

## **NATIONAL QUALITY FORUM**

**Moderator: Lindsey Tighe**  
**May 7, 2012**  
**2:30 pm CT**

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

Female: Hi everyone and welcome to our Cancer Endorsement Maintenance call, first one of Phase 2. Today's focus is going to be on the colon measures. And I - before we get started I just wanted to do a quick poll of our steering committee members. Dr. Bruera? Tenzyk?

Dr. Wendy Tenzyk: Here.

Female: Okay. Dr. Ricciardi? Dr. Lutz? Dr. (Lloyd)? Dr. Gore?

Dr. John Gore: Here.

Female: Dr. (Dale)? (Jared Lobe)? Dr. Alvarnas?

Dr. Joe Alvarnas: Here.

Female: All righty. Well again welcome and I wanted to let everyone know that we do have measure developers on the call and we'll be going through measures from the AMA PCPI, (ASCO) and let's see, ACS.

So as we start, we'll go ahead and start with number 0392, colorectal cancer resection pathology reporting.

Female: Felicia, if you could ask anyone on the line with AMA PCPI to signal, if you can open their lines please?

Operator: And please press star 1 if you do need your line opened. And we'll go to Samantha Tierney.

Samantha Tierney: Yeah, hi there.

Female: ...in the room for the AMA PCPI.

Female: Okay.

Female: Yeah, all of their lines need to be opened for this discussion.

Operator: Okay. Just a moment. (Emily Wilkes) line is opened, V.O. Speights.

Dr. V.O. Speights: Yes. With an A sound.

Operator: Speights?

Dr. V.O. Speights: Yes.

Operator: Thank you sir.

Female: Any others?

Operator: And those are the only ones that signaled.

Female: Sam is that everyone from AMA PCPI?

Operator: And Fay has now signaled as well. Shamanski.

Female: Okay, thank you. So as I was saying, we're going to start with 392. The process will be for the lead discussant to go through the measure and give their impressions of each of the criteria for the measure. And then we'll open it up for discussion by the work group.

So for this measure which is an AMA PCPI measure, our discussant is Dr. Gore on the line.

Dr. John Gore: So this measure is to include basically full pathology reporting including key stage of the primary tumor and end stage of the regional lymph nodes with histologic grade for patients undergoing colorectal cancer resection.

It's a measure that's reported as a percentage, so a percentage that includes essentially complete pathologic information. In terms of the importance to measure colon cancer is one of the most commonly detected cancers.

It's the third most commonly detected cancer and a leading cause of cancer specific death.

So accurate pathology reporting is very important as we'll see in review of the later measures and determination of adjuvant treatments in terms of staging and discriminating between Stage 2 and Stage 3 cancer and possibly in determining eligibility for clinical trials.

In terms of performance gap I thought this might be one of those where compliance is, you know, above 95%. But there was a surprising performance gap documented on review of 2008 to 2010 claims with what they report as 25.8% of patients not having complete pathology specimen reporting.

There is no information on disparities in terms of structure process outcome link. This is a process outcome it's not a health outcome. But I think we can clearly make an alignment between the process of accurate pathology reporting and an eventual outcome likely.

There aren't really a lot of studies to pull from other than guidelines. So it is low level evidence but it's very consistent. I don't think there's anyone out there arguing for incomplete pathology reporting in terms of reliability and validity.

So it does seem to be a measure that would be reliably ascertained either through hand drawn extraction or ideally with an EMR. The measure developers include the relevant ICD-9 and CPT codes that allow you to designate candidate numerator patients.

They also include some relevant denominator exclusions such as recurring cases. And in terms of - sorry, I'm just scrolling down here. In terms of reliability testing they showed excellent ability to reliably ascertain the information from charts in the testing project.

In terms of validity this is similar to some of the other PCPI measures that we've reviewed where they queried an expert panel about their impression of the measure as a rating of - sorry, one second - as a rating of how important the measure is to report.

And it wasn't as strong as you would expect. There was some disagreement and there were some people who were fairly neutral on it. But eight out of 12 of the panel felt that it was something important to measure. There's no risk adjustment for the measure.

In terms of - I'm sorry, scrolling down to usability. I think the measure demonstrates high usability as it's a way to look at the quality of the pathology reporting that is delivered by a local institution. It can be used for benchmarking and definitely for local quality improvement.

In terms of feasibility, you know, these are all elements that are usually fundamental components of a synoptic pathology report and so I think it can be easily ascertained, especially with an electronic health record.

And so I thought that this measure met criteria in importance, reliability, validity and usability for endorsement.

Female: Thank you. So we'd like to throw open discussion to the rest of the work group. And please keep in mind we have the developers on if you have questions. You can direct them to developers also. Were there other comments about this measure?

Dr. V.O. Speights: Well this is V.O. Speights. I'm a pathologist and I am very surprised about the gap there.

Dr. John Gore: Yeah.

Dr. V.O. Speights: So I think this is a very good measure, very practical and very easy to monitor and was very appropriately explained.

Dr. John Gore: I thank you.

Emily Volk: This is Emily Volk. I'm also a pathologist with sub specialty training in GI and I concur.

Female: Thank you. And just to clarify that was Dr. Speights? That was - and Emily was - you were a developer side?

Emily Volk: Yes. That's correct.

Female: Okay, thank you.

Emily Volk: And I know you're probably looking for input from the other side but...

Female: No problem. No problem at all. Any comments from the steering committee?

Dr. Joe Alvarnas: I thought - this is Joe Alvarnas. I thought the measure was extremely well presented and I think there's both a performance gap as well as an important in achieving this - so given that as a measurability I also would support the measure.

Dr. Wendy Tenzyk: And this is Wendy Tenzyk also from the steering committee. I would agree with an excellent presentation and I also support the measure.

Female: All right.

Dr. John Gore: It seems like there's a consensus.

Female: Sounds good. If there's - if there are any more comments about any of the criteria...

Operator: And this is the Operator. I also opened the line of David Witte. If anyone else needs, their line open simply press star 1.

Female: Dr. Witte, thanks for joining us.

Dr. David Witte: I think - I concur with the consensus as it's developed.

Female: Thank you. All right. Well then I think we've completed our discussion for this measure. Then let's move onto our next measure. At 0223 and I believe the developer for this is ACS. And our lead discussant is Dr. Bruera and Wendy Tenzyk.

And do we have either of those steering committee members on the line?

Dr. Eduardo Bruera: Yes. Thank you very much. It's Eduardo and this is a measure proposed by the American College of Surgeons and it implies determination of adjuvant chemotherapy within four months of surgery to patients under the age of 80 with Stage 3 colon cancer.

They propose the measure is very well outlined. They describe the importance of chemotherapy being given in Stage 3 and the importance of giving it in a timely manner within four months. They have very good denominator statements, ages from 18 to 79.

And the type of malignancy the denominator exclusions are well outlined too. The gap has been described also well with regards to the fact that there is high potential impact since there could be a potential 25% difference in survival.

And also they find that they are already committed in both ((inaudible)) in the use of chemotherapy in Stage 3 colon cancer.

So in general the structure is good and basically when I personally looked at this from what has been provided to us in terms of importance and the evidence that adds up it seems to be quite consistent with regards to the scientific rationale was very high.

And basically it sounds very usable from the perspective of dealing data or electronic medical records. It's quite - reasonably simple to calculate the time and the administration of modern chemo. So it looked to be quite feasible.

And so in my impression it did seem to meet the criteria for adoption at this time. I am not an expert in this subject so I looked at it based on the material that was presented and my interpretation of it. So I would welcome a comment from the committee about what other ones feel about it.

Female: Okay. And I just wanted to say Wendy was also the lead discussant on this. Would you like to weigh in at all first?

Dr. Wendy Tenzyk: Sure. I was actually going to say Dr. Bruera says he's not an expert. I'm certainly way less of one. I'm not a clinician at all. But I would definitely agree with his comments in terms of what appeared to be the thoroughness of this.

I appreciated the fact that there were randomized trials that were used which we kept seeing in many of the measures that we've looked at. And also that level of - the evidence was rated as level one evidence. So I thought it was very strong and agreed also with the recommendation to approve it.

Female: Thank you. Any other discussion from the larger steering committee members?



Dr. Joe Alvarnas: Yeah. This is Joe Alvarnas. I would echo the - what I view as the importance of this and the measurability. And as I guess understand it, this is one of those measures that has been chosen by CMS to be both tracked and publicly reported.

I guess I'm surprised at the extent of a performance gap that exists. And it's troubling. And given the - I think the very strong argument and level one evidence that this can have an impact on patient outcome I would also reiterate the importance of maintaining this measure.

Female: Thank you. Any other comments or do we have a comment for the developer or questions for the developer? Okay. Hearing none we'll go onto the next measure. We have number 00225, at least 12 regional lymph nodes are removed in pathological exam and for resected colon cancer.

This again is the American College of Surgeons measure. And our lead discussant assigned was Dr. Ricciardi. And is he on the line, Dr. Ricciardi?

Dr. Rocco Ricciardi: I am on the line.

Female: Very good. Thank you. And we said earlier, at the beginning of the call that the process is a walk through and let us know your impressions to play to the four criteria. And then we'll throw it up into the wider group.

Dr. Rocco Ricciardi: Sure. So I apologize for being late. The - this is a process measure that's up for endorsement and review. And the maintenance measure is that at least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

The data came from the electronic clinical data registry and paper records. And the analysis is ((inaudible)). With respect to impact I think the data here demonstrates conclusively that ((inaudible)) outcomes of the patient that is a high impact ((inaudible)).

Female: Okay.

Dr. Rocco Ricciardi: With respect to performance gaps also a number of studies that were referenced that demonstrate a performance gap debate across the country as ((inaudible)). I can state it that high as well. The next area is evidence for health - exemption for health outcomes.

It's the help of outcome (stability). This - although it's a process measure it is tied to help outcome ((inaudible)). For reliability and validity I think the measure - this measure is exactly - does exactly that it intended to do which is data administrative reliable measures or very valid ((inaudible)).

It is high on both counts. And then for usability I think what the measure developers indicated that it's used by oncologists for the commission of cancer at about over 1500 hospitals, accredited cancer programs.

And although the Commission on Cancer anticipates that the programs will increasingly self-select ((inaudible)) within the context of the communities that serve the National Public Reporting program isn't - hasn't been accepted by for this measure yet.

But they feel - developers feel that it's going to happen ((inaudible)). I think certainly it could be a measure that ((inaudible)). For feasibility the data - the required data almost certainly routinely generated ((inaudible)) delivery. Again so no concerns there.

And there are absolutely no inactive errors that the measures ((inaudible)) under reporting. So overall I thought that this was a good measure, an excellent measure and should be approved.

Female: Okay. Thank you Dr. Ricciardi. Are there other questions or comments from the steering committee members on the call?

Dr. Joe Alvarnas: This is Joe Alvarnas, I would echo I think just the usability and utility of the measure as well as its importance and recommend approval.

Female: Okay. Any other?

Dr. Wendy Tenzyk: And this is Wendy Tenzyk. I would say the same. Thank you.

Female: Okay. Okay. Any other comments about this one or questions for the developer on this one? All right. Well hearing none we will move onto our next measure. We're moving pretty quickly here, 0385.

This is an oncology measure, chemotherapy for Stage 3A through Stage 3C colon cancer patients. This is an AMA PCPI measure. We have as lead discussant Dr. Lutz. And is Dr. Lutz on the call? If not let's see, we're looking at it on the - we're looking at the measure now on the screen.

And do we have any comments we can just walk through if you want to just walk through?

Male: I guess my question would be and I have to plead to a certain amount of ignorance here is, in some ways it seems to overlap with the previous measure.

Female: Okay.

Male: And I'm having trouble discerning how they're different.

Female: Okay.

Male: And the other one sort of just said generically states, patients with Stage 3 colon cancer. And in this instance we're talking about patients with Stage 3A through 3C colon cancer. But - and again please excuse my ignorance.

In the first one we're talking about consideration or administration of chemotherapy within four months. In this one we're talking about chemotherapy within 12 months.

It just seems that these would be measures which look at the same patient population but are applying a different standard to them.

Female: That is the question. Actually is the developer on the line able to speak to that, the differences between this one and 225? Oh. But I don't have those.

Female: Oh, sorry. Which measure are we - were you saying it overlaps with?

Male: Well just - it was - I apologize. Let me go ahead and grab it - 223.

Female: Oh, 223? Okay, got you. Got you.

Male: I mean the definition - the numerator and denominator are slightly different but they're not that different. I find that we're allowed - and again please forgive me if I'm completely misreading this.

But the difference seems to be in the current 385 they define what chemotherapy combinations sort of meet that criteria. We're talking about Stage 3 with maybe a greater level of specificity than what was articulated previously.

And then we're given 12 months here as opposed to four months with the previous measure.

Female: Right.

Operator: And pardon the interruption. We do have a couple of signals over the phone.

Male: Good. Good.

Operator: Kristen McNiff and (Samantha Tierney).

Female: Great.

Female: Yes, thank you.

Kristen McNiff: I'll defer to Sam. Go ahead Sam.

Samantha Tierney: Thanks Kristen. Yeah, so I would agree with Dr. Lutz that these measures are essentially measuring the same thing. The measure from the American College of Surgeons is measuring performance at the facility level.

And this measure was designed to measure performance at the individual physician level. There are some differences to this measure. Essentially the intent is the same. They are based on the same guidelines.

But the reason their 120 day piece is not really built into the measure that you have at the physician level is primarily for sample size reasons and also because we were trying to make a measure that could be used in a same case reporting program.

But the measure does allow for current or previous receipt of adjuvant chemotherapy. So for a patient who, you know, would have received it some time ago we would just expect that they would document previous receipt.

But we - it certainly meant to be consistent with the guidelines and the intent of the American College of Surgeons' measure. But I'll ask Kristen if she has anything to add.

Kristen McNiff: No. I think that was a good summary. Maybe a key point is the unit of analysis being at the physician level for the AMA PCPI measure.

Male: And should we be worried that the timelines for these are different at four months versus 12 months?

(Crosstalk)

Male: ...an inconsistent standard of what represents timeliness in therapy.

(Angela): And this is (Angela). I'll just interject that this is something that we should think about when we get to the in person meeting as we'll be walking through both of the measures and we'll have these side by side so the committee can discuss them.

But if there's an answer from the developer we'd love to hear it.

Operator: And we do have a signal from Andrew Stewart.

Andrew Stewart: Hi. So this is the - I'm representing the College of Surgeons. The - these two measures are - overlap significantly.

But as the representatives from (ASCO) and AMA indicate, the measure put forward by the College was originally envisioned and has been implemented for the purpose of assessing hospital or facility level performance.

The measure that you're looking at here, numbered 385, as I understand it has been conceived to look at individual oncology provider performance if you will. The distinction in stage groups is moot. Stage 3 is - A, 3B and 3C.

So whether or not additional specificity is required on our part is a fairly administrative test to resolve if that's necessary. What I will come back to though is the timing difference. This measure was originally specified, assessed and in a sense validated over five years ago.

And during its original specification and development there was extensive evaluation of timeframe data between diagnosis or presentation of colon cancer and the administration of adjuvant therapy.

Those analyses were combined with the evidence and protocol framework of the clinical trials that have - that informed this standard of care.

And the consensus among the technical panel and the steering committees at the NQF back in 2006-'07 was that the 120 days or four months from diagnosis was a reasonable timeframe within which to expect post-operative adjuvant - post operative chemotherapy to be provided or administered to this cohort of adult under 80 patients.

So that's the origin of the timeframe that exists in the measure that was reviewed previously and is stewarded by the College.

Male: After our previous discussions regarding measure reconciliation I guess we can anticipate that the question will come up when we discuss them as a whole group in three weeks time.

So in some ways if the sponsors who are presenting these measures can anticipate that and articulate that clearly then you'll probably save us a lot of work.

Andrew Stewart: My - Kristen and I know each other. We'll touch base with each other this week and start those conversations. Thank you very much.

Male: Thank you. I think it'll be worthwhile. It will just make it easier to get through this efficiently.

Andrew Stewart: Yeah. I understand.

Male: Thank you for those comments. They were very helpful.

Female: Thank you. Any other comments about the - measure 385? Okay. All right, moving on we have next on the agenda is 1859, KIS gene mutation testing for ((inaudible)) with metastatic colorectal cancer receive anti-epidermal growth factor therapy.

And this is an (ASCO) measure. And for our lead discussant we have Dr. (Dale) or Dr. (Lobe). No? Okay. So let's - we have it up on the screen. And just walking through what the committee or the work group had looked at previously.

It looks like the important piece is mets by a vote of - with impact of two yes, two no for 1B. I'm sorry. I'm looking at the wrong. Go ahead and walk through - do you mind walking...



Female: Yes. I should look at this. Okay. Sorry. I was looking at the screen. I don't have my glasses. So the impact is four high - performance gap one high, one moderate and two insufficient. Looking at the rationale there were some comments about the fact that colon cancer is common.

Metastatic colon cancer is a substantial portion of patients. And there are questions about the evidence on the performance gap. But basically for once the evidence, the impressions were for - voted yes and for - and overall this was rated to pass importance.

So are there any comments from the larger work group on the importance?

Male: I'm doing the other measure - I guess I disagree with one thing where it says it's not really a parrot measure. I think it is because the measure that I'm looking at, 1860, really reflects what comes out of this. So...

Female: Right.

Male: ...I think you can articulate and I'm looking at the (NCCN) guidelines in front of me that for patients with a wild type (KRS) gene mutation it makes sense to make use of these anti-AGFR monoclonal antibodies whereas for those who have the mutated form of the genes it's a complete waste of money.

So I actually find that the measure makes sense. You know, one is - it's targeting our testing and refining it. And I think there is enough of a performance gap that's articulated here to - at least to my mind, to make this a fairly important measure.

Female: Okay. All right. Any other comments on that point? All right. Looking at the scientific acceptability it looks like there was uniform agreement that the scientific acceptability was met. There were some comments about they'd like to see more information given on specifications.

The time window - more detail on time window, numerator details and reliability testing. There's a question on reliability testing - what was the ((inaudible)) ascertainment. So hard data is I think the overall gist of that statement. Hard data would be helpful.

Are there any comments from the group on scientific acceptability?

Male: Well I think I would view that - this measure is meeting that standard of scientific acceptability.

Female: Is there anyone from (ASCO) who wants to get into this?

Female: So do - anyone from (ASCO)?

Female: Felicia could you see if...

Operator: Please press star 1 if you would like to have your line opened. And we'll go to Kristen McNiff and Tim Gilligan.

Female: Great. Thank you.

Kristen McNiff: Yeah, this is Kristen. I can start. We can - I understand that there is a request for a little bit more information about the reliability and we can certainly provide that in - can you just help me understand what other information you'd like more detail about numerator and denominator specs?

Is that what I heard?

Female: Yes. That's correct.

Kristen McNiff: Okay.

Female: That's correct.

Female: Yeah. They're asking for information on the time window for the measure and any additional information on the numerator details.

Kristen McNiff: Okay. All right, I mean - okay, so that's - we can certainly provide that.

Female: And that's in 2 - you're looking at 2A?

Kristen McNiff: Yes.

Female: Okay. Okay. Okay, so we'll look for that from you I think in advance of the in person. Is that correct?

Kristen McNiff: In advance of the in person? I'm sorry. I'm having a hard time...

Female: Yes.

Kristen McNiff: ...hearing you.

Female: Yes.

Kristen McNiff: We can provide that in advance of your in person. Yes.

Female: Okay, great. Thank you. Any other comments from the steering committee on this? Okay. All right, so looking at usability it was rated to pass the usability criteria by the work group members.

And also we looked at feasibility and it looks like two members rate it as moderate and two members rate it as insufficient and I wondered if there was any discussion there for feasibility of the measure. No? Good. Okay.

Hearing none the assessment of the work group as a whole was that it should - it's suitable for endorsement.

Are there any questions from work group members on any aspect of this measure or as a - this measure as a whole? No? Hearing none - any additional comments from the developer on this one? Okay.

Kristen McNiff: I'll provide the additional information you're looking for.

Female: Great. Thanks Kristen. All right, then moving on we'll go to the next one which is 1860, also an (ASCO) measure - anti-epidermal growth factor receptor, monoclonal antibody therapy not received by metastatic colorectal cancer with KRSG mutation. And for our discussion...

Dr. Joe Alvarnas: Me.

Female: ...I have Dr. (Alvarnaz).

Dr. Joe Alvarnas: Hi. I think a lot of what you said in the discussion of the previous measure pairs up with this one. I thought I saw it as a parrot measure with the other one establishing measurement of the gene mutational status as the pool from which we draw at least the denominator statement for this.

In this case patients who have the (KRS) mutation don't benefit from EGFR. So I think this is a well-conceived overuse measure for what constitutes incredibly expensive therapy and I think it seeks to ensure that such therapy isn't applied in a futile fashion.

Again I think the statements of impact here demonstrate not only the prevalence of this condition but what was particularly troubling to me is that there is a significant performance gap of about 15% when one thinks about the resource intensity of these therapeutic modalities.

I think it argues that there's room for improvement in efficiency. I think that they do a very good job of indicating the consistency of the data and the importance of the data.

And then extending through the strength of the data the recommendations from (ASCO) as well as from NCCN are unequivocal in the - this being an inappropriate use of resources.

With respect to the specificity and reliability of the measurement I think that the application articulates that in fact this can be sampled in a reliable way.

And they cite their previous experience abstracting the data from 130 practices with the agreement data having concordance level of 90% which I thought was quite good. Overall I viewed this as - I ranked it very highly actually.

I viewed it as an important overuse measure with a good definition and I thought its potential for applicability at least was quite good.

And I would recommend approval of this measure or that it moves forward to the broader discussion with all of the caveats that were articulated with 1859 also to some extent, applying to this measure as well.

Female: Okay. Thank you. Comments from the larger work group?

Dr. Stephen Lutz: Yeah, this is Steve. Sorry I was a little late. But the only thing I had an issue with in here and I'm not sure I have a suggestion to make it read better but it comes up on three or four of the measures we're going to be looking at, at the next meeting.

When you read through the measure title, any title it has and it's something not received by someone with (KRS) gene mutation it took me a couple of readings through to make sure I understood just from the title what we were trying to get out of it.

And I know, you know, when I write for board examinations they always say you are not allowed to write a question that says something that is a not or a negative because it actually sends you back and forth a couple of times.

So I'm not sure how to word that differently but it struck me for all of the measures that said something not done because when you read through it almost looks like not done when it should have been but it's actually should not have been done. Do you know what I'm saying?

Female: Yep.

Dr. Stephen Lutz: Does that make sense? So I'm not sure if there's a way to - an easier way to word it where it just says something inadvertently delivered or something. But something not done kind of put me off a little bit. I mean it's a minor thing but like I said, I read through it twice.

Female: Any response from the developer on that one, or the rest of the group?

Dr. Stephen Lutz: It's okay. It's only - it's okay if it's only me that thought that. But yeah, it did catch my eye.

Operator: And we do have a signal from Kristen McNiff.

Kristen McNiff: Hi. Thank you. Yes, the wording I agree is a little - a bit of a mouthful. And we actually report it both ways but we do it that way to reverse the directionality of the measure reporting. But certainly it could be we report it both ways. We could, you know...

Dr. Stephen Lutz: Yeah. And I'm not sure which is - I'm not sure which is best. It just kind of - it kind of - the fact that I read it twice and I'm still trying to figure it out and I was emotionally invested in trying to figure it out, I wondered if someone reading through more casually might just sort of not get it.

That was my only concern.

Lindsey Tighe: And Kristen this is Lindsey, just a quick question just to make sure we didn't miss anything. These measures were not submitted as paired were they?

Kristen McNiff: They were not submitted as paired.

Lindsey Tighe: Okay.

Kristen McNiff: They're definitely related and they fight the same evidence, the same guidelines. But they're - we feel that they're really measuring two distinct constructs.

Lindsey Tighe: Okay.

Female: Were there any comments from work group about the two of the measures together? I mean as a possible pair.

Dr. Joe Alvarnas: I think - this is Joe Alvarnas. I think I've kind of argued this before. I think these measures are paired and one without the other doesn't make a lot of sense.

Dr. Stephen Lutz: Yeah, this is Steve. I agree. I think they're both good. I think they deserve to be there together. And they actually enhance each other by virtue that it makes it very clear what we're trying to get at or what the submitters are trying to get at.

Female: All right. That may be a recommendation I would carry forward to the larger discussion at the in person. And is there any comment from the developer about that possibility?

Kristen McNiff: That's - I can - I certainly can't necessarily speak for us but I'll bring that back to our committee. But I think that we would be certainly open to considering it and I can say for sure we'd be open to considering it.

Just the distinction is that the previous measure, 1859 is looking at metastatic colorectal cancer patients who do receive the monoclonal antibody.

And then confirming that the (KRS) testing was done because there was not a recommendation that all metastatic colorectal patients - cancer patients get (KRS) gene mutation testing.

So it's not - so often paired measures the one really defines the other and we actually submitted one like that that will be reviewed later this week. But in this case the denominators in the first measure is targeting a slightly different patient population.



But if you all think they should be paired I'd be certainly happy to bring that back to our committee.

Female: Thanks. Okay. Any other questions about measure 1860 or comments? Okay. Hearing none that concludes our call.

Female: Actually Felicia can we open up the lines for member and public comment please?

Operator: Open every line?

Female: Yes, please.

Operator: Very good. Please standby. All lines are being opened.

Female: And is there anyone with comments? Okay, well hearing none, as far as the committee work is really the next steps. We have two more work group calls this week for the breast cancer measures. And then the in person meeting is scheduled for May 23rd and 24th.

We'll be sending out an agenda shortly. We just didn't want to overwhelm you with four agendas in one week. But it is final and I'm the measure developer ((inaudible)) at this point so we should be ready to go. If you haven't RSVP'd for the in person meeting yet please do.

You should have received an email from Meetings@QualityForum.org. I think they've sent out two at this point so please do RSVP whether you can attend in person or by phone. We definitely need to know.

Other than that unless you all have any specific questions for me we will update you on Phase 1 at the in person meeting. But that's pretty much it for Phase 2 until we see you in a couple of weeks.

Male: Thank you.

Male: Thank you.

Female: Thanks.

Female: Yeah, thank you.

Female: Thank you.

Female: Thank you Felicia.

Operator: You're welcome. Thank you. Bye-bye.

Female: Thank you.

END