NATIONAL QUALITY FORUM

Moderator: Care Coordination
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Operator: This is Conference #93838294.

Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by.

Kathryn Streeter: Hi. Good afternoon, everybody. Thank you for joining us today. This is the Care Coordination Measures Standing Committee Orientation and Measure Evaluation QA Webinar.

I'd like to introduce our project team to you. Here with me in the room is Peg Terry. She's senior director here at NQF. I'm Katy Streeter, senior project manager – and Yetunde Ogungbemi, project analyst. We also have a new staff member that is joining our team, and she will be our project manager for this project. And her name is (May Nacion).

So, today will be a refresher for most of you. On this call, we plan to give you an overview of the National Quality Forum Consensus Development Process, or what we call CDP, and our portfolio of measures. We will also go over the major project activities and the timeline, orient you to the roles of the committee, the co-chairs and staff. Then, we will present a high-level introduction to our measure evaluation criteria. We will also show you how to navigate through the Care Coordination Committee SharePoint page, which is where all project materials and meetings documents will be posted for you. And we will be walking through an example Measure Worksheet.

So, now, we would like to take a roll call to see who is joining us today.

Yetunde Ogungbemi: Don Casey?

Gerri Lamb?

Gerri Lamb: Here.

Yetunde Ogungbemi: Rich Antonelli?

(Samira Beckwith)?

Colby Bearch?

(Ryan Coller)?

(Chris Dessey)?

Shari Erickson?

Shari Erickson: Here.

Yetunde Ogungbemi: Barbara Gage?

Dawn Hohl?

Dawn Hohl: Here. And I just want to let you know I do need to drop off around 1:40.

Yetunde Ogungbemi: OK. Thank you for letting us know.

Dawn Hohl: Sure. Thank you.

Yetunde Ogungbemi: Marcia James?

Emma Kopleff?

Brenda Leath?

Russell Leftwich?

Russell Leftwich: Here.

Yetunde Ogungbemi: Lorna Lynn?

Jean Malouin?

Karen Michael?

Terrance O'Malley?

(Karissa Pachela)?

(Karissa Pachela): Here.

Yetunde Ogungbemi: Ellen Schultz?

Ellen Schultz: Here.

Yetunde Ogungbemi: Beth Ann Swan?

And (Jeff Weaverick)?

Are there anybody that – or is there anyone that was on mute and is having technical difficulties that hasn't been able to speak or say that they are attending the call?

Kathryn Streeter: And, also, please note if you are streaming this webinar from your computer, if you do want to speak or ask questions, you will have to dial in. We have several committee members that actually are on the webinar – logged in to the webinar but they have not dialed in. So, that is why you haven't heard their names.

Before we go any further, Gerri, did you have any opening remarks or comments that you would like to make?

Gerri Lamb: Always. I would love to.

Welcome, everybody. This is a really important kickoff for our face-to-face meeting coming up. So, I'm just delighted to see us going to be able to have

this opportunity to meet again. And I'm really looking forward to seeing all of you and working together.

Thanks for letting me say a few words.

Kathryn Streeter: Thank you. Moving to overview of NQF, the CDP and roles.

Established in 1999, NQF is a nonprofit, nonpartisan, membership-based organization that is recognized and funded in part by Congress and entrusted with important public service responsibility of bringing together various public and private sector organizations to reach consensus on how to measure quality and health care as the nation works to make it better, safer and more affordable. NQF is a forum. There are about 430 organizational members. Membership is diverse and includes hospitals, medical groups, health plans, physician societies and nursing organizations, purchasers, patients and consumers, public and community health agencies, local and state-based agencies and health organizations, biopharmaceutical research companies, medical device companies, and federal agency partners.

We would not be able to do the work that we do without our volunteers. More than 800 expert volunteers such as yourself collaborate in NQF committees annually. And we are a forum. So, everything we do is open to member participation, and all materials are accessible on our website. All of our calls and committee meetings, webinars are open to the public, and we really make sure that all of the work we do is transparent.

So, NQF has multiple activities in the area of measurement. One of the things we are well known for is endorsement and, as we call, our CDP – consensus development process. We have over 600 NQF-endorsed measures across multiple clinical areas, over 19 (in panels and) standing committees. And the CDP is a seven-step process that typically takes about 9 to 12 months to complete. Measures must meet NQF standard evaluation criteria – and we will give you a refresher on that a little bit later in the presentation.

We are also well known for the MAP, the Measure Applications Partnership. The MAP advises HHS on selecting measures for over 20 federal programs, Medicaid and health exchanges. MAP was created in 2010 in response to

Affordable Care Act provisions. Another – sorry. And, also, the MAP does involve over 150 individuals and 90 organizations.

The National Quality Partners Action Team convenes stakeholders around critical health and health care topics. Most recently, topic areas included anti-(microbial) stewardship, maternity care, patient- and family-centered care and readmissions.

We also provide guidance on how to improve measurement and which measurement gaps to focus on. Recently, we have produced measurement framework and guidance in areas related to health IT and patient safety, telehealth interoperability, common community-based services, population health, and rural and low volume providers.

We also work in the area of measurement science. We convene private and public sector leaders to reach consensus on complex issues and health care performance measurement such as attribution, alignment and sociodemographic status adjustment.

So, our consensus development process. You might notice something looks a little bit different here than the last time you all convened to review measures. We have now moved from an eight-step process to a seven-step process for measure endorsement. And what is different here is that we no longer go through a board ratification step. That step has been removed, and we now go through Consensus Standard Approval Committee, CSAC, ratification and endorsement right into the appeals period.

So, as I mentioned earlier, the Measure Applications Partnership informs a selection of performance measures to achieve the goal of improvement, transparency and value for all. The MAP provides input to HHS during pre-rulemaking on the selection of performance measures for use in public reporting, performance-based measurement and other federal programs. The MAP also identifies gaps for measure development, testing and endorsement. The MAP encourages alignment – measure alignment across public and private programs, settings, levels of analysis and populations to promote coordination of care delivery and reduce data collection burden. MAP has

provided input on over 200 measures under consideration by HHS for nearly 20 federal performance measurement programs.

Next slide.

So, this slide is just to give you kind of a visual representation of how CDP and MAP are integrated and how we exchange information.

A MUC or measure under consideration that has never been through NQF may be considered during MAP pre-rulemaking recommendations. MAP may decide to give that measure conditional support pending NQF endorsement. And with that decision, NQF would then reach out to the measure developer and solicit them or try to work with them to submit their measures for review – for an evaluation for endorsement. So, this feedback from the MAP is provided to standing committees such as yourself who are reviewing measures for endorsement.

And, then, the other way it works is that a standing committee such as yourself may be reviewing a measure, may have lots of feedback on a measure that is not being used in a federal program or hasn't been considered through MAP pre-rulemaking recommendation. But, all of your feedback on the criteria – on the measure would be provided to MAP during their deliberations. So, we are continuously trying to improve this information flow and feedback loop to ensure that the MAP and CDP committees can provide each other with useful information for endorsement and for MAP pre-rulemaking recommendations.

So, general duties as part of the role of the standing committee. We bring – we bring you together evaluate the measures in depth and make recommendations to NQF membership for endorsement, and the NQF membership with then vote on the measures.

Your role is to act as a proxy for the NQF multi-stakeholder membership. In the process for two or three-year term assignments are selected at random. Many of you have already served your two- or three-year term and you have renewed your term and are on a second term. And we thank you for that.

You will be working with us to achieve the goals of this phase of work. You will be evaluating candidate measures against the criteria. You will be responding to comments submitted during the review period and respond to any directions from the CSAC.

Duties specific to measure evaluation. We ask that you review all measures that will be put forth to you. Review them and evaluate them against the criterion, make recommendations to NQF membership for endorsement, and oversee the whole care coordination portfolio of measures. This includes evaluating the new measures, endorse measures that are due for maintenance review, identifying gaps and considering other measure issues that arise, such as ad hoc reviews et cetera.

Roles of standing committee co-chairs. And this won't be new for Dawn and Gerri. But, for those of you who are new, the co-chairs co-facilitate the standing committee meetings. They work with NQF staff to achieve the goals of the project, assist NQF in anticipating questions and identifying additional information that may be useful to the standing committee, keep the committee on track to meet goals of the project without hindering critical discussion or input. The co-chairs represent the committee at CSAC meetings and also participate as a committee member.

Here at NQF, our role as staff is to work with the committee to achieve the goals of the project and ensure adherence to the consensus development process. We will organize all the steps and standing committee meetings and conference calls, guide the committee through steps of the CDP and advise on NQF policy and procedure, review measure submissions and prepare materials for committee review. This include staff preliminary analysis, which is something new and we will go over in more detail later in the presentation. We will draft reports and edit reports for committee review, ensure communication among all project participants including the committee and measure developer and facilitate necessary communication and collaboration between different NQF projects.

In addition to the work with the committee, we will also work with the public to respond to queries, make sure the Web information is up to date and accurate and to help the measure developers through this submission process. Our final product is a final project report that will be made and posted to the public and submitted to HHS.

Before we go on, I just wanted to pause and see if there are any questions about the material that has been covered so far.

Male: So far so good.

Kathryn Streeter: OK. So, moving on to an overview of NQF care coordination portfolio. And I know that many of you have been engaged in this off-cycle process and attended a webinar in October that another staff member, (Rachel), was leading and you did have quite detailed discussion about the portfolio of measures.

This particular phase of work will evaluate measures related to care coordination that can be used for accountability and public reporting for all populations and in all settings of care. We are soliciting new measures, and we also have five measure that are due for maintenance review. We did receive two new measures. So, that will bring it to a total of seven measures that the committee will be reviewing.

The two new measures are from developer called the Collaboration for Advancing Pediatric Quality Measures. They are one of seven centers of excellence that are funded through Agency for Healthcare Research and Quality. And they have to do with asthma connection with primary care before and after ED visit. So, you can look forward to two new measures in this project.

The next slide shows you – and this is nothing new. You saw it in the fall, to those of you who are participating. These are the measures that were reviewed in phases one and two and endorsed. And what is bolded and has an asterisk next to it – those are the measures that are due for maintenance review. So, you will be seeing them during this phase of work. So, there are three here.

On the next slide are the remaining three. And, actually, one of the measures was not submitted for maintenance review. That is why there are six here. So, we will make that update. It is the one that was not submitted was the timely …

Female: Initiation of care.

Kathryn Streeter: Yes. Initiation of care.

None of the phase three measures are due for maintenance review. But, they are part of the portfolio, so we wanted to share them again with you here.

And just briefly before we dive into the measure evaluation criteria, walking you through the SharePoint page and showing you an example preliminary analysis by staff, we wanted to share with you the activities and timelines for this project.

As you can see, the call for nominations has closed. And this brings us to our committee today. We did seek five new members. And we thank you for – I think, most of them has joined us today. So, we thank you for joining the committee.

We are holding our committee orientation and QA calls this week. This is the first of two calls. And just a quick reminder. You only need to attend one call. We will be covering the same material in both calls. Although you are welcome to join both, if you would like.

We will be holding two workgroup calls in early February. We will be making assignments to workgroups. You only need to attend one of two calls. But, we do encourage you to attend both if you can. If you know you have a conflict with one of the two dates, please email our team and we will be sure to place you on the workgroup that works better for you time-wise.

The in-person, please note, has changed from a two-day meeting to a one-day meeting. We will now be convening on Wednesday, February 22, instead of the 21st and the 22nd. This is because we have seven measures and, typically,

as you may know, a project like this could be evaluating up to 20 to 25 measures. But, because we have the seven measures, we are fairly – and this is an experienced committee, we are pretty confident that we can cover this in one day.

So, post-meeting call we have scheduled for March 7. We may or may not need that, depending on any follow-up items from the in-person meeting. Public and member comment will be in April. That is when we will be posting the draft report with your recommendations for NQF member and public comment. We have a post-comment call schedule for May 16. Following that will be a 15-day member voting period. The CSAC review will be an in-person meeting July 11 or 12. And the last step of the process is a 30-day appeals period that will be from July 14 through August 14.

Any questions before we dive into measure evaluation criteria?

Gerri Lamb: Yes. This is Gerri. I do. I know that the CDP is certainly our priority for the work on the 22nd. I'm hoping there will also be timed especially for our new members, to talk about some of the off-cycle discussions and look at the portfolio so that we have chance on a go-forward basis to take a look at the portfolio where the gaps are and where we might want to move in the future.

Kathryn Streeter: Absolutely. And we are really hoping to do that as well. And our project team has been working closely with (Rachel), who has been leading you through the off-cycle activities last year. So, we are up to date on the conversations you have had so far and some of the recommendations for discussion items. And we can, hopefully, focus on them during that one-day meeting as well along with the measures.

Gerri Lamb: That is great. Thank you.

Kathryn Streeter: Thanks. And, now, I'm going to turn it over to Peg, who will lead us through measure evaluation criteria overview.

Peg Terry: Thanks, a lot, Katy.

And there's a lot of material here to cover, so I'm going to try to go through it kind of quickly. And we will actually show you an actual measure at the end so you can – what I'm talking about initially – we can actually look at it when we go to the measure at the end of this, my part of the presentation.

So, measures are reviewed against the evaluation criteria that are current at that time. NQF's guidance was updated in 2016. The criteria has undergone significant changes over the last two years with more emphasis on feasibility and usability and less emphasis on scientific acceptability for maintenance measures.

Some of the changes include the STS review, the PR – person-reported outcome performance measures, PROPMs, composite measures – all or none, and we – the two new measures are composite measures – an additional guidance on outcome measures for performance gaps and new guidance on population health and access measure. This new guidance is in place to assist in the changing measurement landscape and to raise the bar on changing the process of evaluating measures against the criteria. Because measure have been endorsed previously does not mean they are automatically expected to meet the current criteria.

So, how do we decide what is good enough for accountability purposes? NQF endorses measures for accountability applications. And many of you know this is public reporting, payment programs, accreditation, as well as quality improvement. We do have standardized evaluation criteria. And as I mentioned, the criteria has evolved over time in response to stakeholder feedback.

The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demand for measures. The criteria evolved to reflect the ongoing needs of stakeholders. Developers know what to expect. End users know that a measure has been evaluated in a certain way.

So, I'm going to now begin with what we call the hierarchy of evaluation and the major endorsement criteria. So, as I go through this, you will see page

numbers on the slide. And the page numbers refer to the Committee Guidebook. So, if you want to look at this later, you can kind of reference this PowerPoint and then go and look at some of the guidance that is a little bit of a deeper dive into the Committee Guidebook.

So, the criteria are in a specific order and that there is a hierarchy, as I mentioned. There is a logic to looking at them in this specific order. The first will be importance to measure and report followed by reliability and validity, scientific acceptability to measure properties. Criteria one and two are must-pass. Note that we will also discuss harmonization and best in class a little later in the presentation.

So, I'm going to take really a quick look at the major criteria. Importance to measure report. The goal is to measure those aspects with the greatest potential of driving improvement. If not important, the other criteria are less important. It is a must-pass. Reliability and validity goal is to make valid conclusions about quality. If not reliable and valid, there is a risk of improper interpretation – must-pass. Feasibility goal is to ideally cause as little burden as possible. If not feasible, consider alternative approaches. And usability and use goal is to use for decisions related to accountability improvement, which is what I have just mentioned. If not useful, probably do not care if feasible. So, one of the things, again, we will look at later is how we evaluate measures that are related and/or competing.

Also, in addition to the major endorsement criteria, we have sub-criteria, which really delineates how to demonstrate that the major criteria are met. How do – how do we know the measure is important and scientifically acceptable? Criteria parallel the best practices for measure development, for example, beginning with identifying what is important to measure and later what is feasible. Both criteria and sub-criteria involve a manner of degree rather than all or nothing. It requires both evidence and expert judgment.

So, let us start with importance to measure and report. I caution that importance to measure and report does not speak to if the topic is important. The process of care for the topic – this topic area is probably very important. Everything we do in health care is important. But, in terms of having the right

measures, not everything needs to be measured. The committee must consider if this aspect of care should be measured. And is extending resources and developing a fairly considerable infrastructure to select and report on data for the measure seem reasonable and necessary? I'm sure many of you have been involved in that in your careers where you are involved in setting up a structure to be able to collect data and evaluate measures. Does the value importance of the – of the information we are obtaining offset the burden of measurement? Very important consideration.

So, when we look at improvement, we all feel like we all like to feel good that we are performing well. But, NQF-endorsed measures have a goal to drive improvement. So, if everybody is getting an A, there isn't a great deal of improvement possible. And as you look at measures in this particular program and others, there are measures that we have had in the past that have what they call topped out, meaning that there is no more opportunity for improvement. So, we are looking for measures that actually continue to have that opportunity for improvement.

So, importance to measure and report, just to quickly go through this, is the extent to which specific measure focus is evidence-based and important to making significant gains in health care quality. And underneath that, you will see three sub-criteria. One is evidence – the measure focus is evidence-based – opportunity for improvement, demonstration of quality problems and opportunity for improvement, data demonstrating considerable variation or less-than-optimal performance in the quality of care across providers or disparities in care across population groups. And for the composite measures, we are looking at the quality construct and rationale.

So, let us talk a little bit more about evidence. So, first, there is outcome measures. And outcome measures, you know, are – we really are looking for a rationale for how the outcome is influenced by a health care process of structure or intervention. So, what particular – and that is all we need to demonstrate that an outcome measure is acceptable. I think, when it comes to structure, process and intermediate outcomes, we have – we look at a lot more evidence to tell us whether the evidence – speaking of evidence – whether there is enough evidence to support this measure.

What we look for in process, intermediate and outcome measure as the what we call the quantity, quality and consistency of the body of evidence underlying the measure, which should demonstrate the measure focus on these aspects known to influence desired outcomes. Are there empirical studies? Expert opinion is not evidence. Systematic review and grading of evidence. The clinical practice guideline is variable in approach to evidence review.

So, some of the things that – you know, as we begin to look at this, we know that there have been published empirical studies. So, the systematic review and grading of desirable expert panel decisions are not an ideal source of evidence. Not all systematic reviews are equal. In 2011, the Institute of Medicine published two studies around performance of systematic reviews and use of systematic reviews in clinical practice guidelines. And we are seeing an evolution of adopting IOM standard for writing and doing of systematic reviews and the use of systematic reviews for IOM process and clinical practice guidance from professional societies.

Process and transition. Many, many measures are based on clinical practice guidelines. But, those guidelines are variable in their approach. The evidence review – and many of them are undergoing current re-reviews based on new evidence. Developers are asked many questions about the quantity, quality and consistency of evidence. And you will see when we look at the measure how we do look at that QQC.

So, in the next page – and I'm sure you can't really read this very well. But, you will become acquainted with this. And you can see this on page 36 in your – in your committee guidelines. And, so, I just wanted to show you the kind of algorithm that you will go through.

And I want to stop here and mention that for the first time, you will have what we call here an NQF the preliminary analysis by the NQF staff of measures. And we will, as staff review each of the criteria – the major criteria. And one of the ways we do this is we actually walk through the algorithm with the guidance that we have to make sure there is a standardized approach and that

we can make – we can evaluate each of the measures based on the criteria that is here.

So, just real quickly, if you look at the algorithm, the top yellowish – if it is yellowish – look is where we have – what we have – how you are looking at an outcome measure. And that is really that you need to find – you need to have one health care intervention process or standard or structure and to actually indicate that there – have a relationship with that in the outcome measure. If that is the case, then it is a pass. Otherwise, it is not – it is a no pass.

For process, structure and intermediate outcome, you go down to the next, number three, box and you would begin your review of the measure there. And as you will see here and we will talk about later in the – when you look at actually the measure, we are going to look at – you will see that the staff goes through and indicate what box they have, you know, addressed and what do they think the evidence represents in that box. So, you will be able to understand how the staff reviewed the measure. We will give you some guidance as you are reviewing these measures because the PA review by the staff or the preliminary analysis by the staff is only the beginning of the evaluations of measures. It is really up to the standing committee.

So, let us go to the next slide.

And things have changed here at NQF. And, so, what we have here is how we evaluate new measures versus maintenance measure and where the emphasis has been recently as we do that.

So, the first one is, under new measures, we look for evidence. We look for the quantity, quality and consistency, those QQC that I just mentioned. We also look for outcome measures to establish a link for the process measure with – that there is a process measure with outcomes. We also – under gaps, we look for the opportunity for improvement, variation, quality of care across providers.

And, then, for maintenance measures, there is a decreased emphasis. So, review measure developer to attest that evidence in unchanged. And you will

see that – and you will see that in our example today that the developer has said and that the analysis shows that there was no difference in evidence. And that is accepted. And we can move on from there. If changes in evidence, the committee will evaluate as they would a new measure. And, then, in the area of opportunity for improvement, data on current performance gap and care variation – that is very important that we have that new information because it does change over time.

Next.

So, reliability and validity, the scientific acceptability of measure properties. Reliability are not all-or-none properties. They are a matter of degree. Reliability and validity are not static. They can vary with different conditions of using the measure. In order to be valid, a measure must be reliable. But, reliability does not guarantee validity. This is something we say here all the time. So, you will probably hear it later in the presentation as well.

Empirical evidence of reliability and validity is expected. Reliability and validity are demonstrated for the measure as specified, not the measure concept. So, measure specifications are addressed under reliability and validity. For reliability, there are (inaudible) specification foundation for reliability and, for validity, specifications consistent with evidence foundation for validity. So, as you can see here that those specifications are very important and they are a part of the must-pass.

Flexible testing options rather than prescriptive are part of what we expect. Specific thresholds are not set. Results should be within acceptable norms. Insufficient evidence cannot be evaluated or considered for endorsement untested. It does not replace need for expertise and judgment.

Reliability can be tested for data elements and/or the measure support. Testing can be done with samples. Prior evidence can be used as appropriate. If empirical evidence of data element validity – separate reliability of data element is not required. And that really means that if you are looking at data elements, you really can use your data from validity to use for how you are

looking at the reliability of the measure. And face validity and measure score as indicative resource is acceptable.

So, this picture – we use this picture a lot here at NQF. And it just really is a way of pointing out how reliability and validity – and the importance of it. So, in the first target, all the measures are quite similar. But, they don't do a very good job hitting the target. This portrays a measure that is reliable but not valid. In the second target, the measures aren't very close to each other or the center of the target. This portrays a measure that is neither reliable nor valid. In the third target, all the measures are close to each other and to the center. The target portrays a measure that is both valid and reliable. Note that in order to be valid, a measure must be reliable.

Measure testing. Empirical analysis to demonstrate the reliability and validity of a – of the measure as specified – we have talked about the specifications being very important – including the analysis of issues that pose threats to the validity of the conclusion about the quality of care such as exclusions, risk adjustment and stratification for outcomes measures and resource measures, methods to identify differences in performance and compatibility of data sources and method.

So, again, let me emphasize that these – we will have later examples to show you how the developer might test this. And here, you can also refer to the Measure Testing Guidance Report. That will be part of the information that you will get on this measure. And we probably – we will be posting those quickly not too – not too long.

So, I just wanted to touch base on a few issues here. Reliability of the measure score refers to the proportion of variation of the performance score due to systematic differences across measure entities in relation to the random variation or noise – as I say here, signal to noise – example of statistical analysis of sources or variation of performance measures, which is signal-to-noise analysis. And the reliability of data elements refers to the sort of repeatability and reproducibility of the measure and uses patient-level data. And a good example of the testing is the interrater reliability. Consider whether testing used an appropriate method and included adequate

representation of provider and patient and whether results are within the acceptable norms.

As you – as you will see as I go down – go through the actual measure, you will see how the specifications, how the numerator and denominator are set up. And you will also get a sense of the source of the data, the level of analysis and, actually, the results of the reliability testing.

So, what I want to do is I want to just show you a little bit of our algorithm. Again, this is an algorithm, as I mentioned, for reliability. It is important that you – and this is not the whole algorithm by way, just – it is just a portion of it. There is a little bit more to it. But, again, it provides us standardized approach or a standard approach. And you will it offers the staff a way as we are doing our PAs, our preliminary analysis, to walk through this and provide that information in the PA summary when we are rating a measure. And just to kind of point this out a little bit, first, just looking at the first – number one box – and we do this by boxes – are the specification precise, unambiguous and complete so they consistently be implemented. And you see – you can go to – you can rate that as low or you can say "Yes" and you can continue to go on.

Here, it talks – under reliability, if a measure is – you know, if the measure is as specified. So, if there are only descriptive statistics, if there is – if the described process for data management is clean or able to look at this actual measure, was empirical, validity tested or patient-level data conducted – so, if they are looking at patient-level data, you can then go to the validity way of evaluation your measure. You can go to the validity algorithm and we will provide you that further guidance. So, as I said before, if you are doing data-level – patient-level data testing, you can use the validity guidance to help you do that.

So, validity testing – key point. There is the empirical testing. And, so, the measure score assesses a (hypothesized) relationship of the measure results to some concept. It assesses the correctness of inclusions by quality. Data element assesses the correctness of the data elements compared to a gold standard. And you will see later the way the gold standard testing is done.

And face validity issue – as we mentioned before, face validity is something subjective – determination by experts if the measure appears to reflect quality of care.

So, again, here is another algorithm, which walks you through a little bit of detail – and I'm not going to go through this. Just so you know, that is on page 50. It is where this is. And then, again, it offers this guidance to evaluate the measure.

So, important to evaluating validity is to how to consider potential threats. There are numerous of validity listed on this slide, and I just wanted to go through those really quickly. One is conceptual. Measure focus is not a relevant outcome of health care or not strongly linked to a relevant outcome. Unreliability – generally, an unreliable measure cannot be valid. I think we said that already. Patients inappropriately excluded from the measurement or differences in patient mix for outcome and resource use measures or measure scores that are generated with multiple data sources and methods or there may be a systematic missing or incorrect data, unintentional or intentional. And these are the kinds of threats that we look at when we evaluate measures for their validity. And they are important. And I know I'm saying a lot of words, but once you look at measure, that will begin to make sense.

So, just real quickly on the scientific acceptability, for new measures, measure specification are precise with all the information needed to implement the measure. And for maintenance measures, you really – if there is no difference – require updated specification. So, you do need to provide some updated specifications. Reliability and validity including risk adjustment – if prior testing is adequate, no need for additional testing at maintenance with certain exceptions if there is a change in data source, level of analysis or setting. You must address the question for STS trial period. And we are still in an STS trial period at NQF.

So, feasibility. Now, feasibility is becoming more important. So, this is the extent to which required data are readily available, retrievable without undue burden and can be implemented for performance improvement. So, there are three parts to this.

First is, for clinical measures, the required data elements are routinely generated and used for delivery – during delivery of care. That means, you know, you can see what they are – blood pressure – blood pressure, test results, lab tests, diagnoses. So, what kind of data can you routinely get during the delivery of care?

B, the required data elements are available in an electronic health record or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible near-term (inaudible) electronic collection is specified. And that is really important as we begin to look at the feasibility of measures.

And the last is the demonstration of the data collection strategy. And that includes a number of things, the source, timing, frequency, sampling. It can be implemented – and that is important. So, what is the strategy that is in place to be able to begin to have the data that can be collected easily?

So, well known and seasoned measures tend to have feasible established data collection strategies. With newer measures, committee members must ask what is the developer's plan. How does the developer expect to collect this data? Does this plan seem feasible? And is there undue burden?

Usability and use – the extent to which potential audiences are using or could use performance results for both accountability and performance improvement to achieve the goal of high quality and efficient health care for individuals and populations. So, under usability, there are four sort or sub-criteria. One is the accountability and transparency. And this is important as you look at measures. Even if measures are out being used today or they have been endorsed in the past and they have been used in accountability program, we really no need to make sure that they are in an accountability program within three years or that there is a plan for them to be publicly reported within six years after the initial endorsement.

Another important factor is improvement – progress to achieving the goal of high quality for individuals and populations is demonstrated. So, even if a

measure has been out there for a period of time and it is not showing any more improvement, then the issue of usability and use may be something to consider whether it should continue to be used. Benefits outweigh the harms. The benefits of the performance measures facilitating progress toward achieving high quality and efficient health care for individuals and populations that that outweighs – or (populous) outweighs evidence of unintended negative consequences in individuals or populations.

And the last is vetting by those being measure and others. Those being measured have been given results and assistance in interpreting the results. Those being measured and others have been given the opportunity for feedback. The feedback has been considered by developers. So, what are the questions you would want to ask? Has the measure been in use for a while? Is it working? Is it driving to improve? Are measures – are things improving? Are we going in the right direction? And do the benefits outweigh the harm?

Again, back to feasibility and usability in our kind of new measures and maintenance measures and how we look at those differently. For new measure feasibility – measure feasibility including the e-measure feasibility assessment – we don't have any e-measures in this group of measures that you will be looking at, but there is an additional review for those measures. For usability and use under new measures, is it used in accountability application and public reporting? Impact and unintended consequences – has that been evaluated?

For maintenance measures for feasibility, there is no difference than the others. The implementation issues must be really prominent. So, we need to make sure that we are able – they are able to collect the data and implement the measure. And, then, for usability, from NQF's perspective of maintenance measures, there is a much greater focus on measurer use and usefulness, including both impact and unintended consequences.

So, at NQF, we actually also look at related and competing measures. And, basically, the way we look at it is, for a measure to be a related measure, there are – basically, there are several criteria. And for a related measure, that is the

same focus or the same target population. Those are considered measures that have the same focus and same target population – are considered relating. The competing measures are those measures that you look at that have the same focus and same population. And, so, the goal here is to really look at measure to see whether we can – we or the measure developers can address harmonization or select the best measure, the best-in-class measure.

So, I mentioned throughout this long – this long presentation that we will be doing what is called a preliminary analysis to assist the committee. I think I have already said this is – and this is the first time you will see it, I think, on the way we do it here. And you will see the ratings the staff gives on each of these criteria. But, I want to emphasize again that this will be used only as a starting point for the committee discussion and evaluation. What we will do – and, I think, Katy mentioned that – is individual evaluation assignment for – each committee member will be assigned a subset of measure for in-depth evaluation. And, then, for those individuals assigned to those measures, those – they will lead the discussion of their measures with the entire committee. And will have what we call a workgroup session to kind of give you some practice in doing that.

Next slide, the workgroup.

Just as I said, it gives – it gives the committee a chance to have some familiarity with the measure, allow practice with the NQF criteria and process. And it really gives the developers a really – a look about what some of the concerns the committee may have at that point. So, it is sort of a heads up to the developers.

Measure evaluation recommendations at the in-person meeting. The entire committee will discuss and rate each measure against the evaluation criteria and make recommendations for endorsement.

And, so, I just wanted to end with something. I think, at least in this part, as we look at – one of the things that NQF has done is they now have a new status. It is called Endorsement Plus. And once we complete our – the staff complete their preliminary analysis, we will be able to inform you whether a

measure may qualify. It doesn't mean that it will pass, but whether it is – whether it will actually qualify or whether it does not qualify for the Endorsement Plus criteria.

And what that criteria is is it meets evidence criteria without exception. And sometimes, measures pass. But, the evidence is not strong enough but the committee votes to have the exception to the evidence. Good results on reliability testing of the measure score – so, it is not data element testing. Good results on empirical validity testing of the measure score, just not face validity, and well vetted in real-world settings by those being measured and others. The committee votes on recommending the Endorsement Plus designation, indicating that the measure exceeds NQF criteria in key areas.

So, I'm going to stop for a minute. I'm going to really take a quick look in a measure so you can get a sense of what a measure looks like to see if there is – and the measure we are going to look at – look at is measure 0067.

(Off-Mic)

Peg Terry: First question.

(Off-Mic)

Peg Terry: OK.

Gerri Lamb: Peg, did you want questions?

Peg Terry: Yes, I do. Thank you.

Gerri Lamb: OK. I have a couple. This is Gerri.

Kathryn Streeter: OK.

Gerri Lamb: And I – and I – hopefully, you know, some of the other committee members, if you've got questions, please also add them.

As I'm looking to the criteria that you just reviewed – and it is just – it is really wonderful to see that level of detail and consistency. I just think it will

be tremendously helpful. Could you speak a little bit, Peg, to kind of the nuance specific to care coordination, particularly in the measure maintenance area? You know, as we have worked with the care coordination measures in the past, you know, I think, we have taken them with the understanding that it is a growing field and that we needed to move things out there. So, the good and the good enough is really relevant here.

You emphasized in measure maintenance that we should be really weighting the feasibility and the usability, you know, heavily. Now, my recollection is in the previous kinds of meetings and discussions, some of the care coordination measures we wanted out in the field because there literally was nothing. And, you know, we could go back and say, well, really, did they meet the good and good enough in terms of scientific merit and importance? Maybe, maybe not. So, do we bring in that history and nuance of care coordination into kind of standardized review?

Peg Terry: Well, that is – that is a big question, Gerri. But, I will take a – I will just take a bit of a stab. So, I have to tell you I'm working in another project right now and we are pulling in some of the care – it is called the Medicaid Accelerator project, and we are finding measures that, we think, would work and we are finding measures in care coordination. I happen to mention that because the Medicaid project is looking at high-cost patients. And, so, I only say that to say, well, maybe they are being – going to be used other ways. Right?

So, back to your original question or your question about how do you weigh measures in care coordination because it is – are they good enough or are they used enough? Is that kind of basically – because they haven't been used maybe as much?

Gerri Lamb: Well, I think, you know, it just – there is a bit of a different history here. And when the care coordination CDP started, you know, we were starting pretty much from scratch. And, so, we had lots of discussions about the need to get things out there and try so that, you know, when I look at these algorithms for importance and scientific merit, you know, we had to kind of take that imbalance with the data that were available. So, we may have moved things

forward that are coming to measure maintenance now that, back then, they wouldn't have met those two criteria.

Peg Terry: So, that is helpful for me to hear. I think, this is a point in time – and you need to see it that way. So, what you are looking at is based on where you are today and where measurement is today and whether you as a committee or the committee feels that these measures are good enough – the measures today in the world we are in today are good enough. And, you know, I can't speak to that. I think, it is up to the committee. But, I think, the measures in this committee – and this is just my personal bias – is that they are very important across many other – much of the other measurement work that is going on now. So, it is sort of that underlying theme or premise of care coordination that goes across many, many work – much of the work done here at NQF, frankly.

So – but, I think, you have to look at it at a point in time and say, OK, well, where are we today? And is this still important for the way the measurement is going in care coordination? And do we need to do more or do we need to not accept some of these measures because they may not be as relevant? So, I think, again, I can't say anything more than just to say that the committee – you are certainly an expert in this. And I know. I happen to know. And others who are in this committee. And you need to look at what you have today see whether you feel like it is – it is enough or good enough or whether they will – they are good enough in the world today.

But, I can't speak to that beyond to say that, I think, you know, the ones that are out there now – and we will need to see if they are being used or they will be used or how it will be used – I think, that is sort of what you are getting it. Usability is very important.

Gerri Lamb: Yes. That is – that is very helpful, Peg. And my other question was what is the goal with differentiating Endorsement and Endorsement Plus. It seems like Endorsement sort of is the good enough. Is the Endorsement Plus "Boy, you get a silver star"?

Peg Terry: Yes, I think so. I'm sorry. Yes, I think, to some extent, it means that you are – it is a great measure and it is really – hits all the target. You know, it is not just data element testing or it is not just face validity, that it is – it hits or meets all the best of what measures can be at that point in time – I must say that. It is always at that point in time.

Gerri Lamb: And what is the goal? Is it to point out to the users in accountability and improvement, "Boy, this one is really, really good and, boy, you might want to go to this one first"? Is that the intention?

Peg Terry: Yes. I think, a measure – that is one of the intentions that they would want to maybe use that one. If you are looking at competing or related measures, that would give that measure a leg up in terms of being the better measure. It will be an easier way to identify it. I think, for developers and for the standing committees, it – you know, once that designation is there, it means that this committee has hit all the right marks. It is not just a good committee – a good measure, but it is really a very good measure.

Gerri Lamb: OK. Thank you.

Peg Terry: And for all the five criteria.

Gerri Lamb: Thanks. That's good.

You know, other questions? This is a lot of information. And I know for new folks, if you haven't been on CDPs before, it is a lot. But, we really do get a lot of support in walking through this.

Peg Terry: Is there – is there any other question? Because there will be time after we do a few more things here to ask questions again.

OK. So, I was going to take – you know, we are going to show a bit of a screen look here at this measure. And this is just to give you – if you haven't seen the way these Measure Worksheets look, this is a look at one. And this was a measure that what – did have a PA or preliminary analysis done by the staff. And I just wanted to kind of walk through it really quickly so you could take a peek at it and see what it looks like.

It has the title, "The Measure (steward)." It has a brief description of the measure. This is a patient who is overprescribed aspirin or Plavix, which is the brand name, within a 12-month period. It has some specifications regarding that. It has a denominator, all patients of a certain age with a diagnosis of coronary artery disease seen in the last 12 months. It has exclusions. You will want to know what they consider the exclusions should be. Just go down a little bit.

This is a – this is a process measure. And what we have in our portfolio are several process measures. Those are process measures. And we do have two composite measures, as I said. The data source is important, it's an electronic clinical data registry. Level of analysis – the clinician or the individual. And it is on e-measure. So, right up front, we know this is on e-measure. And this information does come from the developer.

Can we go down a little bit?

So, for this particular measure, your evidence here – and they have checked off or we – the staff, based on the information, has checked off that this systematic review of evidence specific to this measure. The quality, quantity and consistency of evidence was provided. That (so is) QQC. And the evidence is (graded). That is important.

Go down a little bit further.

So, you see here this is a summary of prior – this is a summary of prior review in 2014. And this gives you an example of a measure where you didn't really need – the developer told you that they had this information before and the developer in this level – and below there, it says the developer attests that there have been no changes in the – in the evidence since the measure was last evaluated.

So, this is good evidence. And one of the reasons this is good evidence is they actually had some – evidence was based on the guidelines. There were 10 guidelines. And the guidelines came from the American College of Cardiology Foundation, the American Heart Association. And they have well

known guidelines. And, so, some of the evidence – they actually give a class to the evidence. This is class one level of evidence. It is A, the highest level. And the second – that is for aspirin. The second one for Plavix, it was a class one. The level of evidence was a B. So, this is very good evidence that – they have already told you that this evidence was this level.

And, so, as you go down farther, you see there is an update to this – to this information. Well, why would they do an update? Well, they did an update. But, the evidence in the – that they did in their new update – and it was a meta analysis – actually did not contradict or did not conflict with the prior evidence. So, they were just giving an update. They didn't actually need to do this, but they did.

OK. So, go down a little bit farther and you get a little bit of the guidance from the evidence algorithm. Remember those things – those pages of algorithms? You couldn't really read them here. It is what we do with it. And this is probably the first time you have seen this kind of look at how we do this.

So, this was a process measure based on a systematic review. And you go to one of the boxes and you indicate the box. The quality, quality and consistency was provided in box four. That's (QQC). And a systematic review concludes evidence is of high quality and consistent. That goes to box 5A. And there are several levels to that.

And so, that – from that, you can see that the evidence was rated high, that you can see the preliminary rating for evidence. And that was a preliminary rating done by the staff. Again, I just want to emphasize that is the staff's recommendation. The committee could look at this and say, "We really don't think it is a high for X, Y and Z." You don't have to agree. But, this is a preliminary analysis.

(Please go down a bit).

And, then, we have information about the performance data. And here, what you want to know is – so, how is – is there – is there improvement in performance? You know, I mentioned before that, sometimes, measures top

out. They don't – you know – or the data from measures is (tapped at). You don't seem to be getting any improvement on performance data.

So, here, what we see is they actually say between 2013 and 2014, we are seeing mean – the means for the performance data. And we can see that they are almost identical. And, so, you do have to wonder whether there is – you know, whether there continues to be significant improvement. It doesn't look like the improvement has been significant between those last two years.

If you go down a little bit, you look at the – there are some descriptive data on disparities. And they provide a lot of information on that. They don't actually do another analysis, but they do provide a lot of descriptive data. And it is by gender, age, race and insurance.

OK. Why don't we go down a little further.

And, so, what the – what the staff did is they gave this a preliminary rating of a moderate. And if you go just up a little bit.

And the reason they did that is because they really didn't see much improvement in the performance data between two years. Now, it is not at 90 percent. It was somewhere in the low 80s. But, it does give you a sense maybe things are flattening out in terms of performance.

OK. So, down to scientific acceptability. We have – here is reliability. And here, what we have under reliability is they have a specification. Very clear. They are talking about the codes used. You know, ICD-9 or 10 or CPT codes and talking about, you know, the types – you know, this is information they are providing from physician practices. Do they have enough patients? So, if they don't have enough patients or not included or excluding the patients if they are in a particular physician practice. They go down and they specify the particular they called specification.

Go down a little further.

And are there exclusions to the denominator? Yes. I have – we have already said they have excluded people. I just mentioned we don't have – we have less than 10 patient encounters for that particular practice.

So, if you go down a little bit, we have some testing. So, here are the testing. It is – they have here – you know, this is on reliability. So, they have what they called data element reliability testing. And here, they are comparing a manual abstraction data from the clinical record compared to automated EHR, electronic health record. And they also are providing that information or what they call measure score or performance score of this particular measure.

So, if you go down a little bit – so, they did both – they did both reliability testing of the measure score and the data element. And I talked about the data element one and the measure – the score-level testing was done on large numbers, you know, 2,400 providers and over a million patient. And they used what they call signal-to-noise analysis using the beta-binomial model.

And, so, what you want to see when you go down here further though is the results. So, you always want to see some results. You want to see some numbers. You want to find out whether – you know, whether there is some way you can evaluate the reliability of this. And you do have – for each of these, you have percentage of the agreement and the agreement of data on the data element level. And you also have some numbers that tell you whether there is reliability for this particular measure on the score level.

And, so, as you go down here further, it is not surprising – and this is, again, walking through the algorithm. So, you have – you know, you have the box one, empirical validity conducted, yes; testing and measure score conducted, yes; and appropriate measure testing results. And, so, when there are two types of testing, they usually look at the measure score as opposed to just the data elements. And here, we have a high rating. Clearly because the results are very high.

Now down to validity. And they actually have the specification. Go down a little further. They are using face validity. I'm sure many of you have looked at this before and understand what face validity is.

And here, they talk about people that are on the committee. They are from 42 members and two different groups – two different committees. And they have the right statement. This is the kind of statement you are looking for. Eighty-three percent agree the measure score as specified provides an accurate reflection of quality and can be used to distinguished good – between good and poor quality.

OK. And, so, as you go down here, you look at the threats to validity. I'm not going to go through that. And they have – they have a little information about something we have mentioned before.

OK. Just keep going down, just (threats to) validity. This is not risk adjusted because we only risk adjust at this point outcome measures. These are process measures, so there is no risk adjustment done in this – done in this measure. And they have – this is the overall mean score performance. And you can see the results here. There is very little difference between 2013 and 2014.

And as you go down here a little farther, they talk about missing values. They don't do an analysis of it, but they do talk about missing values here. And, then, if you look at the rating – so again, we walked through the guidance because – and we basically rated this as moderate, which is all you can do with face validity.

(Go) down. And, then, we get to feasibility. And this is really a look at the feasibility here. I think, the most interesting part here if you go down a little bit further is the usability. So, this measure has been around for a long time. it is used in the Physician Quality Reporting System. And what you find, though, is that the improvement results, as we said, have not gone up a lot.

And, so, go down a little further. So, in the MAP meeting in 2014 and 2015, there is question here about whether this measure really adequately addresses the current need of the problem, whether this measure is that useful. As a result, the preliminary rating for this was so low. Now, I don't – now, just keep in mind this is not a must-pass criteria. But, I just want to point that out.

So, it is being looked at. I actually don't know what happened to this measure ultimately. But, I just wanted you to see that.

That is just a quick look through a real measure that was evaluated by the team here. Any questions? I know it is a lot of information. So, it looks like I should apologize. It is so much information in one sitting.

OK. So, I think we have some concluding remarks or follow up by Yetunde.

Yetunde Ogungbemi: Just give me one second. I'm getting the webinar up.

Peg Terry: OK.

Yetunde Ogungbemi: And, now, I'm going to give you guys a SharePoint overview, and I'm going to show you guys the Care Coordination SharePoint, the committee side that you will be viewing and that you have access to.

So, in order to access SharePoint, you will receive or you will – should have received for new members an email from our nominations personnel at NQF. And it will have your credentials and such included in the email.

And I'm going to go over what your SharePoint will look like and where you can find materials. So, on your screen now, there is a Care Coordination SharePoint committee side. And in this first box, you have your general documents. And inside here, there is care coordination framework domains. And I believe that is from (a last) phase of work. Then, you have the CDP Committee Guidebook, which is something that Peg talked about earlier during the call; your Standing Committee Policy; your committee roster of everyone who is on the committee, and there is included biographies in that document; your evidence algorithm; and, actually, what else is supposed to be here is the other algorithm, the reliability and validity algorithm. And those were something that Peg also went over earlier in the call. And I will make sure to add those. There is also a Measure Evaluation Criteria Guidance, which has been update this – in 2016; an NQF Glossary of Terms; and, actually, the testing algorithm is right there. Pardon me.

So, box here, the General Documents, is basically just general information not specific to every committee or specific to all CDP committees except for a few documents.

In this next box is the measure documents. And this is where you will go to access all your measure document set. All the seven measures and all information pertaining to those seven measures will be included in this box here. And it will be nicely laid out for you by the measure number and the name. And all pertinent information on every measure will be located there for your use.

Going down a bit further, we have the Meeting and Call Documents box. In every meeting that we have – that we have and you all attend, there will be materials there for you to see and for your reference.

Going back up the page, your committee home – this is how you access this homepage here. The committee calendar shows you a list of all the calls. And if you go down a bit to the bottom of the page, just the phase four calls are down here and they are all labeled nicely. And any access information like dial-in and Web links are also – will also be located here. Any committee links – there are none here yet. But, if there is anything that a developer wants to give you for reference or a fellow committee member wants to give you for reference, we will put it here. Your committee roster is located here. It has not been completely filled out. But, these are some of our new members here. And our staff contact is here. I'm not exactly sure if it is updated or not yet. But, we will be putting information here for you all to be in contact with us.

Does anyone have any question?

Dawn Hohl: Hi. This is Dawn. I have been on the committee for a while. But I have not gone into that SharePoint site. Can you send out a reminder on the access website? And I guess I might – not sure I know my password anymore. I might have to set up a new one.

Yetunde Ogungbemi: Yes. I will be sure to give our nominations personnel that information.

Dawn Hohl: OK. Great. Thank you.

Yetunde Ogungbemi: Thank you.

Shari Erickson: This is Shari Erickson. Same thing. I haven't been in the SharePoint in quite some time, so I'm sure that I probably don't remember exactly how to access it.

Karen Michael: Yes. This is Karen Michael. It probably is a good idea to send that out to all of us because I'm in the same situation.

Kathryn Streeter: OK. We will – we will send out an email with information on the link for the site and then also who to contact if you are having trouble with any password issues or login issues. Our help desk is really good in – they can help walk you through that.

Female: Thank you.

Gerri Lamb: Yetunde, I'm wondering if it might not be helpful – maybe Dawn and I can put our heads together. Is any kind of background, contextual documents that might be helpful to folks – I'm thinking of things like the measurement gaps and care coordination because, I think, that was the latest time that the framework was updated. And it might help people think about what the priorities were for measure gaps and whether they are still the same.

Yetunde Ogungbemi: Yes. Thank you. That is very helpful.

OK. So, I'm going to proceed if no one else has any other questions.

(Samira Beckwith): Excuse me. This is (Samira). And it is more of a general question. Because I see up on the screen of course our in-person meeting again? Can you let us know what time the meeting is so we can arrange travel?

Yetunde Ogungbemi: Yes. The meeting will start probably like 8:39 a.m.

(Samira Beckwith): OK.

Yetunde Ogungbemi: But, from our meeting department, you will receive an email with registration and information on travel probably within the next week or so.

(Samira Beckwith): OK. Great. Just hoping that I could travel out that night after the meeting. So, OK. Thank you.

Yetunde Ogungbemi: Yes. OK. Thank you.

So, now, I'm going to review our next steps. So, again, like Katy said before, we are going through our measure evaluation orientation and Q&A calls. This is this week. We just finished our first one. And our second one is this Thursday from 2 to 4 p.m. We encourage you to attend. But you don't have to attend both calls.

The next set of meetings will be our workgroup calls. And they are early February, Monday, the 6th and Tuesday, the 7th, both (at 3 to 4) p.m. Again, the staff at NQF will assign lead discussants and you will be broken up and notified of which group you are in. Again, like Katy said before, please let us know if you have a preference and or not able to attend one of the calls so we can put you on the other one. And the next big meeting is our in-person meeting. And that will be on Wednesday, February 22.

Our contact info – and any time you need to reach us, you can reach out to us, the entire staff, at carecoordination@qualityforum.org. If you have a quick question and you want to give us a ring, you can always dial this number here and our receptionist will get us – get you to one of us. Our project page is here. And the SharePoint site is also located here. And these are links that we will send out to you in that follow-up email.

Dawn Hohl: And that will include all of these slides. I'm sorry. This is Dawn.

Yetunde Ogungbemi: Yes, we can include the slide deck as well.

Dawn Hohl: Great. OK. Thank you.

Kathryn Streeter: OK. If there are no additional questions, that will conclude our webinar for today. And on behalf of our team here, thank you very much for taking the time to attend this webinar. And as Yetunde mentioned, don't hesitate to email us with any questions, anything we can do to help you through this

process. We are here to help. And in the meantime, we will send out that follow-up email. And we look forward to talking with you soon.

Female: Thank you. It was very helpful.

Female: Thank you.

Female: Thank you.

Male: Thanks.

END