NATIONAL QUALITY FORUM

Behavioral Health
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OPERATOR: This is Conference #: 93553822

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Tracy Lustig: Hello, everyone. This is Tracy Lustig with the National Quality Forum. And I want to welcome you all to the orientation webinar for our Behavioral Health Standing Committee. Before – I apologize for the delay in getting started. Before we get started, I just wanted to review a couple of technical issues.

First, if there are any committee members who want to able to speak during the meeting, you do need to dial in to the number that was provided to you. You can listen through the computer but you won't be able to talk if you have a question.

Second of all, connected with that, please know that when – everyone's line is open, so if you're not speaking, please do mute your line. And then lastly, just in case there are any technical issues along the way including our delay, wanted you to know that along with all of you, pretty much our entire team is also dialing in remotely being that it's a rather busy day in Washington today and tomorrow. Most of us are working from home. But I think that we should be good for today.

And then, for the next slide, I just wanted to start off by introducing each of the project team members to you. I'm Tracy Lustig. I spoke, I think, with

most of you when we had an off-cycle review earlier or late last year. But I am – I still consider myself new to NQF. I started back in April, but this is my first time going through the Consensus Development Process.

My background is that I'm actually a podiatrist in case anyone didn't know what my degree meant. I then transitioned to doing health policy work. I was with the Institute of Medicine for 12 years before coming over to NQF last year.

We did neglect to include on this slide, unofficially, on our project team is my colleague, Karen Johnson, who's going to be helping us since we are all newer to the NQF process. So, I'd like Karen to be able to introduce herself.

Karen Johnson: Hi, everybody. My name is Karen Johnson. I am another one of the senior directors here at NQF. I've been with NQF for just over five years now. And I'm tending these days to be kind of buddies to different folks on different projects rather than overseeing many of my own. My background is in statistics and data analytics and most recently in gerontology.

Tracy Lustig: And Kirsten?

Kirsten Reed: Hi, everyone. I'm Kirsten Reed and I will be the project manager for this project moving forward. Similar to Tracy, I am also – I guess, I consider myself new to NQF. I started back in April, so I'm quickly approaching the one-year mark, but as I'm sure most of you know, the process of NQF and the, you know, evaluation criteria is definitely not easy to learn.

So, I am going to be with all of you in learning all of this which I'm very excited about. I'm excited also because my background is also in behavioral health. Prior to coming to NQF, I spent about six years at the National Council for Behavioral Health where I did a lot of work on quality and practice improvement, and a little bit of policy work. So, I am looking forward to kind of being back in the behavioral health world.

Desmirra Quinnonez: Hello, everyone. My name is Desmirra Quinnonez. You may hear staff refer to me as (Dessie) from time to time, it's a little easier to say. But I actually have been with NQF for almost a year. Next year – next week will

actually be my first-year mark. And I'm happy to be able to work on the Behavioral Health team as a project analyst. I've had the privilege of working on several of the projects with Home and Community-Based Services, and Person and Family-Centered Care, and phase three of the Patient Safety project, as well as newly most recently the MAP Hospital Workgroup.

So, I look forward to working with the Standing Committee, as we enter to – and aim to dive into behavioral health.

Tracy Lustig: Great, this is Tracy again. So, next, I just like to quickly go over what we're going to cover on today's call. First of all, we're going to do a roll call for all of you to see who's here, and if you want to do a very brief introduction of yourself, that's fine. We'll also have more opportunity when we're in-person.

I'm going to give you a big overview of NQF, the Consensus Development Process and the roles – we'll give you an overview of the roles of the Standing Committee, the co-chairs, and what we, as staff, what our role is. Give you overview of our portfolio in Behavioral Health and particular the measures that we'll be looking at at the-in person meeting.

We'll review the project activities and timeline. My colleague, Karen, since you have more experience of this, is going to help give you an overview of the evaluation criteria and of our SDS trial period. Then at the end of the meeting, we'll go over the SharePoint which is how we will be able to use and share documents with each other and then certainly next steps.

So, next slide.

And so I'll – before we actually introduce – do a roll call, I'd like to turn over to Peter Briss and Harold Pincus, our co-chairs, to see if they'd like to add their welcomes.

Harold Pincus: Hi. I'm Harold Pincus from New York-Presbyterian Hospital in Columbia University. We've been – Peter and I have been doing this kind of for a while. And delighted to welcome both returning members as well as some of the new members as well.

Peter Briss: And hi, this is Peter. I'm the medical director in the Chronic Disease Center at CDC. And then, I'll just add my welcome or welcome back and I'm really excited to work with all of you on the next phase.

Tracy Lustig: Great. Thank you. And we're delighted to have you as co-chairs especially being so experienced with some of us who still consider ourselves new staff.

And so, Kirsten, I'll turn it over to you for a roll call.

Kirsten Reed: Great, thanks. And excuse me if I butcher anyone's names. I will learn them as we go along the process. Before we jump in, I do just want to say a special welcome to our four new committee members, Shane Coleman, Charles Gross, Brooke Parish and Andrew Sperling. We are all looking forward to working with you.

So as we go through here, if you – like Tracy said, if you could just do a brief introduction with your name, organization and maybe your primary expertise that's relevant to this committee. So, let's start with Robert Atkins.

Robert Atkins: Hi. I'm a psychiatrist, a senior medical director with Aetna Medicaid. Have been with Aetna Medicaid for almost 10 years, and have been involved in our integration efforts, integrated physical and behavioral health, and our value-based solutions efforts looking at those integrated practitioners and assessing their performance and tying that to payment models.

Kirsten Reed: Great, thank you. I don't believe Mady Chalk is on this call. I think she had something else going on, but just want to double check if Mady, are you with us?

All right, Shane Coleman?

Shane Coleman: Hi. My name is Shane Coleman. I'm currently employed by Southcentral Foundation which is an Alaska-native owned and operated health care system in Anchorage, Alaska. My background is psychiatrist. I also did a fellowship with Wayne and Jurgen, Wayne Katon and Jurgen Unutzer, at University of Washington which was focused on studying the interaction between chronic and medical disease and mental health, and included some experiences with

integration focused for Southcentral is also integration. And so, my job here includes quality improvement, strategic planning and then coming up with measures to assess quality and help those (Q.I.) projects move forward.

Kirsten Reed: Great, welcome. David Einzig?

David Einzig: Hey, David Einzig, I'm a child psychiatrist at Children's Hospitals and Clinics of Minnesota. Background, I train in the triple board, so also board certified in pediatrics. I do a lot of consult liaison in the outpatient clinic doing integrated (requirement) of care models. So, I'm super excited to hear other folks who are online participating in those models also. Thank you.

Kirsten Reed: OK. Thanks. Julie Goldstein Grumet?

Julie Goldstien Grumet: Hi, good afternoon. I'm part of the Education Development Center and I'm representing the National Action Alliance for Suicide Prevention. I lead all of the health care initiatives for EDC and the Action Alliance. One of which is around transforming suicide care that health care systems provide, and that health providers are able to provide since many, as you all know, are never well-trained suicide care.

So, I appreciate the opportunity to participate on this committee. Thank you.

Kirsten Reed: Great. Thank you. Charles Gross?

Charles Gross: Hi. Charlie Gross, new member, delighted and humbled to join the committee. I'm national vice president for Behavioral Health for Anthem, government business, so for Medicaid and Medicare. Been with company about 10 years. Trained as a psychologist through a lot of integrated care work before, we knew that sort of it was called back in the day when I worked at Kaiser. My current focus is on physical behavioral health integration, value-based contracting with providers and chronic disease management that's impacted by behavioral health concerns.

Kirsten Reed: Great, thank you. Constance Horgan?

Constance Horgan: Hi, Connie Horgan. I'm delighted to be returning to the committee. I'm the director of the Institute for Behavioral Health at the Heller School at Brandeis University. I'm a health services researcher and our institute does a lot of research in the area of delivery system and payment reform with a particular emphasis on the addiction.

Kirsten Reed: Great, thank you. Lisa Jensen? OK. Dodi Kelleher? Kraig Knudsen?

Kraig Knudsen: Hello, I'm Kraig Knudsen. I am the chief of the Bureau of Research and Evaluation at the Ohio Department of Mental Health and Addiction Services. Most of my work focuses on the program evaluation and quality improvement in the public behavioral health systems here in Ohio. And I also oversee all the researching evaluation funded by the department.

Kirsten Reed: Great, thanks. Michael Lardieri? I believe he had a conflict as well. Tami Mark? Raquel Jeffers?

Raquel Mazon Jeffers: Hi. This is Raquel Mazon Jeffers. I am a senior health care program officer at The Nicholson Foundation in New Jersey. And my grant making focuses on behavioral health integration into primary care, as well as primary care performance measurement. Prior to working at the foundation, I was also the deputy director for Mental Health and Addiction Services for the state of New Jersey. I'm happy to be here.

Kirsten Reed: Great. Bernadette Melnyk? Laurence Miller? Brooke Parish?

Brooke Parish: Hi there. My name is Brook Parish. I'm very humbled to be on this committee. I thank you very much for the opportunity. I'm medical director for Behavioral Health at HCSC. I also work as a Joint Commission surveyor, and also with National Disaster Medical Service. In fact, I'm here in D.C. right now and have a very busy day starting at midnight.

Kirsten Reed: I bet, good luck. David Pating?

David Pating: Hi, I'm David Pating. I'm an addiction psychiatrist, and past chair for addiction medicine for Kaiser Northern California, Kaiser Permanente. I'm a

health commissioner for the San Francisco City and County and a past vice-chair for California's statewide Mental Health Oversight Commission.

Kirsten Reed: Great. Vanita Pindolia?

Vanita Pindolia: Hi, this is Vanita. Welcome to – I'm glad to be back on the committee. I am – I'm the V.P. of the Ambulatory Clinical Pharmacy Programs for Henry Ford Health System/Health Alliance Plan as it relate to this committee. The work really is trying to help identifying medication management programs and towards the new initiative within that behavioral health specifically for transition of care as well as well collaborative care models.

Kirsten Reed: Great. Rhonda Robinson Beale? Lisa Shea?

Lisa Shea: Yes, hello. And it's good to be back on the committee again, too. I am the medical director of Butler Hospital which is a freestanding psychiatric hospital, which is part of a larger health system. So we are also working on integration and are part of an accountable care entity. I am a practicing psychiatrist as well as overseeing quality and risk management at the hospital here.

Kirsten Reed: Great. Andrew Sperling?

Andrew Sperling: Good afternoon. I'm Andrew Sperling, with the National Alliance on Mental Illness and a new member of the committee. I'm very honored to be a part of this. But if you don't know, NAMI is the nation's largest organization representing and advocating for people with serious mental illness and their families. And I'm very much looking forward to hopefully contributing as a voice for people living with mental illness and their families to the work of NQF. Thank you.

Kirsten Reed: Great, welcome. Glad to have you. Jeffery Susman?

Jeffery Susman: Yes, it's Jeff Susman? And …

Kirsten Reed: Sorry.

Jeffery Susman: … I'm on sabbatical from, that's OK, Northeast Ohio Medical University which is great to have. And formerly was the dean, and I'm family physician with a strong interest in integration of primary care and mental health and behavioral health services.

Kirsten Reed: Great. Michael Trangle?

Michael Trangle: Hi. I'm trying to change my career to be non-sabbatical. I like the thought of that.

Jeffery Susman: It's a great job if you can get it.

Michael Trangle: Yes. But I'm glad to be back. I'm an adult psychiatrist who's the senior medical director for Behavioral Health at a regional integrated system of care called HealthPartners. And I'm sort of actively involved in both sort of care improvement areas, both in our health plan and our hospitals and our clinics, both primary care and behavioral health clinics and C.D. facilities.

With kind of a fair amount of active work going on in depression, and working on folks with serious mental illnesses and we – I'd share our version of what used to be the SAMHSA 10x10, talking about trying to extend the life expectancy of folks. Doing a number of studies in our region to look at this flow of psychiatric patients and behavioral health patients in general through ERs hospitals, state facilities, C.D. facilities, group homes, et cetera. And glad to be back.

Kirsten Reed: Great, thanks. Bonnie Zima?

Bonnie Zima: Hi. Bonnie Zima, I'm a child psychiatrist, health services researcher, professor, UCLA.

Kirsten Reed: Great. And then, finally, Leslie Zun?

Leslie Zun: Good morning or afternoon. I'm Les Zun. I wear a couple of hats. One is, I am the president for the American Association for Emergency Psychiatry. I am also on the board of the American Academy of Emergency Medicine. And I am also professor and chair of Emergency Medicine and Psychiatry at

the Chicago Medical School. And thank you so much for having me on the committee.

Kirsten Reed: Great. Thank you.

And welcome again, and we are all looking forward to working with you. So I'm going to pass it back over to Tracy now.

Tracy Lustig: Thank you. And I'm going to try to go pretty quickly through sort of the overview of NQF and the overview of the CDP process just so we can really get into some more of the nuts and bolts.

Just for anyone who might not know, the National Quality Forum was established in 1999. We are a non-profit, non-partisan. And we are a membership-based organization and we work to bring together all the stakeholders to reach consensus on performance measurement and health care.

And I think as with many people, our goal is to make health care better, safer and more affordable. And just to emphasize that as a forum, we do have members. I have a number here of over 430 but I think this might be an old number. I think we're more than that now. But membership is diverse. We have hospitals and health plans and physician society, the nursing organizations and purchasers and patients and consumers and many, many others. And so, we really are trying to represent all of the stakeholders in quality measurement.

We also engage over 800 volunteer experts like yourselves in our committees annually. And most importantly, I think, is transparency. This is a forum and everything we do is open to member participation and all materials are accessible on our website. Today's call and all of our future meetings are held in the public space. And so, members of the public are welcome to join these meetings. And we will put draft reports out for comment as well.

And then next slide.

So NQF works in a variety of areas. Again, I don't want to spend too much time on the other areas. We're certainly largely known for our performance

measure endorsement which is what this committee will be doing today, which is a regimented process that – in which we review stringent criteria that measures need to meet in order to gain endorsement. The Measures Application Partnership, commonly known as MAP, is program within the NQF which really provides an avenue for us to provide advice to HHS on selecting measures for federal programs.

National Quality Partners is part of our, what we now call, the quality innovation side of NQF. And this is another way in which we bring together stakeholders, primarily on members around different health care topics and tried to think of ways to spur action. We've done some work in the past on antimicrobial stewardship, maternity care. We are in the middle – I'm also working on those projects and so we're currently doing some work on advanced illness care, and starting some new projects on shared decision making.

And then, last area that we do a lot of work in is measurement science in general, which is bringing people together on some complex issues that relate to measurement in general, things like our SDS work that Karen will be talking in about a bit later. It's also where we do some of our, what we call, framework projects. And this is where we try to come up with a framework for thinking about measurement in areas where there really is none or certainly not robust measurement.

I'm currently on two framework projects at NQF, one related to telehealth and one related to diagnostic accuracy, just to give you an idea of some of those projects.

So, next slide.

So, our project is a Consensus Development Process, project which we refer to as CDP. We have the seven steps that we need to go through for our measure to ultimately become endorsed. First is that, there is a call for nominations for the Standing Committee, which we've completed. We also already have put out our call for standard – candidate standards, which we refer to as measures.

We are currently in the process of reviewing these candidate standards. This involves us, staff, doing a preliminary analysis of the review – the measures that are either up for maintenance review, which means they've received endorsement in the past and we're going to review them to ensure they should retain their endorsement. And then also review some new measures that have been submitted to us. And this will also – our in-person meeting as part of this review, and that's when we will go through a formal voting by you, the committee members, to make recommendations about which measure should receive endorsement.

We will put a draft report out for public comment and member comments. After that point, we do put the recommendations out to NQF members for them to vote on and ultimately it goes to our Consensus Standards Approval Committee, which you'll hear us refer to as CSAC, who give sort of the final stamp of approval, ratification and endorsement. And then we do have opportunity for (POs) if there is need for that.

And so, again, as I mentioned, the MAP is a way for us to provide advice to HHS on which measures they should use for public reporting and performance-based payment and other programs. While it would be ideal, the measures don't necessarily need to have NQF endorsement.

And so, if you go to the next slide, we are trying to find ways and make it more connected so that the NQF endorsement evaluation process feeds into the MAP process and vice versa. So we see these two activities being very interrelated.

So, we can go to the next slide.

So I want to turn it over to (Dessie), who's now going to go over the role for all of you and for us.

Desmirra Quinnones: Thank you, Tracy.

Harold Pincus: Just one point, just one point with regard to the MAP process since that's what I'm going actually sort of as we speak. It also doesn't mean that if a measure is endorsed, it necessarily gets used or it gets included in CMS programs. So

it goes both ways that not all MAP measures are endorsed and also not all endorsed measures get utilized.

Tracy Lustig: Great. Thanks for the clarification. We're glad to have you again as co-chair who's been through these processes. (Dessie)?

Desmirra Quinnonez: Sure. So I'm going to give a brief overview, high-level overview of the review – the role of the Standing Committee. And I'm just going to – this will be a reminder for those of you who are returning members and a brief introduction for our new members as well.

So, under the general duties of the Standing Committee, your role is to act as a proxy for the NQF multi-stakeholder membership. Typically, the Standing Committee members hold a term of two to three-year assignment and they're selected randomly. I mean, if you have any objections to serving longer than a two-year term, then please feel free to let staff know. But you'll be – the Standing Committee is required to evaluate the candidate measures against the measure evaluation criteria, working with NQF staff to achieve the overall goals of the project. And we'll also expect you to respond to the comments submitted during the review period and to respond to any of the directions that you may receive from CSAC.

So if we go over the Standing Committee's role as far as measure evaluation – or measure evaluation duties are concern, first, we'll say your overall general measure evaluation duty would be to oversee the behavioral health portfolio of measures, and this means evaluating new measures. You'll be evaluating some endorsed measures for maintenance of endorsement, identifying any gaps and considering the measure issues that may arise or if there were any ad hoc reviews that need to be – that are needed as a result of the project.

Also, I would like to point out that there's only one in-person obligation for this committee and that is our in-person meeting that will be in February. But if we are unable to get through all of the measures at that time during that meeting, we may hold a follow-up conference call just to finish up anything that's left over.

The role of the committee co-chairs. The co-chairs are responsible for helping to facilitate the standard – the Standing Committee meetings, working with NQF staff to achieve the goals of the project and also assisting in anticipating any questions and identifying any issues or information that may be useful that we may not have already provided, but anything (that) may be useful for the Steering Committee, the Standing Committee.

Also, to keep the Standing Committee on track so that we make sure that we're meeting our goals of the project without hindering any critical discussion or input representing the Standing Committee at the CSAC meetings, although that may – the CSAC meeting is open for the public to dial in, the Standing Committee to dial in. The co-chairs will be the only ones representing the Standing Committee during that CSAC meeting. And also to participate as a Standing Committee member.

Now, NQF staff role is slightly different. We're a little more involved. We are going to work with the Standing Committee to achieve the goals of the projects and to ensure that the CDP or the Consensus Development Process is being followed. And some of those things are just organizing and staffing the meetings and conference calls, guiding you all through the steps of the CDP and advising on any NQF policies and procedures.

And also, we will be reviewing the measure submissions and preparing the materials for the committee's review. Staff will be drafting and editing any reports for review. And we also want to ensure that we're having cohesive communication for all participants of the project and the Steering Committee, which include the Steering Committee members as well as the measure developers.

We'll also be facilitating any necessary communications and collaboration between all the different NQF projects within the organization.

NQF's role for communication will be to respond to NQF members or public queries or inquiries about the projects. We will be maintaining the documentation and project activities and we will be responsible for posting to

our NQF site and also our SharePoint site, which we'll get to in a little bit later. I'm giving a brief preview of that.

And we'll be working with the measure developers to help provide necessary information and communication for the Steering Committee to make sure that they can – that you all can adequately evaluate the measures for endorsement. And we will also be publishing a final project report.

Now, in addition to working with the Steering Committee, we also work with the public to respond to any questions of inquiries they may have, and to make sure the web information is up to date and accurate, and to help the measure developers through their submission process.

So I know that was a lot of information, but I'll just pause briefly to see if anyone has any questions at this time as far as your roles and responsibilities.

And if none, I'll go ahead and turn it over and we can keep going.

Tracy Lustig: Great. Thanks. (Dessie). So, I'm going to give you a brief, very brief overview of our portfolio and specifically the measures that we'll be looking at our in-person meeting.

So, the Behavioral Health portfolio overall looks at measures related to behavioral health conditions that can be used for accountability and public reporting for all populations and in all settings of care. This is the fourth phase of this project, and the topic areas that are measures that we'll be looking at cover our alcohol and substance use, tobacco use, ADHD and depression.

We do and have solicited new measures for possible endorsement and we currently have more than 50 endorsed measures in our Behavioral Health portfolio. And so, like I mentioned before, we have endorsed measures that are going – undergoing their periodic evaluation in order to maintain our endorsement, which we refer to as maintenance.

And so the next slide.

So, this is a framework that I'm actually currently working on for helping us to find where we might have gaps in our current portfolio and that's something that we'll be discussing at our in-person meeting, because we certainly like to encourage the development of measures and areas where we don't currently have many or have none.

And I'm using this framework that I've actually borrowed from a colleague at NQF and it's looking at sort of episodes of care, but trying to group our measures in terms of the population at risks, so many of the screening measures that we do have. And then after, there's an initial diagnosis how that condition is initially evaluated and managed at the first point of diagnosis and then looking at follow-up care where – either where we have recurrences or how we are caring for chronic conditions.

And I will bring to our in-person meeting, I'll share with you in advance, I've started to already map this. We do have measures that fall into all of these areas and I thought this would give us some better idea of how our measure is occurring – covering the entire care spectrum.

Next slide.

So, on this slide, we have listed – these are all the measures that we'll be looking at in our meeting at the end of February. So the individual measures is a – first is measure 0008, which is a measure that's up for maintenance review and it's the ECHO Survey Experience of Care.

Next, we have measure 0027, which has to do with medical assistance with smoking and tobacco use cessation. Next, we have 0028, which has to do with tobacco use screening and cessation intervention. And then we will have an eMeasure, which is a new measure to us. It's an eMeasure version of 0028, which has the number of 3185.

And I actually probably should have just told you quickly that a quick sheet is that the first number of the measure number tells you which space they were initially endorsed in. So, anything that has a three in the beginning means that it's a new measure to us in this space.

So following that …

(Harold Pincus): You might want to – because at some point, you may want to say something about sort of the difference between the eMeasure versus the regular measure.

Tracy Lustig: Sorry. So the eMeasure version is where it's the same measure but it's collected through electronic data. Did you mean something differently than that?

(Harold Pincus): Well, I meant, in terms of, you know, just say I did more of that it being at, you know, why it's a separate track.

Tracy Lustig: And there are – so we – I'm sorry, is that Karen?

Karen Johnson: Yes. Do you want me to …

Tracy Lustig: Yes …

(Crosstalk)

Karen Johnson: You know, eMeasures are – they're not just based on electronic data. They actually hopefully are calculated with very little human intervention if we assess the idea for eMeasures. So our criteria for eMeasures are pretty close to being the same as they are for other kinds of measures.

There are a few differences, we're a little bit less stringent in terms of what we're expecting for testing, mainly because right now, it's still kind of difficult to find enough data to actually test eMeasures well.

In terms of two different pathways, we actually – and this could be a little confusing. So, there is a separate pathway called the approval for trial use that is something that we set up to help hopefully kind of prod use of eMeasures. If a measure is up for approval for trial use, it would go through our evaluation in a similar way to other measures, but without an expectation for testing.

And if it was approved by you, it would be approved for trial use. It would not be endorsed. So it's a very different animal if it goes through that approval for trial use pathway, if you will.

But, some eMeasures have enough data and have been tested. So they're not really eligible for this approval for trial use pathway. It doesn't make sense for them. And in which case, they would go through the evaluation just like any other measure and potentially be endorsed.

So the eMeasures that are included in this project this time around actually are all eligible for endorsement, so none of them will actually be going through it as approval for trial use path.

Let me stop there and see if anybody has any questions about eMeasures.

And just to maybe hopefully ease your mind a little bit if you're not as familiar with eMeasures. We actually have two folks on staff who understand eMeasures quite well. And as part of the preliminary analysis and we've hinted around at that, I think that might be new to some of you.

We actually have our eMeasure team go through and look at eMeasures and they actually look at the measure logic and the value set, and make sure they actually conform to what we require for eMeasures. And they basically let us know.

So, you don't have to be conversant with those really kind of in of weeds details. We have staff that'll help us with that and will make that very clear to you that, you know, if the eMeasures meet our requirements in terms of specifications.

We also usually look a little more closely for eMeasures at their feasibility because that's sometimes the sticking point for eMeasures. And we ask the developers of eMeasures to provide, what we call, a feasibility score card. And so, that is an extra piece that you'll be looking at for eMeasures as we go through the criteria. So there are some differences, but for the most part, we treat them just like any other measures in terms of the evaluation.

Tracy Lustig: Thanks so much, Karen.

So just to continue, so a couple more measures that are up for maintenance review, 0108, which is follow-up care for children prescribed ADHD medication, 0576, follow up after hospitalization for mental illness.

Then, the next two which you'll see both have threes, it's a little bit confusing, we have – and it's a numbering anomaly. But, 3148 was previously number 0418, screening for clinical depression and follow-up plan. And it's renumbered because it has the new eMeasure version listed just above it at 3132.

I mentioned previously that for 0028, that measure has a new eVersion measure but that number hadn't been updated yet due to some internal processes. But just know that 3148 is actually a measure that's up for maintenance and 3132 is the new eMeasure version.

And then, finally, we have two brand new measures coming to us in this phase, 3172, continuity of pharmacotherapy for alcohol use disorder, and 3175, continuity of pharmacotherapy for opioid use disorder, both coming from RAND.

And so, Kirsten is now going to go over the timeline and then we'll get into the details of evaluation criteria.

Kirsten Reed: Great. Thanks, Tracy. All right.

So as you can see here, we are currently already checking off the box for our first meeting. And then following today's webinar, our next one will be on February 16th. And this is where we will give you the opportunity to ask questions about the measures being reviewed prior to us coming back together for the full evaluation at our in-person meeting.

The project team is currently in a process of doing our preliminary analysis on the measures. And our goal at this point is to get them to you by February 10th, so that you'll have about 10 or so days to complete the evaluation

surveys for your assigned measures. And those surveys will be due back to us from you guys by February 20th.

So, our in-person meeting will take place on February 28th through March 1st, it's a two-day meeting here at our office in Washington, D.C. All of your travel expenses will be covered by NQF and you will be receiving an e-mail from our meetings team at the end of the month with details on booking your travel. So please stay tuned to that. I know a lot of you have had questions about whether or not you can start booking your travel, but please note that that is coming, so don't worry about it at this point.

Day one of that meeting will be a full day, and then we hope to end a little bit early on the second day sometime in the early afternoon. But again, we'll keep you posted on the exact times in the coming weeks once we start kind of putting together and flushing out the agenda for that.

As (Dessie) previously mentioned, there is the opportunity to do another webinar, the post-meeting webinar, which is only be necessary if you don't cover everything at the in-person meeting. And that will potentially take place on March 9th. But if there are no outstanding items, we will cancel it and you guys will all have a three – two hours as I'm sure is a good thing.

Following the in-person meeting, the project team will be busy writing the draft report based on the decisions made at the in-person meeting to prepare for our public commenting period which will run from April 5th through May 4th.

This is really a time where we post our draft report on our website and allow our members and the public to make any comments whether they disagree or agree with the decisions that were made. And then we'll come back together in May for our post-comment webinar, where we'll review any of the comments that we did receive and prepare our collective responses.

So in the call for nominations and in everything else that I've been sending out to you guys, this was initially scheduled for May 24th, but due to scheduling conflicts, we're going to have to reschedule that.

So, please keep an eye out on an e-mail from me that I will be sending to kind of gauge your availability for a new date. But with the tight timeline and when we need to get everything else put out for a member vote, that meeting will likely happen the week of May 22nd.

So following that webinar, the measures will go out for member vote from June 15th to the 19th, followed by a review by our CSAC in July. And then, finally, an appeals period will take place from July 14th through August 14th. At which point, we will finalize the report and back up.

So, I will pause there and see if anyone has any questions on the timeline or the portfolio of measures or anything else that have been discussed up until this point that we can really dive in to the measure evaluation criteria.

All right. Karen, I will turn it over to you.

Karen Johnson: Thank you. Sorry, I was on mute.

So, our measure evaluation criteria, first of all, important to emphasize that measures are reviewed against all of our criteria that are actually current right now. What that means is that, measures that were previously endorsed are now being looked at for maintenance. It doesn't necessarily mean that there as (inaudible), you still have to think about whether or not they meet our current criteria.

Our criteria really have evolved overtime. But there was kind of a big shift back in 2010 and some changes kind of on the margins, if you will, since then. What we have changed quite a bit is our guidance. So, we have prepared a lot of instructions and notes and that sort of thing to help you think about the measures and the materials that you're looking at. And help you determine whether or not they actually do meet our criteria.

So, we'll be going through some of that today and you'll be using that as you make your recommendations for endorsement.

So, our evaluation criteria are standardized, actually, if we can go back to the previous slide. They are standard criteria. And that is actually really nice and

it's really well known and that's part of what makes NQF endorsement it gives – it's cache if you will out in the field, knowing that the process itself is quite rigorous and as are the criteria themselves.

And we do – and going back to the idea of the criteria evolving, you know, we learned more and more all the time. And really the measurement enterprise is kind of always moving. So, things that maybe worked 10 years ago, maybe aren't so much the things that we want to think about or try to measure today.

You know, people are getting much more sophisticated in terms of how they think about testing measures. So, probably those of you who are on the committees before, you might actually see a shift from the work that you did a few years back.

There's some pretty interesting things that are coming along, and I think there's going to be a couple things specifically in this project, that you'll enjoy working at. And you'll be able to see that, indeed, the health enterprise is kind of shifting.

Let's go to the next slide.

So, our endorsement criteria, on this slide, you'll notice that we have a bunch of page numbers. So, first of all, I want to tell you what those page numbers refer to. We have something called the Standing Committee Guidebook. And that should be available for you to look at on the SharePoint page, and we're going to show you that page a little bit later in the call today.

But, the Standing Committee Guidebook, if you haven't had a chance to look at that, I really do encourage you to look at it, gives you a lot of kind of background, some of the stuff that you've already heard on today's call that was a little bit more detail, of course.

And then the last section is devoted to the endorsement criteria. And it goes into a lot more detail, but hopefully, in plain language to the extent that we can, about our criteria and why some of these things are important and why we do what we do. So, the different criteria are described and you can refer to the page numbers on the slides for specific pieces that we wanted to call out.

So back to our major criteria, there are five major criteria and they are actually ordered in a hierarchical fashion, that we believe actually conform to best practices for measure development. So, for example, when you're developing a measure, hopefully, the first thing you ask is, is it important to measure a report knowing that, you know, measurement and reporting take lot of resources. And you want to put your resources into the measure set would be most likely to drive improvements of care.

So we start with importance to measure and report, and it's what we call a must-pass criterion, and it means exactly that. If a measure is not deemed by you guys in the CSAC to be important to measure and report, then, you know, we would say that the other things on this list maybe don't matter quite so much. And that measure would not receive endorsement.

But if a measure does get through the importance to measure and report criterion, we then look at the scientific properties of the measure. So this is – it's both how the measure is constructed and how it works. You know, is it working well with actual data. It's one thing to think that something is going to work well, and it's another to see some evidence that it's doing what you think its doing. So we look at both reliability and validity.

So the overall major criterion, scientific acceptability, and also a must-pass. And within that, we actually look at reliability and validity separately, and those are must-pass as well.

If we get through that hurdle, then we talk about feasibility, feasibility really is all about burden. So it's burden in terms of data collection, or, and/or implementation.

So, notice that feasibility is not a must-pass criterion. We realized that sometimes, things are really easy to do than to measure and other times, it's not as easy. And we don't necessarily think that even if something isn't easy to do, that it shouldn't be done and shouldn't be endorsed.

So, feasibility is possibly one of the more subjective of our criteria, but it's also kind of taking into account the idea that, you know, feasibility actually

can change overtime. Things that were hard five years ago maybe aren't as difficult, you know, today.

Then we get into usability and use. So that is criterion – and we'll get into this just, you know, a little bit more detail as we go. But we really want to know that the measures that NQF endorses are being used, first of all, that they are actually helping to drive improvement. And that there's nothing really bad happening to patients. We want to make sure that there aren't unintended consequences of use of measures.

And then, finally, if a measure gets through all four of the major criteria, then we start thinking about other measures that might be out there, are there measures that are pretty much doing the same thing or doing parts of the same thing. And if so, we want you to at least consider whether there is a need for multiple measures that are basically identical, or are there ways that even if it's fine to have multiple measures that they can become more aligned, so that the data collection and implementation is easier across sectors of the health care system.

Let's go to the next slide.

And as we go through here, if you guys have questions, please feel free to interrupt and ask a question. I certainly don't mind that. And I know that most of you have done this before. So, hopefully, it's just a bit of a – just a reminder for you. And those of you who are new, I realized again that this is, you know, this overview is probably not going to answer every question you have, so feel free to ask.

So, first of all, importance to measure and report, that your first question might be, "Well, how do I know if something is important to measure and report?" And so what we do is we actually have sub-criteria under this main criterion, and the sub-criterion help to determine whether something is important to measure and report or not.

The two major ones that I want to talk about today are evidence and opportunity for improvement. So evidence, we – by that, we just mean that

measures are evidence-based, you know, what's being done and looked when the measures have been in place. And then, for opportunity for improvement, that's basically saying, "Is there a quality problem in X?", whatever is the new measure, "Is there really something going on there that makes us feel like we need to look at it?"

And in terms of demonstrating the quality problem or opportunity for improvement, or sometimes you might see it as – sorry, I just lost my train of thought.

Let me just start over and say that, there are different ways that one might demonstrate opportunity for improvement. So, it could be that, for example, everybody is not doing well at all. So, just kind of poor performance across the board, or it might be that you see some providers, and when I say providers, I use that as an umbrella term. So when I say providers, I might be thinking about an individual clinician, or perhaps a hospital, or a hospice agency, or a health plan, just using that term in a very kind of broad sense.

If you know that one provider is doing really well or another provider who's not doing so well, that gives you the impression that there might be opportunity for improvement. So if there's variation in performance across providers, that would indicate opportunity for improvement.

And then, finally, if you slice and dice your measure results and you look at what's going on for different subpopulations, you may see that some subpopulations maybe aren't getting the highest quality care that they should be getting.

So if there are differences across population groups, that would be another indication that there's opportunity for improvement. So for example, if you were looking at a health plan measure and you see differences in performance for the Medicaid plans versus the commercial plans, then that – you know, there should be no expectation that that would be the case. So, that would indicate opportunity for improvement.

We also have under this major criterion quality construct and rationale. That is an extra sub-criterion that applies only to composite measures. And I don't

believe we have any composite measures in this round of work. So I'm not going to spend anymore time talking about the criteria for composite measures.

Let's go to the next slide.

OK. So, when it comes to evidence, first of all, the idea is that we want all the measures to be evidence-based, but we think about outcome measures differently than other kind of measures. Remember that outcome measures are inherently important, and therefore, we're not necessarily interested in every piece of literature out there that's going to talk about an outcome measure. But instead, what we're looking for is a rationale for how that outcome is influenced by health care processes or structures.

So basically, is there something that a provider can do to affect the outcome of interest?

If, however, the measure is not an outcome measure, so it would be a structured measure, process measure or even a special kind of outcome measures that we call intermediate clinical outcome measures, we want a little bit more in terms of documentation of the evidence-based. And specifically, we ask for a summary of the quantity, quality and consistency of the body of evidence underlying the measure focus. And that should demonstrate that the measure focus or the thing that the measure is doing somehow and that are – influences desired patient outcomes. Or you could sort of then say that if you don't do it, it leads to poor outcomes.

So, we – often at NQF, we use acronyms a lot. You may hear us talking about QQC, so that's quantity, quality and consistency on the body of evidence. When we talk about evidence, we really want the body of evidence. We don't want, you know, just one or two kind of cherry picked articles unless that's all that exists. But to – and the easiest way really to ensure that there's – that you're looking at the body of evidence is having information from the systematic reviews and grading of the evidence. So somebody else has actually gone out and collected everything and kind of just distilled it down to tell you what the quality and usefulness of the evidence is.

So, that's why we really do – we prefer to see things based on systematic reviews and grading. And often, clinical practice guidelines fall under that umbrella of systematic reviews. Not all clinical practice guidelines, as I'm sure you know, are created equally. Some of them maybe do a systematic review but do not do grading. So there's a lot of variation.

So, we have to – as you're thinking about the evidence underlying, we have to think about the – what you're seeing and, you know, how robust it is. I also should mention that when we talk about evidence specifically, we're looking for an empirical study. So, often, the developers will base a measure on expert opinion, which is fine. But, NQF does not consider expert opinion to be evidence per se.

So, it's fine to know that, but you have to take that into account. And we'll – you will be able to see that through our algorithms in just a minute.

Actually, that's a great segue. So, yes, algorithm.

Now, what I don't remember and maybe one of you guys can remind me, when you guys met the last time, so think it would have been in 2013 or 2014, somewhere in that range, did you guys use the evidence algorithms and the reliability and validity algorithms? Do these look at all familiar to you? Anybody in the call?

Raquel Mazon Jeffers: They look familiar to me, this is Raquel.

(Jeffery Susman): Yes, I think we've used it.

Karen Johnson: OK. Great. OK, that is fantastic.

Michael Trangle: Only in my dreams. It's Michael.

Karen Johnson: OK, great.

(Jeffery Susman): Yes, we'll see.

Karen Johnson: I think – and the reason that I asked is, I think you guys may have been the very first committee or maybe right at the very first committee that used these

algorithms, because we rolled those out back around that time. So I wasn't sure if you were in or out with this algorithm.

But the algorithms really haven't changed, they're pretty much the same as they were before, which means, of course, that at least for evidence and for reliability and validity, our criteria really haven't changed. So just to kind of orient you hear, we're not going to go through this call this entire algorithm. But the first question that you ask, you know, when it comes to evidence, is what kind of measure do you have, do you think it's an outcome measure, that's, you know, in box one, the green part there. If it is an outcome measure, then you're going to ask if there is a rationale to support, you know, being able to affect that outcome.

And so, pass and if not, no pass, that would be your decision when we vote. And we do vote separately on evidence as well as an opportunity for improvement.

If the measure is not a health outcome measure, then you work your way down the algorithm. So you can see there in box one, you see the word systematic review and grading. You see in box four, it's our summary of the QQC. And then over, you know, kind of going more to the right, depending on, you know, the strength of the evidence, the amount of evidence and the consistency of the evidence, that would lead you to your rating of either high and moderate, or low. And there's also the option for insufficient. Again, you know, our deal today is not to go through the algorithms but just to remind you that they exist. And they're pretty detailed and hopefully pretty easy to use.

So, let's go to the next slide.

What has changed since the last time you guys evaluated measures in the past, is how we think about maintenance measures. Back the last time around, we treated maintenance measures and that go the same way as we did new measures.

And in terms of the criteria, we still do. But in terms of the process, it's a little bit different. Basically, the idea is, if the maintenance measure actually hit

some of the criteria the last time around, then what we're going to say is this time around when we're thinking about for maintenance, unless something has changed, and as long as it still meets all the current criteria, we might not need to spend a lot of time discussing old ground, if you will, and we were just kidding.

So, under importance to measure and report, what we're saying is for evidence, for maintenance measures, we may actually have a decrease in the emphasis that we place on evidence in terms of discussion. So in other words, if the evidence that was presented the last time is still current, still major criteria, there's probably not a reason to spend a lot of time talking about it, or a lot of time clicking because you guys probably would remember those clickers that you use to vote. We will spend a lot of time potentially voting.

Now, if there are changes to the evidence, then of course, there will be committee discussion and quite possibly voting. So sometimes, it'll depend on the measure. Sometimes there will be completely new evidence that needs to be discussed. And it may make a difference in terms of how you vote for these and have a vote.

Other times maybe, there might be, for example, an updated clinical practice guideline. So, you know, if the guideline has been updated but really nothing is changed, maybe just, you know, reinforces what was done the last time. In that case, there might not be really a reason to spend time voting if it's just kind of, you know, underlining what was found before.

Of course …

Jeffery Susman: Can I just a raise a question please?

Karen Johnson: Oh, yes, please.

Jeffery Susman: So, two questions. One is, who's – is it the developer's responsibility to do a thorough sort of updated review of the evidence to identify whether there's new evidence that undermines the validity or reliability of the measure?

Karen Johnson: Yes.

Jeffery Susman: For example …

Karen Johnson: Yes.

Jeffery Susman: And for example, there's a number of (instance) that I'm aware of where, like an intervention study that focused on particular process measures documented improvement in the process measures but no improvement in outcome.

Karen Johnson: Yes, it would be completely – well, let me make sure I'm being completely accurate here. It's up to the developer to bring that to your attention. If they do not that somebody around the table knows about it, then that person should bring that to the attention of the committee.

You know, in these committees, there's all those, you know, a few people around that are really up on the latest literature and will be able to say, "Hey, there's a hole here that we know about and let's talk about that."

So, that's generally how we do it. But …

(Crosstalk)

Jeffery Susman: Yes, but does the developer has – and they – in this – for the maintenance measures when they, you know, fill out that part of the documentation …

Karen Johnson: Yes.

Jeffery Susman: … did they describe …

Karen Johnson: Yes.

Jeffery Susman: … here's the, you know, the reevaluation we've done to update the data. OK, so they described …

Karen Johnson: Yes.

Jeffery Susman: … there's a section where they sort of – they don't just repeat what they had before.

Karen Johnson: They generally do not. Often, they may – you know, for example, maybe the last time – and it just kind of depends. But maybe the last time they were using, say, a 2012 guideline or something like that, and maybe that guideline hadn't been updated. We would accept that they would do some kind of literature review, you know, from 2012 on. And that's usually what they would say, you know, "We looked, you know, an article from 2012 on", you know, blah, blah, blah and tell you what they did or didn't find.

So …

Jeffery Susman: Yes.

Karen Johnson: Yes.

Jeffery Susman: It would be useful if staff could identify sort of, you know, in the material that there's some potential gaps in terms of, you know, providing that additional literature review.

Peter Briss: In addition – this is Peter. But, in addition, there – in the system as you look – as you look at measure through the system, there are probably lots of checks and balances that would probably expected to catch, you know, additional update in the literature. So remember there are – the committee itself, there are public comment opportunities, there are stakeholder comment opportunities. And so, there were a lot of people that look at all of this that would have the opportunity to know that the – if people missed something.

Karen Johnson: Yes, perfect answer, perfect answer.

Staff will try to do that if we can. You know, as I'm sure you know, we're not expert in every area that we do endorsement projects on. So – and behavioral health, I'll just tell you, is not my thing. So I wouldn't know, I wouldn't be able to tell you that …

Jeffery Susman: You know, that's what I'm suggesting, it's not that they would evaluate the quality of the review, but that there's, you know, some statement where they say that we reviewed, you know, we reviewed the additional literature, you know, from, you know, 2012 to 2016. So that, you know, it's – you know,

there's some indication that they actually conducted review, not that (inaudible) the review, but that they actually did conduct the review.

Karen Johnson: Yes, the developers should be doing that, and quite frankly, if they do that and then just kind of adding to the, say, to an earlier guideline or something like that, we actually do want them to summarize the quantity, quality and consistency, you know, in light of what was there before and what's new.

We – often, the developers will provide a list of citations for you guys, but the idea is that we do not expect you as committee members to have to go pull those papers and read those. So we really do actually expect the developers to summarize that for you.

Now – and again, they – you know, they should be doing that, right, as part of their maintenance of the measure. And they can show their stuff out there. And as Peter said, you know, everybody is human and make mistakes. So, it's – it is certainly – even if, you know, I don't want you to feel like this idea of decreased emphasis means that we'll just brush over it. We actually, you know, do make sure in our meetings that, you know, there's time and (inaudible) to give people opportunity to bring up something if it's not there or, you know, that maybe even the developer didn't know about.

Going back to importance to measure and report with gap or opportunity for improvement. We actually are increasing our emphasis a little bit for maintenance measures. You may know that sometimes, you know, when we're looking at a brand new measure, it's not always easy to know what the gap is or what the opportunity for improvement is.

Sometimes we're relying on, you know, literature that's similar but not exactly what the measure is about, but by the time of maintenance, I really do hope that somebody is using those measures and that we have a more clear idea of what the opportunity for improvement really is out in the world.

So, we are expecting data on current performance. So, you know, unless in unusual situations, you know, we really want data within a year or two. You know, sometimes it's relying on claims, it might two to three years out of date. But, you know, knowing that there was a gap in 2005, for example, doesn't

really answer the question as to whether there's still, you know, a gap or a quality problem in 2017.

So, we are looking specifically and more closely at gap, or opportunity for improvement.

Let's go to next slide.

OK. Our second major criterion, scientific acceptability of measure properties. As I mentioned earlier, there's two main sub-criteria under that major criterion, reliability and validity. And just couple of things to note when we talk about these two things. Number one, we really are expecting empirical information, empirical data to help understand whether we think a measure can be used reliably and in a valid way.

Reliability and validity, though, are not, you know, kind of on or off, all or none. It's usually a matter of degree, and NQF actually does not specify things like, you have to have it simplified with this much. Or, you have to use with methodology, or you have to have, you know, at least this much or higher or we don't consider it reliable. We don't do any of that because it really, you know, how do you feel about those things kind of depends on the measure, quite frankly.

So, you have to use, you know, your best judgment, and again, we will give you – to the extent that we can, we'll give you some interpretation, some guidance if we know of, you know, kind of rules of thumb out in the world to help you with those kinds of things.

The other thing that is really important, it comes under both of these but in little bit different ways, it's because we have good measure specifications. You know, the instructions on how to measure is actually calculated.

We talked about them most of the time under reliability because there – when we talk about reliability, and I'll get into this a little bit more, but we really want consistency in being able to calculate the measures. So, you have to have good, precise, unambiguous specification so that you can ensure consistent calculation.

So, that – we talked quite a bit about specifications under reliability. We also talked about it under validity as well because we want the measures that NQF endorses to be consistent with the evidence. So, if the evidence says one thing and the measure is constructed differently, you know, maybe that's OK. But, we need to have that discussion and that comes under validity.

The other thing – let's just go to the next slide.

This is a slide that we use, and I might just pull this out. It's really just kind of a nice way to get across the idea that, you know, we're really looking for measures that are both reliable and valid. That takes us back to this idea that – of the must-pass. So, we will make sure that measures that are endorsed pass the reliability criterion as well as the validity criterion.

And let's go to the next slide.

So, when it comes to both reliability and validity, as I said, we're expecting empirical analysis to demonstrate both of these things. And we're expecting these analyses to be used for the measure specified. So, you know, if the measure is put forward, is being calculated in a certain way, that's how we would like to see it (test).

But, I also want to note that there's more to measure – to the reliability and the validity piece so just the testing piece. And sometimes that is – would fall into the traps, sometimes with pain, you know, a lot of attention to the testing piece and then maybe not giving so much emphasis to kind of the other things that we need to think about, so especially in the validity and I'll get to this in a minute. But there's things other than just testing that we have to kind of think about and make sure it seems reasonable and we just feel like the measure is valid.

Let's go to the next slide.

We allow testing of really both reliability and validity in two different ways. And NQF, we talked about testing at the measure score level and at the data element level. So when we say measure score, that's the, you know, the

results of the calculation that you do for the measure. And when it comes to reliability, in talking about whether the measure score is reliable or not, what we're getting out there is can – does the results of the measure – can you actually use those results to distinguish between providers. And it actually gets to the idea of variation in – across providers, is it really due to differences in the way that providers provide care, or is it more due to, you know, noise in measurement.

So, we really want our measures because they're being used in public reporting and payment programs, et cetera. We need our measures to be able to distinguish between providers. So, we …

(Crosstalk)

Karen Johnson: I'm sorry?

Jeffery Susman: I have a question on that one. This is Jeff Susman. Are we really trying to get down to the individual provider level, or is it at groups of providers or larger (end), because the ability to distinguish among individual providers is much more difficult and requires much (part) of your data than we typically have as opposed to …

Karen Johnson: Right, right.

Jeffery Susman: … looking at the differences between plans or large collections of …

Karen Johnson: Right.

Jeff Susman: … individual practitioners and their respective patients.

Karen Johnson: Right. And I just want to make sure that everybody is clear that when I'm using the word provider, again, I'm using it in that very broad kind of umbrella way. When I say provider, I'm not making individual clinician, which is what you're talking about. And I would agree, if you're trying to figure out, you know, and use measures to distinguish from one clinician to the other, you do have to have, quite frankly, more data to do that than if you

were looking – if you do find lots of data for a health plan, kind of compare across health plans than for individual clinicians.

Jeffery Susman: Yes …

(Crosstalk)

Jeffery Susman: … is maybe the misapplication of these measures to make distinctions which are applied appropriately to health plan or the – or system level that then …

Karen Johnson: Right.

Jeffery Susman: … are being used to ascertain quality differences among providers by that individual clinicians.

Karen Johnson: Right.

Jeffery Susman: And maybe that is NQF's chief concern, but I think we have to be very clear at how these data are being endorsed for use or these measures are being endorsed for use.

Peter Briss: And Jeff, this is Peter. The other thing about that is that generally speaking, a measure will be – you know, will be specified at one or more particular level. So, it can be at the – sometimes they really are at the individual provider level, sometimes they're more at a plan level or so on. And so, when we're making this judgment in the endorsement process, we'll need to think about whether we believe that there are – if they're reliable, that the measure in question is reliable at the level for which it specify.

Jeff Susman: I think you stated the issue probably better than I did. Yes, Jeffery. Thanks.

Robert Atkins: So this is Bob Atkins.

Karen Johnson: Right.

Robert Atkins: I'd like to expand on that with a similar question that came up actually last time I was out there during the work.

If you look at things at a health plan level, we all know that the way the United States set up its health care delivery, the folks who are affiliated with Medicaid health plans are very different than on a population level from folks that are affiliated with commercial health plans.

And you know, we've gotten to some conversation last time about having the same metric but being able to stratify so that we could identify how to apply that metric to those at least two different large subpopulations. And the person who's sponsoring the metric pretty much said, "That's your problem."

So, that is, I think, an NQF – I mean, I'd be – I certainly would propose that we pay attention to the reality of the way the system is, you know, created and constructed and have – give some direction to how these metrics are used on a comparative basis.

Karen Johnson: Both of those are extremely good point. I want to reiterate Peter's point, first of all, that when we endorse measures, you know, these measures come to us and they say they're specified for, you know, whatever level of analysis and whatever setting, you know, whatever, you know, (inaudible). The specifications that come through, if you guys or the committee say you actually want to endorse that, the measure is endorsed for those – that particular scenario, if you will.

We do realize that some people out in the world take measures and use them in ways that they are not endorsed to be used as. Unfortunately, we don't really have any control over that. But we tried to be very clear in saying, you know, this measure is endorsed for the health plan level of analysis or the hospital level of analysis, so whatever happens to be.

Peter Briss: Yes, this is Peter again. This is Peter again. The other thing that might be said about this point is that, there's been a lot of recent work at NQF and elsewhere about trying to deal with this issue, this fraud issue about dealing with patient population that have quite different sociodemographic conditions.

And so, we might want to table some of the discussion about, you know, the population issues and so you got an overview of the sociodemographic trial period stuff that comes ...

(Crosstalk)

Karen Johnson: Right.

Jeffery Susman: Yes.

Karen Johnson: Yes, yes …

(Crosstalk)

Jeffery Susman: That's coming up right on this slide.

Karen Johnson: Yes, yes. Yes, we'll talk about it very briefly, it's really just kind of an overview. But what I will say is, you know, your point is well taken and I think, you know, you should feel free to talk about those things in the meeting if they come up. I mean, you know, if a measure – you know, sometimes measure's role would apply, for example, only to a Medicare population. You know, and, you know, they're specified only in that way. So maybe that question is a little bit more than this point or maybe not.

But, that would come up probably under reliability as well as validity. You know, are there specifications, you know, in the way that they should be to match the evidence. And you know, if there's something that if you use it, you know, overhear that it's not going to cause work right, so those are – it's fair to bring these things up.

Robert Atkins: That's great, thank you.

Karen Johnson: Yes. Let me go back and talk a little bit about data elements reliability. When we talk about data elements, those are the building blocks of the measure, you know, things like, you know, the diagnosis codes that go into denominators for example or you know, the CPT codes that go into your numerator, for example. There's lots of different data elements that go into measures most of the time.

And when we talk about reliability of data elements, what we're really giving you to there is the ability to consistently pool those data elements from the

data source. So, you know, if you think about, you know, nurse A abstracting data and nurse B abstracting data, are they pulling the same thing. And that goes back to our specifications, you know, if they're clear and unambiguous, then mostly likely it's reasonable to expect that, you know, people will be able to consistently abstract data and calculate the measure.

So, in terms of what we are expecting in terms – as far as in testing for reliability, we actually allow either type of testing, we go in (to assist on both). But, of course, it's stronger if they have both. But measure score or data element testing will be fine.

And when you're thinking about testing, both reliability and validity, these are kind of testing, we think really about, you know, what data were used. You think about what is the (right), you know, or reasonable methods. And then you think about the results. And you know, did things pan out in the way that you hoped. So those are the things that we think about using your evaluating the testing.

And let's go to the next slide.

Certainly not going to go through the algorithm again. But, I'll just point out couple things, this is the algorithm for reliability. You see the green box is the first question is about the specifications. So, if the specifications aren't precise and unambiguous, then we would say (very) low. And it kind of doesn't matter what the testing would show, right?

As a matter of fact, if the specifications aren't precise or unambiguous, it's quite likely that the testing would kind of reflect that as well. So, both of those work together. You can see that rate low is (X aren’t) good. Otherwise, go down and you see box two, was empirical testing done with measure specified.

So again, let's go back a little bit to the previous question, you know, we want to have testing for the things that’s specified. So if you're saying we're specifying this for a clinician level, use the testing at the clinician level.

Testing at the health plan level would be good enough and it has to be at the level that the measure is specified.

If so, then we'd go down to see box four there, the question is, was it conducted at the score level. And if so, then you work your way across. If not, and you're not seeing it on the page here, then the question is, whether it's done at a data element level.

What you don't quite see here is that the – in terms of, is the measure eligible for highlighting, it's only eligible for high if the developer has conducted score level testing. We really are interested in whether or not you can distinguish between providers or not.

So, you could potentially give those measures a higher rating. Now, just because they test it at the score level doesn't mean that it's – you know, the results are what we were really hoping.

So, it could be that they tested that way, but the results aren't stellar. So you may want to still be able to moderate being at high, but you'll see all of that in this algorithm.

Let's go to next slide.

Validity testing. Pretty much the same thing. We're mostly expecting empirical testing. And we allow testing at the score level and at the data element level. We were thinking about the score level in terms of validity. We're trying to decide whether or not the measure results or the measure score really lets people have come to a correct conclusion of that quality.

So we're talking – we're thinking about correctness. At the data element level, we're thinking about accuracy, or correctness again. But I really think of it more as accuracy. So you're thinking about this individual data elements. You want to make sure that what is being used in a measure that's actually reflected in the gold standard.

The gold standard is usually in somebody's medical record. And there are ways that – to let people look at that to make sure that what's, you know,

what's in the claims are what's in the medical record or what's in there. You know, a registry is what's in the record, that sort of thing.

We do allow for face validity. So face validity is not empirical. It's the – it's a subjective determination that on the face of it, the measure can be used to distinguish care, quality of care.

We prefer that maintenance measures coming through have actual empirical testing and we don't require it but we really hope to see that. But sometimes you'll still see maintenance measures coming through and still kind of relying on the face validity that was done earlier on.

Face validity is just kind of the lowest bar in terms of validation methods. So that being the case, we actually have a little bit of requirement in terms of face validity. We want to make sure that it was done systematically, but we know who the experts are. We know, you know, what was asked and, of course, the results were good.

And I'll also point out that when we talk about face validity, we're talking about face validity of the results of the measure, and those results being able to help differentiate quality of care. So, sometimes you might see face validity of how the measure was built, you know, the construction piece, the development piece. That is great, but that's not what we're looking for and what we will accept in terms of face validity for measures that are endorsed by NQF.

Let's go to next slide.

And I know we're getting close to the end of my time here. So I'm going to start talking possibly a little faster to try to get through everything.

This is our algorithm for validity. It's structured in the same way that the algorithm for reliability is. So, again, we start off thinking about specifications in the green box, and then we go to this box two where all potential threats to validity assessed. And if so, then, you know, what kind of testing was done and did it – you know, were the results reasonable to you.

Let's go to the next slide.

And the next slide gets to the idea of those threats to validity that were in that box two. Remember I said that, you know, we – the work – the thing about testing, it's really important part but there are other things to think about, too.

So, there's several things that we asked developers to comment on and think about that could threaten the validity of a measure. And specifically, this is where we start thinking about missing data. This is where we start thinking about exclusions that either were or weren't included in the measure. This is where we start thinking about risk adjustment, whether it wasn't done, whether is it done appropriately, that sort of thing.

So all of these kinds of things could threaten validity and they are discussed as part of validity. So in terms of process, again, I'm kind of going back and forth between criteria in the process. Validity as well as reliability are must-pass criteria. So we talked about – you know, in the flow of things, we'll talk about reliability. As part of that discussion, we'll talk about specifications and then testing. And then we'll have you vote if the measure passes reliability. Then, we go on and start discussing validity.

And we'll discuss – all kind of in one big discussion, we'll talk about, you know, the specifications aligning with evidence. We'll talk about testing. We'll talk about any threats to validity, all of that together, and then vote. That's how that will work.

Next slide.

For maintenance measures, we basically – in the discussion about specifications, there's no difference. You still want to make sure that there's adequate discussion about how the measure is specified and making sure that everything is very clear in terms of the specifications.

In terms of the actual testing and threats to the validity and that sort of thing, we have here on this slide, we're saying there's a decreased emphasis, you know. And what that means is, if really nothing has changed and the prior

testing still holds up (in) our current criteria, then there may not be a reason to spend a lot of time talking about the testing that was done.

However, we – sometimes we see updated testing. So anytime there's new testing that's been provided, we definitely will discuss that and then have a vote. And any kind of outcome measures specifically because you choose your outcome measures and the risk adjustments, those will also be discussed (inline) of the SDS trial, which I'll talk about in just a couple of minutes.

Let's go onto the next slide.

I've really talked about feasibility quite a bit, I think. So it's really, again, the extent to which the data are readily available, minimal burden for implementation and collection. So, when we talked about feasibility, there are these sub-criteria under feasibility. We do not vote separately on those criteria. So we cannot think about feasibility all in one shot and vote on that.

Let's go to the next slide.

On usability and use, this is actually where there has been a change in our criteria since the last time you guys worked with us. So, first of all, again, I've already talked a little bit about the things that we are interested in. And we do usability and use the same way that we do feasibility. We kind of talked about all of these things together. We don't vote separately on 4a and then 4b. All of it goes together. And you'll also notice that usability and use is not a must-pass. So it's important. We want to talk about it. But, you know, if something is not in use, that doesn't necessarily mean that, you know, it won't pass and be endorsed. But when we talk just a little bit about what we mean by these things, 4a, accountability and transparency.

In terms of accountability, we actually – we expect there are measures to be used. So we hope that they are being used. And we really are hoping that within three years of initial endorsement that they are being used in some kind of accountability program, whether that's a CMS program or, you know, individual accreditation programs, things like that, anything that's in accountability program.

In terms of transparency, what we wanted to see is public reporting of the measures that we endorse. And we were thinking that within six years we'd really like to see public reporting. Again, this is not a must-pass criterion, so it's not a, you know, a hard stop, that that's what we're hoping for.

4b is about improvement. The whole point of measurement is to drive improvement. So we'd like to see that there's actually been improvement overtime in using the measure. Then 4c, benefits outweigh the harms.

You know, there's always – you know, there's always an unintended consequences, sometimes they're negative, sometimes they're positive. But we want to make sure that, you know, even if something untoward is happening that, you know, the benefits outweigh the harms. So we're very more – very much strict to think about that and consider that and do that under this criterion.

And we have 4d. 4d, I'm not going to go into a lot of detail here just because of time. But it is a new sub-criterion that we just added last summer. So, you know, we're just now starting to implement looking at this criterion, vetting by those being measured and others. So basically, this is the idea that, you know, measures affect providers, right? Somebody is being held accountable most often with these measures if they're being used.

So we would like to know whether or not folks who are being held accountable, whether it's individual clinicians, whether it's hospitals, whether it's home health agencies, you know, whoever is being held accountable, that they had a chance to look at the data underneath the measure and look at the results. We provided assistance in understanding those things, and being – given the opportunity to provide feedbacks on measures. And also feel comfortable that that feedback is at least heard in some way even if not exactly acted upon potentially.

So, that's what this vetting is about. We were not sure with the kind of thing that it's not happening tremendously a lot out in the field. So it's a way to try to drive that sort of activity by measure developers, including it as part of their criteria.

Male: Question.

Female: Yes. I'm sorry, go ahead.

Male: So, I see three and six-year timelines here, and it strikes me that this sort of means that if we're going to be doing our job for measures that are not new but maintenance measures, are we sort of creating the schedule where we're going to sort of like be reviewing how it's going three years after they're approved or six years?

Karen Johnson: Our maintenance schedule, basically, it kind of is built in. Pretty much we're funded roughly every three to four years to look at things to look at different groups of measures. So, behavioral health, it's been about three, three and half years, somewhere in there since you guys have looked at it again, we now have funding to do it.

So our funding cycles do allow for probably every three to four years to look at measures again.

Male: And do we have a lot of like, you know, individual measures, because we've endorsed a lot of measures. Do we have a lot of like dangling participles that was just – given that how much time we have together in a three-year cycle, we just won't have time to review, or are we going to sort of – will you guys, staff, look at all of them and bring the ones that are either problematic or going great to us?

Karen Johnson: The way it works just in our internal processes is they're "up for maintenance" every three to four years. So depending on, you know, behavioral health is a fairly small portfolio. So, there is January time to look at everything we need to look at. I think there are measures in the portfolio that you guys won't be looking at. It really weren't up for maintenance yet, but we'll get back to them in some way.

So, you know, the three years and six years, don't get too – you know, that's not a hard and fast rule, you know, it is quite likely that our timing won't line up exactly with that. But eventually, we do get around looking in everything again. And then sometimes, you know, for measures that have been around

for a long time, we've looked at them, you know, maybe – we might be on their fourth or fifth go around, maybe fourth on some of our longstanding measures.

So I don't know if that answered your question or not, but hopefully it did.

Jeffrey Susman: I guess another thing that is – who is it up to to identify the measure that needs to come in for renewal? Is it the developer or NQF?

Karen Johnson: It's NQF. We have …

Jeffrey Susman: So you reach out to …

(Crosstalk)

Jeffrey Susman: So you reach out to them and say, "We have another round of this and …

Karen Johnson: Yes.

Jeffrey Susman: … your measure hasn't been reviewed for X number of years. So, if you want to renew it for maintenance, you got to come back in."

Karen Johnson: Yes, that's exactly it. That's exactly how we do it.

Tracy Lustig: Hi, Karen, this is Tracy. I'm sorry to interrupt. We were actually running out of time. So, I know we've given you a lot to cover. If we can finish up this and get to the SDS quickly, so we can go over the SharePoint, that'd be great.

Karen Johnson: Yes, yes, you're right. And the SharePoint, I think, is probably the really important piece that we need to do.

Let's go over – you know, I think for now, I'm just going – I'm going to not talk about related or competing. We'll talk about that more in the meeting itself and explain what we mean.

So, in terms of our evaluation process, I think we've already mentioned these things. We are going to do a staff and preliminary analysis for you. And as part of that preliminary analysis, we're going to, you know, summarize what's

been submitted, give you hyperlinks that you can get back and forth easier in the submission materials.

We're also going to provide – and this is fairly new, we've been doing it for about a year now. But we're going to give preliminary ratings for the criteria. So we're going to tell you what we think the rating should be. That doesn't mean that that's how you should vote. But it gives you a starting point to start thinking about in terms of, you know, discussion and evaluation.

As I believe it was (Dessie) mentioned earlier, we are going to ask you to do an individual evaluation once we release those materials or the (inaudible) on SharePoint thing that you fill out and then that also what you see what your colleagues are thinking about a measure. And all of that information would be available to you at the in-person meeting where we will evaluate the measures that are in the project.

So let's go to the next slide, (Dessie). Actually in the next slide.

There is something new called Endorsement Plus. That's a new designation that we will award, if you will, to measure sets. Basically, it's in – certain with our criteria, and you see that on the slide there. I'm not going to go into that.

We will guide you in that discussion as well. So we will – a staff, first of all, will tell you if the measures are eligible for this new designation. And if they are, you guys would have a discussion if you feel like that they actually, you know, should get that designation.

Let's go very, very quickly into the SDS trial period. And actually, I don't want to see – I wasn't going to spend that much time on it anyway, but I will just alert you to the fact that we are still in the middle of our two-year trial period.

So back in, I think, 2013, somewhere in that range, fall of 2013, we've pulled together a group of experts in both disparities and in measure methodology to help us think about this whole idea of adjusting for sociodemographic factors.

Before that time, NQF actually had a stated policy that we do not want to see measures adjusted for SDS factors. So it's kind of against the rule at that time. But this committee team basically came forward and they actually suggested that they change that policy. Very interesting work, very good work.

So based on that work, our board instituted this two-year trial period, and basically as part of the trial period, we are no longer prohibiting inclusion on SDS factors in risk adjustment approaches.

That doesn't mean that we say that they have to be there. So each measure will be looked at individually to determine if it's appropriate or not. And as the committee, standing committees will evaluate the measure as a whole with everything else, but also be thinking about this SDS adjustment.

And then, this last bullet is just realizing that, you know, there may be reasons why we would think SDS adjustment is needed, but it may not pan out in the empirical analysis, either because the data just aren't there in the first place, you can't adjust for things practically speaking, or maybe the relationships that are suspected are possibly not as strong once you start bringing in another thing such as comorbidities or severity, that sort of thing.

Let's go to the next slide.

So in terms of your evaluation …

(Crosstalk)

Male: Just one point about that quickly. You know, the SDS adjustment thing is really – as I understand it, is particularly focused on process measures in terms of this trial period. But for outcome measures, there is some requirement that risk adjustment be considered.

Karen Johnson: Right. So as a matter of fact, I was just going to say that. So you are helping me out here. What we're particularly interested in for this SDS trial period is for outcome measures, whether or not there's risk adjustment, so not all outcome measures are risk adjusted in the first place.

So the first question, and you would ask this anyway, right, whether we were in the trial or not, is, you know, is it appropriate to risk adjust or possibly to not risk adjust if it's an outcome measure. The trial, the SDS trial, is saying, "Let's go a little further." We want to know when we ask the committee to consider whether there's a conceptual relationship between SDS factors and what's being measured, what is available in terms of data, what did the empirical analysis show. And then finally, what – does the testing match whatever the final specification is for the measure.

So really that, let me be very clear, if it's a structure measure or a process measure, those generally are not risk adjusted in the first place. You could certainly have conversation if you wanted to about whether risk adjustment is appropriate for those kinds of measures or not. And that's the first question you ask, is any kind of risk adjustment needed for those measures and then you could potentially start talking about SDS factors.

But in terms of our trial, we're really specifically interested in having those discussions about outcome measures.

So let me stop, and I know we are so close to the end of the call. If there's a burning question, I'll take it now. Otherwise, I'm happy to talk to you guys offline or via e-mail, however you'd like.

Desmirra Quinnonez: OK, Karen …

Karen Johnson: OK.

Desmirra Quinnonez: … this is (Dessie). Since I don't hear any questions right away, I'm just going to dive right into a brief, brief overview of our SharePoint.

So I – well, I just want to show you – bring your attention to the slide which shows some of the documents that can be found on the SharePoint site for Behavioral Health. And what I'll actually do as I have on the next slide, you'll notice there's a picture of a screenshot of the homepage.

Well, what I'm going to actually do in the effort of time is to screen share with you what the actual website looks like, because I feel like that would be a little easier for you to see.

So let's see. Can you all see my screen now with National Quality Forum at the top on SharePoint site? Kirsten, can you all see that?

Male: Yes.

(Crosstalk)

Desmirra Quinnonez: OK. Perfect. Thank you.

So this is actually the Behavioral Health SharePoint site and this is your homepage. So you'll notice at the top, on the left-hand side where I'm pointing, dragging this way, you will see Committee Home is the first option over here. If you click on that, that will bring you here to your homepage.

So I just want to bring to your attention the general document section where you list the committee guidebook that Tracy and Karen mentioned earlier as well as we've put some historical documents on here from the other prior phases, so that if you need to go back and look at what happened in the first three phases of the project, that you can go and get that there as well.

If you scroll down, you'll see the measure document section. And inside this section, we'll actually have all of your measure document for each measure where it will list your measure number, the measure title, the description of the measure, who the steward is, and I will show you how to get in that as well. And I'll bring to your attention the meeting and call document.

So while we're here, I'll let you know that there's a plus sign that comes in this little box underneath the meeting and call documents, where if you click on that plus sign or on that – the meeting title, it will tell you exactly which meeting has occurred or is upcoming, and it will actually tell you – it will actually list the documents that you can actually click here and open up those documents.

So, just to give you another, if you need to access the committee calendar, you go right back up to the top of the page where it's the committee home, committee calendar and this will list all the upcoming dates that are coming up, meetings for our project. If you look down at the committee roster, you'll be able to find the members, the names and information of all your other Standing Committee members as well as if you need to come down and find our staff document.

So you can feel free to play around on here and you'll notice later when it's time for surveys, we'll actually send you a link to that. That will take you directly there.

But there's only one more thing that I do want to bring to your attention just to make sure that you understand how to get inside the measure documents. And that's when you click on the measure number or the measure document under here, if you click on the measure title under name. All of these documents will actually pop up right here, so that will be your measure worksheet and these are the documents that you need to go through and to be able to evaluate the measures.

And the measure worksheet is the one that you will probably be using the most and that goes through each of the criteria that Karen mentioned earlier that we'll be going through at another time.

So that is a quick wet-and-dry picture of what this looks like. So what I will do now is actually bring it back to Kirsten so you can get ready to take us on our next steps.

David Pating: Can I ask a quick question?

Desmirra Quinnonez: Sure.

David Pating: This is David Pating. You know, sometimes I've had problems getting into the website and I think I've forgotten my password stuff by now. So can – you'll send us a link to be able to find our way back to the right pages, is that correct?

Desmirra Quinnonez: Yes, we can do that. And Karen, can you remind me who they have to contact. I can't remember exactly.

(Crosstalk)

Kirsten Reed: Absolutely, this is Kirsten. You should have received an e-mail. I know there was a lot of confusion around SharePoint. You've probably received one a couple of weeks ago from the e-mail address nominations@qualityforum.org. And in that e-mail, it was actually the incorrect link that was taking everybody to previous phases. So that's why a lot of you are seeing outdated information. And then – so she sent out another like corrected link, and again, it was incorrect. So there's just been a lot of confusion.

So, if you do not have access to SharePoint and you have not received any e-mails, whatsoever from the nomination's e-mail account, please send me an e-mail and I will make sure you get access.

There is a link in the couple of slides. (Dessie), can you go to the second to the last slide that has the actual SharePoint site? Yes, so right there at the very last link, that is the correct one.

What happens a lot of time is our access is different than yours. And so that beginning part, it's staff.qualityforum.org for us and we always have to remember (the chance) to share before we sent it to you and sometimes people forget about that and that's, I think, where all of these confusions stem from.

So if you're clicking on the link and you notice that it says staff and not share, please just change it to share. And you should have access.

(Crosstalk)

David Pating: Can you send out the slides so that we have that …

Male: It came up but that I had to use another account even though I know I have the right name and password. I don't know if that means that you need to send me something, the right connection or that's a different kind of mess up.

Kirsten Reed: Can you just send me – would you mind sending me an e-mail with like what the issue is if it's just accessing it or your password, or what it is.

Male: I don't know, that's why I'm asking.

Kirsten Reed: Oh.

Male: Well, (inaudible) it says use another account.

Kirsten Reed: Oh, interesting.

Male: It was the box below that you showed earlier in a screenshot.

Karen Johnson: So I think if you'll just e-mail Kirsten and let her know that you're having that difficulty, what we can do is they have that link, your username and stuff is linked to a database and I think there's dates on there. So, (somehow) in that they didn't update a date to extend your time or something goofy like that that we can look at that on the back end and try to get it straight enough for you.

Male: And do we have her e-mail? I mean, I know it's on the slides, but can I access the slides later without logging in?

Kirsten Reed: Yes. Yes, they were sent out in an e-mail, yesterday, I believe it was. And my e-mail address is kreed, R-E-E-D, @qualityforum.org. So feel free to send me an e-mail and we can get everything worked out.

Female: So …

David Pating: So I just want to ask, so with regards to the process, will we be doing pre-reviews in subgroups before the main committee? I don't see that we're meeting in workgroups to be able to prepare to be presenters on the measures. So I guess – is that not happening this round?

Karen Johnson: This is Karen. I'll step in. No, we – because you guys are not a brand new committee, even though I know I've realized a couple of you are new. We will not have the workgroup calls. So you'll still do the individual evaluations, but it won't be kind of that workgroup call beforehand.

We will, however, be asking several of you to be prepared to be the main discussant, just like you were in the workgroup calls, you would take on that role within the in-person meeting.

David Pating: Oh, OK, great.

Raquel Mazon Jeffers: So my question is – I think you said this earlier. On February 10th, the – all the information that we need to do the measure evaluation will be available to us. We have a call …

Karen Johnson: Yes.

Raquel Mazon Jeffers: … on the 16th if we have questions. Will we also get our specific individual assignments on the 10th?

Kirsten Reed: Karen, when – how far in advance you typically do the lead discussant breakout?

Karen Johnson: Yes. You know, certainly by the 10th, maybe even before …

Raquel Mazon Jeffers: OK.

Karen Johnson: … just kind of depending on how our ducks are in the rows or not. But yes, by the 10th, if we can, we will.

We may even be able to release a few of the measures a little earlier than the 10th. If we can, we will. And I think probably – is it on – yes, the Q&A call that's on the next slide, we're going to actually go through, not more to the measures in the project, but another measure just to kind of show you and talk about how the process is going to work.

So if you can be on that call, we can certainly talk even more about process and that sort of thing.

Raquel Mazon Jeffers: Great, great.

Kirsten Reed: All right. And then just the next steps, we already talked about, but a few things I do want to just remind you of. That post-comment webinar, I will be

following up if you could find a new date. And I'm – as we said, we will be assigning each of you two to three measures to do a full evaluation on and be a lead discussant during the in-person meeting, but we also do ask that you are familiar with all 10 measures that are under review.

And then, finally, in order for us to assign everyone measures, we do need your disclosure of interest forms on the specific measures being reviewed. I believe there's a few of you that I'm still missing and I did e-mail you. So if you could please send those over to us so that we can get moving on kind of assigning everyone to different measures.

And I think that's all that I have. Are there any other questions?

Female: No.

Kirsten Reed: Great. Well, if you think of something, please feel free to e-mail us at the e-mail address that you're seeing on your screen there, behaviorhealth@qualityforum.org. And thank you all so, so much for joining us today and we are looking forward to working with all of you.

Karen, Tracy, (Dessie), do you have any last things you wanted to say?

Tracy Lustig: No. Thanks for everyone for joining today.

Female: No. Thanks for everyone for your time.

Karen Johnson: Feel free to …

(Crosstalk)

Karen Johnson: … send e-mails or ask if you have any questions. That's the only thing I would say. If something comes up, just ask.

Female: Definitely.

Kirsten Reed: All right. We'll be in touch. So, thank you.

Female: Thank you.

Male: Bye.

Female: Bye.

Male: Thanks a lot.

Male: Thank you, thank you.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END