NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
March 25, 2014
2:00 p.m. ET

Operator: Welcome to the conference, please note today's call is being recorded. Please standby.

Wunmi Isijola: Hello everyone thank you again for joining our Surgery Steering Committee Orientation. I just want to start off with some brief introduction. My name is Wunmi Isijola and I'm project manager here at NQF. I'm also joined by Andrew Lyzenga the Senior Project Manager. Amaru Sanchez the Project Analyst, Reva Winkler the Senior Director. We also have our – another individual Melinda Murphy who will also be working with us on this project.

So we just wanted to start off by seeing who actually joined the line so we want to do brief roll call. So if you can start of Amaru.

Amaru Sanchez: Yes. Anthony Asher, are you on the call? All right, Joyce Bonnett?

Joyce Bonnett: I'm on the call.

Amaru Sanchez: Robert Cima?

Robert Cima: (Inaudible).

Amaru Sanchez: Great, Richard Dutton?

Richard Dutton: Rick, I'm here.

Amaru Sanchez: Perfect, thank you. Elisabeth Erekson?

Elisabeth Erekson: Yes, I'm here.

Amaru Sanchez: Perfect, Lee Fleisher?

Wunmi Isijola: He's actually on via chat.

Amaru Sanchez: OK, Frederick Grover?

Frederick Grover: Here.

Amaru Sanchez: Perfect. William Gunnar?

William Gunnar: Go ahead. Yes, Bill Gunnar.

Amaru Sanchez: Perfect, (John Handy)?

(John Handy): Here.

Amaru Sanchez: Mark Jarrett?

Mark Jarrett: I'm here.

Amaru Sanchez: Clifford Ko? Barbara Levy? Barry Markman?

Barry Markman: Here.

Amaru Sanchez: Kelsey McCarty?

Kelsey McCarty: I'm here.

Amaru Sanchez: Lawrence Moss?

Lawrence Moss: Lawrence Moss, I'm here.

Amaru Sanchez: Amy Moyer?

Amy Moyer: I'm here.

Amaru Sanchez: Keith Olsen? Collette Pitzen?

Collette Pitzen: Hi, I'm here.

Amaru Sanchez: Lynn Reede?

Lynn Reede: Here.

Andrew Lyzenga: Gary Roth?

Gary Roth: I'm here.

Amaru Sanchez: Christopher Saigal?

Christopher Saigal: Here.

Amaru Sanchez: Robert Sawin?

Robert Sawin: Yes, Bob Sawin here.

Amaru Sanchez: Bob Sawin, sorry. Allan Siperstein? Larissa Temple?

Larissa Temple: Here.

Amaru Sanchez: And A.J. Yates?

A.J. Yates: Present.

Amaru Sanchez: Great, thank you.

Andrew Lyzenga: And this is Andrew Lyzenga. I just wanted to note that we are actually still working to finalize the committee. We may end up adding one or possibly two more members. Probably just one more member and we will be working shortly there after to select our Co-Chair then we will let you know what our decisions are on that front very soon, to just something to keep an eye out for, all right.

Wunmi Isijola: Thank you, Andrew. OK. So just to give an overview of what we'll be talking about today, I'll definitely be giving a background on NQF in this project, what our project focus is, an overview of our criteria, the role of U.S.

committee members, just a brief tutorial on SharePoint as well as the measure evaluation process.

So, as some of you may or may not be aware, NQF is a private non-for-profit voluntary consensus standard setting organization. We operate under three parts commission to improve the quality of American Healthcare. So initially we're building consensus on a national priority goal for performance improvement and working in partnership to achieve them.

We're also endorsing national consensus standards for measuring and publically reporting on performance as well as promoting on the attainment of national goals through education and some outreach programs. So we're governed by the board of directors, the board committees in partnership and that includes CSAC which is our consensus standard approval committee, our leadership network as well as our national priority partnership. We also have a host of member councils which includes consumer health plans, health professionals, provide organizations, purchasers, the prior and industry.

So what are consensus standard? Our purpose really is accountability and performance improvements. We essentially think that this is important because not all QI measures meet the merit of endorsement.

And why do we need consensus standards? It gives an opportunity to conduct peer reviewing of these measures. It's the first time that many of these measures have been reviewed by a multi stakeholder perspective. So it gives us an idea of just broad use in scope of things.

And to date, NQF has over 700 endorse measures that are utilized within various organizations and entities, including Federal State Community and Facility. And you can see that break out there.

And just kind of process and this is kind of what we're undergoing as committee members. Initially we sought up with the corporate nomination, which includes the process of convening you guys as multi stakeholder body. As of right now we have 25 individuals who have been appointed. Our next process is the corporate consensus standards, and that's really our corporate measure, and that's why we're asking developers to submit information on

measures that they wish to have reviewed and evaluated by our committee. And that's new and previously endorsed made in this measure.

We also have standards review process. Currently our team is undergoing staff reviews of these measures that have been submitted. And our submission process is actually ended we receive all of our measures last Monday. So we're on that process now, but at certain point in time we're going to ask you as committee members to really start participating by attending calls like this, the orientation as well as completing preliminary evaluation of the measures by attending our workgroup calls as well as attending the two-day in-person meeting.

And after that meeting the staff will prepare a draft report that summarizes your recommendations on the measures that will be posted for public and NQF member commencing.

As we're soliciting a multi stakeholder input we encourage the committee to share their report with colleague and invite them to submit their comments. The committee will then need to review the comments of this and then determine appropriate resources. So that's kind of our eight step process and that's what we're going to be facilitating throughout this project.

So, we have NQF evaluation criteria process and these are the main factors that U.S. committee members will be looking to evaluate the measures that have been submitted for endorsement, importance to measure and reporting, scientific affectability, feasibility, use and usability and then we'll also talk about harmonization as it relates to the selection of best in class with competing or related measure.

And so, are there any questions? OK. Move forward. So our portfolio currently includes about 70 measures. And really within this project we're hoping to look at measures that really talk to a host of surgical areas, but specifically the measures in questions which are roughly 35. They're looking at general perioperative care, surgical database participations, and procedures specific measure. And as I mention we have over 70 measures within the area of surgery.

So, this is just a brief snapshot of all the measures that we currently have under review. More details with regards to these measures will be provided to you so can take a more in-depth look at all of these measures when you begin to work into your workgroup call. So, this is just a timeline of just some of the milestone basically within project.

As mentioned last Monday, was submission deadline for developers to provide us with their measure for consideration. We're doing our orientation call today. U.S. committee members, we will be facilitating a host of workgroup calls and then we'll have our in-person meeting in May where we'll convene for recommendation of endorsement. As I mention, the draft report will be posted in July for a public commenting and you can see the other milestones days moving forward.

So, just a kind of give you an overview of your role as standing committee members, you will act as a proxy for the NQF multi stakeholder membership. We bring together these groups of experts to evaluate the measures and depth, and ultimately making recommendations for endorsement and then ultimately voting on these measures.

And we ask each committee member to serve two or three year terms. We will be randomly selecting that but if you do and in fact have any objections for serving longer than two years, please let us know in advance.

You'll also be working with us ultimately to achieve the goals of this project, which is providing recommendations for endorsement, evaluating the candidate measures against the criteria which I mentioned before and we'll get into that a little more in detail shortly, as well as respond to comments submitted during the review period, and lastly, respond to any directions from the CSAC.

Additionally, you will be reviewing all measures. Although, we will be designating committee members within workgroup calls we do expect all of the committee members to have reviewed all of the measures against the criteria, excuse me, as well as give the rationale for their rating for each criteria, and as mentioned to provide recommendation to NQF membership

for endorsement. And lastly, part of your responsibility is to oversee the surgery portfolio of measures and this includes identifying if there are any performance gaps or gap areas that you think that we should have measures within our portfolio. And we will be providing you with a list of our full portfolio as it relates to the measures that you will be reviewing within this project.

Now, we also had Co-Chairs. As Andrew mentioned before, we're still trying to finalize those details. But as Co-Chair, we're asking that they facilitate the standing committee meeting. So that's our workgroup calls, that's our in-person meeting, as well as working with us NQF staff to achieve the goals of the project. We do get a lot of questions and things that relates to our project but we're asking the Co-Chairs to really assist and identify some of these questions that may be in the foreseeable future.

Keeping track of the goals of the project without hindering or critical discussion, I know at times we get into heavy discussion on some of the criteria but really just staying on topic and on point with the criteria at hand, as well as representing the whole of steering committee members at our CSAC meetings, as well as participating as an individual steering committee member as it relates to voting.

OK. So, our role, what are we doing to help facilitate this? We're organizing calls like this. We're organizing the meeting. We're guiding you through the steps of the CDP project – process, and that's that eight-step process that I mentioned earlier but also making sure that we're all in line with how policy then procedures and that either goes (inaudible) any conflict of interest that you may have, reviewing the measures submission forms which we're doing currently now and preparing those materials for you that committee members. And that will also be posted on the SharePoint site which I believe everyone has access too, as well as drafting and editing the report for your review.

And we're making sure that we're insuring that all communication on all projects are consistent and concise. We do have a lot of dialogue at times with our developers but making sure that the additional supplemental materials are being conveyed to you so that you can make informed decisions

as it relates to recommendations for endorsement, as well as facilitating necessary communication weekly in NQF project.

We're always and ongoing, we're responding to the NQF members, public inquiries about the projects, so for example even with the roster we were receiving public commencing. So we're constantly in connection with the public as it relates to this project, as well as maintaining the documentation of the project activities and making sure it's up-to-date, posting relevant information to our NQF website in the project page, working with measure developers to provide you with the information necessary, as well as publishing the final report which is what we'll do towards the end of this project.

And now, we'll just go of an overview. As I mentioned, everyone should have had access to our SharePoint site. Amaru is just going to give a brief walkthrough of just some of the pieces that you should be looking forward to as you kind of run through some of the document that's been posted.

Amaru Sanchez: Right. Hi. My name is Amaru Sanchez. I'm the project analyst staffing the committee. Over the next few minutes, I'm going to brief you, walk you through the main components of the committee SharePoint site. The SharePoint site will be the primary means by which the staff and the committee will be such sharing important meeting measure and call information. So this would sort of like your main hub. This slide here displays kind of some of the main areas you'll find with SharePoint Aid.

There will be a screenshot on the next slide to sort of put this all into kind of contact and I can sort of help navigate that. But I just wanted to briefly walkthrough what you will find into the different sort of topics.

Under committee home, you will find the majority of the information, the materials that you'll be using as a committee member. There will be a tab under there. You'll notice in the screenshot titled "General Documents". And under this you will find sort of any background and reference information such as the standing committee guidebook, CDP standing committee policy, the measure evaluation criteria and other documents.

These materials are posted to provide you with sort of a necessary tool to insure your effective participation in the meeting. Other materials that you'll find under the general documents section is essentially came from the measures document set which are folders, housing all measures specific related information such as the measure information sheet as well as any appendices that were submitted by our developers. We're still on the process of development – reviewing and developing those so you'll have access to those shortly.

And finally, some other materials you'll find within the committee home is meeting call documents such as the agenda, dial-in and, you know, web streaming information. Other notable areas that you'll see on the SharePoint site include the committee calendar, where you can find all meeting and call and dates for the project, committee links where you can find any relevant hyperlinks related to our projects. The committee roster where, you know, you can obviously see who else is on the committee with you.

Staff contacts which where you find info on how to reach us, you know, our e-mails as well as our phone number and then a link called survey tools which is where you'll be receiving your individual measure assignments for upcoming meetings.

So, as you see here all the main areas that I just mentioned are to the left, you know, and what is displays here is the screenshot of the committee homepage. So that's just sort of like what it look like. I know it's says cardiovascular right now but we're, you know, we'll be updating the surgeries in SharePoint site to mirror the exact same format. So, if you need any reference materials you can easily find them here.

Wunmi Isijola: And just making sure that everyone has access to their SharePoint log-in site at this point, and if you do not please send us your e-mail so that we're making sure that you're up and running and good to go.

Amaru Sanchez: Just one thing I do want to note that this has been sort of not an issue but something we've gone a lot of questions about, that in order for us to (inaudible) maximized space on our webpage, we sort of added this

functionality that expands and contracts documents, you know, something that you'll notice here, what's highlighted in red is that functionality, you know. If you'll – when you go to our committee page you will see a plus sign, you know, you can click that and it will expand that section and there you'll see all the documents that we've uploaded for that.

So if you have any trouble sort of, you know, seeing it or not seeing that information and there is that plus sign, you can definitely expand it. And likewise, once you're done with that section, you can click it and then it will then contract again. But I know this is sort of new, some of you have your have been on this committee report and navigate through SharePoint. But as always, you know, we're at your disposal and don't hesitate to contact us if you have trouble of finding materials, et cetera. Thank you.

Wunmi Isijola: So now, we'll just kind of go over at the criteria. This kind of helps U.S committee members really take a look at the measures and really give your input and review it based on our evaluation criteria. So Karen Johnson will be speaking to that point. Karen?

Karen Johnson: Hi everybody. Thanks for letting me come and talk to you today. I'm not really part of your regular project team but Reva had something else that she had to do so she asked me to go over the evaluation for you.

So, as we go to the slides – go ahead and go to the next slide. We will be pointing out to you some of the basic key points in and we're also be referring throughout the slides to the particular pages in the steering committee guidebook.

So, let me process my remarks by saying if you haven't had a chance to read that section of the steering committee guidebook, I think it would be useful for you to do that. We tried to write it in such a way that it's easy, you know, kind of a more (layman) language, trying to get rid some of our jargons, so hopefully we were successful on that. And so again, just encourage you to try to do that.

So, we do have our measure evaluation criteria and basically the criteria try to reflect desirable characteristics of performance measures. And when we

endorse measures at NQF we – that faith that they are suitable for accountability applications as well as quality improvement.

So keep that in the back of your mind. Those are the – that's really the reason that we have the criteria that we have. Again, they are standard. They have evolved somewhat overtime. If you've been on committees before you would probably recognize a little bit of difference in what our criteria now compared to what they were, particularly in the use and usability section. I think that's the one that has changed the most recently.

And let's go to next slide.

Andrew Lyzenga: And actually if I could just jump in, Karen. Karen mentioned that the criteria has been evolving as has our guidance around those criteria. And there are some criteria where the actual sort of specific for the criteria have not changed too much but we've provided some additional guidance and sort of protocols around those criteria to try to increase the consistency of reviews across committee.

As Karen also just noted there in that slide, we have had a bit of a feedback from stakeholders on this process. And one of the things we have heard is that sometimes the measures developers and other interested party signed that there's some inconsistency across committees. One a measure say that, you know, passes the evidence criteria or important criteria in one committee maybe wouldn't pass in another just because the committee is sort of applying that criteria in a slightly different way.

We've tried to do some work around the criteria and our guidance around the criteria to sort of increase that consistency. We've developed a couple of what we've called algorithms that provide you some sort of decision logic in terms of evaluating the criteria.

And just as a sort of general statement, we would really ask you to really try to base all of your evaluation to your review in your deliberation, trying to ground those things in the criteria as suppose to just sort of, you know, talking about your general sort of in question and feelings about the measure. We really would like to have our decisions grounded in those criteria so that we

can maintain consistency and a certain degree of rigor in evaluation of the measures. So, go ahead Karen.

Karen Johnson: Very important point. Go ahead on the next slide. OK. So, our criteria on page 32, the overall criteria are shown for you, page 32, the steering committee guidebook. And basically, the criteria, there are five major criteria and each one has sub-criteria underneath it but we look at them and evaluate measures in this order that you see on the screen.

So, that order is actually very deliberate. So what we want to do is look in endorse measures, first of all that are important to measure and (report). And what we mean by that is these are the aspects that have the greatest potential for driving improvement.

And I think the other thing there to think about is what we're getting out with importance to measure and report is it's really almost a little bit of a higher bar than what we – what you would think of as important to do in clinical practice for example.

So, if a measure comes through and you deem it not "important to measure and report", does not mean what you're saying is not important to do in practice it's just mean that it doesn't quite meet the bar of being a national consensus standard for in-person.

The second major criteria is reliability and validity. That's the scientific acceptability as measure properties, and basically that's the part that says, we want the measures to conform to good measurement (science). And for measurement, what that really comes down to is reliability of the measure and validity of the measure and we'll get into that just a little bit more later on.

And on the screen what you see in the red is the term must pass. So basically, importance to measure and report and scientific acceptability are what we call must pass criteria, and operationally what that means is as you discuss and you vote is a measure did not pass importance to measure and report then that's pretty much the end. The measure goes down and will not be recommended for endorsement, so we would stop discussion at that point.

And the idea there is as we go down in the hierarchy there of feasibility and usability, basically, you know, it kind of doesn't matter how feasible a measure is if it's not important or if there's not good science behind it, that's the idea of this hierarchy.

Feasibility really has to do with data collection burden and also ease of implementation, usability and use. We're trying to see that measures are going to be used and not only that they're going to be used but also that they will drive improvement.

And then finally, our fifth criterion has to do with related or competing measures. And what we're getting at there is the idea that we would prefer not to have a lot of measures out there in the measurements base that are either duplicative or some more in some ways that not in others, it creates confusion among the public who are trying to use these measures to make choices. It's confusing and burdensome to folks who are implementing measures. So our look in terms of relative in competing measures and that evaluation is trying to get to that point there. OK.

(John Handy): This is (John Handy) from Portland, Oregon. I have a question because I had a trouble when I read the guidebook. I'm having trouble understanding the difference between the importance to measure and report and usability and use.

Karen Johnson: Yes. Well, on the bright side, they are very interrelated but basically importance to measure and report, what we're looking at there is what is the evidence behind the particular action or intervention or process. Is there actually room for improvement that sub-criterion (1B) which is opportunity for improvement and then high priority. And then usability in use is just basically saying is it in use or cannot be used.

So, you can have – and as a matter of fact we do have good measures in our portfolio right now that nobody's using. So I guess I'm not quite sure maybe you can elaborate a little bit on what was confusing and I can try to hit that.

(John Handy): Well, an example might (inaudible), because to me it seems like once you've gone through the importance of a measure and the reporting of it, I guess I don't understand what usability and use brings beyond that.

Karen Johnson: OK. So, I think when we say importance to measure and report, I think it might be just a terminology there. It is kind of both in a way, because importance to measure and report is not – what we're saying there it's not just importance to measure but also the reporting or the use of the measure is also important.

But when you actually are looking at and evaluating on importance to measure and report, the three sub criterion underneath it which is again evident room for improvement and high priority actually is a little bit different than use and usability where you will actually look and see has this measure been in used.

And actually the use and usability criterion was strengthened recently and we now have almost use by date. I think it's three years. After three years, we expect the measure to be used in an accountability application and after six years in a public reporting application.

So again, we actually expect it to be used out there somewhere. And even further and really chartered to show some time, we would like to see actual improvement because of these. So, I still am not sure that I've gotten to the gist of your difficulty, but we can keep trying if you'd like.

(John Handy): You know, you're a lot closer, I don't mean to belabor the point, thank you.

Andrew Lyzenga: There's also an element in use and usability of – well, so you can have a measure that, you know, has or is very well evidence based. It's high and, you know, it's very important. You know, it addresses an area of high importance and has a potential for improvement. But then, you know, maybe the – I think as part of the use and usability that has to do with sort of interpretability by the end user, the consumer or the – whoever is making a decision based from the information that's coming out of the measure. That's not as spelled out in our criteria as much, but I think it's kind of part of the making a judgment as to whether, you know, the information that comes out of the measure is useful for the intended audience, not just that it's in use, but that it's useful

information that you can use to base, you know, healthcare decisions on healthcare, Karen?

Karen Johnson: Yes. I think with our new criteria, we've kind of pulled away a little bit from that, but it's still underneath that. It's still underneath that. I mean, yes, it is underneath that.

Andrew Lyzenga: All right.

Karen Johnson: Yes. Yes.

Andrew Lyzenga: Thank you.

Karen Johnson: And I think as, you know, as you go through some of the evaluations, some of the – you know, it'll become more clear as you get – as you actually try to apply these criteria.

OK, well, I've actually – I've already given you the bird's-eye view of this slide but importance to measure and report. Basically, this is where we're looking at evidence, opportunity for improvement, and high priority. Those are the main sub-criteria underneath. And the – those sub-criteria themselves, not only is important to measure and report as a whole, what they call must ask, but also these sub-criteria are.

So, for evidence, we really expect to see empirical evidence showing that the process or, you know, whatever is the focus of the measure that there's actually an evidence based for that that, you know, that you can show a linkage between that thing and improvement in patient outcome. So, you know, it sounds like some of you at least have had a chance to look at the guidebook. We have, you know, exceptions to evidence and that sort of thing, but we hope that exceptions are rare. So, we really do look for national consensus standards or endorsed measures that have a followed evidence based.

For opportunity for improvement, basically it's just a demonstration that there is a gap in care or opportunity for improvement. And there's a few different ways that you can see that. One is if you look at data and pretty much

everybody is doing poorly across the board. Well, there's plenty of opportunity for improvement there. But you may also see some measures showing that, you know, some folks are doing really well but not everyone is. So, that's what we talk – what we may like variations and performance.

And then another way actually that you can see a need for improvement is if there are disparities in care. So, that's why we ask for disparities data, you know, if certain subgroups of the population are being cared for in different way than others, that is also indication that there is more room for improvement.

And high priority endowment, almost a giveaway criteria, very few things I think would come across that would not meet our priority and criterion. Basically, we are looking for measures addressing national health goals or priority or a high impact of healthcare. So, does it affect a lot of people, is it a high cost aspect of care, that sort of thing.

We're showing here 1D, quality constructing rationale. You will have to worry about that only if you're evaluating composite measures. But basically, the quality constructing rationale is – that's the place that the developer would basically tell their story about their measure. You know, what are they trying to measure and why did they build it in a way that they did. So, that's what 1D is.

OK, next slide.

Evidence. So, evidence is – so now, we're going even further. Now we're doing the deeper dive. The evidence criterion really depends on what kind of measure you're looking at. So, basically, outcome measures, we're not going to ask for the level of detail about evidence that we do for other types of measures. That's what we're trying to get across here on this slide.

But other measures, intermediate outcome measures, those are measures, for example, like values of blood pressure or HbA1c level, that sort of thing. There's intermediate outcome.

And process measures, we really expect to see empirical evidence and, by that what we mean is we'd like to know about the quantity, how much of it is there, the quality, what kind of studies are they, are they strong studies, are they not so strong studies, that sort of thing, and then of course consistency of the body of evidence. And the body of evidence there is something that's pre – it's a small phrase there but pretty much we would like to see the full body of evidence. We are not interested in cherry-picking a paper or something like that that may support a measure when there might be a whole bunch of other papers out there that may cast out on that particular measure. So, we want to see information from the entire body of evidence.

We prefer evidence that comes from systematic reviews and grading of evidence. And that could include things like the US Preventive Services Task Force, the systematic reviews, Cochrane Systematic Reviews, and many of the folks who billed clinical practice guidelines also systematically reviewed (inaudible) evidence.

I'm sorry?

(Off-mike)

Andrew Lyzenga: (Inaudible) mute your lines. Thank you, appreciate it.

Karen Johnson: Thanks. So, we do that for systematic reviews if possible. Those, you know, they are – the other reason that we prefer that kind of evidence is that is the easiest evidence for everybody involved. It's easy for the developer when they're submitting their information, if they can go do a systematic review. That is – just makes things easier for them.

We – I think I've already mentioned, we want empiric study, so expert opinion is not considered evidence.

OK, go ahead on the next one.

Here's our algorithm. So, to build on what Andrew mentioned earlier about – not only about criteria changed somewhat but also our guidance have changed quite a bit in the past few years. And these algorithms are a very visible

change in our guidance. We used to have different decision tables and that sort of thing to help you break, for example, evidence. We're trying something new here with these algorithms. And what we're trying to do here is basically I'll ask all the questions that we need to, to help you evaluate and we've put it in a form here that try to be pathway.

So, the first, for example, the first box here for evidence asks whether you're – if the measure that you're evaluating an outcome are not. And again, just a reminder, if it's a health outcome we're not asking for empirical evidence, we just want to know about the rationale about why a particular measure is important and how it might relate to at least one process or structure, that sort of thing. So, basically, the rationale.

If it's not a health outcome, then you go to the rest of the algorithm. And the first thing that we ask there in box three is, is the measure based on a systematic review and rating of the body of evidence. And if so, then will you provide us a summary of the – we call it the QQC, the quantity, quality, and consistency. If yes, then you go over to box 5A, B, and C, and you think about separately quantity, quality, and consistency and that leads you to your ratings of high, moderate, or low.

Andrew Lyzenga: Just a note, Karen. We have a couple of calls scheduled in the next month or so which are I think labeled tutorial calls or Q&A calls, and we'll be walking through this algorithm and the testing algorithm and a good bit more detail as well as the evaluation process in general. So, if this is a little bewildering, you know, for now we will be giving you a little bit more sort of guidance and education around that.

Karen Johnson: Yes, we will also be (inaudible) fairly new. We will be asking you how they work for you. We're very interested in knowing if they're useful and helpful for you to as you write.

OK, let's go to the next one

Criterion two, reliability and validity. Again, this has to do with the scientific acceptability and measures, the measures of science behind them. And what we're looking for are measures that produce consistent results, that produces

results that allow for distinguishing between providers, measures that are accurate in terms of how they're constructed and the data that go into the construction. And then also measures that allow for accurate conclusions about quality. So that's what we mean by reliability and validity particularly.

The slide here shows you the sub-criterion underneath and as we go further into reliability and validity on the next one or this is pretty much?

Male: Kind of a little bit.

Female: OK. All right. OK. Reliability – let me talk just a little bit about measure specification. Specifications are the foundation of a measure. When we say specifications we mean things like, you know, what were the codes used to determine a numerator and the denominator with our certain folks or patients or diagnosis that sort of things, excluded from the measure. That's what we mean by specification.

So, in terms of reliability, since reliability has to do with consistency you need precise specifications so that you can have different people implementing the measure and coming out with similar results across.

We also ask for testing for reliability. And the testing is empirical analysis that show that a measure is reliable. For validity, validity is a little bit more complex. Again, specifications come into play with validity but when you're talking about specifications and validity what you're asking yourself there is are the specifications consistent with the evidence?

So, what you'll find when you do your evaluations is you'll be talking about evidence quite a bit. And sometimes it's a little hard to see that, you know, should going to be talking that this point under evidence and, you know, under the first criterion or do I need to be talking about it under scientific acceptability, and sometimes the answer is both. And we will help you as you go through the evaluations to tease those out.

Validity, there's also testing, so again, empiric analysis for validity testing. But validity also – to consider a measure valid you also have to consider threats to validity. And there are certain things that make treat in validity and

we actually go through some of these as sub criteria, I guess you could say, taking a look particularly at exclusions, risk adjustments for outcome measures, comparability of data sources if there is different ways of computing the measure you want to be sure that they get comparable result that sort of thing.

Let's go to the next slide.

Reliability and validity, this is just a real quick picture trying to illustrate some of the ideas behind reliability and validity, but basically what you have in this target is adapt to the different measures or different measurements I should say, and the center is the true value, and you – what you see in the first target there is several different measurements that are all fairly close that they miss – they miss the bull's-eye. So what you're seeing there is measures that are reliable but not valid. So, reliable and that they are consistent, they're close in values but they're not hitting that bull's-eye. So, they're not accurate.

And the middle one there is showing you measurement that's all over the place neither a reliable nor valid, and then finally the third target is showing you measurement that is both reliable and valid, again, consistent and correct which is what we're starting for.

OK. I think I pretty hit this to some extent, measure testing is empirical analysis. It's very important to see both for reliability and validity we are expecting testing, and we are expecting to see testings for the measure specify. So, basically that means, however, the measure is submitted, you know, with certain codes and certain exclusions, that sort of thing, and the way that they, you know, calculated and the way that the developers are showing you on their forms, that is how the measure should be tested.

OK, next slide.

The other thing that I really haven't talked about is on the different – two different levels of testing we allow. So for – this actually applies to both reliability and validity testing that basically we allow testing at two levels, one is the measure score and that – this is, you know, the computed value that that results when you compute the measure. And for reliability measure score,

that's where you're trying to see if you can actually distinguish between providers.

The other way that you can do reliability testing is, testing at the data element level, so that's looking at the patient level of data that goes into a measure. And what you want there is you want repeatability or reproducibility.

So again, if I were pulling patient's data and computing the measure and if Andrew is doing it, we would expect for the same patient, we would expect to get very similar results. If – you know, so we're looking for consistency across folks who are computing the measure.

When you're evaluating testing what you're looking for is basically three things. You want to look at who was tested, you want to look at what's the methodology appropriate, and then finally what were the results of the testing. So, those three things are what you're going to use to evaluate the testing.

OK. Next slide.

Figures or algorithms for reliability, the green box basically asks about the specification. So again, the specs are foundational for reliability. So, if the specs are not precise and (ambiguous) then you are not going to have a reliable measure. But if they mean they are then that takes you down the path, was empirical testing, conducting with the measure is specified. So again, that's using – doing the testing as it's specified is very important.

So, if so, that takes you down to box four. And box four asks about with testing done at the measures four levels. And if so, then boxes five and six ask about the method and the results. And then, I don't know if you can go further down on that algorithm or not. No. OK.

If you went down the box, I guess seven, it would be asking what testing done at the data element level. The – what you will see here in – as Andrew said, you go through that later on the Q&A calls. But testing at the performance measure score level is more – is actually a little bit more preferable than at the data element level.

Ideally, we would see testing at both levels, because each tells you something different about the reliability and the measure. But there is a possibility of getting a high rating if testing is done at the score level, if you were able to see the rest of this algorithm, you would see that this testing was only at the data element level, moderate would be the highest rating that you could get.

OK, validity testing. Again, both are allowable in terms of testing at the measure score level or the data element level. Validity at the score level, basically, is it's all about relationship.

What you're trying to show is that you have a measure and you're trying to say that your measure tracks with something else. You hypothesize for example if you have a measure of discharge instructions and, you know, the importance of them or something like that, then you might say, you know, if I have good discharge instructions I expect to have fewer readmissions. That could be your hypothesized relationship.

And there's lots of different relationships that could be hypothesized. So when you're looking at validity testing at the score level, you're just looking at, you know, what's the relationship with the developer? Is it trying to (inaudible) exist and what does the testing show, you know, did that validate the measure or not?

At the data element level, that's again, where you're looking at that patient level data that goes into the measure. And what you're trying to do there is just to make sure that that information is correct or accurate as compared to the goal standard.

So the example there might be if you were – if a measure was based on data from a registry, for example, then you might look at the different data elements from that registry. Go back and look at the actual medical record and make sure that what's in the registry actually conforms to what's in the paper record. And that would demonstrate accuracy at the patient, you know, of the patient level data.

For literacy testing, we do allow (not) from non-empiric testing. That's what we call – in this case, we allow phase validity to be demonstrated. And as I'm

sure you all know phase validity is a subjective determination that on the phase of it the measure appears to reflect quality of care.

We do ask though that if that's the direction that the developer wants to go in terms of supporting their validity of their measure. But they don't just make a statement and say, you know, we think it's valid, but that they actually discuss and describe their systematic assessment and, you know, what kinds of questions do they ask and who did they ask and how – what were the results of that assessment, OK?

And here is our algorithm for validity and it's similar in many ways because the reliability algorithm, again, you're going to start by thinking about the specifications and their consistency or not with the evidence.

But you also have to bring in the threats to validity. And again, that has to do with things like exclusions, (inaudible), that sort of thing. If you get passed those two, then you look at the level of testing measure score versus data element versus phase validity, OK? Yes.

Threats to validity, I don't want to go too much in here but basically conceptually a threat to validity is that what's being measured isn't really a relevant outcome or isn't strongly linked to a relevant outcome.

And to some extent, that will come out in your evidence discussion. But generally, we also realize that an unreliable measure won't be valid. One could argue that it might work the other way to the – a non-valid measure might not be reliable. But that's a little bit different way of thinking about things.

But really, the ones that you'll be most looking at I think are the exclusions. So where certain groups of patients inappropriately excluded from the measurement. Difference within patient mix for outcome and resource use measurement. That has to do with the risk adjustment methodology. You know, should a measure have been risk adjusted? And if so, with the way that the adjustment was done and is that a valid way of doing it?

Measures generated from multiple data sources or multiple methods. So for example, if you can look at a measure and get data from those paper and claims, then you should feel comfortable that it doesn't matter which way you do it, you would get consistent results.

And then also, systematic (listing) or incorrect data. Again, a missing data, if there's very little missing data it'd probably won't matter but if there is or if there is a particular group that systematically is dropped from the measure, that is a potential problem.

OK, next slide.

OK, feasibility. And I know I'm going long here. Let me go a little fast here. Feasibility really has to do with burden and with ease of implementation. And basically, the most feasible measures are ones that where the clinical data are generated during a peer process. In other words, you're not expecting clinicians to do something different just so you can measure something.

This isn't always the case that a lot of our measures are still based on paper medical record (extraction) but arguably, things that are already in some kind of electronic form ore going to be more feasible to collect and take less time and effort. And also, the data collection strategy can be implemented.

And I think I'll leave it at that. There're all kinds of, kind of interesting conversations that will happen around feasibility. But again, you don't want – the trick with feasibility is sometimes it's hard to know about some of the feasibility aspects if it's a brand new measure and haven't been in use, but often you can make a good judgment about the feasibility.

OK, usability and use, the extent. OK, so this is getting actually at what Andrew was talking about, the extent at which potential audiences are using or could use performance measures for both accountability and performance improvement.

So, you know, I also should point out that when we say accountability programs or that sort of thing in NQF, that's kind of an umbrella term that we use here. And it could mean things like public reporting, it could mean

accreditation or some sort of certification. And it could also mean payment incentives or disincentives, that sort of thing.

So accountability, programs (inaudible) a very broad term here. And it looks like I was right. We expect them to be measures to be used in at least one accountability application within three years after initial endorsement, and are publically (inaudible) six years.

So basically, what that means, if you have a new measure coming in and you're evaluating a new measure, what you will ask there or what you will look for is that there are some kind of (inaudible) that, you know, developers are – have some sort of an idea about where it will be used and how it will help basically. And then three years later, (inaudible) endorsement maintenance, we actually see whether it's in use or not.

Improvement is progress toward achieving that goal of high quality, efficient healthcare. What we would love to see is the link between measurement and desired outcomes. That would be great here.

And if you had that, that would also be evidence of validity of your measure as well, right? But improvement could also just be improvement in performance. So for example, maybe when a measure first goes into use, the performance rate is 50 percent. And three years later, it's ratcheted up to 75 percent. Now, that's improvement in the measurement.

Finally, 4C, benefits that outweigh the harm. So this is the idea about potential unintended consequences. And so, you know, those things happen no matter how careful people are so we want to definitely discuss that. I think the – what we're interested in is unintended negative consequences for the patient is of paramount importance.

But we also want to be careful that we're talking about real things, not theoretical things that somebody might could think of that may happen, you know …

So all of that kind of gets – we won't both separately on all these different things that all kind of gets wrapped up into use and usability. And then transparency, I'm not used to seeing this is (4D) transparency.

Male: Just for repeat measure?

Karen Johnson: You know what? I think it is …

(Off-mike)

Karen Johnson: Yes, this maybe – sorry, yes, maybe this resource use measure. So, that's why I'm not used to doing evaluation of resource use measures so I apologize. Yes?

Andrew Lyzenga: Just to interject.

Karen Johnson: Sure.

Andrew Lyzenga: Actually, I went back and looked at our task force report on usability and use of measures. And Karen was in fact correct, that was leading you straight the issue of – in understanding and interpretability for audiences that the task force actually decided explicitly that that should not be considered under the usability criterion.

But it really is I guess about the issue of use – being used in accountability or quality improvement and applications and that sort of thing, and the issue of interpretability for intended audiences should not really be considered under the usability criterion.

Karen Johnson: Yes

Andrew Lyzenga: I'm sorry. I posted the task group force report on usability and use on the SharePoint page so you can have access to that if you want to dig a little bit deeper into that.

Karen Johnson: And it is kind of tricky. And, you know, I can see why Andrew remember that as a guidance from what we use today. I think part of the reason maybe that it came out is being as something you would consider in the evaluation is

a lot of times implementers will take a measure and then they'll display it in some way maybe with, for example, a (four-star) system or you know, some sort of way to display. And a lot of times how it's displayed later on really impact how people – how usable it is for the average person when they're looking at things. And that's kind of – that's outside the control of NQF, and really outside of our criteria.

OK, next slide.

Related to competing measures. You don't have to worry about this too much right now, NQF staff will inform you which measures if any are either related to others or competing with others.

A competing measure basically, you know, will bluntly, it's basically measures that have pretty much the same numerator and denominator, for the most part. You're looking at the same process in the numerator and the same target population in your denominator.

So, measures that are competing the question for you there is, is there any – is there a good reason to have two measures that are doing basically the same thing? You know, sometimes there is and sometimes there's not. If there's not then your task as the committee would be to decide which is the best of the two. Sometimes you'll see best in class, is the terminology that I guess tossed around sometimes.

Related measures are, for the most part, measures that either have a very similar target population in denominator or very similar measures for the numerator, but not both. So, there the idea is, for example, if you have a couple different measures looking at patients with diabetes you would hope that unless there's a really get reason for not having an identical definition of how do you define diabetic patient, you would hope that they're the same, right, the same ICD-9 list (within).

Yes, again sometimes there are very good reason why specs are different, but not always, OK. All right. And do you want me to go through this part Andrew or you …

Andrew Lyzenga: I can talk to that. So, we – this is another part of our attempt to sort of help in our guidance around the measure evaluation process, and also to put – you know, provide a way to feed some of the input that comes into our process into your evaluation. So, what we will be doing is we'll be putting together some measure worksheet. So worksheet for each of the measures and that will provide you just some brief information on the measures, its basic numerator, the denominator level of analysis data source, that kind of information specs.

And then underneath that we will have a section for eMeasure technical review if applicable for measures that come in as – with specifications, we actually have a separate process for reviewing those specs and we will have a place where we'll give you the input on that eMeasure review, right. I don't think that we have an eMeasure technology.

To date, we don't have an eMeasure, so that probably won't be applicable in this project. But, in addition we open up all the measures for public comments, once they're submitted to NQF. And so, we have I believe two-week comment period before our work group meeting.

Karen Johnson: Correct.

Andrew Lyzenga: And we'll receive those comments and we'll put those comments in these worksheets for you for each measure. There're might also – we also open up measures basically in perpetuity for implementation comments, is what we call them through our (PPS) system which is basically our database on the website, and people can go in there and enter at anytime comments on the use and implementation of the measure. And we will also see those into this form for you if any have comment on the measure.

And addition to those public comments will have a section, where we will provide your work group comments on the measure. What we are going to do in advance of the workgroup is we'll send you out some survey or a survey link and we will ask you to provide some thoughts and comments on each measure for those that you've been assigned in your workgroup. And we will include that information that you've submitted in the measure worksheet if

you have it in, again, in one place public comments, comments from your fellow work group members.

And then finally, after the work groups NQF staff will sort of pull that discussion together into few concise points and summarize what you've talked about in that workgroup for the broader committee. And that will be provided to the committee in these worksheets again.

So, you'll basically have all that information from each measure, the public comments that came in, the pre workgroup comments from the workgroup members, summary of the workgroup discussion, and you'll all that in front of you as you look at the measure in the in-person meeting and you do your actual rating of the measure. Does that all make sense?

Karen Johnson: Any questions?

Andrew Lyzenga: Yes, any questions about that?

Karen Johnson: And any questions about the evaluation criteria at all?

Male: No.

Andrew Lyzenga: All right. And then the measure information form, that's the measure itself, what has been submitted by the developer that will include, again, the basic measure information numerator, denominator, but as well as all of the detailed specifications and the information that the developer or steward has entered related to feasibility, usability, importance of scientific acceptability, et cetera.

We have – also, for those who've been on committees before, we used to have all of the information in the same form. We have now provided measure developers with the opportunity to enter their evidence information and their testing information in separate forms. That was actually the request from them. Sometimes they have information that doesn't really fit or format easily into our submission form so we allowed them to provide that in a separate form.

But, we will be attaching those to the submission form itself, so you have it all in one place. I will put some hyperlinks within the document so you can just jump to those sections as needed.

So you'll have in that measure information form, again, all the detailed measures specifications, the evidence attachment, the testing attachment. And then also we will provide for you any additional information that the developer has provided. Sometimes they give a code sets, for example, maybe an excel file of the code sets or another reference material.

We'll have all of that for you both on the SharePoint drive. We'll actually follow up all on the SharePoint as Amaru walked you through a little bit earlier. If you have any questions about that, feel free to reach out to us.

But, all that information is available to you on the SharePoint site and you should have everything you need there. Again, it's a lot of information, so please do contact us if you have any questions or clarification just, you know, we want to know where exactly you find – want me to find some specific piece of information or anything like that, just reach out to us and we'll help you walk through it.

Wunmi Isijola: Again, and if you have any questions as it relates to your role as committee members, again, as Karen mentioned and Andrew has mentioned, you can always refer to the committee guide book and that gives you a snapshot of the measure evaluation criteria, just your roles and your responsibilities as well as any other information as it relates to our practice and policies.

(John Handy): This is (John Handy) from Portland, Oregon. Again, reading through the committee guide book and listening to your discussion here, it seems like it might be particularly informative for us to be able to loosen in on the consensus standards approval committee meeting and I know that they are public.

Do you guys let us know when they are so – because then they are the final or one of the main steps after we finish with it, as to what they're looking for and kind of how that goes.

Andrew Lyzenga: Yes, as you mentioned, the CSAC calls are all open to the public and we will certainly let you know when that is coming up for this project and we would certainly encourage you all to call in if you have the time.

And one thing I should note is that actually our Co-Chairs, we haven't – as I mentioned earlier, we haven't selected our Co-Chairs yet but we will ask our Co-Chairs to attend that CSAC meeting when we go and bring our near recommendations to them.

And those Co-Chairs will sort of act as representative of the committees and will speak to the discussion and deliberations of this standing committee for the CSAC and answer any questions for them at that time.

So that sort of special duty of the Co-Chairs but we would certainly welcome and encourage you all to call in for the CSAC call when the measures are considered to know what that kind of discussion is and what the discussions has been about.

(John Handy): I wasn't even speaking necessarily about vis-à-vis our committee work but just to show how they function with it all, but they might be informative.

Wunmi Isijola: Definitely.

Andrew Lyzenga: Sure, sure. Yes, we can give you – we can send you the schedule for the CSAC call as well and you're absolutely welcome to call in for any of those to just get a sense of how that process work, it's a good point.

(John Handy): Thanks.

Karen Johnson: Yes, this is Karen. It might be really interesting too because CSAC doesn't only talk about the consensus maintenance process of the endorsement projects but also some of the other things that are going on at NQF around measurements.

So for example, you may have heard about all the work that's going on about controlling for socioeconomic status and risk adjustments models, because that is a very big topic right now and just a lot of different things in terms of

governance and how the process works that would give you a flavor a little bit more about how NQF work in terms of process and particularly around measurement endorsement.

Wunmi Isijola: Are there any other question?

A.J. Yates: Yes, this is A.J. Yates from Pittsburgh.

Wunmi Isijola: I got you.

A.J. Yates: Yes, quick question. The – in the validity and the reliability process, do we have – does NQF have tools for looking at the potential for low ceilings and bunching at ceilings, and in particular the potential for dynamic bunching of ceilings, in other words overtime, people learn the game and learn to potentially exclude patients by class and not by individuals and end up all bunched up as basically heard class of the patients for the sake of being at the top of the ceilings.

A lot of these CMS projects or in value based payments are based on where you stand versus a benchmark and it's a dynamic benchmark, I'm just worried about the sealing effect.

Karen Johnson: That's a good question. It is difficult I think when you're evaluating the scientific acceptability of a measure to distance yourself on how it might be used later but we try to (think) we could do that if possible. So to extend that you can, we ask you not to consider how it will be used later again as you mentioned maybe in particular program for example.

That said going back to validity, so I think some of the things will be touched on in your discussion because you will look at if there are actual exclusion from the measure itself, you know, different class of the patients sort of or that sort of thing. So that is something that comes up in validity and we ask you to evaluate that also in terms of evidence, you know, if there's no good evidence to say a certain group should be excluded then have a measure has been excluded in, you know, that's a red flag for you.

Andrew Lyzenga: Yes, and it seems like that may – the precision of this specifications may also speak a little bit to that. So it's definitely a question you want to be having in your mind I think to some degree when you're thinking about these questions of reliability and validity and I don't know that there's, yes, anyway we can really give you two specific guidance around that but if there are issues that you have seen in practice, certainly we would ask you to bring those up at the meeting and to have them at the point of discussion again maybe around whether there are – the exclusions that are in the measure are appropriate or whether it's specified in such a way that it reduces deeming of the measure and allows for consistent application with the measure across provider.

So those are I think certainly good points to bring up as we have discussion of these measures.

A.J. Yates: This is Yates here again. And the reason I brought it up is that as you're probably aware at the Yale core group already has, you know, pulled out the – and CMS started using hospitalcompare.gov for total hip and total knee replacement and it took some insight and to even get obesity included as one of the risk factors but as a spectrum of disease, it's not being used as continuous variable.

So it's a lot easier just to exclude obese patients from your practice or from a hospital's practice than to take the risk of the higher risk at the ends of that spectrum of disease. And so the reason I'm bringing this up is I just let the national meeting last week and one of the symposiums, I'm not going to mention them by name but three nationally known medical – not academic, but large medical systems, their executives and their chief surgeons stood up and said they're were going to tell their surgeons to exclude patients with BMIs over 40 from hip or knee replacement.

And that's denying people by class as suppose to denying them as individuals. And I'm just worried about that than being extended to other hard to guiding those continuum or hard to risk stratify systemic diseases that have a continuum of disease that mild at one end and severe at the other but everybody gets lumped into one class and gets excluded for the sake of meeting those moving benchmarks.

It's just up and to think about it as committee and I'm just throwing it out that the CMS currently isn't allowing for exclusion criteria in those measures that are being used for health – hospitalcompare.gov and so exclusion criteria maybe something that we have to look at carefully.

Karen Johnson: Yes. And this is Karen. It sounds like you would be looking at that example you'd be looking at the threats for validity specific we're looking at the risk adjustment model.

A.J. Yates: Right.

Karen Johnson: And then also under the potential unintended consequences section under use and usability. So you probably be hitting in a couple different ways.

Andrew Lyzenga: Thanks for that Dr. Yates. Those are very good points and we'll definitely want to talk about that.

A.J. Yates: All right. So I didn't interject.

Wunmi Isijola: No problem.

Richard Dutton: Hi. This is Dr. Dutton with a much less (inaudible) question. How do you expect us to act or what is acceptable behavior when a member of the committee, me in this case was involved with development of a measure that a committee is considering.

Andrew Lyzenga: So we have actually – yes, we have a policy in place where a member who has been involved, directly involved in development of a measure, we would ask you to recuse yourself from the discussion of that measure.

So we'll – that's how that's going to play out in practice, we'll sort of see I don't know if we'll ask you to really step out of the room or just to sort of, you know, mute your mic or how that (inaudible). We would ask you to recuse yourself from the deliberation on that measure.

Richard Dutton: Thank you.

Andrew Lyzenga: You're welcome.

Female: Are there any other question?

Lawrence Moss: Hi, this is Larry Moss. Who are the developers of the measures? How are the developers selected and is there any pruning process that we're seeing a subset of the submitted measures or do we see all of them?

Andrew Lyzenga: You see all of them, I mean, everything that comes in to this project as at least to the extent that they have provided a complete submission and we are in the process of reviewing the submission right now for completeness, there are certain things that they don't, you know, fill out certain fields or have just given us, you know, no information in certain places that we really require information and we just won't even consider that measure it's just, you know, doesn't even have sufficient information to evaluate.

But to extent that they have filled out the forms and they submitted it by the deadline, we will take anything that's been submitted and it is sort of your charge as the standing committee to evaluate the measure against the criteria and to make a decision to, you know, see if it meets those (bars) or not.

We don't have any process either of, you know, selecting developers. Any developer who wants to submit a measure to NQF is welcome to do that at anytime and we will, you know, take that submission and we do have a process of sort of sorting out measures that have been submitted and assigning them to topic areas so a measure that has come in that we deem to the related to surgery will come into this project or a subsequent project that you'll be working on and a patient and a measure that, you know, comes in and deem to be related to say patient safety will go into the safety project.

But any measure that has been submitted to NQF and meets the basic, you know, requirements for a measure, we will review it. Does that answer your question?

Lawrence Moss: Yes, thank you.

Barbara Levy: This is Barbara Levy calling. Just asking about my (CCPI) involvement. I'm on the executive committee of (CCPI) and so indirectly involved in measures that will come through but not directly involved in the measure development, so that might be something we'll want to think about going forward.

Wunmi Isijola: OK. Definitely and we will just ask you to disclose that information but as we move further within the project, we will be sending all of you measure specific DOIs, Disclosure of Interest form. And that that time you can select or state whether or not you may have a conflict of interest.

Barbara Levy: Great. Thanks.

Wunmi Isijola: Are there any other question?

OK. So it seems like we have about half an hour left but just want to talk about some next step. As we mention, there are a lot of information surrounding the measure evaluation criteria and I'm sure once you had a chance to look at the committee guidebook and some of the information surrounding the criteria, you can come with questions on April 15th or April 24th. These calls are in fact optional but we do suggest to come and ask any question as it relates to the criteria, at that point we'll be able to answer that. So, prior to you going into your workgroup calls you are ammunitioned and ready to go to evaluate those measures.

As mentioned, we will be providing a value weeks and surveys. I apologize for the date but we will be providing them for a preliminary evaluation surveys and that maybe access on this SharePoint site as we become closer to those state we will in fact – I'll provide that to you, travel logistics to attend the important meetings that are taking place in May.

Our meetings department will be in contact with you in the middle of April and as we mentioned, the workgroup calls will take place as well in May. So if there aren't any other questions, we will give you 30 minutes back of your life and we will end the call.

And as always if you have any questions or concerns or you're not sure about any information, please reach out to myself or any other project staff and we'll make sure to help assist. Andrew, do you have anything to add?

Andrew Lyzenga: No. Nothing from my end.

Wunmi Isijola: OK. Well that being said, thank you again for joining the call and we look forward to speaking with you next month.

(Crosstalk)

Male: Thanks.

Male: Thanks.

Female: Thank you.

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

END