perspective and collectively advise the Lead Organization as they carry out their required activities</li> <li>• Consult on development of, and modifications to, Transformation Plans</li> <li>• Support hospital and payer recruitment</li> <li>• Advise on development of arrangements with payers</li> </ul>	<ul style="list-style-type: none"> <li>• Independently decide whether to participate</li> <li>• Implement the Model according to the Transformation Plan</li> </ul>	<p>Adhere to <i>following 3</i> alignment criteria:</p> <ul style="list-style-type: none"> <li>(1) financial</li> <li>(2) operational</li> <li>(3) quality</li> </ul>

\*Note that this list of responsibilities is not exhaustive. The Notice of Funding Opportunity (NOFO) will provide the full list of activities.

† CMS will specifically require Medicaid participation.



# Advisory Council

The Advisory Council will advise the Lead Organization on activities including, but not limited to, developing and updating Transformation Plans, hospital and payer recruitment, developing arrangements with Aligned Payers governing APM alignment and data-sharing, monitoring the progress of the Model, and identifying any necessary changes.

While specific membership will differ by Community, the Advisory Council **must include the following representatives:**

The SMA (if the Lead Organization is not the SMA) even if the SMA is physically located outside of the Community

At least one Participant Hospital

At least one Aligned Payer

At least one beneficiary or caregiver

The Advisory Council must include a **representative from at least three distinct entities** from the following list:

Primary care provider

Health care provider of substance use disorder treatment and/or mental health services

Additional Participant Hospital

State Office of Rural Health

Additional Aligned Payer

Community stakeholder group

Long-term care facility, home health provider, or hospice provider

An Indian Health Service (IHS) facility or local tribal community, as applicable

The U.S. Department of Veterans Affairs (VA)



# Participant Hospital Eligibility

To participate in the Community Transformation Track, a Participant Hospital must be an acute care hospital (defined as a “subsection (d) hospital”) or Critical Access Hospital that meets **at least one of the below requirements**:

1

**Located within the Community** and **receives at least 20%** of its eligible Medicare FFS revenue from services provided to residents of the Community

- or -

2

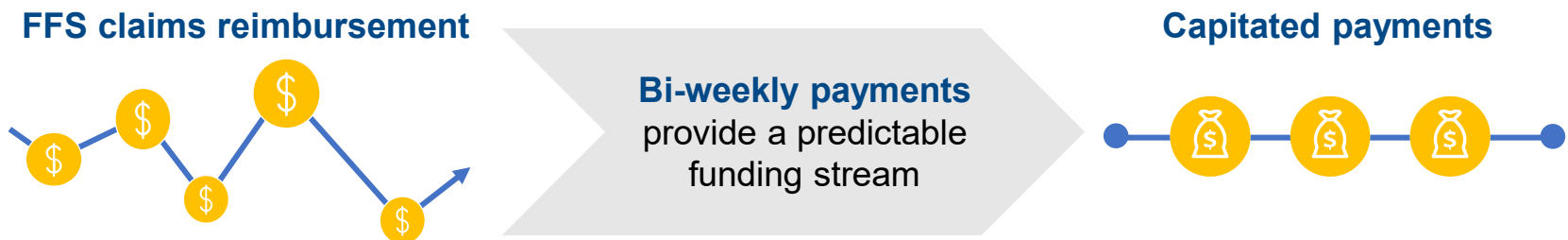
Regardless of facility location, provides services to residents of the Community that in **aggregate account for at least 20%** of the eligible Medicare FFS expenditures of the Community.

**Organizations that are not eligible to participate as a Participant Hospital:**

Federally Qualified Health Centers (FQHCs)	Stand-alone ambulatory surgery centers
Rural Health Clinics (RHCs)	Stand-alone skilled nursing facilities (SNFs)
Facilities providing dialysis services exclusively	Organizations that provide home health services exclusively

# Capitated Payment Amount (CPA)

CMS will replace Participant Hospitals' FFS claim reimbursement with bi-weekly payments that equal the annual CPA over the course of the Performance Period.



CMS will administer each Participant Hospital's CPA through **5 steps**:

1	2	3	4	5
Determine baseline revenue using historical expenditures	Apply prospective adjustments	Apply a discount	Apply mid-year adjustments	Apply end-of-year adjustments



# Aligned Payers

Each Lead Organization must secure multi-payer alignment for its Community. Aligned Payers must meet three criteria to ensure as much revenue as possible is included in the APM such that transformation is further incentivized as a rational business decision for Participant Hospitals.

**Medicaid participation is required and commercial payer participation is recommended**

## *Alignment Criteria*

Criteria	Definition
<b>Financial alignment</b>	The payer offers a financial methodology that aligns with the selected APM.
<b>Operational alignment</b>	The payer offers changes to provider contracts or benefits to support care transformation
<b>Quality alignment</b>	To the extent practicable, payer uses the same set of quality measures to adjust payments or track performance

# ACO Transformation Track



# Participant Eligibility



CMS anticipates selecting up to 20 ACOs to participate in the ACO Transformation Track. Under this Track, CMS will provide advanced shared savings payments to encourage these ACOs to participate in the **Shared Savings Program** and quickly advance to two-sided risk models. This track will be of interest to rural providers that want to take total cost of care accountability for their communities.

Each CHART ACO must meet the following eligibility criteria to participate in this track:

- 1 Rurality Requirement:** A majority of ACO providers/suppliers are located within rural counties or census tracts
- 2 Shared Savings Program Participation:** Must start a new 5-year agreement period in the Shared Savings Program at the start of the Model

Preference will be given to ACOs based on the proportion of their assigned beneficiaries residing in rural areas.

**CMS will outline additional eligibility requirements in the forthcoming Request for Application (RFA).**

# Advanced Shared Savings Payments



The ACO Transformation Track incentivizes participants to move from shared savings-only arrangements to greater financial accountability for both shared savings and shared losses, while also maintaining or improving quality of care.

ACOs will be eligible to receive advanced shared savings payments through **two mechanisms**:

1

**One-time upfront payment** to participate in 5-year Shared Savings Program agreement period

2

**Prospective per beneficiary per month (PBPM) payment** for up to 24 months (two years)

Each CHART ACO's one-time upfront payment and PBPM payment will vary based on **the level of risk** that it accepts in the Shared Savings Program and **the number of rural beneficiaries assigned to it** based on the Shared Savings Program assignment methodology, up to a maximum of 10,000 beneficiaries.

# Repayment of Advanced Shared Savings Payments

CMS will seek repayment of advance shared savings from CHART ACOs by reducing the amount of any shared savings payments that are owed to the CHART ACO upon annual reconciliation in the Shared Savings Program.

The amount of a CHART ACO's balance deducted in this way **will not be greater than the CHART ACO's earned shared savings amount** for a given performance year.

For example: If the CHART ACO **does not generate sufficient shared savings** for performance years 1 or 2 to fully repay advanced shared savings payments received in those performance years, CMS will **recover the balance** from shared savings earned in the **subsequent performance years**

**CMS will pursue full recovery of advanced shared savings payments from any CHART ACO that does not complete its initial Shared Savings Program agreement period or the full term of the CHART participation agreement.**

# Model Timeline

The Community Transformation Track will begin July 2021 with a pre-implementation period, and the ACO Transformation Track will begin January 2022.

Milestone	Approximate Date*	
	Community Transformation Track	ACO Transformation Track
<b>NOFO / RFA released / Application portal opens</b>	September 15, 2020 (NOFO Released)	Spring 2021 (RFA)
<b>Application deadline</b>	February 2021	Summer 2021
<b>Participant selection</b>	Spring 2021	Fall 2021
<b>Pre-implementation period</b>	July 2021 – June 2022	N/A
<b>Performance periods</b>	July 2022 – June 2028	Jan 2022 – Dec 2026

\*Dates are subject to change.

# Resources and Contact Info

For more information about the CHART Model and to stay up to date on upcoming model events:

## Visit

<https://innovation.cms.gov/innovation-models/chart-model>

## Follow

@CMSinnovates

## Email

[CHARTmodel@cms.hhs.gov](mailto:CHARTmodel@cms.hhs.gov)

## Listserv

[Sign up for the CHART Model listserv](#)