NATIONAL QUALITY FORUM

Moderator: Angela Franklin
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1:00 pm CT

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Female: Okay, hi, all. Welcome to the behavorial health steering committee, work group call #3, and we'll - we're going to be walking through several NCQA measures, and we'll go - related to schizophrenia as well as one CMS ((inaudible)) schizophrenia, and the process for today's call is that we'll get from the work group our preliminary evaluations of each of the measures.

Each of you was assigned a measure and to serve as lead discussant and what we'd like from you as lead discussant is to start off our discussion of the measure just discussing your highlights of the measure going through the four criteria. When you're completed, we'll throw it up to ((inaudible)) we'll throw it up into the rest of the group.

And also we have measure developers on the line from both NCQA and I believe the Florida QIO to discuss their measures. So if we feel like you want to ask them a question, feel free to do so at any time.

So with that said, I'd like to go through quickly a quick roll call. Carlene Phillips?

Carlene Phillips: Yes, I'm here.

Female: Nancy Hanrahan? Bonnie Zima? Mark Wolraich? Lisa Shea?

Lisa Shea: Yes, I'm here.

Female: Harold Pincus? (Dody Kelleher)?

(Dody Kelleher): Here.

Female: Parinda Kajtri?

Parinda Kajtri: Here.

Female: (David Mancuso) said he could not join us, so he's not on. Leslie Zun?

Dr. Leslie Zun: Here.

Female: Thank you. And all right, so at that point we'll go ahead and start with our first measures, and Dr. Zun, I believe you're the lead discussant for #1938, ED utilization for mental health conditions by people with schizophrenia, and that is an NCQA measure.

Dr. Leslie Zun: Yes, and I'm not exactly sure of the protocol to present this, but I'll do my best, and perhaps if you guys want to help fill me in, that would be great. I'm going to go through each of the four criteria, but I'm going to give a little bit of background first. So this is a measure for individuals 25 to 64 years of age with schizophrenia diagnosis who have an emergency department admission for mental health.

So it's a mental health admission from the emergency department, only adults that are being looked at here, so if we look at the first item, which is impact, opportunity, evidence, importance to measure, and report, I'll try to go through this again briefly, but giving a little bit of background. So it appears that people with schizophrenia use the emergency department at a high rate and we're not exactly sure why. They do have higher rates of medical comorbidities and early mortality.

So that's really the importance here. The opportunity for improvement, 1B is since patients with schizophrenia are at increased risk for bad health outcomes, primarily because of their increased medical comorbidities, they have higher rates of emergency department usage. So now I'm going to go onto the - let's see - 2, item 2, which is reliability, validity, scientific acceptability of measure properties.

And so here, we're looking at numerators and denominators. The numerator would be the admission to an emergency department with a mental health diagnosis during a - the measurement year. The denominator would be Medicaid beneficiaries, if I read this correctly, Medicare beneficiaries - Medicaid beneficiaries between 25 and 64 of the measured year.

And then we're looking at two separate claims of schizophrenia as primary diagnosis, or one inpatient claim with schizophrenia as a primary diagnosis and a prescription for antipsychotic in the measurement year, ten months of continuous enrollment in the measurement year. Now if we go to - I'm not sure how much detail, so I'm kind of just skimming over this, as you can imagine, because there's a lot more here than I'm going through.

Female: That's fine.

Dr. Leslie Zun: Okay. So item #3 is usability. Here, the issue is really that the usability is - this would apply to state Medicaid programs and evaluation of the state Medicaid programs. The fourth is

feasibility, so here we're looking at the validity and reliability of the measurement of the rate of admission and readmission, and this is going to be looked at through the 22-state Medicaid analytical - analytic extract data files.

And there is reliability and validity associated with that, and the fifth item - you only mentioned four, but I thought we were looking at all five. So I'll mention that as comparison to related and competing measures. Now here it says not that there are no other measures, although I thought we went through in the list - there's no current measures, but I think there's some proposed measures that may be related to this topic as well. Now do I get to give a commentary?

Female: Yes, please do so. Yes, please, and we'll get into - we'll discuss each section in more detail as we get into large group discussion, but give your summary.

Dr. Leslie Zun: Well, the problem that I have with this measure - or my concern with this measure is, unless we look at available resources for patients with schizophrenia in each state, it's going to be really hard to use this measure as any kind of quality measure, because if the state Medicaid program does not support, for instance, outpatient treatment or outpatient visits or medication prescriptions, then how - they use the emergency department because they have nowhere else to go, so unless there's some associated measure of resource availability for these patients, I think that it's hard just to look at one isolated component, and that's my summary to the best of my ability at this time.

(Adam): Great. Thank you. At this point, we're going to pull up the evaluations you all submitted. So we received four evaluations for this measure, I'm sure some of the things that you highlighted, Dr. Zun, will be covered in these evaluations here. So we'll go through here.

We were split two to two on importance, so you can see from the comments, small sample size, but we were - there was a range for each of the subcriteria between high to insufficient. Moving onto the scientific acceptability...

Female: Before we move onto scientific acceptability, does anyone else from the larger work group want to comment on the importance to measure and report for this particular topic area, within your review? Did anyone see anything that raised an issue or anything that you wanted to bring up to the measure developers?

As we mentioned in the emails, the importance to measure and report and scientific acceptability are both must-task criterion, so just before moving on, were there any other comments about the importance criterion?

Dr. Leslie Zun: Yes, I want to mention something else, too, for importance. The high impact that's mentioned here and the importance of it is related to the medical comorbidity and early mortality for these people. But nothing in this measure either measures that, measures the, you know, the incidents, the treatment, or the effect of the measure at all related to medical comorbidity, so I had trouble connecting the dots here.

Lisa Shea: Yes, this is Lisa. I think that's what led me to ((inaudible)). I thought that there was insufficient evidence presented here for the opportunity for improvement, because it was unclear how to connect the dots. Well said.

Carlene Phillips: This is Carlene and I appreciate what Leslie and Lisa said, because this is my first time doing measures, so that was my question on just about every one of them, I'll tell you. What are they going to do with the information? Yes they do - they are high utilizers of emergency departments, but how does that - what is that going to change by measuring? So I appreciate your comments.

Female: Is there - does someone from NCQA want to speak to that?

(Jeremy Gottlidge): This is (Jeremy Gottlidge) at NCQA. We had - we do have other measures in the schizophrenia set that do look at really more effectiveness of care and these measures were submitted to really just look at access and utilization, so it's - it would really be up to the user to look at the rates and decide how best to improve those rates. And so it really is a process measure.

Female: So the user would be the insurance company, Medicaid?

(Jeremy Gottlidge): For these measures, they are for Medicaid state reporting, so not the health plans.

(Adam): Great. Thank you for clarifying that. Do we have any other comments about the importance criteria?

Nancy Hanrahan: This is Nancy Hanrahan. I would like to ditto that. The concern I have at this being a measure of quality, the connection between measuring the utilization of emergency room visits by people with mental illness, serious mental illness in particular, is so fraught with you know, community and network kinds of variables. I'm not sure that you - if you did some kind of risk adjustment for all those particular variables, that would be one thing, but I just don't really see this as a measure, a quality measure.

(Adam): Great. Any other comments?

Female: From - any other comments from the committee or the developer on this piece of the measure? Okay.

(Adam): Okay, we'll move on to scientific acceptability. Here again, we were split two and two. We had three high, one moderate for the - for reliability, and then for validity, we had two high and two insufficient. Do we want to - any comments about that?

Female: Particularly around the reliability and validity testing - if you found it to be sufficient, if you found any strengths or weaknesses, now would be the time to bring that up.

Dr. Leslie Zun: Well, this is Les. As far as the reliability, I'm just so - the numerator and denominator is - I look at these as very problematic. So for the numerator we're looking at admissions to an emergency department with a mental health diagnosis, and then the denominator is a little confusing to me. Is that all Medicaid beneficiaries 25 to 64, or is that two separate claims, or 10 months of continuous enrollment, or all of the above?

Female: Is there a response from the developer?

(Jeremy Gottlidge): This is (Jeremy). It's all of the above. We've looked for people with schizophrenia within the age group. They have to be a Medicaid beneficiary, and then for stability of diagnosis, that's why we specify the number of visits in an outpatient setting or an inpatient setting that you're required to have to be in the denominator. So inpatient setting you're required to have one diagnosis for schizophrenia, a primary diagnosis. And then for any outpatient setting, we require two diagnoses - or in fact, two visits, each with a diagnosis.

Dr. Leslie Zun: So and my question is again going back to the principle here. We're saying they have higher morbidity and medical comorbidities, but we're not using medical comorbidities at all in the numerator or denominator.

Lisa Shea: Right. That was my concern as well. You know, this is ((inaudible)). If you look at just the comorbidities with people who have schizophrenia, they may go to the emergency room for blood

pressure, you know, other kind of cardiovascular disease, and we have many, you know, fully controlled, you know, patients with poorly controlled disease. How are you going to capture that? And those are the contributing factors to the high mortality.

Female: Any other comments about that, discussion about that?

Nancy Hanrahan: This is Nancy Hanrahan. I'd just like to maybe hear from the people that submitted this and their thinking about why they chose this particular measure, you know, the measure of how long they stay in the ED and whether they, you know, get admitted as an example of, to me, a quality issue. The actual attendance to the emergency department for a particular problem - I think that that is - that's less clear.

(Jeremy Gottlidge): This is (Jeremy).

Sarah Scholle: ((inaudible)) from NCQA.

(Jeremy Gottlidge): Okay.

Sarah Scholle: I just wanted to give you a little bit of insight into our - the technical advisory group that worked with us to develop this measure. They thought this was an important indicator of poor outpatient care for people with schizophrenia, and the - our reliability and validity testing showed that it was related to other poor outcomes like inpatient care, etcetera.

So they felt like this was an indicator of poor access to care that would lead to - and a poor outcome. And that's why they wanted us to include this in this suite of measures, and as you can see it's one of several different kinds of measures that we looked at that address like, pharmacology, addressing physical health needs and other issues for people with schizophrenia. So they saw this as being part of a suite of measures.

We wanted to keep the denominator as broad as possible, because it was - is based on claims data, and so we're looking just at people who have schizophrenia. We're concerned about how we would identify people with certain kinds of comorbidities, and we knew that these comorbidities were common, but instead we felt like that the panel recommended that we keep it this broad definition of people with schizophrenia. And I'll ask my colleagues - we're all in different places from NCQA today, so I don't know if either of my colleagues on the call has anything else to add.

(Jeremy Gottlidge): No, I think that was a good summary, Sarah.

Female: Any other comments from the steering committee?

Lisa Shea: Yes, this is Lisa Shea. I just had a question about the validity because there is a heavy reliance on the space of validity. And I understand there was this tag, but it would be helpful to have more details about how the people felt versus just saying that they agreed with it. It leaves me not really knowing how much did they agree with it, the way that that was determined and so forth.

Sarah Scholle: So maybe what I could do is just describe the process that we used, because we don't - would that be helpful?

Lisa Shea: Yes.

Sarah Scholle: Okay, so this - these measures and this applies to the entire suite of measures that you can review from NCQA today. These were developed under a contract with - from the federal assistant secretary for planning and evaluation, and we were asked to develop the ((inaudible))

measures for Medicaid for states to use to evaluate Medicaid's programs, and we were asked to use claims data only to ensure that these measures would be easily feasible within the states.

So our first step was to develop - to conduct a review of the evidence and the existing measures to identify priority areas. We were asked to develop measures that addressed pharmacology or use of medications, use of psychosocial services, and physical concerns for people with schizophrenia. We're not presenting any measures of psychosocial treatments because we could not find reliable and valid ways to measure those in Medicaid claims data.

So we're focusing on measures that get it - access and medication needs, or screening and monitoring of cardiovascular disease and diabetes. So that's the suite of measures that are presented to you today and other health issues. We - after the evidence review involved a broad review of evidence, we presented that to our technical advisory group. The advisory group included representatives of multiple stakeholders including states and psychiatrists and other kinds of providers, and consumers and we asked the group to prioritize all the number of issues.

So we started off I think with about 30 topics, measure topics, and ended up with the ones that we're presenting to you are the ones that made it all the way through our process of evidence review, public comments, review by a variety of stakeholders including state Medicaid directors, state mental health and substance abuse directors, and managed health care plan directors.

So we've put a lot of public input into the feasibility and usability of the measures. And then we tested the data. All the measures were tested in the Medicaid analytic extract process, which is I think we're about 20 states that had data that we could use to look at the experience that the people with schizophrenia. So the denominator as you'll see, we tested alternatives for how to define the denominators and received some different denominators, but it's based on this age of the definition of schizophrenia that you see there.

And some of the measures apply to people with bipolar as well. So we reviewed all the specifications with all the different groups that I mentioned there, and what you're - and so you're - we did not have formal testing or quantitative where we counted up and rated the measures, so on specific criteria, but we asked for our panel to think about first - the first step was looking at the evidence space after they said these are measures that have sufficient evidence.

We've looked to see - we've tried to develop specifications and then we tested those, and some measures we couldn't develop specifications, so things dropped out along that process, and that's why - but it ended up with those five measures that you have in front of you are the ones that count, that met the - and our public comments showed that these met sufficient criteria for important evidence-based feasibility and usability.

(Adam): Great, thank you. Are there other comments? I know we're running a little short on time for this measure. We have a lot of measures to...

Dr. Harold Pincus: This is Harold Pincus. Can you hear me?

(Adam): Yes.

Female: Yes.

Dr. Harold Pincus: Okay, I got on late, and then for the longest time I was muted. Nobody could hear - for some reason it wouldn't work.

(Adam): Well, sorry about that. We're glad you're here.

Dr. Harold Pincus: But one question I had has to do with a number of these seem to have been developed for specific purposes, for example for state reporting on Medicaid. But it's my

understanding that once it's endorsed by NQF, it's, you know, potentially can be applied to many other purposes.

Female: That's correct.

Dr. Harold Pincus: So one question is how do we evaluate the use of these measures beyond the very specific purpose that is described in the measure submission worksheet?

Angela Franklin: Well - this is Angela - you'll be looking at the feasibility for, as you just said, broader use of the measure, so that'll be part of your evaluation, how it can be used by a broader group.

Dr. Harold Pincus: Okay.

(Adam): At the specified level of analysis.

Angela Franklin: So that you're...

Dr. Harold Pincus: Wait a minute, so that means at a state level rather than for example at a plan level?

Angela Franklin: Well the measure was specified I believe at state level, is that correct?

Female: Yes, I think that's right.

Dr. Harold Pincus: Okay, because that was not clear that that's actually - that because at least in my experience these measures then get applied, even though it's intended to be at a state level, it often gets applied at a plan level.

Angela Franklin: Well right now we're just looking at the measure before us and how it was specified and tested, because we can only really - we can only endorse what the measure is specified for, so if someone does take it up and use it for a different purpose, it really wouldn't be based off the NQF. We're just basically recommending it for use at the state level.

Dr. Harold Pincus: Okay, because that was not clear at all in terms of how one sort of reviews the evidence.

(Adam): Yes, and this is since - you have to check to whether or not the evidence supports use at a state level, and any other use beyond that is - would that - is outside of the scope of this measure. Okay, so let's wrap this up here now. So I'm sorry, was there another comment?

Female: Yes, just a clarification. There are what's called noms at the state level now, which is data that can be collected at state level and is probably used by Medicaid to do something around quality I suspect. And those measures were not - did not come through NQF. I think they came through an initiative that was from SAMSA, and there's some tie-in to those data which are fed into - from the state into SAMSA to some agreement they have about getting that data.

And there are some states that do it well. I think there are about 20 of them that do it well, and most others don't. So the question here for me is a clarification, is if we accept an NQF measure, and it's clear that it's at the state level that we're - that this measurement is occurring, it's - is there a purpose in that, that does better than the SAMSA measures do or does it matter?

(Adam): For our purposes it doesn't matter.

Female: Okay.

(Adam): It - we're just endorsing the measures and then beyond us endorsing them, however it's used is up to the user, the discretion of the user.

Female: Okay. That's helpful. Thanks.

(Adam): Okay. Yes, so here, let's go over the - we just discussed this, but the usability and feasibility ratings here. We had a moderate for reliability and validity with one insufficient, and not surprisingly a moderate overall rating for usability. We had a moderate overall rating for feasibility, and then for suitable for endorsement it was split two to two.

So again, we have a small sample size here, but it shows a split within the committee, and this will be - this is a very good discussion. It'll be a good starting point for the in-person meeting for this measure. Do we have any final comments before we move on to the next measure? Great. All right, the next step we have, 1937...

Dr. Harold Pincus: Hi, this is Harold.

(Adam): Yes.

Dr. Harold Pincus: Just one - I might have missed this discussion point, but one thing just to lay out as an issue is the extent to which, you know, under certain circumstances you want to encourage emergency department visits.

Female: Now is that a question for the developers, so you're asking?

Dr. Harold Pincus: Yes, well, I guess it's a question sort of conceptually related to the measure.

Female: Okay, so that's something the developer would have to speak to. I...

(Adam): Do we have any comments on that?

Sarah Scholle: Harold, what do you mean? This is Sarah Scholle.

Dr. Harold Pincus: Yes, you know, if somebody is sort of, you know, is having significant symptoms, you might, you know - it's part of the rescue plan which you develop, you know, with a patient might very well be that - for them to come to the emergency room.

Sarah Scholle: Okay, so - right, so this measure is not - may not 100% - may not be the ideal performance rates or 0%, I would say, let's just say, should not be the ideal performance rate on this measure. And there could be times when an emergency room visit is appropriate care, but the thinking behind the measure is that emergency room visits are generally a failure of the outpatient system.

And being able to compare states at a state population level, if you had higher performance - higher emergency room visits in one state compared to another, that would signal a problem at the state level in access to care, and so it would, you know, get you to thinking that there's - that that is a state that needs to invest more in its outpatient services.

I think that was kind of the argument for this, a way to compare states to other states in availability of services and the use of the ED visit, and see the ED visits as a poor outcome.

Dr. Leslie Zun: This is Les. I think that's an appropriate measure, but that's not what the proposal said. The proposal clearly said about the issue about higher morbidity and mortality and that kind of - so I would say that my recommendation is that this needs to be reframed appropriately for what you're trying to accomplish, because that's not what it says to me.

Sarah Scholle: Okay, thank you.

Dr. Leslie Zun: Yes.

Female: Just in the interest of time, we were able to capture a lot of these issues. We'll be sure to - we're going to write up a summary as staff, and we'll be sure to go back over this during the in-person meeting. But just in the interest of time, I think it would be best now to move on to the next measure, which is 1937, follow-up after hospitalization for schizophrenia, and I believe (Herinda) and (David Mancuso), you - those are the primary reviewers for this measure. (Herinda), did you want to give us a brief overview of any issues?

Parinda Kajtri: Well, did you want to give me - want me to give a brief overview of the measure, or just any issues?

Female: A brief overview of the measure, if you could go through each of the criteria and give your comments as well, and then we'll open each - at that point we'll open it for discussion by the group.

Parinda Kajtri: Sure, and I will make this brief. I know everyone has reviewed this and has a copy in front of them. The measure title is follow-up after hospitalization for schizophrenia, and they're looking at seven and 30-day follow-up. In terms of importance to measure, impact opportunity, the first criteria, less than half of patients with a diagnosis of schizophrenia keep their initial appointments following psychiatric hospitalization, so it's a significant concern if you're trying to provide rapid treatment on an outpatient basis, follow-ups to inpatient hospitalization, and most people, you know, certainly over half don't show up.

So you know, clearly in terms of importance to measure and track, there is this consistent national trend. In terms of the reliability and validity under, you know, number two, the numerator

statement, is you know, all patients with a diagnosis of schizophrenia who have - are hospitalized and then had an outpatient visit, you know, within seven days, and then within 30 days of the visit.

(Adam): Great. As you know - any concerns about any of the four criteria, major criteria?

Parinda Kajtri: Well, I think it's, you know, I just wanted to - I feel like what we've said before in terms of their, you know, many - it's multifactorial, you know, with the different contributing issues in terms of whether or not people come. People don't show up for follow-ups for a variety of reasons. A significant one is a resource issue, but there are a number of social issues, and you know, other issues that play a role in whether or not people are able to make their follow-up visits.

So you know, that's, you know, that's certainly one, and then the second one is, you know, how will this be used, and can it be used really for quality to help promote, you know, access to better resources and care to improve the quality of care, you know, provided to people with schizophrenia after hospitalization.

The other question I had, and this may be minor, but if you look under the denominator, they look at ages 24 - 25 to 64 in the initial brief description, and then later on in a detailed description they say no upper age limit, so I was a bit confused by that.

(Crosstalk)

Parinda Kajtri: If you look at two...

(Adam): Oh, go ahead.

Parinda Kajtri: No, it's under 2A1.7, denominator details.

(Melesh): Hi, this is (Melesh) ((inaudible)). That's actually - the no upper age limits in there, so the measure is original 25 to 64.

Female: Okay, that's something we might need to have you fix before the in-person meeting if that's possible.

(Melesh): Sure.

(Adam): Great. So thank you for the overview. That was very helpful. Now I think we'll - in the interest of time, we'll go over the ratings, and maybe we can get some discussion out of the ratings here. So we'll start with criteria one, so here we have it passed four to one, and we have the importance for the high impact, we have the ((inaudible)) is high, five to one. And then moving into the evidence criteria here, excuse me, we have a few toward moderate to low, and some insufficients.

So I was wondering if anyone had any comments about that or wanted to raise that as an issue. Okay, so I'll move on to scientific acceptability then. Here we had again a few toward moderate to low, much we had a range here, and then for the overall it passed four to two. Do we have any concerns about the reliability and validity?

Okay, moving on to usability and feasibility. So here we've skewed more towards - definitely skewed towards moderate. We had one high and five moderate for usability overall, and we had four moderate and two high for the feasibility. Did anyone want to raise any concerns about the usability and feasibility of this measure?

And again, just if you go back to our previous discussion again, this was specified for the state level, so that again you're looking at it at the state level, and that's where we specified for - it'll be up to the user to make sure that they follow these specifications.

Male: Now isn't there a very similar measure at the plan level?

(Adam): We could check. Is there?

(Melesh): This is (Melesh) with NCQA. Yes, there is a similar measure in here, and generally the differences are for the one in ((inaudible)), it's specified for all product lines, and it's follow up for hospitalization for mental illness, and the age ranges are different. The ((inaudible)) measure is six and older.

(Adam): Okay, and that's the - actually we'll be discussing that one next. That's the 0576.

Female: So maybe I'm jumping the gun here, but I was wondering if there was any way to harmonize these - the two measures.

Dr. Leslie Zun: Yes, that's exactly what I was thinking.

(Adam): Yes, that'll be a discussion at the in-person meeting. We'll be putting together processions. We'll be putting together a side-by-side comparison of the measures and we'll have the discussion and we'll need to make sure that the - that a big focus now at NQF is that we have a lot of measures endorsed, but now we want to make sure that we are choosing the best in class and harmonizing to make it as easy as possible for the users to collect this data.

Female: Okay.

Male: So you will be harmonizing all measures that are sort of near neighbors to this?

(Adam): Yes, that's - are related and competing. That was meant - it's a part of this mission form, but again we'll be going through the measures for both measures that are being proposed, the new proposed measures, and measures that are for maintenance as well as previously endorsed measures.

Female: And part of the process is we want to make sure we get through each measure and each measure stands on its own. If they are recommended for endorsement, that's when the harmonization occurs. So we do that at the in-person meeting.

Male: Okay, but it would be good for the agenda to kind of lump those things together.

(Adam): Yes, they will be together during the in-person meeting. We're actually just finalizing the agenda for the in-person meeting, and that'll be included on there, which measures are being considered for related or repeating, or for - for the interest of time for these, we - we haven't proved them that way.

Female: Right.

(Adam): We just need to - want to make sure that we evaluate each measure on its own merits, and then we'll be discussing the related and competing issues at the in-person meeting, and possibly if we don't have time to really cover all the issues we'll be scheduling workgroup calls after the in-person meeting to really cover those issues.

Female: Also prior to that meeting you'll be getting a side-by-side comparison to review so you'll have that top of mind when you go into the meeting.

(Adam): And that should go out late this week.

Female: Just another point of clarification, what does it mean by the measurement year?

Female: Could someone from NCQA speak to that time window?

(Melesh): Yes, so that's a 12-month period. Typically for ((inaudible)) measures, it's January 1st through December, end of December.

Female: Okay, so it's a 12-month, 365-day time frame.

Sarah Scholle: Right. It's framed that way so that depending on how people implement it, they could either implement a measurement year, a calendar year, or they could - the fiscal year, depending on how their datas are.

Female: Thank you.

(Adam): Great. Okay, so then, just to wrap up this one was suitable for endorsement by a five to one margin, according to the workgroup evaluations. So again, we'll be using these evaluations as a starting point for the in-person meeting, as well as the summary of the discussion from these measures, and something we didn't mention before, if you - if this discussion here in the workgroup call has changed your mind about any of these evaluations, feel free to go back into the survey tool and submit an updated evaluation.

And then we'll make sure we have the most up-to-date evaluations for the in-person meeting, and we'll have a deadline of that of Friday. And we'll send out a reminder of that, but that was a big discussion there on 1937. So we'll move on again to the next one, which is 0576, unless there are any additional questions about 1937.

Lisa Shea: I did have a...

(Adam): Yes?

Lisa Shea: Yes, but the concurrent validity - I was just wondering if that was statistically significant, that - the beneficiaries in the lowest performing states had higher related hospitalizations, 19.4%, 19.3%, versus the higher performing states. But it - I didn't see evidence that you know, that that, you know, is that statistically significant or not. That was my question.

(Adam): Okay, can anybody speak to that?

Sarah Scholle: We're looking up the results right now to see if there's anything to that.

(Adam): Yes, I think it's up on the screen here. We have the - is that what we were discussing, the concurrent validity right there?

Sarah Scholle: Okay, why don't we get back to you with that answer?

Lisa Shea: Okay, thank you.

(Adam): Okay, yes. All right. So we'll wait for follow-up on that. All right, so we'll move on to 0576.

Female: And I would ask if Harold's not permanently muted, that - since I think he's familiar with this one, if he would summarize it.

Dr. Harold Pincus: Which...?

Female: This is 0576.

(Adam): Yes, we're actually having a problem here with the Word doc opening up, but...

Female: Follow up after hospitalization for mental illness?

(Adam): Yes.

Female: And maintenance.

(Adam): Let me just redownload that document, but in the meantime, Harold, did you just want us to go over - do you have the document in front of you?

Dr. Harold Pincus: Yes, I do, although I - this was one that I was not supposed to review. They switched it for me, but...

Female: Oh, sorry. I thought you were still on it.

(Dody Kelleher): This is (Dody).

Female: That was a recent change. Sorry, (Dody).

Female: Sorry, (Dody).

(Dody Kelleher): I will try to do this without too much coughing, but I will be brief. So this is a...

Dr. Harold Pincus: I mean, this is ((inaudible)) to the one we just reviewed.

Female: Yes.

(Adam): Yes, but just to make sure, I mean, we want to talk about any outstanding issues or concerns that you found while reviewing it.

Female: Right.

(Adam): So it's up on the screen now.

(Dody Kelleher): Okay. So this is 0576. This is a measure that was originally and last endorsed in 2009. This is a maintenance review of the measure. It's an NCQA steward measure. It's a very similar though, with the idea that measures - the percentage of discharge is for members from six years of age and older who are hospitalized for treatment of not just schizophrenia but a broader set of mental health disorders, and who had an inpatient visit, an intensive outpatient encounter, or partial hospitalization.

And there's two rates reported, much like the last measure - 7 and 30. Excuse me. I didn't want to do this. And let's see. It's a process measure with multiple data sources and multiple levels of analysis. It - I believe has high impact, or the potential for high impact, and still has a performance gap. And it seems to have a sufficient from my point of view quantity, quality, and consistency. It's I think very reliable and moderate - there's moderate validity. And I think the biggest issue for me is harmonization.

Female: Thanks, (Dody).

(Adam): Great, thank you for that. So here we'll - I'll pull up the steering committee evaluations. So here we go.

(Crosstalk)

(Adam): So then - so you said - so it passed five to one on the importance. So yes, we did have high impact and opportunity for improvement. That was skewed very high. The evidence - we see more of a range, but again skewed towards high to moderate. Do we have any other comments about the importance?

Dr. Harold Pincus: The one issue I would have in terms of the opportunity for improvement, this measure's been around for a long time and there hasn't been much improvement, and I wonder if there's been any investigations about what's behind that.

(Adam): Okay, does NCQA want to speak to that?

Dr. Harold Pincus: Is it an issue with the measure, or is the issue with what people do about the measure?

(Dody Kelleher): Yes, Harold, this is (Dody). I have no proof, of course, but I suspect that - I can remember 15 or 20 years ago when this first was a process put in place in the health plan managed care environment, and since that time I'm not sure if at least at a plan level if this has the same attention in the day-to-day institutional processes as it did back then, but that's just my sense of it. So I don't know that it's the measure.

Dr. Harold Pincus: I just wonder in terms of its, you know, in terms of NCQA's, you know, continuing observation and examination of these measures, whether they've sort of looked into that. I know they've brought it up, that it hasn't improved, but you know, it just makes one wonder if, you know - because I agree. I think this is an important measure.

I think it is potentially an improvable measure, and it just, you know, sort of clothed in question for, you know, what would appear to be a reasonably good measure that is important and has implications for you know, cost and quality and everything else, you know, why it hasn't budged that much.

Sarah Scholle: So this is Sarah from NCQA, and Harold, as you know well, the ((inaudible)) measures in the ((inaudible)) set have not - in general have not had as much improvement over time as measures such as the diabetes or hypertension.

And so we know that we have a range of performance on this measure, and that we do have some high performing plans on this measure, but that in general we see not great performance on this and on other vital health measures.

And we know that it's - that some of the characteristics of how ((inaudible)) health care is paid for contribute to that. I don't - I know that - so that's what I can say, is we know that there are high performance, or high performance is possible, but perhaps the incentives haven't been around for a plan to make it.

(Adam): Great. All right well, just in the interest of time here, that was a great discussion about that. We're ready to move forward to the scientific acceptability here, and again this passed by a five to one margin, with a, you know, skewed to high to moderate. Do we have any concerns about the reliability or validity? Okay, we'll move on to usability and feasibility.

So here we were a bit more split between high and moderate, four to three for usability nd three to four for feasibility. Do we have any concerns about the usability or feasibility of this measure? Yes, and if we're hearing none, we'll just pass by a seven to zero margin for suitable for endorsement, so that's very good, and do we have any final comments about measure 0576?

Dr. Leslie Zun: Yes, this is Les. I'm wondering how do - why did we choose the age six as the initial date or age? Is there data or evidence that we're based that age on?

(Adam): NCQA have a comment about that?

Sarah Scholle: This is Sarah. I think this measure pre-dates most of us on the phone, and I'm imagining that they - that it was based on looking at school age kids and thinking about school age and above and being concerned about identifying a reliable denominator under age.

(Adam): Okay.

Dr. Leslie Zun: I just wondered what the most recent data shows and what the incidence is under six years old.

Sarah Scholle: Well, fair enough.

(Adam): I'm assuming we could follow up prior to the in-person meeting. Is that okay?

Dr. Leslie Zun: Sure.

(Adam): Great.

Sarah Scholle: Okay.

(Adam): All right. So that's good, and we'll move on now. We're going to do 1935 with Dr. Pincus.

Dr. Harold Pincus: In this - in some ways this is sort of a - really easy to think of as sort of a paired measure with 1936.

Female: Correct.

Dr. Harold Pincus: This is a measure that looks at the continuity of antipsychotic medication, and together the first one - and they differ, and one becomes the denominator of one - the numerator of one becomes the denominator of the next one so that this specific measure measures the proportion of people with a diagnosis of schizophrenia who have received at least one measurable - one prescription for an antipsychotic medication.

And then 1936 looks at the proportion of people who - looks at the proportion of days for which their prescriptions would cover over the course of an evidence year, the course of an enrollment year. And so you know, the measure - 1935 by itself is not a terribly impressive measure because it essentially looks at, you know, somebody with schizophrenia got a single prescription for an antipsychotic medication, and with being a chronic illness, it's, you know, that's not terribly meaningful.

But in order to be able to understand the context of the second measure, you need to have that. So - and so that's one of the questions I had, is that when one endorses a measure like this, is it - does it have to be always twinned with the other one?

(Adam): Yes.

Female: Yes.

Dr. Harold Pincus: Because I would...

(Crosstalk)

Dr. Harold Pincus: ...that this is an acceptable level of care.

(Adam): Yes, this is a paired measure, so 1935 and 1936 are a package.

Dr. Harold Pincus: Okay.

(Adam): Our number system here is incorrect, so this is - it's paired with 1936 here. This is - for some reason 1939 and 1940 come up in our system, but it's 1935 and 1936. And just for the whole group here, these were included late. I noticed we didn't receive any evaluations for it.

This was just included at the end of last week, so this is something that we'd ask you guys to please look over prior to the in-person meeting and we'll be having a discussion about these measures a little more in depth at that meeting, but we can definitely fully start that here.

Dr. Harold Pincus: But you know, from my point of view, I'm clearly - the maintenance of continuity of care and particularly continuity of antipsychotic use has been - has significant degree of evidence associated with better outcomes for patients, less hospitalization.

And so that would argue for this being, you know, meeting the first criteria of sort of impact and opportunity and evidence of importance to measure and report. By and large, the performance on this is not so great, so that, you know, goes along with that.

And I'm talking about this from the point of view of both measures. It's hard, you know, it's hard to talk about these two without talking about them together. Is it okay to do that?

(Adam): Yes, absolutely.

Dr. Harold Pincus: Okay. So that together the two of them sort of make sense, and you know, clearly meet the criteria for importance.

(Adam): Okay, great.

Dr. Harold Pincus: One of the issues in terms of reliability and validity and scientific acceptability is the issue that, you know, in some ways, that you would not necessarily expect 100% of patients to be getting this. There has to be room for the acceptability of the medication to patients. Patients have, you know, a right to not take the medication. There is significant side effects with these medications, so that all needs to be considered, so that 100% is not necessarily the ideal.

And one of the issues, it's not clear what the optimal benchmark is. That's one limitation of this. On the other hand, as a, you know, as I think Sarah said before, as a way of comparing states' performance with regard to this, it can be very important to try to understand how to sort of expand this and improve continuity of care with regard to patients with schizophrenia. So I would find the reliability and validity acceptable.

But I did want to ask a question of NCQA, that when you compared states from 2007 to 2008, you found that actually a majority of states changed quartiles, and that performance on the earlier year only accounted for about 6% of the variance. And I just wanted to get a sense about how does that compare with other sort of measures that you've used with regard to reliability and what you think is going on there.

Sarah Scholle: So Harold, so your specific - it's kind of hard to know what's going on with this measure. It could reflect issues around the eligibility within states for Medicaid, because we looked at people on Medicaid who were not duly eligible, so that it was - we were - the only data at first we had was the MAX data, the Medicaid analytic extract, and so that data set is - includes ((inaudible)) certain claims only for Medicaid. So people that move on to Medicare would not be in our sample.

So in looking at the data from year to year, we wondered if we might have gotten some changes in the state in who is eligible, and that might contribute to it. I actually don't know. We saw more consistency in some of the other measures.

Dr. Harold Pincus

Sarah Scholle: So Harold, so your specific - it's kind of hard to know what's going on with this measure. It could reflect issues around the eligibility within states for Medicaid, because we looked at people on Medicaid who were not duly eligible, so that it was - we were - the only data at first we had was the MAX data, the Medicaid analytic extract, and so that data set is - includes ((inaudible)) certain claims only for Medicaid. So people that move on to Medicare would not be in our sample. So in looking at the data from year to year, we wondered if we might have gotten some changes in the state in who is eligible, and that might contribute to it. I actually don't know. We saw more consistency in some of the other measures.

Dr. Harold Pincus: Well, that raised concerns, though, in terms of again the feasibility of collecting sort of similar data across states and across time. If - is it expected that the - this would - if people were duly eligible, how would that be handled going forward, in terms of having pharmacy data from both the Medicaid side and the Medicare side?

Sarah Scholle: So say that - okay, so for the field test, right? So for the testing that we did, we only had access to the Medicaid analytic extract.

Dr. Harold Pincus: Right.

Sarah Scholle: A state that's using this could use their Medicaid data. They could have their managed care plans report the data. They could combine their state data with data that are available now

from CMS for their Medicare population. We've certainly heard that that's the way states would like to use the measure. So but...

Dr. Harold Pincus: So shouldn't that be instantiated in the measure definition?

Sarah Scholle: I don't know if the definition is...

Dr. Harold Pincus: That was my one - I mean, I think it's a good measure, but it has to be - I mean, my bottom line, I think it's a good measure, but I think that there has to be some consistency in the sources of the data, especially if you're going to compare states. If there are states that are using, you know, some states are including Medicare data and some states aren't, and you know...

Sarah Scholle: So sorry about that. I will check. I think our denominator specs are not - are silent on that, so we allow states to apply it based on how they do it, but I'll - we can verify that for you.

Dr. Harold Pincus: Yes, so that would be my sort of a major concern in terms of, you know, again, if the intent is to compare states' performance, and to compare states' performance over time, you know, there would - it seems that you'd want to have a clear consistency of the data sources and the eligibility.

Dr. Leslie Zun: This is Les. I'm sorry. I'm going to have to excuse myself for another meeting. I'll see you all in a few weeks, I guess. Thank you.

(Adam): Thank you very much.

Female: So that's something we can follow up with NCQA with on - offline?

(Adam): Great. Do we have any further comments on the measure pair of 1935 and 1936?

Dr. Harold Pincus: I don't.

Female: Larger group, any other comments about the paired measures, 1935 and '36?

Female: I just have another question. Are most of these measures at the state level? I mean, every one so far has been a state-level measure. I just wondered if that's...

Dr. Harold Pincus: No, one of them was actually a plan level measure.

Female: Right.

(Adam): So the 0576 was a plan level measure. But if you...

Female: And we have a measure coming up that's going to be, you know, non-state level.

(Crosstalk)

Female: What do you mean by plan level?

(Crosstalk)

Female: Pardon?

(Adam): It was health plan performance.

Female: Health plan - you mean the individual plans? Is it at the individual level?

(Adam): No, it means - it's not at the individual clinician level. It's at the health plan...

Dr. Harold Pincus: The health insurance company.

(Adam): Yes.

Female: Okay, great. Thanks. I'm trying to get oriented.

Lisa Shea: I also had just a question in terms of these last two measures, in terms of is there a way of accounting if a patient is in the hospital for a long period of time, because then their claims - there'd be an interruption theoretically, even though they're, you know, they're still on the medication, because it's not getting processed through the pharmacy. Or would the claims capture that?

(Adam): We have a clarification on that?

Sarah Scholle: So this is Sarah. I'm going to actually ask my colleagues if they can respond. I believe that we do require that there be a period of observation in the time so that we can see that, but have we accounted for hospitalization, (Melesh)?

(Melesh): I don't think we have, and that's one limitation of the measure.

Sarah Scholle: Yes. Okay, because we - you wouldn't have the drugs that are having during the hospitalization.

(Melesh): Right.

(Adam): Okay, thank you. Do we have any final comments about 1935 and 1936? And again, these are available on the share point site for review prior to the in-person meeting. Yes, and again, if possible, if you could enter votes for this prior to Friday.

Female: And that's also for all the measures, if any of you haven't had a chance to enter in your preliminary evaluations for these two measures, or any of the other measures that we're going over, if you could please do that before Friday, and like (Adam) said, we'll send out an email reminder, but just another heads up.

(Adam): And if you want to revise your - anybody who's already submitted an evaluation still, that'd be great. Okay, well I think we're going to move on here now to 1879.

Female: So 1879 is another measure that was recently added to our phase one review of measures, and Dr. David Einzig was very kind of go ahead and review this measure for us. He reviewed it in the Survey Monkey. He's not able to join us for today's call, so we will do a quick overview for him for the measure, and then also...

(Adam): There we go. All right.

Female: And then also go through his comments about the measure, and then open it up for the larger group.

(Adam): All right, so first we'll read over quickly the brief measure information ((inaudible)). So has - the description of the measure is it calculates the percentage of individuals 18 years of age or greater with schizophrenia who are prescribed an oral antipsychotic medication with adherence to the antipsychotic medication, and it's defined there.

And so the numerator is individuals with schizophrenia who filled at least two prescriptions for any oral antipsychotic medication and have a proportion of days covered for antipsychotic medications of at least 0.8; and again, the denominator individuals at least 18 years of age at the end of the measurement period with schizophrenia, with any two claims of oral antipsychotic medication during the measurement period. We'll let you guys read over the denominator exclusions and the rest of the measure, but we'll move over to the evaluations.

Female: And just to give you a little more context about this one, this one is also related to 1935 and 1936, and we also - it's also related to an existing measure that we were not able to review in this phase, and that's 0544, which we'll have mapped out for you prior to the in-person meeting. So with that, Evan?

Evan Williamson: Hi, everybody. This is 0.544?

Female: Use and adherence to antipsychotics among members with schizophrenia, and that one's previously endorsed. It won't be able to be reviewed until phase two of this measure, but we still - I mean of this project, but we still have to look at all these measures together when doing a comparison to related and competing measures.

Evan Williamson: And that's for organization purposes, or for deciding who's best in class?

Female: Well, at this point it'll be looking at harmonization measures, because we're not really able to do best in class on 0544 at this point. We'll have to deal with that in phase two and...

(Adam): Sorry, so here we'll review Dr. Einzig's review of measure 1879 under the importance, so for the rationale for - it's the high impact and opportunity for improvement, as if often for medication compliance contributes to the high - the need for higher levels of care and poor quality of life for

patients with schizophrenia. And then for evidence, he reads, evidence is high, and he believes there's good evidence. So he rated the importance...

Male: Just - could you clarify, how is this measured? What is the - I don't have the information in front of me, but what exactly is this measure specifically?

Female: What is - I'm sorry, what was the question again?

Male: Yes, the numerator and denominator definitions.

(Adam): See, there, they're up on the screen.

(Crosstalk)

(Adam): So it's 18 years of age or greater with schizophrenia, prescribed oral antipsychotic medication and...

Lisa Shea: I think that...

(Crosstalk)

Lisa Shea: ...that these - this measure is measured looking at the number of prescriptions that were refilled.

(Adam): Yes. Okay. Do we have any other clarifications about the measure itself? All right, so I think Dr. Einzig rated it as a yes for the importance criteria.

Female: But before we move on, back to the larger work group. Is there - are there any other comments right off the bat as far as the importance of this measure based on the numerator and denominator?

(Adam): And again, we understand you haven't had time to review this or look over it, but we - if there are any other things that come to mind right now.

Male: I think that it would be really important when this is presented in the full group to display what's similar and different across these different, very similar measures.

(Adam): Yes, and that - we will have that ready for - we'll send it out later this week so you can review it prior to the in-person meeting next week.

Male: Yes, for example, this requires that there be at least two prescriptions and also deals with the exclusion around injectables.

Female: Right, right.

(Adam): Yes. All right. Are there any other comments about criteria one? Okay, all right. Next we'll go over scientific acceptability, and we'll read the rating. It was rated as medium on both, so he said increasing the denominator size to 45 yielded higher reliability, and there were several threats to validity, missing data, cash prescriptions, and possibly other ways of getting medication with samples.

So that's - those are just a few things that Dr. Einzig noticed, but he rated scientific acceptability as a yes. All right, moving on to usability and feasibility, they're both rated as high, or usability's rated as high, and so everything seems straightforward. For feasibility, if - there was an

incomplete as well as a moderator, so it's not currently in use is why there is an incomplete, and - but it appears ready to be put into use.

So these are rated as suitable for endorsement. So again, this is something that's available on the share point site, 1879, and we'll be sending out a reminder email for you guys to review this prior to the in-person meeting.

Female: Are there any questions on this point for the developer? I've added that I know you all haven't had time to really look this over, and we'll be sure to take a deeper dive and Dr. Einzig will be at the in-person meeting.

Female: And another point, I believe we have someone from the developer on the call, and if you could just walk us through a little bit, they did a very good job with the harmonized pieces, what this measure is harmonized with and how it competes with other measures, if you might want to tell the work group about that.

Kyle Campbell: Sure. This is Kyle Campbell from SNQI. I'm the project director for CMS. This measure is harmonized with the other NQF endorsed measures that look at medication adherence. In a previous voluntary consensus project, NQF asked developers to work together to identify a standard methodology for identifying medication adherence, and so we worked very closely with the Pharmacy Quality Alliance, to have another measure for medication adherence, that's NQF 541, along with the other measures in our CMS portfolio. And that's how we arrived at the proportion of days covered methodology that's incorporated into this measure.

(Adam): Great, and as you can see on the screen here, they've filled out section five with the related and competing measures with a list of those measures you just mentioned. So that's again on the share point site for you to look over. And if there are measures that are not included in this project that you would like to look over just to see the similarities and how they're harmonized, that's all

available on the NQF site under search for measures. You can put in the measure number and it'll pull up all the information related to that measure.

Dr. Harold Pincus: Just one quick question. When you say you harmonized it with measures that were not specific to ((inaudible)), the - one of the questions that comes up with this is the validity of the point eight, and is there - what's that based upon? Is it specific to schizophrenia, or is it sort of the generic expectation in terms of use of chronic medications?

Kyle Campbell: It's really - the evidence is really specific to the therapeutic class. So in this particular case we've cited a number of studies related to schizophrenia with antipsychotic medications that have shown that the 0.8 is the appropriate threshold for the outcome, and those studies are - they're in our measure information form.

Similarly, the evidence then varies depending on the type of chronic medication, you know, and the therapeutic class that you're looking at. But we have - NQF had asked as a part of that project to look at a standard methodology for measuring adherence, and we did quite a bit of work with our technical expert panel on this, and arrived at the methodology that's presented in this measure to be most appropriate for measuring adherence for antipsychotics and the chronic medications and the other measures.

Dr. Harold Pincus: Okay.

(Adam): Great.

Female: Any other questions for the developer about this one?

Female: No.

(Adam): Great. Okay, so we'll move on to 1926. I believe that's Carlene's.

Carlene Phillips: That's correct. This measure is cervical cancer screening for women with schizophrenia. The numerator is one or more pap tests during the measurement year or two years prior to measurement year and the denominator is women 25 to 64 age with a diagnosis of schizophrenia. There was a previous measure on this, but apparently it's already been endorsed, number 0032, which was for women 18 to 64, and the reason for changing this one has to do with more able to diagnose at an older age. I don't quite understand why they said that, but that's what they said.

In terms of importance, I'm not really prepared to present today. I didn't think I had to until next week, and I don't remember what I put down. I have some questions about this measure that I'll bring up. A lot of the things that they related to is quality of schizophrenic care. It doesn't really seem to relate to percentages of patients with actual cervical cancer with schizophrenia.

So I was just a little confused by the whole measure as to why we would be doing this. But in terms of importance, obviously it does have some importance for the outcome for women who do get diagnosed. Early screening means better outcomes for them.

(Adam): Great. Thank you for the overview. So we have - here we have four to one for importance, and we had sort of a - the high impact and opportunity for improvement, rated as high with a few moderates. Moving on to the evidence, that was rated more skewed to moderate, and there was a range anywhere from high to insufficient. Do we have any other comment? Anybody want to make a comment about the importance?

Dr. Harold Pincus: I mean, I think that one of the issues - I think the - whether or not individuals with severe mental illness get access to and receive preventive and primary care services is very important. Is this twinned in any way with the sort of population based measures to see if there's

a disparity between the performance on - for this population as compared to the general population?

(Adam): Not at this moment.

Female: Could we also hear from the developer, any comments about that?

Sarah Scholle: So this measure is based on an existing ((inaudible)) measure for health plans that looked at cervical cancer screenings for women, ages and there is, as you mentioned, there's a different age group. The difference in the age is based on our - for all of the schizophrenia measures, the age is - the starting age for the diagnosis is age 25.

So this measure we're looking backwards because they could have had that screening earlier than their 25th birthday, and so that's - our panel felt that using schizophrenia diagnoses before age 25 would lead to some variability in what - in who gets into the schizophrenia diagnosis category.

So it is - it's aligned with the existing ((inaudible)) measure, and but it's not officially paired with it, but it would allow for comparisons between people with - women with schizophrenia and women with - general population.

Female: So I...

Dr. Harold Pincus: The general population starts at 18 or 21?

Lisa Shea: Well the guidelines - the new - the recent changes in the guidelines from ACOG and NCI, ASTCP, are at - they moved it from 18 to 21, so that was my question, is why is this not reflecting the most recent changes in the guidelines?

Male: So this measure was submitted I believe in February, and the guidelines came out in I believe mid to late March. So this actually doesn't reflect the most up-to-date recommendation, and I think it may need to be revised.

(Adam): Yes. Oh, no, what Sarah said was important, because even if it was - even though the guidelines for when somebody starts cervical cancer screening are - have been shifted to 21, you know, the consistency of the definition of schizophrenia, you know, also is something that people weren't - that NCQA and - might be used with a standardized, given the fact that there's a fair amount of individuals who may harbor a diagnosis of schizophrenia, but really it was a, you know, it's not a valid diagnosis as it turns out to be, as people get beyond the adolescent stage.

Male: So it's a trade off.

Female: With regard to the guidelines that were mentioned, did - I heard the developer say it maybe needs to be looked at. I wondered if - were you thinking about this for this measure, for this period of time?

Sarah Scholle: So the guidelines just came out, and so we haven't had a chance to address it in the documents that you have in front of us. But given those new - the new guidelines, we know that the ((inaudible)) measure will be reevaluated, and so it would be part of our course to - natural course to update it, but we - perhaps that's something that we could investigate before we go to the in-person meeting.

Female: Great.

(Adam): That'd be great.

Female: Any other comments about the importance of this measure?

(Adam): All of the evaluations.

Female: And if not, then we'll go ahead and move into the scientific acceptability specifically the reliability and validity testing.

(Adam): Okay, so as you can see here again, there was a range with mostly moderate, but it passed four to two for scientific acceptability. Do we have any comments about the scientific acceptability? Okay. So moving on now to the usability and feasibility, again here we have a skew towards moderate amongst ((inaudible)) quality improvement as well as the overall usability. Any questions about the usability of this measure?

All right, and then feasibility here, it looks like we had a few mostly high, high to moderate, and then for the overall feasibility, it was four moderate and two high. Did we have anybody want to comment about the feasibility of this measure?

Female: Okay.

(Adam): All right, great. All right, so overall this measure passed four to two for suitable for endorsement. Do we have any overall comments about the measure?

Female: Or questions for the developer?

(Adam): I want to make sure to - we'll follow up on the - with any issue with the new recommendations prior to the in-person meeting to make sure that we have that information available for the overall discussion. Okay, great. So next we'll move on to 1932, and I believe Nancy will be the lead discussant on that.

Nancy Hanrahan: Okay. So apparently, people with schizophrenia are at twice the risk of the general population for developing diabetes. It's got to be associated with the use of antipsychotic medications. This measure is to promote I believe diabetic screening for people with schizophrenia, and they also include bipolar disorder, who are prescribed antipsychotic medications. As I get to understand this measure a bit, I understand that there is already a measure for bipolar illness, and that there is some collapsing of these two. Am I right about that?

(Adam): Yes, 0003 is the ((inaudible)) for diabetes for bipolar disorder.

Nancy Hanrahan: Okay, so they are proposing that for individuals aged 25 to 64 years of age, with either schizophrenia or bipolar disease and prescribed psychotic - antipsychotic medications, that they be screened for diabetes, and they're using the numerator as one or more glucose or hemoglobin A1C tests performed during the measurement year, and the denominator would be the adults aged 25 years and older as of December 31st of the measurement year, with schizophrenia or bipolar disorder diagnosis who are prescribed an antipsychotic medication.

The - it's also interesting to note that they are excluding anyone in the denominator that already has a diagnosis of diabetes, which I think is a good idea. They used claims data. They encountered data to do the measures, which makes it of course user - or accessible, but as everybody knows there's some problems with that data. So it's - let's see.

Oh, yes. The measures are not risk-adjusted or stratified, and there is validity, faith validity for group responsible for overseeing measure development, and some other types of groups. It appears that this is all part of a prevention kind of screening initiative for people with serious mental illness, and what else should I say? The measure looks good.

I, you know, I think that there's again there's only - oh, yes, one of the things I wanted to get some feedback from you all about is that the criteria for doing the measure, so what would trigger this measure, is if somebody had one or more of these hemoglobin A1C tests or a glucose test in the measured year. I wonder why - I would think one - only one would be not reliable enough, and that two, two or more would be a much more reliable numerator to use, and I wonder if folks had any thoughts about that.

Female: Any comments from other work group members of the developer?

Nancy Hanrahan: I know it's arbitrary, but you know, if you get one result, there could be some, you know, problem with the measure, the lab.

(Dody Kelleher): Well, I think, you know, this is (Dody). I think if we think about the sort of population as a whole, you go for a physical once a year, hopefully, and it would be a theatered screening procedure for anyone to be, you know, be given a script to go to the lab and get a fasting glucose or for some people now a hemoglobin A1C.

So you know, where we're - in my experience, someone with a serious mental disorder is less likely to get screened on at least that routine a basis, so you know, I would think that that would be appropriate threshold. One would be an appropriate threshold and either or would be an appropriate threshold, clinically.

Nancy Hanrahan: I think so. Yes, I could agree with that. Thank you.

(Dody Kelleher): Sure.

Nancy Hanrahan: That makes sense. So you know, I think this is a good measure. It's going to certainly promote some attention to doing the screening in this population, which is needed.

(Adam): Great. Thank you very much for the overview. Oh, sorry, and anything else?

Nancy Hanrahan: No, no, good.

(Adam): Great. All right, thank you very much. All right, so we'll go through the evaluations. Starting off on importance, so we had a high impact, a bit of a skew for opportunity for improvement. We had one insufficient, and some high and moderates. For some evidence, it's skewed toward moderate, but with a range, and then overall it was three to one on importance. Do we have any other comments on the importance section?

Lisa Shea: No, I actually just had a question in terms of the correlations with - it being correlated with mental health emergency room utilization, and I think this came up before. I was just trying to understand how a measure that's getting at physical health, you're looking at a correlation of a mental health emergency room utilization versus you know, admissions for diabetic ketoacidosis or other sorts of things that would be more related to the measure. I just was having trouble understanding that.

(Adam): Is there any clarification on that from the developer?

Sarah Scholle: So in our field testing, we had a limited amount of time to do this, but we looked at all the measures to see how they related to hospitalizations for schizophrenia as a kind of a test of validity, of this is addressing something important, and it is interesting that the measures that seem to be less highly correlated with hospitalization are the monitoring measures, diabetes and cardiovascular health.

And so that stays in the bottom percent, and each have higher people - a bottom quartile of performance in those measures had the most patients that were hospitalized. And so I think, you're right, well, were they hospitalized for schizophrenia?

Were they hospitalized because of - it would be more direct to look at hospitalizations for ketoacidosis, but what it's showing you is that they're getting hospitalized and maybe there's attention to their screening during the hospitalization, but it is a measure of - it is related to poor outcome for this population, so it may just be an indicator of poorer care in general.

(Adam): All right, thank you. All right, so we'll go back to the ratings, move on to the scientific acceptability. Here again we had a range between high and low, and then insufficient for the validity section. And overall it was a three two on the scientific acceptability. Does anybody want to discuss the reliability or validity of this measure?

Nancy Hanrahan: This is Nancy. I'd say it's no better or worse than the ones that we've seen so far.

(Adam): Okay, thank you. Great, okay, so we'll move on here to the usability and feasibility, and here we had the mostly moderates, and overall moderate with one insufficient for the usability. Do we have any comments on the usability of this measure?

Nancy Hanrahan: I think it's an easily user friendly kind of variable, because you can get it from the claims data and it's objective.

(Adam): Great. Yes, that's - yes, definitely. Any other comments? All right, so we'll move onto the feasibility, and again here so for a foray for the byproduct of care processes, we have a four to one for high, and then the rest we had kind of a mix between high and moderate.

And overall we had two high and three moderate for the feasibility. Do we have any questions about the feasibility? All right, overall it was a three two suitable for endorsement, so the committee was split here on the suitability. Do we have any comments on the overall suitability of this measure?

Dr. Harold Pincus: What were the - do we know what the negatives were, the people who voted no?

(Adam): It's clear we had - or if you're on the screen here, so it looks like with no we had insufficient for usability, a no for scientific acceptability and a no for...

Dr. Harold Pincus: Right, I mean...

(Adam): ...for importance.

Dr. Harold Pincus: Are any of those people on the phone to just explain their thinking?

(Adam): Lisa, are you on the phone?

Lisa Shea: Yes, I'm on the phone. So and again, I'm new to this process but it seemed to me, one, that my understanding of the guidelines have to do with that you have to have - that you should be having a couple of risk factors. So being on an antipsychotic is a risk factor, but then another one, so just that was one issue.

And then the - unlike some of the measures that I've seen where people go article by article and really delineate the data, it was hard to know that this data that's being presented was specific to the group that was being measured. So that was one issue, and then there weren't - they didn't look at - and I agree with what Nancy said, that it wasn't any better or worse than any of the other measures that we've looked at, but there weren't any threats to validity assessed.

So I was just basically going by, since it's my first time doing it, going by the book and looking at all the definitions and everything and just reading it based on what I got here.

(Adam): Yes, that's great.

Dr. Harold Pincus: I guess one question I had, I mean, I guess - I thought that there were actually specifically endorsed guidelines from the APA and the American Diabetic Association with regard to this.

Nancy Hanrahan: There were.

(Adam): Does the developer want to clarify that?

Male: So we did cite ADA guidelines, and the Mount Sinai Conference, which was a publication from 2004 for...

Dr. Harold Pincus: I thought there was a joint APA/ADA statement on this that was more recent than that.

Male: The ADA guideline is from 7/11, so if there's something that's...

Dr. Harold Pincus: Is that specific for people with schizophrenia...?

Male: No, that's for...

Dr. Harold Pincus: ...and on antipsychotics?

Male: No, that was a general population screening.

Dr. Harold Pincus: I think a specific one also...

(Adam): Okay, well, we can clarify that prior to the in-person meeting. We'll put that on the list, and we'll definitely be sure to present that information when we discuss this measure during the meeting.

Dr. Harold Pincus: And again, is this sort of twinned with the one that's looking at people with diabetes and schizophrenia?

Female: So that's the - if you're talking about 0003, and we could scroll to section 5A, it's not twinned with that one, and if the developer could really just walk us through the differences, there, we did a good job with discussing. Right here.

(Adam): Yes, it's right here on the screen.

Female: If - does the developer want to speak to the harmonization piece on - with 0003, bipolar disorder assessment for diabetes?

Male: Yes, so ultimately I think some of the major differences are the years for the population. We were consistent with our other measures in keeping the 25-year age range, while the bipolar disorder measure included individuals 18 years or older. I think I'm not 100% sure about the bipolar disorder measure and if that's solely claimed, but ours was solely claimed. And I think those were the two major differences, and also the NQF endorsed measure only included atypical antipsychotics, and ours had a prescription - or a claim for any medication.

Dr. Harold Pincus: Ideally you'd want them harmonized, because I mean, together they would give you a picture of the whole population, people who you know, should be screened and people who are, you know, should be you know, have already been screened positive.

Male: I think that's something we can look into.

(Adam): Great, so we'll look into that and we'll discuss that at the meeting. And yes, we'll have the chart by the end of the week of the related and competing measures for these. Excellent. All right, do we have any other further comments on 1932? All right, hearing none, we'll move on to the next one, which is 1927, and Bonnie, I believe is the lead discussant on that.

Bonnie Zima: Can you hear me?

(Adam): Yes.

Female: Yes.

Bonnie Zima: Oh, good. Okay and I apologize for any feedback. I'm on an old county program land line, and I will send my written comments as well to Sarah just to make sure. Basically this indicator is structurally very similar to the one we just discussed. Cardiovascular health screening for people with schizophrenia or bipolar disorder, it is a process measure.

The data source is administrative claims. The level of analysis is at the state level, so it's a population measure, and of course the steward is the NCQA. The numerator is very specific. It's one or more LDL cholesterol screenings, which appears to be identified by a procedure code. Just a minor point, on those procedure codes is it just ordered, or do those procedure codes also include like documentation that it was done?

Sarah Scholle: It's claims data, so these are services performed.

Bonnie Zima: So it would be ordered. The test was ordered?

Sarah Scholle: No, it means the test was done. It's the service provided, not an order.

Bonnie Zima: Okay, okay, okay. And then in the denominator, basically the - it's Medicaid beneficiaries, and it looks to me like the database used for this measure was the MAX claims data, restricted to 22 states, fee for service, persons that met eligibility for disability and were continuously enrolled for 10 months. It does not include persons enrolled in managed care Medicaid or those that might have lost coverage during the 10 months or might have been receiving Medicaid for another eligibility code.

Age range we've discussed, between 25 to 64. Primary diagnosis, schizophrenia bipolar, as identified by two separate outpatient claims or one inpatient claim, and in addition to that primary diagnosis they have to have at least one, it looks like pharmacy claim for any antipsychotic medication. The eligibility - eligible medications include both typical and atypical antipsychotics. The implication here might be that the risk for elevated LDL might vary by medication type.

For the denominator exclusion similar to the other one, the bottom line is that it's excluding people with cardiovascular disease that have already been detected based on claims data. This might impose a bias towards those that are likely to access care for a number of very different reasons and be continuously insured, but this is actually a very common limitation using claims data. On evidence, it appears that the sources for the literature review are guidelines with and without systematic reviews, retrospective reports and literature reviews.

The rationale for high impact appears to be that among this target population there's greater lifestyle risk factors, and also higher non-treatment rates for hyperlipidemia among persons with schizophrenia. There's also some literature that supports that LDL and triglycerides, that the risk of it being elevated might vary by medication cross. There is assumption here that the improved

screening will lead to proper diagnosis and treatment, and this too is a common conceptual leap in process measures related to screening.

And oftentimes the rationale, even if it's not perfect, is that the argument is that if we improve screening, it's an important first step. Performance gap is based on a comparison of percentile rates of adherence divided into quartiles, and it shows that it's quite feasible to stratify by gender and race using the Medicaid claims data. Evidence ratings, which I think is a new way for NQF to do business, this is a process measure, and so rating the evidence was a bit difficult.

Assessing quality and consistency I think usually requires examining the study design and methods, and that information was not available. However, the application correctly notes that the measure assesses an opportunity for treatment, and I think that's a key word, opportunity. Reliability is based on specifications, and looking at the specifications they appear very clearly written. As far as reliability testing, it looks like they used data from 16 out of 22 states. Just a point of clarification, did that mean that six out of the 22 did not have data?

(Adam): Any clarification from the developer on that?

Sarah Scholle: I think that meant that the states didn't have sufficient people in the denominator for the two years. I'm looking at this chart to see. It was a data availability issue rather than a problem with it.

Bonnie Zima: Yes.

Sarah Scholle: Okay, we had a number of states that had not enough people in the denominator to be able to assess...

Bonnie Zima: Okay.

Sarah Scholle: ...the reliability over two years.

Bonnie Zima: So just a problem with sample size.

Sarah Scholle: Right.

Bonnie Zima: Okay, okay. And anything why the 22 states were selected?

Sarah Scholle: We used the MAX data, and so we looked at states that had complete - that appeared to have complete data in the MAX files. And so our colleagues at Mathematica who did the testing have a lot of experience, and because the MAX data are based on fee for service claims, it's primarily states that are fee for - that have Medicaid fee for service rather than managed care, because where there's managed care the encounter data may not be...

Bonnie Zima: Right.

Sarah Scholle: ...sufficiently representative.

Bonnie Zima: Right, right. So at least for 22 states, there was some completeness with the data and it appears that 16 states had sufficient sample size to do the reliability testing. And it looks to me like reliability testing was based on really examining on the stability of the performance at the state level between two years, 2007 and 2008, defining that slightly more than half, 50% of the state, 9 out of 16, found no change between the two years, and understandably then a correlation was it looks like in the moderate range of .43.

Validity, similar to some of the prior measures discussed was based on face validity, based on a multi-stakeholder technical advisory group plus gathering public comments, focus group data,

from experts like Medicaid Medical Directors' Learning Network, Managed Behavioral Health organization, state mental health commissioners and medical directors. Concurrent validity, again this was brought up with the diabetes measure.

It looked at relationship to use of mental health hospitalization, and ED use for schizophrenia, and what they found was a negative relationship, but again that might not necessarily support the validity of how LDL screening improves diagnosis and treatment of cardiovascular disease, which I think is the ideal that this measure's trying to strive for.

And what they did find was that for persons that - or state health plans that did a lot of screening, they also measured very high on this one. Potential threats to validity were not examined because restricted to persons who access care. We discussed the usability and feasibility based on 50%, 56% of the states, and again, evidence that adherence to this measure relates to improved detection of cardiovascular disease or treatment was not available at this time. That's it.

(Adam): Great. Thank you very much for that overview. That was excellent. All right, here, we'll pull up the ratings, and go over those quickly in the interest of time. We have like 12 minutes left here in the call, but we can get through two measures after this one. All right, so first we - here we have the importance, and that passed unanimously four to zero. We had a range of moderate, mostly moderate for the evidence and high for the impact and opportunity. Do we have any other comments about the importance?

Great, so moving on to scientific acceptability, it seems we have a skew to moderate, but we have a range, and it was three to two passing scientific acceptability. Do we have any comments about the reliability or validity, any concerns, questions? Great, okay, so we'll move on to the usability and feasibility. So here - so we had predominantly moderate for the usability, again with a range here. Do we have any comments about the usability of this measure? Concerns or questions?

All right, moving on here we have for feasibility, an area in which we had kind of split between high and moderate with the overall skewed to the moderate. And so do we have any questions about feasibility? All right, so overall this passed three to two, but again, ((inaudible)) split with the sample size here. So do we have any questions or concerns about overall the suitability for endorsement for this measure? You know, anybody got any questions, overall questions for the developers on this measure?

Dr. Harold Pincus: Well I think overall it would be useful again to consider how to harmonize all of these sort of general medical screening and - of individuals with schizophrenia and/or bipolar disorder in some kind of standardized way.

(Adam): That's a great comment, and we'll definitely be looking at that in our related and competing with similar population groups, so we'll make sure that we cover that during the meeting, and that's going to be a big portion of that, and may scroll again onto additional calls afterwards. I think that's definitely a critical aspect of these measures. There were a lot of them in there, and we can definitely do some work in that area.

Dr. Harold Pincus: And it's not just standardizing for this to, you know, the preventive health screening, but also for the part - also for the ones that have comorbidity, you know, the parallel measures, you know, like, you know, 1932 and 1934.

(Adam): Yes, definitely, great. So that's a...

Dr. Harold Pincus: Or 1920 and 1933, those ones, you know, they're, you know, so that again, so you're going to get a picture of the full population.

(Adam): Yes, well, we'll definitely be discussing that.

Female: Okay, I'll make a note of that.

(Adam): Great, so we'll - yes, we're making a note of that. Do we have any other comments about 1927? Great. All right, so moving on, we're going to move onto 1934.

Female: Okay.

(Adam): And Lisa is the lead discussant on that.

Lisa Shea: Yes, so I think this measure again as we've discussed is pretty similar in terms of the sample size, the fact that we used - that was used and how it was determined, but this is specific diabetes monitoring for people with diabetes and schizophrenia, and it again looks at people ages 25 to 64 who have schizophrenia and diabetes who received diabetes monitoring as specified by having both a glycosylated hemoglobin test and a LDL test during the measurement year.

And again, it is a process measure using administrative claims at the state level. It - in terms of its impact, it certainly does address a health priority related to population health, serious mental illness, and there is a high co-occurrence of schizophrenia with diabetes, which is particularly related to the medication used to treat schizophrenia.

It was unclear though to me in general that the rate of non-treatment in the general population is - I'm sure it is higher with people with severe mental illness, but also probably high in the general population. But there was a level of variation in performance, and so there did seem to be an ((inaudible)) there in terms of the gap. In terms of the body of evidence, again, the whole body wasn't summarized. It was - we do have to take the leap that screening - that by screening you will improve the management.

There was not a systematic evidence review. There was a reliance based on guideline based on effort consensus in selected individual studies rather than the entire body of evidence. Going into number two in terms of reliability and validity, the measure specifications were precise. There did appear to be empirical evidence of reliability from the measure score.

The correlations in between the ((inaudible)) of consistency of the measures, higher performing states and the lower states, flexibility weren't assessed and there was a reliance on face validity, on using the technical assistance group and there was also again the concurrent validity relying on the utilization of the mental health ER, which we've already discussed.

On the measure - moving on to three, the measure was determined to be useful by focus group, public comment, and the tab, and high performance were stable over time except in smaller states, and there did seem to be - the measure did seem to be feasible in terms of being able to use it.

(Adam): Great. Thank you very much for that overview. We'll go on to the ratings here, get the right ones up. All right, here we go. All right, so it - overall for importance it passed four to one. Looks like we had a range here in the evidence, but mostly at moderate. The quality of the evidence had a range from high to insufficient. Does anybody have any comments, questions, or concerns about the importance criteria?

All right, moving on to scientific acceptability. Here that passed three to one, again with a range for both reliability and validity. Do we have any comments about the reliability or validity of this measure? Okay, all right, we'll move onto usability and feasibility here. It looks like they passed - they both had mostly moderate. Any comments about the usability or feasibility?

All right, and overall we had a four two suitable for endorsement vote. Do we have any comments on the overall measure or any questions for the developers?

Female: Go ahead.

(Adam): Yes, go ahead.

Lisa Shea: The question I had is that the standards are you know, doing hemoglobin A1C every six months, and I guess I'm wondering why it's one? You know, if they want to make it consistent with ABA, and that was my main concern, because every six months if it's well-controlled, and if it's not well-controlled, it's every three months per ADA. And you know that for many people with mental illness it's not well-controlled. So I guess I'm just wondering why this the looser if we're really wanting to increase quality of care.

(Adam): You want a developer to clarify that?

Sarah Scholle: So this measure is aligned with existing measures for the general diabetes population, ((inaudible)) screening once during the year. And if you ask for the six months, it's really saying you know, you could imagine somebody having it at the beginning of the year, and you know, it could really be the time window.

You might just have it, you know, in the next year and it might not count. I think it's a point well taken, and we can go back to our experts on the diabetes world to understand whether it's been considered to look at it more than once. But we were trying to align with an existing measure.

Lisa Shea: Right, I mean, but if you look at the - I mean, it's tighter than the 1C.16. You know, it does perform a 1C test at least two times a year for people meeting treatment goals. So that is established.

(Adam): Yes?

Female: Is this something - I'm speaking to the developer now - is this something that you wanted to review for this period of review and get back to us on?

Male: Yes, we'd be happy to.

(Adam): Okay, that's great. Thank you.

(Dody Kelleher): This is (Dody). I was - I know we're running out of time, but I would expect to hold discussion around why these screening measures are for both bipolar and schizophrenia, and the monitoring measures are only for schizophrenia.

(Adam): Do we have any clarification on that?

Sarah Scholle: So I know that our - we've spoke with our advisory group about this at length, and (Melesh), can you recall the rationale for focusing on the - focusing on schizophrenia?

(Melesh): So we did test it that way. I don't - that's probably not a good answer, but originally we tested the monitoring measures with - the monitoring and the screening measures differently with different denominators.

Female: Does that answer your question? That was...

(Dody Kelleher): It answers it. Again, I don't think we have time.

Dr. Harold Pincus: It's also a little bit different also in that for the monitoring ones it doesn't require that the patients with schizophrenia have antipsychotic medications.

Female: So can we have a little more discussion quickly around that, because I think it's going to come up at the in-person, so we just want...

Dr. Harold Pincus: I mean, in some ways it makes sense that, you know, the issue, you know, it's for the screening thing, it's a particular issue where people that are on antipsychotic medications, and you know, so they - you can have you know, a broader diagnostic category, whereas if you're not limiting it to you know, for the monitoring component, if you're not limiting it to people who have antipsychotic medications, then having a more specific diagnostic category would make sense.

(Adam): Great. Any more comments about that?

Female: Okay.

(Adam): All right, do we have any other further overall comments about 1934? Great. All right, so we'll make sure we address that prior to the in-person meeting. We'll have that discussion. All right. We'll move onto 1933. Now...

Female: This was (Dr. Mark Walrich). Do we have him on the line?

Carlene Phillips: I'm sorry. This is Carlene Phillips. I need to leave for another meeting, so...

Female: Okay. I'm sorry we've gone a little bit long. It looks like we don't have our lead reviewer on this call, so we'll just walk through quickly.

From #1933, this is cardiovascular health monitoring for people with cardiovascular disease and schizophrenia, and this is also a NCQA measure. Level of analysis is at the state level. The numerator statement is one or more LDLC tests performed during the measurement year. The denominator is adults 25 years and older as of December 31st of the measurement year with a

diagnosis of schizophrenia and cardiovascular disease. And then this is a monitoring measure, and we'll - in the interest of time, walk through - have (Adam) walk through our reviews.

(Adam): Okay, so importance passed three to two, and I think we had a range here for the evidence again, anywhere from high to insufficient. And the importance and opportunity mostly skewed towards high with moderate for the opportunity for improvement. Do we have any comments about the importance of this measure? Any questions for the developers? All right, hearing none, we'll move on to the scientific acceptability. Again, we had a range...

Dr. Harold Pincus: Harold, I'm going to have to step off.

(Adam): Okay, all right, thank you. Any further comments about the reliability or validity? All right, and I think we had - for usability and feasibility we had mostly moderate here, and split for feasibility. Any comments about the usability or feasibility? All right, and then overall we had a four to two suitable for endorsement vote. Now do we have any overall comments, questions for the developers, about this measure?

Angela Franklin: This is Angela. I just wanted to let everyone know, again, there's a harmonization issue here with the general diabetes monitoring measure, and that's 0063, diabetes lipid profile. And we'll be putting that measure into our discussion at the in-person meeting as we discuss the measure. And there are important differences, if you check in section five of the measurer that the developer has drawn our attention to.

(Adam): Okay, sorry to rush through this here at the end, but...

Female: Overall questions?

(Adam): Any overall questions? Great. Well, I want to thank everybody for joining us on the call today. We'll be sending out some information later in the week regarding related and competing and further information about the meeting next week. You know, we're looking forward to having you all here in Washington and really diving into these measures along with the rest of the ones that were discussed in the other two workgroups.

Female: And for the developers on the call, we'll be following up with you on the various measures where they're in question. Just we'll do that via email and feed that to the committee as they - as your responses come in.

(Adam): All right, well, thanks, everybody, again, and we're looking forward to seeing you all.

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