NATIONAL QUALITY FORUM

Moderator: Leslie Vicale
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Operator: This is Conference #: 29009574

Leslie Vicale: So I'd like to welcome the standing committee to the call. Thank you again for taking time out of your schedule to join us. I'd like to introduce myself, I'm Leslie Vicale the project manager of the Cardiovascular Team here at NQF and with me today I have Sharon Hibay Senior Director, Vy Luong, Project Analyst and we will be expecting Wunmi Isijola as soon as (inaudible).

I also would like to find out what other H.R. any other NQF staff who are on the call with us today?

Reva Winkler: Hi, it's Reva, I'm here.

Leslie Vicale: Hi, Reva. So we have Reva Winkler our other Senior Director joining us. So, first I'd like to do preview the purpose and the agenda of the call. First we will begin the call by reviewing and discussing the cardiovascular phase team measures deferred by the standing committee for reconsideration that is 0670, 0671 and 0672.

Then we will review and discuss comments with this during the post evaluation public member comment period which ended on February 27th for the phase two evaluated measures.

Lastly we'll provide any input on proposed responses to the post evaluation comments and determine whether reconsideration of any measures or other courses of action are warranted.

Before I turn it over to our co-chairs (Mary) and Tom, I would like to first ask Vy to take roll call of the community members we have joining us today.

Vy Luong: Thank Leslie. So, great, I will start off with co chair Mary George?

Mary George: Here.

Vy Luong: Thank you. Tom Kottke?

Thomas Kottke: Here.

Vy Luong: Great, thank you. Sana will not be able to join us today. So, next off is Carol Allred? Linda Briggs?

Linda Briggs: Here.

Vy Luong: Thank you. Oh Carol, thank you. Leslie Cho?

Leslie Cho: Yes, here.

Vy Luong: (Joe Clevlac)?

(Joe Clevlac): Here.

Vy Luong: Great, (Michael Crouch)? (Elizabeth DeLong)? (Ted Gibbons) well, I just wanted to make sure (Ted) is on the phone. OK, (Ellen Helga)?

We're hearing a lot of back noise, if you're not – if you won't be speaking if you can just mute your lines for the time being. So, again Ellen Hillegass? Judd Hollander? Thomas James?

Thomas James: I'm here, thank you.

Vy Luong: Thank you. Joe Marrs?

Joe Marrs: I'm here.

Vy Luong: Thanks. Gerard Martin? Kristi Mitchell? George Philippides? Nicholas Ruggiero?

Nicholas Ruggiero: Here.

Vy Luong: Oh thank you. Jason Spangler? I know Jason will be joining us shortly. And then Mark Valentine? And Mladin Vidovich?

Mladin Vidovich: I'm here.

Vy Luong: Hi, thank you. And that concludes the roll call.

Elizabeth DeLong: Hello?

Vy Luong: Yes, hi.

Elizabeth DeLong: Hey it's Liz DeLong, I got confused, apparently I need to keep the volume down on my computer and be on the line on my telephone, is that right?

Vy Luong: Yes, so thanks Liz for joining us. Sorry about the confusion. And at this actually I would like to just call out some developers to see if they're on the line. Do we have anyone from Joint Commission? Do we have anyone from CMS?

Female: From Joint Commission.

Vy Luong: Oh great, thank you. CMS? Heart Rhythm Society?

Female: Yes, we're here.

Vy Luong: Thank you. The ACC?

(Joe Allen): (Joe Allen).

Vy Luong: Thank you, Joe.

(Penelope Celest): Hi, and this is (Penelope Celest) also from ACC.

Vy Luong: Great, thanks, (Penelope). Children's Hospital Boston? And AMA PCPI?

Female: Hi, AMA PCPIs on the line.

Vy Luong: Great, thank you so much. Well that concludes the roll call for both the standing committee and the developers. I will not hand it back to Leslie.

(Bob Reflechy): Well I'm on the call, (Bob Reflechy) with PCNA.

Vy Luong: OK, great, thank you.

Leslie Vicale: All right, thank you very much, Vy. Before I turn it over, oh I'm sorry, now I would like to introduce our co chairs, Mary George will be facilitating a meeting with Tom Kottke joining her and he's joining us from a conference. So, thank you very much for facilitating the meeting and I'll turn it over to you for your opening remarks.

Mary George: Well great and thank you to everyone for taking time, not only to be here on the call this afternoon but for all of the preparatory work that you've done and reading through the documents that were sent ahead of time. This is Mary by the way I do want to call your attention to a couple of things in the documents that NQF sent to us, but I think are very important to keep in mind as we listen and participate in this conversation today. And one of them is the NQF guidance for evaluating evidence for measures of appropriate use.

This is a very, very helpful document, it's only about four pages but in there on page one which is call your attention and where it's talking about evaluating the evidence because the evidence for appropriate, inappropriate use measures should primarily focus on the lack of effectiveness or benefit of the test to procedures to patients. Patient Safety consideration such as unnecessary exposure to radiation may contribute to the risk benefit evidence. Cost and resource use are not the focus of appropriate used measures.

And then towards the very end of the document, there's some very helpful information in reviewing the evidence according to the NQF established criteria and algorithm. So, keep that in mind as you evaluate these measures.

Tom, did you have anything you wanted to add?

Thomas Kottke: No, I think that summarizes this quite nicely, Mary.

Mary George: OK, great. I guess we'll go ahead then ...

(Crosstalk)

Tom James: This is Tom James sorry to interrupt on that but I don't recall seeing this particular document before and probably it's my fault but where does resource use come into play and when this get sent to CMS?

Reva Winkler: Mary, this is Reva and I can try and respond to that. Tom, you know, these measures are not unlike any of the other process and outcome measures you're reviewing. They are often cost or resource use implication on over use or under use of various processes of care. But within these measures there is no data that uses cost like a cost and resource use measure and that's what we're referring to.

Tom James: OK, thank you.

Mary George: I think that was something that we were particularly concerned about when we first started to look at this and have the conversation of whether they belong in the cost and resource committee and decided that they really belong with us, so that particular reason. Any other questions before we …

Elizabeth DeLong: This is Liz, I don't know if its my technical, lack of expertise, but is there any way to make this a full screen rather than having all the colored boxes and attendees listed on the left hand side?

Vy Luong: Hi, Liz, it's Vy. I don't believe there's something we can do because we're screen sharing it right now.

Elizabeth DeLong: Got it, OK.

Vy Luong: Sorry.

Elizabeth DeLong: I can read I just, it would be better to have it full screen. Thanks.

Vy Luong: Yes, sorry about that, we'll keep that in mind next time when we're developing materials.

Mary George: Any other questions or comments from the committee before we get started?

OK, we will start with measure 670 and the measure developers are on the line. So, (Joe) and (Penelope) if you could give us just a few brief comments about the measure.

(Joe Allen): Sure, so 670 is addressing imaging and the use of the setting of (prior) to lower surgery for a pre-operative assessment of cardiac risk and this is for non-cardiac surgery member. So, this is lower risk, non-cardiac surgery. And when we last discussed this, there are lots of questions about the evidence-based. And so we've added quite a bit related to the guidelines as well as two studies that have been conceded related the performance gap and discuss it but, I don't know if you want me to go through each of the additional evidence pieces or if you want me to kind of stop there.

Mary George: I think, probably have you stop there and then as the discussion go through each section and maybe opportunities along the way. Thank you. So, our discussions for this are Joe Cleveland, Nic Ruggiero.

Joseph Cleveland: It's Joe Cleveland here, I'll start the discussion. And as referred measure number 670 cardiac stress imaging not meeting appropriate use criteria and this is pre-op evaluation low risk surgery patients steward is the ACC.

Since this is a process measure and basically as such the – we spend a lot of time discussing the evidence last time. So, I think all, in the spirit of trying to be somewhat focused jump to that. The developers has presented a lot more evidence for supporting this, both guidelines forward evidence both studies.

You know what, when I look at this, looking at the algorithm and it was helpful, Mary I thank you for putting me in to have guidance for evaluating evidence because I do think that, you know, we can, you follow the algorithm that is for our committee guide book on algorithm one, guidance for

evaluating the clinical evidence. I think that probably the – we can start at box seven at the bottom of the page and it's at the bottom of page six of the hand book for people that might have that up online or something like that.

And essentially the question is the empiric evidence submitted but without systematic review and grading the evidence, you know, we can say, yes does the empiric evidence include all the study in the bio and there's a lot of body of evidence here, huge amount of work. And so, you know, I think that there is a high certainty that benefits that way under (inaudible) facts, that is that we obviously don't think it probably wise to subject people to studies with low yield in a little risk population so.

You know, I could certainly support personally going down that series of questions or rate the evidence as moderate. Now if people obviously think that the evidence is not there and I think it's also, probably then you jump down in the next page and could rate this as a type of situation where you follow the algorithm to the point where the steering committee I guess if we agree that it's beneficial that hold providers accountable in the absence of the empirical evidence.

If the group doesn't think the empirical evidence is strong enough but there's benefits to patients we could also rate this as insufficient evidence with exception and I think that was one of the really stumbling blocks that we kind of – from what I remember our discussion January kind of got hung up on and I, you know, what there's a substantial amount of new evidence that's been presented here that makes me comfortable, actually saying that I think the evidence can rate as (inaudible) for this.

I'd be happy to open that up to discussion or other's thoughts and I guess I should seek my other co-reviewers thoughts too on that.

Female: Nicholas, Nic, do you have any comments?

Nicholas Ruggiero: I apologize I missed the meeting in January but I think Joe hit right on the head with what he was saying, I think he's right on.

Mary George: Any discussion on the evidence?

Thomas Kottke: Yes, Tom Kottke here. I agree with Joe, I think in particular there's very strong evidence that in low risk individuals that test, the difference between the positive and the negative test does not predict outcome in leads – tends to lead to more angiograms which in intervention which then does not lead to improve outcomes. So, I think we have strong evidence that testing in this low risk group does not improve outcomes whereas the test themselves in high risk groups predict outcomes very strongly.

Mary George: Other comments? If not we'll move on to performance gap.

Joseph Cleveland: So, this is an area that I think, you know, is probably, probably should, there are – as you read the evidence from the, that's again in the document, the performance gap to me seems like it varies. It's cited anywhere from 2 percent of these things being, you know, inappropriately ordered to as high as 17 percent and that's a broad range and the studies that are cited actually are all over the map.

I think Leslie sent us a very useful document that probably the committee should look at to in this research letter that was in a link in the e-mail that came yesterday that basically is from a series of authors (Kerr), (Chen), (Sesmen), (Comeris) and (Bram Delamaflu) looking at this exact question and to cut to the chase of that they started two groups of patients. These are the patients undergoing low risk surgery in the V.A. system, patients undergoing low risk surgery in the Medicare System. And the routine kind of pre-op of the stress test ordered in the V.A. system was actually .67 percent of V.A. patients and it was about 2 percent of Medicare patients. And so, these are retrospective again cohort study that looked at, you know, the representative sample for the Medicare was 5 percent sample fee for service claims and I think the V.A. they were able to actually use the V.A. probably I'm assuming it was either the (Kurt) system or some other system that's on the V.A.

So, one could argue I guess that these data suggests and this was just published online last month in February, so it's kind of the most contemporary study whether one study should sway us or not is always, obviously a question, but this would argue that there is a pretty low performance gap here

that – and actually at worst we're seeing 2 percent of these inappropriate studies ordered in the Medicare population.

There are other studies that are older inside and they're proposal in the document provided by the developer, measure developer that it could be as high as 15 percent. So, I'll throw that open to discussion I guess for my colleagues as well.

Male: Let me just chime in on that particular because I didn't have a chance to look at it and was sent on to me last night.

Joseph Cleveland: Sure.

Male: There was a 5 percent sample, CMS and MedPAC did an analysis of the same data but with a 100 percent sample looking at outpatient department, physician offices and independent testing facilities and found a consistent in 2012, 5 percent rate across the board. So, I'm not sure that that research letters since there wasn't a lot of documentation in it and it was only a 5 percent sample captured fully of that population. But two other studies, both the annals of surgery one from 2013 by (Sheffield) and the MedPAC report both found 4 to 5 percent in Medicare sample with the trend being up from 1997 through 2012.

Joseph Cleveland: That's helpful, thank you. I think, you know, I mean I think that 5 percent is, you know, again then that does say, you know, again under the priority and kind of volume of these things, you know, it becomes high priority because a lot of these are then done so.

Tom James: If I can make a comment on that too, this is Tom James. Several years ago when I was at Humana, we were asked by AMA PCPI along with four other health plans to take a look at the same kind of thing in the commercial data set. I don't recall the numbers but it was so small that none of us considered to be significant.

Thomas Kottke: Tom Kottke here. A couple of things really impress me reading the literature, even, first as even papers published in 2013 were using 20 year old data. And then this – much of the data are not, I wouldn't consider contemporary except

for (inaudible) and then the (Fonseca) paper which just came out in, I believe in March. I mean this month in (JAC) showed there's really no trend in the use of the nuclear studies of stress echos over the price to contemporaries if the data can be.

But one of the issues is that the regions are getting the studies is not known and I recognize that you can't get that from administrative data, you can only see if there's a claim for the test. But it appears to me that there is a possibility that for example nuclear stress testing before low risk operation is very low but follow up stress testing after angioplasty is much higher, it would be very nice to be able to distinguish between those two indications and I'm wondering if the big data from United Health Group, if United Health Group can get their hand on the but given that they'd probably don't have access to reasons for test, they'd probably get their hands on that either in the past, you go to the large medical groups like Kaiser.

Mary George: Other comments on gaps? If not we'll move on to priority.

Joseph Cleveland: Yes, I think this is obviously a healthcare priority. The, sorry it's my phone going off there. The, again, this falls into, again to me a significant healthcare problem in the sense that, you know, these are costly tests. The inappropriate as Tom Kottke pointed out kind of a downstream kind of untoward effects of this perhaps leading to and geography yet another costly invasive test were not trivial. So, I would argue form those standpoints that this is a high priority issue.

Mary George: Other comment? As you know, we will be voting online after the call. So, we will continue on with the liability.

Joseph Cleveland: So the reliability specifications, this basically, the level of entity being measured is the imaging facility, data source is registry, paper medical records, NEHRs there is a data collection sheet from the focus, the ACC registry parts quality improvement programs for the ACC again that was included.

And so the idea is that there will be a sampling measure, sampling method to at least assure at least there's a certain volume of cases of I think 30 that have to be implemented in a 60 day time window to ensure that there is sufficient volume to report the measure, that makes sense for me from at least the initial specifications.

With regards to reliability testing, the testing for reliability was done with the data sample from the Mayo Clinic in 2005. And it was tested, the level of data elements using inter reliability of two nurse (obstructers), essentially doing those, the agreement, the (CAPA) number was .72 which is relatively reasonable for this type of thing. So, again I think the reliability testing meets the criteria too as well, stop me Mary from going to far if we need to stop. Let's see, do we need to talk about, we need to talk about that before we go to validity correct? Yes.

Mary George: Right. We should clear if there's any questions or comments on reliability.

Joseph Cleveland: So.

Sharon Hibay: So this is Sharon Hibay, so just in general are there any other comments first about the specification? OK, having heard none if we can go on to additional comments about reliability testing? OK, Mary?

Mary George: OK, we'll move on to validity.

Joseph Cleveland: So, again validity, I give the specifications, I think that these specifications are consistent with the validity evidence proposed. Impaired validity testing of these measure was done to basically look at the relationship between appropriate use score and predictive (score) value of (MPI) and there was found to be no differences in again outcomes between subjects with abnormal versus normal imaging test.

So, I think that at least as far as I can see, the validity seems relatively reasonable too as well and I don't see any threats of the validity in terms of exclusions, the measure is not risk adjusted. So, that's something that's not applicable to this measure.

And the only issue I guess was how missing data will be provided because that was something that was unclear to me when I went through trying to understand and I think I might ask our ACC folks how they'll deal with the missing data for this.

(Joe Allen): So we are looking for folks to code this as they come into an imaging lab. So, although, you know, folks have looked back at charts to see if they could pull this information. We do suggest for this measure that they use the form prospectively and so, they would be, would have the opportunity to code each of this from the start and so we don't and have not encountered issues with folks missing data elements.

Joseph Cleveland: OK.

Mary George: Any other comments on the validity? Hearing none, we'll move on to feasibility.

Joseph Cleveland: So, again the feasibility, the data source for this is registry or paper records. Again I think that those are reasonably things to obstruct this from. There were, I guess, some of our original comments had to deal with whether this elements are routinely generated in terms of things or not but I think the focused questionnaire that was submitted to me seemed to answer that, I think this is feasible in terms of the capture this and the implementation of this measure so.

Mary George: Thank you. Any comments on feasibility?

(Joe Allen): I just wanted to note that in 2017 for Nuclear (CT & MR) which is our main focus of this measure, although there is stress echo as well. But for those three advanced test CMS, Medicare will require data capture through an electronic means for this type of information so it will become even more standardized going forward.

Mary George: Thank you. Any other comments about feasibility? All right, we'll move on to usability and use.

Joseph Cleveland: So for usability and use, this measure is currently used for a PQRS and CMS. Again it's used as part of the focus, again registry for I think lab accreditation, QI, utilization management things like that. Particularly I think in regionally too as well with concentrations in Delaware and Pennsylvania and the measure is not reported publicly and according to again the developers, there have been no unintended consequences or anything from the use of this to suggest that, you know, there would be something again untoward happening from this so.

Mary George: Thank you. Any comments on usability? All right, well thank you so much for that great overview. Any last comments on 670 before we move on?

(Joe Allen): I guess, just, this is Joe Allen, overview as we go through each of this and we're about to (part) each one of them. I know there were some comments related to kind of the variability and you know I guess I'll say that, you know the studies do show variability for each of these measures based on the center and we see that consistently. And that the issue at some centers might be pre-opt testing in this types of patients and other might be repeat testing after PCI. Others might be asymptomatic that's driven a lot by their referral base whether or not it's a hospital that is doing a lot of surgery and kind of a regional center versus maybe more folks are out there in the community who are performing this imaging and are really taking referrals from primary care versus a group that's more kind of a large cardiac practice that might be monitoring patients on going which might result in more post PCI and so I know it applies to all these measures so I wanted to kind of state that's why you do see the variability quite a bit.

And the numbers that are reported looked at both the overall population of rarely appropriate task set or done and then the specifics for each measure try to address the frequency for each of those. But as you put that variability together sometimes, you know, the average might be lower but there's high variability between each of them so I just wanted to note that.

Mary George: Thank you. Any last comments on 670? If not, we'll move on to 671. Leslie, Tom or Mladin?

Leslie Cho: Yes, I'm here, it's Leslie, hi everybody. This is measure number 671, it is cardiac stress imaging not meeting appropriate use criteria routine stress testing after (perpetrating) coronary intervention.

It's much similar to the previous one except these types of caveat of the PCI. And if you look at the appropriateness criteria 2015, I just want to ask the measure developers, where in the 671 document, do you make exception that are listed in the appropriateness criteria, the exceptions being incomplete revascularization and prior (left main) coronary artery (stent), because I didn't see that in any of the measure document papers.

(Joe Allen): Right, so as a way of measuring this, it is looking at each of the test and then categorizing them based on registry sheet, looking at the main reason for testing and so, we look across all reasons for testing and then each of the center uses that form to then look at the ones that's how – as a primary and only reason being a asymptomatic patient after PCI. But they have the opportunity and the registry phone to check off a number of other items and so, the measure is created from that data collection form which includes a number of other reasons why the patient may be arriving for testing, so these measures are looking at those three.

Leslie Cho: Right, so I guess what I'm trying to say is two things. One is that you have to buy the registry in order to do this for the most part yes?

(Joe Allen): Anybody can collect using these forms which we make available and the specifications are based on the criteria which anybody can collect, the registry is one method for doing that but we've had several centers collected at on the spreadsheet.

Leslie Cho: OK, so the in the appropriateness criteria which this measure is based off of, it has both PCI and CABG and yet that measure is only targeted towards PCI, is there a particular reason why CABG is not listed?

(Joe Allen): Yes, so we had looked at all the frequencies for the reasons why testing was really appropriate and the ones that we are focused on in these measures came out amongst the top three to five reasons why testing was really appropriate.

CABG did not come up almost at all in any of our test and so this really just focuses along with the other two measures on the most common reason centers had really appropriate testing.

Leslie Cho: I guess the other thing that I am very concerned about is if you look at the appropriateness criteria and it's published in 2015. In the asymptomatic without ischemic equivalent, indication, one of the main indications for stress testing for asymptomatic patient is incomplete revascularization, additional revascularization feasible, prior left (main) coronary, you know, left (main) stent. Which I really would strongly encourage the developers to put into the measure, because really I'm looking at this, I've read this measure now twice, and I really couldn't find it.

(Joe Allen): Right. So in order to construct the measure – yes sure.

Leslie Cho: If we're talking about evidence which you and I both know these appropriateness criteria, even though some of the, you know, it is consensus of experts, it's very important to have this exclusion criteria in there.

(Joe Allen): Right. The measures is constructed and we agree with you that that, those are important reasons, they're constructed on the denominator of all imaging that was conducted. And then the numerator is the primary reason for the imaging is asymptomatic post PCI less than two year. We don't list every other possible reason for imaging so that denominator which includes all imaging would include patient that were symptomatic, without a prior history of PCI. Asymptomatic patients that were diabetic, acute coronary syndrome patients and so, the measure is really looking at those that were positively coded for that reason not – the exclusions would be not falling into any other category but that.

So, there was a long list of reasons beyond just the follow up or PCI, why the test could have been performed. We're just looking at the reason being, that the only reason selected was that they were asymptomatic in less than two years after (PCI).

Leslie Cho: I know but one of the reasons why we sometimes test patients to our asymptomatic after PCI less than two years is for left main stenting, is for incomplete revascularization.

(Joe Allen): Right. So they would not show up in this measure because they would not have an indication that would read asymptomatic post PCI less than two years.

Leslie Cho: But they (are) symptomatic by your criteria because there is no symptom, you know what I mean?

(Joe Allen): They would have an additional indication being incomplete revascularization.

Mary George: OK, and that would be where?

(Joe Allen): And that would fall into another reason why the test was performed. So, in the form it has a number of different reasons why the test could be completed, this only looks at those, the only check boxes are on asymptomatic and they have a history of a PCI within two years without any other check boxes, anywhere else on the form.

Leslie Cho: And is the registry form part of the packet, part of the measurement packet?

(Joe Allen): Yes.

Leslie Cho: And what page was that on?

(Joe Allen): I don't know how, NQF can search that, maybe the staff could direct you there, it was an attachment with the measure testing.

Leslie Cho: Is there, the form attached Vy or Leslie?

Vy Luong: Yes.

Female: And so the link is provided in the submission form, we will make sure we call that out to you at the end of the meeting as a follow up.

Leslie Cho: OK, that's good OK. So, the – so in terms of the evidence for asymptomatic testing in patients post PCI who are asymptomatic without the two detail

things that we just discussed, I think, you know, the evidence is good that those patients really do not need routine stress testing. In terms of opportunity for improvement as you've previously pointed out the range in terms of the variability in terms of testing across the country is quite large.

You know it's interesting to see anywhere from 0.9 to 4.8 percent and then there is one part where the developer states the inappropriate use could be among individual practitioners and one group can be as high as 10 to 70 percent. So, I guess it's very variable. So there is an opportunity for improvement. Can I just go on or should I stop or what?

Mary George: Let's see if either Tom or Mladen has any comments on the evidence or the gap or anyone else?

Thomas Kottke: Tom here, no I think Leslie is pointing out the measure, I think it might be helpful, not as a modest patient to the measure but as an (inaudible) in the (inaudible) extensive left main and incomplete revascularization because that wasn't exactly included. Even though I understand the rationale of the ACC.

Mladen Vidovich: I agree that's a very good point that Leslie pointed out. I can't agree more, I did not catch this myself.

Mary George: Any other comments or discussion on the evidence of the performance gap?

Sharon Hibay: This is Sharon from NQF. Could you please just reiterate that one more time, we want to confirm it for the meeting materials follow up, and we were having just a little bit of a hard time hearing you, so if you could speak up that would be helpful as well.

(Crosstalk)

Nicholas Ruggiero: Nic Ruggiero for one second, one of my colleagues is out of the work today and there's an emergency in the cath lab, I will try my best to get on the call as soon as I see what's going on.

Vy Luong: I'm sorry who is this?

Nicholas Ruggiero: It's Nic Ruggiero, I apologize there's a – yes, I will try my best to get on as soon as I see what's going on I apologize.

Vy Luong: OK, no worries, thank you.

Female: OK, so I'm going to move on. In terms of priority, I think it's a high priority for NQF and the reason being that, you know, this testing not talking about the (CAC), you know, a lot of this testing especially stress nuclear has a fair amount of radiation and can lead to false positive which can have untowards, you know, consequences. So, I think in terms of priority it is a high priority.

Mary George: Any other comments on priority? If not, we'll move on to specifications and reliability.

Female: Reliability, so we'll talk about scientific – is that scientific acceptability, reliability and validity I guess. So, in terms of scientific acceptability, you know, the numerator we talked about is a number of stress test performed in asymptomatic patients with the caveats we discussed within two years of most recent, PCI denominator being all stressed test.

The onus is on the imaging facility which I think is, you know, it's plus or minus I've always said that only because, you know the guys who was ordering the test should actually be held responsible but that's just my own personal feeling.

But in terms of, in terms of scientific acceptability, I think it's moderate. True denominator would be, you know, all patients having PCI, asymptomatic and then what not. But that's just the way I think the registry is set up.

In terms of reliability, it's tested only at the data elements level so, by the NQF criteria I think that's just a moderate, it can't be the highest possible score.

And then finally validity, I think, you know, the validity that the measure providers, the evidence that the measure provider, measure developers provided I think is reasonable. So, in terms of the scientific acceptability, reliability and validity, I think, I don't really see a big problem with the measure.

Linda Briggs: Hi, this is Linda Briggs. I have a question about the denominator because if all people that are tested, you know, with this test and that seems to me like it's an awfully broad brush. To me it seems like the more appropriate denominator is those patients who are coming to these procedures that have a history of having had a PCI. So, because that's the group that you really want to know whether the testing timing is appropriate or not. So to dilute it by every other person that's having a test just doesn't seem appropriate to me.

(Joe Allen): So the measures were constructed with the effort to help highlight for an imaging lab, what were the most frequent rarely appropriate test and as I said some centers have a high primary care referral base where they're not having a lot of history of disease. And so, the asymptomatic little risk patient population shows us more there in that large cardiovascular practice as I said it may focus on this one and in a community based hospital referral center, it may be the pre-op.

And so, going into the measurement you don't really know where you're focus and where the appropriate test would be. I agree that it would multiply the effect to focus on only those host procedure and whether or not they were having imaging but the centers themselves really don't know.

And so part of the measurement effort is getting them to focus on where their area of improvement needs to be and by picking these three it picks up the three most frequent things that they may see in their population but they won't know necessarily before they go in which of those three things will show up most frequently. So we're trying to help them across the board with all their imaging and focusing on where they need to work with the referral base to improve versus just trying to pick one particular area for that to improve.

Leslie Cho: But the numerator is PCI patients who are asymptomatic within two years. So, to say that you're looking across three measures here, you have two, three individual measures, each one has to stand by itself. And this particular measure should be among patients have had actually had a PCI and I don't think that that's terribly difficult to determine, that could be asked of the patients when they come in or, you know, it might be something that is listed

on the test form or whatever. It's information that would have been captured on the form that you're talking about. So, I don't see why that denominator couldn't be just PCI patients.

And that would be more appropriate to say these are – potentially inappropriate ones as the numerator and these are, the denominator is all patients that would be, you know, that have in this population of appropriate or the population that we're talking about. You know, we're looking at PCI patients here. This is all about PCI and the timing of whether or not they should be having a nuclear or a CPA or whatever at that time. To say everything that comes in the lab that doesn't, that's not appropriate.

(Joe Allen): Well we are first a quality improvement project and then NQF asked us to develop measures that would help capture the essence of that quality improvement effort and our emphasis is on helping labs to better understand their case mix that's coming in from the referral base as well as their own internal orders to help them understand their appropriate use rights and I agree 100 percent with you that, you know, changing the denominator and focusing only on the sub section of folks that are post PCI would be a great sub analysis for any lab that notice that this was a particular issue to kind of use as a tracking measure but our goal was to have a consistent set of denominators across each of the three measures so that they – no matter where they were getting their referrals could understand that 5 percent of their imaging was really appropriate related to pre-operative and seven percent of 10 percent were related to post PCI.

And then another 10 percent were related to asymptomatic that they could add those three things up and say OK, well that's 20 some percent of my imaging is rarely appropriate. And then, you know, have that discussion with the referral base. It was meant and intended to look across.

I agree with you that, you know, if they were only focused on this particular measure, the denominator could change but our effort is to get the group to focus on overall where they can improve.

Mary George: That was a very helpful explanation. Other comments? If not, we'll move on to validity.

Leslie Cho: Well I think in terms of validity, once again I think it is, it's, it is – the specification does align with evidence and the validity testing I think is reasonable. So, I think in terms of validity the measure (inaudible) problem.

Mary George: Any threats to validity?

Leslie Cho: I don't think so, I mean just once we really talked about initially which is that, you know, the incomplete revascularization, the (inaudible), you know these things I think are the threats to validity. And, you know, I've made my feelings clear about the denominator in the past but, you know, and we've had this discussion just now. If it's a quality metrics or what not, I mean I don't think there is any further things we can ask the developers to do. But I, yes.

Mary George: Thank you. Any comments from the committee?

All right, we'll move on to feasibility.

Leslie Cho: I think this is very feasible if it's something that the, the lab can do without additional cost of buying the registry, it's something that is downloadable and can be done through electronic or even just a chart based data retrieval. So, I think that it is very feasible.

Mary George: Any comments on feasibility? All right, we'll move on to usability and use.

Leslie Cho: This is not a measure currently in use correct? That's correct right? Like in terms of NQF this is a brand new measure for you guys correct? Vy and Leslie?

Female: No.

Male: No. It's been in use.

Leslie Cho: Oh it's been in use. So what's our inappropriateness? So, this is what we asked last time too at the meeting that we had, a (phase) meeting about not

January because I wasn't there but the one previous where we talked about having the measure developers come back to us and give us some numbers and these have been measures that had been in place. Has anything ever come of that?

(Joe Allen): In the form it does discuss the number of places than has been put in both in our quality improvement project as well as Delaware and Pennsylvania and then, you know, there have been a number of studies as has been cited in each of the measures where they have been used.

Leslie Cho: And so there is definitely the improvement in the decreasing of inappropriate test under these measures?

(Joe Allen): There was a meta-analysis that was cited that, that showed, you know, some limited improvement in some but not all and the particular voluntary community the one that we reported the ...

(Crosstalk)

Leslie Cho: Is that the (inaudible) paper you're referring to?

(Joe Allen): Right.

Leslie Cho: OK, I mean I think, OK, so, OK there is that. So in terms of usability and use I mean I think it's very usable since – and it has shown moderate, moderate improvement in certain quarters. OK.

Mary George: Any other comments from the committee on usability and use?

Leslie Cho: Will these measures ever do you think become like the (ASPEN) measures where they're reported publicly?

(Joe Allen): It is likely that as the 2017 mandate for documentation of appropriate use comes off that that will be a discussion as a part of its mandated collection for Medicare. I would suspect that Medicare will put in regulations that would encourage that but we will see.

Mary George: Other comments or questions?

Female: I think the – I mean – it'll be interesting because I think the teeth in the measure is when it gets publically reported, you know, and then everybody sort of motivated because they see their numbers are going to come up, to maybe have better improvement.

(Joe Allen): Well the 2017 mandate requires at least data collection and then the 5 percent of outliers will have to go through prior authorization within two years – year amongst the 5 percent outlier and so that – even without public reporting to generate improvement because nobody want to go through a prior authorization for Medicare for this types of test.

Female: OK. And then finally the related any competing measures. I mean there are similar measures but not one for PCI like this. So, there are really no competing measures.

Sharon Hibay: OK. Is there any other comments related to the related and competing measures for 0671? OK, I'm doing a bit of time check right now were at?

Vy Luong: 2:05.

Sharon Hibay: 2:05 and we're at least to do 0672 and the comments table. So, without further adieu if there's no further comment, can we move on to 0672.

Mary George: And this is Mary, any brief comment on the major developer?

(Joe Allen): No, I just want to go right ahead and get into the discussion.

Mary George: OK. And Michael?

Sharon Hibay: So this is Sharon Hibay one more time. If we can just kind of target this conversation for 0672 to any additional items that we want to talk about that might be varying from 0670 and 0671.

Vy Luong: We have Michael Crouch. Are you on the line Michael? And Dr. Ruggiero, are you on the line?

Nicholas Ruggiero: He had to go up to the cath lab.

Vy Luong: OK, so I thought I did work on Dr. Crouch was on the line for this measure. And I just want to double check if Dr. (Gibbons) has joined us.

Thomas Kottke: Tom Kottke here, I can you want me to just walk through this quickly. I mean.

Vy Luong: Yes.

Thomas Kottke: You know, the evidence – everything is exactly the same here except for the rest of the other two which we answered all the questions except for the numerator and this is asymptomatic. What is it low risk – low risk patients I mean their on asymptomatic low risk patients who're or even low risk than patients who have had prior PCI and took last two years in asymptomatic. And so I am given that we really haven't had any other comments on the other two measures. I think that the thing that applies the other two measures apply here that we – meets our criteria for liability and validity and importance and usability and use.

Mary George: This is Mary. Are there any additional comments that any one would like to make on this major in particular?

Sharon Hibay: So we just want to make sure that we walked down through this various different criteria – when we review this measure so, it sounds like especially related to evidence (inaudible) numerators slightly vary that generally the same themes that we talked about is 0670 and 0671 or the same 4067 too. And I'm hearing no other additional comments for evidence.

Thomas Kottke: Yes, the evidence is exactly the same.

Female: Yes.

Thomas Kottke: And good evidence that there's no benefit to testing these patients and potential harm.

Sharon Hibay: Anything related to performance gap, opportunities for improvement?

Thomas Kottke: The performance gaps are the same, they're variable and like we heard from ACC that they depend on the particular the (inaudible).

Female: Yes.

Thomas Kottke: But they're important.

Sharon Hibay: Any other comments related to performance gap? How about priorities?

Thomas Kottke: It's a high priority since the tests are expensive and the potential time from false positive test is quite significant.

Sharon Hibay: OK. Anything else related to priorities? OK, we'll move on to scientific acceptability the reliability, anything specific to this specifications?

Thomas Kottke: The same reliability criteria were applied here – were implied in 670 and 671.

Sharon Hibay: Any other comments related to the specification? How about reliability testing Tom?

Thomas Kottke: It's the same – the same as for 670 and 671.

Sharon Hibay: Any comments related to the reliability testing? Validity specifications?

Thomas Kottke: The validity specifications are the same as for 670 and 671.

Sharon Hibay: Anything further related to the specification for validity? Validity testing?

Thomas Kottke: These also are the same validity testing that applies to 670 and 671 and is it adequate.

Sharon Hibay: Any other comments related to validity testing? Threats to validity?

Thomas Kottke: Since it's not risk adjusted I don't see any threats to validity.

Sharon Hibay: How about missing data as well, Tom?

Thomas Kottke: We've heard from ACC that data are complete as they're sent into their register.

Sharon Hibay: OK. Any other comments for meaningful differences or missing data from the rest of the committee? All right, feasibility?

Thomas Kottke: The fact that this – these register has been – used those documentation and feasibility.

Sharon Hibay: Usability as well Tom?

Thomas Kottke: They're being used and so it makes our criteria for usability of use.

Sharon Hibay: Any other comments from committee related to feasibility usability or use? Related and competing?

Thomas Kottke: There are related but no competing measures.

Sharon Hibay: All right, any other comments from the committee related to related and competing measures? Any other comments from the committee related to or the developer related to all three measures that we want to make sure that we get into the meeting materials. OK, very good, Vy, do you want to review the process that's going to happen after the committee meeting?

Vy Luong: Sure. So, as Mary has mentioned and Leslie. We will be doing – we will be sending the standing committee and e-mail after this meeting with survey links to both – to all three measures for voting where 670, 71 and 72. And they will be SurveyMonkey link. I will send that out by 5:00 p.m. eastern standard today the latest. And you will have opportunities to vote the due date would be to until this following Monday March 23rd at 12 p.m. I understand that's a short turn around time, but we will begin member voting soon after that, so we would really appreciate it if you can submit your votes by then.

Wunmi Isijola: And hi, this is Wunmi. I just wanted to make sure. I know we had an bridge version of kind of voting process. But during the surveys, please provide any comments that may not have been discussed during this call. We want to make sure that your recommendations are being reflected in the report.

Vy Luong: And with that, Mary, I'll turn it over to you to key up the discussion on comments (inaudible).

Mary George: I'm sorry, I was on mute. This is Mary. Sharon, do you have any comments that you want to make about the public comments you received?

Sharon Hibay: Yes, I would – thank you, Mary. Again this Sharon Hibay and the committee have the memo, the post comment call to discuss public and member comments. They received the memo, it provided some the memo, it provided some guidance of these discussion and the comments that were received. Through our analysis we have various different themes that we have provided the committee and we will be reviewing those comments by exception underneath the themes that we have outlined.

Generally speaking those themes are updated guideline implications. The burden paper record measures and obstruction, recommendation for improved measure, recommendation for further development of advanced care or directive measures and then we have some measure specific comments as well. And of course as always we want to be able to provide the committee with their opportunity to provide any questions or comment they have on the comment table that we may not have included in our memo as well. So, Mary if you like we can just kind of walk our way down the memo itself.

Mary George: That would be fine. Starting with the theme one which is updated guidelines implications. And this primarily had to do with the some guidelines that came out mid major development process and with the CHA2DS2-VASc as oppose to the (CHADS2) to scoring. And we had a nice explanation from the developers on this.

Wunmi Isijola: Hi, Mary, just to interject for I apologize. This is Wunmi Isijola. And I just wanted to give the objective of this. So, we received 31 comments during the public and member commenting period. It was – it was based on the recommendations of the committee's deliberations during our in-person meeting. As Sharon mentioned it highlighted – this memo highlights all of the things that came out of them. Some of the comments were in support of your recommendations, some of them question them.

We want to provide you with those themes in order for you to provide your feedback from the committee's perspective and we have action items to make sure that we're capturing the committee's response.

So as Mary is going through each theme, it really speaks to what we've identified as some of the overarching things that were placed within this comment table. And Mary sorry to take it away from you, I'm going to turn it over again to Sharon just to provide more in an overview of what these things have outlined. But we also have the developers on the call to provide any further clarification in response to any of the comments. So, Sharon, do you want to?

Mary George: Go ahead, Sharon.

Sharon Hibay: Thank you, Mary and thank you, Wunmi, for teeing that up I appreciate that.

OK, so for theme number one update the guideline implications. So we had our several comments received related to two measures so 1525 and 1524 both of them from ACC, AHA and Heart Rhythm Society. They provided up – the measures are from ACC. Excuse me. But there's an AHA, ACC and Heart Rhythm Society guidelines to the management of patient with afib and they recommended updating the CHA2DS2-VASc from the CHA2DS2, which is no longer recommended by the updated guidelines.

As I recall this is a question that actually came up during our in-person meeting and I think as the developer wants to provide some feedback that would be helpful. I believe that (Penelope) is on the line?

(Penelope Celest): Yes. I am. Thank you. So this was definitely something that had come up at the meeting and what we have shared with this committee and then I'm happy to share it again.

Today is at the time that the measures were required to be resubmitted for endorsements. The new atrial fibrillation guideline had not yet come out. It actually came out after the facts but because the measures were split into two phases into phase one phase two, the atrial fibrillation measures were

reviewed and in fact this is – and so therefore the guidelines had come out post our submission process.

We had mentioned to the folks who had raised this as an issue at the face to face meeting as well as the comments that we received through the public comment period that we are in the process of providing the atrial fibrillation measures and do planned to rely in them in accordance with the recommendations of the guideline to include chat box too for those two measures. Even though 1524 is not, you know, moving forward for endorsement for NQF staff on call so I know that one internally once the writing committee starts that process of looking at the whole entire atrial fibrillation measures set.

The reason – There was one comment that was submitted which was, can you make the change prior to endorsement as you all on now on the committee. One of the requirements that NQF has is that all the data that's provided to validate the measure be based on the measure specifications that are proposed by the measure developer again because at the time that we submitted the measure, the guideline actually said that CHA2DS2 was appropriate. The data that was provided was based on that.

So we're in the process of making sure that the data elements are collected in PINNACLE and that will have additional data that provide once this measure comes up for re-endorsement but again, it did not happen to a alignment in terms of when the measure forms were required to be submitted and the timing of the guideline release.

Sharon Hibay: Thank you, (Penelope). So other question is changes to this measure will be available for the next annual update, should the measure be recommended for endorsement?

(Penelope Celest): So during the process of including the CHA2DS2-VASc in PINNACLE. I don't exactly know at the top of my head when that endorsement, sorry, when that as a process will align but I would think that probably by the time of, not this year's annual (inaudible) but the next one. Does that make sense? Not the 2015 but the 2016 one yet, we can include the updated measure

specification because by that time the writing committee should have already finalized the paper by that time and which are also already be programmed in there, so I'm thinking we should at least be able to update the language.

The only thing that I'm not so sure that would be as feasible as you know, how we do have to rerun all the data but it does cause a quite extensive amount of money to do, it cost, you know, anywhere from $8,000 to $4,000 to run so I think if we did it in the annual update we would update the measure specifications that probably that provide the updated you know, testing data when the measures are out for full endorsement just because otherwise we'd have to run it twice and incur that substantial cost.

Sharon Hibay: OK. Thank you for that clarification and just to remind everyone. We're talking about 1524 where in the in person meeting that measure was not recommended for endorsement by the committee and 1525 where that measure was recommended by the committee.

OK. So the next thing I'd like to ask is that we have some proposed, a proposed committee response drafted and I wanted to put that out for comments to the standing committee. Are you acceptable for this language? And then we will also ask if there are any further action items. Should the committee reconsider the recommendation of this measures based upon the comments and the proposed, the response from the developer and the proposed committee response.

OK. Having heard no further action items, we'll move to the next measure or the next theme. The next theme is the burden of the paper record measures, this was general comments related to three measures 2438, 2439, 2443 where the comments are emphasized their concern with endorsing paper based measure as a burdensome for end users and the data abstraction as we provided the three measure.

We also have proposed committee response that we provided. We do not have developer response in relation to this but is someone from the joint commission – these are all three joint commission measures. If someone from the joint commission on the call would like to comment?

Elvira Ryan: Hello. Yes. This is Elvira Ryan from the joint commission. We had submitted a response to the comments and I'm sorry that they are not available for committee today. With respect to the burden of data abstraction these measures are part of the set for our advanced certification in heart failure program and these measures were implemented over a year ago and in addition to being pilot tested prior to that and throughout the pilot test and since implementation of these measures, we have received no feedback with respect to an undo burden for data collection.

Typically, what we find and especially with our certification programs, is that they are geared to the measures and they pretty much set up their documentation in such a way that for purposes of their programs, they know exactly where to look in their record for the information that is required for data abstraction for the measures. And we actually have not received any feedback from any of our sites that are in the program that this has been a burdensome to them.

Sharon Hibay: OK. So again, this provided a proposed committee response and also in action item questions, should the committee reconsider the recommendation of these three measures based upon the comments received and the developer response.

OK. Having heard no feedback, we will keep the language that's proposed and no further action is required on these measures.

And we will be incorporating the developer's response in our report in the meeting material follow up.

OK. Theme three. Recommendations for improved measures. There was, this is in relation, the first one is in of relation to 0543, there were a number of recommendations received for this measure and this measure was recommended by the committee. Since the time that the in person meeting and actually in the last few weeks, we have clarified that this measure is going to be retired by the developer and so they recognize they will be forfeiting their endorsements, as this measure will no longer be utilized in a CMS

program. CMS is the steward for this measure. So I think we could move on to the next measure.

1525, this was a measure recommended by the committee. There were a couple of recommendations for that. A few of them, a recommendation to include at risk for thromboembolism. A recommendation to consider the role or impact of percutaneous, excuse me, closure devices and a recommendation to include patient preference or refusal in the measure.

We want to make sure that we open this up for the developer to respond to.

Are you still on the call (Penelope)?

(Penelope Celest): I'm sorry. I couldn't hear the last comment that you need, Sharon. I apologize.

Sharon Hibay: No, that's OK. So, there were three commendations for 1525, a recommendation to include at risk for thromboembolism, recommendation to consider the role or impact of percutaneous closure devices, and a recommendation to include patient preference or refusal.

(Penelope Celest): Yes. And so, patient reference or refusal what we had submitted or the response to that one is that measure – NQF is seeking to re-endorse does actually include patient reason as an exception to the measure. So it is currently in there.

With regards to the other two having to do with the at risk factors as well as the PCI component. Those are two things that I've actually written down and do plan to take to the writing committee to actually consider and updating the entire measure certification for again both 1524 and 1525, you know, with the guide to 1525 which is the measure again that you're looking at re-endorsing.

So there are things that we'll definitely be considered by the writing committee as they go forward. But the only one like I said that was potentially not as clear as the patient reason because that is currently an exception included in the measure.

Sharon Hibay: OK. Thank you, (Penelope). And you are correct. Those comments are available on – and they are in the table for committee review.

So, in relation to this measure, should the committee reconsider the recommendation of this measure? And how should the committee and the NQF encourage for meaningful measures. We'll get to that second question after we answer – after we review the next measure as well.

So, in relation to 1525, should the committee reconsider the recommendation of this measure?

OK. Again having heard no additional recommendations, we will have this language into the report and notes that will be no further changes to the measure.

OK. 2440, that measure was not recommended by the committee. And we have provided a comment. There was a recommendation of transmission of record within 24 hours not 7 days. And that was discussed during the in-person meeting.

Any further guidance on 2440? OK.

And overall for the whole theme of this about recommendation for improving measures. Are there any other recommendations from the committee or the NQF is required (also) from NQF to encourage more meaningful measures?

OK, again, having heard none. This information will be put in the report and there's no further changes or actions required.

Theme number 4 is recommendation for further development of advanced care/directive measures. Comments were received from health plans regarding advanced directives and end of care of life. Kind of life care, sorry. Transpose that one.

The developers emphasized the importance of measuring advance directive as an essential to addressing quality of life and cost issues especially related to

end of life care. Other commenters highlighted the continued effort need to develop advanced directive measures and that should be a priority.

Specifically related to 2441 and 2442, both of those measures were not recommended by the committee. And we have a proposed response for the committee as well.

We also noted during the committee conversation the in-person meeting that there is another advanced care plan measure that addresses the documentation of discussions regarding advanced care surrogate decision making in a variety of different populations and a variety of different settings. That's already in the NQF portfolio.

Is the developer on the line that they would like to provide any comment?

Elvira Ryan: Yes, hi. This is Elvira Ryan again from the Joint Commission. And we were – you know, under the impression that these measures were not recommended, so we didn't really received any comments to respond back to. But as I look at the committee's proposed response with the concern about the duties of discussing with the patient being passed off, we have within our specifications provisions that define who would be the healthcare providers who would deal with this with the patients and that would be advanced practice nurses, physicians, social worker, pastoral care or trained nurses to do so. So, I just wanted to offer that further explanation with respect to detail within our specifications.

Sharon Hibay: Thank you for that clarification. We appreciate that. For the committee, we have proposed the committee response, and also we asked the question whether for their action is required. Should the committee reconsider the recommendation of these measures based upon our developer's response today?

OK, having heard none. We will accept the comments as proposed and no further action is required.

We have some measures specific comments so we can move to the next theme. For 2461, in-person evaluation following ICD implantable device.

One commenter (inaudible) recommended that the timeframe for follow-up visit to be stratify. A developer has provided a response. Is the developer on the call that would like to provide a synopsis of their response?

Female: Sure. This is Heart Rhythm Society. We have Dr. (Paul Vorosi) with us.

(Paul Vorosi): Hello. Yes. I think it's important to recognize that the evidence as we've documented here in the form of Dr. (Hess') manuscript published in 2013, as well as the joint Heart Rhythm Society, European Heart Rhythm Association expert consensus statement clearly recommend the 2- to 12-week interval. And in that 2- to 12-week interval there's a clearly demonstrated gap in performance as evidence in the (Hess') manuscript.

It will be our strong recommendation to keep the – the specification and stratification windows as we have identified with that 2- to 12-week window.

Sharon Hibay: OK, thank you for that comment. Is there – we have provided to promote – proposed committee response. This was – this measure was recommended by the committee. Should there be any further action item or and suggestion of the proposed response? Is there any further discussion by the committee on this?

OK, having heard none. We will accept the proposed committee response and no further action for this measure is recommended.

Next is measure 2474. This measure was also recommended by the committee. One comment or question to the decision with the respect to the performance gap of the measure? Is the developer on the line should respond to this comment?

Female: Yes. Dr. (Vorosi) is still on the line.

(Paul Vorosi): Their concern was that there was a lack of performance gap in pericardial tamponade after afib ablation. There are relatively limited data in general on performance after afib ablation but there is a wide range in rates of pericardial tamponade from site to site. We continue to believe that measurement of this

adverse outcome which really should be a very low risk in high performing centers is worth continuing ahead with.

Sharon Hibay: Some committee discussion on the responses?

OK. We have proposed a committee response and also action items should the committee reconsider the recommendation of this measure.

OK. Having heard no additional response, we will accept the proposed committee response and no further action is required of this measure. At this time, I'd like to open the conversation up to any other comments or questions related to the measures discussed and it's based by the committee members.

Mary and, Tom, do you have any question specifically?

Thomas Kottke: No, I don't. I just would like to remind people of the SurveyMonkey that's coming out and they have to vote by March 23 or all those work will be for naught.

Mary George: This is Mary again. Just a reminder for those of you that haven't found the documents I mentioned at the very beginning in terms of how we're looking at the three measures but we're moving on so please be sure and consider that.

Leslie Vicale: Hi. This is Leslie. Operator, would you please open up the line for and get member in public comment at this time if anyone would like to offer up their comments to the public regarding any of the comments discussed on this call with the committee as well as the three measures that were reconsidered at this time.

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

And there are no questions or comments at this time.

Leslie Vicale: OK. Thank you. If there are no comments, the survey will be, for the committee will be provided in the follow up e-mail. First, I'd like to thank Mary for facilitating this call. And I'd like to thank our lead discussants for

the measures that were under reconsideration. I'd also like to thank the standing committee (inaudible) for the meeting tonight.

We would like to discuss and see if anyone else dialed into the call who was not previously part of the roll call in the very beginning.

Jason Spangler: Hello. This is Jason Spangler.

Leslie Vicale: Hi. Jason.

Jason Spangler: Hello.

Leslie Vicale: Thanks for letting us know that you dialed in.

Jason Spangler: Sure.

Leslie Vicale: OK. And I'd like to remind everyone of what Vy mentioned earlier. The deadline for voting on measures 0670, 0671 and 0672 will close on Monday, March 23rd at 12 noon. So following this call again, we'll provide an e-mail that contains the voting link by close of business today and again if it's very important that anyone cast a vote no later than noon on Monday.

Following the close of voting, member voting will open. Next month, we will have a CSAC in person meeting. It's scheduled followed by the board review and in person meeting. We will keep you all informed on what's going on and what's happening with that information.

Lastly, we'd like to remind you that these three calls from measures submission is now open. And we'll close at the end of June. Vy have sent calendar invitations to the September in-person meeting for phase three.

Vy Luong: So I've sent calendar invites for all of the meetings for phase three, you should all have received it. Please let me know if you have not.

Leslie Vicale: Thank you, Vy. So please follow up with us through e-mail if you have not received any of that information. Again thank you for joining us today.

If you have any additional questions, please (inaudible) now or you can contact any of us for (inaudible) or call after the meeting. Great. Thanks so much everybody. Thanks for joining. Take care.

Mary George: Thank you, NQF staff.

Male: Thank you.

Male: Thank you very much.

Male: Thank you everybody.

Female: Thank you, Mary.

END