HUSCH BLACKWELL

Hospice Insights: The Law and Beyond

Episode 17: COVID-19 Hospice How-To Series: Hospice Physicians are Being Tested by COVID-19, and Increased Scrutiny Lies Ahead—What to Expect and What to Do

August 5, 2020

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Meg Pekarske	Hello! Welcome to "Hospice Insights: The Law and Beyond," where we connect you to what matters in the ever-changing world of hospice and palliative care. "COVID-19 Hospice How-To Series: Hospice Physicians Are Being Tested by COVID and Increased Scrutiny Lies Ahead–What to Expect and What to Do." COVID-19 has affected all aspects of hospice care, operations and personnel including the person whose judgment lies at the center of the Medicare hospice benefit, the hospice physician. From new regulations addressing telehealth and virtual visits to the practical challenges brought on by the pandemic, hospice physicians have had to adapt to ensure continuation of services that are compliant with CMS requirements. In this episode Meg Pekarske and Bryan Nowicki discuss the increased significance of, and scrutiny applied to, hospice physicians in the age of COVID-19 and identify potential traps and opportunities. Welcome Bryan.
Bryan Nowicki	Thanks Meg.
Meg Pekarske	I'm glad you're here to talk about hospice physician issues, which I think as we start this, you know any feedback you as listeners what to give us on topic ideas would be much appreciated and we had thought about

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	doing a hospice physician series so this is our testing in the waters of, is this something you want to hear about and so in this episode Bryan and I wanted to talk about some of the things that we find to be challenging in COVID-19 for hospice physicians and what to do about that and so hopefully you know everyone listening will find this helpful. And it's not downloaded much Bryan and we'll just move on from firm disposition but I think obviously really important area and I think COVID-19 has created a lot of challenges all around and we've had to pivot on how we provide care and the role of virtual visits and that that is something that is permitted and how you as a hospice physician may need to ask different or additional questions maybe to get at the issue of clinical eligibility. So, with that background you know of our most recent podcasts I think, or maybe two podcasts ago was about the AseraCare precedent and the central criteria that hospice physicians, you know they are responsible for determining eligibility and playing that gatekeeper role. And so, I guess Bryan why don't you talk about sort of the, regardless of COVID, what is the legal standard as it relates to hospice physicians and what they need to be able to demonstrate.
Bryan Nowicki	Sure, happy to do that and Meg you know that you and I have talked for years about hospice physicians and making sure that their role really can't be overemphasized. We see them – we've always seen them as central, especially in the work we've done with audits and appeals and defending clinical judgment and I know we've encouraged our clients to give their hospice physicians that role and to make sure they bring on hospice physicians who are truly top-notch, just because they touch almost everything that matters to the hospice in terms of patient care and payment. So, I think what we're seeing is those discussions that you and I have had, they're getting recognition and they're reflected by the courts by what CMS is doing and continuing to emphasize the importance of that role. So I think this is timely and I think the role of physicians and the scrutiny that's going to be on them is only going to expand as you know taking a, maybe a defensive approach to it as auditors really focus in on what physicians are doing and providing that additional scrutiny. But yeah some things that haven't changed by, that haven't been changed by COVID but has been out there over the past several years includes the AseraCare case that you mentioned and you know a very important hospice case came out in 2019 but that case I think was very clear in describing that the role of the hospice physician is really central to the hospice Medicare benefit and the eligibility inquiry and put a lot of reliance on that doctor's exercise of clinical judgment and even suggested that there should be considerable amount of deference paid to that hospice physician who's making real-time determinations and doing

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	a real-time analysis of patient records. So, I think that is kind of a move in the courts that have brought the central function of the hospice physician into really clear relief.
Meg Pekarske	Well and Bryan, I mean I think that, you know absolutely it's that central role but I think that, you know the challenges that we've been dealing with is and where I think regardless of even the favorable precedent is about like wow what is, is your opinion reasonable, right? And so, what's in the record to support that and I think that you know that's sort of the new challenge, right. Like as our records with COVID look a lot different and we're matching up, you know the conditions of payment which I think is always really important that the conditions of payment, there's not been additional flexibility around those. Like you still have to have an election that meets the requirements, you still have to have a certification and whatnot and so I think that – and the narrative requirement of face to face and all those things but I mean Bryan what do you see as the challenge? So we have and let's just say AseraCare is the lay of the land for the rest of time, we'll cross our fingers, but let's just say that is, like what do you think is the challenge as a hospice physician with COVID given how we hear care is being provided now under COVID?
Bryan Nowicki	Well I think what we've seen with AseraCare and in its wake is the government trying to switch positions a little bit on what they're really reviewing. It was at one time they're looking at whether the physician's clinical judgment was exercised appropriately and that's what AseraCare addressed. What we've seen in some more recent cases – and now the government is saying well we're not really looking at what the physician is saying, we're just looking at the documentation and the medical record so it's not really an attack on the hospice physician so much as is a critique of the medical record. I think the line gets blurred between those two things really quickly and I think it's hard to distinguish those two but to the extent the government is going to be saying no we're just looking at the medical record apart from the exercise of clinical judgment, but not tie in those too closely together, it becomes all the more important for hospice physicians to make sure they're documenting their exercise of clinical judgment in the record. Their thought process, I think the narrative already requires a synthesis of facts into conclusions and I think we can see the government taking that more seriously or being more aggressive in policing that but just making sure the record really reflects all the essential elements of the exercise of clinical judgment. I think is the next, the next area for hospice physicians to find some

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	improvement in is that documentation, whether it's a narrative or a physician visit or if they're doing the face-to-face encounter.
Meg Pekarske	Well and I think that you know this is, that has been the work of the day forever what you just described right, good narratives, face to face and now I think with COVID it's brought different challenges. And I was on the phone yesterday with a client and it was a really interesting conversation and how I think there's new challenges with these times because you have – there could be less richness in the documentation I think as we've had to move in some circumstances to virtual visits that do our patients begin looking just like data points and you're not getting the subtlety. Obviously audiovisual telehealth services are you know better, but I still don't think that they're a replacement for you know seeing the surroundings that someone – and you know in that context as a physician you're looking at the medical record. Now that's maybe before we even go down that pathway more. I mean I also think that the shift in length of stay, right if you're in an area that's getting a lot of COVID, I mean your length of stay is short, short and so this whole idea about eligibility and prognostication and if you're taking on a lot of short-living patients because of the delay of referrals because people aren't seeking medical care or you know you're getting patients who are COVID and terminally ill. So I think in terms of you know if you're length of stay, you know are you going to be critiqued when they only live seven days perhaps not but obviously you still have people on service that may be living in their home but essentially aren't short-living and I think that's sort of the wrinkle we're really focusing on here with the new challenges of COVID is you know if our patients are in nursing homes and were tested and being able to see those patients, what are the kinds of things that if I'm a hospice physician I want to be thinking about and scrutinizing the medical record because maybe we can't get our chaplain in there and so you and I talk about the pros and cons of chaplain documentation, about the rich conversations they have with non-verbal patients sometimes and you know the disconnect that sometimes can exist but I also think that the social worker and chaplain notes can also really add to the "painting the picture of a patient."
Bryan Nowicki	Meg you're absolutely right in terms of what COVID has done to the ability to get access to patients and it could change the entire patient profile of a hospice where now they're getting shorter length-of-stay patients. Does that make the longer length-of-stay patients stick out even more? It could be a new dynamic you're looking at in terms of an overall patient population. And so, with that together with the limitations that might be brought

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	about by COVID where we need to use telehealth and virtual visits just because that's what nursing home insists upon or that's what a patient prefers, or we think that's the safest way to go. We've got to understand what those limitations are and work around them. With telehealth you might get, you get to see whatever the frame of the phone or camera or whatever it is shows you, you get to hear whatever the microphone picks up but you don't get to smell if there's other things in the context of the room that might be significant. I mean are you hearing every creak of every bone. Are you hearing every wheeze and that sort of thing? And it's not, you know that obviously would impact a physician who's trying to do a, if they're doing the face to face or if they're just doing a patient medically necessary visit. But it also impacts the what is typically the eyes and ears of the physician in the routine way and that is the nurses, the chaplains, the volunteers, the social workers, it's going to impair their ability and I think it's important for all of these clinicians to recognize what is being limited, what are the limitations of telehealth and how do you try to overcome them. Do you need to have longer visits? Do you need to zoom out and zoom in over certain things? Do you need to allow quiet for the microphone to work properly? Do you need to have some other sort of, you know multiple visits? Maybe an in-person visit with appropriate PPE to get that full sense of the context of the patient. And I think all of that filters into the documentation. I wouldn't, I don't think it's a good practice just to document a telehealth visit as you would an in-person visit. Rather take the limitations of telehealth and kind of work them into your documentation and document how you're going to try to overcome that or whether it matters that you had a limited telehealth visit as opposed to a regular visit. So, there's some understanding and acknowledgment of that.
Meg Pekarske	Yeah and I mean I think that COVID obviously has launched telehealth and when I say telehealth I mean audiovisual and a whole new way that I think hasn't been able to be jump-started and I don't think there's really putting the, you know back in the bank so to speak. Like I don't see us pivoting backwards on that and I'm not talking for the hospice industry, it's sort of healthcare large. I mean I don't know that we'll continue to have the waiver to do telehealth visit or those face-to-face visits via telehealth after you know the public health emergency here but I think you raise really important points which is I think what we are all as nurses and social workers and physicians is you're assessing the patient. You are using your sensory abilities, my sight, my hearing, my all of this to assess the patient and it's not obviously that you're not asking questions and taking measurements and things like that but you're using your eyes and ears to do this and so I think when you're not seeing people in-person, you might just ask different types of questions. Like you have to be more probing and you know I think that the reliability of

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	people self-reporting stuff when you can't go see it yourself can be a challenge. So I think it's exactly what you said is understanding the limitations and compensating those, for those things in a different way like you said maybe these telehealth visits are actually longer because you have to really pull out information and I think that hospice professionals have the absolute right skills to do that. We're graded developing rapport and taking the time to really listen and so I think that we as opposed to you know other healthcare professionals really excel at that. So perhaps hospice physicians having to take on that role because there are extenders like you were saying of nurses and social workers, chaplains, you know aren't getting their eyes and ears on patients in the same way and so how do you work maybe differently as a team and maybe physicians are doing their own visits more because they need to see with their own eyes the patient and so there could be more opportunity for telehealth for physicians beyond just like the face to face but doing those things.
Bryan Nowicki	Yeah I think that's right and I think really leadership in this area needs to come from the hospice physician because the decision comes back to the hospice physician on what orders to write, whether to certify or recertify a patient as terminally ill if the – if a virtual visit or a telehealth visit is not going to give you as good of information as an in-person visit would. I think you used a perfect word for that Meg, and that is you've got to compensate for that. You've got to find a way to overcome that. I think it would be a big mistake for clinicians to use a virtual visit or telehealth visit and say well you know because it was telehealth, we couldn't do a physical exam, we couldn't do this period. You've got to say well we couldn't do this like we usually do so here's the alternative, here's the workaround. You know we couldn't feel the patient's joints, or we couldn't kind of lay hands on the patient to examine wounds or ulcers or something like that. So how do you do that? What is the workaround for that particular item? Does a nurse need a little more direction or guidance on what to look for and what's important to report back to the physician?
Meg Pekarske:	Well and I think that to that extent you know the caregiver right, we're not the 24/7 caregiver for our patient as even when your scheduling times to talk you know really making sure the caregiver is there and they can be providing information as well and maybe you give the caregiver additional tools. And tools I mean like physical tools if they're, and you and I are not clinicians but if there's tools that would be helpful for us so we can say when we call you we'd like to do X or whatever and use this to do X or something because I think when I said that my conversation with a client was the patient becomes data points. I mean data points are incredibly important, right? I mean I think it's one of the things that

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	hospices continue to – pressed on is well show me the decline and measurements and MACS or weights or you know let me quantify this decline for me and so I think we still have to find ways to quantify that decline and it might need to be more like self-reports, like you really need to be able to ask how much you're eating and be – get people to be very descriptive of what that is and knowing the limits of our patients and the role caregivers might have to have and so and nursing homes, obviously staff are very stretched with all the challenges they have but maybe it's making special time to just talk with them right, is in addition to meeting with our patients to you know cause you can't do it all in one night. You're not walking into the facility and then you talk to whatever floor nurse and whatever and so yeah, I think it is, it's not business as usual and so we, and you and I experience in how we practice law is different, right? I don't take paper notes, I have to type all of my notes. I mean it's like old dog new tricks, like that's hard and I think you have to realize you know the limitations and I think it also brings opportunities right. I mean there can be opportunities to do more visits right, even though they're via telehealth and might be I can access my patients more because it's easier to be able to facilitate.
Bryan Nowicki	Yeah, I think once hospices get more accustomed to telehealth and overcome any obstacles or finding ways to compensate for the limitations, it just becomes another, another vehicle to connect with patients more frequently, more effectively and I think the learning curve has kind of been forced upon hospices by COVID. Like a lot of things have been forced on a lot of people. I never imagined I'd be working from home you know for this length of time.
Meg Pekarske	...with kids.
Bryan Nowicki	With all their....
Meg Pekarske	And your internet still works!
Bryan Nowicki	Right. I have – my internet is constantly being hijacked by Netflix and PlayStation and so on but now I'm kind of accustomed to it and I'm glad, at the end of this I'm kind of glad I was forced into this position, it forced me to work from home and there's some parts of that that are really good but just like I think hospices, the learning curve is imposed on them, they've got to come through and get comfortable with telehealth and virtual visits but then it just opens up a whole new opportunity to connect with patients. Another thing that you and I have encountered is since we've been work from home, we've probably seen more of our partners from all of the offices across the country that our firm has than we would have if we had been in the office. I mean Zoom meetings are everywhere

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	now and people I never would have, never would have seen I'm meeting now regularly with regularly via Zoom, Skype and WebEx and all that. So, there is a bright side to all of this. It's forcing us to become, to adapt and adapt in ways that are going to ultimately be more efficient and I think good for hospices.
Meg Pekarske	Yeah well and I think what you said is a physician being a leader in this area because the physician is the gatekeeper and I think that they're the dot connector, they're the gatekeeper and so does the physician need to be asking more in their own telehealth visit even if it's not the face to face to get comfortable because the legal standard has not changed. You need to exercise your clinical judgment, your determination needs to be reasonable and there needs to be information in the medical record that supports that and so you know we can't go back to well this is what people said at the IDT meeting but you know the medical record doesn't support that. So I think that it's very critical that the medical record remains rich and so how you document a virtual visit and the format I think for most people, you know they might have created a different template for that since you know those, most of those visits can't go on the claim form. But just making sure that you're monitoring that and then ask good questions and maybe different questions and I think you know utilizing our skills to really be patient and develop rapport and get people to tell us how they're really doing right because for decades we've been dealing with this Bryan but oh the patient says they're doing well.
Bryan Nowicki	Right.
Meg Pekarske	Well in comparison to you know I can't really eat much, I never get up, you know I'm bed bound, I'm sleeping you know whatever. I mean it just, so we need to probe and more and so I think that's important. I think the – and it's timely that we're doing this because the medical review is slated to start up again August 3 and so while program integrity audits like UPIC audits have never been suspended, we haven't seen any new UPIC audits start up but I think potentially they will and then obviously the different TPE that was going on before, and so I think we're going to get some real-time feedback on is the government thinking what we're doing is sufficient cause they're going to apply the conditions of payment that have always existed. We've been relying on these flexibilities and waivers and how are those two things going to mash up because things aren't business as usual and so I think there needs to be a pivot by contractors too about what the expectations are. I just, and as you know you try to be optimistic, but I mean we're probably built to be pessimists. Like you know there's a concern that you know they're going to apply their same checklist of how I evaluate and not sort of take into account

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	maybe, you know I think the realities of the day.
Bryan Nowicki	Right and I think, you know, a few ways to combat all that is make sure that the record demonstrates the realities of the day. If they're going to say this visit was inadequately documented because we're just documenting it the same way we always have without recognition that it was a virtual visit or it was a telehealth, then I think that's something that the auditors are probably going to take advantage of. We need to show them that we've adapted to this. We've kind of encountered limitations but we've attempted to overcome that and it's a whole new world out there in terms of how you evaluate patients and I wouldn't expect the auditors to be all that forgiving, as you said, but as long as we document what we are doing and why we're doing it, that's the best we can do to combat that; and with these audits coming back online as of August 1, it's not so much the UPICs that are going to bring the COVID response to the forefront. I mean UPICs are typically going back a few years. UPICs are going to look back at COVID maybe in 2024, or whatever, or 2023, but what is going to be more immediate are the TPEs and the ADRs ongoing SMRC audit which often times are looking at records in the much more recent past and we already know from our experience, Meg, with OIG audits, the OIG has already been out there with a survey trying to find out from hospices how they're dealing with COVID in a number of ways. So, they've already started that. They're interested in knowing how hospices are doing in the midst of COVID and now these medical reviews are going to add, now that they're being implemented again, that's going to add to the kind of scrutiny and I think the government is anxious to learn how hospices are doing in this area and I think the auditors are very interested in beginning work again so they can start generating alleged overpayment amounts, which is part of the basis on which they get judged by the government. So, I think we're expecting auditors to come out really hungry to do work and be aggressive about it and the government really having a vested interest in seeing how the documentation has changed so that they can react to that and make further adjustments as necessary. So, I think the next level of scrutiny we're going to see in these audits is going to be—I'm predicting that it be more aggressive than we've seen in the past. So, we need to get those medical directors in that leadership role out in the forefront of leading their teams in the telehealth and virtual visit COVID world so that we have the tools we need to respond to audit requests and then appeal them, if necessary, going forward.
Meg Pekarske	Yeah, and I think that that care plan and how much does the—if you look at what we actually did versus what the care plan said, how does that align, right? So, while the hospice physician doesn't necessarily have a direct role in that, I think that the direct role we're talking about with

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	hospice physicians is, you know, that engagement at that IDT meeting about, you know, really maybe being more engaged in terms of looking at what's documented, trying to, if there's holes there, about well so how is this patient really doing, you know, what's their intake like or, you know, whatever it may be and maybe brainstorming different ideas about how we can get additional information to fill out the records. Again, I think, you know, folks across the country are still really struggling and that's why I think it's—I don't even like talking about audits because I think people are so overburdened right now especially, you know, folks in Florida and Texas and, you know, as we're recording this, are really buried in a lot of challenges right now. So, as you said, it might not be so much a length-of-stay issue but more care plan issues and did we do what we said we were going to do and what is it that we're actually doing and how do we document it and whatnot.
Bryan Nowicki	No, I think a good question around the IDT meeting where if you're a hospice that is using a lot of telehealth or virtual visits, for the hospice physician to bring up is okay we're doing telehealth. For this particular patient, does telehealth limit our ability to assess this patient and in what ways and how do we overcome that and get that discussion going—kind of on a patient-by-patient basis to begin with but I think that's going to help the entire group decide, okay yeah it does limit us in this way because this patient we really need to kind of use our sense of touch when we do an assessment or a face-to-face encounter or something like that, how do we overcome that and then you form a plan for how to actually compensate for that limitation.
Meg Pekarske	Yeah, because I think like the inability to visit our patients as you alluded to earlier, we can't change the world ourselves and say you must let me in but I mean I think it's dealing with those realities and as you said documenting what those realities are. Don't assume that the government is going to say oh well I know it was COVID so I'm sure you couldn't have gotten in if you wanted to, you know? So, I do just think that the physician leadership role is important and I think using our physicians to do more telehealth, potentially, visits so they're getting more comfortable because I know when you and I are defending cases, the more physician documentation we have and the medical records, the better we feel about it because you have contemporaneous documentation that is demonstrating the clinical judgment and you know, in this case, the physician assessment of the patient. I think there's really an opportunity for physicians to be maybe even more engaged directly with the patients that are on their team then perhaps they were even before just because you don't need to schedule time to drive all across the service area—they're actually able to do these more efficiently. So, I think, this is for another day but I'm doing a plenary session for the Kentucky Hospice

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	Association and we're going to be talking about what you had alluded to which is (a) these telehealth visits are really great, right, how do you put that back like how do you pull that back because, you know, and I think there's a push-pull there. I think that, you know, hospices, I don't think you can take the personal touch and what I mean when I say personal touch, I mean like physical touch out of what it is we do, like that is so much—there's, you can't really probably quantify that value of comfort that is provided by bedside care and I think that our staff who provide service, that is why they got into hospice care. So, but I think that there is just like we feel that work from home and I think the world is planning for people, but I mean aren't going to want to work in the office five days a week anymore. So, you know, how speculations whether or not these flexibilities will continue or not, I mean, I think that that's going to be the new challenge assuming that everything goes back to "normal." How is it that you have to flex back and get your staff that say no, because it's a before and after COVID. Like, oh you're seeing your patients three times a week and now you're just doing, one visit a week and, and so I think that that's probably something on the horizon, too, is we spent all this time adapting and now we're humans and we finally, after five or six months, okay, I've learned this new way and now it's like you can't really remember the old way we used to do things and it's like I think that will be its own challenge as we come out of this is what does care look like and what flexibilities is the mask going to allow moving forward and whatnot. I think that's sort of a stay-tuned issue but it's something I've been thinking a fair amount about.
Bryan Nowicki	Yeah, and I expect that a lot of hospice staff, clinicians, chaplains, social workers, they're not eager to do telehealth or to have virtual visits replace actually visiting with the patient because I think it is that human contact that is such a big part of compassionate care at the end life not just over the phone but actually being at someone's bedside, being able to hold their hand, all of that stuff is probably what some hospice folks really enjoy about the work they do and if that serves their mission. So, you know, I don't think we're saying there's going to be an all virtual hospice out there in the near future. I don't think that would be a good thing but it really—it's opportunities to expand and build upon what you're doing and, you know, it'd be great to get back to that human contact part of it which, hopefully, we will eventually get to. But then what can a virtual visit and telehealth do to improve even upon that situation?
Meg Pekarske	Exactly and as we're talking about this it reminds me that in my Hospice Innovator Series, one of the questions I would ask each person I was interviewing and it would usually be about the last question is, Do you think you can ever take the human out of hospice? Because I was talking about you know in 10 years in the role of technology in all this,

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	obviously, I was asking this question before COVID. It's just a déjà vu moment as we're talking and I think, that those conversations reveal that, yes, technology can be our friend and allow us to do more and different but I don't think that it replaces that. I think that though as we want to move upstream beyond just our six-month prognosis bucket and I think that we'll probably be starting a palliative care podcast series because there's just so much opportunity there to get upstream and a lot of that care may be more remote case management and things like that and so I think the tools that we're learning now in terms of how effective we can be in using remote monitoring for patients could be really helpful as we try to transform to hospice 3.0 or whatever we're calling it, I think that there's a lot of interesting lessons that will come from this that actually may be critical to our transformation. I think that hospice, you know, is on the brink of really transformative change and that we're trying to get people to see the skills we have in a new and different way and that, you know, ill and seriously ill patient populations, even if you're not terminally ill, we have those skills and tools and case management and whether that's in-person or telephonic, I mean we have the tools that we can use so I think it's a really interesting time. Obviously, we don't have a crystal ball to know what all the lessons are going to be. I am hopeful that, you know, if these audits do really start up again and hospices are a target but I do hope that there is a recognition of the realities and challenges because we're all just humans trying to take care of other humans and deal with something that none of us have ever dealt with in our lifetime. So, I hope that there is some reasonableness that prevails, but I think—I'm an optimistic, you know, Bryan.
Bryan Nowicki	That one and with medical review starting again August 3, it'll probably be, you know, late this year or into 2021 that we'll start seeing how the government and its contractors are going to approach that so, yeah, I will try to be optimistic with you that there's some recognition that this was a very traumatic time for the whole country and especially for healthcare providers and they'll recognize a lot of the challenges that were faced and be reasonable about it.
Meg Pekarske	Yeah, so, because we all just trying to do the very best we can and, so, well I appreciate your time and I think a lot of insights to come as we live the real time and that's why we love our podcasts is it allows us to really provide real-time information and so I think if we are catching wind of important things and some of this medical review stuff we'll let our listeners know and so, thanks for your time, Bryan, and you're going on vacation for a short time so, you know, I was listening to a podcast and they talked about what we're doing for vacation and you're going to Pennsylvania.

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Bryan Nowicki	Yep, that's where I grew up and see extended family and go to a couple lakes and an amusement park and getting the whole crew and we travel in two cars now, so getting the whole crew out there, it'll be a great time.
Meg Pekarske	And, so, but you are going to not get COVID.
Bryan Nowicki	I promise.
Meg Pekarske	You promise. Well I 've got to align the stars so that everyone will stay safe but so, I will see you when you get back from Pennsylvania and we'll have new, I'm sure, things to talk about when you return so thanks for your time, Bryan.
Bryan Nowicki	My pleasure, Meg. We'll talk soon.
Meg Pekarske	Well that is it for today's episode of Hospice Insights. So long and thank you for joining the conversation. To subscribe to our podcasts, visit our website at huschblackwell.com or sign up wherever you get your podcasts. Until next time, may the wind be at your back.