NATIONAL QUALITY FORUM

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Operator: This is Conference #19030167.

Leslie Vicale: Good afternoon, everyone. This is Leslie Vicale. I'm a Project Manager for the Cardiovascular Measure Endorsement Project here at the National Quality Forum. Thank you all for joining us today. And I would like to turn the call over quickly to our co-chairs, Tom Kottke and Mary George.

Thomas Kottke: Yes. This is Tom. I just like to welcome you and thank you for taking time to attend this call because quorum is so necessary for us to complete our work, which we involved and fully engaged in. Mary?

Mary George: This is Mary. And I'll just echo what Tom said, and thank you for making time for this on your schedules today.

Melissa Mariñelarena: Thank you, Tom and Mary, and hi, everyone. This is Melissa Mariñelarena, the Senior Director on this project. And, again, I want to welcome everyone and I thank you for joining the call.

So briefly, I just want to remind everyone, the purpose of this call is to review the comments that we received for the six PAC measures that we separated from the rest of the projects. So we're going to briefly review the comments that we received. And then we also had the request for reconsideration for five of the measures that we're not recommended during the in-person meeting. And then, we're also going to read – we're going to vote on – over our suitability for the one measure were consensus was not reached during the in-person meeting. And then, I'd also like to welcome Francois, the measure

developer, and his colleague, Amita, who are also on the phone. And thank you for joining us today.

And now, I'd like to turn it over to Leslie, and she's going to take roll from the committee.

Leslie Vicale: Hi, everyone, thanks very much. So I'm going to go ahead and read off the names of all the committee members, and if you could just speak if you're on the phone. And if you're not already dialed in as a committee member, please ensure that you're dialed into the call so you may join the discussion for this call.

Mary George?

Mary George: Here.

Leslie Vicale: Tom Kottke?

Thomas Kottke: Here.

Leslie Vicale: Sana Al-Khatib?

Sana Al-Khatib: I'm here.

Leslie Vicale: Thank you. Carol Allred?

Carol Allred: Here. I'm here.

Leslie Vicale: Thanks. Linda Briggs?

Linda Briggs: Here.

Leslie Vicale: Thank you. Leslie Cho?

Leslie Cho: Here.

Leslie Vicale: Thank you. Joseph Cleveland?

Joseph Cleveland: Here.

Leslie Vicale: Thanks. Michael Crouch?

Michael Crouch: Here.

Leslie Vicale: Thank you. Elizabeth DeLong?

Elizabeth DeLong: Yes.

Leslie Vicale: Thanks. Ellen Hillegass?

Ellen Hillegass: Here.

Leslie Vicale: Thank you. Judd Hollander?

Judd Hollander: Here.

Leslie Vicale: Thank you. Tom James?

Tom James: Present.

Leslie Vicale: Thanks. Joel Marrs?

Joel Marrs: Here.

Leslie Vicale: Wonderful. Gerard Martin?

He's in clinic. Kristi Mitchell? OK.

George Philippides?

Nicholas Ruggiero?

Jason Spangler?

Jason Spangler: Present.

Leslie Vicale: Thanks, Jason. And Mladen Vidovich? OK. And I would like to just remind all the call participants today, all of the committee members. Before speaking, if you could go ahead and state your names for the record and also it

would facilitate any measure of discussion so we know who is speaking. And I also wanted to remind all the committees that in order to vote for the measures that we're going to be discussing today, we've provided you all with a SurveyMonkey link via e-mail. It was sent to you at the top of the hour. You may use that link to vote as we move through the discussion today while the information is fresh. But we will also be summarizing the discussion of the call as well as providing the audio of the call, too, if you would like to vote after the call or for any members of the committee that are not available for the call right now.

So thank you very much, and I'm going to turn the call back over to Melissa.

Melissa Mariñelarena: Thanks, Leslie. So just like we did during the last call where we reviewed the comments that we received for the measures that the, I believe, is 17 measures. We have the comment theme, and it was one general theme for these six measures. And the theme that we received from the comments were that the commenters agreed with the committee's recommendation to not endorse five of the six measures under review, with the suggestion to refine the measures to differentiate between facility and provider performance levels. And NQF staff has drafted a proposed committee response, and we're going to ask if the committee approved to this response. And if not, then we'll ask for you to refine this response.

So the response that we came up with was that the committee has reviewed the comments and taken them into consideration prior to the measure reconsideration process for the five ACA-3 measures and one measure where consensus was not reached.

Is everyone OK with that?

Thomas Kottke: Yes, Tom here, that's fine.

Melissa Mariñelarena: Thanks, Tom.

Mary George: Mary, I agree with that.

Michael Crouch: Hello, Michael Crouch, I agree.

Melissa Mariñelarena: Thank you.

Joseph Cleveland: Joe Cleveland, I agree.

Melissa Mariñelarena: OK.

Tom James: Tom James, I agree.

Melissa Mariñelarena: Great.

Jason Spangler: This is Jason, same.

Melissa Mariñelarena: Great. Thank you. So the next item on the agenda is we're going to review the measure where consensus was not reached. And this is 2751, the proportion of patients undergoing an angioplasty procedure or a PCI that (has a potentially) avoidable complication. And before we get started, Amita is going to take two minutes, very quickly. She's going to provide some additional clarification on one of the documents that was sent to you. And it is attached in the memo.

So, Amita, go ahead. And I think, Amita – her line should be open, operator.

Amita Rastogi: Yes. So this is – can you hear me? This is Dr. Amita Rastogi. I'm the Chief Medical Officer with HCI3 and I work closely with Francois de Brantes. And colleague Andy Wilson, the PhD from Brandeis, is also on the call right now.

And the only comment I want to make is as our country moves forward towards MACRA and the MIPS and alternative payment models, the exact measures we feel will provide an addressed areas of patient safety, care coordination, and the newly added category of efficiency and cost reduction would also be helpful here.

So in the last committee discussion, the committee members felt that the list of PAC measures is huge. And in our formal appeal, we provided some additional information, where we just reorganize the information by its categories. So instead of the 800-plus lines of code that was a little daunting to the PAC members, to the committee members, we have maybe about 60

groups of (CCS) category groups of complications. And in fact, a PAC list is more restrictive than many of the NQF-endorsed CMS measures such as all-cause, unplanned readmissions and other measures which have already been endorsed by NQF, where they look at all kinds of related and unrelated complications. We have a more restrictive list.

So that was the only comment we wanted to say. And then the other thing is that, these PAC groups provide an opportunity to drill down, to help, you know, members like providers or wherever the level of measurement is being done, to engage in focus process improvement activities. So this PAC measure is not only a measure but also a tool for improvement. And since it's only related to the index conditions, it picks up all kinds of complications at the patient level, but then it's also helps provide this focus on what are my top two, top three PACs that we can focus on. Thank you.

Melissa Mariñelarena: Thank you, Amita. And I'd like to refer everyone to the document that she is talking about. It's Table 1 in the memo that you received from Leslie.

And at this time, I would like to ask the standing committee if they have any questions for Amita, and this is just any general questions. And if you have any measures-specific questions, we just ask that you save those for when we actually discuss the measures.

Sana Al-Khatib: I have a general question. This is Sana Al-Khatib. Thank you so much for providing this overview. I just wanted to double check on one thing because I remember during the in-person meeting that we had some confusion regarding the attribution of these measures that you have. At some point, you mentioned the physician. In other points, you mentioned that if would be the facility or the hospital. Would you please weigh in on that again, just so we can have clarity regarding the level of attribution.

Amita Rastogi: Sure. So as our memo states, these PAC measures can be used at any level where the PAC have been attributed. There is no restriction there. The testing that was done was for the two procedures like the PCI and the pacemaker. So those two, the level of attribution was at the facility and then the testing that we did for the chronic conditions, the heart failure measure, the arrhythmias,

hypertension, and coronary artery disease, for that they attributed them to physicians. And the attribution logic can be created (inhibitory) depending on the user of the measure. There's no restriction but the analysis that we did, we provided – we used a simple attribution logic where we look at the counts of E&M claims over our one-year period. And the physicians who had the highest evaluation and management count, those with the ones who were attributed.

Thomas Kottke: So, Tom Kottke here. Maybe I can clarify or help clarify that. There's attribution only if there's sufficient number of procedures or events performed. And so, if a physician only has two or three or five, there's not going to be any attribution simply because statistically you can't identify outliers.

Francois de Brantes: Hi, this is Francois de Brantes; if I can clarify another point. The NQF rules require that measure submitted be tested. And so, as Amita mentioned, the testing that we did for the reliability of the measure was done at the facility level for the two procedures and was done at the physician level for other conditions.

The inclusion of a physician or a facility as part of the measurement group requires both minimum sample sizes as Tom just mentioned and reliability (issue). So, even if there is a sufficient sample size but there's not reliability in the results of the reliability testing, then those facilities or physicians would not be included in the measurement. And all that is detailed in the documents that were submitted.

(Crosstalk)

Amita Rastogi: To add to Francois's comments. So, when the reliability testing is done, we found that different data sets gave different reliability outputs. So one data set may say the minimum sample size should be 30 to get the reliability of more than 0.7. And another date set may say that the sample size is 50 to get the reliability of 0.7. It all depends on the amount of variability that is seen in that data set within provider availability and across provider availability. So, to identify the signals from the noise, that's what the reliability analysis does and reduce the (RAND) method NQF had provided to us so nicely. So, that was

the method that was used and be demonstrative that different data sets can give different reliability in different sample size request.

Melissa Mariñelarena: Great, thank you. OK, so now, we are going to move on to 2751. Leslie is going to provide a review of the votes from the in-person meeting. This measure you are only going to be revoting on overall suitability, and that will be on SurveyMonkey. Again, you can vote on it while we're on the call right now or you have until February 10th to submit your votes to us. And then, I believe Tom and Mary are going to provide also a – they're going to summarize some of the information from the meeting. But, first, Leslie is going to provide a summary of the votes from the in-person meeting.

Leslie Vicale: That's right. Thanks, Melissa. OK, just as reminder and this is also up on the slide that you see in front of you, for the importance of measuring in report, health outcome rationale, 65 percent voted yes, 35 percent voted no. Opportunity for improvement, 41 percent voted high, 35 percent moderate, 12 percent low, and 12 percent insufficient. Composite logic, 65 percent voted moderate, 12 percent voted low, and 24 percent voted insufficient.

For scientific acceptability or reliability, 65 percent voted moderate, 24 percent voted low, and 12 percent voted insufficient. For validity, 71 percent voted moderate, 18 percent low, and 12 percent insufficient. And for composite analysis, 12 percent voted high, 53 percent moderate, 18 percent low, and 18 percent insufficient.

For feasibility, 47 percent voted high, 41 percent voted moderate, 6 percent low, and 6 percent insufficient. And finally, for use and usability, 41 percent voted high, 41 percent moderate, 12 percent low, and 6 percent insufficient. And, again, we will be voting on overall suitability for the measure.

Melissa Mariñelarena: Thanks, Leslie. So, we're going to turn it over to Tom and Mary to summarize the information from the in-person meeting just to refresh everyone's memory from the discussion that we had that day. Go ahead, Tom and Mary.

Mary George: This is Mary and thank you very much. I'll just remind you of the – just a few bullet points of things that the committee talks about in reviewing this

measure. As Leslie said, we did not reach consensus on the overall suitability, but we agree that reliability, validity, feasibility testing were adequate. We remain concerned that type two PACs were too broad and that facility would be held responsible for PACs unrelated to PCI.

The committee also questioned equal weighting of the PACs. We discussed that for sometime such as the fact that a postprocedural fever would be equally weighted with say sepsis or a hemopericardium.

And – but we did agree that weighting could be arbitrary. The committee also expressed concern over the large sample size needed to reach an acceptable reliability level with this measure. And one committee member suggesting reporting PAC rates could potentially lead to unintended consequences such as a reduction of PCIs performed in high risk patients in an effort to reduce PACs.

So, with that I will turn it over to our discussants, Joe Cleveland and Tom Kottke.

Thomas Kottke: Joe, do you want to chime in?

Joseph Cleveland: Tom, this is Joe here. Unless you want to go first, but I certainly – I think the discussion base helps clarify some things. I think that also some the original, you know, things are still present in terms of waiting of, you know, these individuals (from understanding any) composite measures. So, those are my thoughts.

Thomas Kottke: Yes. I actually think this measure is well thought-out. Of course, if – when events are rare or things are highly unreliable, the sample size doesn't need to be large. They'll be variable depending on the quality of the data set. If I take, if I sort of ask myself what do I want for my patients, if they're having bad outcomes from whatever source, I'd like to know that.

And I think the – well, I know that this measure, the way it's constructed, it's better than an arbitrary somebody picking up on a single event, you know, hospital or a couple of events, where there's – they just happen by chance, the

pseudo clusters, and people get, will use the word dinged because it showed up in there.

For a pseudo cluster, this measure would only identify through clusters of poor outcomes, and I think that's important. And regarding the possibility of avoiding procedures and high risk patients, sometimes, there's – it's appropriate not to do procedures if you're actually making outcomes work. And so I actually think – I think it's a pretty good measure, and I think it will help improve patience safety and patient quality.

Judd Hollander: So this is Judd Hollander. I'm actually just wrestling with what we know today that we didn't know when we were in the room. And unless I'm missing something, it seems that, you know, this past most of the, you know, line items and, you know, failed one that was particularly related to the concerns that were addressed today about the clamping of items and the lack of waiting.

And that exactly the same today accepted to put into different buckets but it the same line items reorganize. And so, you know, I just throw back the question as, you know, why would any one particular individual who thought it passed fail it today, or who sort of failed before pass it today, what's really different?

Thomas Kottke: Yeah, it's Tom here again. I'd say well, maybe they simply reconsidered the evidence and feel that their vote was wrong the last time.

Joseph Cleveland: And I think – to echo – this is Joe here, to echo Tom's point a little bit. I mean, I guess this idea and, you know, some people where, again, concerned about fever or whatever and were bringing up this things. But I think Tom does raise a very cogent point that it's rare when a patience has a bad outcome that there is just one isolated thing and that's kind of the beauty of composite measures, right? You know at least in the cardiovascular (world).

You know, one of my patients has a stroke, it's likely they're going to have a pneumonia. So, you know, there's breath and test technology, I think that's one thing done comfortably. I mean I know they're not – we have a lot of discuss about the weighting, but at least you could capturing these things as clusters, and that they truly will be real that these things also associate

together. You have a greater chance, as Tom, points out, picking up an outcome that might be unfavorable.

Yes. We wrestle all the time. I mean, we wrestle with this idea of cardiac surgeries, we go toward public reporting and I'll just tell you the (STS) is now looking at, you know, individual physician level stuff. We're not there yet but I think people are very squeamish, the same point.

There's been tangential at best evidence that behaviors are modified by such things. And, you know, is just, you know, I don't know, that's always raised as kind of straw man. I'm not sure we're facing these individual patients. It's the fact that you're going to – be thinking I'm not going to offer them or I think I can get them through. Conversely, there are times and we should probably not do things.

Leslie Cho: I have a question for the developer. This is Leslie Cho. In the past drill down, what was the number one cause of, what was the number one (factor)?

Amita Rastogi: I can pull it up and tell you in a minute. And just one more point in response Judd Hollander's question, what is different?

Last time, this was the last measure that was being voted on, and as you can see for the overall, the committee, only 10 votes for this. When there were 17 present, but by the time it reached the overall discussion many people had dropped of or left (inaudible), right. I'm just pulling up the (right) portfolio.

Linda Briggs: This is Linda Briggs. While she is pulling that up, I was looking back through the list of items that were listed as PACs. And, well, I agree that any adverse out come that's associated within (Inved) is important. Some of the things that are on the list, I can't even figure out how they're on the list.

For example on both the CID measure and this PCI measure, oral bisphosphonates is listed on the PAC list. What does that have to do with anything?

Francois de Brantes: Right, so this is Francois de Brantes and as the memo that accompanied our reconsideration tries as clearly as we can explain. We as measure

developers, like measure developers around the country including the American College of Cardiology and many others, leverage the clinical classification system that was developed by AHRQ.

And so when we picked groups of codes that are relevant for a specific domain, we take the entire group and we're not the only ones to do that almost every single measure developer does exactly the same thing, and we all recognized that the CCS classification isn't perfect.

I think that's feedback that certainly should be redirected back to AHRQ, but as I stated and is done throughout including by again the ACC, we leveraged the AHRQ's clinical classification system. And so going through a dissection or reclassification of something that has been done by AHRQ is not simply time consuming, it's not particularly helpful and that's the reason why measured developers leveraged that clinical classification system.

Amita Rastogi: Yes. And to add to Francois comment, so to the extent, those don't show up in the patient's claims data then it will have no impact on the PAC counts or PAC rates. And to the answer to your first question, respiratory insufficiency was the top one which is the 13 percent, the top …

(Crosstalk)

Leslie Cho: OK. So that is – this is Leslie Cho, I'm sorry. So that is one of my biggest complaints about these measures because I will be discussing 2740. When you have – so you did a PCI on a patient, they come in with respiratory insufficiency and we're talking within 90 days, which is above the 30-day acceptable sort of standard, I think. And when you impute respiratory insufficiency, outpatient, inpatient whatever in facility on a claim database, I really don't think that that captures what we want to ask which is, you know, from the PCI, was there a patient related adverse event. That's not what respiratory insufficiency may or may not get that. That is my biggest problem with these measures.

The fact that I applaud the measure developers for trying to come up with something like this but as we all agree, and have agreed multiple times, claims data is an extremely poor reliability and when you do inpatient, outpatient and

take something as big as respiratory insufficiency and then say that is a patient adverse event. I just find that very difficult to swallow.

(Crosstalk)

Amita Rastogi: … sufficiency is much higher in your data set versus another provider that's when you would be considered, you know, not at par or below average. But if you drill down to the codes which AHRQ categories respiratory insufficiency has, it's asphyxia, apnea, change stroke respiration, hypoxemia, endotracheal tube wrongly placed, failure to introduced or removed the tube, encounter for respiratory dependence, mechanical complication of respirator and other dependence and machines supplement to oxygen.

Leslie Cho: Look, it also includes – does it not COPD exacerbation?

Amita Rastogi: No, it does not.

Leslie Cho: OK. So then how is respiratory – so is respiratory insufficiency only defined by ventilator?

Amita Rastogi: So I just read out, so apnea may not be ventilator, asphyxia may not be, hypoxemia may not be …

(Crosstalk)

Leslie Cho: So how is measure then applied in an outpatient setting then?

Amita Rastogi: So if any of these code show up in the claims data then it's picked up, so all we are going is looking for these codes which group into that group called respiratory insufficiency, and if it's present in inpatient or outpatient then it's picked up.

Thomas Kottke: So Tom Kottke here. Again, again, you know, I've actually, you know, with our cardiology group if we're getting a whole bunch of respiratory failures in the 90 days following our procedures, so I'd be very interested in that because of – as we become accountable for total cost of care and the patient outcomes. This is important stuff for us to know and that maybe not due to exactly what

we did in the cath lab. But there are patients and we'd like to have good outcomes.

Leslie Cho: I know but I think that's my biggest thing is it that you impute to the PCI these complication which may not be related to the PCI event, it's the imputation of these complication that I find – that I have a very difficult time accepting.

Mary George: This is Mary George, and I wanted to go back. And I believe this corrects the record. There was a statement that when we voted on the overall acceptance of these measures that there were only 10 votes and I believed that there were 10 yes votes and seven no votes. So I just wanted to correct the record on that, any other comments from the committee?

Helen Burstin: Mary, this is Helen Burstin. I just want to weigh in just quickly on the original question that started this about why are we looking at this today and why is this any different. Again, any measure that goes through a committee we don't reach consensus, we as a matter of course always bring it back to the committee for reconsideration. It doesn't mean we have to completely redo and re-litigate some of the issues but perhaps just look at the overall voting and see if there any comments that came in that may have had an influence. In this case, look at how the ratings for example, on the individual criteria link up or don't link up to the overall suitability.

So this isn't a request to have you completely start from scratch and redo it again or forget any details here. But just look to see with the fact that this measure was right on the bubble was presented the votes to you. I believed (Lisa) sent that out, so everybody could see the votes on the individual criteria and the overall suitability. And we'll just ask you to revote on that as part of our process.

And then lastly, since they will be entering into the reconsideration discussion again. That is also baked into our process, that any developer can request reconsideration from the standing committee for – and provide additional information that they have done as well as reconsideration for our consensus there as approval committee.

So I just want to let you know that this is not outside of our usual process. We're actually just following along our usual process and just want to reassure folks this is the standard operating procedure here at NQF, thanks.

Mladen Vidovich: This is Mladen Vidovich, I'm sorry, a little bit late, but I was not in an open line, so I was trying to speak, but you can't hear me.

I do feel that the developers are onto something right. You know, this is the future and I think Big Data will be very important in analyzing multiple associations which we currently with, you know, let's say small data and imperfect statistics are unable to capture. And we all have done papers and published, you know, that where we try to adjust the baseline differences and we said, "You know, unmeasurable confounders couldn't adjust for observed differences, right? You know, obviously the more data you add, the better it is.

Nonetheless, I strongly feel that this measure as proposed is way premature, I think it attribute – as Leslie said some complications within 90 days to APCI, which may or may not be related. I think time will probably proved these measures to be very valuable. I think as we are going to alternative payment methods with the Affordable Care Act and MACRA, I think this is a different time.

I think measures like this will be needed. But at this time, I think endorsement by this committee, I think will be premature and I think would not reflect what most practitioners that you asked understand about their practice and understand about their data.

So I think if we say the NQF, yes, we do endorse this measure, that a 90-day disaggregate complication after a PCI tells you about the quality of a program. I think that's just (literally), I think, this measure can not adjust for, let's say, my hospital where I'm in inner city with a really high risk population, and maybe five miles away from here on the shores of Lake Michigan. There's a hospital that take a completely different patient mix.

And I think endorsement is a big thing and I think in this committee says that truly we endorse this, I don't think this is right. And I think practicing

cardiologist in the community, if they get measured like this they'll be very surprise to see like where it is come from.

Again, if we past forward 10 years from now, and I think and measures like this will be probably more common use, but I think at this time I strongly believed this is non-endorsable.

Leslie Vicale: Thank you, Mladen. So again, just want to remind everybody that you're going to be voting on overall suitability for these measures. This is a facility level measure. It is not physician level, so just remember that.

Again, remember to stick to the NQF criteria when you are casting your vote. We can resend that to you if you need to. I know you already voted on the criteria, but I think it is worth taking that into consideration if you want – when you re-look at this and you're revoting.

And quickly if we can ask Tom and Mary, just to do a very quick summary of what we've heard here and just for the record. And then we will move on to the reconsideration of the additional measures.

Mary George: So this is Mary and I'll briefly try to recap. We heard some new information from the developers today. We've had a very good discussion around what is different this time around than what was before. We've had some more thoughtful discussion about how the measure could be useful in large care organizations being able to drill down on the patients that they care for as an organization.

We've had some discussion around data quality, and we've had some discussion that reflects, I think in some manner that the logic of the measure. So, I think we've had a pretty good discussion around all of the items here.

Tom, anything to add?

Thomas Kottke: No. I don't have anything to add at this time.

Leslie Vicale: Great. Thank you. OK. So moving on, we are going to start with the reconsideration of the measures. And we can start with 2740, this is a

proportion of patients with coronary artery disease that have a potentially avoidable complication.

And with this one, we are going to start …

(Off-mike)

Leslie Vicale: Yes, yes. I'm sorry. We're going to start from of the beginning on this one because this one failed with evidence.

Helen Burstin: I'm sorry, just a quick question. This is Helen. Since the developer's response is actually collating all of the measures in a general way. I'm not sure we need to go measure by measure and I prefer maybe Tom or Mary could open a discussion with the, you know, summarizing the developer response. And then perhaps just a general discussion of the measures, and then we can do the individual measures as appropriate.

But since the developer responses for the set, it seems logically we would stay potentially – I think these issues are more macro as they laid them out as opposed to measure specific.

So I don't know, Tom or Mary could just maybe walk through the developer rationale and then we could invite Francois or Amita to give some opening remarks as well they've like about, why they requested reconsideration.

Thomas Kottke: Sure, Tom here. The developer requested reconsideration based on the fact that in their opinion, the committee failed to vote on the merits of the measure on specific evaluation criteria but rather on their acceptability to many members of the standing committee as a potential source of personal accountability.

The evidence provided for most of the submitted measures was and is for all intents and purposes identical, the main difference between the first four and the last two was level of measurement. They stated at several instances, members of the standing committee expressed support for the validity of the submitted measures if the level of measurement were a group of providers or health system. But we're nervous about attribution at the individual level.

The proposers stated that none of the evaluation criteria under consideration for a measure ask or suggest that measure of a standing or that members of a standing committee assess a criterion based on personal feelings.

So basically, they felt that the committee did not apply the algorithm appropriately.

Helen Burstin: Mary, anything to add before we ask Francois or Amita to say anything?

Mary George: No. Tom summed that up well.

Helen Burstin: Great. OK. So Francois or Amita, would you like to make any comments before we open up to the committee?

Francois de Brantes: No. Look, the memo I think summarizes our – all the arguments for request for reconsideration. What I would say about one topic that keeps coming back which is the length of time during which the measurement is being done.

One year is a standard time window for measurement of the cost of care associated to a condition and therefore should be and is also, the time window for the measurement of these types of quality measures in much the same way as for procedural episodes that time window selected is 90 days.

And you can look at, for example, the recently announced mandated Medicare joint replacement episode or bundle which takes a 90 days post-discharge period. And the quality measures that are associated to that initiative also last for the entire 90 days.

So, the time windows that we're using are perfectly consistent with what is being used as standards within the industry. And I think, you know, again, we've heard today that there are lots of personal feelings about whether or not these measures might impact someone. And I'm going to point everyone back again to – the submission materials that we put together for this measure where we calculate is a risk adjusted overall comparative rate that includes all of the individual frequencies of these avoidable complications. And then standardizes against that.

And therefore, no one is dinged for anything rather you get feedback on whether or not your particular risk adjusted rate of complications is higher than, lower than or average. And that's what a measure is design to do and that's what this measure does. It doesn't ding anyone, it's simply creates a comparative performance.

Thomas Kottke: So who would – Tom here. Who would like to comment or raise any questions?

Carol Allred: This is Carol Allred, and I have a question. I was not at the in-person meeting in September, so I missed some of that discussion but I am confused about who assigned the liability or the responsibility for the various PACs either to the facility or to the physician?

Thomas Kottke: So Carol, maybe I can answer that. They're only assigned at a level where there's statistical reliability. And so with small sample sizes of physician, unless the sample size of adequate of physician would not be held responsible for a set of PACs. And so, it's basically determined by the number of cases that a particular physician or particular facility has. And so we don't have, we don't have problems with small numbers. And I think, one of the things this measure does is protect against arbitrary attribution.

Carol Allred: OK. Is that in the same with the patient safety measures?

Thomas Kottke: I can't answer …

Carol Allred: Because it appears to be than a number of the patient's safety measures would be the responsibility of the facility.

Thomas Kottke: Francois, do want to answer that or?

Francois de Brantes: Yes. So, again, it's depends on the specific unit of measure that you're looking at. So for certain things, patient's safety measures are in fact attributable to facilities because what's being measured with both, for example, hospital acquired conditions or by definition focused on facilities. There are other patient's safety measures that are done and can be measured more at the physician or practice or group level because they are not facility

specific. So it really depends on the individual or the specific, you know, safety measure they'd be looking at and at your – that you're accounting for in the delivery system.

Carol Allred: And my question is who then makes that decision whether it goes to the physician or whether it goes to the facility?

Francois de Brantes: Well it's a question of – as Tom alluded, the way they measures – the way we designed the measure is we'll look at the extent to which, first – well, so first, it's a patient-centered measure. So the first question is did the event occur? So did the complication occur?

And then the second question is, did it occur within the context of a specific condition, illness or injuries. So ones those two things have been determined, then you can say, all right the specific event occurred in event and it can be attributed to a specific condition, illness, or treatment, or injury.

Then the next step is to say, which a provider whether it's a physician or a facility can be reasonably attributed a management of these procedure condition, et cetera. To the most part, conditions are assigned to physicians, procedures can be assigned either to the surgeon or whoever does a procedure or the facility. So it's not necessarily one or the other, it can be both.

Then the final step is as time suggested to perform a rigorous reliability test during which the minimum sample size required to have a reliable measure is determined by the test itself.

So for example in the materials that we submitted, we showed that for some data sets and for some of these conditions or the procedures, the sample size requirement varies. And you can, therefore, only reliably measure either facilities or physicians that achieve that minimum sample size that is required for reliability.

So therefore, not everyone can be measured because they have insufficient sample sizes and therefore, unreliable measures. But those who have insufficient sample sizes, you can generate a reliable measure. And that could be that, again, either at the physician level or at the facility level.

Carol Allred: What I'm trying to get at is who makes decision ultimately? Did it go to either the physician or the facility? And I am probably the only patient on the committee that has no medical background per se.

Francois de Brantes: Well, as measure developers, in our submission, you know, and this is true for pretty much any measure developer. You defined a measure and it's tied to either a particular condition or a procedure, then the decision of how that measure is used is really up to those who end up by deciding to use the measure. We've actually done a step beyond most measure developers and saying we – in our recommendation, the measure should only be used to the extent that you can achieve and demonstrate that you've achieved reliability in testing the measure and determining then the minimum sample size requirements.

But there's no – there isn't a definitive answer to your question because to a large extent, if you're thinking of this is a patient and we have a choice of where to go for a particular procedure, some of that decision might be driven based on your understanding of how well a facility is doing in managing or in a particular procedure. But another part of your decision might be made based on the qualifications of the physician that's going to be doing that procedure.

So, you know, from my perspective as an organization that pushes quite strongly for quality and price transparency, we would say both you as an individual should have the right to know – to have an answer to both of those questions. How well does the facility do in treating patients who have a PCI and also how does the surgeon that is going to perform that procedure for the cardiologist that's going to perform that procedure? How well does that physician do in managing that kind of procedure? So it should be both.

Carol Allred: Yes, it should be. But there, again, who makes that decision? Is it the facility that has the biggest slice of the pie in that or is it someone judging the physician?

Thomas Kottke: Carol, Tom here. It would be whoever is actually applying the measure. And so we have some payer, let's say, Blue Cross Blue Shield of California, you know, some arbitrary that says, "We're going to evaluate our physicians and

facilities on (peer) continuous interventions. They take a look at facilities first and evaluate those facilities that had sufficient reliability based on sufficient numbers, and then look and see if there were physicians who had – also had the adequate numbers.

So if that physician is made by whoever is applying the measure and we would expect that it's probably either …

(Crosstalk)

Carol Allred: OK. So the insurance provide primarily would be the …

Thomas Kottke: Yes, and insurance payer.

Carol Allred: OK.

Francois de Brantes: Or in the case of a state where you have an all payer claims database, it could be the decision of the state agency that managers that all payer claims database, to apply it to whomever they can provided again, it needs the reliability testing.

Carol Allred: OK. But it appears to me that the number of the patient safety measures in here would be more appropriate to be analyzed at the facility level. And that was my point.

Thomas Kottke: It depends on the sample size. If you have a physician with a huge practice, but analyze that physician against other physicians with huge practices but physicians with small practice, you wouldn't be able to – and in fact it would – because it's very difficult to risk standardize in one's head.

Carol Allred: Yes.

(Crosstalk)

Thomas Kottke: … does risk standardize and it also, I think, you know, protect against the occurrence of pseudo clusters small. You know, they have two bad outcome – you're an operator and you have two bad outcomes in a week. And, you

know, up marches the administrator and say "Hey, you know, you're finish". Well, I mean, that's not enough to do anything on and the measure will tell you that.

Carol Allred: OK. How is the measure going to tell you that? Just because it's a small sample size?

Thomas Kottke: Yes, pretty much.

Carol Allred: Pretty much? OK.

Francois de Brantes: Yes.

Thomas Kottke: You can't make it for instance from small, you know, small sample sizes.

Tom James: Tom?

Thomas Kottke: Yes?

Tom James: Yes, Tom James is here. Can I stand in line for the next question.

Thomas Kottke: Sure, go ahead.

Tom James: OK. Francois, can you describe what the difference there are in the methodology that you're using here compared to an (STS) methodology? Because to me, the sounds analogous. This is more on the PCI version of what would be an open surgical procedure.

Francois de Brantes: Are we talking about PCI or something else, Tom?

Tom James: Yes. Comparing your set of measures here with what STS has for that – for open procedures or for CABGs?

Francois de Brantes: Oh, what the – you mean the measures that the Society for Thoracic Surgeon has?

Tom James: Right exactly. Because those have been out for so long, it becomes kind of a standard I kind of think that we would be looking on the – for the cardiologist is something to be similar to the cardiothoracic surgeons.

Amita Rastogi: Maybe I can answer that. So you're right, the STS only creates for open heart procedure. For the cardiologist, these measures are not really out there for so long. There were something that came out recently, we'll have to look at those but our PAC measures are pretty comprehensive. They look at all cause harms to the patient which are relevant to the index condition.

Francois de Brantes: So that there are some similarities, Tom.

Tom James: OK.

Thomas Kottke: Other comments?

Elizabeth DeLong: This is Liz DeLong. I'm not sure I understand the lack of connection between how physicians who should understand these procedures and understand the attribution to them. I don't understand why that should be discounted, but the note that came back from the developers was that the clinicians on the room took the wrong perspective towards the evaluation of these measures.

(Crosstalk)

Amita Rastogi: Yes.

Francois de Brantes: Yes. Well, so, this is Francois, if I can just answer that question.

Thomas Kottke: OK.

Francois de Brantes: The main point is that there was – when you take a composite measure, like this one, and you create a risk standardize rate, by definition, it's a measure of comparative performance. So it's not a measure of absolute performance. It's a measure of comparative performance.

So, if you focus on a particular diagnosis code, and you say, "This particular diagnosis code, I can't possibly be held accountable for this particular diagnosis code," that's not what the measure does. It misses completely the point of the measure that it's – absolutely not what the measure does.

What the measure does is it looks at across a cohort of either physicians or facilities for a specific procedure or a specific condition, whether or not for the patients that they manage. There was an occurrence of one of these events. And then it looks at the totality or the frequency of those events across those patients and it compares that frequency, that overall frequency with the frequency of everyone else. And it risk standardizes back to the average.

So, the whole discussion of this particular diagnosis code, how can I be held accountable for something like this that might happen, you know, blah-blah-blah. That's not the way the measure is designed. And that's not what the measure does.

The measure creates a comparative – or look at a comparative analysis of the rates of these – of the occurrence of these events across a cohort of patients for similarly situated physicians managing patients with that condition.

Elizabeth DeLong: I understand that. What I don't understand is that there are a number of complications wrapped into this. And I think this sentiment was that, if one person had a number of these complications but they weren't very serious, they were going to be dinged as much as somebody who had more severe complication. That's my recollection.

Francois de Brantes: Well, so, then you go to the point of how do you wait an event on one patient versus another patient. And whether or not there even can be appropriate waiting across these types of events. And I would point you to …

Elizabeth DeLong: Exactly.

Francois de Brantes: Right. But I would point you to a number of existing measures that have gone through and been endorsed by the NQF that very similarly take a broad view of a large number of potential events that occur and occurred to patients.

Some of them are more severe than other and similarly, they don't apply any waiting more than they look at frequency. Because ultimately, the frequency with which something happens as a feedback mechanism to a provider is the important feedback is, are you having a frequency? And I think Tom said it

earlier, are you having a higher than average frequency of occurrences of events relative to your peers?

And if you are, that might be something that you – that might be valuable information to you. And it certainly might be very valuable information to patients.

Leslie Cho: This is Leslie Cho, I have a question. Maybe the NQF staff can answer. What other cardiovascular measurements that has been endorsed that had a broad ranging imputation like this? Any – can you guys name one, so we can have an example? Because the developers keep on saying it's been endorsed by the NQF. So can you guys name an example?

Helen Burstin: Yes, Leslie, this is Helen. So I mean, certainly, I think, as was mentioned earlier, if you look towards the measures that use more of the claims based data, certainly the cardiovascular related readmission measures.

Leslie Cho: That's within 30 days. We're talking about one year measurement here.

Helen Burstin: Right. I'm not – I'm sorry, what specifically we're talking about the timeline or just talking about the broader attribution, the broader responsibility, certainly the cardiovascular readmission measures.

I don't know of anything else at a one year timeframe, but we can certainly take a look. But some of the AHRQ patient safety indicators also rely on many of the same sort of claims based measurement that we're talking about here.

Judd Hollander: Right. And this is Judd. I would say as well and I think this is getting at the comment that is made. I think our role as a committee is to evaluate individual measures and to evaluate in the condition where we are in theory, you know, the experts are weighing in, does this measure work?

And I would say, it doesn't really matter if it was endorse by a different group and a different disease with a different timeframe, and they did something that's somewhat analogous. Because I don't think if someone came forward with a measure that someone else refused that they would be on the side of the

fence saying, "Well, I know wasn't accepted by another committee but I think you should accepted here".

I think our job within the cardiovascular arena so say, "Does this measure make sense and does it meet the NQF criteria?" And personally, you know, measures are all relatively new and something that was approved two years ago might not be approved today. And so I think we just need to evaluate based on what's presented to us and what we have in front of us in our area where we have some expertise.

Helen Burstin: And Judd, this is Helen. I think that's a fair comment. I would say though that one of the things we really strive to do and the reason, I think, it is an important question is, we need to have consistency across our committee fellows, consistency in approach and consistent application of the criteria.

And since that one of the main issue raise part of the reconsideration request. That's the reason, I think that is a fair question overall. But I hear that each individual committee, fix the way those things to make their own determination. But, again, that consistency issue, is one, we had been hit with pretty harder times for the developers.

So it is, you know, I think fair game at least to have that conversation.

(Crosstalk)

Michael Crouch: Michael Crouch, I have a comment.

Thomas Kottke: Yeah.

Michael Crouch: My concern is with the validity of the measure. With that including, many, many conditions would have no conceivable causal relationships to the index condition. And I'm not concerned about waiting and all of that, I just think that there lot of things at this list that shouldn't be counted toward relative rates for anybody at the institutional level order at the, you know, provider level because they have not in to do with – no conceivable, anything to do with the procedure that this patient have.

That's my concern if this not a valid measure of relevant adverse outcomes. It's a measure of the whole bunch of things, many, many of which have nothing to do with the procedure and anybody conceivable causal world.

Mladen Vidovich: This is Mladen Vidovich again. My biggest fear is that we cannot foresee the unintended negative consequences of this. And I think, again, I think this is the future, Big Data in the future. But at this time, this is premature and I don't think this committee can endorse this.

I think measures could be used by a variety of payers, the government, by Medicare of – and I think the unintended consequences are very, very huge and unforeseen. And I don't think that we're ready for this.

Sana Al-Khatib: This is Sana Al-Khatib. I would like second what that said before, Mladen, talked – I'm not sure who was speaking. I completely agree with that comment. Because I think that – and at least for me when we were at the meeting, that's was biggest concern that he have in this for 700 or 800 different conditions may of which are not related to the procedure, and you are holding the physician accountable for that.

And, well, I completely agree with what Mladen said about, you know, the future and the Big Data. And I'm very supportive of big data. I think we need to be informing, hopefully the government if we can, all these entities that make these decisions about the best way to use those data, in an informed way, not just to say, "Well, this is how the government wants us to do. Let's go ahead and do that".

And to the extend that we can be, you know, informing people that this is actually the right way to do it, we want to look at conditions that even can be remotely related to the procedure, I'm all for that. We certainly need and want to hold physicians accountable but don't hold them accountable for 700 or 800 different conditions that may have nothing to do with what they did.

Amita Rastogi: So, Sana, just to reiterate the comment that I made earlier, they are not 800 conditions. For example, hemorrhage maybe one condition and it has 20 different codes. Then, that becomes one. It's no 20 different conditions.

In the (same), sometimes the same condition may have multiple, multiple codes. And all of them have been grouped together into homogenous categories by CCS. So that's what is – so that's why the appeal that we came, it's not 800 conditions.

Michael Crouch: Michael Crouch here.

Sana Al-Khatib: I'm just talking about why we voiced the concerns in the meeting. Now, I agree, I read the memo that was circulated and I agree with what you're saying. But I think there are still concerns about some of the conditions that were bundled or that were included that may have nothing to do with procedure, or with the condition or, you know, so that is my concern.

Linda Briggs: This is Linda. I would agree with what was just stated that we have to be concerned with the validity of the measures that are being included in this group of PACs while, yes, you may bundle them because they're alike, because maybe they're hemorrhage.

As I was talking about oral bisphosphonates before, it's in the list of things that all have to do with adverse drug events. But what do – again, if oral bisphosphonates is somebody's, like, put on them during the timeframe of 90 days for a PCI or year for, you know, the CAD and that's in both of the indicators, that both of those measures that are being brought forward.

Well, they may fall out in general. These aren't valid measures for quality for this particular problem, for either CAD or for PCI. So, it makes no sense for things like that to be included. And these become compound events across a large group of people.

(Data N), the quality of (Data N) is equal to the quality or affects the quality of the data that comes out of a measure. And it's really important that we have quality on both sides.

And one of the things that was held up in terms of being – are we doing the same kind of measures across different groups, cardiovascular surgery, et cetera. One of the measures that actually the developers held out as being similar was one related to knee and hip replacements.

And I have to point out that there was a limited number of complications listed for that particular measure and they were big ones. They are acute M.I., pneumonia, sepsis, septicemia shock as one group bundle. Surgical site bleeding, pulmonary embolism, mechanical complications and then periprosthetic joint infection, and you can see how that would be – those would be reasonable things.

There are multiple codes that are listed for that because I actually went and looked at this information to see if I was being fair. And the codes, they're all line up with the kinds of things that would happen as the complication of a hip or a knee replacement.

Amita Rastogi: Well, just to give you a feedback on the example you were using, the adverse effects of drugs in PCI, it's 0.58 percent of all the drugs that are listed in that CCS category. And then similarly, in coronary artery disease, if its 0.9 percent. And this is across all patients, all providers, overall in that data set that we looked at.

OK. So, as an individual provider level, if consistently every patient of yours is having an adverse effect of bisphosphonate then you would stand out as an outlier. But that is the only time you would stand out as an outlier.

Tom James: Yes. This is Tom James. And as a primary care physician, I'm used to being judged for things that may not be under my direct control. But I'm looking at my patient in a global sense.

And when I'm working from the insurance company side, I'm looking at a population and how well do people receive their care one place or another. I know that there are number of individual events which may not make sense. But when you start the real numbers involved, those pan out in the long run.

Certainly, there are no cardiac drugs that are free of side effects and yet, we don't discount the drug as a whole. So, I'm more in favor of just recognizing. It's not perfect but I don't want the perfect to be the enemy of the good.

Leslie Cho: It's Leslie Cho. And, you know, I reviewed the 2740 measure and this is a coronary artery disease one year. And I looked at the PAC, the number one, sort of, PAC. It was uncontrolled diabetes.

Now, whether that – so you get admitted with unstable angina, you know, whatever. And then, within that one year, if you had uncontrolled diabetes in your claims data, then you are – then that is counted against you.

Now, to me that has – that to me that makes so to me that has just has an overwhelming implication, right? Because that patient is seen by the – not just by the cardiologist, but maybe by their internal medicine doctor and maybe by their endocrinologist, it's an outpatient thing. And there is just so many issues related to why that cannot be adverse patient related effect imputed to the coronary artery disease admission one year ago.

And for that to be the number one PAC or measure 2740, I think speaks volume about the issues related this measure.

Amita Rastogi: Well, it also points a very important point that quite often. And I'm overlooking after my patient of coronary artery disease. I'm overlooking the fact that they have other concurrent problems. And this is a hospital acquired condition, this particular – it's a HAC code.

And if that shows up consistently in all my patients with coronary artery disease, then I better make sure that I refer that patient to an endocrinologist and I have some …

Leslie Cho: So let's take a – let's take Mladen inner city patient as an example, OK. Where the hemoglobin A1c is consistently high. Then that facility – and you don't have disparities, you don't socioeconomic data broken down here in 2740. And that facility, that physician will actually have higher risk than the other patient.

I just find these measures – I'm going to vote the way I voted in D.C. in September. I don't think these measures currently, in this current state are at the high standard of NQF and I don't think they should be endorsed.

Mary George: This is Mary …

(Crosstalk)

Francois de Brantes: If I can just address the socioeconomic thing for a second. If you look at again at the documentation that was provided, we're very clear that the measure should be calculated separately for Medicaid populations then for commercial populations. Because the single best indicator of disparities and still ends up by being the type of insurance that someone carries.

So I just want to make it clear that you – we don't commingle and we didn't in this submission and we talked about it. We do not commingle data sets or populations in order to avoid exactly that potential for a physician, for example, treating many more Medicaid patients than someone else having a different resolve because of population of patients that they manage.

Mladen Vidovich: This is Mladen Vidovich again. Again, just based on my research, and I've actually even published a paper about income of insurance status and outcomes in the PCI, (I don't) remember exactly. It is really, really, really difficult to adjust for socioeconomic status. There is so many confounders that if you look at (inaudible), primary language spoken at home, income and the ZIP code, you name it.

Just look at Flint, Michigan, lead in the water. I mean, there's so many things that you can throw into this mix that you are just unable to adjust, you know. And then, give this measure an NQF endorsement and then us as NQF telling a practicing cardiologist and interventionist like, here's your measure and this – you're going to be measured by this. And by the way, folks we endorsed, I don't think we're doing disservice to anybody. Again, fast forward 10 years …

(Crosstalk)

Francois de Brantes: You might be doing some service to patients but …

Male: Yes, yes, that's what my comment if – if I got a whole bunch of patients I am sending off or doing angioplasties on whatever and their diabetes control is crapped. I mean, I think it's …

(Crosstalk)

Mladen Vidovich: You may not. Until you're a third party payer may just under pay the hospital which takes care of this underserved population and they can go bankrupt and then you are going to have a huge what we have in Chicago just south of me where I'm seating right now. We have a black hole hospital zone between me and University of Chicago which is a beautiful stretch of Lake Michigan; we have no hospitals believe it or not. As recent these years ago, we would get thrombolytics maybe two miles from me.

So I don't know and we have a food desert south of me. We may have a hospital desert south of me. If these measures that are endorsed actually result in third party payers not paying this hospital because they serve in underserved patient population. I'm not sure that …

Male: That's not …

Mladen Vidovich: I'm not so sure that you're going to do service to the patient, I don't know.

Mary George: This is Mary and I just like to say one thing. And as I think about these measures, I think they would be far more suitable to large accountable care organizations if anything and perhaps not any other – at any other level.

Sana Al-Khatib: And this is Sana Al-Khatib. I just want to build on what Mladen was saying, you know, I wouldn't just focus on this socioeconomic status. I would also take the patients comorbidities into account and since we did not have our patients representative with us in D.C. in September, I think it is important to make sure that patients understand what's at risk here because if physicians are going to be – or facilities and/or facilities will be dinged for any complication that the patient comes back within a certain time frame. You can see how that's might have major unintended consequences where people are going to just pick the healthiest of the healthiest patient to do procedures on. And so now, you're depriving a big, I would say that maybe the majority

of the patient population that we see will have comorbidities and as such are more likely to come back to the hospital with, you know, conditions, complications, issues.

I think that certainly needs to be taken into account as a very probable, I would say, unintended consequence if we have these endorsed, these performance measures endorsed.

Francois de Brantes: Yes. Just, again, this is Francois. If you read the documentation, you will see that comorbidities are absolutely taken into account in doing the severity adjustment for the patient. So I just think it's important to go back to what the documentation says, what the measure actually does and you guys are speculating that a measure is going to close hospitals down. It's so absurd that where is that a criteria for NQF determination of reliability of a measure, and it is just an absurd conversation.

Thomas Kottke: Well, so actually I'm just going to fight backed on that because you're taking a caricature of the conversation. And the first thing we vote on is important to measure and report what's the health outcome rationale, and what you're hearing us discuss is not fear of closing a hospital, you're hearing us discussed that we're not sure there's an outcome rationale by combining all these things. You did exactly step 1A of a measure. It is something that if doesn't get passed nothing else should be considered.

So I actually think we've had a very thoughtful conversation for, you know, an hour or more down at the face to face meeting and so quite a bit of time now. And I think to be dismissive of it is inappropriate.

Francois de Brantes: What I'm dismissing is the discussion that suggest that the publication of a measure is going to close down a hospital.

Mladen Vidovich: Well, I'll tell you back, I think you are taking this as a specific example. I will just then take this notion to high level unintended consequences. And you can strike this, close the hospital down.

But I think I used this as a caricature often unintended consequence and there's ample literature about public reporting of PCI outcomes in the state of

New York. I'm sure most – everybody on this committee is familiar with this. And I think the unintended consequences are pretty large. And it's – till the jury is still out if public reporting of PCI outcome is a good thing or not.

Francois de Brantes: And supporting that, I mean, although I don't really like to make decision by anecdotes. I practiced in New York when they started with their public reporting of the CABG results. And I can't tell you the number of times I had people that needed the risk surgery in the E.D. and nobody would operate on them. And with the surgeon actually said, "Too high risk going to impact my numbers." I watched people die in front of me with surgeon that said on at least two occasions.

Amita Rastogi: Yes. The interesting thing is New York has adopted these measures. The cardiac folks in the DSRIP Medicaid effort have unanimously agreed to use this PAC measures already. It's already been accepted by their (Inaudible) standing committee.

Helen Burstin: Tom or Mary, I wonder if we want to just see if there's any other additional comment specifically on in the individual measures or any other additional comments broadly, I'm not sure we're getting into further discussion that's going to help people when they need to do a certain policy.

Thomas Kottke: I would agree. We seem to have brought up pretty much what everybody wanted to bring up. It doesn't seem that any minds have changed, as there – does anybody have any question or any comment that has not been made before that they – either a question that would clarify their, or help them vote more cogently or is there a comment that anybody wishes to make that would – they feel would inform the committee so that they could vote more cogently?

Hearing nothing, maybe I'll turn it back to Leslie or somebody at NQF? I think we had the discussion around these measures and people need to vote.

Leslie Vicale: I'm sorry, Tom, can you restate that?

Thomas Kottke: I think we've, you know, I haven't heard anything new. People have, I think, pretty much declared their positions and offered both some concerns and some

anecdotes. And I think we've pretty much exhausted the new material coming in, unless somebody has a question that will help them vote more cogently, or they have a comment that they feel has not been brought up that would help others understand better the issues.

And so, I thought hearing nothing, let's go back and talk about, I guess, we have – we have 15 minutes to a member and public comment.

Helen Burstin: You can do public comment right now, Tom, that's fine, if you think it's appropriate.

Thomas Kottke: Yes. I think unless somebody wants to say, it's inappropriate to go to public comment and I think we should go to public comment as this time.

Leslie Vicale: That's fine, Tom. And since we're a little bit early, we're just going to make sure everyone is aware, if you're listening into the call and on the web that we're going a little bit early. We're about 15 minutes early. So what we will ask the operator to do is to go ahead and ask for any public comments. And then, we'll just ask him to hold that open for just an extra minute or two incase to folks need to just catch up with the call.

Female: Can I ask – I'm sorry, I didn't catch your instruction. So are we to vote again or are we going to assume, we just kind of stay with the previous votes?

Thomas Kottke: Yes, you have to vote again.

Female: I have to vote again. OK.

Thomas Kottke: Yes. Everybody needs to vote again.

Leslie Vicale: Hi, this is Leslie. I just wanted to remind everyone I had sent an e-mail containing the SurveyMonkey link at the top of the hour when the call started at 3:00. Every single measure criterion for each measure has a question that must be answered. So we're just asking you consider the discussion today as well as the information that was submitted by the developers that was contains in the committee memo that was sent to you all as well as the measures submission information that was also part of the document that were sent out

to the committee in order go through the criteria. Each criterion must be voted on.

And we ask you to submit those votes no later than close of business on February 10th.

Thomas Kottke: So please vote so that we haven't wasted a couple of hours and the tremendous amount of time on the part of the developers.

Mary George: Yes. Thanks, Tom.

Leslie Vicale: Thanks, Tom.

Mary George: So were there any public comments?

Leslie Vicale: Can we ask the operator to ask for any public comment?

Operator: Certainly. To make pubic comment, please press star one.

And there are no public comments.

Leslie Vicale: Thank you very much, operator. And just to make sure everyone is aware as we monitor our webinar here. We have not received any public comments via the chat window either.

OK. So I just want it to review the adjusted timeline for these measures, so if we could just keep ahead to that slide give us just a moment.

OK. As you can see here, depending on the committee including the outcome, the project task will draft an addendum to the draft report and we will post that for NQF member vote. And that would happen for February 25th through March 10th. And then the – all the measures being reconsidered and discussed today including the measure where consensus was not reach will be brought for the CSAC review and approval on March 23rd to 24th that's their in-person meeting.

And then finally the executive committee and the board of directors will have the opportunity to measure as well at their meeting on April 6th, and

following that an appeals period is scheduled for April 8th to May 7th. And, again, this is dependence upon the outcome of the vote from the standing committee and we will continue to keep the committee as well as the measure developers aware of the outcomes to this vote. And any additional public information will be posted to the public cardiovascular projects page.

And, so again the votes are due by February 10th, close of business. I will send an e-mail out with a summary of this call as well as the audio recording to assist with any voting. However, if you feel like you have enough information to go ahead and vote, you may do so at your leisure before the 10th.

I'd like to just turn the call back to Mary and Tom for their closing remark.

Thomas Kottke: So I'll jump in and thank all of the committee members. First of all, thank the measure stewards for their hard work and thank the committee members for their thoughts. And I know this is a lot of work and a lot of thought around this. And I like to thank you, but also remind you, please vote so that all of this is not for (not). Mary?

Mary George: Yes. I, too, want to thank the measure developers and particularly for your coming back, having taken another look at the PACs and your grouping and that's all the helpful information that you provided for us today. And committee members as always say, you know, really thank you for your thoughtful discussion.

Leslie Vicale: Thank you so much, Mary and Tom, and to all the committee members as well as the measure developers.

On behalf of NQF, I like to thank the members of the public who the join the call. And we wish everyone a wonderful afternoon and we'll speak to you all soon. Thanks again.

Female: Thanks.

Male: Thank you.

Female: Bye-bye.

Female: Thank you, bye-bye.

Female: Thank you.

Male: Thanks. Bye.

END