NATIONAL QUALITY FORUM

Moderator: Pulmonary/Critical Care
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OPERATOR: This is Conference #42314089.

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

Shaconna Gorham: Hello. I would like to welcome you to the Pulmonary and Critical Care Condition Standing Committee Orientation. We are very excited about this project and look forward to working with you all. For the next two hours or so, we are going to share a high level overview of the project, NQF criteria, and the role of this committee.

My name is Shaconna Gorham and I am a Senior Project Manager here at NQF. I've been with NQF for one year now. In addition to this project, I also (staff) the Eye Care, Ear, Nose, and Throat Project; the Cancer Project; and the MAP, Medicaid Adult and Child Task Forces.

Poonam?

Poonam Bal: Hi, this is Poonam Bal, I'm sure a few of you have received e-mails from me. I'm the Project Manager on this project. I've been with NQF a little over two years. And my workload has been mainly around renal, behavioral health, and I've worked with the measure application partnership as well.

So I'll give it to our Project Analyst, Janine.

Janine Amirault: Hi, there, my name is Janine Amirault, and I'm the project analyst on this project. And I'm fairly new to NQF over the last four months or so. And I'm very exited about this project, and …

Poonam Bal: OK, thanks, Janine. So, we'll go ahead and start with the agenda real quick. So, you will see that we're going to do – this call will really give you an overview of how the National Quality Forum works, the Consensus Development Process, or you'll often hear as CDP, and our portfolio of pulmonary measures.

We'll go over the major project activities and time line, (I want to give you) role of the committee, the co-chairs and staff, and we'll present a high-level introduction to our measure evaluation criteria. And we'll also be giving you an overview of our SDS trial period. We do have measures that will be involved in that trial.

So, before I go any further, I want to pause. I saw that our consultant Robyn was on the line. Robyn, would you like to introduce yourself real quick?

Robyn Nishimi: Sure, sorry, (sitting here working away). I'm Robyn Nishimi, I was the Chief Operating Officer when NQF was established. And I've moved into consulting and more project-based content role. And I apologize for being late and pleased to be a part of the team.

Poonam Bal: OK, perfect. Thank you, Robyn. Now we're just going quickly go, do quick introductions of the Standing Committee. I do want to let you know that we do have a lot of candidates who are still in the process. We've been gap filling since the initial comment period has gone out. Those candidates have mostly received their acceptance letters; however, they do need to go through additional comment period. And for the members of the public that are on the line, that will open very soon so you'll be able to see the additional members and provide any comments that you may have. We did not list those individuals yet because they're not considered final in NQF. And so, this list only everyone that's gone through the commenting period.

So with that said, I want to open it up. If we can just go in the order that's everyone is listed on the call. If you could just introduce yourself and provide

us a quick cap of what your expertise are. I'll give it to Janine to start the roll call.

Janine Amirault: Right. We're going to go ahead and start with Dale Bratzler.

Shaconna Gorham: Dale, are you on the call?

Janine Amirault: OK. So we'll go ahead on to Bruno DiGiovine.

Bruno DiGiovine: Yes, thank you. This is Bruno DiGiovine, I'm the Division Head in Pulmonary and Critical Care Medicine at Henry Ford Hospital. I've worked in quality, a number of different roles. I've worked with the Institute for Health Care Improvement as a faculty member. I've worked with the Keystone Center for Quality in Michigan and I'm also on the board of the ABIM, the critical care board.

Janine Amirault: OK, great. Kim Elliott? William Glomb?

Poonam Bal: (Nan), I just wanted to make sure. I see that they're on the webinar, do they not have open lines?

Operator: They need to dial in.

Poonam Bal: OK, no problem …

Operator: But William is on.

William Glomb: I'm on.

Poonam Bal: OK, perfect.

(Crosstalk)

William Glomb: Sorry. I'm a Pediatric pulmonologist and intensivist from Austin, Texas, 30-year career, and now the Senior Medical Director for Superior HealthPlan, which is the largest Medicaid and managed care organization in the State of Texas. I've worked with NQF on this committee in the past and also with (NQHC) and other governmental quality boards. Thank you.

Janine Amirault: Thanks, William. Stephen Grossbart?

Stephen Grossbart: Hi, Steve Grossbart here. I actually have a new role. I'm the Chief Analytics Officer at Mercy Health. I've served on a number of NQF committees and co-chaired this earlier version of this committee a few years back. And I worked – as my new title suggests, I worked a lot in performance measurement and performance process improvement. And I'd previously served as quality officer of Mercy Health, which is the largest hospital system in the State of Ohio.

Janine Amirault: Edgar Jimenez?

Edgar Jimenez: Hi, good afternoon, everybody. I'm Edgar Jimenez, the Vice President for Critical Care for the service line of Baylor Scott & White, which is pretty much the largest system right now in Texas. I have worked with Orlando Health before in quality operations and the past president of the World Federation of Critical Care. Physician for over 35 years, and I (sit) also on the ABIM, on the Critical Care (Exam) Committee and with innovation with many things from Telemedicine, Telehealth, and other things that – they're obviously going to be very important as the future is being looked at. Thank you very much and pleasure to be here.

Janine Amirault: Thanks so much. David Lang?

David Lang: Yes. I am the Department Chair of Allergy and Clinical Immunology, and Respiratory Institute at Cleveland Clinic. And I also have had the pleasure of previously serving in the Pulmonary Critical Care Steering Committee. I also am currently involved with the National Partners Antibiotic Stewardship effort. I've been involved with development of quality measures and a couple of roles in the American Academy of Allergy, Asthma & Immunology. And I teach evidence-based medicine in our medical school here at Cleveland Clinic. I'm pleased to have the opportunity to contribute.

Janine Amirault: Great. Richard Murray?

Richard Murray: Hi, good afternoon, everyone. Richard Murray, I'm the Deputy Chief Medical Officer at Merck. In my former life, I was the Co-Director of the Adult

Asthma Program at the University of Pennsylvania, primary care physician, and used to be an asthma doc and researcher. I've not worked directly with NQF, although I have been closely involved with important quality (preference) for a number of years with …

(Off-mike)

Richard Murray: So, I'm looking forward to …

(Off-mike)

Janine Amirault: Thank you. James O'Brien?

James O'Brien: Hi, I'm Jim O'Brien. My current role is I'm the Vice President of Quality and Patient Safety at an 800-bed hospital in Columbus, Ohio. Prior to that, three years prior to that, I was an academic medicine doing mostly health services research. I've also served as the Chairman of the Quality Improvement Committee that interfaced a lot with National Quality Forum for the American College of Chest Physicians and co-authored a paper with some members at the National Quality Forum. And I'm the Chairman of the Board of Directors of a not-for-profit called the Sepsis Alliance, which is dedicated towards raising awareness of sepsis.

Janine Amirault: Great. Thanks so much. Susan Pollart?

Susan Pollart: Hi, I'm Susan Pollart, I'm with the University of Virginia. I'm currently the Senior Associate Dean for Faculty Affairs and Faculty Development at our school. I started my career, after residency working (inaudible) in the allergy division and spent the first 10 years of my career working on allergen identification and epidemiology of asthma. And then it carried that forward into career, as a family doctor, as an academic family physician looking at asthma guidelines and providing education about application of guidelines and primary care practices. I continue to practice in family medicine with a focus on allergic disease, although much of my time now is devoted to leadership in the school of medicine and the dean's office.

Poonam Bal: Thank you, Susan. Before we move forward, I just wanted to give everyone a reminder to please, if you're streaming from your computer and dialing into the call, please mute your computer otherwise we will get that echo sound that you heard earlier. Thank you and I'll give it back to Janine.

Janine Amirault: Sure. So moving down the line. Crystal Riley?

Crystal Riley: Hi, good afternoon, everyone. I'm Crystal Riley, currently work as the Manager of Healthcare Policy for Baxter. In the previous life, I worked in the policy shop for the joint commission where I was quite intimately involved with quality and performance measures during that time served on a few technical expert panels for CMS, helped at (vet) measures as they, while in their way through their stewards in that entire process. Prior to that, I was actually a practicing clinical pharmacist that focused on patient safety in large hospital systems. So, this is my first time actually serving on an NQF Standing Committee; so very happy to engage and be a part of this effort.

Janine Amirault: Thanks, Crystal. David Stockwell is there?

David Stockwell: Hello, I'm David Stockwell. I'm a Pediatric Intensivist at Children's National in Washington D.C. I spent several years as, in the chief quality officer role here at Children's National and then also I had done some additional work with the American Board of Pediatrics and Development, Pediatric Critical Care Measures, and was also on the earlier iteration of this committee. So, looking forward to getting us going.

Janine Amirault: Great. Is Chana West there?

Chana West: Yes, good afternoon. This is Chana West. I'm a registered nurse, currently working at Booz Allen Hamilton. For the last nine years of my career, I've been in health care quality, primarily focused on clinical quality measurement. I've supported kind of the full gambit. I've worked in measure development testing, drafting NQF submission documentation, implementation, performance improvement, (putting) validation of publicly reported data for over 900-bed hospital in California. And a big part of my work lately has been electronic clinical quality measures and (things) related to that. So, this

is my first time working with NQF in terms of Standing Committee, but I'm happy to support.

Janine Amirault: Thanks for that. And lastly, is Donald Yealy on the line?

Donald Yealy: Thanks again for the invite. I participated in the last iteration of the Pulmonary and Critical Care Standing Committee. I'm a Chair and Professor of Emergency Medicine at the University of Pittsburgh, oversee 20 emergency departments and nine urgent cares, about a million visits a year; and Senior Medical Director at UPMC, which is the largest integrated academic health care financing and delivery system in the country, oversee the medical staff for those 20 places.

The quality and safety stuff that UPMC rolls up to me and my personal area of research has been in sepsis, you're familiar with the process trial; pneumonia with the Pneumonia Severity Index and the PORT Score; and pulmonary embolism, the outpatient treatment of these, all about assessing illness burden and opportunities to intervene early.

Janine Amirault: Is Dale Bratzler on the line? Kim Elliott?

Poonam Bal: OK, thank you, everyone. We'll proceed with the call. So, I wanted to start out with giving some background on NQF. The National Quality Forum was established in 1999 as a non-profit, non-partisan, membership-based organization that is recognized and funded impart by Congress and trusted with public services responsibility of bringing together various public and private sector organization to reach consensus on how to measure quality and healthcare as a nation work to make it better, safer, and more affordable.

So, our mission is really to lead national cooperation to improve health and health quality through measurement. We try to do that through three forms. One is to be an essential forum. As a forum, we do have about 430 organizational members. Our membership is diverse. It includes hospitals, medical groups, health plans, physician societies, nursing organizations, purchasers, patients and consumers, public and community health agencies, local safety agencies and health organization, biomedical research companies, medical device companies, federal agencies, and so on. As you can see, the

list is pretty intensive. We do also have more than 800 expert volunteers, that includes now everyone on this committee, to really assist in collaborating with NQF's work. And we truly appreciate, you know, taking your time out to be part of this great work.

We are also very transparent. As a forum, everything we do is open to member participation and all materials are accessible on our website. Thus, this call is also open to the public.

So we – NQF activities are – we have multiple activities in the measurement field. The first one is performance measure endorsement. So, we – this is what you're currently part of. We have 600-plus NQF endorsed measures across multiple (clinical areas), 11 enabled standing expert committees, and that constantly is increasing as we get more and more topic areas. For people that were previously involved with NQF, we started the Standing Committees about two years ago. We really felt it was important to have that continuous input from Standing Committees.

So, the eight-step process, which we'll go into more detail as we proceed to the orientation, typically requires about nine to 12 months to complete reviewing the measures. The main criteria that we look at are important measuring report, scientific acceptability and measure properties, feasibility, usability and use, and consideration of competing or related measure.

The next major aspect of our work is the Measure Applications Partnership or MAP as we fondly call it. This advises HHS on selecting measures for 20-plus federal programs, Medicaid and health exchanges. NQF created MAP in response to the Affordable Care Act in 2010. We (conveyed) private and public sector (alterations and stakes) measure improvement from federal health program.

The MAP group provides input (to HHS) measures for public reporting, performance-based payment, and other programs if we strongly encourage alignment across public programs in between public and private programs. MAP has provided feedback on Medicare programs, core measure sets for

adult and children, Medicaid, health insurance exchanges, and dual eligible beneficiaries. And this (risk) can grow as more programs are built.

This work involves about 150 individuals and 90 organizations. The next big portion of our work is the National Quality Partnership Action team. This group conveys stakeholders around critical health and health care topics, and really (serve) action on patient safety, early elective (deliverables), and other issues. Some examples of the work that we have in this realm is the maternity care, patient and family-centered care, and readmissions. And a lot of these work does also fall into our MAP and our CDP work.

(One) activity that we have around measurement (inaudible) where we really try to be a moving force in the measurement field, we convey private and public sector leaders to reach consensus on complex issues in health care performance measurements. And some of these topics would be attribution, alignment, SDS adjustment. And we'll talk more about SDS as we proceed in this (inaudible).

We also have created framework and guidance on (inaudible) patient safety, (home) and community-based services, population health, and rural and low-volume providers. And well continue to (expand this as we move forward).

(Off-mike)

Poonam Bal: … I'll ask that everyone please keep your lines on mute. We just want to make sure we won't have background noise …

(Off-mike)

Poonam Bal: … as I mentioned (here), you're part of the NQF Consensus Development (process) or CDP.

(Off-mike)

Poonam Bal: The first step is the call for …

(Off-mike)

Robyn Nishimi: Poonam?

Poonam Bal: Yes?

Robyn Nishimi: This is Robyn. Operator, can you mute the line? We're getting feedback from talking, I mean from typing.

Operator: Yes, I sure will.

Poonam Bal: Thank you, Robyn. Thank you, (Nan).

OK, so moving forward. The first step in the endorsing process is the call for nominations. All the committee members have gone through that process. And at this point, we are still going through that process for some individuals to really fill those gap areas. We find it's important that we have as wide a variety of experts on the committee and then we have the expertise that we need. This step is a little more – we have to think beyond just what the measures are currently in the portfolio but to think what could possibly coming. Because this is a Standing Committee, so if more work were to come in, this committee would also be the ones reviewing those measures.

Moving forward, we do have a call for candidate standards or measures. This is really how developers can submit their measures for review. This process has concluded. We are going through the process of reviewing those measures now.

So the Candidate Consensus Standards Review is probably the most lengthy part of the whole process. This stems from the initial review of the measures, making sure prepping that work for our Standing Committees, and then our Standing Committees reviewing that measure and providing their initial recommendation.

After we have received the initial recommendation, staff will write up a summary of comments and recommendations and post that for a public and member comment period. Once that is done, the Standing Committee will be brought back together to review those comments and see if the comments have affected their view on the measures. And in the past we had had

comments come in that had been impactful to the decision of the committee ultimately made.

Once the committee has, you know, given a final recommendations, we will take that to the Consensus Standards Approval Committee, or as we often call it CSAC. The CSAC will review the committee's recommendations and will approve those recommendations. After that point we will go to the executive committee of the board to ratify those decisions.

While at this point there's one more chance for any measure that is recommended, we do have an appeals process. So if any point, the general public feels that a measure is moving forward that they feel will be (inaudible), the community order that they feel is, we didn't, the process was not met properly, they're able to appeal that measure and we will consider that at that time. Once the appeal process closes and all issues are resolved, the measures – decisions are considered final. And as I mentioned earlier this does take generally around nine to 12.

So I did want to get in to a little more detail of the Measure Applications Partnership. We, at NQF, are really trying to make sure our work is correlated with the MAP work. In the past, it's been a little siloed, but we're working towards really combining the work together and making sure to input that the MAP committees have provided to the endorsement process is, you know, included and then vise versa; whatever recommendations the endorsement committees have made is shared with the MAP.

And so, I did go over a majority of these topic areas already, so I won't (delve) too much more on that. But I did want to show you a quick diagram of how, you know, information flows between all the different sectors. So you can see at the top is NQF endorsement evaluation. That's really what we're doing right now. That evaluation will be summarized and provided to MAP.

MAP will receive a MUC list, which is given by CMS to review. If any of the measures on the MUC list are currently endorsed measures or measures that came forward for endorsement or are not recommended, that feedback would be provided to the MAP workgroup as they make their decisions. However,

on the opposite side, if the measures they received in the MUC list are not currently endorsed, the (open) MAP will recommend that the MUC, or measure under consideration, which we like to call MUC, we love acronyms here, will be given conditional support pending NQF endorsement.

That information – NQF will take, will reach out to the developers to encourage them to apply to appropriate project. Often, the projects we are funded for are based on that topic. And we'll take that feedback once the committee is informed, and put it to our evaluation of endorsement. And so in that end, it's a big circle, and it's important that we all work together to make sure that the best measures are out in the field.

Shaconna Gorham: Thank you, Poonam. This project will evaluate measures related to pulmonary and critical care conditions. The measures can be used for accountability and public reporting for all populations and in all care settings. We will take a look at the measures in this project and the topic areas they address in the next few slides. NQF solicits new measures for possible endorsement. Currently, we have 30 endorsed measures within the area of pulmonary and critical care. Endorsed measures, otherwise known as maintenance measures, undergo periodic evaluation to maintain endorsement.

Next slide. The next few slides show the measures in this portfolio. Those measures with an asterisk indicate measures for maintenance review. The measures highlighted in purple are the 18 maintenance and for our new measures that will be reviewed in this project. The measures in orange, although part of the portfolio, will not be reviewed in this project. I would also like to note, there are a few measures not listed on the slide that are endorsed within the pulmonary critical care area, so they are being retired by developers. So as you can see on this slide, there are four asthma and one asthma/COPD measure in the project. There are also four COPD measures.

Next slide. There are three pneumonia and one imaging measure. We have five critical care and four new measures. There is a mix of outcome and process measures, which is good to see. As we know outcome measures are the (decided) preference. As Steering Committee members, we ask you to take ownership of this portfolio. Meaning, not only participating in the

evaluation but by using your knowledge and expertise in the field, your contacts in this field, helping us to identify gaps in the portfolio and measures to address those gaps, as well as identify measures that are being developed or used in these topic areas that can make the portfolio even more robust.

That is a review of our current portfolio. I will pause to see if there are any questions on any of the information that we presented thus far.

Operator: At this time, if you have a question, please press star one.

And there are no questions at this time.

Shaconna Gorham: OK. So in that case, I will turn it back to Poonam.

Poonam Bal: Perfect. Thank you, Shaconna. So, as you're aware, this is the first meeting of the Pulmonary and Critical Care Standing Committee. The orientation will (conclude) shortly with – along with that, we have – (about a week or so), we have our first, we have measure evaluation Q&A call. These calls will really be your opportunity to ask any question that you have after you've seen the measures and you have a chance to look at them. It's also where we'll go through a measure samples potentially. If the measure will not be a measure that's being reviewed in this project, but is a measure that's gone through endorsement process. So we'll – that measure will be used as kind of a guiding light to see how you should be going through the measures and reviewing them.

There are two calls. You are only requested to attend one of them. If you would like to attend both just for your own use, you can, but you're only asked to attend one.

Next, we'll have workgroup calls. This is where you're really going to get into the meat of the project. We will be reviewing the measures. The 22 product measures that we have will be divided amongst the four meeting. You will be assigned to attend one of those workgroup calls. You will be shortly received an e-mail asking you if you have a preference or which workgroup call you'll attend.

Again, you're only asked to attend the assigned one. However, if you would like to attend all four or some of them to hear the comments of your committee members on these measures, you can. During this time, (although we) speak about the measures and go through the measures as we would in the in-person meeting, we would not be making any sort of determination or rating the measures at this time. This will only be an opportunity for committee members to start the discussion and get some questions answered. Often, we request that developers attend the call in order to answer those questions for you.

After that, we will have an in-person meeting, which will be a two-day meeting in Washington D.C. on March 15th to 16th. This is mandatory for being on the committee. And at this time, we will ask the workgroup members to give feedback on what was discussed during the workgroup calls and have a much larger discussion with the full group.

At that point, we will actually be providing recommendations and rating the measures. We'll also be doing the related and competing discussion at that time. (Just a note, by) related and competing, we do wait to do related and competing until all the measures are discussed or at least the ones that are related and competed to each other because we want you to make an individual decision on the measure before comparing them to other measures.

After the in-person meeting, for whatever reason, if we're not able to complete all the work that we need to complete in the in-person meeting, we do have a buffer meeting, the post-meeting conference call. We will only have this meeting if we have run out of time during the in-person. Oftentimes, the meeting does get canceled. However, there's no guarantee until we get to in-person meeting and see (how'd that go).

After that, as I mentioned, we will go to comment on your recommendations, and we'll have a post-draft report comment call. During this time, you'll review comments and determine if you would like to change any of your decisions or to add more detail to your recommendation.

Those are the main committee time line date. We do obviously still go to CSAC (and board), but the co-chairs will represent the committee on the CSAC call. And the board (call of the staff) will represent the committee. So these are the only calls you're required to attend.

Also additionally, if the CSAC, you know, disagrees with any committee decisions or feel a certain process, CDP process was not met and they ask that the committee review those measures, that would be another meeting that we'd set up and we would obviously reach out to you to get your availability to find the best time for the committee. That rarely happens but it is a possibility so I want to keep it on everyone's radar.

OK, so, the role of the Standing Committee. Generally, your role is to act as a proxy for the NQF multistakeholder group. You know, you are asked to join the group as an individual based on your expertise. But we do want you – we obviously – as I said earlier, we're trying to keep as diverse of a committee as possible. You are expected to serve two to three-year term whenever we start a Standing Committee we do try to vary the term. So we have at least half the committee that's been around and can train any new committee members that joined. So that decision will be made during the in-person meeting by randomly selecting either two to three terms.

We also asked that you work with NQF staff to achieve the goals of the project. Ultimately, the goal of the project is to have recommendations for endorsement and to provide feedback to the developers. So we hope that you work with us to provide that.

You will be evaluating candidate measures against, measure evaluation criteria. In that sense, we do ask that you review the criteria in advance and try to get as familiar with it as possible. And of course, staff is here to provide any guidance that you need, and that's really purpose of the Q&A call if they give you guidance on the criteria as well.

Also to respond to comments submitted during the review period, we do have a pre-meeting commenting period which will be provided to you. You do not respond to those questions directly but you do use them to influence your

decision. And then we do have the comment period which the committee will be providing responses to. Those responses will be provided to you by staff as a starting point. And as through our discussion, the committee can decide what they feel like their response should be. And then, again, as I mentioned, you do respond to any directions from the CSAC. If CSAC would request that you reconsider a measure or measures, we would ask that you come together to do that.

So moving forward, all members do review all measures. We do have the workgroup calls where we ask you to really focus in on certain measures and then we also will be assigning lead discussant for measures. However, while those people will be expected to be the experts on the measures, we want the full committee to review all measures so we can have an impactful discussion. Again, to evaluate the measure against each criterion, we do have a rating system. So we really want the committee to focus on the criterion that we're speaking to at that time. So we're refraining from jumping to reliability and validity. We run evidence and so on.

Again, to make recommendations to the NQF membership for endorsement, and over – and this is really the important part of having a Standing Committee, to oversee the pulmonary and critical care portfolio of measure. We really want to promote alignment and harmonization on one (front) so we don't have multiple measures that are covering the same thing. But we also, in order to review the portfolio, identify the gaps to assist developers and which area they should focus on next.

OK, so the role of the Standing Committee co-chair, the co-chairs will co-facilitate the Standing Committee meeting, they'll work with NQF staff to achieve the goals of the project, they're going to insist NQF, anticipating questions and identifying additional information that are maybe useful to the Standing Committee. Basically the co-chairs will be our first, really the people out in the field, helping us understand what kind of issue that could come up in the in-person meeting, what measures we should be more conscious off and so on.

And also to keep the Standing Committee on track to meet the goals of the project without hindering critical discussion and input, you know, we have so many experts on this Standing Committee and we all want to make sure that provided point of views put forward. But it's important that we stay on track and finish our review in a timely fashion. So the co-chair really helps us in keeping that going.

They'll represent the Standing Committee at the CSAC meeting, and we'll participate as a regular Standing Committee member. Just because they're co-chair it does not mean that they cannot put additional input to the meeting.

Next, please. So the role NQF staff, obviously we'll work closely with the Standing Committee to achieve the goals of a project and to ensure adherence to the consensus development process. We will really be your experts on the process, the criteria, and nearly anything else that you need help with. We will organize (and start) the Standing Committee meetings and conference calls. We'll guide the Standing Committee to the steps of CDP and advise on NQF policy and procedures. We'll review measure submissions and prepare materials for our committee review. We'll go over that in a second, what we do to prepare for the meeting and help with your preparations as well.

We draft and edit the reports of Standing Committee review. We – and then, we ensure that communication among all project participations including Standing Committee members and measure developers are complete.

Lastly, we facilitate necessary communication and collaboration among different NQF projects. So, as you saw earlier in our portfolio, we have multiple measures that are not currently being reviewed in our project, and they're being reviewed in other projects. It is our role to make sure that even though those measures are not in our project, that we are communicating with the project leads to make sure that they're aware.

So communications, we do respond to NQF members or public queries about the project. We maintain documentation or project activity. We post project information to the NQF website, we work with measure developers to provide necessary information and communication for the Standing Committee (to

fairly and adequately) evaluate measures for endorsement, and lastly we publish the final project report. You know, we are just the touch base for everyone involved in this project, may it be the Standing Committee, the developers or the general public. It's our job to make sure everyone is well-informed and feel that they would be able to provide the feedback if necessary.

All right, with that, I'll give it to Shaconna to go over our criteria.

Shaconna Gorham: Thanks, Poonam. So today's presentation about measure evaluation criteria is really a high-level summary of the committee guidebook. We hope after this presentation you will take advantage of the information in the guidebook to learn more about NQF processes and criteria.

Most recent NQF guidance was established in 2010. The criteria haven't really changed but the guidance on how to evaluate measures against the criteria has changed, (raising the rigor). Because measures have been endorsed previously, it does not mean they are automatically expected to meet the current criteria.

NQF endorses measures accountability applications, meaning public reporting, payment programs, and accreditation, as well quality improvement. Criteria are standardized to ensure we hold all measures to the same standard. Criteria have evolved over time to reflect the learning experience and feedback from the performance measure enterprise. So that includes the measure developers, the implementers, people being measured.

So you may ask, how do we decide what is good enough for accountability purposes? The answer is standardized criteria that is known to all. Developers know what to expect, and users know that a measure has been evaluated in a certain way.

Next slide. OK, so we have four main evaluation criteria. The page numbers on each slide reference where the information can be found in the committee guidebook. The first criteria, importance to measure a report. The goal is to measure those aspects with greatest potential to drive improvement.

Next, reliability and validity, measure properties; they are the results of the measure. So other results of the measure, reliable and valid. Reliable and valid results are necessary so implementers can make accurate assessments of quality.

Next is feasibility. And feasibility is critical as measurement has become a greater part of the healthcare enterprise. But it is costly and time-consuming, so we want to work with data systems and method that causes little burden as possible.

Usability and use. The goal is to use for decisions related to accountability and improvement. So those measures have an impact. Who is going to use the measure? How is it currently being used? Has been there improvement over time? These are the type of questions the Standing Committee will focus in for measures that have been endorsed and then used for a while.

Criteria one and two are must-pass criteria. We will also discuss harmonization of related and competing measures to reduce the burden as much as possible. We will discuss that a little later in the presentation.

So next, the importance to measure a report. Also, just a reminder, pages 36 and 38, we'll go into further detail in the guidebook. I just want to highlight that the word is importance and not important. Importance to measure a report does not speak if the topic is important. The process of care for this topic area is very important. Everything we do in health care is important. But in terms of having the right measures, the committee must consider if this aspect of care should be measured.

So the importance to measure a report is determined by three criteria. First, you have your evidence; second, your opportunity for improvement. So we really want to see a demonstration of quality problems and opportunity for improvement. What will this measure address? How will it improve quality of care today?

The opportunity for improvements might be overall poor performance, significant variation in performance, variation among different sub-populations particularly around disparities, whether it's age, gender, or race.

Also, the quality construct and rationale. So, the questions would include, why were these comments, these components of the measure put together? What is the quality construct? We do have a composite measure in this portfolio.

So next is evidence. The measure – the requirements for evidence differ depending on the type of measure. So, we must identify whether a measure is an outcome, process or an immediate outcome measure. For outcome measures we are really looking for the rationale. Now, there is something actionable, some process or structure actionable in the delivery of health care that can impact outcomes.

For process and intermediate outcome measures, the quantity, the quality, and consistency of the body of evidence outline the measure, should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes.

So, we want to evaluate any study design flaws, biases in those studies, and look at, are the results among the studies consistent? The evidence we are looking for are empirical studies, not consensus or not expert opinion, but we really prefer the evidence to be in the form of systematic reviews and grading of the evidence.

Next slide. So the next slide demonstrates our algorithm. And the algorithm, again, can be found in your guidebook and it's really a series of questions in a decision tree to help you apply the criteria. Again, if you become familiar with the guidebook and we really ask you to become familiar with the algorithm because it will help you to do your evaluation.

All right, importance to measure a report. The criteria emphasis is different for a new versus the maintenance measures. For new measures, as we discussed, we look at the evidence, the gap, and opportunity for improvement. For maintenance measures, while we look at those things, there's a decreased emphasis on evidence. We require measure developers to a test, evidence is unchanged from the last evaluation. And then we ask the Standing Committee members to use your expertise in the field to affirm that there is indeed no

change in the evidence. However, for amendments measures, there's increased emphasis for gap and opportunity for improvement because we want to look at trend over time, the results of the measure being used.

Next slide. OK, our second criterion is reliability and validity which are really the crux of a good measure. So we want to be sure there is sufficient evaluation and testing of the measure to determine it can produce reliable and valid results. Reliability is based on precise specifications including exclusions. For reliability testing, we expect to see testing in some way developers can test data element or measures score, either one or both are acceptable.

Validity is – there's a lot of potential threats to validity. So they include – we want to make sure the specifications are consistent with the evidence. We want the validity testing, again, as I mentioned a little earlier the data elements or the measure score. We want a justification for exclusions, as well as to its adjustment. So, has adjustment been done? Is it appropriate? Also, identification of differences and performance.

Next, another potential threat, it's comparability of data sources in method. So, is the measure results comparable? Also missing data is another threat to validity.

Next. OK, so the next slide is really a picture to help you understand the concept of reliability and validity. Each dot on the graphic represents measurement. And the first target, all of the measures are quite similar, but they do not – but they don't have a very good job of hitting the target. This portrays a measure that is reliable but not valid. And the second target, the measures aren't very close to each other or to the center of the target. This portrays a measure that is neither reliable or valid. And the third target, all of the measures are close to each other and to the center of the target. This portrays a measure that is both valid and reliable. So it is important to note that in order to be a valid a measure must be reliable. But reliability does not guarantee validity. We ask developers to present testing with statistical results and data to make the case that their measure is indeed reliable and valid.

Next slide. So, again, we're looking for empirical analysis to demonstrate the reliability and validity of the measure as specified.

(Off-mike)

Shaconna Gorham: Reliability testing can be, again, at the measures score or data element level. By measure score we mean the result. The measure score refers to the proportion of variation in the performance scores due to systematic differences. Signal to noise analysis is a commonly used analysis.

Data element refers to the repeatability or reproducibility of the data and uses patient level data. They're the individual pieces that create the measure result. So, when looking at information provided by the developers, the Standing Committee will make an assessment of whether the developer made the case that their measure is reliable. We encourage you to ask questions of the developers as they will be available on our different calls and at the in-person meeting.

OK. So, again, we provide another algorithm to help you through the assessment of reliability. Again, the algorithm will help you think through and apply the criteria.

So validity testing, empirical testing of the measure score and the data element. The measure score assesses a hypothesized relationship of the measure results to some other concept. The data element assesses the correctness of the data elements compared to a gold standard. Face validity is a minimum way of meeting validity but still acceptable; again, another algorithm as a tool to help you evaluate the validity of the measure.

OK, we went over these a little bit as we talk about threat. So these are threats to validity. There are numerous threats to validity. They include conceptual, unreliability, our patients inappropriately excluded from the measurement, differences in patient mix for outcome and resource these measures, measure scores that are generated with multiple data sources and method, and systematic missing or incorrect data. Developers responded to questions on how they (thought) about potential threats to validity and assess the impact of these threats on their measure.

So, again, as we look at scientific accessibility and the criteria emphasis, again, are different for the new versus the maintenance measures. For the new measure, as we discussed, we look at the measure specification. However, we do not require developers – I'm sorry, we do require developers to update specification. However, for reliability and validity, there's a decrease emphasis if prior testing is adequate. There's no need for developers to submit additional testing at the maintenance level with a few exception. Also, the developers must address the question at SDS trial, of the trial period, and we'll go over that in more detail a little later.

So, criteria number three, feasibility. It's really the extent to which the required data are readily available, retrievable without undue burden. So, how easy is it to do the measure? How costly is it to do the measure? What resources are necessary? So we're looking for measures with least amount of burden, so the measures can be implemented. For clinical measures, the required data elements are routinely generated and used (during) care delivery.

Other required data elements available in electronic health records or other electronic sources. There should be a demonstration that the data collection strategy can be implemented. Well-known and more season measures tend to have feasibility established data collection, feasible established data collection strategies. With the newer measures, the committee members should ask, what is the developer's plan? How does the developer expect to collect this data? And does that plan seem feasible? And is there undue burden?

Criteria number four, usability and use. Particularly important as we look at our maintenance measures is really the extent to which potential audiences are using or could use performance results for both accountability and performance improvement. Performance results are used and at least one accountability application within three years and are publicly reported within six years after initial endorsement.

Improvement progress towards achieving the goal of high-quality efficient health care for individuals and population. Also, we want to ensure that the

benefits outweigh the harm. So, some questions that you as committee members would ask, has the measure been in use for a while? Is it working? Is it driving to improve our measures? Are things improving? Are we going in the right direction?

Next. Feasibility and usability and use. So, again, this table shows the emphasis for new measures as well as the maintenance measures. Really, I want to point out that for usability and use, the increased emphasis is to increase emphasis for the maintenance measures because we know we want to see a greater focus on measure used and usefulness.

The last criterion related are competing measures. Related measures are those measures with the same measure focus or same target population. Competing measures have both the same measure focus and same target population. So, we push for harmonization among similar and related measures so the definitions of the measures are the same for example. We really want to reduce the chaos and foster harmonization and make decisions about closely related and competing measures.

So, as I mentioned, NQF criteria has evolved and is somewhat detailed. The guidebook goes into much more detail than its high-level overview provided today. So, again, I encourage you to read the guidebook because that will definitely help you do the evaluation process. The developers submit information into our database, and the NQF staff – we take that information submitted by the developers and prepare what we call a preliminary analysis of the measure submission. The preliminary analysis or P.A. will be the starting point for the committee's discussion and evaluation.

As Poonam mentioned earlier, each committee member will be assigned a small number of measures for in-depth evaluation. But the entire committee is expected to participate in decision-making during the in-person meeting. Because this is a brand new committee, we will convene workgroup calls, and these calls will assist you with your first evaluation. The calls will ensure initial familiarity with the measures, allow practice with NQF criteria and processes and give early feedback to developers of the committee's questions and concerns. At the in-person meeting, the entire committee will discuss and

rate each measure against the criteria and make recommendations for endorsement.

So, we realized that was a lot of information. We want to take a few seconds and just open the lines up for questions.

Poonam Bal: And also, just a reminder, staff does analyze information ahead of time and provide it you in a summary form. So don't feel overwhelmed that you'll have to go through the measures and handle all these yourself. We will provide support (throughout). But let's open up for question.

Operator: Thank you. At this time, if you have a question or a comment, please press star one. Again, that is star one for question or a comment.

You do have a comment from Jim O'Brien.

James O'Brien: Thanks. I just had a question about how measures are assigned to which standing committee? So, how is it decided in where they go?

Shaconna Gorham: The measures are assigned according to your expertise. (Aside from expertise), you will get your measure assignments well before hand.

James O'Brien: So, I guess I was asking not just the committee members, but which standing committee gets which measures?

Poonam Bal: So, we do the – when we receive projects from CMS, we start look through our current portfolio of measures to see where they best fit in based on when they were, the measure was last reviewed. And sometimes measures can fall into different category. So that's why you see that measures in the portfolio aren't necessarily in our project. They maybe a better fit in a different projects or perhaps the developer is currently doing upgrades or there's new guidelines that maybe coming out. So, all those are taken to consideration when measures are assigned a project. We really try to fit the measures into the best project as possible and also be flexible with the needs of the developers.

If they are going to be making some major updates and their measure could go possibly in (inaudible) projects, we would, you know, obviously, pick a later

one for them. Or if a measure is really competing with another measure, we'll choose to keep those measures together in that sense. So that's kind of the things that we consider when we assign measures to projects.

James O'Brien: So, it's decided by NQF internally, not by the measure developers, for example?

Shaconna Gorham: Yes, that's correct.

James O'Brien: Thank you.

Operator: And your next question comes from the line of Edgar Jimenez.

Edgar Jimenez. Thank you. (Inaudible) but a quick question. You know, unfortunately, I have not been able to reach the slides. I mean the URL that was sent (goes) – I was sending Poonam an e-mail that goes to the server, the shareware, but I mean, was there another e-mail because I have heard this great talk and no slides at all. I haven't been able to link to any.

Shaconna Gorham: We apologize. We will definitely send the slides out after the call.

Edgar Jimenez. OK.

Poonam Bal: And also, (Nan), could you possibly help Edgar get on the webinar or have someone assist him.

Operator: Yes, one moment.

Poonam Bal: Thank you so much. Were there any other questions?

Operator: Yes, you do have a question from Don Yealy.

Donald Yealy: Hi. I just wanted to – it's not so much a question but a follow-up about the previous question about how things are assigned. It's my understanding that new measures, the developer may suggest where it should go, but NQF makes the final decision; very much like if you send the manuscript and you suggest, which, you know, area of a journal it might go to. That doesn't – it isn't determinative but it's suggestive. And then NQF tries to decide which best

match is. A classic example of this is a sepsis measured could fall in our area or could fall in infectious disease.

Poonam Bal: Exactly, yes.

Operator: And there no further questions or comments.

Poonam Bal: OK, perfect, glad to hear that. And obviously, if you do come up with questions later or for whatever reason you weren't able to ask your question now, you can always e-mail staff and we'll be able to provide you …

(Off-mike)

So, with that, I'll give it back to Shaconna to go over the SDS trial period.

Shaconna Gorham: OK. Thank you, Poonam. So I would like to provide a little background. The NQF convened the SDS expert panel in the fall of 2013 to consider if, when, and how outcome performance measures should be adjusted for SDS or related demographic factors. Diverting perspectives on SDS adjustment has been discussed. One, adjusting for sociodemographic factors will (match) disparities. The other perspective adjusting for sociodemographic factors is necessary to avoid making incorrect influences in the context of comparative performance assessment. The panel recommended and the NQF board approved a two-year trial period. All measures must be assessed individually to determine if SDS adjustment is appropriate.

So, just to go into a little detail about the SDS trial period, the scope of that trial period, newly submitted measures, all measure submitted to NQF after April 15th will be considered a part of the trial period. Previously, endorsed measures, measures undergoing endorsement maintenance review during the trial period will also be considered fair game for consideration of SDS adjustment. So we do have a few measures in this project that will fall into this.

The Standing Committee will continue to evaluate the measure as a whole, including the appropriateness of the risk adjustment approach. The Standing Committee will continue to use the validity criterion to evaluate the

appropriateness of the sociodemographic factors as well as clinical factors. Again, staff will complete P.A. and identify areas of focus to ensure the SDS requirements are met.

During evaluation, the Standing Committee will be asked to consider the following -- is there a conceptual relationship between the SDS factors and the measure focus? What are the patient level sociodemographic variables that were available and analyzed doing measure development? Does empirical analysis show that the SDS factors have a significant and unique effect on the outcome in question? Does the reliability and validity testing match the final measure specifications?

So, a conceptual description. The Standing Committee will review this information provided by developers and consider the following questions on the slide. Is there a conceptual relationship between the SDS factors in the measure focus? Is the SDS factor present at the start of care? And are they caused by the care being evaluated? So, the measure developer must provide description, logical rationale, or (very informed) by literature and/or context experts of the conceptual relationship between patient sociodemographic factor, patient clinical factors, quality of care, and measure focus.

The Standing Committee will review the patient level variables and consider the following questions. How well do the SDS variable that were available and analyzed align with the conceptual description provided? Are these variables available and genuinely accessible for the measure patient population? The measure developer must describe patient level sociodemographic variables that were available and analyzed during measure development.

The empirical analysis, the Standing Committee should examine the two sets of empirical analysis provided by the developer. First, the measure developer must provide the analysis and interpretation of the importance of the SDS variables and their risk adjustment model. The analysis may include variation is in prevalence of the SDS variables across measure entity; empirical association of the SDS factor was the outcome; contribution of the SDS factors to unique variations in the outcome; as well as the assessment of

between unit effects versus within unit effect to evaluate whether the effect is due to poor quality. Second for the trial period, the measure developer must report and compare performance scores with and without a feedback SDS factors and the risk adjustment model.

Testing and specification for stratification. If changing from a non-SDS adjusted risk adjustment model to one that is SDS adjusted, then the measure developer should provide updated reliability and validity testing. If a performance measure includes SDS variables in its risk adjustment model, the measure developer must provide the information required to stratify a clinically adjusted only version of the measure result by the relevant SDS variables. So this information should include the stratification variables, definitions, specific data collection items and responses, code value sets, and the risk model covariance and coefficient for the clinically adjusted version of the measure when appropriate. For more information, the slide directs you to the project webpage.

OK with that, we will open again for questions.

Operator: At this time, if you would like to ask a question or have a comment, please press star one.

And you have a question from Bruno DiGiovine's line.

Bruno DiGiovine: That's OK. Thank you. Yes, I just had a question. I could see how an obvious place where this could be an issue would be in readmission data or readmission quality metric. Is the NQF – are you at – is there going to be a standard that says, if you're looking at readmission then SDS is relevant? Or do we have to say, for asthma readmission, it's relevant, and for COPD readmission, we're going to look at whether it's relevant, and for sepsis readmission – I mean is there any sort of standard that if you're looking at this quality metric we will assume that SDS would be relevant?

Shaconna Gorham: Robyn, would you like to answer that?

Robyn Nishimi: Sure. You would need to make it on a measure by measure basis depending on the rationale for (organic conclusion) and the data that the developer provides with and without the adjustment (in it).

Bruno DiGiovine: OK. So, there's no standardization around readmission? And so, we assume that readmission for COPD maybe impacted but asthma would not be?

Robyn Nishimi: It would really depend on what the data from the developer show depending on how they risk adjusted and what factors, SDS factors, they did include or didn't include. They may or may not show an impact of those factors.

Bruno DiGiovine: OK, thank you.

Operator: And there are no further questions at this time.

Poonam Bal: OK, perfect, thank you. So, give us one second. We're going to be going over the SharePoint site, and Janine will be doing that overview for you. Give us one second.

Janine Amirault: So, because the committee SharePoint page is where you'll be working from and accessing materials from, we just wanted to provide a brief overview of how to navigate the site just to orient you. So, accessing the SharePoint, the link in is on the slide, and we actually just pulled it up here to walk you through it. And if you – you should have received an e-mail from nomination with access to the SharePoint committee site as well as login information. So if you have not received this e-mail, please feel free to notify us by sending e-mail to the pulmonary inbox.

I'm just going to start off, you'll see in the middle of the screen, there is a reference material section, and this is where you can find the Standing Committee policy materials as well as the Standing Committee guidebook which was referenced a few times throughout the presentation. And the guidebook will serve as the main reference for, what it means to be on the committee as well as the NQF processes and criteria, and all of that.

Moving along, you'll see the general document section. So in this section, you'll find things that pertain to this committee specifically such as the

pulmonary roster with bios. And then below that you'll see the measure document. So this is the section that you will find the measure worksheet from what you'll actually be working from. And, they'll be listed according to measure number, and we've just inserted a test. So you can see when you're trying to access these materials, you'll just click on the blue area and it should open. But if at any point you're having any problem accessing anything, just shoot us an e-mail and we'll help you troubleshoot with that.

And then moving along – oh, within another measure worksheet, and I know it was touched upon, but there'll be the preliminary analysis, pre-evaluation comments, public comments, information that was submitted by the developers. So that will be the evidence and testing attachments, spreadsheets, and additional documents for your reference.

Below that, we have the meeting and call document section, and this is where you'll be able to access things like slides and agenda. So, we apologized for the delay, but we'll get that up shortly, the slides to the SharePoint.

And then if you just turn your attention to the left-hand margin, there are some other helpful links here such as the committee calendar. And in here, you'll also see calls and meetings listed here with the dates and time. And you can also click on those for more information as well as the committee roster link and that will be updated once finalized, as well as the staff contact. So, you can – well, here our e-mails are here in case you have or just need to grab those.

The last thing I wanted to draw your attention to is here under surveys, the committee preliminary measure evaluation. So as a part of NQF process, we ask that the committee members provide feedback on the measures that were assigned to them before the workgroup calls. So, this input can be done by accessing the measure evaluation tool on the left-hand side of this page. And then, what you want to do is select Respond to the Survey, and you'll just see – eventually a dropdown menu with the measure numbers will pop up and you just select the one that you are going to be working on.

So, I think that is the end of kind of the walkthrough. I think I'm turning it back to Poonam.

Poonam Bal: OK, thank you. Just some clarification, we often have mentioned something called the (pre-analysis). This is something that we started around the same time we started standing committees where staff will go through and do the initial review and summarize the information for you. It's a lot more condense information and easier for you to follow up. Obviously, we still ask that you, you know, you're the experts, you know, please (inaudible) the information and make your own distinctions, but we do want to summarize the information. So that's what we refer to is the (pre-analysis).

And in that doc, we have another document called the measure worksheet. And so, you'll – when you go on there, you'll see the measure worksheet and that – what you'll find in there is one (pre-analysis), but you'll also see attachment such as the evidence in testing. Any Word document will be included in that measure worksheet. When we receive – as I mentioned earlier, part of our process is a pre-meeting comment, public and member comment. So we'll include those public comments in this worksheet as you receive them.

As Janine mentioned we ask that you do initial review of the measure before the workgroup call. And, again, those assignments and all of these requests will be provided to you again in e-mail form. So, no worries that this is the only notification you'll receive. But those comments from the workgroup will be also included in the worksheet. So when we get to the workgroup call everyone can easily see what's been written. Those are anonymous, though, so, it will not list that this person said this comment. It will just show up as these are the comments that have come in, in order to allow a safe place to make comments and also allow everyone to read each other's viewpoint and see what's going on. Along with that, if you – if there's any spreadsheets or diagrams or any additional documents that have been provided, but then we were enable to put them in the measure worksheet for whatever reason, you'll also find them in that section that Janine went over earlier in the measure worksheet section.

So with that said, I just want to open up for questions.

Operator: At this time, if you have a question, please press star then the number one on your telephone.

And there are no questions at this time.

Poonam Bal: OK, perfect. Well, I just wanted to conclude with next steps. We already went over the time line, but then what's really coming up is the Q&A call. Again, we strongly encourage you to attend one if not both. It's not required, but as you saw, when Shaconna was going through the information, it is a good chunk of information. And while we try to, you know, really do the analysis for you in advance so it's easy for you to understand, you know, the more times you hear the better for you.

So, you know, please attend this Q&A call. if you have questions, come prepared with them. If not, we will be doing an overview and you can definitely ask questions as they come to you. We'll be having the workgroup calls. We'll be e-mailing you shortly asking you what your, which one you would like to attend if you have any preferences. And then we will – soon after that, we'll send out assignments so you know exactly what measures you'll be responsible for as a lead discussant but also the workgroup member, and eventually as the committee member for those workgroups. And, again, we will all be meeting in person on Tuesday, March 15th and 16th.

So, with that said, I'll give one more opportunity for questions. And if we do not have one, we'll conclude.

Robyn Nishimi: Poonam …

(Crosstalk)

Operator: At this time, if you like …

Robyn Nishimi: I'm sorry, before we do that, operator, Poonam, I just wanted to make sure folks understand that on the measure evaluation Q&A, what we're going to do is walk through a measure evaluation sheet. We won't be using a project.

We'll be using an example that staff have created as the standard to be used across all projects. But it will go through each of the different sections. You'll be able to see the kinds of information you get from the staff preliminary analysis and the kinds of question that we would ask the committee to think about in both measures specific workgroup discussion and at the in-person meeting.

So, we'll go through in detailed steps. The material that we cover on those two calls will be the same, but some people do find it useful to attend both. And it's only on the workgroup calls that you're going to get your specific pulmonary measures.

Poonam Bal: Thank you, Robyn. And to add even more to that, when I say come with questions, I do mean about the criteria and the process and not necessarily about the measures. The questions that are specific to a measure would have to wait until the workgroup call. So, thank you for that clarification, Robyn.

(Nan), go ahead and open up for comment please.

Operator: Thank you. At this time, if you would like to make a comment, please press star one.

And there are no comments at this time.

Poonam Bal: OK, perfect. Well, in that case, everyone gets a little more than 30 minutes back of their time. We really appreciate (those who joined the line). On the last page here, you'll see our contact information. Feel free to e-mail us or call and you have the project pages listed here, which is open to the public, and also the SharePoint site which is for the committee only. If you have any question, go ahead and e-mail us. Otherwise, we will be posting the slide deck and the recording to the website shortly. So if you missed a portion or just want to review it again, it will be available to you.

With that said, thank you and have a great day.

Shaconna Gorham: Thank you.

Poonam Bal: Bye-bye.

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

END