

CMS Special Session Transcript: Quality Improvement Organization (QIO) 12th Scope of Work

April 20th, 2017

In order to do that we have an agenda that we have laid out for you. We will talk about some of the logistics involved in some of the polling questions that we have and how to get your input from the people who are here in the room and focus better on the phone and online as well. But, we do want to give an overview of the 11 the scope of work and some ideas that are out there for some the aims and goals, current and future work. We also want to talk a little bit about partnerships. And we also will have a patient who will be joining us a bit later. Again the most important part is to get your input. Occasionally as we go through the agenda we will stop. We may ask a polling question to get your thoughts and ideas. And our technical people will assist you on how to do that. And then, we will wrap it up at around 3:45 PM this afternoon. What I would like to do is turn over to our technical experts to describe some of the requirements if you are online and using the app.

Ladies and gentlemen the easiest way to connect to the audio is to allow Adobe connect to dial to your telephone. You could join the audio by dialing 1-800-832-0736 and entering the code 327-3435 pound. To view the dial in information at any time while you are on the live webinar, click on the information on the information icon on the top right-hand corner of the screen and click view info. Also, to view the presentation and full screen click on the 4 arrows above the slides. And you can ask a presenter a question or share a comment by using the chat pod displayed on the right-hand side of the presentation screen. To speak over the phone and into our discussion, get into the queue by pressing *#. If you are expressing technical difficulties please email the email address on your screen. If you on the phone line but are unable to log into the event via your computer you may access the slides by visiting the URL listed here. If you are attending this webinar in person and would like the ability to view the presentation on your phone and participate in live polling during the event, we ask that you download the Adobe connect app on your phone at no additional cost. And here below you can find the links to download the Adobe connect. And as a reminder, please put your telephone on mute when we go live on the presentation.

Some ground rules. I do want to highlight a couple of things. However you submit your input, by a here face-to-face or over the phone or over the chat box, please identify yourself and your organization. We would encourage those of you who are in the room to use the app. It would be helpful in tallying up the responses and looking at trends. And, if you're not able to use the Apple don't have that ability, we do have a handout that was given to you when you came in today. And these are all of the questions and you can handwrite your responses on that. If you are not using the app, and you are here in the room, complete the form and we will collect those at the end of the session today. We are going to go ahead and try it out. If you would like to find out who was in the room. Folks that are here, focus on the call and the chat box as well. Wanted to get a sense for the participants. So we would like to get you started on that. Let's go ahead and open the poll question. And what you will see is a distribution of the participants.

I am looking at the numbers as we are tallying. And I am seeing that the number of patients or patient family advocates is a small percentage so far. I thought it was worth acknowledging the larger audience on the phone that we did have a special session last week that was focused on patient and family. We had strong participation in that session. We thought it was important to do that, because there was more detail that might be necessary for patient and family members who are less concerned with the bureaucracy. I wanted to acknowledge that.

Later on you will be seeing a slide or 2 we have summarized that fact. Will get to that a bit later thank you. Also nice to see the large number of providers we have joining us today. And later in the session, we will lead a discussion from the provider group. Let's wait another 2nd or 2. Let's close the poll at this point. What I would like to do now is have the folks I was speaking today introduce themselves. And, I would like to start.

Hello I am [indiscernible]. I am the director for the deputy director for the Center of clinical standards and quality. Good afternoon and the director of the CMS director. I am Tracy I am a division director. Thank you for coming and being with us this afternoon and spending your time as we are excited about having you here in the forward to what you are going to be telling us. We're going to talk for a little bit and do some for a lot. I am the deputy director for clinical standards and quality. And we have many of the drivers of change and improvement. Including many of our value-based purchasing programs. Public recordings and coverage and analysis. We have many areas and within that comes quality improvement work. And we had a delegation from Indonesia yesterday and I have the opportunity to spend the afternoon with them and I was trying to explain what we do in our center. So they said let me get this straight, on one had you are doing corrective action and on the other hand you're helping them? And you support them? And I said yes, it is difficult sometimes to understand our role. But that is in fact, we understand that we can be supportive and change agents in more than one way. It's important to bring all of those things together and that is what we are here to talk about today. The quality and poor mental organization. I see some familiar faces and some not so familiar faces. I'm going to take a moment to explain what a quality improvement organization is. And I am going to start with the legal definition because quality improvement organizations are around because of statutes. It was recognized many years ago that in order to have a complete system, we need to have claims and those processes in place but we really need to have a way across the country to have an infrastructure that ensures good quality care. By law, the mission of the quality improvement program is to improve the effectiveness, efficiency, and economy to leverage the medical program. We are to ensure that Medicaid pays for services and goods that are reasonable and necessary and provided in the most appropriate setting. That would help provide protection by adjustments and claims. We have emergency medical treatment and labor violations. And other responsibilities that look at efficiency and effectiveness and all those kinds of things related. That is what the law says. Let me give you my definition of a QIO. If I had to put in my own words, I say that QIO are change agents. We have all kinds of tools to make change. They are partners. And you see a number of the partners on this site. We need to make sure that we are promoting improvements. We foster collaboration. We bring a group together at the last night and facilitate those people who are working with the same patient and family and we never stop to understand what that person's contribution to the healthcare system. They look at the evidence and they explore best practices and then they facilitate learning. It is a dynamic learning community full of new ideas and processes that can confer change. Not only that and were looking at new models of care. They make sense of data. They are knowledge

about the data sources that are available and how to use and apply that data practically in a practical setting and helping to chart the course of beneficiary care. It's not only CMS programs. We can see what we are doing here. But the QIO in the community, while we may know about Medicaid programs, we might know what Blue Cross/Blue Shield is doing, but being in the community, they know the county health department if using that initiative. It is weaving all of the various things together. It becomes essential when you think about what clinicians and patients are facing as they try to navigate. Since making is essential. They help to transport the healthcare system.

When you think about all of the programs coming down the pike, it is not unusual that when we began to sit around and think about how will we implement this? How will we get this done? A couple of sentences within that conversation, a QIO name will come up. We are in the midst of implementing public payment programs and all kinds of things. The quality improvement organizations are critical in that. And they have to get results. And I will highlight this in just a moment. That is a laundry list of things that happen without quality improvement organizations. Why? Why do they do those things? And that is the key and why we are here today. And at the center you see the beneficiaries and the family members. And that is the reason we are here. And why we want to talk to that. How do we improve care beneficiaries and their family.

How do we make sure they complied that provide the best care possible despite the system barriers that may be present. How do we continue to work and make progress? We are interested in learning each day. We note now -- we now know more than we did 5 years ago. And we will know more in another 5 years. It is constant evolution. We need to plan for the future. In 2019, we will attempt to launch the next round of our QIO work. And it will be known as the 12th scope of work. We are currently in the 11th the scope of work. We are looking for ideas of where do we go from here? We have to start thinking about that now in order to have things in place so that when we get to 2019 we will be ready to go. Today's session is the opportunity to hear from you, gather information so that we can divide the process along the way. It sounds like a long ways off but those who have been involved in this program know, it will be here before you know it. This is not new or the 1st time that we have held a public session, but there is a new energy around it. We are looking at how we design programs and engage the users. The human centered design. And looking to see not what CMS means to gain out of this but what makes the difference on the front lines? I am excited to see that we have 25% of the folks in here are providers of care. We want to be able to hear from you. And those contractors that will make this happen. We are now implementing a program and we sit in offices will be watch people put information in, and the team has had some listening sessions and I challenge them. And I say this is nice but what did the clinician say about this? And they put up with me. [laughter] and they want input. But really, in the field inputs. But we all have a new energy and new excitement. The last thing I used to describe a QIO is that they get results. And that is important. We are using resources, valuable limited resources to fund this work and it is extremely important that we be able to say without a doubt, here is what were getting. Here is the value in continuing the work. There would not be a 12th scope of work, or 11th, or 10th or anything if there was not some way to show growth. 24,000 readmissions have been prevented. Think about that number. And this is the 11th scope of work high level summary. We are still in the midst of that and giving early data from the 11th scope of work. And already we can see the value that were getting. The potential adverse drug events that have been avoided because of this work. We see instances where, the influenza

vaccinations and pneumonia vaccinations are increasing. A lot of the work is being done by the quality innovation network. The way we approach our work, we have quality improvement networks which work to aim and target our goals for improving care. And it is focused on the clinicians and providers in the community that they serve. We also want to have an entity that is focused on the patient and families. And that is the [indiscernible]. And finding opportunities across the system on where we can make improvements. How many of us have had instances or our own family members saying, Aunt Sally has to be discharged from the hospital, I do not think she is ready to go. We have a system in place that can look at that to make an objective determination. That is why we are here. And that is what the QIO does and that is the value that we get. And my question to you is how do we do more of this? How do we look to where the hockey puck is going? With all the transition that's going on right now we need to be thinking about that. I thank you for coming and I'm going to turn it over to Tracy.

We wanted to give you a high-level overview of what were currently doing in the 11th scope of work. That began in August 2014 and goes through July 2019. The QIN-QIO are focused on generating outcomes through improvement activities. We have a strong focus on learning and action networks and communities. We highlight who is doing well in any given area and try to replicate that on a larger scale. We also focused on direct technical assistance from experts in the area of improvement that we are working towards. As well as integrated communication. And our focus in the 11th scope of work is that we have a strong focus on reducing health disparities and improving cardiac health. We have a strong focus on reaching the community level to reduce readmissions. To reduce the utilization of inpatient services in general, and to reduce adverse drug events. We also are working in the nursing home setting, and we see a huge number of nursing homes across the country to reduce harm and improve quality. We are also focused on providing assistance to those clinicians who are participating in the new quality payment program. As well as taking information from the beneficiaries and using that to initiate improvement initiatives. We have a number of special innovation projects as well as national work in the area of developing communication and behavioral health. This is the focus for the 11th scope of work. They are all driven by analytics to create improvement. We have the beneficiary protection brand that we mentioned earlier. That list concerns from patients. We have the beneficiary oversight, which does claim review and validation as well as the termination review. And then the beneficiary engagement. To make sure that we are engaging both the patient and their families. And hearing their feedback in real time.

The slide talks about how we plan to do this work. This is a part of the presentation where we start to tell you what our plans are. You will have an opportunity to share feedback on what we are thinking. I will say that I love this graphic. We want smart goals. We want to set smart goals. Even though I am the junior of the 3 executives on the team, it takes a lot for me to take that spec to keep up. They are fast, moving aggressive leaders.

So in my office I keep this posted on my whiteboard. I have a posted up there that says that this is not a time. I have a post that that says some is not a number. You need to tell us how much you're going to provide on that date. In the last post that I will share with you is, hope is not a plan. We have to lay out how we plan to do what were going to do have a date tied to it and have an exact number for what it is we are going to achieve by that date. Part of our goal setting is an aim towards achieving national impact for this program. We want to cover the landscape and make sure that we touch as many inefficient areas and providers as we possibly can as we

do this work. One of our partners and doing the work is the strategic innovation engine. We plan to work with them to test and think about and research innovative ideas and use that as a way to funnel into future work. We also want to take all of the innovations that have been developed and scale them for national impact. We want to test those and look at the outcomes and the results and if they are promising go big. Go logical national with whatever it is that is possible on a large scale. We want to take all of the data and learning and feed it into our quality improvement work so that we are getting the impact that we want but doing it in a smart way. That were using the progress of innovation and data analysis to funnel into how were going to do future work. And that is part of our goal setting and how we pan to approach it. These are our approaches. One of our top approaches is to maximize competition. We are stewards of taxpayer dollars and we need to be consistent and wise and how we procure those funds. So this is a way for us to do this in a smart way and that we are wise in how we spend our trust fund dollars. We want to be flexible in how we do this work. Once we set our outcome and goals, we want to team up and partner with quality improvement organizations and providers to determine how that should be done. And we want to be tight on what the outcome should be. We do not want to spend a lot of time to hating to the QIO's or how to achieve the outcomes. You are the experts. And you know that. The part of the session is gathering your feedback. We want that to be a continuous cycle where you tell us the best way to achieve the national impact that we are aiming to have. We want to have close partnerships with patients and other federal agencies and with our private partners.

We are elated to see that we have so many partners here with us today. We really what impact from the masses. We know that 5 years is a long time. We want to make sure that as we go into a phase we are developing what were going to do in the next scope of work we get as much input from as many people as we can. I know these next 2 will be favorites among some of you. We went up you were but more important measures. Were not aiming for beam accounting. We want to measure the things that matter. Measure the things that get impact and have a few smart measures and not spent a lot of time counting things that don't add up to increased outcome. Less reporting and fewer contract deliverables. We need to have deliverables that are smart. We would like to use our data in a transparent way. Making sure that we hone in on the data that's most important and useful if the way that we would like to do our reporting. And then, lastly, we want to work in clinical practices, hospitals and community. This is where healthcare is happening and we want to partner and work in those settings and make goals that help us achieve the maximum outcome from our settings. So we will go to our 2nd polling question. This question, this polling question is all about the approaches that I just discussed. We would like for you to pick the most important 3 of these approaches and provide us with your feedback. [Participants being polled] for those of you online or on the phone. To answer a question it's easiest if you put it on the app. If you would not mind save the URL one more time: <https://TCPI.adobeconnect.com/CMSspecialsession>.

If you are not using the app are having problems with it,, please use this website. Once you log into the app, turn your volume off or it will broadcast through the phone. If you are struggling with the app, you do have the sheets to make your responses. And we will collect those.

Let's take another minute to do that. There is an opportunity for open ended submissions. And we will do that in just a minute. Let's take a minute or 2 before we close the polls. I want to make sure everyone has a chance to submit. I want to point out, people are getting adaptive on

Adobe connect and this technology. If you look at the chat box, you will start seeing members of the audience starting to help each other out by typing in the URL that we were having the URL that were having difficulty with. I have been reading and saw a few people seem to be having trouble with the audio on the phone connection. So this is an opportunity for dialogue with people out there who are listening. I have a handheld mic. And if you can give us a little feedback if the audio has improved out there. We can work on that as well. We want to model a learning community as we go along. The Mecca real-time learning community. -- A real-time learning community.

And one of the benefits that you will see comments on the chat box and you can respond to those as well. Learning from others and building on other people's comments as well. I will allow another half minute or so to respond to the poll. Look at the poll results in the room. And you can see in the chat box. And I think you can tell, I'm reading more important measures with focus on outcomes and results. It's truly amazing. Were you could choose 3 things.

Later on we will go to some open ended questions as well. And people will have an opportunity for things that you do not see on the list on how to give us comments on that as well.

Now is a good time to do that. Let's close the poll. And that's move onto the next slide. Throughout the session we will have polling questions and we will also ask open ended question. Now, we would like to open it up. We have 3 mechanisms to get your input. One is online. The app that you have. But we also have the ability for you to speak up if you would like. And people online can do that as well. However you would like to submit, and if you have problems with the app, use those sheets if you are in the room. And if you would like to speak up, we do have microphones throughout.

My name is Jerry I am a family doctor from California. My request is that the QIO statement of work has disaster analysis of medical disasters that are publicly reported. There are 2 cases of disaster analysis that have taken place that I am familiar with. The 1st one I wrote myself with 2 doctors. Wherever 700 patients were damage. \$500 million payout by the living medical center that was kicked out of the Medicaid program. 2 doctors lost their license. And no government agency including my contract provider and Mike carrier recognize that there was a problem. And a lawsuit was filed that identified the problem. And we wrote a disaster analysis and we asked the QIO to write a disaster analysis to find out how is it possible to 700 patients to be seen in an institution over 6 years and no one analyze how it could happen? So the QIO refused to write a disaster analysis because it was not part of the scope of work. The disaster analysis was done by the Senate finance subcommittee on health which was published online. And that was the 2nd disaster analysis I am aware of. Other than those to analysis, there were none.

So when the hospital is California was tagged with a \$4 million payout for damaging several patients by 2, the knowledge of, I called the QIO and asked them to do an analysis and they refuse. And I contacted every federal agency between the FBI in the OIG, the California medical Association, and the medical Board of California and all of them refused to do a disaster analysis. In my opinion, the public must know how is possible that an institution that would -- where program safeguards are in place, patient can be damaged over several years by several doctors without any accountability at that time until they get popped by a lawsuit. A lawsuit means that the government failed to find the problem. So the problem is the government

failed to find it. My contractor failed to find the problem. That is a failure. A failure of data analysis. So we must now move forward to do with the National Transportation Safety Board does. And we need to have a national safety patient board that will look at these kinds of problems and easily report the findings. The cases can be discovered. And the details can be analyzed by the QIO and be identified if necessary in order to file a court settlement where the information is trying to be kept confidential so that patients cannot find out. And then we can move forward to know where our mistakes are and where our institutions have failed us where the conditions of participation have failed and then, we can fix the problem and have better healthcare.

To have someone else in the audience? What are we noticing online? A couple of comments that we are getting. What I have is Denise and Susan over here who are helping to synthesize comments that are being made in the chat box. A couple of things that are mentioned it's working with patient group's. And allowing flexibility during the scope of work and also focusing on rural health specific concerns. And also, we also noticed a trend dealing with collaborative work across healthcare settings. And the other comment that was interesting is aligning measures across settings. These are some of the trends that we are beginning to pick up. I wanted to ask Patricia, is there anyone in the queue waiting to speak?

Currently there are no participants on the phone line. Any other comments I guess one more than we will move on.

I am Natalie Grace. I would like to re-irradiate many of the comments that are coming up in the chat. Things that will be important that will continue to be intentional about supporting the work across the community. Some of the topics that we are focusing on that are the most challenging are the readmission events and stewardship. Both are impacted and care setting across the continuum. We are working with the inpatient setting, we cannot make an impact without support across the continuum. And continuing to support the work that way. >> I want to mention that one of the ground rules is to keep your own parking lot. If we don't get to you, enter it into the chat box. And we will record everything and consider everything. One final comments.

I would like to emphasize the ongoing flexibility of submission of a state or regional project that may be identified by the data analysis that is being done in our region that are being proposed on our work. I can speak to a project that the Great Plains QAM has been doing over the last year around colorectal cancer. I think the ability to allow the QIO in to propose on a project that could span the full 5 years would address issues around health equity and population health. Because of knowing their own population and being able to identify areas that our providers would find most important.

We appreciate all of your input. Even though we did not get to you verbally, or did not identify, please continue to enter items in the chat box. For people in the room, there are spaces for each response. I would like to turn it over.

Good afternoon to each of you. I am the director and I am going to talk a little bit about collaborations. We have heard from each of our speakers about the importance of collaboration and partnership. I am pleased that we had the comment about allowing flexibility to focus on

health equity and I support that. One of the reasons we may have been asked to talk about collaboration is because if you look on the next slide, some of the disparities that we see in our healthcare system and healthcare quality, we cannot achieve our goals without collaboration and partnership. And throughout all of our work we are working across the spectrum of healthcare systems to focus on them. As you know the work that you're doing when you look at the next slide to reduce this disparity and quality we cannot just focus on medical care. And you have seen this. Medical care results are 10%-20% of our health outcomes. We need to think about the behaviors and social circumstances and other factors. We need to work collaboratively to do that. On the next slide, it shows some of the work that we have been doing in the collaborations. We cannot get to our goals without the collaboration here in terms of achieving health equity. And it shows some of the ways we have been able to do that. We are working to implement our CMS equity plan to improve quality in Medicare as well as the QIO and the scope of work to define health equity and a number of places. Transforming critical practice initiatives. And, we are excited about the latest one in terms of the accountable health communities. Where focusing on some of those risk factors and working across spectrums. Also we launched with rural and our connected care campaign. And working in collaboration with the federal health care policy. We really wanted to encourage that approach across on why collaborations make the difference. Collaboration makes a difference. I'm sure all of you are aware because they were so gracious in sharing in the, when they were awarded the award for the equities that they have died, these were the specifics. And we know that since then, they have seen an increase in improvement. Instead of 87,000 lives we are at 125,000 lies. And instead of the 2.1 viewer medical errors, there are 3 million viewer. And the savings have grown to \$30 billion. Those goals would not have been achieved without many of you in the room and on the phone and your participation. As we think about moving forward, it shows what you have said. Collaboration across the health system that were talking about here and our work in working with our colleagues, but also, how do we get down to the level of the individuals that we are trying to help in supporting that? We all have expertise in given areas but it is through our collaboration across each level that we can achieve more of the goals that we are looking for. As we are heading into the next stage and thinking about our work, I would like to leave you with a bit of a thought. There are a number of partnerships that are challenging you to build bridges to those you may not normally think about partnering with. To span the pool of collaboration that you have and to see where there may be gaps that we have in terms of what we can do. And building those bridges to bring in more people into our tent that we will further drive the outcome that we have. And as a final thought, I leave you on the next lie, we would welcome the opportunity to collaborate with each of you in your work to help you in achieving quality care outcomes. You can learn about the work we are doing.

I am Paul and I am Dennis. You will see a daunting task and we set ourselves a bold goal of getting through all 11 categories in the 11th statement of work in the next 3 minutes. I will start us off with diabetes care. The reason I want to start there is because of what Dr. James just said. In our QIO diabetes care is privileged to be involved in the diabetes self-management education for low income minorities with diabetes. It is one of the tasks that we already have hard data that has a positive return on investment. This is a good idea. Speaks not just to medical but to show factors and it is effective. It's a good illustration of everything that Dr. James was just talking about. That's an example of work that makes a difference in the community.

I will talk about the work that is currently going on in the 11th scope and care coordination and medication safety. We have a program under way, you hurt a little bit about this from Tracy Archibald at the beginning where she briefly covered the 11th scope. But QIO's are working with 294 communities across the country in community-based coalitions to try to reduce unnecessary admissions and readmissions. Patients were discharged from the hospital, the last thing they want to do with go back to the hospital. They want to be discharged and stay healthy and out of the hospital. When that happens the patients are better off and it also reduces cost. Similarly, these 294 communities are teaming with QIN-QIO currently to address allocation safety. We focus in the 11th scope of work on the highest risk of medication safety issue which includes opioids. And that is a significant challenge. This is something that we have high on our priority work for our 11th scope of work and also the 12th scope of work. I will mention that our initial results on the care coordination front, we estimated 24 we estimated 24,383 per where readmissions as a result of this work which translates to over \$200 million in savings for the American taxpayer. >> I'm going to direct your attention to C2 on the screen which is our nursing home care task. We have a robust work with nursing homes. And we have a number of different measures. One of the biggest projects is using antipsychotic agents. And that project has been successful. We also have competent measures that include 13 types of Masters which includes how they are reducing their mobility. This is a robust piece of the work that we are doing currently in the 11th statement of work. We are asking you here today to think about the 12th statement of work. I want to highlight another thing which is collaboration. I was around when they introduced the robust scope of work. And we had many partners. To very powerful nursing home associations. We are very glad to have this continued partnership and engagement. And we invite all of you to come in on this very important scope of work.

One of the things that have been essential element of the QIO program is to assist providers in complying with the reporting requirements associated with medical payment programs. That is a significant element of the 11th scope of work and it is taken off particular significance with the bipartisan passage and the quality payment program. QIO's are accountable for assisting nearly 400,000 clinicians across the country with the new reporting requirements that are associated with the quality payment program. QIO's work closely with hospitals and payment providers that report to Medicare. That is an important part of this work. Our intention is to provide exceptional customer service.

Going to try with my partner in an effort to hit this three-minute deadline. I'm going to divide combine 2 into one.

The one is cardiac health. Cardiac disease and heart attack and stroke are the number 1 causes of death in the United States. And this program is a prevention program that addresses that type of work to get everyone who needs it to control hypertension and control high lipids and cholesterol and get people to stop smoking. The other one in this is antibiotic stewardship. We would that we really expanded that with the help of our partners. We try to work in as many different settings as we can. And trying to get to the cutting edge facilities like dialysis. Absolutely key to preventing healthcare acquired infections.

Going to take a page and hit 3 of these quickly. Our purpose in sharing this 11th scope and drilling down deeper than what you heard already, is we are going to ask you to identify the 3 areas that you think are most important for continuation. It may be that we will do more of the 3

areas but as part of the work of gathering input we will ask your advice on that in a few moments. And right after that we will give you a preview. Of what people are telling us. Right now we want to focus on what were doing now.

On the behavioral health front, you heard that they are working with 1400 practices across the nation to increase behavioral health screening for things like depression. On the transforming clinical practice, they have an important role in supporting 29 transformation networks that have voluntarily join the transforming clinical practice initiative to prepare themselves to prosper in the alternative payment programs. And another area where a now that's a tremendous amount of work has gone on his 328,000 immunizations have resulted as a result of the work we QIO's. That is our lightning tour of the 11th scope. We have not covered everything but we wanted to give you a sense of that as we move to our polling question. Our challenge to you is to identify the top 3 things that you would say should be continued from the 11th of scope as we consider the work with constructing the 12th scope. So we welcome your input on these.

That does not mean to continue as a carbon copy of what we are doing now. We always want to do things better. Some of you in the audience may have special abilities and knowledge and think you're glad they're in the nursing home but they need to improve intervention in some sort of way. We are open to that. As you answer the question, it could be exactly what we are doing now or what were doing now with improvements and enhancements. Connect the public input is critically important to us. We also want in every way possible to them I the work of the 11th scope and 12th scope as we construct it with the priorities of the new administration. We have heard consistently that behavioral health and opioid and obesity these are concerns. One is do a quick announcement. We have pronounce with the login if you need that. We have live help here in the audience for anyone that is having trouble. [speaker-low volume] I will make an added comment. I have been with the QIN program for 15 years. I think it's something like 35 years of work to improve immunizations. But I do see trends, immunization is important but they can be rolled into other projects. I think people ever get more sophisticated, their learning how not to have tasks that are focused on one or 2 narrow measures. And maybe the polling results are an expression of that growth in the community.

[speaker-low volume]

Our measures to providers and beneficiaries. I wanted to share those with you. [speaker-low volume] let me repeat this one more time. Trends that we are seeing online and in the chat box on rural health, advance information and increase communication on CMS measures and increase communication to beneficiaries on how they can help shape QIO work.

Let's talk about some of the future work.

This is the most exciting pioneer of all. -- Most exciting part of all. We had several conversations with many of our partners, we are not finished yet. And it has a table in front of you, we are going to pick and select ideas that we have heard while preparing for the 12th scope of work. Our next statement of work starts in 2019 and it runs for 5 years. These are the ideas that we are getting from talking to people like you and sessions like this. I'm going to start with behavioral health. My wife is a psychiatrist and this aspect of care reminds me of what Dr. James said. It is often neglected and compartmentalized. We are hearing overwhelming support, almost whatever we turn, primary care and specialty care and even getting out the care

coordination that we have to learn as a country how to bring ethical health and primary care together with behavioral health in the same place. And it turns out that a collaborative care model works well to do this. That is what you see in the 1st bullet. At that is one of the most frequently cited improvements that we don't have currently that would be like to move to in the 12 statement of work. This integrates with substance abuse programs. It's not just depression or bipolar disorders. Substance abuse has become an epidemic. And that links to the 1st box on opioid use. We hearing that as a priority from this administration and coming up in every listening session that we have. We want to hear specific suggestions as how to do it best. On the last point that she made about specific suggestions, I want to complement what I am seeing coming into the chat. I am seeing a lot of people who are commenting on the specific things that we are talking about and making specific suggestions about improvements and how we do the work. And I want to say people who are doing that and encourage them to keep on doing that. Again we are sharing this based on a lot of listening that we have done. We have consulted with many federal partners. We have consulted with patients and families. We intend to do more of this paper the list that we share with you comes from all of the interactions that we have had so far. We will continue to integrate the list as we move forward. We will not talk about all these things but I will mention patient safety. You saw earlier clear James shame that Mike shared the results that we have been able to achieve. We are currently working with 4000 of the nation's 5000 hospitals as a support contract and the 11th scope of work. We are seeing improvement and production that and reductions. This is one of the issues that are coming forward for the 12th scope that people are saying that we should consider continuing as we move forward. You are talking about patient safety. I want to use this time as a cue to get one of our colleagues, a special guest that will join us, and I will tell you more about her in a minute. She is on the line, the reason I am reminded of that is because Sue and her family have been affected by diagnostic care. I am embarrassed now to admit that as scientists and university academics and is are studying the accuracy and the timeliness of dike noses, they are learning something similar to what we were 15 years ago. At that is, we are not good as a profession at dike noses at dike Gnostic accuracy and timeliness. And sadly it's not a matter of giving the tightness is wrong. Our patients are harmed. And Sue Sheridan's family can tell you about that. It is hard to measure. We have had several sessions. We don't have a perfect measurement system but with thinking it is important enough that it won't start until 2019 that were putting at that top of the 2nd column. That's a brand-new area that we not gotten into before that we are considering. I'm going to go back to the 1st, and talk about administrative burden and burnout. This is something that we are hearing consistently which is why it is on this list. It requires attention. Part of the attention -- were talking about clinicians and physicians who are experiencing change in the American healthcare system and the dealing with changes in reporting and changes in the health issues like opioids. Lots of changes in the overarching system of care that they're operating within. We hear a lot about burnout. And this is an area that has been identified as a key potential area. We have the opportunity to hear Mike Leavitt speak about transformation and the journey of shifting from paying for the volume of services to paying for value. His belief was that, one of the principal limiting factors of doing it better and faster if the clinician workforce. And the burdens associated with more complex work associated with pain for value. You have to count and measure things in new ways. This is one of the areas where we are looking for the 12th scope of work. The wonderful thing, and you will see an unusual word for a government slide. The word that I want to point out is joy. Create joy at work. One of the things that we see all of the time in our current work as part of

the 11th scope is that clinical practices and hospitals that have figured out how to prosper in the current environment experience joy. And that is the goal. It is not just reducing burden and dealing with burnout is helping to bring back the joy that attracted so many clinicians. And we see this happen. In the work that is currently going on and we see this happening in the work that's going on and transforming pinnacle practice initiative. We see this going on with many elements of the 11th scope. The challenge is to do this with system and methods that that is one of the things that were looking up for the 12. I have to -- quickly. I would say it is a joy to work with an executive like Janine. One of Janine's many skills as she is highly diplomatic. Submit the last of these topics. --

The last of these topics, chronic kidney disease. We want the care of all people with end-stage renal disease. It costs about \$30 million a year. A lot of people don't know that there is a tiny parallel program that's been authorized with statute that's charged with within the dialysis community. That reality has been present for decades overshadows a causal analysis of this important community which gives us basic medical facts. That you don't wake up in the dialysis. There is a process depending on the cost that leads to end-stage renal disease.

They have been asking us for years is been seen as an issue that we cannot get into. But this time we are thinking differently. Patients are telling us that if CMS got involved in kidney disease and reached out in a patient centered way, we could prevent a lot of end-stage renal disease. And that's a new way of thinking for CMS and that is what is represented in the box. It is an important problem. But we are considering that it's time for the QIO to move in that direction.

I will mention one additional item. Value-based purchasing. This is work that we are currently doing in the 11th scope. We know that these programs, the trajectory and history of these programs looking backwards and looking forward if that we should expect continued evolution. And our belief is that the input that we are hearing is that QIO's need to be positioned to continue to provide support and customer service to clinicians and hospitals and other organizations that will have reporting requirements associated with the Medicare program. That is another element of the 12th scope that in some ways is a continuation but is also new. We wanted to include that on the list. This is all to get your input around the top 3 tasks that we would like to ask the people in the audience to pick the top 3. That before they do that, I see people's wheels going around in their heads. I wanted to let you know that we had 2 slides from now that will be talking about crosscutting areas. There are topics that we think are a top priority but we could not put them in an individual silos. They are health equity, patient family engagement in the care and rural health. We will address those topics separately. We did not put them in any of these topics because we think all of the topics belonging all of these categories and that's coming up. For those of you who will say what about personal family engagement, we will talk about that and I'm going to talk with Sue Sheridan a bit. The metal pole is open.
-- The poll is open.

[Participants being polled]

I am having a hard time looking at the column on the left and drawing a line to the bar on the right. I think in future iterations of polling that would help someone like me. There is a clear trend towards product improvement for behavioral health. Palliative care. Of course.

We will have another opportunity to provide input for things that are not on the list as well. We will go ahead and close the poll. We do need to move on. Some of the trends that we have not mentioned before is medication reconciliation across facility. And prevention. Thank you for all the input that were getting. Continue to provide that.

We are moving onto a focus question. Is that right?

Not quite yet. I see it on the screen. Submit there we go. It's not what other initiatives should be included in the 12th scope of work. This is open ended. This is another opportunity for people in the room – If you would go to the center microphone the other ones are having some problems.

I was in charge of off label drug use I recommend that drug safety and effectiveness be included. The reason for that is Medicare pays for medications like cancer drugs. And often the data is based on a few patients in a couple of studies. We don't collect enough data to know when it really works and how bad the cancer really is. And whether it works or not. So was spending a lot of money on drugs where the effectiveness of it was not so clear. And not clear enough to get an FDA approval. In that area I think we need to collect better data. I suggested that to the California medical Association. In the medical Association agreed with that. And I think the oncology community is trying to do that with some of their initiatives. The coding system is not sufficiently granular to tell us what works and what does not. We need to look for a better way to collect granular data on the effective mass and the use of anticancer drugs. And that ties into your initiative. That one more comment in the room. And do we have anyone on the phone line?

There are no participants in the queue at this time.

You have noted other palliative care that you have the idea of helping beneficiaries understating their options. I want to underscore the need to support practitioners who don't receive training and how to engage in these conversations about advanced illness. They are out there on their own making it up as they go along. It makes very well with your value-based purchasing initiatives. To help measure the practitioners performance in the semester. The oncologist has done and incredible amount of work and working on this measure. Great to patient centered opportunities. One final comment. >>

I have special instructions. If you go to the next slide which is cross coming topics, is easy to remember. Claire James with health equity. Person/patient and family engagement. And rural health. You have those 3 topics. I would like you to go backwards in the slides to slide 29. I wanted to go backwards as you look at those topics and go through the 3 would just looked at health equity patient and came and will help. As you go down those topics you can imagine the priorities in every single topic on the board.. The family should be engaged in every one of these. Were starting to toy with the idea of actually bringing patients into the design process of the QIO's and the networks and asking them how would we design safe systems. And rural health cuts across everything. Just because you are in rural health it does not mean that it is not important. Every single one of these topics should, overlap with crosscutting areas that you may have some other crosscutting areas. We do not have a specific question we wanted to get this time to Sue Sheridan. Please go to the chat box and type in other areas that you are thinking of.

What were going to do is spend time talking with a patient advocate who is one of the most unique patient advocates in the world. Focusing on the middle crosscutting area on person, patient and family engagement. I've had the privilege to work with is person for 10 years. I 1st met her when I was a codirector. And I am so pleased to be able to tell you that after spending 6 years as a codirector we were able to convince her to come as the patient advocate to work as that's met at CMS. She is an employee.

It goes over things that are self evident like quality of care and coordination. Understanding all costs of care. I have experiences in my family. I wanted to turn it over to you Sue to talk to our audience about your perspective and how your helping us at CMS to see the world differently.

Let me tell you it is a privilege, and Dennis you use the word joy. To work with the MSN to be part of transforming our healthcare system. I want to underscore the importance of this webinar. I always loved CMS webinars. I love to read the chat boxes of all of the innovation and ideas. It is infectious. In this presentation is going to be quick. What brought me to CMS were 2 significant diagnostic areas in my family. My late hundred and that's met my late husband passed. And it was a simple failure of communicating. 4 years prior to my husband misdiagnosis, my son suffer permanent brain damage from newborn jaundice that was not treated appropriately. So today he has sample policy. He has a lot of challenges in life. But he is smart and funny and a delight. But he should not have to live with the challenges that he has. My family saw and experienced the weak link in our healthcare system. And I know I cannot change what happened to my son and my husband, but I wanted to be part of the solution. And over the past 20 years I have been engaged and family efforts and research and developing healthcare delivery systems improvement and empowering patients to help manage their chronic illness. The good news is, over the 20 years I have witnessed the power and value of family engagement that has resulted in better care. So hearing what they said about the beneficiary being the center of the QIO, that family engagement can cut across all aspects of family engagement. I am not only delighted and joyful to work with CMS but as a patient advocate, I see all the opportunities at our tips to improve care, and I'm also delighted and joyful that the level of commitment to family engagement that is tapping into the wisdom and passion of the person and family communities to ensure optimal patient experience in health and well-being outcomes that matter most to the beneficiary. And I think this is a strong statement that CMS is putting out there. And in my role, having living in this role for 20 years,

I feel that momentum is going to be a wonderful asset of ours. And as I get involved more with CMS, and I want to engage them in all the work that we do at CMS across all of the program areas and all the components I believe are going to see, including CIO work that we will see improved outcomes in the beneficiary world. I had to share that. Including the polling, that there is enthusiasm around outcomes. I have been watching the chat box. And how patients end up as one of the most patient centered areas that we can focus on. I also want to highlight a person and family engagement strategy that we just launched. It's on our website. And I must give a shot out 2 qualities. You are my QIO in Idaho. I am looking forward to how the QIO and the scope of work can tap into the passion and energy and knowledge of their patients. With that I will end. And thank you for including me in this webinar.

Thank you so much, and your comments are appreciated. At the risk, a negative reaction we will erase the breaking get you out early. Just a warning, I am going to reverse the order of the questions. Just be thinking about that.

Let's go on to slide 34.

Now we're asking the question how can the QIO's better help you accomplish your organizations and your constituents quality goals? Let's go ahead and think about that and submit your thoughts.

I have a comment, I know that we have questions coming in over the chat. And they are seriously coming through. I did catch one or 2 questions about patient and family advisory Council and whether the QIO's have them. We do. If you go to QIO program. or, you can find out which QIO is operating in your state or area and contact them to get connected with the beneficiary and advisory Council. And we use those advisory councils for all different aspects of our work. We would like to have a continuous feedback loop with that patient. If you are interested please reach out and join one of our family advisory councils. We would love to have your input as a regular part of our work.

Say that my name is Bill Murray. The CK D prevention and early detection, as you mention it can slow the SRD. I was diagnosed in 1997 and given 5 years until I would be on dialysis. I change my eating habits and lifestyle and a few other things. Now I got 17 years. Now, it is doable. The options for home based it's probably not part of the QI QIO here. Chronic disease management should include CK D. Along with diabetes and heart health. And that's because, 67% of people who are diagnosed are led there by diabetes or heart disease. And if you include them in the education and the dietary changes, it would go a long way.

Thank you so much and thank you for taking the trouble to come here. Smack a couple of things coming up on my is cancer detection prevention. Communicating the total cost of care to patients and providers. And another trend is palliative care education.

Thank you very much. Anyone in the queue for the telephone?

No participants at this time.

What we want to do, let's go on to the next question. What else should CMS know as they start to move in this direction as the best of the QIO program? What else needs to be intricately involved in doing this work? This gets into the concept of collaboration and partnerships. I want to echo what Dr. James said.

My opinion is that it is the collaboration that David and part of the program. If there was a side of fashion without the extent of collaboration that we had with him and without the federal government I don't think these results would have been generated. So this concept is key. It is difficult to execute an unlimited government environment. Any suggestions that you have in the chat box about additional collaborations we could look for or foster would be appreciative. It is happening. There was a comment in the chat box about you need to continue to integrate areas of aging into the work. And I saw some others and I will also add area agencies on aging. People are being very responsive to that.

We have a couple of people who would like to make comments Ms. Mac thank you. When we are working with clinicians, they are looking at the patient in front of them and trying to meet their needs, not what insurance they are on. It would be more helpful for the frontline people if they could be more collaboration at least to the level of Medicare and Medicaid. But then across all other insurance. But the message that comes across as challenging for them.

Good afternoon. One that I love this area of collaboration and thinking about those nontraditional community partners that can support our strategies that we are trying to fix the amount readmissions and the host of things we are talking about. Even back to the EDC project. Just nontraditional community partners. It is hard. But it does cut across the health equity piece and supports the social determinants piece. They are assets in the communities where we are seeing the readmissions. And the issue were having around population health. How can we dig down another level even below the tripling of looking at those communities that are seeing that there are multiple communities and we know that there are assets they are. And we can understand how to bring the resources that they have to support our healthcare system globally? That we have one more comment. And then we will move on to the final questions. I am a kidney patient. I started to Alice's August 22, 1999. Just a reminder and a thought. I am not healthcare professional I am a patient. When I go home at night, dialysis, death and dying is on my mind. No furlough days for me. All of the decisions that are being made there are people behind it. Not only meet people like Bill. People who signed up for it. And until you affection is not important. But there are people behind it we have families and children in all communities all people and races, men and women and children especially the black community we need to be reminded of this and think about it. This is a team effort. There is no I in team. Together everyone accomplishes more. Team.

I'm going to turn it over to Paul. I think were going to build on this tournament comment. We're going to start thinking and speaking together and giving your suggestions on how to make this team and connected to the QIO program. That is the reason I wanted to do these in reverse order. On question 7, is the last question in the deck. But in many ways I think is the most important question of all. We are focusing now on the last few minute on patients and the patient's relationships with the providers and quality and safety. I think it builds nicely on what we heard. The question is how can QIO's help integrate patients into quality improvement. We're trying to do that more and more here at CMS. That's why there are patients in the room that is why we hired Sue Sheridan we have a long way to go. We are far from ideal state. But we are opening the door and was starting to do that. We would like for you to think with humans and type into the chat. If you have ideas for us about how we can do this better. How do we engage patients and get them more involved in design and how to get them involved through the entire five-year statement of work contract? Any ideas or suggestions or places to point us as we draw of this work would be helpful. If anything is coming in that you want to share don't hold back.

Some of the shorter statements are some of the most about Desmet most profound. Open the door and invite them in. There are lots of recommendations. I see technology is coming up yet in some ways the way that all of this is going on shows the power and the ability to be more responsive to larger numbers of people. And that is part of the key to unlocking the engagement of the patient more fully. I know from our experience, that one of the things that patients can do, and an exceptional way is Hopis often large bureaucratic healthcare institutions to bust

through change. There is a lot of inertia. I think the patient voice brings in authenticity and a need and a demand for the changes that are necessary to improve the system. I think that is a special asset that patients bring.

I have other people helping us out. These are some of the short poinsettia coming through in the chat. Promote shared decision-making with taking. Make the patient a partner in his or her care. Tell patient stories. We heard some of Sue's stories today and the gentleman in the front row. Tell their stories and it is powerful it makes a difference. In the last one, they did not explain what, but I think it is true that technology helps. One of our long-standing QIO employees this week had a retirement party. And Janine and I cannot be there. But one of our fellow employees came in with the iPhone at the end of the day and said would you like to say hello to this person. I don't know how to do this but push the button and I recorded a 3 minute video and send it across the country. Those types of things seem simple, especially to our children but I think they can help patients get better involved in the care.

My name is Andrea I am with provider resources. And I think that, when you reach out to the children, you have stopped smoking campaigns they look at their parents and say you cannot smoke. No one cares about being a patient and to your place into that environment. I think just like there are campaigns to stop smoking and wear seatbelts, you have to campaign to make people aware that it's okay to speak out. That it's okay to ask questions. At that the petitioners need -- if talk that millennial's are coming clinicians and things may change. But we need to go to the youth and raise them to know that it is okay. And that is something that QIO might want to start working. And engage the children that can be part of the change for our future.

Thank you for that comment. I thought in the chat a comment about creating -- and that's what you are talking about. Sue Sheridan is one of those. I also saw another comment saying that having the patient as part of the QIO composition should be a requirement. It is and you have patients who are participating in every organization. We also have those beneficiary and family advisory committees. That a part of the organizations to make sure that we are getting feedback about people in the community receiving care. Thank you for the comment.

A couple of minutes ago I was looking in the back room and I saw 5 people heading to the microphone and I looked away. Please feel free to get up we have a few minutes. We are having people harvest punchy little phrases. Improved health literacy was one. Create smart consumers of healthcare. Start patient engagement earlier in life. And patient to patient communication which is another good idea.

A Dr. called me from time to time because they are concerned about poor quality in their institutions. I got a call a couple of weeks ago about [indiscernible] not being read for a year. And the doctors who call me are concerned about being retaliated against one doctor is viewed as being threatened with his job. Doctors call me because I'm known as someone who does not want to talk to the government. And I will call the government for them. My suggestion is that the QIO reach out to doctors who work in hospitals. And invite them to report quality concerns confidentially so that they cannot be kicked out the medical staff for dropping the time of poor quality for these patients. If the QIO will reach out to doctors to report quality concerns so that they know who to call and what to say without being fearful of being disenfranchised.

Thank you very much.

I am watching the clock. We have 2 more questions to go through. If it's okay with you we will go backwards to slide 37 in question number 6. At this is trying to turn the telescope back to the providers. We have a lot of representation from the QIO community. We would like to hear from providers and patients to imagine in your mind receiving technical assistance during the statement of work on any of the topics we talked about. What can the QIO's do best to help you with your quality goals as a provider or a patient? How do you envision the QIO's working best? We heard an example of that with the last comment. But any other ideas of how QIO's can best assist you with your quality goals, providers and patients. Anything coming in? >>
Providers need education on how to communicate with patients is the 1st one.

Let's go to the phone.

I am a patient associated with the renal network. I am a kidney patient. And I am a retired nurse of 40 years. I tend to look at things from both points of view. My comment was for the previous question. I think it has to do with educating patients that when they want to communicate something that they don't feel is right, that there won't be any retaliation. A lot of the patients I talked to now are afraid to say what they are thinking of what is going on with them because they are afraid that the caregivers will retaliate. And we need to educate patients and we need to provide a safe environment for them to be able to talk about their care. What they find good at what they bind does not meet their needs. I think this is important.

And the patients in the front row here were vigorously agreeing.

Feel free to anyone on the phone or in the room, especially in the chat box, we do not have to take the questions in order. We recently held a focus group with some of the positions asking them if there was information that she wanted to receive and it was through a webinar. What time of day would you want to have it? We started in the morning. We went to the afternoon in the hands raised up. Between 7 PM and 8 PM. Although we are doing a lot of taping and making it onto man it does not allow for interaction. I think we need to consider the customer.

I am watching the clock. I want to check the phone again. I thought someone said there were patients on the phone? Is there anyone else in the phone line? No one is on the phone. I'm going to move to the last question and could you remind me, other things to be done after the last question? After the last question, we will prohibit to providing -- we will pivot it to providing a wrap up. This is the last question. It is a typical question. Technical and important. Not everyone in the audience is going to weigh in on this. Is less about leadership and culture them about the technical craft of our trade. What quality improvement tools and resources are most valuable to you? It is directed at the providers and patients. I will give you an example of the types of things that the program has created. Traditionally we will put together these change packages which are based on the review of the literature. And then an approach to helping patients to improve their diabetes control. We would have all of the things necessary in the change of package. We also have created videos. We run a lot of webinars. And when I 1st started in CMS 15 years ago we were really big into what I want technical assistance. Where people who are experts would go out to a hospital or a practice and provide what I want technical assistance with customized assistance with data interpretation and quality

improvement on-site. That is expensive and very hard at the time. There are 16,000 nursing homes. But, whatever it is those are things we are thinking of. Which tools and resources are most valuable to you? If you have any answers please put in the chat.

One of the things that we see is peer to peer sharing. The list serves is in meals that is emails were anyone can ask a question.

We are very into the lean methodology. We are learning to use different tools to improve quality of the processes we have here in the agency. That's another thing that we are doing. >> The staff of these organizations and very few physicians are able to participate that's something to think about. The other thing is to provide -- algorithms on how to participate. Some of them don't know what these things are. A lot of algorithms and simplified approaches on what quality measures are appropriate to you. Simplifying a lot of it. It would be helpful. And demonstrating what is of value to their patients. Maybe focusing on that a little bit.

I have the latest report from the site. Here are 4 more bullets the cavemen on this question. One position to position engagement. That's an interesting idea. For many years I ran a geriatric medical fellowship. And I know the power of position to position engagement. Number 2 pediatric related tools. I want the audience to understand that we are authorized by a law and the statute tells us that in the law which we cannot change we must address the needs of the Medicare populations. That law was made it best Mac back we can change laws and you need to ask about your statutory authority. Third is video learning tools. And forth on this list is funding of subject matter experts for regional networks of quality improvement. Those are all good. This is the last chance for anyone in the room if they have a comment. If there are any collars on the line. Someone is at the microphone.

I know this question was targeted to providers. But from the perspective of working with providers, our experience with tools and resources to the extent that they can be personalized, it does not necessarily mean delivered at the level of the position. But talking to the position of having awareness. What are the priorities in the practice? Access to data and delivering tools and resources that are very specific and personalized data elements were you can drill down. I think it's important as a resource to help them understand what generates their angst and not necessarily ours. >> We have a cadre of students coming up a student is becoming aware of quality improvement and quality measurement. An implementation science. And team science. I would like to see QIO's involved more. Because the academics of quality measurements. This next-generation, I'm not quite sure where that law is. But we should continue to have that conversation.

We're going to check in with the operator. Can you hear me, were coming to the end of our time together. I want to check one more time with the operator if there's anyone on the phone line would like to make a comment? Samet no questions on the phone line.

Thank you for that reminder. We have one more comment here in the room. And I am about talked out.

This goes back to one of the earlier questions. It has to do with opportunities for collaboration. Someone sitting back here mentioned about the state focus of 24 that's my 21st century cures

act. There is a lot of money that has been awarded to the individual states to deal with the opioid epidemic REMIC and mental health problems. And perhaps that's an area where come up right now the money would be allocated but for the next go round, they said they will make the state work for. It seems to me that taking the expertise of the QIO working within their own state they could really push that. So that there is evidence-based methodologies going on so that people do have access to care.

We want to thank you for your participation. We will give you some instructions about next steps. This is not your last chance to comment. I want to add a personal note. I dedicated myself after I got into medical school to the care of the prayer that Mike frail and elderly. They were all on Medicare and Medicaid. Ultimately I came to Medicare because I thought the system could be improved. What I saw on the front lines was not doing the trick. I made that difficult decision 15 years ago and I have to say it's been the best chapter of my life working through this agency. We have made so much progress forward. I think that agency is becoming more open and interactive. With providers and patients as well. I want to thank you all for turning out and going through this marathon session. Thank you for your wise opinions and input and thank you and virtual man for the chat box which is wonderful. And I will turn it over to my colleagues to close it out to prison it I will share that I joined the federal government 15 years ago. And I think this was the best decision that I've ever made in terms of the future progression. We are here to change the nation and we need your input. Critical input.

And what we should be doing going forward. We cannot put this work together without your input. We implore you. We need the resources to communicate with us. We will take all of the input into consideration and plan to use it as we go into this development stage. I want to thank you all for being here and know that we appreciate you sharing time with us today.

I want to double down on what you said just a moment ago. It is our intention to take your input and to use it. We want to use as much as we possibly can. At some level I look at the chat and there's lots of input coming in. This is not the 1st session we have had. We are getting a lot of bead back. It is a lot to get around. But we want to put this input to work. I want to note that we have 2.5 years of work in front of us. We have a robust resource program of work.

Many of the ideas that are coming to us here are things that we are going to wait to act on until August 1, 2019. We get a lot out of these sessions. We know we can put these to work right away. That's also our commitment. When we see good ideas, we have offers and suggestions of things we should be doing want them to put to work as quick as we can. We are eager to have your input. We also know from experience is not just what you say to us about what we should do it's about what you do with us. The systematic engagement and involvement of patients in our work has made a tremendous impact to generate the kind of results we have been talking about here. And I love the comment that was made by one of our patient representative earlier. Together everyone achieves more is what I wrote down. And I think that's the honest truth. When we work together that we service the chili in the energy and the possibility and the actions that lead us to a better plan. That is what we try to do every single day is what we want to do more of. And we need to be a partnership with you to do it. I'm going to add my voice. I love this work I think this is a blessing to be able to do this kind of work and be able to do it together. Thank you for being here thank you for your ideas and thank you for the work you've already done and that you will continue to do with each other and with us.

Before we go, we have communication strategies and channels open to you. Because this is a large federal procurement we abide by all laws. It is all public information sharing and it requires free and open competition. Without any favoritism. If you want to keep track of the procurement is still 2.5 years away but it takes us that long to get it out. Follow us in the federal registry. The federal register URL is up there.

For those of you who cannot make it, if you want to send additional comments we have set up a special QIO program email box. And that is on the screen. Am I supposed to do anything else? We will close it down and thank you for your participation. [Event concluded]