

National Quality Forum
Moderator: Sheila Crawford
September 12, 2012
2:00 p.m. ET

Karen Johnson: Good afternoon. This is the NQF Team here in Washington, DC. It is Karen and Suzanne this afternoon with you. Thank you for calling in to the Neurology Endorsement Maintenance Phase 2 Workgroup 3 Call. This is our call where we will be discussing Parkinson's disease measures, so welcome and welcome especially to Peter Schmidt, our newest addition to our committee. So, Peter, welcome to the Committee.

Peter Schmidt: Thank you.

Karen Johnson: Sure thing. I want to hand it over now to Suzanne for a roll call.

Suzanne Theberge: Hi, everybody. As Karen said, Karen and I are here for NQF and I am just going to run down a quick roll call of the committee members and then the developers, so we know who is on the line.

Michael Kaplitt, are you here?

Michael Kaplitt: I am.

Suzanne Theberge: Great. Thank you. Jane Sullivan? Great. Jack Scariano? OK. Mary Van de Kamp?

Mary Van de Kamp: Yes, I am.

Suzanne Theberge: OK. Risha Gidwani?

Risha Gidwani: I'm here.

Suzanne Theberge: Great. We know John Duda can't make it today and – Peter Schmidt?

Peter Schmidt: Yes, I'm here.

Suzanne Theberge: Thank you. And who's here from AAN?

Female: We've got Rebecca Swain-Eng and Gina Gjorvad from the AAN.

Suzanne Theberge: OK. Great. And is there anybody on the line who did not introduce themselves? Great. OK. Just a quick housekeeping item. I'd like to remind you to put your phone on mute when you're not speaking to reduce interference in the line and also please don't put

us on hold if anybody calls you because we'll get your hold music and it's kind of distracting.

So with that, I'm going to turn this over to Karen. Thank you.

Karen Johnson: Thank you, Suzanne. So just to start us off a little bit, we're going to do the very quick rundown tutorial here and overview of Phase 2. We are looking at 22 measures in Phase 2. And you probably noticed as you were looking at the measures, very few of the measures this time around have been tested for reliability and validity. And I know Suzanne sent an e-mail out explaining what was going on there.

But that will probably make things a little easier in some respects because there is not the testing and that's where things have to plow through on most of the measures; however, what is different is Phase 2 measures compared to Phase 1 measures really has to do with evidence. And for the next part, I believe the Phase 2 measures have more limited evidence space than the measures that we looked at in Phase 1.

So that will probably present some challenges to you as you have to struggle to balance what you know is important to do and practice and balance that with the idea that when we're endorsing national standards for quality improvement we are really looking for measures that were the most likely to drive improvement.

So we want to have a pretty high bar really when it comes to having evidence-based measures because it takes a lot of resources to collect data and make things public that sort of thing. So again, we just really want to have really strongly evidence-based measures and that is one of the reasons that we asked for our developers to be very transparent as to what evidence that exists.

I also just want to remind you – I'm sure you do recall from (these tutorials) and the work that we did in Phase 1 that we really do have a hierarchy of preference for measures. If we could, everything would be outcome measures. But that is very difficult to do often times. And therefore, we do have a lot of process measures. But when we endorse process measures, we tend to want to endorse those. They are most closely linked via evidence to decide the outcomes.

So the terms proximal and distal become important. And therefore, we ask developers to make us understand how their measure are focus, what they are trying to measure, how that links relate to the desired health outcomes? And what that does is it really helps us understand really how the proximity of the measure to the desired outcome.

And that exquisite statement, if they can actually vocalize that, also gives us the blueprint of the evidence that we are expecting to see. So if the link is verbalized then you also would know the evidence that you should expect to see in Section 1C of the submission. So I think one of the – really the fundamental question particularly as you're looking at the evidence sub-criterion is does the evidence meet NQF criteria for quantity, quality, and consistency of the body of evidence.

So again, it is a different question than, you know, if this is this an important practice to do. So with that set of introductory remarks, I think I will stop. And just so we're all clear about what we're trying to do on this call, we ask you to look at these six measures in depth. Go ahead and give it that deep dive on this.

I've asked many of you to be lead discussants just to kind of walk the group through the measures. And what we're trying to do is do things very similarly to how we do it in the (in-person) meeting. So lead discussant, I will ask you to very briefly just give a very brief description of what the measure is and what it's trying to do, and then, we'll start right after that on the criteria.

And with that, we would start with impact and discuss briefly what the results of the preliminary evaluations were. And with that, if there seems to be very few concerns about a particular sub-criterion, we don't need to spend very much time at all with a maximum of 15 minutes per measure. That doesn't give us a lot of time. So we will try to not discuss too much the things that everybody is happy with and instead discuss the things that maybe are concerning.

And pretty much, this will be a conversation between the committee members and – but do remember that we have the developers of this measures on the line. So if you have particular questions that you would like to address to the developers, please do so, and I'm sure they would be very happy to answer your question.

And because these are a little bit different in terms of thinking through the evidence, I might (inaudible) and possibly will play a little bit greater role perhaps in this workgroup call that I might in the (in-person) meeting because I want to make sure that pertinent points in terms of how to think about the different sub criteria are that we've touched on.

So with that, I'm going to hand it over to Michael who will start us up with Measure 1973. Michael?

Suzanne Theberge: I think your phone might be on mute.

Michael Kaplitt: Oh yes. I put it on mute because you told me to. Sorry. So yes, I just have a quick question before we start. I just want to let you know that I have to be off the call at 3:00 unfortunately. But hopefully, we can make a lot of progress by then.

One quick question though, so this issue of the reliability and validity testing, are we not going to discuss it because clearly that's not something that's been done for pretty much any of these measures and it sounds like you guys were accepting that and it's OK? So do we not – are we going to spend time even having a discussion? Because then we shouldn't bother discussing it, right? (Inaudible) discuss for most of these measures.

Karen Johnson: For the most part, that is correct. I think the exception is a discussion is necessary on the actual specifications of the measures. So if there is something that looks off or concerning to you in terms of how they are specified, how the measures are actually specified then we would definitely talk about that.

Michael Kaplitt: OK. All right. OK. Well then, I'm happy to start. So this measure is 1973 which is the Annual Parkinson's Disease Diagnosis Review and the goal of this measure is to try to capture the percentage of patients who are having their – who have been diagnosed with Parkinson's disease and then are having their diagnosis reassessed on at least an annual basis if not more. And the basis – so the numerator for this is the number of patients that are being reassessed. Denominator is all the patients – is all patients with Parkinson's disease with certain minor exclusion criteria.

The goal of this measure is based on the belief that Parkinson's disease is largely a clinical diagnosis. There are many of us who believe that there are other ways that could help with that diagnosis but none of them are universally accepted or considered gold standard.

So Parkinson's disease is still considered to be essentially a clinical diagnosis, and therefore, the initial constellation of symptoms that lead to that diagnosis may not necessarily accurately – given accurate picture what the patient's true disease is and that those symptoms can change over time and it is those changes and symptoms that could lead to a reassessment of whether the patient truly had Parkinson's disease or not. And so that's the overall goal.

And the rationale behind that is that treatments for Parkinson's disease – for idiopathic Parkinson's disease are effective usually for that disease and can be in most cases, but they are often ineffective in other diseases that can present like Parkinson's. So it is important to make sure that people are getting the right therapies and that they are not getting inappropriate therapies that can do the more harm than good if the diagnosis is wrong. So that's the general (just) of the goal of this measure.

Is that – I think – I think with that we could probably get into the specific sub-measure, you know, sub-criteria, right?

Karen Johnson: Right. That's great. Yes.

Michael Kaplitt: OK. So for sub-criteria one, which is impact – I mean I looked at – it's interesting because I'd look at the various reviews. I tried to upload as many as I could although some of them I didn't get to, but it sounds like – it seems to me like there was fairly good agreement on most of these things which is that – so the impact, I think, was generally felt to be high from my recollection. I don't have it in front of me. I looked at it yesterday.

But obviously, like I said, there is – there is pretty good evidence that there is a substantial misdiagnosis rate in – oh, thank you for putting that up. OK. Now, I could see it. So there is pretty good evidence that there is a substantial misdiagnosis rate in Parkinson's disease. And so if something – if there was a measure that could improve that, I think most of agree that that would have reasonable impact.

I mean I can tell you as someone who specializes in treating patients with Parkinson's disease in particularly with advance therapy such as surgery or experimental therapies that a misdiagnosed patient can be enormously problematic if you wind up doing a treatment

that is particularly an invasive treatment that may actually make them worse rather than better or if they get enrolled in a clinical trial that could prevent and otherwise promising therapy for moving forward because patients who would be incapable of responding to that treatment are enrolled mistakenly with the diagnosis of Parkinson's disease.

So there are many ways in which a measure that could improve the diagnosis would have real impact in both current treatment as well as development of future therapies and I think that's the – that was the overall view of most people. I think there was a couple that had concerns but – is there any discussion on that point?

Peter Schmidt: This is Peter Schmidt. I – in the submission, there isn't a lot that specifically addresses the impact of this particular measure.

Michael Kaplitt: Right. Well, I'm going to get to that in a second. I mean that was really more 1C which is the evidence. I was talking about the overall rationale because that's 1A.

Peter Schmidt: Yes.

Michael Kaplitt: 1C is really the evidence and I agree with that. If you want, we can move on to that because there I have more concerns about that.

Peter Schmidt: I was – I was not – you know, I'm new to this but I was not entirely clear on the impact statement. Is – I googled around national health priorities, national health goals, and I wasn't entirely clear how you arrived to that standard. But I do agree – I agree with Michael that this is an important factor and there is a lot of evidence from misdiagnosis.

Jane Sullivan: This is Jane and I would – I would agree. I think conceptually I would, you know, echo what people have said about the importance of the diagnosis, but I'm not sure that I find that compelling data in the developer submission.

Michael Kaplitt: Right. So let me – maybe I can add to that, because I agree with what you guys are saying. I mean from the evidence standpoint, which is the one (inaudible), that's why I had a major issue because when you look at the evidence that was cited – so there's reasonable evidence although (inaudible) even that is not detailed. I mean most of us in this field know that there is a big discrepancy and that there's a big error rate in diagnosis, particularly among non-experts and even among experts.

There is sort of an unattributed statement in the evidence that says that there is significant error rates in diagnosis but there is actually no data, no – you know, what that error rate is, what makes it significant, what the basis is for that is not referenced, but having said that, most of us know that that's true.

The bigger problem that I have – and I agree. I'm not saying that just because I know something that's the reason I'm going to vote in favor of it and you should provide the evidence. But I agree that that's a big problem and I think that in the end anything that can be done to improve that will make a big difference in Parkinson's disease.

The real problem here is that there is virtually no evidence provided to suggest that annual review actually makes that better. So for example, is there evidence that if somebody does not really understand Parkinson's disease, the general practitioner or general neurologist that's sees very few Parkinson's patients, if that person makes an inaccurate diagnosis initially, is there any evidence that ongoing repeated reviews actually improves that diagnostic accuracy by that physician?

Referral to an expert or something, that's a different story but that's a different type of measure. So that was my issue with this and I think that's what you guys are driving at if I'm – if I'm presumptuous enough to be paraphrasing what I think you're driving at.

Mary Van de Kamp: Michael, this is Mary. I – that is – that was my question. Obviously, the misdiagnosis is like high concern. We need to have a measure that drives that behavior. But a bad diagnosis one time does that necessarily improve if there isn't a change of – possibly a change of the – of physician in the specialty area. So but is it – is it one of the things that the more you look at the better the chance is that it will be discovered? Is that – you know much more about this disease relative to that than I do.

Jane Sullivan: This is Jane and I guess I have a broader question which is – I guess I was reading this as looking at – looking for data to support that the specifics of this measure, which is review of medications and for the presence of atypical features, had high impact. Then even though conceptually, of course, that makes sense. I didn't find that there was support that those two things would really impact care and I'm sure they do.

And I guess the second part of my question is this measure and one other one that we're looking at involves two different things together. So in this it's medications and atypical features and another one it's surgical, nonsurgical, pharmacological interventions. So I'm not sure. Maybe NQF can give us some guidance about how to really look at what the measure supposed to capture, how broad that is, and how much evidence the developer is supposed to provide us that that is really an important feature to look at.

Karen Johnson: This is Karen from NQF. And I think in terms of impact, we ask for very little in terms of having demonstration as impact. It's basically either does it hit a national priority goal or is there – the easiest one is does it affect a lot of people. So for this one, the developers tell us that there are about a million people who has Parkinson's disease. So that statement there enough – is probably enough to (inaudible) like impact would be OK.

But then you get into the question, as Michael said, as evidence. And there what we want to see is – we want to see evidence that the process, in this case, that's being put forward which is doing an annual assessment. We want to see evidence that there is some kind of desired outcome. So you guys are suggesting that the desired outcome might be improved diagnosis which would then link to improved treatment, and you know, better – you know, less morbidity.

But that is exactly the kind of evidence that we would like to see. And in this case, the developer has relied on some guideline information, and with those guidelines, they have been able to some extent see if – talk about the level of evidence because their guidelines

at least one of them was graded. But the grade or the (NICE) guideline with the level D which is based on community reports opinion and then the AAN guideline is – has a level B recommendation which is that it's probably effective.

So – and then I think the studies that underlie those guidelines have more to do – in the first one, the NICE, it has more to do about communications about Parkinson's. And then the other one I'm not sure that I wrote down.

Michael Kaplitt: But the problem – the problem here that I think a lot of us are having is that the issue with this – is that there is really not a single – even within those guidelines, OK? There is nothing taken out of those guidelines that says, “Here's the basis for which the guideline was written that says that this, you know, makes a difference.”

The reason that I personally am focusing on the issue of diagnostic accuracy is because that's the way this thing is written. I mean I personally agree that that's an important thing, but I'm not just putting my own personal viewpoint into this. If you look at the evidence that is cited – almost all of the evidence that's cited is referring to diagnostic inaccuracies in Parkinson's disease.

So that is what the presumption is that the basis is for this measure. It's not that I'm making that up. The problem is that all of that evidence basically refers to misdiagnosis rates or inaccuracies in diagnosis in Parkinson's. There is not a single thread of evidence that's provided that says that this particular measure that the annual review by anyone, any physician, improves diagnostic accuracy.

(Inaudible) it should be provided, but that's not – telling us that it's – that basically showing evidence that there is a big problem with diagnosis in Parkinson's disease really relates more to impact. It does not relate to evidence supporting this particular measure which is a different sub-criteria.

Peter Schmidt: And the NICE guideline, their quote under – in this section is “no evidence was found on the most appropriate frequency of follow-up after the initial diagnosis of the disease” and it says, you know, there are guidances that it should be – should only be diagnosed by a specialist with expertise on the differential diagnosis of Parkinson's disease. So it's very difficult to go from there to a general statement of a review of diagnosis.

Michael Kaplitt: Right. So one of the big concerns I raised later on which sort of relates to this but it's, you know, it's a different criteria is the issue of unintended harm due to the measure, etc. And in the same vein as what you just said, one of my concerns was that – first of all, the developer, you know, and this was a criticism that I made later on of this but the developer basically does not recognize any potential harm of this.

But in my view, if you have a measure like this that says that you are performing good quality by reviewing this annually and that we know has impact. There's no good evidence out of those impact when the general public does this.

So there's going to be a full sense of security in the validity of the diagnosis, let's say, if this keeps going on or vice versa. People may start to question the diagnosis because of the fact that things change that they're not familiar with, and they're incapable of handling, and then you change the diagnosis inappropriately by reviewing it, you know, that way.

You know, again, I think that we need to do a lot more to make sure that people have the right diagnosis and that they are being treated properly going forward and that they're having, you know, proper, whatever, reviews of everything. But there are potentially serious unintended consequences of this because people will think, "OK. Well, I'm doing great by reviewing this" and they keep reviewing the same wrong-headed information.

(Peter Schmidt): Yes, I totally agree.

Karen Johnson: So with that discussion, then your question in terms of rating the evidence is what is provided with that demonstrate that the evidence meets the NQF criteria for quantity, quality, and consistency.

Michael Kaplitt: Right. I mean personally put insufficient because I can't say it's low because in view it's not there. If the evidences were there but I thought it was poorly done studies, that's when I would rate it low. But when it's not there, I just – I say it's insufficient.

Karen Johnson: And that is the proper interpretation of the rating scale. Yes.

Michael Kaplitt: As well as my personal view. I don't know about others but that was just my view.

Karen Johnson: This is Karen again. A few people who did the preliminary evaluation still rated the evidence to quantity and quality as either high or moderate. So maybe the folks who made those ratings, is there anything that you know personally or that you saw in the submission that made you rate high or moderate rather than insufficient as Michael said he has done.

(Peter Schmidt): So I rated it higher than I think I would after this discussion because when I initially rated it I was focusing on the topic of the measure and not the specific wording of the measure.

Karen Johnson: OK.

Peter Schmidt: So there is – there's reasonably good evidence that diagnosis is an issue. You know, there's quite good evidence that – you know, there's Nebraska Registry Study. There is the – there are a number of things about diagnostic uncertainty addressed in the NICE guidelines in terms of how patients learned about their diagnosis that looking back it is Class 1. You know, it's not RCT type class but it's a deep dive into data that says that patients who were poorly diagnosed.

So the issue of diagnosis has good evidence. The specific measure I addressed in the next section. So I may have done that incorrectly. But I thought that, you know, taking this –

taking diagnosis and review of diagnosis as something that's important to consider definitely is supported.

Karen Johnson: OK. Great. Thank you, Peter. And I think in terms of your note that how you kind of answer the issue in the next section and what you will find as you go through this criteria and you get more or even more familiar with them is that a lot of the same issues have to be dealt with under evidence and under reliability and under validity. So you may be, you know, waiving the same kind of thing and in several places really.

Does anybody else have any comments about maybe why they thought the evidence rated high or moderate? OK. Michael, do you want to go ahead and talk quickly about the gaps information that was provided and how the committee rated the gaps.

Michael Kaplitt: Yes. I mean, you know, again the performance gap information to me was a little vague. You know, meaning that again I didn't see a lot of evidence that show – there was one paper that I think – though – but it wasn't even, I think, in this measure. It was in another measure that I had reviewed or something. But there was some data in some measure that showed that, you know, a significant percentage or not having the diagnosis reviewed annually.

So I forgot exactly what it was, but it was something – my recollection that it was something like 50 or 60 percent of specialist are reviewing it annually and only maybe 35 percent or something like that of general practitioners are reviewing it annually. But I don't think that it was actually in this measure that I saw that. I think it was in a paper from a different measure that we reviewed.

So I mean the evidence was OK. I guess. I mean I have a big problem with relying on the NICE study because this is – because what ever performance gaps there in Great Britain is not necessarily the performance gap here. It is a different healthcare system.

So you know, with regard to the gap in the United States. I don't know that that's great evidence for that. This (inaudible) study that they cited was a particular, you know, drug study about patients with Parkinson's disease or something questionnaire. You know, they was talking about how like education improves diagnostic accuracy but I don't know that's a great evidence of performance gap.

There was another paper, I forget which one, that I think did show it. So I thought it was alright. I thought that there was – even my (inaudible) that there is probably a big problem here but I didn't see a lot of data that disparities among different population.

I saw disparities among Parkinson's disease treatment, et cetera, among different populations but not about this specific measure of regularly reviewing the diagnosis even though I suspect that's true. But I didn't see any evidence on that. So that's why – I forgot. I think I may rate it as a medium but I don't remember exactly because I thought there was something there.

- Karen Johnson: OK. Great. And just so we're clear, since the measure of focus is about doing an annual assessment, then what we would expect to see for the gap is some sort of indication of what percentage of physicians do conduct an annual assessment or maybe even better is the variation amongst physicians who do annual assessment.
- Michael Kaplitt: I know. I agree. I think – I forget which one. It was like the 2004 or 2007 paper from a bunch of (inaudible) and a bunch of other people. I just – I know him so I remember his name from that. But I think it was cited in one of the other reviews that actually more upon this particular point, but I don't know if it was actually in here.
- Karen Johnson: OK.
- Peter Schmidt: No, that was in here. That was in here. The (inaudible).
- Michael Kaplitt: So it was. OK. Fine. So I mean I think that's how you could do that actually put some of those numbers too and that's why I said that was something at least.
- Karen Johnson: OK. Great. OK. Any other concerns about gap or questions about gap?
- (Peter Schmidt): Just one comment. The NICE guidelines actually drawn data from around the world. A lot of these papers were done in the United States in the NICE guidelines. It's not just U.K. data.
- Michael Kaplitt: OK. I, you know, I thought that their – I thought that most of their – most of their point about disparities and other things related to data from their own healthcare system. So I didn't realize that. I knew about some of the other things in terms of, you know, the importance of doing certain treatments and things like that came from around the world but I didn't realize that their healthcare delivery guidelines came from that. So if that's wrong, then I apologize.
- (Peter Schmidt): No. They draw a lot from U.K. studies on disparities but they referenced bunch things on not racial disparity but on disparity of practice.
- Michael Kaplitt: OK.
- (Peter Schmidt): Across physicians – you know, across general physicians versus – so this performance gap versus disparities. They're disparities gap is not appropriate but their performance gap stuff is.
- Michael Kaplitt: OK.
- Karen Johnson: And I think Michael hit another point just in terms of the disparities information. I think not just on this measure but on several of the other ones. A lot of the disparities data refer to adherence or treatment prevalence – sorry, prevalence of PD or adherence to meds or that sort of thing.

But if you were looking at disparities data in order to demonstrate the gap, you would expect to see disparities related to the measure of focus. So again, it would be disparities and annual assessments. That's just a clarification.

OK. Michael, do you want to go ahead to reliability and validity? Again noting that testing that haven't been done yet but this could be a discussion of the specifications if there's any – anything that's needs to be discussed under that.

Michael Kaplitt: I mean, you know, (inaudible) in the fact that, you know, there – you know, that there's insufficient reliability and validity data because as you said it hasn't been done. Beyond that – I mean in terms of like the numerator statement, and you know, denominator, whatever, I don't personally have as I would call major issues with that.

Jane Sullivan: This is Jane and I guess I want to back to the point of relative to the numerator. There are two different things here. So I'm not sure exactly how that would captured then how you would – do you have to have both things documented in order to pass on this measure? That's just not clear to me when there are different aspects to the numerator.

Risha Gidwani: I agree and even – this is Risha. The presence of atypical features – let's say that – they put a few out there. Let's say that the physician reviewed one of the current medications and one of the atypical features, would AAN consider that that physician gets a yes according to this measure?

Karen Johnson: Is that a question you'd like to address to the developer, Risha?

Risha Gidwani: Yes, it is.

Karen Johnson: Rebecca, would you like to answer that?

Rebecca Swain-Eng: Actually, Gina will answer that question for us.

Karen Johnson: OK. Thank you.

Gina Gjorvad: (Inaudible).

Karen Johnson: Gina – go ahead. Make sure you're not on mute.

Gina Gjorvad: Yes. Can you scroll up so that we can see the actual or scroll to the part where we can see the actual information on the measure? So you're asking about the numerator statement.

Risha Gidwani: I am. So as Jane was saying, there are two components of the numerator and then even with each of the two components, which are the review of current medications and the review for the presence of atypical features and that latter the presence of atypical features, there is a number of different examples.

The question becomes what if you only review medications and not review atypical features? What if you review both medications and only one or two atypical features? How would the physician manage the (scores)?

Gina Gjorvad: Well, because there's an "and" there, they would have to do a review of their current medications, which I'm assuming that they should be doing anyway, and then also look for an atypical feature. So if they find one, then – and they only find one, that's fine. But as long as they're reviewing and making sure there are no atypical features, that meets the measure.

Risha Gidwani: What was the rationale for not specifying what atypical features should be assessed?

Gina Gjorvad: We try not to, you know, dictate exactly, you know, what kind of assessment test they have to do and what kind of, you know, things they are looking for so that, you know, if something were to change before the measures were re-reviewed and there was another atypical feature that was identified in the interim. We're not saying you can't do it.

Risha Gidwani: I'm not a clinician. So I defer to my clinician colleagues. But to my colleagues, if let's say, a physician only assessed fall risk and didn't assess symmetry, symmetry onset or progression or tremor, I mean that to me seems like it's not actually providing necessarily high quality care.

And in my preference will then be to say of all of the characteristics, we know that it should be monitored. Let's specify those, understand this is the minimum, and then if new characteristics come up to the literature as being important, we just add them to the measure. But – clinicians, what's your take on that?

Michael Kaplitt: Well – this is Michael. So I can tell you that, you know, the way I originally read this – but I agree that the wording is not very precise. In fact, the physician is evaluating the patient for the presence of any atypical features which makes the presumption that they're looking for all potential atypical features and noting any that occur. That's the way I read it. When they said for the presence of atypical features, meaning did they have any atypical features not are they specifically only looking for one type of atypical feature but did they have any which makes the presumption that they have to be looking for all of them.

I agree with you that it could be enumerated. My only concern is that the statements earlier in the – in the measure that kind of outlined what certain types of features can be considered atypical, you know, then you're getting into a whole other level of sort of evidence that's going to have to be justified as to whether every one of those criteria are really justifiable as being considered atypical because I am not sure I agree with every single one of them that was outlined in there or that they will have equal weight.

So unfortunately, the diagnosis of Parkinson's disease and the presence of atypical feature is still a somewhat judgments based or somewhat subjective, you know, concept and I think that the goal of this measure is to basically – or of this numerator is make people

think about the fact that if something out of the ordinary – that's not typical for Parkinson's disease to develop that should be noted.

Whether there would be benefit or harm in specifying certain atypical features, I just don't know. I would personally have my concerns, but I agree with you that the way it's written is vague enough that it can do equal harm by letting people kind of feel like they've done their job when they're not really comprehensively evaluating the patient. So I don't have a great answer for this because that's some of the vagaries of this disease.

(Jane Sullivan): To discuss this from the atypical features (piece) and the other issue was – I'm just playing devil's advocate, why isn't there a measure that says does a med review, that's one measure, and then there is another measure that says assesses for the presence of atypical features? It just seems like there is an awful lot of stuff in here that would be hard to determine whether somebody was actually successful on this measure.

Female: Yes. I think that goes in to the quality improvement piece. If the physician scores a no on this, you don't know whether the intervening factor needs to be review of current medications or the review of atypical features.

Rebecca Swain-Eng: This is Rebecca and I'm at the academy and I can speak to about a little bit why they are incorporating the same measure. This measure initially started out to be an annual review measure and the two things that they found were the most important things to review were the current medications and the review of any atypical features that may indicate that the diagnosis of Parkinson's disease is not correct.

So they wanted to put those two measures in there because this is an annual review of Parkinson's disease, the diagnosis, and I felt those two issues were the most important for the clinicians. And they felt by looking at the emergence of any atypical features, this could influence any prognosis and medical treatments. They found that it was very important.

And I'm sorry I didn't catch the name of the physician that was talking earlier. I believe it was Michael who was talking about whether or not this is referral to just one atypical feature or if it could be any. The intent of the measure was that this is looking for any atypical feature and that the reason that it's not specifically specified that you have to do this one exact test that you're looking for, this one specific feature is that the clinician group felt it is important to leave it up to the clinical judgment of the clinician that was using the measure. (Use) the best judgment in what they felt was important for that specific patient.

Michael Kaplitt: Yes. And I would say, you know, that – as I was saying earlier, I mean I don't disagree with that overall. I think to the point, you know, if I felt the evidence was here to support that, I don't disagree with this as a numerator statement except for the fact – I agree it could be maybe worded better.

You know, you could say review of current medications and review of – you know, and review for the presence of any atypical features or something like that, you know, not just

the atypical features, meaning making clear that you need to look for any type of atypical features that should be there.

I would say that the value of having them from my perspective as a clinician of having them in one measure is, as you said earlier, let's say somebody does a good review of medications but doesn't review atypical features or vice versa. If the evidence were there to support this measure, I would say they should fail if they only did one and not the other.

My personal bias is that doing both of these things is important. My problem with this measure goes back to number one, which is the evidence. But I'm not separating the reliability of the numerator statement out from the evidence making the assumption that if the evidence were OK, would this be a valid numerator and I personally think that if the evidence were there, both of these things probably should be in the single measure. You should fail if you haven't done both.

Mary Van de Kamp: Karen, this is Mary. I have maybe a more tactical question. Just as I am trying to think if the – this is a physician measurement, is it – is it true claims data but it looks like just an evaluation and that's how they determine it rather than what was done within the evaluation?

Karen Johnson: Yes. The way they specified it – they actually specified it for lots of different data sources. But if it were claims, they are just attesting to it through a CPT-2 code.

Mary Van de Kamp: Right.

Karen Johnson: Yes.

Mary Van de Kamp: So Michael, is this – and this is – is there is a CPT code that would differentiate assessment within that or would it be just an evaluative code?

Michael Kaplitt: Well, I honestly don't recall. I have to look at that because I don't – I don't think that there's a code that specifies all the different sort of pieces of it.

Mary Van de Kamp: So I guess...

Karen Johnson: No. There is one CPT category 2 code for the whole measure in itself.

Mary Van de Kamp: That's what I know (inaudible).

Karen Johnson: (Inaudible) Part A and Part B.

Mary Van de Kamp: Yes. And so as we think through this we know that this measure is going to be used for an evaluative measure for physician. The only thing that we can really tell from the kinds of data that for the most part that are most easily accessible as we learned is that it's through the claims data. And then it's sort of a mute point and that the intent is that, you know, the definition of annually valid would be inclusive of all of these metrics.

(Michael Kaplitt): Right. But isn't that kind of a systemic problem with many PQRS measures?

Mary Van de Kamp: Right. That's what I'm saying is that...

(Michael Kaplitt): Unique to this now unfortunately.

Mary Van de Kamp: Right. Yes. That's kind of what I'm pointing out that we can talk about it but then if it gets through you – if one of the ways that this used then and it doesn't differentiate, we're still left with a global evaluative code that would determine whether they did or not and not what they did.

(Michael Kaplitt): Right.

Rebecca Swain-Eng: One thing I would – this is Rebecca again. It looks like I just jumped real quick. One additional point that I'll make is that the Academy has developed a module for Parkinson's disease that has this measure actually split up into two parts; whereby, the conditions that are completely in their maintenance (inaudible) Part 4 Performance and Practice module, they are asked to report whether or not they are doing Part A and Part B and they looked at it separately the reason that data combined.

We've only got a few people that have completed the study so far but it is in place to see where the gap is. Is it really with doing the review of the current medications or is it with the review of the presence of the atypical features. So we will be able to combine that data to know where the gap lies, is it Part A of the measure or Part B of the measure. And we're combining the data from both Part A and Part B to get the overall score for who is actually completing the measures successfully.

Male: So can I just make a suggestion since we're already 50 minutes into this call and we're spending time on a measure that by agreement there's no data on right – or subcategory where there is no data on? I think the way NQF said this – was that the main thing we should be reviewing for this particular part is whether we agree with the numerator statement or not.

So I think the discussion about whether they should be separate or not is a valid discussion. But I'm just worried that we're starting to get off track here, you know, into areas that are not relevant to what we can talk about today.

Karen Johnson: This is Karen. I think you're right. We are way over time and I think it was OK because a lot of these questions that you're rattling with are going to be the same throughout all the measures. And one thing that I will note just from the NQF perspective and having, as Michael said, the stronger measure of where, you know, both things are important and you should fail if you don't do both of these important thing.

NQF definitely recognizes that kind of thing with the idea that clinicians could do internal quality investigations, if you will, to figure out where exactly is it failing kind of the way Rebecca describes with her – with the system that they're setting up. So NQF would not – would not necessarily think that two measures would be better than one combined.

Is there anything that you want to bring out for usability or feasibility, Michael?

Michael Kaplitt: Yes. Hold on. So for – where was it? Yes, for feasibility, you know, again – you know, when you get into the various subcategory – usability, I don't know that I have. I just again thought that it was insufficient because there's just no data that's provided.

You know, all the statements are, "Well, we don't have data yet. We're working on it." But I don't think that it's, you know, personally a terribly difficult measure to use. As we just said, it may be too easy to use. So I don't – I don't know. You know, I don't think there's much data there.

As far as feasibility, everything from four, you know, below – 4A which is how the data elements are generated, again I just felt that it was insufficient. You know, 4B, are the elements needed for measure specified available electronically? The answer is some data elements are electronic sources. I don't know what that answer means, you know.

So which data elements and which aren't then why are some – so that means we can't or cannot use electronic sources for all the data elements and then 4B electronic source that could be specified by the fourth quarter of 2012. Well, the measures have been submitted here now. So you know, same thing that other things which are listed are not applicable. So the feasibility, I just – again, I just don't think that there was a lot provided.

(Peter Schmidt): I have two comments. One on the usability, my understanding is that the usability question is not about usability by the physicians but usability for public recording, you know, by third parties. And as we discussed earlier, there is no evidence that somebody who doesn't know how to diagnose Parkinson's disease could diagnose this the second time around.

Michael Kaplitt: Yes. I would agree, but I'm sorry. I missed the – in my comments specifically for the – for the three, you know, A2 answer, I said the exact same thing you just said which is that the usefulness for public reporting – in fact, you know, the results are meaningful, understandable, and useful for public reporting, I agree with that, that's – I mean I guess I made that comment earlier when I was talking about No. 1, that I didn't think that it was but I agree with you on that.

Peter Schmidt: And then in the feasibility, I think that – that the submission is kind of incorrect because most of these billing codes are stored electronically and so almost any clinic you go can pull up a list of how many patients they have seen in the – anybody using an EMR can pull up a list of how many people meet the – the denominator criteria and if you got electronic billing, then you can pull up the patients who have the numerator criteria and it's pretty, pretty common that people have it.

So I – you know this stuff seems to be in – I go to clinics all the time and asked them for essentially the new numerator statement or – I'm sorry the denominator statement and they give it to me, 5 minutes. So I actually think this is a quite feasible measure, it's just the other issues that we have discussed.

Karen Johnson: OK, any other comments on usability or feasibility for this measure?

Michael Kaplitt: Well, maybe again since these – these statements were almost repeated verbatim in all of the other measures maybe, since it probably doesn't have to be re-discussed every time, maybe we can ask developer when they – and answer to that point when they say some data elements are available electronically and that, you know, others are going to be reevaluated or, you know, for their availability or whatever in the 4th quarter. What are they are referring that's not available and that needs to be determined this – this fall?

Rebecca Swain-Eng: Sure, this is Rebecca, I can speak to that. So, as the one clinician I was just mentioning, yes we do have the ICD-9 codes that are readily available and your EHRs that can help you identify your denominator for the patient population for this measure. What's not quite in there yet is what we're developing which are called eSpecification which are all of the code sets and the value sets that go into developing the eMeasure which works directly with the EHR to be able to have to not to do a chart obstruction or to have a – have to do a large data gathering where you're searching through medical records.

It's something where it (inaudible) to EHR to be able to – to (quickly) have that information available within your Epic System, or whatever system you're using, so that you can see very clearly that this patient – with this patient whether you did or did not meet the measure, performed the measure successfully.

So the eSpecifications and the eMeasure are something that measure developers are relatively new at developing and I know the National Quality Form is helping developers to develop these eSpecifications but it's not simple to do it. It's very time intensive and we're working with a couple of different consultants from (inaudible) and then with a code set specialist, if you would, with RxNorm, ICD-10 (inaudible). All these different coding systems going forward, so that we can develop these to go into the EHRs, into the EMRs, that's what we mean by (some data) elements have not been fully specified yet in which is what we're on currently in the 4th quarter of 2012.

Peter Schmidt: So, Rebecca, you're going to make a validated assessment that if it's completed, it's going to go into the work flow and – and, you know, if you complete that then this CPT code will automatically be selected if you're using (inaudible)?

Rebecca Swain-Eng: So, it's – the developing the appropriate code sets, value sets that will go into the eSpecification and then working with what the (inaudible) has developed as the Measure Authoring Tool and Quality Data Model to get an eMeasure format. So basically being able to turn it from human readable into computer readable. So working with your EHR, so you perhaps would have a pop-up that would ask about the question or you would have a specific feel that would ask specifically about this measure in itself.

So that's we're working towards, is getting – so it's more – I don't really want to use the word automated but it's – it reduces the burden on the clinician to complete the measure

and that's something the Academy is looking forward with all of our measures that we developed in the past and will be developing in the future.

Peter Schmidt: So could you revise this based on the criteria that you're using in developing those sets like assessed diagnosis according to UK Brain Bank Criteria or something like that?

Rebecca Swain-Eng: It's currently written for ICD-9 codes, but something going forward, we're going to be developing it for ICD-10 which I'm sure everybody is aware will go into affect very shortly and then also looking at a lot of systems are moving to the (link) system and being able to purposely have the codes that go into those systems. So no matter what diagnosis system you're using or coding system you're using, you will be able to pull the patients that you need or find the patient that are eligible for this measure.

Karen Johnson: This is Karen and while this is a really fascinating discussion, I think given our time constraint I think we need to stop talking about EHRs and eMeasures right now. The only thing I will note is that NQF does not require at this point submission of eMeasure specification. So, it's not something that we necessarily expect to see from developers.

Mary Van de Kamp: This is Mary, I wanted to just speak to the usefulness for public reporting under 3a and it's – already being used in the PQR system. I guess my questions goes back to, is this a useful measure relative to the fact that, if we're only asking is it done and that this through – through a code where I was able to say yes or no, then it's useful.

If we're looking at the quality of that, I think we all sort of struggle back to what is that evaluation entailed but I think if the purpose is to look to see if something occurred, it's very useful. And that kind of goes back to what I was – I think we're talking earlier is that, is this – is the purpose – overall purpose of this measure to just ensure that evaluation are taking place and I don't think so because I think, as you pointed out, whether a quality component.

So, I'm almost back to the beginning which was in light of the time is not helpful but is the purpose of this, to just determine if evaluations are occurring on a regular basis and is there evidence to show that works because that ultimately tells me whether it's useful or not in the usability piece.

Peter Schmidt: But how do we finish this?

Mary Van de Kamp: Exactly.

Karen Johnson: Well, what was done is we've taken practice time here to go through all of the sub-criteria but those of you who were present for phase 1 know that we will do is go through the sub-criteria and the must-pass of criteria are exactly that, they must pass.. So just for example, is you got to impact. That's very first one on the list right now. Is it failed impact according to your – this joint committee's evaluations, then we would stop right there and it would go no further. So you wouldn't even get to have the juicy conversations about evidence or usefulness and that sort of thing.

So in terms of the workgroup call, basically we wanted it to be able air all the different concerns that you had when you took the deep dive and I think we've been successful with doing that. In the in-person meeting, it could very well be that some of these points won't be raised because we just don't even get to them, you know, if the measure dies early on.

Michael Kaplitt: I mean my suspicion is and unfortunately I'm going to have to leave the call but I don't – I will tell you now that my comments are pretty similar across the board. I mean I think that the biggest concern her for most of these, is the evidence issue which is still a must-pass criteria and as you said is even if their liability and validity are – are lesser issues, you said evidence is an important issue for you guys and it's obviously important for us.

And the issue is, is the evidence presented justify the rationale for using this particular measure that it's likely to have a meaningful impact on quality and that's the problem here is that we all know that most of these things that are being proposed are things that probably are important or that maybe important but the evidence is not great and there is – there are arguments to be made that it can actually do harm if it's just implemented without clear evidence because you could be simply reiterating the problematic data or problematic diagnoses from the beginning. So, I think that's unfortunately just a theme across many of these measures.

Karen Johnson: Thank you, Michael and thank you for staying on our call and hope your next thing does well.

Michael Kaplitt: Thank you.

Karen Johnson: And I think Michael is right. These measures are very similar in many ways, you know, as he mentions the ways that the feasibility and usability sections were filled out, were very similar and that sort of thing. So, I think as we go through the remainder of the measures, unless there's burning issues on – on these particular things, we probably won't spend much of any time on those pieces and maybe – maybe we should just concentrate on the first criteria, the important to measure a report and talk very briefly as we go through about impact and gap and then spend the majority of what time we have left on evidence and you know, we don't have to even spend the entire remainder of the – of the hour. I mean if – if your answer and your feelings are the same all the way through for all the measures that's fine too.

Peter Schmidt: So, if there is some final outcome to this first measure.

Karen Johnson: Well, I think in terms of your evaluation the first time through, it looks like it was and I'm just looking at my notes, it looks like it was a – a split between yes it should be recommended and no it shouldn't be recommended. And I think as Michael stated and – there are some difficulties with the measure and the big one is evident and there's not going to be like a final, final from the workgroup.

What we will do is write up a summary of your conversation, you bringing up the point that you guys felt was important and we will provide that summary. It will – it will look very similar to what you already had in your hand and what's on the screen. It will – it

will have the notes that you guys made as you went through and did the preliminary evaluations but we will go through and add in summary and then in the in-person meeting you can take the summaries from all the different workgroups and use in – in some cases questions will be asked in the workgroup and possibly answer to your satisfaction and – and maybe you don't need to use time in the in-person meeting to cover that ground.

Michael Kaplitt: So Karen, this is Michael. One quick question, I just don't remember from the in-person meeting last time, in the – in the information we get from the workgroups, does it show this – the voting outcomes on this sub-measure as well?

Karen Johnson: You know in the past, we always have and quite frankly this time around I was not going to include the voting.

Michael Kaplitt: I would argue strongly to not include it and I tell you why but unless you want to spend time re-voting all of these things. I think it is clear from the discussion that the vote that was taken initially for some of these measures is not going to turn out the same after the discussion. There needs to be a lot of time re-voting if that is the case and I don't want to be in in-person meeting where everybody every time keep saying, why – why did you guys vote like if you feel this way, you know.

Karen Johnson: Right, right.

Peter Schmidt: Yes, I agree with that.

Karen Johnson: Yes and I think the other thing that we have learned is – not so much for you guys because, you know, this is phase 2, so you know how the process worked but – especially for folks who are (brand) new to the process. This – you know this workgroup in doing the preliminary evaluation is really a way for you guys to get used to how to rate and we often her statement like, “oh, I didn't realize that is what I needed to be thinking of and if I have to vote again right now, I would change it.”

So you know, again, this – this – this voting numbers are really to kind of kick off conversation. That conversation had been kicked off now and I don't think I'm hearing from you guys that you actually want to see those numbers. So, we will not be showing those numbers.

Michael Kaplitt: OK great, listen, I'm going to run. I'm sorry but thanks very much.

Karen Johnson: Thank you Michael.

Michael Kaplitt: Bye.

Jane Sullivan: Karen, can I – this is Jane. Can I ask question just for clarification with regard to the past discussion. If my memory that in the in-person meeting, the person who was presenting the measure briefly summarizes the conversation that went on in this workgroup call. So, that we certainly could do without numbers but am I clear that would be the same format in the October meeting?

Karen Johnson: Yes, so I think the difference would be in the October meeting for example, let's – let's say that for – for this measure that we just went through, let's say that nobody had any concerns about impact or performance gap. You would in – in the meeting, what you would do is introduce the – the measure very quickly and then we would discuss impact and you would probably say something on the order of committee members felt that the measure developer demonstrated this measure had impact, and you would probably leave it alone.

We would then ask you to vote on impact, then go to the next thing, gap and if there was no, you know, major points with gap and everybody pretty much agree that gap was demonstrated, you would – you would say something along those lines. And then like for this one with evidence, when it comes time to talk about that, you would start, you know, lay out the three or four major things in – that came up on evidence. And again, you can use our workgroup summaries that will provide you to help, you know, remember those things.

Jane Sullivan: Thanks that's helpful.

Karen Johnson: OK, good. Yes, I think what we've learned is we don't want to, (10) minutes of our meeting talking about two people said and two people said that. That's not that helpful.

Mary Van de Kamp: Karen, this is Mary and has a memory similar to what we did with some of the (inaudible) as we look at this and I think to your point and I don't know what the other committee members feel but I think unless there would be something different in our measure, maybe we could go through it like that but – but I think that as you said, there's – there's a concern that it's consistent across the measures.

Again, while I am very supportive and advocate for the rehabilitation component, I'm – I saw – I feel that there are some of the same concerns, so I – I just been trying in light of time in knowing that we had been through this before and other measures that are (firmly) basis. Is there way that you think that we could address these and not restate?

Karen Johnson: Not – not go through each one in particular?

Mary Van de Kamp: Or we could go through each one but we would then highlight if there's anything different or, you know, kind of recognizing that all lead through there and it was, you know, with the same concerns evident and then move on, you know what I mean. I'm just trying to think through because we – we have done it, we're challenged by this in the past in order to give each measure the right amount of attention. I don't want to lump them, absolutely but in order of trying to be sure that we don't have to restate and make sure that we identify if there are significant changes that we could touch on them but – but maybe the overall thought of the work leaders is – is there something significantly different.

Karen Johnson: Right, no I think that's a great idea. As I was going through things, I think the things that I noticed oftentimes the gap really wasn't noted very well because the measure focus may not even – I mean these are new data.

Mary Van de Kamp: Right.

Karen Johnson: New measures, so there might not be a lot of information to pull from but I think in general the things that were similar across was an insufficient evidence in terms of the gap that is out there and then the evidence is the big one. So maybe if we just walk through each one and we'll just talk very briefly if there are different points or maybe – maybe disagree, maybe our general agreement is that there isn't evidence that one of you know something because, you know, this is what you do when you know that there is evidence for – for something. So why don't we try it that way and see how we – how we do?

Peter Schmidt: Great, let's – we should probably move on.

Karen Johnson: Yes, yes, so Jane you want to take over on 1982, the psychiatric disorders assessment?

Jane Sullivan: OK. I – I'm looking at and I agree with you there's a lot of similarities. So, this is a new submission from (inaudible). This is looking at people with the diagnosis of PD who are assessed for psychiatric disorder. And I think it's – seems like most people who looked at this, 5 people out of 6 thought that the impact was high.

I think as compared to the prior measure there is some evidence in here about the percentage of people who has psychiatric disorders with PD. So it's specific to the measure and it breaks down the types of psychiatric disorders, so I guess I would say that it seems like the – the impact in this regard for this measure is – is relatively well supported.

Karen Johnson: OK, I – yes, unless there's any disagreement with that statement, let's go onto gap.

Jane Sullivan: I think that the performance gap here was similar to the prior measure, was not well reference. It was hard to distinguish opinion about performance gap from actual data, was largely conceptual and the one problem I had was that the one piece of data which was the patient's survey, asking them whether they'd been assessed by a mental health professional. I don't know about the validity of that data, so I think that while 4 out of 6 people thought that there was evidence for performance gap or that it's a tie, it was similar to the prior measure not as well supported.

Karen Johnson: OK, any – any discussion from the committee members on – on that summation?

Jane Sullivan: OK, I take that as a no discussion. So moving on, I don't know that there's much that can be said about this measure in terms of the evidence that's very different from what was said about the measure, just looking at what people wrote. I'm not compelled to think that there's much other discussion points here unless other people do. OK.

Peter Schmidt: So I – let me, I just want to add a lot – some of the evidence says that this is difficult, that depression is difficult to diagnose in Parkinson disease because of – because the interactions of motor features. And so I think that's going to be important when we get to

the actual numerator statement where it doesn't specify any sort of validated instruments for your assessing depression in Parkinson's.

- Jane Sullivan: I think that's an excellent point and it goes back to a set measure that kind that says, that you will do it but not how you will do it and that goes to quality. You could – you could check the box that says I looked it but how – how well you actually are able to differentiate psychiatric disorders from not depends on the tools and the methods that you use to assess that and that's not spelled out but I think that goes to – that goes to measure specification if I'm correct.
- Karen Johnson: Yes, that's right. So, everybody's in agreement about lack of evidence presented in terms of what this measure is trying to do, unless I hear otherwise? OK for the specs. You've noted that there is not a – instruments and not then specified. Any other questions or concerns about the scientific acceptability, either well in this case in which data, the specs.
- Risha Gidwani: The – this is Risha, the developer cite a NICE guideline but the NICE guideline recommends following the evaluation with treatments if there is a need for the (inaudible) condition but the developers do not actually make that link to treatment just from a larger quality of care perspective. If you assess the person and determine they have a psychiatric disorder but then they're not link to treatment, that doesn't seem to really be serving the patients' needs. I'm sort of wondering why there isn't that step further to actually seek appropriate treatment for the patient if you get a diagnosis?
- Rebecca Swain-Eng: This is Rebecca, again in behalf of the developer. It was assumed that if you did identify an issue that you would appropriately treat the patient. It's not (exclusively) said the measure but it's assume that you use your professional judgment and responsibility to appropriately treat the patient.
- Karen Johnson: And this – this is NQS here, so I think – again this takes us back to that slide about the hierarchy of measures and preferring measures that are more proximal to desired outcome. So, I think the NQF preference would be to have if you are going to do a process measure, you would have a process measure on treatment and you would assume – even if you fell backwards, you would assume that if you were doing treatment, then an assessment has been made.
- Jane Sullivan: So, it's that question not relative to this particular measure but – but maybe another measure, a process measure, is that what you're saying Karen?
- Karen Johnson: No, I'm just pointing out that I think part of the problem about the evidence with these measures and really does go back to the – the difficulty or – not the difficulty, the – the hierarchy of preference. So, there – there lots – there's lot of evidence about the types of treatments and – and that sort of thing and less evidence about assessment.
- So, I think what you guys are pointing out was, Risha with your treatment question, is really you're – you're suggesting a gap in the measure in the measure world and – and you're suggesting, you know, you're making suggestions on other measures that the developer may want to consider.

Jane Sullivan: Yes, (inaudible).

Peter Schmidt: So on the treatment issue, my assessment – this was – there is a sort of all or none validity aspect to this where you can say no one who is – you know everyone who is not assessed for depression, gets no treatment. And so when you take the studies of people who got treatment and showed that it was effective, then you can make the argument that assessing for depression is the first step in treating for depression when it's found. And so, you know, the all or none methodology is a reasonably well accepted methodology for establishing evidence.

Jane Sullivan: Well it kind of goes back to some of the measures we've said in the – in the first wave, referred for rehabilitation, assumes that the appropriateness of rehabilitation has been assessed.

Peter Schmidt: Right. You know, but I – I have the same problem with the fact that, you know, there – there is evidence that diagnosing depression is challenging in Parkinson disease and that many validated instrument for assessing of depression in the non-PD population are not appropriate because they – they include in the set the physician assessment of aspects of the patient's affect that will be effective by motoric symptoms of Parkinson disease, OK.

Karen Johnson: So again, I think you're giving the developer several good ideas about potential avenues for other measure development. So, I – I think what I'm hearing Peter is that, you know, if you were going to do a measure about depression in Parkinson's, there are some things that you have to consider when you're building that measure.

Peter Schmidt: Right.

Karen Johnson: OK, is there any other discussion that you want to make in terms of 1982 – measure 1982 that hasn't already been pretty much covered?

Jane Sullivan: As you look at the – people made I think (inaudible) mirrored the kind of comments that people made on the first measure, so I'm not sure that there's anything else that warrants discussion.

Karen Johnson: OK, well with that, let's go onto measure 1985 and I'm not sure, did Dr. Scariano joined us? OK. Just briefly, this measure is looking at patients who are queried about sleep disturbances at least annually and that's the numerator and the denominator is Parkinson disease patient. And I think in terms of impact, the developer did mention that there's lot – there's lot of Parkinson disease patients. What they didn't tell us is how many of them had sleep disturbances, at least they didn't write in that section. I think it was addressed a little bit later on in the submission.

But gap, I think it's pretty much the same discussion that we had before, to have shown gap I think what they need to show is what percentage of physicians do not ask annually about sleep disturbance or alternatively what is the variation in terms of rates of asking about sleep disturbance.

- Peter Schmidt: Well I just – again there’s an all or none. You can look at evidence of injury due to sleep disturbance or traffic stop for untreated sleep disturbance as evidence that patients have got untreated sleep disturbance. It doesn’t go to the issue of whether it’s queried about but I don’t know if we, you know, it said the link from querying to treatment is not obvious.
- Karen Johnson: Right and that – that you put your finger on it, you know, in terms of gap that’s – that’s what we want to know because what you’re saying you want to make a – a national standard for querying. So what we’d like to know is, you know, if everybody is already doing it, why do you need to measure it? You know, maybe there is data that tells us that everybody isn’t already doing it and if not, then that’s what we would like to see in the section. Does that make sense?
- Peter Schmidt: So let me just (pull), I – I said I did not – I did not see evidence of high impact going back to validity.
- Karen Johnson: OK, OK.
- Peter Schmidt: I don’t think there’s evidence of high impact in this.
- Karen Johnson: OK and – and I think what you’re – you’re saying there, is you’re not sure this measure would have a high impact on quality, is that what ...
- Peter Schmidt: You know that’s a different statement. I mean I know that sleep disturbance is a big issue, I’m just saying that the – that the submission does not provide evidence of high impact of – of (inaudible).
- Karen Johnson: Right.
- Peter Schmidt: And you know, I know that treating sleep disturbance. I – I’ve actually quite involved in studies of sleep disturbance in Parkinson disease and I know that treating, appropriate treatment of sleep disturbance and Parkinson disease is a high impact for the people who suffered from sleep disturbance. I’m just saying that there is no evidence presented for high impact of sleep disturbance or of this particular measure.
- Karen Johnson: Right. I think my – if – if I were on the committee and I were rating this, I would say, oh, they didn’t really answer it in section 1a.3 because all they told us was there’s a million people with Parkinson disease but then I will read a little further in 1b2 at bottom of page 2. They actually have a sentence there that says, “sleep disturbances are among the most common with the prevalence ranging from approximately 40 to 90 percent. So, that would be enough for me to – to give them a pass on impact if I were doing the rating.
- Peter Schmidt: And you know, I know from personal – from research that I do that it does have – you know that this is a high-impact thing. I just was noting that was missing.
- Karen Johnson: Right, right. And – and I think in the other – in the other measures, they don’t necessarily get to that level of detail on – on their impact statements.

Peter Schmidt: Yes.

Karen Johnson: OK, how about evidence, is there anything different about this one than the other – the other two that we’ve already talked about or the do you have the same concern pretty much?

Peter Schmidt: Yes, there is no evidence on assessment and in fact the – the – what’s interesting is in this measure that NICE guidelines deviates from this and that the NICE guideline says that they should – it should be treated if the patient complains about sleep disturbance. You know, (inaudible) a complete history should be taken if the patient reports sleep disturbance but it does not actually say you should assess for sleep disturbance.

Karen Johnson: And that’s a really good point and I think is – let me see if I can find it quickly. We actually do ask I believe in section – bear with me while I look for it and this is just the FYI. There’s a section in the validity section that asked about – yes, section 2b1.1 which on this measure would be on page 11 and they didn’t fill it out because they didn’t do the validity testing but we actually asked the developer to describe how the measure specification are consistent or not with the evidence that’s supporting the measure of focus.

So, that would be a place where they could be given that kind of information that you just mentioned, that you know the way they constructed the measure doesn’t quite line up with the guidelines. OK, usability, feasibility, anything on that, that you want to discuss? OK.

Female: (inaudible).

Karen Johnson: Go ahead.

Female: Hi, so I have this, you know, kind of another question about this is, how does sleep disturbance (inaudible) is actually going to be defined. There were a couple of different things like – that were noted in here. I think in some of what the developers were saying about, you know, restless leg syndrome, hallucinations, different phases of sleep, amount of time in REM. So, I’m just wondering if this is the same sort of the thing where all of these different components are assumed to be assessed, even though they’re not specified in this measure.

And then the second question is, about the caregiver. So, the developers noted in the document that many times the sleep disturbances will cause the caregivers to sleep in a different room from the patient and so I’m also wondering whether the caregivers are going to appropriately be able to answer those questions on behalf of that patient.

Peter Schmidt: They have actually researched on that. There has been research done at the University of Miami about identifying RBD, REM sleep behavior disorder and that most patients cannot – do not – denied – identified REM sleep behavior if it’s identified by its symptoms but that – they will – if you ask them about falling out of bed, that’s a great screening question

and the point of that is – is actually not that easy to identify, even though it's very easily treatable.

- Female: So given that, is it then, you know, potentially, you know the next step is to say instead of just having a blanket statement about querying about sleep disturbances, having a measure that more specifically guide physician on the way in which they query.
- Female: It seems like that question is a similar question to what we asked, if we're not that you assessed something but how you assessed it?
- Female: Yes.
- Peter Schmidt: And so, I have a question for the NQF people. If there's a measure for like aspirin for CABG, coronary artery bypass graft, do you guys say aspirin or do they say give the patient something? Is it your style to talk about – to directly address the evidence for a specific intervention or that your style to say, there's evidence that you should do something, did you do something?
- Karen Johnson: What we hope for is to have a specific things if there's evidence for it.
- Peter Schmidt: OK, so this is an opportunity where there is – there are specific assessments and specific responses to those assessments that are not included in the specification.
- Karen Johnson: OK, so what you're pointing out here is some concerns about how the measure is specified and also potentially going even a little further and making again some suggestions about future measure development perhaps.
- Peter Schmidt: Yes and frankly if there was something that said, you know, you should go on the AAN website and – and download one of the three or four assessments that are all posted there based on evidence-based, you know evidence – I think that would be a much stronger measurement.
- Karen Johnson: And just out of curiosity, I know we are getting close on time but if you're a just family practitioner or, you know, not a Parkinson disease specialist, would you even know that those instruments exist or is that kind of (inaudible) knowledge for experts?
- Peter Schmidt: I would think that if you put in the – in the CPT, you know, they get to earn that CPT code. You put that in the template use at assessment.
- Karen Johnson: OK.
- Female: The other issue and this maybe just a larger issue but for the sake of understanding quality of care and functional specifications across the (inaudible). It's preferable to use the same instrument to assess disorder. If we have, you know, each physician using his or her own judgment, some using instrument, some using verbal phrases that are put together in different ways to determine what sleep disorders are happening, we're not really going to

be able to get a picture of the prevalence of sleep disorders across patients nor what interventions are actually improving sleep disorder.

That's more of a long-term issue and more of a sort of higher level issue but if we're going to be endorsing quality metrics, it seems reasonable to think about how they might be used not just for directly improving care for a single patient but rather improving care for all Parkinson's patient.

Female: Yes and I would say you – you improve providers that way too because if people are using (inaudible) own homegrown measures, they become better educated and better providers if they're using standardized validated measures to assess these things.

Rebecca Swain-Eng: This is Rebecca, just speaking for the developer here, very briefly to answer your question. We had discussed whether or not this measure should had been in assess using a standardized tool or querying measure and the workgroup felt that there wasn't a standardized form or questionnaire that was regularly used by both primary care physicians, neurologists, and other conditions that may see patients with the diagnosis of Parkinson disease.

They felt that putting in as querying left it up to the clinical judgment of the clinician who was using the measure to use the tools that they had available to them at that time. And I know it has been said that in future measure development or we can look at this to see if there has been a standardized questionnaire or tool developed that would be more applicable for this population that will be using the measure.

Peter Schmidt: Well, sleep is assessed in the PDQ-39. It's assessed in the (inaudible). You could lift – you could say an assessment similar to one of these validated instruments. It's just – it's very difficult to – to imagine, you know, when I read these measures I think this is 40 percent of Americans with Parkinson disease who never see a neurologist throughout the course of their disease and it's very difficult to imagine that somebody who's getting primary care in the Texas Panhandle is going to get their sleep disturbance assessed adequately.

Karen Johnson: Some really interesting discussion, so again if – I'm playing timekeeper here so ...

Peter Schmidt: Yes.

Karen Johnson: Let's – let's go ahead with measure 1988, Mary that's yours and maybe just very briefly note if there are any concerns ...

Mary Van de Kamp: Karen, could you – could you make that intro again. I'm sorry I was unmuting and I missed the ...

Karen Johnson: Oh, sorry, measure 1988. Can you just very briefly note if there were any concerns other than I guess the ones that have already been noted on impact gap evidence?

Mary Van de Kamp: Right. I – I don't think so I think and this is I think systemic to the challenge in the rehab world that's out there. There is some strong evidence that – that's while we all anecdotally (end) patient's satisfaction, I know that this is critically important. The evidence to support this is – is not as strong and I think in the – if I read through many of the measures, this one was more from a committee standpoint, more globally agreed upon in terms of every area that was sort of addressed, not – not supporting the – the overall evaluative or the rehabilitation therapy options as a measure, not that there isn't great value in that, is there – there potentially has impact but not through this, so what we're able to tell through this information. Is there anyone in the committee that disagree with any of that.

Jane Sullivan: This is Jane. This is when I – I think I had strong feeling about the exclusion one of the instances, is the patient has no known physical disability due to Parkinson disease and for a number of reasons. I – I'm concerned about that exclusion. I think that, you know, it's a progressive disease. At – at one year, if they don't have a disability, there's no reason to suspect that they won't have a disability within that upcoming year. There's a lots of burgeoning literature about the neuroprotective effects of exercise.

Mary Van de Kamp: Right.

Jane Sullivan: The fact that people who are in this population are less active, even before they had physical disability, so I put a bunch of references in my comments because I feel like I would really like to advocate that – that exclusion be removed.

Peter Schmidt: And Jane I ...

Mary Van de Kamp: I can add why that exclusion was added because I felt that if a patient was really early on – on the development or the diagnosis of Parkinson disease and it clearly had no sort of limitations that didn't want to have to do this measure with them and discuss rehabilitative therapy options when it didn't apply to that patient at a specific time. But it doesn't mean that you couldn't do this measure, it's just gives people that ...

Jane Sullivan: Right.

Mary Van de Kamp: But clearly, there isn't – this doesn't apply to this patient. You don't have to do it. It doesn't mean you cannot do it, it just means you do not have to do it.

Jane Sullivan: And I would argue that it does apply to this patient. I think whether or not they're showing physical dysfunction, the likelihood is they will and to do some prophylactic counseling, I – I think has major benefits.

Mary Van de Kamp: I think so. I mean I – I hear what the developers were saying, Jane. I think I totally agree with you if – if taken in that context but I think if we're going back to the purpose of – if we go back to the usability and the – and that if this is not – it's coded then that could be a potential negative to the provider than it may had been, than it wasn't appropriate, not that it couldn't be or wouldn't be but that it wasn't unlike the annual which (inaudible).

You know, there is no exclusion. There may be a clinical, medical reason that this wasn't done at that point in the claims data. Is that – can I ask the developer if that is correct?

Rebecca Swain-Eng: That's correct.

Mary Van de Kamp: OK, so I think – I think that, again and this again goes back to the usability and purpose of this but if we're using this to determine appropriate care based on coding and that the rehab wasn't coded, it could have been very – appropriately not to be coded in that one claim that's reviewed for that time but then clearly the time periods for coding are far more frequent and if there is a change, would then show up at a later point.

Jane Sullivan: OK, I just want to go on record as opposing that and saying that just because somebody doesn't show mobility dysfunction, doesn't mean that – that should be – that – that option shouldn't be discussed because that maybe at a very appropriate time to get (inaudible).

Mary Van de Kamp: Absolutely, I absolutely hear what you're saying. I think that's right and I think you also can't make some (inaudible) decision without an evaluation of a rehab professional to determine there was nothing there or could be not preventive. But I think if I look at in a context of how this is being used, then it had a – you weren't going to be (inaudible) if you didn't use it because there may have been a clinical reason for that.

I think that and again – and I would hope that the developer if we go through this one specifically, you know again, as Jane said, there is good data that's coming out relative to, not even rehabilitative but more preventive and wellness component within this disease that – that we heard and build the evidence to support this – this measure going forward.

Karen Johnson: Great, thank you. Risha, do you want to go ahead and tackle 1983 and again if there's anything different?

Risha Gidwani: Sure, just before we move away from 1988, I'm just going to register my same concerns that I'd been talking about with the other measures and that's we're aggregating three different components: Physical therapy, occupational therapy and speech therapy.

And I wonder if we should be understanding those more specifically to understand for quality improvement purposes, where to intervene and then also that the measure only talked about assessing options rather than linking a patient to treatment options and that also the guidelines that the authors mentioned are very specific and the – the measure, however while citing the guidelines, doesn't actually get as specific as the guidelines that is based on.

So, I – I said that quite a bit over the course of this meeting, so I'll just move on then to the 1983 cognitive impairment or dysfunction assessment. So, the brief description to new submission, numerator is all patients who are assessed for cognitive impairment or dysfunction at least annually and this unlike the other measure doesn't have the caregiver component into it. The denominator, all patients have a diagnosis of Parkinson disease. There are no exclusion.

One thing that I will mention before I just sort of talk about the impact information is that I wasn't quite sure what the developers meant exactly by cognitive impairment or dysfunction. I saw some things about depression. I saw some things about dementia. I saw some things about psychosis but I wasn't sure what the boundaries of this measure really entailed. We – we can go back to that I guess.

In terms of – of the impact, in terms of importance to measure and report, one system said yes, four people said no. With the impact, two people rated it a high to a medium, to a low. Performance gap, two people rated it a high, one to a medium, one to low, one an insufficient. I have to say that I'm a little confused as to why we have four no's for the importance of measuring report but less than four no's for the impact in the performance gap. Something doesn't add up there.

In terms of the impact, they didn't really – they gave us information about the percentage of patients that had non-motor symptoms. Five non-motor symptoms or one non-motor symptoms but I didn't get information actually about the percentage of patients that actually had cognitive impairment.

For opportunity for improvement and the performance gap, the authors mentioned that and I'll quote, "the presence of psychosis, depressive disorder, increasing depression severity, age, duration of PD, cognitive impairment, apathy, sleepiness, motor impairment and percentage of time with dyskinesia were related to greater disability and by varied analyses. Entering these factors in a tumult for aggression analyses, only the severity of depression and worsening cognition were also view with greater disability and these accounted for 37 percent of variability.

So that was their information, just indicating that there was cognitive impairment, rather than indicating that there's a lack of assessment of cognitive impairment and I think that's in line with some of the other information we've seen throughout the course of this meeting, is that the – the evidence is really about disability rather than the assessment of the disability. So, I guess I'll stop there.

Peter Schmidt: So on – on the incidence, everybody with Parkinson disease has cognitive decline and you know many of them have cognitive impairment but there's nothing to connect the assessment. Again, you could use an all or none methodology to say anyone, if you're not assess for cognitive assessment, then you're not treated for cognitive decline if present, which I think is why I gave this medium but – and there definitely is a performance gap (inaudible) for the outside knowledge.

Karen Johnson: And Peter just quickly on that, so you are – your personal knowledge – knowledge tells you that physicians often do not ask about cognitive dysfunction?

Peter Schmidt: Well, it is not, generally it's clear when a patient is, you know and again I'm not a neurologist but it's generally clear when a patient is demented. Mild cognitive impairment and executive dysfunction – executive dysfunction is not easy to identify without an instrument in the course of a brief encounter and is correlated with falls. Executive dysfunction is the – is the component of cognition that's most correlated with

falls. So, there is evidence that – there is evidence not presented here but there is evidence that – that cognitive dysfunction is underdiagnosed.

Risha Gidwani: So in terms of the diagnosis, this is Risha, if a patient does have cognitive impairment, would they, themselves, actually be able to speak to that or would they not recognize it?

Peter Schmidt: Generally not. I've – I've spoken with the patient who was measured as having a 40 percent drop in – a 40-point drop in her full scale IQ after surgery and she was not aware.

Risha Gidwani: So, that's interesting because this is the one measure that doesn't actually include the caregiver. And I – perhaps so than this would a variable to more, reasonable for an outside party associated with the patient actually to help in assessment.

Peter Schmidt: That's a great point.

Female: Yes, although if – if you look at the rehab component, cognition is a – is a very strong area of assessment by both the speech and language pathologists and the occupational therapist. So, there are standardized test to – to look at cognition. Again, you know, better – I mean equal and supportive of having caregiver involvement but there is – there is specific cognitive assessments that would help determine the cognitive impact. And I totally agree with you Peter that – that it is and sometimes undiagnosed area that causes some of the falls as opposed to – even – even the physical limitations.

Female: And actually this is one of the places where the – the guidelines recommend a specific screening (inaudible) talked about the MMSE.

Female: Right.

Female: And for dementia, so when you look at what the recommendation is versus what the guideline is, the recommendation, is that a lower (inaudible) versus the guideline.

Risha Gidwani: And I believe those guidelines for AAN-owned guidelines. I think on – on page 6, when they quoted verbatim the guideline recommendation, they talked about the Mini-Mental State Exam and the Cambridge Cognitive Examination from the AAN QSS, April 2006. So, perhaps the developers can speak to why they didn't specify the use of these instruments?

(Rebecca Swain-Eng): So, the recommendation statement said that these are (inaudible) tools that should be consider, not the only ones that are possible and that was one of the reasons that they were not specific in saying or stating that you have to use one of these two tools. We're leaving it up to the clinician judgment as to which measure or which tools they would want to use.

Certainly, the MMSE and the CAMCOG are possibilities but the clinicians or the workgroup felt that they shouldn't be limited to which measures they may or – excuse me which tool they may or may not use for this measure.

- Female: Is there an option for measure to be written with recommendations for screening tool or assessment tool because I think that might help implement something that's of a higher quality.
- (Rebecca Swain-Eng): Sometimes, we've added a parenthesis and put an e.g., so for an example in there for specific tools that we – that the clinician or whoever is doing the measure can use.
- Peter Schmidt: But couldn't you, couldn't you say ...
- (Rebecca Swain-Eng): (inaudible) worksheets for the patient, flow sheets for this. We do provide this additional information into the patient's flow sheets.
- Peter Schmidt: Couldn't you say, use one of these instruments or other instrument with class 1 evidence in Parkinson disease?
- (Rebecca Swain-Eng): It's assume that you're using ones that are, you know, valid and that are being used commonly in practice. So, I guess the same – the same thing, just rewarding at a different way and was putting an example in there. I mean we could make it a little bit more black and white I guess if you want to call it that but it is assumed that you would use ...
- Female: Statement.
- (Rebecca Swain-Eng): One of these tools.
- Peter Schmidt: OK, but again I guess, we're getting into the weeds here where in fact the major issue here is that there's no evidence for simple assessment and there isn't a clear linkage between assessment and outcomes. That is treatment that drives – you know its assessment and treatment that drives outcome where there is evidence and I don't know whether it's NQS policy that – I mean in prior discussion on these measures, you know, the NQF people have told us that they like to see things where there is a direct linkage and there is, you know, there is a step that's assumed and I think it's dangerous in a National Quality Program that's not just being executed at academic medical center with interdisciplinary care teams to assume that assessment results in treatment or intervention in this case.
- (Rebecca Swain-Eng): Yes, I agree with the statement.
- Karen Johnson: OK, this is Karen, your timekeeper one more time. I would like to use, found a couple of other things to talk about with the 1983 measure, so that gives us by really compacting things, 3 or 4 minutes to talk about the last measure 1989. Peter, that one is yours, so let's see how you can do on really condensing this stuff and ...
- Peter Schmidt: OK, so this one is Parkinson – Parkinson's disease medical and surgical treatment options reviewed, and it's a little ambiguous. It talks about pharmacological and nonpharmacological treatment as well as surgical treatment reviewed at least once annually.

And so my read on it was based on the title that it's medical and surgical, although I'm not clear – I – I try to access the CPT codes for this and I don't have the subscription, so I didn't see what the CPT code actually says but it's – I think that there is – there is a lot of evidence to illustrate the paramount importance of medical and surgical outcome – options, the PD outcome but it's not clear that – that reviewing them results in better outcomes.

There's – there's a lot of anecdotal data that – of that nonspecialist physicians will overmedicate their PD patient because they are in fact reviewing the medications and when the medications aren't working well, they just add another medication and not titrate the existing medications which is usually the best option.

So in their evidence statement section, there's no evidence for review of medical and surgical options. You know, review – as review and there's no evidence for the frequency and then just to kind of jump – get to the chase, if the physician is not reviewing the medical and surgical treatment options, I'm not sure what the patient is doing at the office.

What is the physician doing, is the physician is not reviewing medical and surgical options and that kind of – the – the troubling thing at the end of, you know, in my assessment of this. And how's that? That sort of 2 minutes.

Karen Johnson: That's very good. Any workgroup members have any other comments that's a very profound question you just asked Peter.

Female: I know one of the – one of the points that we have to get to at some point is the harmony between measures and the first measure we talked about also includes a review of current medication. So, there seems to be overlapped in here, added to the fact that this seems like it has a lot of elements that would determine whether someone had met the criteria or not.

Peter Schmidt: So, there is actually a difference between review of current medications in the context of the diagnosis review and they have a slight difference because my – my read of the first one was, that – that's looking at all medications to see whether there is – it's a drug-induced – in Parkinson, a drug-induced tremor and also that there's – there's an aspect of – of the differential diagnoses of Parkinson disease in response to medication and sometimes patients will not respond to the antiparkinson medicate, you know, levodopa because of gastric motility issues and things like that. And so, the response to medication is an aspect of reviewing the diagnosis and it's sort of a, you know, it's (inaudible) by separate aspect of medical optimization. Does that address that?

Female: Yes, thanks. Well, I think I really hadn't consider that but that makes a lot of sense.

Peter Schmidt: OK.

Karen Johnson: OK, any other discussion about 1989? OK, just so you know when we write up the summaries for these measures, we will probably write one summary that then get pasted

for the most part in the (optic) measures with a few things that are different but for the most part, it will be the same summary all the way through.

OK, thank you guys very much for looking so closely and thoroughly at these measures. I am going to hand it over to Suzanne to tell us about – to actually ask the public comments and then tell us about the next steps.

Suzanne Theberge: Thanks, Karen. (Amy) can you open the lines for public comment?

Operator: At this time, if you would like to ask a question. Please press star 1 on your telephone keypad. We will pause for just a moment to compile the Q&A roster. Again, that was star 1 for question. There are no public questions at this time.

Suzanne Theberge: OK, thank you. OK, thanks everybody for a great call today. So for the next steps for the committee members, you're next. That is to start looking at the remaining measures in the project. Everything is posted on your SharePoint page, so please start looking at those measures for review in a couple of weeks at our in-person meeting.

You should have received an e-mail last week with the registration and travel information for the meeting. Please let me know if you didn't get that. I understand a couple of folks it seems to have gotten eaten by their spam filters, so please let me know if you don't have that information and please do register for the meeting. We need to know that you're attending, so we can get to a room and all that stuff.

And we will also be following up with you next week, with the call transcripts, the call recordings, and the summaries of all the workgroup calls to assist you in your review of the other measures. For the measure developers, we will follow up with you separately regarding any changes that may need to be made and we also asked that you register for the meeting whether you're planning to attend by phone or in-person, so that we can make sure we have chairs and everything set up for you. So, are there any questions?

Peter Schmidt: Yes, Suzanne, this is Pete. I'm an out of the office for the whole week, so if you could – I did not get that e-mail. I do not recall seeing that e-mail and I'm not in position to review (inaudible) effect and see if it was there.

Suzanne Theberge: OK.

Peter Schmidt: If you could just resend it to me, that would be really helpful.

Suzanne Theberge: Yes.

Mary Van de Kamp: Suzanne, this is Mary. My assistant had reached out too. I hadn't seen the thing and unless they send her a note today, that it wasn't quite ready. It was just coming out, so I'm not sure that we all have – I mean I'm not sure that it's still not coming I guess, it's what I'm saying.

Suzanne Theberge: The meeting e-mail?

Mary Van de Kamp: Yes, the hotel and travel arrangements.

Suzanne Theberge: Yes, you should have gotten a travel arrangement e-mail and I will – Peter I will follow up and make sure ...

Mary Van de Kamp: OK.

Suzanne Theberge: That was resent to you. I think they're still finalizing the hotel but that was ...

Mary Van de Kamp: Oh, that was probably, yes, I misunderstood that. I think you're right.

Suzanne Theberge: Yes, they should know that you need a room.

Mary Van de Kamp: Yes.

Suzanne Theberge: So, that they can make sure there's only one.

Mary Van de Kamp: Right, yes. I should jump ahead to get into that room.

Suzanne Theberge: OK, yes, any other questions? Great, well with that I think we can wrap up. Thanks very much for your time and you know if you have any questions how things proceed, please let us know.

Female: Thanks very much.

END