



Disparities National Coordinating Center (DNCC) Presents:

From Improvement to Activism: How the Tools of Community Organizing Can Transform the Work of the QIO

Moderator: Matthew Mittleman
September 10, 2013
1:00 pm CT

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the DNCC Monthly Training Call. During the presentation all participants will be in a listen-only mode.

Afterwards we will conduct a question and answer session. At that time, if you have a question, please press the 1 followed by the 4 on your telephone. If at any time during the conference you need to reach an operator, please press Star 0.

As a reminder, this conference is being recorded Tuesday, September 10, 2013. I would now like to turn the conference over to Matthew Mittleman, Communications Specialist. Please go ahead sir.

Matthew Mittleman: Thank you very much and good afternoon everybody and welcome to the DNCC Monthly Training Call entitled, "From Improvement to Activism: How the Tools of Community Organizing Can Transform the Work of the QIO." We are very excited to bring you today's Webinar as this has been a topic that has been raised throughout the conversations that the DNCC has had with the QIOs over the past month.

Before we get to the presentation, I have a quick save the date reminder for our upcoming October Virtual Conference. The conference will take place on October 1 from 12 pm Eastern Time till 4:30 pm Eastern time. So please mark your calendars - save the date. We encourage you as QIOs to participate as a group. So if you could also schedule a conference room it would just make for a more interactive conference.

And here's a rough draft of our agenda for the virtual conference. We've had the great pleasure and wanted to thank all the QIOs over the past month for taking the time to discuss disparities within your states. We have been able to identify great practices that QIOs will share on community engagement and the collection of data during our October virtual conference during two different sessions.

Community organization is a key tool that QIOs use to transform health care. Today you will hear from Ella Auchincloss, the director of ReThink Health, on the topic of community engagement. Many QIOs had the pleasure to meet Ella in 2011 and 2012 at Quality Net.

And since joining ReThink Health that same year, Ella has helped develop and lead community projects for the CMS QIO program and will describe the successful Healthy Columbia, South Carolina campaign in today's presentation. So without any further interruption, Ella, the floor is yours.

Ella Auchincloss: Thank you so much Matt and thank you to the Delmarva Foundation for Medical Care for, and DNCC, for inviting me into this conversation. I just want to say right off the top that addressing issues of health disparity are - it's just I think one of the hardest work that any of us can do. And it really does

get to some very deeply systemic questions. And it's something I think that none of us can and should do alone.

So I'm very heartened that there are people on this Webinar from all over the country who are - who gather with the sincere intention of making a dent in health disparity. I came to my work in ReThink Health through my work in faith-based organizations and my sincere desire to make our communities communities of vitality and purpose. And the longer I've been in this work I have come to understand that the QIO is uniquely positioned to be a very transformative stakeholder in the system.

Not only do you all represent the biggest payer usually in the room, but you also represent the voice of people who are rarely represented in these rooms. You often are the only voice of the poor, the only voice of people who have no other voice, not only in issues -- big systemic issues around health and health care -- but some of the bigger issues in society at large.

So I'm here because I believe that part of the work of recovering our civic muscles is in learning how to do this. I will say off the top that what we will be talking about today is not brain surgery. It is very fundamental work and -- doesn't mean it's easy work but it's very fundamental work -- and we've seen the transformation take place.

We've seen it at places like Delmarva. And I hope very much that we can continue to work with QIOs in helping them understand themselves as the pivotal players we know they can be.

My goal in this Webinar is to introduce what we mean by organizing, what the theory of change is, how we can look at the theory of change as a path toward health system transformation. This will illustrate how these tools can be used

by the QIO to help the QIO map the local health care system to bring together people who may not - their sharing the same goals may not be obvious and to mobilize them toward the common goal.

And then I want to show you some examples of our work in the field, specifically one campaign that we worked on that is still an ongoing health initiative. And obviously I hope that what I say today will spark your interest in learning more.

So just to illustrate what I mean by community organizing because the longer I'm in this work the more I realize there's a lot of confusion around that phrase. I'd like to start by what it isn't and by offering just a short listing of what some common theories of change are in health care.

The most obvious one is just the notion of - you're a member of an organization and you accept your marching orders by virtue of hierarchy. Your compliance is incentivized by your pay, and, you know, it's a command and control kind of setup. And I don't mean that in any pejorative way. Sometimes there are organizations that need very much to exist like that and there are numerous examples where change can and is made with that theory of change.

Another theory of change says that if we can redesign the process we will take away the problem. So if we can redesign a particular intervention in health care, we'll take away the problem or the disease.

Another one is that the change would be made if people had the skills and the knowledge to make the change.

And the last two are very similar in that they are about making sure people - if people know about the problem that it goes without saying that action will follow. So there's a lot of (effortation) around this. There's a lot of - if we're just making you aware then the problem will go away.

And we think that for some of the deeply systemic issues around health disparities that some of these theories of change work - there's a lot of variations to the extent of their efficacy. But we're here to talk to you today about a particular theory of change that really starts from the people for whom the challenge really exists.

So in this theory of change, it is about people who build power to create the change. Within the people, it is people who are not acted upon but people who develop their own agency, who can come to a shared understanding of the current and urgent challenge that they face, who know by virtue of that challenge and hope that they can change it together, recruit and develop leadership from within their own native constituencies, and they build a community and power from that coming together, and that power is used to make the change that is being called for, the change that addresses the challenge that the constituency faces.

Here's another - if you see the slide you'll see this is another way of looking at it, that in the slide to the left, the image to the left, the big fish is eating all of the little fish. The little fish are scattered and confused and there's no way that any of the little fish can have any impact on what happens to the big fish unless they organize and chase the big fish.

The challenge of this theory of change in the context of health and health care is that often there's not one big bad fish or one big bad guy. The system has to be well understood in order to understand why things are the way they are.

But unlike other grassroots mobilizing initiatives, it's not always obvious that you're organizing against anything but rather that you're organizing for something.

So gain what we've done at ReThink Health is that we've repurposed these age old tools because this has been going on as long as democracies have existed. And there's even evidence of it in Biblical narratives. This has been going on for many years.

A lot of these tools were developed in the black church in the South and have been repurposed. So we have repurposed tools of the volunteer activation and community engagement and democratic behaviors where the work of ReThink Health is to see whether we can bring them to bear towards (unintelligible).

And all of this starts with very specific definition of leadership. Everything we do emanates from this definition, so it's worth spending a bit of time on this slide just to unpack what we mean.

In our construct -- in the construct of this theory of change -- leadership is taking responsibility for enabling others to achieve purpose in the face of uncertainty. There are three key elements to this definition.

The first one is in taking responsibility, you are stepping out yourself. No one has bestowed the authority upon you to take that leadership. You have taken it yourself. You are, in stepping into that uncertain future, in being sort of maybe that first person who is stepping out and taking that responsibility, you're immediately focused on the fact that you are enabling others to join you and to take up the question of achieving shared purpose.

So it's not about you. It's not about the leader. It is about the way that the leader is supremely focused on empowering others, empowering others to achieve a shared purpose in the face of uncertainty. The only way that you know what the shared purpose is is if the leader deeply knows her people, if the leader has done the work of really understanding what is motivating her and what is motivating her people.

So again the organizational structure that emanates from our work presumes that for us leaders are not necessarily people who have been appointed by an organization but rather you might imagine a community leader, say, in one of your communities who is that person that always seems to show up, always seems to speak out, always knows how to turn people out when it matters. Those are the kinds of leaders that embody this definition of leadership.

So what we teach in order to engender this kind of leadership are five key leadership practices.

And the leadership practices are designed to take the resources that exist within a community -- however seemingly impoverished it may seem, okay -- to take the resources that exist within that community, all right, and to translate those resources into the goal through the use of public narrative or shared story, which is the leadership practice of uncovering your own motivations for why this work matters to you and commencing that story to the story of the urgent challenge of the people, really articulating what Martin Luther King called "the fierce urgency of now."

What is the challenge that you as a people face and what can we do together - that we as a people face and what can we do together to surmount that challenge? That not only is a way of inviting a group of people to take action

alongside you, but what we've discovered is that in articulating that story, you are also tapping into your own source of motivation.

I had to think long and hard about why I really cared about this work in the context of health and health care. I have an advanced degree in theological studies. I really thought that I was heading down a very different direction.

And when I was invited to first see this work I thought well what do I - I'm not a health care professional. I really don't know that much about, you know, the quality improvement practices that you all seem to know in your sleep.

Then I thought about my mother. And my mother is this incredibly strong, vibrant woman who - she's the youngest of seven children. She was born to a very rich in love but poor economically family. My grandfather fled Pancho Villa's army into Texas and my grandmother was already living there. And they had eight children. And my mom as the youngest one was the fierce one. She was always the one that was speaking for someone who didn't have a voice.

And she's been that person her whole life. I have met so many people who have come to me over the course of my life and have told me what my mother has done for them. And yet my mom, this strong stalwart woman, has been the patient of 13 surgeries, none of them related.

And I began to realize over the course of working with people like all of you that my mom sitting right in front of me was this perfect example of a person who gave up her agency 100% when it came to pursuing her own health and health care. But she relied entirely on what the doctors would say and as a result my mother's medical history has been extremely debilitating to her overall wellness.

And I realized wow, I have a health care story. And it is squarely in my sights to imagine a system where people like my mom -- a strong, educated woman - - have a voice in the system and can speak up for themselves and can ask questions and just can claim what's theirs by their own rights as a patient.

So I believe strongly in the power of narrative and its ability to really activate people to take action. So we do a lot of coaching around how to tell a story and how to use that story as a source of motivation and inspiration for a group.

And then we borrow right from the community organizers' playbook around building relationships. We teach teens how to map power, how to map the various people in the system, how to conduct one-to-one meetings in a way that kind of gets to what the resources are, what the motivations are.

And we help people ask people to join them. That seems like a really obvious thing but what we have found in our work is that it is often the case that people are afraid. People are afraid to ask for something specific.

And we like to think that the work that we're doing is important enough to where in inviting someone to ask -- in inviting someone to join us -- that we're actually inviting someone into doing something extremely important, extremely consequential. So what I like to tell the QOI teams that I work with is never be afraid to ask someone to join you in this work because what you're doing is inviting them into something that matters a lot.

We also teach, we believe, and we know by virtue of good management science -- a lot of the research that's been doing by members of our ReThink Health team -- that the most effective teams have the best and very

intentionally created enabling structures. They have teams that are formed with a strong sense of shared purpose, very deeply grounded in their values.

They have specific, well-articulated interdependent roles. They know how to meet well. They have effective agendas. And in their meetings they do meaningful work. And they have ground rules and norms that govern their group behavior.

This last piece, I cannot underestimate how important articulating a set of specific group norms is. You probably know that group norms exist in any group from a preschool group to the most sophisticated C-Suite. And what we encourage teams to do is to make the norms explicit rather than implicit as they exist in all forms of function and interaction.

And we do a lot of coaching around that. And we believe that group process -- good healthy group process -- is very, very important to the work of seeing change, particularly with people who are not accustomed to holding on to power and to speaking out against power because it's very easy to get discouraged in this work. And if you don't have a team that can hold you in the tension of some of this work it becomes almost impossible to do.

We do a lot of work around coaching the team structure. We take coaching very seriously. It's the leadership practice that not only we teach people how to coach but (we) re-coaching through each of these leadership skills that I'm talking about here.

Then we move on to teaching strategy. And for us, strategy is the strategy that emerges from the resources that exist within the team. So we looked very deeply at - all right, here's our team, here's who they know, here are

resources. We mapped them very carefully. And then we helped teams devise a strategy that is derived from their own resources.

The story that we use a lot is a story of the Montgomery bus boycott where all the people had in that particular social movement was their bus fare. And the bus fare was less than five cents. What they were able to do with their bus fare changed the world. So again it's the idea that strategy is getting the change, forging the change that you want to see using the resources that you have available to you now.

And then action -- our final leadership practice that we teach -- has to do (more) with leadership environment, the idea that we take actions -- be it a, could be - I'll give you an example of a launch of a campaign or some kind of action that we take in the field. We take that action with very specific instruction in the very specific way that is intended to develop the leadership of the team. It is intended and structured in a way that it can be evaluated and it is a opportunity for effective practice.

So these leadership practices - public narrative, building relationships, creating strong team structure, creating strategy, and action - are how we get to this organizational model. This is a model we call the snowflake model. And we believe it is the ideal model for gathering on the basis of shared values.

So in community organizing, remember the theory of change is people who gather on the basis of shared values. So this would be the model of how they combine. And it would start with a dedicated core leadership team. That is what those bigger dots are, okay.

Those links between those big dots represent not only the relationship linkages but the strength of the relationship. So those linkages are the glue, if you will, in that snowflake, are those relationships and those - your relationships, the gold of an organizer. An organizer is rich if they have relationships.

So the goal of an organizer is to build as many relationships on the basis of shared values as possible. The only way you know how to do that is by going out and talking to people and really finding out what they care about and really asking them very specifically how they can join you in this work.

So I'll give you an example of how we used this set of tools in a community that unfortunately is very archetypal in terms of the prevalence of health disparities -- ZIP code 29203. If anybody is from South Carolina -- specifically Columbia, South Carolina -- if they could put that in the chat box. I don't know if that's possible, but if they could that would be great.

But we were invited by the Rippel Foundation to explore how the tools of community organizing could be brought to bear in a particular area of South Carolina that had what to us was a significant challenge. And it's all laid out in this slide.

There's a preponderance of the population is overweight, hypertension, that's in the state alone. But in this particular ZIP code in this neighborhood of Columbia, a third of the residents are uninsured. There's a lot of unnecessary ED - use of the emergency department - and a significant number of residents who are unable to pay.

The vicious cycle is probably pretty obvious to all of you who are really in the thick of this. It's the limited access to care causes delayed medical treatments

and the overuse of the ER, which causes poorer outcomes and rising medical costs and then raises the cost of public and private insurance companies, which then causes employers to drop health plans and the public sector to cut services, which in turn again limits access to care.

So this was the cycle that we were looking for a way to break. The goals that, which was an action research project that was partially funded by the Fannie Rippel Foundation. It was also supported in terms of some funds and a lot of people who really, really came to the table with a big heart and a desire to roll up their sleeves.

It was supported by the South Carolina Hospital Association, Palmetto Health, some payers in South Carolina. It started with frankly eight people who came to us and said we really want to learn how to organize. And they came from eight different sectors of the health system, not necessarily the community, but the health system in Columbia.

And they wanted to develop organizing leadership skills. They were looking to increase access to quality and affordable care. They wanted to develop some real links into the community and they wanted the community to begin to own its own health and wellness. And they were looking to reduce some of the costs.

One of the other goals that they have is to develop a team to reinvest savings. I'm not going to spend a lot of time on that because that could be another Webinar, but that is very much work in process around this goal.

So here were the constituencies that were brought together over the course of this campaign. I will say that this campaign, the foundational period of this campaign, which is the period before the launch, was almost a year. So this

does not happen overnight. Building these relationships takes a very long time and is a very deliberate and painstaking process. And we believe that it is the key to really seeding any real sustainable change in the community.

So these were the groups that we organized -- faith-based organizations, neighborhood associations, parents and schools, senior centers. You can see the panoply of health care providers and nurse practitioners and payers.

And one set of stakeholders that really came to the fore that we were not - we just hadn't really thought about at the beginning was the public health school at the University of - I think it's the University of South Carolina. It's the local university in Columbia. They have a public health school and those grad students turned out to be very enthusiastic supporters of our work and are people that have shown a lot of energy and passion for engaging the community.

So we set a date for an official launch of this campaign to be March 2012. So in the May of 2011 this vision team of eight people came to Boston and we engaged in a core leadership training along the lines of what I just described to you in those five key leadership practices.

Their charge was to go out and recruit more people to attend a team training. At that team training, again, we went through the leadership practices but we also worked very hard with them at imagining what a campaign could look like.

And by campaign I mean something that has a beginning and an end, that's building capacity over time. But something that we could measure and say, okay, at the end of this period we know that we've accomplished something.

So by the middle of July we had a 20-person core team. The purpose of the core team was to begin to set plans to launch a town hall meeting campaign. And that town hall meeting kicked off at the end of that summer. And through the fall there were a series of house meetings.

And again, we were building more and more leadership from within the community to come to those house meetings and to opine on some of the issues that were being talked about.

And all of that culminated in a community issues assembly where 200 people from within the community came and voted on how this community could pursue a healthier future for itself. And from that community issues assembly we had yet another training with even more leaders to prepare for an official campaign launch that occurred in March of the following year.

So just to sort of go back and dissect a little bit of what happened during the house meeting campaign - and this is what I mean by using story and using the one-to-one relationship tool that we teach. This is what can happen. There were 45 house meetings within six weeks. And by house meetings, I don't mean that necessarily that all of them happened in people's living rooms. Some of them did.

But a number of them happened in schools and coffee shops and in hospital conference rooms, whatever. But there were 45 meetings where people were getting together and talking about what is it that we care about? What are the issues? And the whole purpose of that was to - what organizers would say - was to cut the issue, to figure out what it was, what is the thing that we can do together based on our resources.

And at every single meeting, people were asked who can you invite? The end of this six-week period, there were almost 740 people engaged. On average we had 16 citizens attending these house meetings and you had your core team supporting the house meetings.

So all of this led to a peak of this community assembly which met in the fall prior to the kickoff. And at this community assembly they engaged in a very big group collective decision-making process to decide okay what will our focus be? How will we work together to improve the wellness of 29203 -- which by the way I neglected to mention has the largest amputation rate associated with them - or had the largest amputation rate associated with diabetes in the country.

So what they decided was that they would bring together various stakeholders from around the community and that they would sign a covenant. And that this covenant would agree to have all the constituencies working together to increase primary care, to provide support for healthy behavior, and to develop a stewardship body that would begin to reinvest any savings back into the community.

So - just want to - not going to say much about that. So our kickoff, the thing that we did together on March of 2012, we had 500 people come. It was essentially a public commitment ceremony where we had some very senior state officials come. We had the C-Suites from some of the most important payers in the region -- providers, hospitals in the region -- come.

They all stood up to a podium and they all publicly agreed that they would support the community in improving its wellness. We had some exercise demonstrations. We had health screenings. We had healthy food donations. You can see a picture here.

We had that banner are all the people that signed onto the covenant. And what it was was really a public display of intention and it helped with the more powerful people in the community to feel publicly safe that they were going to do this. So then it was really up to the campaign later on to ensure that, you know, they were going to be held accountable.

So the campaign is finishing its year. Actually, no I'm sorry, it's probably about 18 months old now. They have had to relaunch the core team. The people that started with the campaign developed and gave ownership from within the community. They have developed a number of community focused health care innovations like cooking classes, like health coaching.

They've had a lot of health fairs. They've done a lot of screenings. I don't know the specifics of the care access sites but I know that there have been several new ones in places like grocery stores, places like drug stores, that kind of thing.

And so, you know, it's going to take a while before we know specifically what kind of specific health disparities have been changed. But what we do know is that the hospitals now have relationships, and the provider community now has relationships, with places that they were never speaking to before. The faith based community, for example. That is become a very key pivotal player in this community around health and health care.

So this is what their campaign snowflake look like, right? They have the core team. They divided the teams according to roles. They had one team that was focused on developing new access for primary care.

There was one team that was really focused on bringing the community together at community centers, churches, etcetera, and really getting them involved in defining what their core issues were to make sure that the people in power knew what they were facing.

You know, there are no sidewalks in this community. Turns out the community is a food desert. You drive into this community, you don't find a grocery store with fresh food. So there are some really obvious things that need to change in order for some of these health (unintelligible) to really make a dent in some of these health outcomes.

And then the snowflake quadrant on the right is the group that's coming together to make sure that the covenant is enforced and that the savings are shared.

This is a photograph of the covenant and people who signed the covenant essentially filled out this card and provided some of their information. So this would never have worked were it not for the commitment of the core leadership team. It could never have worked if it just came down to just one person.

Like I said it was a group of eight people who began their training in the spring of 2011 that moved on to 35 including through the summer, who did - the stats are all right here for you to see. But the way that this campaign got to scale was through a team that was absolutely committed to developing leadership in others and enabling others and always bringing along others and doing the dangerous work of going out into the community and getting out of your comfort zone and being willing to listen when you're very, very challenged.

We had a very tough moment in one of our meetings where a woman stood up and said, you know, I have a hole in my floor. I have a hole in my floor because I live in public housing and no one can even fix my floor. And you want to talk to me about my blood sugar?

And you have to be able, you know - again, if you were alone, if you weren't part of a team, I personally would be completely derailed by a conversation like that. But I think with that woman, what I experienced when I heard that lovely woman say what she said was, you know what? She's standing up for herself now. She's learning. She's getting agency so she can talk to the director of her housing project to get her floor fixed.

So what have we learned from this? We've learned that if you don't involve the community -- and by the community I mean the citizens, the patients, the people who the health care systems typically act upon -- you won't go very far down the path of sustainability.

That said, it's really important to find the right kind of community leaders. That's another - that's the subject of another Webinar. But we're very specific when we coach our teams about what kind of leadership they want to look for within the community.

I said personally, I always want to work with people who two things - hope and a learning (bias). I can handle a lot of other things if they have those two things right - hope and learning (bias), the ability to try something new, the willingness to try something new.

I don't think this campaign would have launched unless the core team had a really strong core commitment to one another. And the times that there were areas within the snowflake where it was really clear that those loyal sub core

teams weren't strong, we had a lot of trouble with those teams. It's very hard work but it's not a precise science. And to try to get it perfect is really in this case the enemy of the good.

I want to again thank Delmarva for letting me tell the story. I hope that you all have a sense of just how important and passionate we are about this work. I'd like to open it up - give the ball back to Matt, whom I don't see on the panel - to begin to take up questions.

And maybe I'll just invite Barbara Levin to speak very briefly. She is someone we've worked a lot with at Delmarva who's done - she and her team have done a fantastic job in engaging the community, a group of seniors, around food justice. And then we can take questions.

Matthew Mittleman: Yes, operator, if you could give instructions for queuing up questions. And while people are queuing up Barb will tell her story.

Operator: Thank you. Ladies and gentleman if you would like to register a question, please press the 1 followed by the 4 on your telephone. You will hear a three-toned prompt to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3.

If you're using a speakerphone, please lift your handset before entering your request. One moment please.

Barbara Levin: Okay Matt?

Matthew Mittleman: Yes.

Barbara Levin: Hi I'm Barb Levin and I'm a joint member of the DNCC and also work with the Baltimore SIP. We have a Special Innovation Project. And we've been very blessed by having a (reaping) coach for our project as do all the SIPs.

And we have worked very closely with our coach to develop a project called HELPS - Healthy Eating Linking Partners for Seniors. As a physician and a public health person for the past 40 years, I must say that I came in as somewhat a doubting Thomas. But I have been very, very impressed with what the public narrative does for getting people to work with you.

And working with this team of quality improvement people as well as community health outreach people, I've been aware that their being able to articulate their story and involve the people around them in trying to make a change has been very effective.

I've advocated for Ella to present today because as I've listened to the responses to surveys and to the environmental scans for the DNCC, often I sensed there's a sense of feeling somewhat impotent and unable to make a change in the area of disparities.

And we at the DNCC hoped that her comments today would be a restarter as we start this fall and the new year to getting back on track with working on altering some of the disparities we find in the system. We'd like to thank Ella for her presentation today.

Matthew Mittleman: Yes thank you Barb. Operator are there any questions in the queue?

Operator: As of this moment there are no questions queued up.

Matthew Mittleman: Okay great. Ella if you could go to the next slide please.

Ella Auchincloss: Under, okay, that one?

Matthew Mittleman: Yes perfect. So just to wrap this up, thank you Ella very much for joining us and the QIOs. Just wanted to let you know there's some new learning toolboxes coming out this month. Recently posted to the CMS Pulse Web site was data toolbox which is very intuitive as far as different data sources and how to look at data for disparities within your state as well as the health outcomes toolbox. And both of those are posted on our Web site, CMS Pulse.

People with disabilities - we sent out initial versions. Since then we've had a lot of input and people sending us additional resources to be added. So we appreciate that. That will be coming out shortly.

And a widely asked for one was the health literacy, which is also coming soon. And these toolboxes are really great. Just the other day we had a QIO call and ask if we had any translation services available and we were able to send them one of these toolboxes. So there's a lot of great information in them if you take the time to look through.

Also coming soon is a cardio-vascular health resource guide for consumers. So be on the lookout. Those will be sent out through the list serve and also posted on CMS Pulse. Next slide please Ella.

Also during the calls over the past months, there's been interest in several different affinity groups which will be forming. Again this will be the opportunity for QIOs to learn from one another as well as best practices across the nation.

The different topics are going to be around data, rural health, behavior health, which has become increasingly popular throughout the interviews and scans that we've conducted as well as community engagement. So we hope that people within your QIOs will decide to join one or multiple of these as we think it will be great value added to you. And next slide please.

And then of course, want you to continue to visit the CMS Pulse. Send us stuff to post. We want to be able to feature great work. A lot of QIOs want to know and learn from one another what's going on around disparities within their states. So again that's cmspulse.org and we hope to hear from you. And, you know, even if you have some feedback on the Web site, we're more than happy to hear about it. Next slide.

So again thank you very much to Ella and everybody for participating on the call today. Once you click out of this you'll be dropped into a six-question survey. If you could take a minute to complete that, that would be greatly appreciated as we use those surveys to plan moving forward.

And again just another final announcement. Next month, October 1 will be our virtual conference. We really hope to see everybody there. And reserve your conference rooms today and get (trains) to join together to make it more interactive. Thank you all very much.

Operator: Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.

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