NATIONAL QUALITY FORUM

Moderator: Lauralei Dorian
November 12, 2013
1:00 p.m. ET

Operator: Thank you for participating in today's Behavioral Health Phase Two Comment Call. The purpose of the call is to discuss proposed responses to comments received. This conference call will be open to the public. The public will have an opportunity to provide comment that will help to inform the Steering Committee's discussion when invited to do so by the Steering Committee co-chair.

Other members of the Steering Committee or NQF staff, please mute lines to limit interference. Please note that this call will be recorded and transcribed. The recording and transcription will be posted to the project page on NQF's web site within 7 to 10 business days of the conference call. Thank you very much for your interest and participation.

(Lauralei Dorian): Great, thank you. Good afternoon everybody. This is (Lauralei Dorian) from NQF and I am joined here by our team Helen Burstin, Elisa Munthali and Poonam Bal. Thank you very much for dialing in today. We appreciate your participation. Before we get started I'm just do a quick roll call of the Steering Committee so we know who we have on the line.

And I just wanted to remind everybody to please keep your phones on mute if you're not speaking just to reduce the background noise. So I know I heard (Harold) and (Peter) both called in. Do we have Caroline Carney Doebbeling? (Nadie), I heard you call in (David Ainzech), Nancy Hanrahan, (Emma Hu), Dodi Kelleher, she just call in. Can you – (Peter), (Harold), can you confirm that you can hear me?

(Harold): Hi, it's (Harold).

(Lauralei Dorian): Hi.

(Harold): I can hear you.

(Lauralei Dorian): OK, great.

(Peter): Yes. And this is (Peter). I can hear you too.

(Lauralei Dorian): OK, great. (Florenda Cultry)? (Mike Laurier)? (Nadie Negell)? (Tammie Mark)?

Operator, is everybody able to hear me? I wanted to make sure because I know some of these people are on the call. I could see them on the webinar and make sure that they could speak.

Operator: Yes ma'am. Everybody is on with an open an line and they can hear you.

(Lauralei Dorian): OK. (Bernadette)? (David Patton)? (Arlene Phillips)?

(Arlene Phillips): Yes, I'm here.

(Lauralei Dorian): (Vernita Andolia)? (Jeff Samoth)? (Lisa Shay)?

(Lisa Shay): Yes. I'm here.

(Lauralei Dorian): Great. (Jeffrey Stuffman)?

(Jeffrey Stuffman): Present.

(Lauralei Dorian): OK thanks. (Lynn Wagner)? (Mark)? (Bonnie)? And last (Dan)? OK and can I just ask the developers on the call to identify yourselves please?

Ann Watts: Ann Watts from the Joint Commission.

Celeste Milton: Celeste Milton from the Joint Commission.

(Al Campbell): (Al Campbell) from (FMQAI).

(Crosstalk)

(Shin-shin Liu): (Shin-shin Liu) from NCQA.

(Paulette Tipton): (Paulette Tipton) and (Jefferson Larson) from Minnesota Community Measurement.

Female: (Inaudible).

(Lauralei Dorian): Great, thank you very much. So it has been a while since we last met. So just to quickly remind you of the topic areas in this project we had the tobacco use, the alcohol and substances measures, the depression and major depressive disorder measures and the hospital based inpatient psychiatric services measures. You recommended all of them other than two which we're turned for importance.

Today, on the call we're going to be discussing the measures as I noted in my e-mail you received over 300 measures which was great because we have a lot of comments, because we had a lot of engagement with members of the public and members of NQF. Luckily, for us and I think for our work today most of those comments can kind of be categorized into four major different theme.

So those are the themes that we're going to go through on the call today specifically they're all detailed in your memo that the memo that I sent you last week. But we've don't want this to prohibit you from raising any questions about any of the other comments that we receive so I sent that Excel spreadsheet to you as well.

So you're free to bring up anything that you would like. The major themes are there on the webinar in front of you, we receive comments related to the evidence supporting this (week) of the tobacco and alcohol substance use measures from the Joint Commission.

We received comments about the appropriateness of the setting, in-patient psychiatric setting for those measures as well. The reliability of the substance measures and also support for measures that were not recommended.

So with that, I would like to turn it over to our co-chair, (Harold) and (Peter), who will lead you through the different theme and before the committee begins a discussion of those themes, we will also give the developers an opportunity to respond. So (Harold) and (Peter)?

(Harold): So, (Peter), do you want to take the tobacco on?

(Peter): Sure. So this is (Peter) and welcome everybody. Thank you again for your continuing engagement. We're delighted that you're here and we are delighted with the level of public and stakeholder interest in these things and thanks to the staff and the developers for efficiently, you know, sort of grouping many comments we received.

So maybe before we dive into the – would anybody like to raise other – any other issues that we ought to get on the agenda that, you know, that aren't yet reflected in the themes that their – as they are laid out in the memo?

Hearing none. And so, I'll assume that silence in this context type means that people are generally comfortable with the themes that are laid out and so – I definitely just start with the first one which potentially has to do with either the quality or the generalizability of the tobacco and substance measures in the hospital setting and maybe perhaps we ought to ask for comments from the developers before we start.

Celeste Milton: Thank you, (Peter), this is Celeste, from the Joint Commission. In discussing scene one, that would be looking at the Tobacco Treatment Measures. We did go back and review the literature and we provided you with an abundant of evidence basically, coming from two large Cochrane Meta-Analysis that look at some of the interventions in the hospital and talking about the effectiveness of those.

In particular there was a Cochrane analysis in 2012, where they did 50 trials. So, there is a large body of evidence that really does support the Tobacco Treatment Measures which of course on build upon the others. The first of course is looking at screening, the second is looking at doing some counseling and offering cessation medication during hospitalization. The third is, to offer continuing counseling and medication at the time of discharge. And, of

course the fourth would be a follow up to see the patient quit status and whether they're still in counseling or taking the medication.

(Peter): Well, the fourth was not supported, correct?

Celeste Milton: That is correct. In our evidence, however, before if you want to talk about that now they're – it really does as an indication in addition to …

(Harold): Actually, that (inaudible) I just want to be clear that …

Celeste Milton: Sure.

(Harold): … really focusing on the responses to the three recommended ones.

Celeste Milton: Correct.

(Peter): And so, and so, the general these general issues – thank you to the Joint Commission for formulating a response the – these issues about effectiveness and in generalizability that this measure were it certainly came up in the initial committee discussion. And I think that the committee's conclusion – the original conclusion sort of reflected that discussion at this point why don't we pen the floor to committee member discussion about these issues and the proposed response.

(Jeff Sussman): So, this is (Jeff Sussman), first of all can you clarify – I assume we're not re-looking at measures that were rejected like for example the fourth – the follow-up on …

(Peter): Correct.

(Jeff Sussman): So, we're just focused on the responses from public comment and did you know if there is response to this?

(Peter): Correct.

Male: Yes.

(Jeff Sussman): So, it seems to me that there's still as according to cases, there was before I think the Cochrane Meta-Analysis is set up pretty persuasive as per discussion, I think was very robust initially. So, I don't see much merit and any change in our recommendation based on the comments we receive.

(Madie Negell): This is (Madie), I would support that. I thought we had a thorough discussion of the issues.

(Jeff Sussman): So, we had a couple of – we have a couple of comments – basically, thinking that we've handled these issues in the original discussion and may not have heard things in my – in the comments. So, we receive that are likely to change those views. Does anybody on the committee have a, either want to also speak in support in that point of view or wants to raise an alternative point of view.

(Peter): I'm sorry. I was cut-off for a little bit. So, could you just repeat what (Madie), was agreeing with.

(Jeff Sussman): In brief – I think in brief, I think, it was that the committee on the first round of discussion of these measures considered the evidence of effectiveness of this in hospital interventions then considers the likely generalizability of that evidence. And it is determined that we felt as a committee that the evidenced were strong enough to support these measures and that. That we haven't, we likely haven't heard responses in the public and stakeholder comment that would change that.

(Peter): OK. Thank you very much.

Dodi Kelleher: This is Dodi Kelleher, (inaudible) (Peter) and I support that stand as well.

(Caroline Phillips): This is (Caroline Phillips), so let's start to agree with that as well.

(Mike Laurier): Yes. I would agree with that statement, (Mike Laurier).

Male: Is there anybody that doesn't?

(Peter): Hearing none, that sounds like a consensus, that sense of the committee. Does anybody want to take a last chance to object to that?

Hearing none, (Lorelei), do you have what you need on that question?

(Lauralei Dorian): I do. Thank you, that's great.

(Peter): So shall we next tackle the three sub measures?

(Lauralei Dorian): Yes. Perfect. Thank you.

(Peter): And would the Joint Commission like to summarize their response please?

Celeste Milton: Sure. Thanks, (Peter). This is Celeste again from the Joint Commission. And, basically what we're looking at in support of the three substances measures. Once again, one built upon the other. We're looking first to the screening then if there's unhealthy drinking identified that a brief intervention would occur. And then finally for those patients that are identified as having either substance use or alcohol use disorders that there would be some form of follow up after discharge that could either be prescription for an addiction medication or an addiction referral for ongoing treatment after they have left the hospital.

And, once again this is supported by a Cochrane review that occurred in 2011. Looking at the brief interventions and you know screening for the patients that the hospital actually is an ideal setting because a number of these patients will come in as a result of having an accident, their trauma patients coming into the emergency room will have other illnesses that could be linked to the fact that they do have a situation with alcohol. So, the review basically support what these three measures are setting out to do.

(Peter): So, so the issue – it seems to me that the issues related to this measures are, are conceptually similar to the issue than tobacco ones that we just discussed. Again, they have to do with the evidence or effectiveness of the suite of the intervention. And/or the, the generalizability of that evidence.

And as with the last set of evidence – interventions, these are not new issues and these are issue that the committee spends from time on and the initial deliberation. And so, again, I'd like to have you – I like to open up the four to the committee to see, yes, and to see you know I'm how you feel about these set of comments.

Male: I want to (incur) at the end of your summary. I think essentially we've looked at that data considering the conceptual issue in. And I don't see anything compelling in the comments. (Inaudible), thanks.

(Madie Negell): Nor do I, this is (Madie). I don't think much has changed.

(Lisa Shay): This is – sorry go on. This is (Lisa) and while I know that we did rehash as I do just looking at the comments from the public want to note that I think there seem to be a lot of concerns about it being singled out perhaps in psychiatric hospitals which of course are doing a comprehensive statement plan already under age (bps) one.

And that the idea that or supporting the specifications with the (inaudible) support that is – could be complicated. And I believe the Cochrane review is talking about seizing opportunities from medically ill patients but of course all the patients coming into psychiatric setting are being screened.

(Peter): So, I'm trying to follow your point, are you suggesting because there's already a screening process that somehow there should be exception for psychiatric hospitals?

(Lisa Shay): Well, that I think that putting together the treatment and (inaudible) comprehensive thought process (inaudible) is secondary to the other issues that might (inaudible) the idea of having these intervention in addition to do that (inaudible) getting help might be a burden (inaudible).

(Peter): You're breaking up a little and leaves for me that if you are – please if your not speaking would you please mute your phone.

I got about half of the last comment, so why don't we just the next theme is going to relate specifically to the generalizability of these, of these

interventions to psychiatric hospitals. And so, why don't we take the implementation issue if the – if the gist of this particular comment is about the implementation of – potential implementation issue of these measures (inaudible) hospital let's table that discussion until we've gotten through the effectiveness and generalizability in general hospitals on this theme, is that OK?

(Lisa Shay): Sure.

(Peter): So we've now gotten a couple of comments that suggest that at least two of us think that things – on the effectiveness and generalizability fronts likely haven't changed a lot from the initial committee deliberation are would anybody else like to weigh in on that topic especially if you have no alternative point of view, please.

(Madie Negell): This is (Madie), my alternative point of view is that I would want some assurance given what I know occurs clinically in hospitals – psychiatric hospitals. I would want some assurance that people were being screened for alcohol and drug – alcohol and tobacco use. I don't – I know it's supposed to happen but I haven't been convinced that it does.

(Peter): Other comments?

Male: You know, (inaudible), I think it's – go ahead.

(Peter): All right, yes. I'm sorry. Other comments specifically on the suite of alcohol measures?

(Madie Negell): Do you want to talk about the psychiatric hospital issue or you want to park that at the moment?

(Peter): Let's finish the general discussion on the substance measure first. And then we'll take on the feasibility issues on – in psychiatric hospitals if that make sense.

(Madie Negell): All right. Yes, that sounds good.

(Peter): So, anybody else like to weigh in on the substance measures, please?

(Jeff Sussman): And this (Jeff), the public comments that were made.

(Male): Yes.

(Mike Laurier): OK. Guys, this is (Mike Laurier) and I don't think really much has changed and I would support the measure.

(Peter): So let's give – sounds to me like – it sounds me like the – the sense of the group based on the opinions that are going to expressed are that the public comments haven't likely – haven't greatly changed the sense of the group about these measure from the original committee deliberation – would knew would anybody like the before we call that a consensus, would anybody like to raise a contrary review. We will still talk separately about the feasibility of implementing these measures in psychiatric hospitals specifically.

OK. Hearing none, it sounds to me like on both suites of measures in theme one, the sense of the group is that the public comment hasn't changed the sense of – are sense of these measures and they could continue to be – we can continue to recommend approval, I suppose. (Lorelei), do you need anything else on that theme.

(Lauralei Dorian): No, thanks, Peter. That's perfect.

(Peter): So, and so moving on the theme of the feasibility challenges of addressing these, yes, implementing these measures in psych hospitals in particular, (Harold), would you like that to lead this discussion?

Female: (Harold), are you on the line?

(Harold): Yes. Sorry. I lost you for a minute.

Female: OK.

(Harold): What was the question?

(Peter): So, (Harold), I think we're ready to move on to theme two. And feasibility of implementing these measures specifically in psych hospitals, would you like to lead that piece of the discussion?

(Harold): Sure. So, I guess the issue was that the concern that the endorsement of the measures for using in patients in psychiatric setting saying that the appropriateness of the brief intervention may not – in the setting of such intensive treatment may not necessarily – that the evidence doesn't necessarily support that in that context. And the representatives from the Joint Commission want sort of elaborate on their response.

Celeste Milton: OK. Thank you, (Harold). This is Celeste from the Joint Commission. When we did the initial testing of this measure actually of these measures I should say, they were entirely in one set, there was the tobacco and alcohol measures, the TAM measures. And part of our pilot testing activities, we actually had a psychiatric hospital involved in the testing activity. And so, therefore it is equally appropriate to use in inpatients psychiatric care setting as well as a general hospital.

And in addition to that there's been a recent study at least for tobacco intervention. (Inaudible) did a study 2013, it was a randomized trial looking at tobacco cessation interventions and specifically a psychiatric care setting and really found that there was no – nothing different in doing it in that setting versus in the general setting.

And the big thing of course would be that most of the patients with psychiatric illnesses tend to have heavier tobacco use than the general population. So it really is an area of concern that these patients receive the screening and interventions as appropriate.

Male: Discussions on the committee.

(Lisa Shay): This is (Lisa) again, so regarding the tobacco, I think the issue that maybe is raised is not necessarily doing the screening or even offering interventions in the hospital but have to do with the referral to an evidence that based outpatient program afterwards. I don't what out there rest of the country but I

can tell you in the area where we are that would be a hard process to find that would be, you know, accepting people on a regular basis that weren't participating in research.

So, that would be – that could possibly be an issue. I don't necessarily have that issue with the screening piece. And I will re-iterate regarding the sub measures that I think in hospital setting that people are actually are receiving intensive treatment targeting their mental health issues as well as their addictions. And it's already being measured under age (bps) one in terms of doing that screening and incorporating it in the treatment plan.

(Harold): Other comments?

(Florenda Cultry): Hi, this is (Florenda Cultry). I absolutely agree. I think it is very important to screen and raise these issues but the expectations for referral for outpatient treatment. I think is, you know, very, very difficult to do that with limited options.

The other issue frankly is that most people who are screened are not going to be ready to engage in, you know, that level of out patient treatment. Most people may say yes but they're not going to follow up and they're not going to engage. They're just not at that level of readiness to change.

So, I think that we want to definitely raise the issue and put our focus on that but recognize that just because we asked the question doesn't mean that even half the people are going to want to make that behavioral change at that moment and to make that responsibility on the psych unit or the inpatient setting, I think not quite sure what we would get from that, you know, in terms of outcomes.

(Jeff Sussman): I never encountered a point of view, this is (Jeff Sussman), I think that we should be encouraging our psyche units to have an equal investment in smoking and alcohol cessation. The follow up on an outpatient basis is extremely important. If you look at particularly for psychiatric disorders one of the more common, perhaps the most common morbidity medically is cardiovascular disease.

(Harold): Yes.

(Jeff Sussman): And that we should be aiming for system improvements that allow one to really get a – hold on more effective multi-focal intervention. So, while I understand there's a lot areas for lack of adherence and a lot of issues, you know, if we benchmark one institution versus another, I suspect there are some institutions that do it a lot of better than others with equal severity in types of patient. So, I'm speaking in favor of keeping this.

(Mike Laurier): This is (Mike Laurier). I would echo that and be in favor of keeping this measure especially if we're looking to coordinate care. Whether you're in a psychiatric hospital, whether you're in medical facility, when you leave those facilities have a responsibility to reach out and ensure that care is coordinated.

So this is just another step and if they do the intervention, make the referral and on the smoking, I didn't see an evidence-based smoking cessation program at the smoking associations. So, to coordinate with their primary care provider and have that and what should become a longitudinal care plan for that person when they live whatever setting, I think it's important to keep it there so it follows the person as they move forward.

(Peter): This is (Peter). On the tobacco side, at least that it strikes me that – so the comments were sort of lumped around pose tobacco and substance abuse, it strikes me that on the tobacco side, at least the availability of evidence-based treatment doesn't raise the same issues and so if there are folks – (inaudible) if quit lines and meds are available essentially everywhere, and so, OK, if these people have issues with availability of substance abuse treatment. I wouldn't lump that together with tobacco where the issues are probably different.

Female: That might be true, (Peter), but I think quit lines are specifically excluded from the measure as a referral option for the tobacco.

(Liz): This is (Liz) with Joint Commission. I know actually quit lines are one of the referral sources.

(Harold): Other comments?

Male: I think in the more and more as we're looking at the integrated care, the assessment that we should be working holistically. And let's say the data come out with only 5 percent of the patients, are referred appropriately against benchmark or improvement down the line. I expect some people have a secret sauce and others don't in this regard. And that we should be encouraging that improvement.

Male: And certainly the burden of these issues in psyche facilities is very high.

Male: Yes, I guess the question, one question I had is that the objection is raised in terms of it being less applicable in inpatient psychiatric settings or at least, and I'm not sure I understand that argument.

Male: I think the argument would be something around competing demands that you know, there's so much going on in the typical psychiatric patient's life, that you know, to asking them to quit smoking and could alcohol which …

Male: That's not …

(Crosstalk)

Male: That's not acceptable.

Male: I'm just raising – what I am seeing in the issue, maybe I'm not fully comprehending it.

Male: Yes.

(Peter): Yes, I heard it that way too, (Harold). I heard, this is (Peter). Essentially, the main concern seemed to be a feasibility concerns of a variety of kinds, either competing measure or just competing needs or lack of referral facilities or some combination of that.

Male: Well I guess my question. Maybe somehow explain – explain it but I don't see how that's different in the psychiatric settings, I mean the competing issues for somebody coming out with that, you know, co-morbidity of heart decease and renal disease and other kinds of things, they have a lot of competing issues also.

Male: Right.

Male: I think I agree totally.

(Caroline): This is (Caroline), I would weigh in that. I'm supportive continuing these measures. Some of the competing other measure are NCQA seven days and 30 days follow up. And I would think this work hand in hand very well together because the addiction issues can be addressed with those visits. I don't think there's any reason to focus in that psychiatric hospitals are inappropriate.

Female: I agree with that.

Female: (Inaudible), I agree with that as well.

(Peter): This is (Peter) taking off my chair, I think I kind of agree with that too.

Male: So is there – is there anybody that wants to speak in favor of not including these, not recommending these measures? OK, so I guess that's the decision, consensus. So should we move to theme 3?

(Peter): Yes.

(Harold): So this was an issue we raised about the reliability of this sub one measure that we have all the agreement rate and this agreement rate for alcohol use that is – was a concern. Does the measure developer want to respond?

Celeste Milton: Hi, thank you again. This is Celeste Joint Commission. I think during our discussions that we had on the call, we did note that the overall measure agreement rate was 75 percent at the threshold of an acceptable agreement rate. The one data element in question, part of it really had to do with whether the screen – the prescreening question do use you alcohol and if yes, in the past month, if you're male, have you had five or more drinks on one occasion or female? Four or more drinks on one occasion would be considered a validated tool and there is some confusion on whether it was validated or non-validated if you were asking that prescreening question, we since put

additional guidance in the note for abstraction. We've made it very clear that those can be used as the first step. And then if there is a positive response for the second prescreening question, then you would go and actually use one of the listed validated tools.

(Dan): Comments from the committee?

Female: Really it sounds like that issue was then addressed.

(Florenda Cultry): Yes. This is – this is (Florenda), this is exactly the methodology that we used clinically in a 53-site system and it works very smoothly and very well.

So I would certainly be …

(Dan): Sounds good to me. I would be in favor of the assessment.

(Peter): And certainly, this is (Peter), the reliability of the measure, this is something that we certainly talked about the first time through this and so this is another issue that strikes me as not having really raised new substantive issues that the committee hasn't already addressed.

(Harold): Anybody who want to speak against retaining the recommendation for endorsement?

So I guess we have a consensus.

(Lauralei Dorian): Great. (Harold), I was thinking before we move on to the rest of the comments. We might open the call up for public comment now.

(Harold): Sure.

(Lauralei Dorian): So, operator, will you see if anybody is on the line who would like to make a public comment. And everybody's line should be open.

Operator: Yes, at this time, if you would like to make a public comment, please press star 1.

There are no public comments at this time.

(Lauralei Dorian): OK, great. Thank you. We can move on to the last (inaudible).

(Harold): This is – these are issues around supports for measures not recommended. Is that correct?

(Lauralei Dorian): That's correct.

(Harold): And the first one was for adult major depressive disorder. And, apparently, a comment there is suggested that the committee recommend for endorsement the adult major depressive disorder expressing the belief that by ensuring accurate diagnosis, the value of assessment, it could lead to improvement. As I recall, this is something we had fairly extensive discussions about.

(Madie Nagell): I can't quite – this is (Madie). I can't quite understand that. They really said a belief. Is that correct? That by ensuring accurate diagnosis, you could get improvement? Which are no evidence? I guess not.

Male: But I think a really extensive evidence that diagnosis alone is not a very effective …

(Madie Nagell): Right.

Male: … intervention.

(Harold): And this was the discussion we had.

(Madie Nagell): Yes.

Male: Yes, it is.

(Madie Nagell): Right.

(Harold): Is there anything new here?

Male: I don't think there is anything new to answer your question, (Harold), I think hold this territory pretty extensively and I don't see anything compelling.

(Harold): OK. Any discussion from the committee considering this measure?

OK. The next one was (Inaudible) which was focus on people being discharge on multiple anti-psychotic medications. And as you recall, the feeling that this measure did not stand on its own because looked at alone, there was relatively little that a provider could do about it given the short length of stay. And really the – it was really used as a denominator for the more important measure of, you know, people that were discharged. We checked – on multiple anti-psychotics with (classification).

Anybody that wants to speak in favor of retaining that measure?

I assume that there's a consensus that we would, you know, not change if you see a failure to achieve endorsement status.

Male: OK.

(Harold): OK. And then the last one is the tobacco use measure in terms of the setting status after discharge. And, apparently, one commentator suggest that the measure could be strengthen by connecting post-discharge tobacco or substance status with documentation that the patient has received follow-up treatment.

Sure, exactly, you know, was there anything beyond that in terms of understanding exactly what they're talking about, (Angela) or (Lorelei)?

Female: Sorry, could you repeat that last part?

(Harold): I wasn't sure exactly what they where proposing in this objection.

Female: I think it was those people who where unhappy with the fact that it was not recommended, so they just wanted to bring that to committee's attention.

(Harold): OK. But there was no additional data or information provided?

Female: Correct.

(Harold): Anybody want to speak in favor of retaining this as an endorsed measure?

So, hearing that, I assume there's consensus to continue our non-endorsement. Are there any other issues that anybody on the committee wants to bring up? Is it time now to hear from any public comments?

Female: Yes, exactly. Operator, are you able to check for public comments, please (inaudible)?

Operator: If you would like to make a comment, please press star 1 now.

Female: All right, well, it sounds like there are no public comments. So, that was good, we finished quite a bit early.

Male: I very much appreciate everybody's blinding efficiency. Thank you very much.

Female: Yes. So, I just wanted to go over a few of the next steps. We are opening this report up for member voting on November 19 and that'll go through December 6. We're expecting to take your recommendations to the (ESAC) on the December 10th and have board endorsement by January.

And then I did mention this on an e-mail, but I wanted to remind you again that we have received funding for our third phase of this project which is pretty exciting, but there's plenty of time to give you a break.

We do have a call for nominations. It's already open, but it actually doesn't close until June of next year. And we have a call for measures assessment as well, and that doesn't close until July. So, we actually won't be convening anybody until midway through 2014.

But I did want to note, again, that NQF is moving (ceding) standing committees. And so we will all – everybody who's seated on the committee will have to submit a new nomination form. And all of that information is online and I'll be sure to send out the material to you as well via e-mail. But I would highly encourage all of you to submit a nomination. You've been a great committee to work with. And thank you, especially to (Harold) and (Peter) on the call today. Thank you for leading it so efficiently.

(Harold): One quick question. Is there any like specific priorities in the phase three that are being focused on?

Female: There (aren't), we have a number of maintenance measures, but we actually – in the call for measures, we listed the areas that you had suggested for gap areas when you met in person. But other than that …

Helen Burstin: Yes. And, (Harold), this is Helen. Just one thing to add, since we have a fairly significant lag before this next project begins, it'd be a great opportunity for those on the committee to really help us go out there and prospect if there are some good measures perhaps in use, the health systems or plans or others that might be appropriate to bring forward because I think there are some specific gap areas that we should be really picking measures up and please let us know, we've got a good amount of time to get that pre-worked on. And we would love to round the portfolio and it's such a, you know, such an important space.

Dodi Kelleher: This is Dodi Kelleher. I don't have a specific developer or a measure in mind, but I sure would love to see more outcomes measure.

Female: Yes.

(Harold): And I think it's just terrific that you're doing it with so much time to let people actually respond and think about what can be put together. You know, so especially (that's) a rush thing.

Female: Right, exactly.

Female: Good work everybody.

Female: Yes. Are there any other questions?

(Harold): Well, thank you all and thanks, of course, to the staff of NQF for being so helpful in this.

Female: Thank you, yes.

(Peter): Thanks everybody, this was great.

Female: We'll be in touch.

Male: Bye-bye.

Male: OK. Bye-bye.

Operator: Ladies and gentlemen, this concludes the call. You may now disconnect.

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