Measuring outcomes in behavioral health

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Goals for Today

• Know the behavioral health measures used in NYS Medicaid programs
• Understand how to translate system level measurement initiatives into agency level activities
• Learn about functional needs measures for individuals with serious mental illness in NYS
Why do we measure quality and performance?

Short Answer: Health care has become increasingly expensive and we’re not getting the outcomes that we want.
Health care spending as a percentage of GDP, 1980-2013

*2012
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.
## Health Care Quality, Spending, and Social/SDH Spending

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall Ranking (2013)</th>
<th>Quality Care</th>
<th>Effective Care</th>
<th>Safe Care</th>
<th>Coordinated Care</th>
<th>Patient-Centered Care</th>
<th>Access</th>
<th>Cost-Related Problem</th>
<th>Timeliness of Care</th>
<th>Efficiency</th>
<th>Healthy Lives</th>
<th>Health Expenditures/Per Capita, 2011**</th>
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</thead>
<tbody>
<tr>
<td>AUS</td>
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<td>4</td>
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<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>$3,405</td>
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</tbody>
</table>

Notes: * Includes ties. ** Expenditures shown in $US PPF (purchasing power parity); Australian $ data are from 2010.

Leading to focus on quality of health care


Impact of behavioral health conditions on health care costs and outcomes

Ten medical conditions with the highest estimated spending in 2013

- Mental disorders
- Heart conditions
- Trauma
- Cancer
- Pulmonary conditions
- Osteoarthritis
- Normal birth
- Diabetes
- Kidney disease
- Hypertension

Utilization and spending by Medicaid enrollees with behavioral health diagnoses, 2011

One in five Medicaid beneficiaries had behavioral health diagnoses but accounted for almost half of total Medicaid expenditures

Federal programs resulting from legislation

Key programs authorized by legislation:

• Pay-for-Value programs for hospitals and physicians
  o Physician and Hospital Quality Reporting Systems
  o Value-based modifier

• Bundled payments

• Meaningful use for Electronic Health Records (EHRs)

• Accountable Care Organizations (ACOs):
  o 2012: Medicare Shared Savings and Pioneer Programs
  o 2017: Shared Savings Tracks 1, 2, or 3

• CMS will tie 85% of all Medicare fee-for-service payments to quality or value by 2016 and 90% by 2018
Accountable Care Model

Effect of adjusting the target budget on the amount of shared savings

- Adjusted target budget
- Baseline
- Actual performance

Amount of Shared Savings With Adjusted Target Budget

$ per bundle or member
Why do we measure quality and performance?

1. Monitor and understand systems, providers, and populations

2. Internal Quality Improvement
   a. To support point-of-care decision making
   b. For provider continuous quality improvement projects
   c. Managed care organization performance improvement

3. Accountability
   a. Public reporting
   b. Value-based payment
NYS Behavioral Health (BH) Performance Measures
NYS Medicaid Program
Quality and Performance Measurement

• Medicaid Managed Care: Quality Strategy and Quality Assurance Reporting Requirements (QARR)
• DSRIP Performance Measures
• Value-Based Payment Program and Roadmap
• Behavioral Health Clinical Advisory Group (BH CAG)
# HARP VBP Quality Measure Set

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Steward</th>
<th>NQF Measure Identifier</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPC Breast Cancer Screening</td>
<td>NCQA</td>
<td>2372</td>
<td>Cat 1 P4P</td>
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<tr>
<td>IPC Cervical Cancer Screening</td>
<td>NCQA</td>
<td>0032</td>
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<td>IPC Chlamydia Screening for Women</td>
<td>NCQA</td>
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<td>Cat 1 P4P</td>
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<td>IPC Colorectal Cancer Screening</td>
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<td>Cat 1 P4P</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Eye Exam (retinal) Performed</td>
<td>NCQA</td>
<td>0055</td>
<td>Cat 1 P4P</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Foot Exam</td>
<td>NCQA</td>
<td>0056</td>
<td>Cat 1 P4R</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</td>
<td>NCQA</td>
<td>0575</td>
<td>Cat 1 P4R</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>NCQA</td>
<td>0059</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]</td>
<td>NCQA</td>
<td>0057</td>
<td>Cat 1 P4P</td>
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<tr>
<td>IPC Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>NCQA</td>
<td>0062</td>
<td>Cat 1 P4P</td>
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</tbody>
</table>

**Acronyms:** CMS: Centers for Medicare and Medicaid Services, NCQA: National Committee for Quality Assurance
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<tbody>
<tr>
<td><strong>IPC Comprehensive Diabetes Screening: All Three Tests (HbA1c, Dilated Eye Exam, and Medical Attention for Nephropathy)</strong></td>
<td>AHRQ</td>
<td>Composite Scoring Measure not endorsed, but includes 0055, 0062, and 0057</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>IPC Continuity of Care from Inpatient Detox or Inpatient Care to Lower Level of Care</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>IPC Controlling High Blood Pressure</strong></td>
<td>NCQA</td>
<td>0018</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>IPC Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</strong></td>
<td>NCQA</td>
<td>1932</td>
<td>Cat 1 P4P</td>
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<tr>
<td><strong>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)</strong></td>
<td>NCQA</td>
<td>-</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>Follow-up After Hospitalization for Mental Illness (A) within 30 days; (B) within 7 days</strong></td>
<td>NCQA</td>
<td>0576</td>
<td>Cat 1 P4P</td>
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<tr>
<td><strong>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</strong></td>
<td>CMS</td>
<td>1879</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>IPC Initiation of Pharmacotherapy upon New Episode of Opioid Dependence</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>IPC Medication Management for Patients with Asthma</strong></td>
<td>NCQA</td>
<td>1799</td>
<td>Cat 1 P4P</td>
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<tr>
<td><strong>Percentage of Members Enrolled in a Health Home</strong></td>
<td>OMH/OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
</table>

**Acronyms:** AHRQ: Agency for Healthcare Research and Quality, OASAS: Office of Alcoholism and Substance Abuse Services, NCQA: National Committee for Quality Assurance, OMH: Office of Mental Health
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</thead>
<tbody>
<tr>
<td><strong>IPC Use of Alcohol Abuse or Dependence Pharmacotherapy</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Maintaining/Improving Employment or Higher Education Status</td>
<td>OMH/OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Maintenance of Stable or Improved Housing Status</td>
<td>OMH/OASAS</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
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<tr>
<td>No or Reduced Criminal Justice Involvement</td>
<td>OMH/OASAS</td>
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<tr>
<td><strong>IPC Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</strong></td>
<td>CMS</td>
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<td>Cat 1 P4R</td>
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<tr>
<td><strong>IPC Preventive Care and Screening: Influenza Immunization</strong></td>
<td>AMA PCPI</td>
<td>0041</td>
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<tr>
<td><strong>IPC Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</strong></td>
<td>AMA PCPI</td>
<td>0028</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Potentially Preventable Mental Health Related Readmission Rate 30 Days</td>
<td>OMH</td>
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<td>Cat 1 P4P</td>
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<tr>
<td><strong>IPC Statin Therapy for Patients with Cardiovascular Disease</strong></td>
<td>NCQA</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td><strong>IPC Statin Therapy for Patients with Diabetes</strong></td>
<td>NCQA</td>
<td>Not endorsed</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td><strong>IPC Use of Spirometry Testing in the Assessment and Diagnosis of COPD</strong></td>
<td>NCQA</td>
<td>0577</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
</table>

**IPC Measure is also part of TCGP/IPC Measure Set**

**Acronyms:** OMH: Office of Mental Health, OASAS: Office of Alcoholism and Substance Abuse Services, AMA: American Medical Association, PCPI: Physician Consortium for Performance Improvement, CMS: Centers for Medicare and Medicaid Services, NCQA: National Committee for Quality Assurance
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<td><strong>IPC Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder</strong></td>
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<td>Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) or Home and Community Based Services (HCBS)</td>
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<td>Not endorsed</td>
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<tr>
<td><strong>IPC Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
<td>Cat 2</td>
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<tr>
<td><strong>IPC Continuing Engagement in Treatment (CET) Alcohol and Other Drug Dependence</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
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<tr>
<td><strong>IPC Asthma: Assessment of Asthma Control – Ambulatory Care Setting</strong></td>
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<td>Not endorsed</td>
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<tr>
<td><strong>IPC Lung Function/Spirometry Evaluation (asthma)</strong></td>
<td>AAAAI</td>
<td>Not endorsed</td>
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<tr>
<td><strong>IPC Patient Self-Management and Action Plan</strong></td>
<td>AAAAI</td>
<td>Not endorsed</td>
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<td><strong>Mental Health Engagement in Care 30 Days</strong></td>
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<td>Cat 2</td>
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<tr>
<td><strong>IPC Use of Opioid Dependence Pharmacotherapy</strong></td>
<td>OASAS</td>
<td>Not endorsed</td>
<td>Cat 2</td>
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</tbody>
</table>

*IPC: Measure is also part of TCGP/IPC Measure Set*

**Acronyms:** AAAAI: American Academy of Allergy, Asthma, and Immunology, CMS: Centers for Medicare and Medicaid Services, NCQA: National Committee for Quality Assurance, OASAS: Office of Alcoholism and Substance Abuse Services, OMH: Office of Mental Health
How does your program fit into this larger measurement approach?
Medicaid Population
Medicaid Managed Care Plans

<table>
<thead>
<tr>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
</tr>
</thead>
</table>

Plans are often measured on Follow-Up (7- and 30-day) after inpatient MH Hospitalization (FUH)
Performing Provider Systems (PPSs)

Plans are likely to contract with PPSs around the same FUH measures.
But does it make sense for you to measure FUH?
Maybe not...
What should you do?

• Understand where your practice or agency fits in the larger system of care
• Know the oversight and payment authorities’ priorities for the system of care
• Develop your **Value Proposition:**
  o What is your expertise?
  o Align some (not all!) of your agency’s priorities and strengths with the system priorities
  o Implement tracking and reporting of key agency practices that align with the system priorities
  o Have summary reports ready for external audiences—brag about what you do well!
Priorities for BH System Transformation in NYS

1. **Shift the locus of care:** Improve care transitions; offer prevention, early intervention, and crisis services; decrease inpatient admission and ED visit rates.

2. **Promote Integrated Care:** strategies to incentivize integrated (medical - behavioral health) care.

3. **Improve functioning and recovery:** Increase the numbers of individuals returning to work or school; decrease criminal justice contacts; promote individuals’ pathways to recovery.
What should a community-based organization measure?

1. **Shift the locus of care:** Don’t need to measure readmission rates, but consider tracking adherence to your agency’s relevant Policies & Procedures, e.g.:
   a. Check-ins with all clients within 7 days of discharge from hospital or emergency department to check symptoms, reconcile medications, and review aftercare appointments
   b. Enrollment in a Health Home, and regular communications with HH Care Manager
   c. Accompany clients to aftercare appointments in first 30 days following discharge from hospital
If it won’t change how you behave, it’s a bad metric.
What should a community-based organization measure?

1. Shift the locus of care
2. **Promote Integrated Care:** Don’t have to measure blood sugar and cholesterol, but consider tracking:
   a. Attendance at annual primary care appointments/wellness appointments
   b. Monthly medication reconciliation for both psychotropic and general medical medications
   c. Regular reviews (e.g., monthly or more when in crisis) of safety plans for individuals with depression or history of suicidal thinking/behavior
What should a community-based organization measure?

1. Shift the locus of care
2. Promote Integrated Care
3. **Improve functioning and recovery**: Identify key elements of your vision/approach to care and measure adherence to related Policies & Procedures. Examples include rates of clients with:
   a. Complete, comprehensive Plans of Care
   b. Personalized recovery goals
   c. Housing stability
   d. Involvement with justice system
What do NYS residents with SMI need to live in the community?

NYS Community Mental Health Screen:
• Individuals enrolled in a HARP or HIV SNP
• Screens completed from October 2015 – December 2017
• 16,121 individuals
Living Arrangements and Living Status

N=17,223*

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>With spouse/partner and/or relatives</td>
<td>7,808</td>
<td>45%</td>
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<tr>
<td>Alone</td>
<td>6,598</td>
<td>38%</td>
</tr>
<tr>
<td>With non-relative(s)</td>
<td>2,817</td>
<td>16%</td>
</tr>
<tr>
<td>Private home/apartment/rented room</td>
<td>12,900</td>
<td>74%</td>
</tr>
<tr>
<td>Mental Health supportive housing</td>
<td>2,535</td>
<td>15%</td>
</tr>
<tr>
<td>Homeless (shelter or street)</td>
<td>1,059</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>852</td>
<td>5%</td>
</tr>
</tbody>
</table>

* Data were not available for 140 individuals
Performance of Independent Living Skills

Independent Living Skills Performance
Mean Score
N=15,543*

Transportation 0.74
Phone use 0.14
Managing medications 0.69
Meal preparation 0.64
Managing finances 0.98

IADL scores can range from 0=Independent to 6=Total dependence. A score of one indicates setup.

* Data were not available for 17 individuals and 562 were excluded for not performing skills within the assessment period.
Performance of Independent Living Skills

Independent Living Skills Performance
Number and Percentage of Individuals who Scored Four or Higher
N=15,543*

- Transportation (N=1,499) 10%
- Phone use (N=239) 2%
- Managing medications (N=1,222) 8%
- Meal preparation (N=1,285) 8%
- Managing finances (N=1,986) 13%

IADL performance scores of four or higher include the following performance categories:
- Extensive assistance - help throughout task, but performs 50% or more of task on own;
- Maximal assistance - help throughout task, but performs less than 50% of task on own;
- Total dependence - full performance by others during entire period

* Data were not available for 17 individuals and 562 were excluded for not performing skills within the assessment period.
Life Events

Life Events within the Last Year and More than One Year Ago
N=16,097*

- Lived in war zone or area of violent conflict (combatant or civilian): 6% Total
- Victim of sexual assault or abuse: 31% Total
- Victim of crime (e.g. robbery, exclude assault): 27% Total
- Review hearing (e.g. forensic, certification, capacity hearing): 6% Total
- Victim of physical assault or abuse: 42% Total
- Parental abuse of alcohol or drugs: 29% Total
- Major loss of income or serious economic hardship due to poverty: 40% Total
- Immigration, including refuge status: 3%
- Victim of emotional abuse: 48% Total
- Failed or dropped out of education: 44% Total
- Distressed about health of another person: 53% Total
- Witnessed severe accident, disaster, terrorism, violence or abuse: 30% Total
- Death of a close family member or friend: 67% Total
- Child custody issues: 19% Total
- Conflict-laden or severed relationship (include divorce): 39% Total
- Serious accident or physical impairment: 39% Total

* Data were not available for 24 individuals
Social Connectedness Indicators

Number and Percentage Participating in Social Relationships within the Past Month
N=15,313*

- Other interaction with a long-standing social relation or family member (call, email, text) (N=12,150) - 78%
- Visit with a long-standing social relation or family member (N=10,467) - 67%
- Participation in social activities of long-standing interest (N=6,944) - 45%

* Data were not available for 808 individuals
Current Employment Status

N=16,103*

* Data were not available for 18 individuals
Enrollment in Formal Education

Number and Percentage Currently Enrolled in a Formal Education Program
N=16,094*

* Data were not available for 27 individuals
Functional Outcomes

Individuals with SMI state preferences for services and supports

Among the 76% who were unemployed and not seeking employment, only 16% preferred changes in employment reports. Why is that?
Perception of Care

Most individuals with SMI members feel involved in their treatment

Percentage Responding Usually or Always
n=168

- How often did BH providers listen carefully to you? 85%
- How often were you involved as much as you wanted in your treatment? 83%
Perception of Care

But many feel unable to set priorities and pursue interests

Percentage Responding Usually or Always
n=172

- I am able to set my own goals in life: 65%
- I am able to do things that I want to do: 62%
Violence Indicators

Number and Percentage with Indicators of Violence
N=16,104*

- Violent ideation (N=4,078):
  - Within the past year: 15%
  - More than 1 year ago: 10%

- Intimidation of others or threatened with violence (N=4,352):
  - Within the past year: 17%
  - More than 1 year ago: 10%

- Violence to others (N=3,320):
  - Within the past year: 16%
  - More than 1 year ago: 4%

* Data were not available for 17 individuals
Criminal Justice Indicators

Number and Percentage Who Were Arrested or Incarcerated
N=16,107*

- Arrested with charges (N=7,703):
  - Within the past year: 42%
  - More than 1 year ago: 6%

- Incarcerated (jail or prison with overnight stay) (N=6,816):
  - Within the past year: 38%
  - More than 1 year ago: 4%

* Data were not available for 14 individuals
Summary

- Measurement-based care and quality monitoring are increasingly important elements of agency and practitioner practices.
- Value-based payment models will replace fee-for-service.
- BH performance measurement has lagged but is rapidly catching up.
- Get comfortable with measurement strategies and programs.
- Advocate for development and use of measures that matter most to us and our clients.
WELL, BASED ON THE DATA, I’D SAY OUR COURSE IS CLEAR...
Thank you!