NATIONAL QUALITY FORUM

Moderator: Suzanne Theberge
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Suzanne Theberge: Good afternoon, everybody. Welcome to the Neurology Workgroup Four Conference call. This is Suzanne Theberge at NQF. I'm here with Karen Johnson and Jessica Weber, my colleagues on the project. Thank you for joining us this afternoon.

We are going to start with a brief introduction if we could just have all the Steering Committee members introduce themselves just really briefly your name and where you're calling from, any order of discussion on the agenda. And then we'll have the developers introduce themselves just so we all know who's on the line.

Dr. Labovitz, are you on the line? All right. Dr. Kapinos, are you on the line? Dr. Barsan, I think you're next.

Bill Barsan: I am, Yes. I am Bill Barsan from the University of Michigan, an emergency physician.

Suzanne Theberge: Thank you. Dr. Cooney?

Gail Austin Cooney: Hi. I'm Gail Cooney. I'm a neurologist in Palm Beach, Florida working primarily in palliative medicine.

Suzanne Theberge: Dr. Tirschwell?

David Tirschwell: Yes. David Tirschwell. I'm a stroke neurologist. I work at Harborview Medical Center which is part of the University of Washington in Seattle.

Suzanne Theberge: And Ms. Suko.

Jolynn Suko: Yes. I'm Jolynn Suko and I am the administrator for the Neuroscience Institute and Virginia Mason also in Seattle.

Suzanne Theberge: And Dr. Hackney.

David Hackney: Hi. I'm David Hackney. I'm a nuero radiologist at Beth Israel Deaconess in Boston.

Suzanne Theberge: Great, thank you. And have any other Committee members joined that haven't introduced themselves yet?

Daniel Labovitz: Daniel Labovitz here. I'm a stroke neurologist and Monterfore Medical Center in the Bronx.

Gregory Kapinos: And Gregory Kapinos, neuro-internsivist in Rhode Island.

Suzanne Theberge: Thank you. And now, to the developers just let us know who's on the line?

Ann Watt: This is Ann Watt and Karen Kolbusz from the Joint Commission and we have Dr. Lee Schwamm with us as well.

Diedra Joseph: This is Diedra Joseph from the AMA-PCPI. I also have justification and testing staff.

Penelope Solis: Penelope Solis with American Heart Association and American Stroke Association and we have Dr. (inaudible) on the line as well as (Meaden Alan) who is the AHA staff.

Suzanne Theberge: Great. Thank you, everybody. I'm going to turn the call over now to Karen Johnson to get us started on the measure discussion.

Karen Johnson: Thank you, Suzanne. Thank you everybody for joining us on the call and also for taking the time and the effort that I know you put into reviewing these measures and filling out your preliminary evaluations.

I'll just let you know kind of the process for the call. We will be going through eight measures on this two-hour call. That means that we don't have a lot of time for each measure. So, we're going to try to keep each measure's discussion to about 10 minutes or so. I think maybe the first measure or two might take a little bit longer than that, but that's what we're going to try to do.

And as NQF staff, I will be the one to help us to fall on time if we get a little bit off track. We have asked all of you to be lead discussants for various sectors. So, as the lead discussant I will ask you to very briefly introduce the measure and maybe a minute or so just describe what the measure is.

And then we'll proceed through the four criteria for evaluation. And when you are discussing that, let's start with the first one, importance to measure and report. And that, I would like you to just very briefly summarize the scores that were given in these preliminary evaluations and then really focus your comments on things that maybe came up as concerned about that particular criterion.

And on the first one, I'll help you along so everybody kind of knows how it should go. So as Suzanne mentioned and as you've heard already, developers are on the call. So, there will be plenty of time to ask them specific questions if you have questions for them.

So with that, I think we will go ahead and go straight into the first measure and so the first one that we're going to discuss today is 1952, time to intravenous thrombolytic therapy from AHA, ASA. And Dr. Labovitz, I believe this one is yours.

So, can you go ahead and just introduce the measure first.

Daniel Labovitz: Yes. This is a measure for patients who are treated with IV t-PA after ischemic stroke regardless of when the t-PA – when the t-PA was initiated, how long after the stroke occurred. The measure is meant to establish how much time passed between time to arrival in the hospital and initiation of the t-PA treatment.

So, whether the patient was treated in less than three hours or in a three for four and a half hour window, the time to treatment is measured. The concept behind this is that the faster a patient is treated with t-PA, the better the chance of recovery there is and the lower risk of hemorrhage, even lower risk of mortality.

The American Heart Association looking at getting what the guidance found that shorter door-to-needle time is more associated with better outcomes. Potential concerns are that a rush to treat might lead to treatment that's either inappropriate or errors made on exclusions.

All in all is I saw it in the reviews. I think generally our group liked the measure, the chief – this chief concern about it, of course, being that the strong push to early treatment might lead to unexpected outcomes.

Karen Johnson: Great, thank you. So, lets go straight into the importance to measure and report. And if you could just summarize very quickly the – any particular areas of concern that anybody may have had.

Daniel Labovitz: Yes. And I'm sorry I'm still opening that report up. So, it's going to take me a second. I looked at it before. I think the main concern that I saw was the issue of – well, two things. One, is this truly going to lead to benefit. Has that been established? And two, could it be that by pressing regardless of arrival for early treatment and measuring that, doctors might feel compelled to treat that when they haven't got all the facts together.

And I think those are – those are worthy points to address.

Karen Johnson: OK. So, would anybody like to comment particularly on impact or gap or possibly on this one maybe evidence in terms of evidence for the measure?

Bill Barsan: This is Bill Barsan. There is no evidence from the literature that early treatment is in fact leads to more problems at least from the evidence out there. In fact it would suggest that it leads to last.

So, I'm not – I'm not sure the evidence that's there that treating quicker is necessarily more dangerous.

Diedra Joseph: I agree with that.

David Tirschwell: Yes, I agree with Bill as well. This is David Tirschwell from Seattle. They presented, I believe it was in this measure, the results of one of these analyses from the huge number of patients from get with the guidelines. And I thought it pretty convincingly showed that outcomes if anything were better in the patients that were treated more rapidly.

Of course, there is always the possibility that those that have more experienced centers, who can treat more rapidly, and that if we rush the less experience centers that don't treat as many. So, you know, I think to some degree, we can't be 100 percent sure. But, I would – I guess I would also think that that information would be equally available going forward.

And considering I think the strong evidence that this benefits individual patients if they can get it earlier, I think the chance of benefit far outweighs any risks.

Gregory Kapinos: I agree. I'm Gregory Kapinos. I think I'm the one who put that comment in the – down that measure that could lead actually to try to really rash the patient to make a decision.

I think that if we implement that measure and there's really the NQF data that really compares hospital, I'm just – I would just worry that the sooner doesn't necessarily mean the better. If you don't have a system in place where the attending is reachable in a timely fashion and then the residence make this actually the last one to give the call and to implement the (inaudible), I don't necessarily think that it threw a larger center seeing in more complex patients might actually have a slightly delayed within the three-hour, let's say on an average again, I think it used be a two hours. It doesn't necessarily mean that this hospital is less good than a hospital that gets there (inaudible) one hour and a half.

The half hour difference in the measure might not necessarily lead us to significantly improve and outcome. And sometimes if the system is now in place although some stroke attendant to really make the call, then actually there could be some increase in the – in the complications.

But overall, yes, I think that if we are to pick into like making that measure implemented or not implemented, of course, I would like to implement that measure. I think it's going to be a good message that the earlier the better. I just had in mind this just other comment about the fact that it doesn't necessarily mean that one hospital is there then another based on slightly shorter time to (inaudible).

David Tirschwell: I think you bring up an excellent point. The potential for different hospital having different patient levels of complications sort of beg the question about whether somehow these rates and measures here should be adjusted somehow for that. And of course that would be a tricky thing to do.

There are a bunch of exclusions that are listed sort of suggesting that if there's a clear reason why there's a delay that they fall out of the measure, so, I guess there's a little bit of protection via that.

But I think you're right, you would sort of wonder whether risk adjustment might be something that would be appropriate in this case.

Gregory Kapinos: Well for intense seizures, I've seen a lot of differences in different centers. If you have an MRI that is available for high (inaudible) therapy, actually you can – you can thrombolize a patient that had a seizure at the onset of any ischemic stroke if your DWI is positive and you know that the patient did – indeed have this ischemic stroke and as a consequence had a seizure.

The longer you don't t-PA, the (inaudible), I think you're doing the right thing. So, just be dealing the t-PAs because I'm going to see an MRI, I don't think I'm doing the wrong thing. But if we're implementing that measure and then the NQF will give a bad score to my hospital because I'm opening an MRI on the seizing ischemic patients. Then I think this measure is misleading.

David Tirschwell: But they won' specially in fact seizures are called out specifically as an exclusion and that patient's delay wouldn't count against you.

Gregory Kapinos: OK.

David Tirschwell: But it is still a good question because I think no matter what list of exclusions they come up with, they can necessarily – can't necessarily cover them all.

Daniel Labovitz: Yes. I thought that actually the measure did nicely on coming up with common reasons for there being a delay, you know, the requirement for treatment for severe hypertension, inability to confirm patient's eligibility because the family's got to be called in Mexico, whatever the reason is.

And I think it's a good first step. We may learn once this measure is adopted more broadly that there are other things that need to be added and perhaps there is room to conclude a fudge factor where really any excuse can be put in as long as it's recorded.

But I think what this really achieves and what has been a major focus for American Heart as part of their – the part of the stroke initiative is it's a response, a very strong data that faster is better by and large.

I think we're fighting against a situation where in the initial NIDS trial, the data showing that early treatment was better was not part of the original report. It was part of a secondary analysis to where that finally emerged. Every other trial using t-PA and meta analysis has shown early treatment has a higher chance of improvement and the lower risk of hemorrhage, but it's – though the initial news that went out to all neurologist and I would still remember which is still part of our – which is still shaping practice I think is the sense that just get the t-PA in, but don't worry about the time so much.

And I know from my own institution where we've got nine neurologists treating with t-PA and we treat about 60 cases a year, there's a wide variation in practice. Some of us are quite slow and others are quite fast. And the difference is some are spending enormous amounts of time when getting consent, lots of time explaining risk and benefits.

And, you know, what we're working on changing practice, this initiative, this stamp of approval I think would help enforce to it.

Bill Barsan: Now, I agree with that whole heartedly. I mean, I think the issue is that even the people who are not as fast if the patient comes in at two hours and five minutes, they'll usually find a way to get to treatment in within three hours. And they come in at one hour, they will take two hours to get them treated.

Daniel Labovitz: Yes.

Bill Barsan: And that's you want to avoid.

Daniel Labovitz: We're trying to get over that. There is – it did occur me there could be a perverse effect of this that if somebody was trying to gain the system, they have a patient where they're running late.

Now, the ED forgot to call the stroke neurologist or, yes, the CAT scan was – we had to have somebody getting a big abdominal study. They might be attending and say, "Well, I'm just going to write just make an excuse for not treating with t-PA rather than get a ding for too much time spent."

I don't think people would do that, but just to toss out there, you know, conceivable unexpected outcome.

David Tirschwell: I agree with all of that, but I would like to bring up rules question that I would address to the NQF representatives. This denominator includes stroke patients treated with IV t-PA from three to four and a half hours and that use to t-PA is not FDA approved.

I did read in one of the many documents that I was given to read that everything in NQF endorsed measure should be FDA approved. Can NQF representatives comment on that?

Karen Johnson: This is Karen. I am still fairly new here, but I don't believe that I have heard that particular thing. And Suzanne and Jessica are shaking their heads as well. So, that is something that I will ask others here and clarify for you.

David Tirschwell: Well, I didn't to make it up. I've read it in one of your documents.

Karen Johnson: OK.

Lee Schwamm: This is Dr. Schwamm just on behalf of the measure developers. Could I comment that the measure is not suggesting that patients to be treated, it's not a measure looking at the rates of treatment in the three to four and a half hour window, it is saying that if you make the decision to treat with the thrombolytic agent that you should be doing so as quickly as possible.

So, I think it may not directly address that issue about FDA approval.

Bill Barsan: Yes, I think that's a great point, Lee, because it's really – it's not the decision to use t-PA. That's not what this measure has anything to do with. This measure has to do with one you've decided to do it, you should do it quickly, right?

Lee Schwamm: Right. And actually I just wanted to, if I could, just provide some backdrop from the articles that have been presented to you in supporting the measure. I just want to reassure you that there is a tremendous amount of hospital variability.

So, if you look at the rates of t-PA use, in fact hospitals have admit 100 to 300 strokes, ischemic strokes a year far outperform hospitals that admit 300 strokes a year. So, there are hospitals at all levels of annual stroke volume that are capable of administering t-PA within 60 minutes.

Our current rate across the country is a decimal. It's less than 30 percent of patients that are being treated within a door-to-needle time of 60 minutes. And I would just call your attention to an article that came out this week from Finland from (Marko Kassi) where they treat routinely within 20 minutes ED arrival and 94 percent of the several thousand patients presented were treated within the target of 60 minutes.

So, I think we have been allowed ourselves to be very complacent and reassure ourselves that we're taking all this extra time because we need to be careful that we're not closing harm, but in fact every five – 15-minute delay in treatment was associated with a five percent reduction in mortality. Fifteen minutes sooner that you start treatment, every 15 minutes of five percent decrease in in-hospital mortality.

So, we have a really powerful drug with a powerful benefit that's highly time dependent and this measure will help hospitals gather the resources they need in order to meet these benchmarks.

Karen Johnson: Thank you for that. You guys have already touched on the scientific acceptability of this measure particularly the question about risk stratification in that was more of the comments that was made.

Do you guys want to ask the developers if they have any comments about risk stratifying in some way and note that that is generally something we wouldn't think about for an outcome measure, not a process measure, but.

Daniel Labovitz: Daniel Labovitz speaking here and I'm always interested in hearing what Lee Schwamm has to say. But I have a hard time imagining how we would set up a risk stratification for a process like this.

I think that instead the developers did very clever to identifying common causes for requiring more than the usual amount of time. I don't know what more we can do than that.

Lee Schwamm: Actually, so I'd love to respond to that because I think there's a – there is a genuine concern that risk – through risk adjustment, you might actually adjust a way important differences in the delivery of care.

And what we're tried to do is pattern this measure directly after the door-to-balloon NQF endorse measure which tries to account for the kinds of reasons that patient level characteristics that might cause undue delay at the patient level rather than trying to create a post-hoc risk adjustment variable.

So, what we've tried to do is provide adequate opportunity for sites to document that at a case-by-case basis why they should be excluded from the measure. That was not what we had originally done when we started target stroke. We just started with a straight measure with no exclusions.

But in moving towards this NQF process, we have recognized that not all patients are appropriate for rapid treatment as has been mentioned on the call and rather than discouraged treatment or penalized hospitals who, for example, take 15 or 20 minutes to get the blood pressure into a treatable range and therefore extend the time, but increase the total number of patients being treated with t-PA.

We have modified the measure in this way and we think it's a tremendous improvement in the measure of construct. And we're very hopefully and excited that this measure will be NQF endorsed and that will become available for public reporting purposes to really help hospitals drive improvements.

David Tirschwell: Is there a plan to include, Lee Schwamm in any of the get with the guideline's assessments or I certainly haven't heard about it for Joint Commission.

Lee Schwamm: Yes. So, it is part of – it's already an existing quality measure within the GAD with the guidelines program. It is the key measure for targeted stroke. And hospitals going forward will be using this measure for recognition criteria within the GAD, with the guidelines program.

And we hope once it achieves NQF endorsement to actually promote perhaps to an achievement level measure which is our highest domain for measurements.

Karen Johnson: Great. So, you have already…

Female: I would just echo your comments from an improvement perspective. I would be very worried about risk adjusting some really important factors out of this. I think this is from a target bed, it wouldn't matter hospital size or really even with complex patients, we would really want to drive improvement across the board on this measure.

Lee Schwamm: And I guess the only other comment I would make, some people have questioned, why not just pick a median time? Why are you picking up percentage of patients within this goal? And that is because measure constructed in this manner are very insensitive to outliers.

So, if you have one patient who arrives in, you know, within 30 minutes, but takes three hours to treat, they don't exert an undue influence over the measure. And I agree with the previous panelists, this is about system's approach to identifying and treating thrombolytic patient having t-PA available in the emergency room, starting treatment as soon as the CT scan is negative, not delaying treatment for complex functional neuro imaging which doesn't alter the outcome of the treatment decision for intravenous therapy.

And we think all hospitals can achieve this target if they make a coordinated effort to do so. And we think that's one of the great advantages of the NQF and creating measures that are endorsed.

Bill Barsan: Yes. I would agree with Lee. I agree that I don't think risk adjustment is appropriate in this.

Karen Johnson: OK. Does anybody have any other comments regarding either usability or feasibility and I know you've already touched on that to some extent. OK and then it looks like only one person maybe with unsure whether they would feel that they could recommend it for endorsement.

So anymore conversation about this measure before we go on to the next one?

Gregory Kapinos: So, I don't remember if it was a quick no or yes, but yes, I'm essentially the one who put the comments about the time pressure that might not be best, but that's essentially my point of view is that we should endorse this measure and it's a very good thing to implement it.

So, if nobody else in the panel who have voted no, I'm the one retracting that no one there.

Karen Johnson: Great. OK. Sounds like we're ready to move on to the next measure then. And this is Dr. Kapinos' measure 0437.

Gregory Kapinos: So, 0437 is the measure to be decided by the Joint Commission, correct?

Karen Johnson: Correct.

Gregory Kapinos: Joint Commission for capturing how many patients are getting treated within two hours of the last known (inaudible) normal. Actually in the definition, I had a question here. So, there's this two-hour onset and then which implies that within three hours of the last known normal. So, three hours from where you are getting to the hospital or three hours.

I was a little bit confused on the – on the definition. So, can somebody actually explain to me what was exactly going on, why there is like this two hours and three hours?

David Tirschwell: Two-hour hospital arrival, three-hour treatment.

Gregory Kapinos: Yes.

Lee Schwamm: It leaves you one hour, the 60 minutes we just discussed, it leaves you idealized denominator. So this only includes patients in with whom the team has at least 60 minutes to make the evaluation and start the bolus.

If you included patients up to two and a half or maybe two hours and 45 minutes, many patients would not be eligible because the evaluation could not be completed in a timely manner. And so, it would be very hard to interpret what an appropriate percentage would be to achieve.

Gregory Kapinos: OK. But doesn't this imply then that it's almost important. So, it means that for many hospitals, it's not feasible to give this t-PA within an hour of an ER arrival, which to me would be – I mean if you really have a system that is in place where you aren't giving t-PA within an hour, then actually, your denominator should be a little bit larger than the current one, right?

Lee Schwamm: I think that's the – well, I mean, let me say two things, one, this measure has been in place both in the Joint Commission and GED with the guidelines for many years now. And the number of additional patients who are captured by expanding this denominator to anyone arriving within three hours, treated within three hours, so making it as liberal as possible doesn't change the number of patients in the numerator by very much.

The vast majority of patients who are treated are the ones arriving within the first two hours. And those are also the ones with the most severe strokes because they tend to present sooner.

And so, this is an idealized denominator. So you do – you don't capture all strokes, but what you capture are the most sensitive proportion of the strokes which allow you to measure your system performance.

So, it's not about did every patient who could get treated with t-PA get treated. It's about among the group where we would all agree, this patient is eligible and appropriate for treatment, how well does your system perform in those. And we can extrapolate from that to cover the more unusual case.

Ann or (Karen) would you modify that at all?

Ann Watt: No. I think that you stated it very well. I guess the only other thing is – this is Ann I'm sorry from the Joint Commission. I guess the other thing that I would say is that when we initially pilot tested this measure several years ago, we did not have the two-hour limitation for the denominator and then the complaint that we got about the measure was, well so if – it's impossible for us to do t-PA if the patient comes in two and a half hours or two hours and 45 minutes and we're being gigged for that.

So, basically that's why we made that change because it seemed to be the lesser frankly of the concerns of the hospitals.

Gregory Kapinos: What happens though with the patients that are actually eligible for a 4.5 hour because of the – because they don't have a diabetes person or a remote stroke and all those criteria. So, actually this measure will not have any – will not be supposedly measuring. Like each of the hospital gets a lot of those patients that don't – that don't have the contraindications for t-PA between three and four and a half hours if anything is giving them more time to give t-PA, so their number, their score will be better, correct.

Ann Watt: This is Ann from the Joint Commission and this measure is agnostic as to the three to four and a half hour time period. It only measures those people who have t-PA administered within three hours of the time that they received their stroke because as has been pointed out, FDA has not yet approved t-PA for three to four and a half hours. And so our measure doesn't address that.

Lee Schwamm: So, I think that's an important point. It's not that those patients are not important. There are other quality programs that provide tools for hospitals to measure performance in those subsets of populations but they don't have the strongest levels of one, support that this measure does.

And so, I think it's a combination of the science that supports the evidence of good outcomes and thrombolysis marries to the science of quality improvement and performance measurement that allows us to construct this denominator over which there really should be little disagreement about appropriateness, where there might be lots of disagreement about two and half hours or two hours and 45 minutes or treatment within four and a half.

It's a treatment of the standard group of patients who make up the vast majority of t-PA treated patients.

Gregory Kapinos: That's good. I have another question actually about the length of stay of the 120 days. I did not understand why we exclude the patients with a very long hospital stay.

Ann Watt: This is Ann from the Joint Commission. This is actually an artifact of all of our performance measures and that is because we require measures to be submitted to us on a quarterly basis. And also for those measures that we have with which we're aligned with CMS, the – because of the billing cycles for CMS that we can't have people who extend over a quarter.

It's got nothing to do with the clinic goal content of the measure at all.

Lee Schwamm: Although one would also argue that patients who stay in the hospital greater than 120 days reflect very unusual outlier patients. And so, their outcomes including their discharge destinations might not be reflective of the care processes but rather things like lack of insurance or non (inaudible) things like that.

Daniel Labovitz: That is an exceedingly rare exclusion. We have a few undocumented patients who wind up staying for a year or two, but it's really rare.

Lee Schwamm: It's very rare that we have any patients who stayed that long of any kind.

Gregory Kapinos: But just to make sure also on the rationale, why did somebody leave it blank on the – I mean, out of the six evaluator, so the question on the health outcomes so that next time everybody is on the same page.

So, all those measures that we are measuring today, I think none of them are measuring directly the clinical condition or dysfunctional outcome of our patients. Therefore the (inaudible) correct?

Daniel Labovitz: That's correct.

Lee Schwamm: That's correct, that was an error. That was me and that was an error.

Daniel Labovitz: I think I might have done the same thing, I don't know.

Lee Schwamm: Oh, just to give you one last piece of information that I just ran some data in and get with the guidelines. So just – and so, year 2012 year-to-date, 4,660 patients out of 6,032 arrived within two hours and retreated within three.

If you look at the additional number of patients who arrived within three and a half hours and retreated within four and a half hours, so looking at that extra component of patients, it only added another 225 patients.

So, the additional numbers of patients in that three to four and a half window are still relatively small. And the – you know what, I'll take that back. Let me – I have to run that number again. I apologize.

Daniel Labovitz: That is expected. This is Daniel Labovitz speaking. That is expected for two reasons. One, some hospitals still are treating in three to four and a half hour window waiting for an FDA approval or further data. And two, patients, when they come in early tend to come in really early.

They have – added number of patients arriving in the three to four and a half hour range is much smaller. It's not a 50 percent increase. It's a 10 percent increase.

Lee Schwamm: Well, actually – so the incremental number is about a thousand patients. So, it's about a 20 to 25 percent increase. So, still 80 plus percent of the patients are arriving and being treated within the first hour or treated within the first three.

Gregory Kapinos: Any other comments on everybody else, otherwise it looks like all the answers were very harmonious, everybody said the same thing and we should endorse that measure.

David Tirschwell: One other comment and I can't remember exactly what it was. It doesn't interfere with my enthusiasm for this measure. But the data that was presented for validity and I think it was in another – the other Joint Commission measures as well, the tables were really hard to read. And I just – giving that feedback to the Joint Commission, they didn't (CAPA) statistics and I had a lot of trouble figuring out exactly what it all meant.

(Karen): And this is (Karen) and I will come to Joint Commission's defense here. The way our system works right now, they can only put in unformatted text. So, I'm sure they started out with a really pretty table and it just kind of got ugly with our system. So, that's an NQF thing.

But you're right, I think they provide a percent agreement number, not (CAPA) statistics.

David Tirschwell: OK.

Gregory Kapinos: Somebody included a comment that this measure, the 0437 is relatively similar to the 2022 but slightly better formulated and with the inclusion, exclusion of course have being more harmonious with what usually people do with the AHA guideline.

I agree with that too. I felt like the other one was a little bit more difficult for me to grasp exactly what was – what was different.

So, if we have to endorse only one of the two, the 0437 was pretty straight forward as opposed to the NQF 2022.

David Tirschwell: I agree with that too.

Daniel Labovitz: Daniel Labovitz here, I completely agree.

Bill Barsan: Yes, me too. I reviewed 2022 and I much prefer 0437.

Ann Watt: And I would agree with that as well.

Karen Johnson: And this is something that...

David Tirschwell: Sorry, I just found my papers on the validity thing. So, I guess the problem I had was that the data elements there's a numerator and a denominator which are just not defined.

I mean I know what the numerator and denominator for the measure are, but that's not what these numerators and denominators referred to in the testing results for the validation.

So, again, I would suggest you take a close look at what you're putting in there and try to explain it a little bit better.

Karen Johnson: (Karen) from Joint Commission, did you want to add anything about that comment?

Ann Watt: This is Ann from the Joint Commission and if you could refer us to a page number we're having a little bit of a difficult time following.

David Tirschwell: I know, it took a long time for me to find it again too. So, I don't know. Do you have the NQF documents?

(Karen): Yes.

Ann Watt: Well, we have a document that we submitted to NQF.

(Karen): And we have a document that was outlined.

Ann Watt: Yes, we do. OK. We have the online document. You know what, I'd rather than take up the committee's time. We'll be prepared to discuss this at the Steering Committee meeting.

David Tirschwell: Sure.

Ann Watt: Thanks.

Karen Johnson: Great. And I do want to add in, this is Karen from NQF, I do want to add in just one thing in terms your of ratings or reliability and validity. Just to remind you these ratings are based to a large extent not on how high the statistics might be. For example, they have, you know, really high percent agreement, but the ratings for reliability and validity have to do with whether or not things were tested at either only a data element level or a tested at both data element and measure score level.

So, just remember that as you're doing your ratings as you go through the projects.

Ann Watt: Thank you, Karen. This Ann at the Joint Commission. We do have the answer. I'm sorry, not that I've had the chance to look at it, it's clear what the question was.

If you're asking – well go ahead, (Karen).

(Karen): All right, yes this is (Karen) at the Joint Commission. For the testing results on page 23, we were looking at the agreement rates. The inter rates of reliability rate. In this review for the time period, fourth quarter 2010 to third quarter 2011, there was a total of 739 patient records reviewed. It's in the top paragraph.

Now, some of the cases are excluded and you have the exclusion details in other sections of this submission. So, when you look at the denominator, that is the number of patient record which were reviewed and 712 agreed for the clinical trial data element for example which gave you an agreement rate of 99.7 percent.

Ann Watt: So, unfortunately because of the for manning of this table, the denominator actually is 714, the numerator is 712. That's just the number of – the denominator is the number of the 739 records that ended up being evaluated.

Male: So, why would – I mean, so for IV thrombolytic initiation time where there are only 27 out of 739 in the denominator, you know, why are they almost all missing?

Ann Watt: It's a good question. I don't know. That one we will have to look into. Thanks.

David Tirschwell: So, that's not required to compute this measure possibly and probably is though.

(Karen): It's excluded in other data element that's why they didn't get that far down in the algorithm.

Ann Watt: Yes, that is the reason why.

(Karen): Because we know only a small percentage nationally are actually receiving the t-PA. So that's not really the added surprise in that we get only a few in the numerator being (inaudible).

David Tirschwell: It's the ones that got t-PA.

Lee Schwamm: This is a random sample of charts, not a sample of all patients who receives t-PA. I'm not – is that what you're saying?

David Tirschwell: Yes, I understand that better now. But, again, you could see that maybe that wasn't all particularly well explained.

Ann Watt: Well, thank you for your comment. We will take it to heart and I'm sure NQF will as well. Thanks.

Karen Johnson: OK, this is Karen from NQF and I think in terms of time, we need to go on to our next measure. So, Dr. Barsan, would you like to take on 0242?

Bill Barsan: OK, great. I'd be happy to do that. So, this measure comes from the AMA-PCPI and the purpose of this is to basically evaluate how many patients who arrive at the hospital with ischemic stroke within 4.5 hours were considered for t-PA administration.

And I think the idea behind is, I mean, you know, some of the other measures will, you know, look at it if you decide to do it, how quickly did you do it and are you deciding to do it on appropriate patients. I think this is more again a measure of, you know, whether people are thinking about doing this on patients who arrive.

I think there are a few issues with this in terms of, you know, the four and a half hours. And again you're not advocating that people get t-PA within four and a half hours, but, you know, nevertheless, I would say that's probably a little bit late to start considering if that's, you know, the patients in the, you know, in the denominator.

And I think the other thing that I guess I would worry about with this two is just that this is totally dependent on, you know, how well people are documenting things. Most of this data or a lot of it is not going to be able to be pulled electronically in terms of some of the exclusions.

So, I'm not – this had less – this was less clear to me in terms of the value. I thought some of the other – some of the other measures that looked at t-PA administration were, you know, evaluating a little more critical elements than this one in particular.

Karen Johnson: OK, will anyone else on the workgroup care to discuss really any of the – any part of the measure?

Gregory Kapinos: So first of all, if you think about it, you're going to give it more? So, just by measuring how many hospitals have clinicians that think about t-PA within the Female 4.5 hours, it's linked towards giving more and therefore better outcome? Is there a data on that because when I read the article, I was not totally convinced with all of that.

Lee Schwamm: That was part of the problem I had I guess. You know, I could see that the thrust might not be necessarily that people think about it more as that anybody who comes in, you make sure you document something in there. If you're not going to treat them, it doesn't necessarily mean you're really thinking about treating them.

Gregory Kapinos: Exactly yes. So, testing the sticker like a resonance using stickers for stroke, stroke was considered and you have all the contraindications. And actually that led to them just like protecting themselves on why you did not use t-PA rather than just – rather than really forcing them to think about giving it to the next (inaudible).

Karen Johnson: This is Karen from NQF. And I think maybe it might be a good time for maybe Diedra from AMA-PCPI to talk about the fact that this measure and the next measure, 2022 t-PA initiated is a paired measure and maybe that will help clarify some things.

Diedra Johnson: Hi, this is Diedra at the AMA-PCPI. Thanks a lot, Karen. So, as you previously stated the measures 2042 and 2022 are pairs. The considered measure is basically I think your summation was correct is to make sure that patients are considered and evaluated for t-PA as is outlined in the data.

Very few patients actually receive t-PA and it's been shown in the data as well as the medical literature that t-PA does improve outcome in stroke patients and it's paired with the measure 2022 which actually does capture the administration or the initiation of thrombolytic therapy and that measure is actually harmonized with the Joint Commission measure that was just reviewed.

Daniel Labovitz: Daniel Labovitz here. I find it that this structure with two separate measures like this is – adds complexity without adding clarity. And I think having a treatment – a mandate effectively to consider t-PA up to four and a half hours goes beyond what some hospitals are willing to consider.

So a hospital where treatment in the three to four and a half window is forbidden by the local investigator preference or the legal department or whatever are going to score poorly on this.

Also it doesn't really accommodate well the fact that somebody showing up at the four hour and 15-minute mark has zero chance of getting treatment, but that still accounts as a ding and there's no – there's no escape from it. I think it's just not a – not cleanly done. And I'm very uneasy about imposing a 4-1/2-hour window mandate that's – this is different from the time measure that we discussed previously that also incorporates patients who get treated with t-PA out to 4-1/2-hours. But the only – in that – in that measure, those patients were only including if the hospital choose to treat. If a hospital doesn't choose to treat in a three to 4-1/2 hour window for the time measure, there's no time. And it's not – it doesn't count as a ding.

David Tirschwell: This one count as a ding either as long as you consider it and say that you, you know, you decided not to do it.

Daniel Labovitz: Yes, but then you've got a – you got to document it. There's expense in that. There's documentation issues with that. I think it's just not clean and...

David Hackney: I think – I think the argument is it's kind of a pointless exercise to go through that when you know you're not going, you know, when the person shows up. You know you're not going to treat them so what's the point in having to chart all of that discussion.

David Tirschwell: Quite honestly from a practicing neurologist perspective, these days of somebody comes in with an ischemic stroke anywhere close to a treatment time window, you probably are obligated to write down not keep secret in your head, reasons why you decided to or not to pursue any aggressive treatment. I don't think that's unreasonable.

Daniel Labovitz: But to some extent, this is an – this isn't going to be a neurology documentation issue. This is going to be – you know, if you work in an emergency department and you know you're a neurologist, down three patients said come in, you know, after three hours and you're not even going to call them for somebody who comes in an at four hour or three-1/2 hours.

David Tirschwell: So, I agree with that as well. And I think, again, it's a three – if it's really just the three to 4-1/2-hour issue, I found the NQF document that it was called the evidence tasks force from 3/20/2011 and I'll read you directly specific drugs and devices including quality performance matter should be for food and drug administration approve for the target condition. So, they are approved but if the target condition is stroke presenting within three to 4-1/2 hours, it doesn't qualify in.

And quite honestly, I think the lack of FDA approval will meet with much resistance from hospitals implementing this. And I mean it's hard to say that that's not a leg to stand on that you shouldn't have to do it.

Female: Hey, this is (inaudible)...

Daniel Labovitz: But there's so many things that we do that are not (inaudible). And I feel like you then...

David Tirschwell: But quality measures are in about anything that, you know, the sophisticated stroke centers willing to do. There are about what three hospitals, every day in every place should be doing.

Female: So but the t-PA measure goes out to 4-1/2 hours. I mean, there are guidelines that suggest that you go out to 4-1/2 hours. And so there are some hospitals through that might be uncomfortable with it but the vast majority of people should be considered out to 4-1/2 hours. That it gets to be now a little bit sticky if somebody who is just on the edge as a mild stroke. And so that's why this measure – it goes out to number one, 4-1/2 hours and is only considering. It doesn't actually have a you must give it if you're eligible. So this measure looks paired with that other one actually takes into account going out to 4-1/2 hours. And it takes – and I think considering and documenting any stroke patients within 4-1/2 hours.

I think it's part of the standard of care not just for a neurologist and academic medical centers are Ivory Towers, it actually, I think, is standard of care for everybody across the country. In this day and age, if somebody presents within the t-PA time window, you have to document your thought process for not receiving IV t-PA.

David Tirschwell: Well, I agree with – yes.

Female: This is a guideline – it's not a (inaudible) prude for sure but it's in the guidelines and I think that's standard of care.

Gregory Kapinos: Yes. And as you said also with the – actually with the Electronic Medical Record and now many of the – many of physicians and neurologist have template. It's very easy for them to see that now that the NQF adopted that measure, they will have to just slightly transform their (inaudible) their templates of their notes to see that they considered t-PA and they – and they will – therefore meet the criteria.

So, I also keeps that really imposing much to every clinician whether they are a neurologist to actually just put a sentencing that they considered (inaudible) and then they can explain why they did not use t-PA. So, I agree that – I don't see a major drop of adopting that measure.

Female: And I do think it's important is that the fact that it goes out to 4-1/2 hours, I mean, this measure was designed so it would go out to 4-1/2 hours. I mean, this measure was designed so it would go out to 4-1/2 hours and so that category of patient is covered in a quality measure.

Lee Schwamm: This is Lee Schwamm. Only comment – could I ask you to clarify is the issue of performance because it seems to me that it was only, you know, three to five percent of patients getting t-PA that – your performance will instantly be 97 percent on this measure. And so, if you doubled your t-PA rate from six to (inaudible) percent of all patients presenting to your hospital, your actual performance on this measure rather than doubling goes from 94 percent to 97 percent.

And so, it seems to me more that it's just insensitive in measuring the really difficult work of documenting and actually treating patients. So it rewards you for so many patients for whom t-PA isn't really even a consideration that I just don't – I'm concern and maybe the measure is constructing the way that it's sensitive to changes in actual, you know, rates of evaluation by neurologist.

Female: But is this a denominator patients who arrive within 4-1/2 hours? Are you saying Lee that the vast – that this measure is for all ischemic stroke patients who arrive?

Lee Schwamm: No, I'm actually just trying to clarify among the patients arriving within 4-1/2 hours, mot eligible patients but this is all patients arriving within 4-1/2 hours. So, it's still a small percentage of patients who are getting t-PA treatment. And so, (inaudible)...

David Tirschwell: (inaudible) though as to what greater percentage than three percent.

Lee Schwamm: Right.

Female: Yes. Well, we – all patients who arrive within – I think I'm missing the point. I think I'm (daunt), my apologize but for every ischemic stroke patients that arrives within 4-1/2 hours, they should be considered for IV t-PA. What...

Lee Schwamm: I just think the question is if you're doing the job of actually giving t-PA, those – you're getting – you're credit for many patients and all you have to do is check-off a box that says knowledgeable.

David Tirschwell: So I – so – right.

Female: But there's a point that there's the paired measure actually is an administration. This is actually on consideration. So they actually are two different things. And I think the side of the group was that their combination will more fully and comprehensively evaluate the quality of IV t-PA evaluation and administration. That one or the other by itself doesn't necessarily cover the whole campus.

And so this actually – one is, you know, administering it quickly within that, you know, within three hours and one is considering enough to 4-1/2. That's kind of is the blanket of doesn't necessarily cover the whole campus.

And so this actually – one is, you know, administering it quickly within that, you know, within three hours and one is considering enough to 4-1/2. That's kind of is the blanket of IV t-PA consideration.

Daniel Labovitz: Daniel Labovitz here.

Ann Watt: Suzanne, I have a question. This measure seems to be pointing out a potential gap and that we're not – there may be a population of patient that should be considered that we're not considering? I guess I'm wondering if few of the measure – developer can speak to that gap. I mean, is that a gap?

Diedra Joseph: So yes, this is Diedra from AMA-PCPI. That's correct. That's the patient population that we're – or the gaps that we're looking to address.

Ann Watt: And I guess you also have this in the – it's in the CMS PQRI. Can you speak a little bit about have you seen that population get larger or as you've been, you know, that Paul covered out in the AHA, ASA, get with the guidelines. Have you – I mean, what is the experience then?

Diedra Joseph: So, the measure – earlier version of the measure was actually in PQRI program from 2008 I believe have filled 2010 but I'm just looking at my documents have verified that.

Daniel Labovitz: The results that (inaudible) presented suggest that 79 percent of the patients reported did not meet this (inaudible). So that sounds like the massive gap but it's probably more documentation than whether or not the doctors actually thought about it or not.

Suzanne Theberge: But I think that that's one of the key things. Documentation is now what is that – if you don't document it, it wasn't done and so I think that we need to dramatically change our approach to treating these patients within this three to 4-1/2-hour window (inaudible).

Daniel Labovitz: You know, I got to...

Bill Barsan: Daniel Labovitz, sorry to interrupt. I disagree with that to some extent. Although I think in terms of doing quality measures and medical legal reporting, yes, if you don't write it down, it wasn't done. But I think in terms of true care that winds up leading to identification of documentation shortages but not care shortages.

I'm just uneasy about a measure which winds up actually having a lot to do with documentation and not quite so much with delivery. What I really care about is did the patient get t-PA? And this measure is so parallel to that but not directly attacking it. I've much rather seen concern t-PA delivery as an outcome. I'd like to see that outcome and I'd like to see that as much as possible. I'm a little less concern about whether you thought about it but there's an obvious reason why you didn't give it and then maybe you wrote it down or maybe you didn't.

Female: Your point is very well-taken. And I think the preference of the group that came up with this measure was the same thing. But given just a vague (inaudible) of this 4-1/2-hour window FDA approval, you know, the benefit might be slightly less. Maybe there's a little bit more judgment involve that the consideration seemed to be the best option or the better of the two options.

Daniel Labovitz: Can I ask, Lee Schwamm, are you still on the line?

Lee Schwamm: Yes.

Daniel Labovitz: You may know more about this than anybody else but, I mean, I know that t-PA was just at least I've heard this. I haven't it seen written anywhere was just sort of refused approval by an active FDA review in the three to 4.5-hour time window. Is that – to your knowledge, is that an accurate statement?

Lee Schwamm: So there's – to my knowledge, I think it's been publicly released about this and I don't know whether denials by a panel result in a publication. But the Genentech submitted data to request an extension of the label to three to 4-1/2 hours and the FDA said they was insufficient data presented for them to extend the label.

It was not – to my knowledge an expression of a concern about patient harm but rather since there were no U.S. patient enrolled in the trial that was presumably presented that there was insufficient data for the U.S. to extend the label. Now, I don't – I think that is different than the FDA being silent on the issue but it's not the case of the FDA issuing a black box warning or identifying a procedure is unsafe.

Daniel Labovitz: I didn't agree that they didn't identify it as unsafe but they very clearly didn't identify it as safe and as FDA-approved. And quite honestly, I think any hospital could use that to decide administratively not to use the extended time window despite what the stroke neurologist that the American Heart and Stroke Association think.

So, again, quality, you know, is about the most broadly applied – performance measure should be about the most broadly applied standard of care and I really think that the three to 4-1/2 time window is not quite there yet. You know, quite honestly, I don't think the quality measure will change that much if you restricted this to the 0 to three-hour time window.

(Irene Catherine): Can I just bring up one other point? This is (Irene Catherine) from that measure group that there is a difference between the measures that we're talked about before from The Joint Commission and these are physician reported measures. None of – and if you think should be considered when thinking about these two measure set.

Lee Schwamm: (Irene), you might want to expand on that.

(Irene Catherine): So this is a PCPI measure so this is for physician reporting and then The Joint Commission one is a hospital level reporting measure.

Diedra Joseph: So actually – this is Diedra from the AMA-PCPI both the considered and the initiation of t-PA measures are specified at the facility level.

(Irene Catherine): Oh, I'm sorry. Sorry about that.

Diedra Joseph: That's OK.

Karen Johnson: This is Karen from NQF. And you guys has had a really interesting discussion and I hate to kind of step in. But because of time, I think I probably should. I did want to make sure that everybody understand what paired mean with NQF. So that means that the two measures t-PA considered and initiated dose is endorsed by NQF. It means that they must be used as a pair. So, that is just one thing that I wanted to make sure everybody was aware of.

And really quickly, you've already talked to some extent about measure 2022, the t-PA initiated but maybe we can take just a couple of minutes and is there any concerns with that measure that you want to air on today's call?

Bill Barsan: Yes. So, this is Bill Barsan. Some of the – some of the denominator exclusions I had issues with in terms of, you know, some of the warning conditions or whatever, you know, advance stage and some of these different things that really or not contraindications to treat stroke severity, mild stroke severity, or too severe that to me, imply that those kind of patient are shouldn't be treated. And I think that's somewhat concerning.

And I think that, again, as we talked about before, I think that if you compare it this one which is looking to measure I think the same kind of process, you know, I think the 437 does it better than this one does personally.

Diedra Joseph: This is Diedra from the AMA-PCPI. Thanks for your comment. I just wanted to point out to the workgroup that the list of exceptions that are included in the measure is actually exactly harmonized with the exclusion list that is included in The Joint Commission measure. So, it would be the same concerns with regards to both measures.

Bill Barsan: OK.

David Tirschwell: So it speaks that same measures, is that what you're saying?

Bill Barsan: There's a wide (inaudible).

David Tirschwell: It didn't seem wide to me either.

Diedra Joseph: The listed exclusion is the same.

Bill Barsan: Denominator exclusions and the other one is documented reason for not initiating IV thrombolytic. There are not all these things about advance stage, et cetera, that are in there. I didn't find those anywhere.

Diedra Joseph: Oh, I'm not sure if The Joint Commission staff can speak to this but that exact same list does appear in the specification. For The Joint Commission measure, I don't know if Karen can speak to that issue.

Karen Johnson: That would be Karen from joint commission?

Diedra Joseph: Yes.

(Karen): I'm sorry, we missed that last part. Was there a question for The Joint Commission?

Diedra Joseph: Yes. This is Diedra at the AMA-PCPI. We were just discussing the exclusion and exception list that is included in the t-PA initiated measure. We're just pointing out that the list of exceptions that is included in measure 2022 have actually been exactly harmonized with the list that appears in your specifications for the – for The Joint Commission measure. And I wanted to just see if you are caring to speak to that issue.

(Karen): You know, this is (Karen) of The Joint Commission. I haven't actually looked at the submission for 0220. So, let us look at that and get back with you, OK?

Diedra Joseph: Fantastic. And just for your – for clarification, it's the list of warning and contraindication that's included.

(Karen): Oh, yes. That's – OK, I understand.

Karen Johnson: And this Karen from NQF. And maybe this is – can Joint Commission folks explain you have a reference in your material to your data element manual. Were those details being there and not in your submission?

(Karen): Actually, the warnings and contraindications that would make thrombolytic therapy an advisable is the table that's included in the measure information for stroke for. It's not actually data element but it is a detailed was taken directly from the FDA labeling instruction which is really reference information for the abstracters so that – in the data element, reason for not initiating thrombolytic therapy it's listing all the possible reasons that might be acceptable.

So, it's really more of an informational table. The exclusion in our measure would be – if any of those reasons were documented for the data element reason for not initiating thrombolytic therapy then the case would be excluded.

Diedra Joseph: And so then, this is Diedra at AMA-PCPI. So, our list that we've harmonized with that list that you just spoke to is actually list of exceptions versus exclusion. And the use of exception is allowed for clinical judgment by

this division. And we listed them as a list of examples. It does not need to be inclusive or exclusive list. So it's still land with the list that include in the (inaudible).

Daniel Labovitz: Daniel Labovitz here. Diedra, I can see the work that went into that. And I've – I knew that the game of establishing national quality measures, we're honored to be part of the conversation. But I worry because what I see most other doctors and what I've seen in court, somebody was point to a measure like guess and say, "Look, the AMA says that you – if you're old you shouldn't get the t-PA. Do you agree, doctor?" It puts I think the emphasis in the wrong place. And I'm uneasy but I don't think – I don't think our data support that exclusion.

And calling an exception and you clarified that very nicely but I don't think that that subtlety is going to play out well across the country. The conversation on the phone now being much more sophisticated than perhaps what's going to happen in the emergency department in the middle of the night in the world tend to see.

I like to make things as simple as possible. If the doctor – I like the idea of the doctor saying up – I'm not seeing a t-PA because of X and that's the deal. He made the call. Maybe it's the wrong call but I'm a little leery of us imposing requirements which aren't data-based.

Diedra Joseph: So, again, I would just like to clarify that they're not requirements. They're up to the physician's clinical judgment and we do include the definitions and the differences between exceptions and exclusions in our major documents as well as in the – we have included in the NQF submission form. And I would just also add that this methodology have been in place for a PCPI measures for quite some time. We have tested to use the exceptions and it's widely used. So hopefully that will address your concern.

Daniel Labovitz: I've got another question about the document that was submitted regarding the estimation of electronic health record. I think it was all the PCPI submissions that said that, you know, all of the data were in electronic health records. And so, does that imply that they are for the use of these measures that whoever is doing it, the physicians that are participating in this program have all of the data elements as a part of their AHR so there's no data abstraction whatsoever. Is that what that means? No manual data abstraction?

Diedra Joseph: Are you – I'm sorry, are you asking about all of the PCPI measures that are just being...

Daniel Labovitz: Well, this one said, for example, that there was the claim that it was fully AHR implemented. So does that mean that every physician that's reporting on this quality measure, there's no chart obstruction. They just pull it electronically from their medical record?

Diedra Joseph: Can you please refer to what's best when you're addressing what's in the form.

Daniel Labovitz: I probably can. Hang on a second. It's in the feasibility section. And it's sector 4B under feasibility. That's all data in – all data elements in electronic health records.

(Carrie): Right. So, this is (Carrie) from the AMA-PCPI. Perhaps NQF staff could help clarify that question but our understanding is that that question is asking if all data elements are available from electronic health record.

Daniel Labovitz: Who's electronic health record? From any electronic health record in the world or...?

(Carrie): I would have to defer to NQF on what the intent on intent of their question.

Daniel Labovitz: Because they're not available in my electronic health record, I could tell you that.

(Carrie): This is (inaudible).

Daniel Labovitz: Specifically coding the doctor's notes is something that the AHR is still struggling over. Some of the other stuff might be.

David Tirschwell: Right. But they're saying everything.

Daniel Labovitz: Yes.

David Tirschwell: So that's what I didn't.

(Carrie): So if NQF could clarify the intense of the question then I'll respond to what we found in our testing?

David Tirschwell: That sounds fair.

Female: What NQF is asking is whether or not all elements in the measure are available in AHR in the five considerable fields.

(Carrie): Great. And our testing projects untested at a limited number of institutions, somewhere typically between four and six and we found that all of the data elements were in fact available in these AHRs. Yes, there are probably still many AHRs that do not have all the functionality implemented but you can see in the testing results that the four practices that we had which were a large group practice in an urban Midwest setting with a full AHR that was APEC, a medium-sized hospital based neurology practice in the Midwest with some AHR which was IDX transitioning to APEC, a small group practice in urban – in the urban south which had paper and claim data source about when not tested in the AHR obviously.

And a large group practice in the urban East Coast setting with a full-aim AHR called (Serrano) which I'm not particularly familiar with.

David Tirschwell: So you said one of them wasn't fully electronic?

(Carrie): Right. So three of the sites we tested in AHR environment. The other site was tested in a paper and claims environment.

David Tirschwell: I guess – I just don't know what the point of that question is, Dan. I mean...

Daniel Labovitz: Yes, it means if you have an AHR, this would be in there. But obviously if you don't have an AHR then it's not in your AHR.

David Tirschwell: But I've got an AHR and it's not in there.

Daniel Labovitz: Right.

David Tirschwell: So, I mean, (inaudible).

Daniel Labovitz: So you have.

David Tirschwell: That it's possible to do this in an AHR fully electronically? Is that sort of what the question is driving us? I mean, because that's – then that then your answer would make sense.

(Carrie): Yes. Our understanding and again, NQF, please feel free (inaudible). If we are understanding incorrectly, we would want to know that. But our understanding is that this question is asking that it is possible if it isn't that feasible that an AHR could collect all of this data and you could get the information back out of the AHR. It's not 100 percent of AHR. It's not every AHR, every physician practice in the entire world. It is feasible in some AHRs at this time.

David Tirschwell: In this, what the information are you – did you check for when you look in AHR.

(Carrie): Well, we look for every data element that is necessary to calculate the measure. And we look to ensure that it would be possible to calculate the measure from the electronic health record.

David Tirschwell: Without?

(Carrie): Just our message.

David Tirschwell: Correcting data down electronically.

(Carrie): I'm sorry.

David Tirschwell: I mean...

(Carrie): Beginning of that.

David Tirschwell: I mean, if the data are in free tax notes that somebody has to go through and pull out.

(Carrie): I agree. That would not be possible unless you had natural language processing and your electronic health record exercise.

David Tirschwell: Oh then I guess I would – the question as very little meaning because I can't imagine that any of these are impossible to put that where they were so well-define that I would think they're all feasible to be in electronic health record.

(Carrie): OK. I'll defer to NQF as to the importance of the question that they're asking but that's how we interpret it and that's how we entered that.

David Tirschwell: Yes. All right. That's fine.

Karen Johnson: And this is Karen from NQF. And I will send out an e-mail later on to the full steering committee explaining that question just a little bit better so that everybody will be on the same page on that.

We are running short on time. So, I hate to cut-off again but I'm going to ask Dr. Kapinos to discuss measure 0438.

Gregory Kapinos: Holding down until I see the measure to refresh (inaudible). Here we go 438 is submitted by The Joint Commission for the measure of how many patients have been receiving antithrombotic therapy by the end of hospital day two out of all the patients that were admitted for stroke.

So, I think there was no main concern. Let me see if anybody from the workgroup had any concerns about the rationale. Everybody's commenting on the huge gap and I don't see any other main concern of...

David Tirschwell: Pretty much commenting on the lack of a huge gap.

Gregory Kapinos: Yes. That's what I meant here. So, since it sounds like a – or the old that they have that it's furnished, it's already telling us that there's a 98 percent already compliant with that measure. The question of few reviewers and the workgroup was well done if there's no practice gap what's the – what's the need to implement that measure.

Gail Austin Cooney: This is Gail Cooney. I was the one that have that concern with this measure in the next one. I'm just not sure how much better the 98 percent we can expect to get.

Daniel Labovitz: Daniel Labovitz here. I agree. I think when you meet – when you're measuring something...

Jolynn Suko: This is Jolynn Suko as well. I cited the same thing.

Daniel Labovitz: That's far.

Jolynn Suko: I wonder if we have achieved what we – I mean, what are we gaining by having this measure be a focus, so much quality improvement, at the same time, I wouldn't want us to lose the game that we've made nationally. Putting up someone from the NQF could comment on that. I mean, it seems to me that there's other measures that we would want hospitals to focus on given that there isn't as much of a gap in this one but is there any (inaudible) have you thought about this or...

(Ann): Excuse me for interrupting. This is (Ann) from The Joint Commission. And I will at the NQF (inaudible) but one thing I did want to point out to you is that the total number of hospitals collecting on these measures for us and this entirely voluntary. This is not all Joint Commission accredited hospitals are required to report on these

measures. Hospitals get to choose what measures they report on. So this is a self-selected samples. There's only about 1,000 hospitals that report on this. And so, our feeling is that, OK, if there is 97 percent performance rate on hospitals who are self-selected for this measure set presumably because they have a special... The likelihood for the other hospitals in this country achieving that performance is fairly low.

Daniel Labovitz: I think the data from get with the guidelines suggest that the performance is extremely high as well on this measure, granted again, those are self-selected hospitals that are actually doing stroke quality assurance but it's a wider slot of hospitals. It leaves very, very little room. Most of the patients are being missed I suspect. You will do – maybe running into systems or documentation issues. And I just have a hard time believing that if this isn't being widely practiced even in hospitals which don't do QA.

Karen Johnson: And this Karen from NQF. And let me address your question about how's NQF thought about this. Yes, we have. And what the steering committee will need to do is to think about and evaluate, you know, the numbers that has been provided by The Joint Commission. And also their explanation that you just heard in terms of why they think pretty much the measure has not been topped out and make a decision as to what you think about that.

We do have a special status for measures which we call reserve status. And that's not something we bring out for every measure but for certain measures that pretty much have been topped out and but also meet several other requirements, you know, they have to be really stellar measures in several other ways is the committee think that the measure has been topped out but it's still a great measure and it's still worthwhile being a national standard then we could consider putting it in as a reserve status measure.

So, you would have to first decide whether or not you think it's topped out and then think about whether you would still deserve that reserve status or not or whether it should just be discontinued as NQF endorsement.

Daniel Labovitz: Daniel Labovitz here again. Thanks. That's an interesting category. I like to know more about it. But I think the broader question is I'm asking your experience now, is there a measure where we've ever gone from 97 percent to 99 percent. Is there any measure which achieves better than 97 percent or 98 percent as this one does.

Karen Johnson: Right off the bat I do not know the answer to that.

Daniel Labovitz: I'll bet it's almost unheard off.

Lee Schwamm: This is Lee Schwamm. I think the challenge here which you really crystallize is what is the value of sustaining high performance? And the one concern I have about decommissioning measures related to discharge or by hospital day two antithrombotic therapy is that we know there's a 25 percent risk reduction of desk and disability for all patients with ischemic stroke.

So it affects a huge number of patients. So, despite the fact that the performance is high. The attributable benefit of this measure is seeing across the entire ischemic stroke population unlike, say, the thrombolytic therapy measure which actually covers relatively narrow (slot) of those patients.

And I think it – I think that we see that despite the fact that performance is high, we have I think the largest number of hospitals and which we have almost no data are the very small world and frontier hospitals that aren't in guide with the guidelines that aren't in The Joint Commission program. And we really don't know that much about their behavior with respect to initiating therapies. And from many of these patients, therapies are differed to the primary care physician after discharge.

And I just would ask the panel to think carefully about the message that might be sent by decommissioning measures that relate to antithrombotic therapy. But I agree with you. Performance is unlikely to improve. It's really about sustaining at this point.

Daniel Labovitz: I mean decommissioning can't be interpreted as no longer of importance. And I can't imagine that that's the message that goes out with decommissioning. So – and I guess, I'm also not sure all of these measures unless they're suddenly required and I guess they will be required by CMS. We won't have any data on with those small hospitals who will never being get with the guidelines are doing.

Lee Schwamm: I mean, my – what I would urge you to consider would be to reapprove the measure, allow it to be collected in the core measure set and the meaningful use measures and then you'll have at the time of the next evaluation of this measured data to address the question of just how different is the performance between voluntary and non-voluntary hospitals.

Gail Austin Cooney: This is Gail Cooney. Is there a way to make this measure applicable in a non-voluntary way? I guess that would be make it mandatory.

(Ann): This is (Ann) at The Joint Commission. And I can tell you that CMS have this entire stroke – The Joint Commission entire stroke measure set is slotted to be included in CMS as in-patient hospital reporting program which doesn't make them their use mandatory but as you know it does mean that if hospitals don't collect and report on this data that they will not be getting our full market basket increase. And so, we anticipate that they will be ticked-up by the vast majority of hospitals that receive CMS reimbursement. And I think that that is for data collection beginning.

Gail Austin Cooney: January 2013.

(Ann): January of 2013.

David Tirschwell: So this is going to happen no matter what the NQF does.

(Ann): Well, I really don't know CMS's relationship with NQF endorsed measures. Sometimes they're required, sometimes they're not. And honestly, I don't know for this one.

David Tirschwell: Seems like a bigger policy question that those beyond the scope of what this committee isn't about figuring out what CMS is going to do. It's about evaluating these measures on the criteria that were putting in front of us.

Jolynn Suko: This is Jolynn again. And I agree, I wouldn't want to see this – I wouldn't want to see our performance decrease and it would be great to have the world hospitals and this maybe more of a decision for the entire committee. I think just, you know, what should we endorsed – what are the biggest priorities that we're already at 98 percent, you know, it is something we'd want to consider for that reserve status. Does this probably is not for our discussion today but it's just something to throw out there.

Karen Johnson: And this is Karen from NQF. And again, I hate to cut-off this discussion but I believe we probably should go on to the next The Joint Commission measure. It is quite similar in ways maybe, Gail, could you introduce that measure. And I believe it may have some of the same questions in terms gap and that sort of thing.

Gail Austin Cooney: It does have the same kind of measures of questions – 0435: Discharged on Antithrombotic Measure on (inaudible) listing too long. Antithrombotic therapy is looking at the proportion of ischemic stroke patients prescribe antithrombotic therapy at hospital discharge. This has been an affect since 2009. And like the measure we just discussed, this one actually has even slightly higher performance standards that had been demonstrated in The Joint Commission to get with the guidelines program are all fairly consistent at that level.

And the main issues on this again where the question of performance gap. And I do have one question for The Joint Commission that might help me to understand it better. There was a notation that this data was required to maintain their primary center designation. What proportion of reporting institution use it for that measure. Is that really skewing the data?

(Karen): This is (Karen) from The Joint Commission. I don't that skewing the data, we do know that right now we have approximately 950 sort of like primary stroke centers certified by The Joint Commission across the United State. And one of the requirement is maintain their certification status is collection of data for all eight measures in the stroke (inaudible). So that was the reference that was made in the commission.

Karen Johnson: Did any other of the committee members have any other questions or concerns about this measure?

David Tirschwell: This is David Tirschwell again. I think this is of tremendous importance. And we're struggling with the same high level of rates so I think the NQF has to come up with a different category not reserve but I think they need

to come up with a quality measure hall of fame where the best measures that you've topped out but are still hugely important end up living in eternity.

And, you know, because I – I don't know. I just think the decommissioning is totally dissatisfying. It sounds like and – it's obvious of high importance.

Lee Schwamm: This is Lee Schwamm. Could I just ask the NQF to clarify if a measure is NQF-endorsed, it does not require CMS or other agencies to collect that it really makes it available for them to use in measurement programs should they choose to do so. Is that right?

Karen Johnson: That is correct.

Lee Schwamm: So, removing endorsement for the measure generally takes it off the table for most of the agencies that would normally collect quality data. But having it approved merely makes it available but those programs could still choose not to use that as a quality measure for pay for performance or pay for reporting but it would remain available to them should they choose to do so. Is that right?

Karen Johnson: Correct.

Lee Schwamm: OK. Thanks.

David Tirschwell: So Lee, one of the criteria for approval is the demonstration of a performance gap and that's what we're struggling with.

Lee Schwamm: Yes. You know, we have – I think the catch-22 that the sites that we think are most likely not at this high level are precisely the sites that don't report any stroke data. And, I mean, I will tell you that when we started this ago with get with the guidelines, baseline performance on the early antithrombotic measure that the antithrombotic of 48 hours or hospital day two was only at about 85, 86 percent. So there has been substantial improvement year by year in that measure despite the fact that many people thought it wouldn't improve at all from its baseline.

I just worry that if we remove the endorsement, it will disappear from measurement programs and hospitals will focus their energy in attention on other measures that are being...

Karen Johnson: All right. This is Karen again from NQF. And it sounds like it's going to be a very fruitful discussion at the in-person meeting. So – and we will definitely when we write up our notes of this call, we will make sure that we include discussion on that.

If there aren't any more concerns on that particular measure from the committee, I would like to go on now to measure 325. It is quite similar but it is supported by AMA PCPI and I think that (inaudible) you have that measure.

Male: I do. So right, this is – was originally endorsed in 2007. The brief description is it's the patients with ischemic stroke or TIA who were prescribed antithrombotic at discharge and – let's see what else. There's a number of, I think, reasonably appropriate exclusions. There is no risk adjustment or stratification. This is a – as far as I can tell, a clinician level measure of the AMA PCPI and – well, that's the overview.

Moving into the important measure; most people thought it was obviously important, although – and I was one of the people that raised the fact that they reported 53 percent non-compliance, which is of course in shocking contrast to the 98 percent plus compliance rate from the Joint Commission and get with the guidelines. So it's a little bit puzzling how to put that all together.

Let me see if were there any other issues with the important to report – the important and the evidence. It seemed pretty, pretty consistently approved.

Female: So this is the – just the AMA PCPI. If I may, I wanted to speak to the issue of the gap – the performance gap that was reported.

David Tirschwell: So the data that we have reported is actually data from the PQRS system, the CMS Physician Quality reporting system. And that's why it's probably different than the joint commission data again, the measure specified at the physician level. And so for 2008, there was gap in shares on a 53.03 percent and then for 2009, it was 85.1 percent and 2010 was 82.8 percent. So I just wanted to make that clarification.

Male: Yes. It seems to have gotten a lot better. But even 20 percent not complying with is – it seems a little hard to believe.

Female: Well, just to add to that…

David Tirschwell: But you could have it.

Female: Just to add to that. The PQRS system is a voluntary reporting program, and about 24 percent of eligible professionals participate – participated in the program in 2010, so that's the data that we have to go on.

David Tirschwell: Yes. And your reliability seems…

Female: And (inaudible). And a question on that; is that data in the PQRI data that's submitted on provider claim. And the reason for my question is for those hospitals that are using either paper-base claim sheets. My hunch is that, that would be documented in the chart but maybe not on the claim sheet. Do you know that?

Female: So the CMS PQRS system is reported through claims. I didn't quite understand the second part of your question.

Female: Well, I guess my hypothesis is that – if a physician has rounded on a patient and this chart – you know, and done this work, documented it then chart –depending on how your – you submit your claim, whether it's a chart slip or if it's electronically, whether or not they circle the right code about their discharge on this, my hunch would be that it would be variable. But that – I have no evidence to support that. I just – I would say that, you know, it just kind of – if it's this claims base data, I know on our system which is on paper, you know, document in the chart.

Male: So it's a documentation thing you're suggesting as opposed to a true reflection of performance?

Female: Yes. My hunch is – I mean, it'd be curious to me to look at that data and look at the chart to see if it was documented in the patient's chart and not submitted on the claim.

(Carrie): Yes. This is (Carrie) from AMA PCPI. That's an interesting theory. I don't have any data to back that theory up. I will say that CMS does consider everything that's submitted as a claim to be – it needs to have documentation in the chart to back that up, otherwise, it's a fraud and abuse issue. So they do consider that the information that they get from physicians is accurate and are right.

Daniel Labovitz: And, you know, your reliability study suggest that there was a re-abstraction of charts and that there was a very high level of agreement with the original data as submitted. You know the other thing that's interesting and contrast this with the other antithrombotic measure, other than it being hospital-based versus clinician-based is the inclusion of the TIA sub-group. And I think especially, the joint commission measure goes to considerable length to explain that they excluded the TIA group because of unreliable identification of those patients by ICD 9 coding. And I guess I wondered whether that might not be a point of contention with this measure – and a partial explanation for the low performance. If you didn't think they had a TIA, you probably wouldn't discharge them on an antithrombotic and who knows how the coding is going at discharge.

Karen Johnson: Diedra, did you have any comments on that question?

Diedra Joseph: I wasn't aware of the – of a question there but I'm hoping that Dr. (Casan) is still on and maybe can speak to the workgroup rationale for including the TIA patients and in the denominator.

(Casan): Yes. I'm sorry I was – I was on another parallel conference. The – I believe that the reason that they chose the TIA measure was because of the concern that TIA patients – even though it's more of a garbage basket TIA

patients, it's important for quality purposes for that specific subgroup and that actually might be the subgroup of patients that might require more quality efforts than patients who have a more obvious diagnosis of stroke.

I can't speak to the accuracy of the TIA diagnosis in this specific hospital. I understand that there are issues. But if the diagnosis is made that patient has TIA, by definition that patient should fit, you know, a quality measure and if it's not then that hospital maybe should not code that patient as having a TIA.

David Tirschwell: Daniel, I don't know what – with more recent performances on this – this is David Tirschwell again, but I do find it a little bit troubling, the big mismatch. And, you know, because people are investing a lot of time and money in this, I guess I'd like to see a little bit more study done on the reliability side to see if they can identify why there is such a big mismatch.

(Casan): I mean, I would think this could be harmonized with the joint commission measure that looks at the same question and make them both more valuable.

Daniel Labovitz: Daniel Labovitz here. I agree with that. I think harmonization would be a nice step here because they are trying to do the same thing. Just to comment on the TIA question. I was uneasy about the elimination by the JC of TIAs because it invites TIA to continue to be a garbage basket diagnosis.

We're – I've been working very hard with the hospital. It's a long process but trying to get the coding more in lined with what the doctors are thinking. And right now, coding, we will say that if some – if an intern writes – rule out TIA, on day one, that can be the diagnosis even if the stroke attending writes on day three, this was carpal tunnel.

So it's – it is a problem. And I don't think these measures are quite the lever to get that fixed. But if we – if we abandon TIA, it's going to be forever awful.

Diedra Joseph: This is Diedra at the AMA PCPI. I just wanted to add that another reason why TIA is included in the denominator population is because the supporting guidelines do reference the importance of any thrombotic therapy for TIA patients.

Male: (Inaudible) to respond from an NQF – from joint commission perspective. The – this was the recommendation of the expert panel that the joint commission pulled together and the concern I think very explicitly was for true TIAs, that all of this scientific-base recommendations were highly appropriate. But when the panel realized that they would be held accountable at their hospitals for every patient in whom the diagnosis of TIA was applied. The accuracy of that diagnosis when applied through a billing and coding mechanism was felt to be unacceptably poor so that you would be held accountable for failing to have start in an thrombotic therapy in a – and a statin in a patient who came in with dizziness.

So I think it's not about whether or not the interventions are appropriate for patients who meet the indication, it was about the lack of specificity in the coding that made people feel that the target population was not likely going to be accurately characterized. We have struggled with this as well. And it really is – in a registry where you can prospectively identify and include anyone who you feel has the appropriate diagnosis, only the true TIAs get in. But in a claims-base model where you have complete capture of a list ICD 9 codes and all of those patients need to be screened and entered, then you have those challenges.

I don't know what the right answer is but that's the rationale for focusing again on the idealized population of stroke patients while simultaneously emphasizing the importance of having protocols in place to treat TIA patients.

Karen Johnson: Thank you very much. This is Karen again from NQF. And I think – just because of time, we do need to go on to our next measure that you have put your finger on that the TIA question is something that will come up not just TIA question is something that will come up not just in this measures that the other workgroups (inaudible) and talked about. So this will definitely be something that will come up in the in-person meeting for multiple measures.

So that said, let's go on to our last measure that we have about – we can spend about seven or eight minutes on this last measure so, Jolynn would you like to take measure 0439.

Jolynn Suko: So, 0439 is discharged on a statin medication. This is up – this was originally endorsed in 2008 and it is from the joint commission. It focuses on ischemic stroke patients prescribed a statin at discharge and that the numerator and the denominator is ischemic stroke, patients with an LDL greater than or equal to 100 or LDL is not measured or who are on a lipid lowering medication prior to arrival.

As we looked at the importance to measure, there was widespread agreement around importance to measure also on the evidence – widespread agreement, scientific acceptability, usability and feasibility and suitability for endorsement were all very high. These, like some of the other ones I think for the questions came in to play were, are we approaching a feeling in performance around this measure. So with that I'll open it up for further conversation.

Is anybody there?

Male: Well, I think that was the issue for me was – it was the same thing, how much better can we get and is it worth chasing that incremental improvement.

Male: That was my only concern with this measure as well. I think these are tried and true well salted measures and we've been doing them for years. They're very well written and set-up that the algorithm for identifying numerator, denominator is well established but maybe it's time to be done. And I just will make the additional comment – I was impressed by Lee Schwamm's point that perhaps these need to be kept active for just a little while longer while we're – while CMS picks them up.

I just worry – CMS moves slowly. If we pick – when CMS picks this up, it may never ever drop them. So that said I'm done.

Lee Schwamm: This is Lee Schwamm. I just want to respond. I'm delighted you think we've made great progress on this measure. I can tell you that we in – to get with the guidelines in 1,600 hospitals, we're only at 90 percent. We've seen a steady rise over the last five years. I don't believe that we are by any means, tapped out of this measure, and I think estimates suggests that this is one of the main reasons why we've seen a decrease in stroke mortality in the last decade. And I think we actually have a long way to go here and I think most cardiologist would tell it would be sinful if 10 percent of their patients were being discharge without statin after coming in with an acute MI.

So I – while I'm delighted that we've seen progress, this has been a very challenging measure for hospitals and I don't think we're at the point where we can deemphasize that and particularly with increasing concern in the media and from the FDA about potential side effects of statin. We've already seen what we think may be a dropping off particularly in the use of intensive statin therapy because of concerns about side effects and the development of diabetes.

So I would urge you strongly that this measure is by no means tapped out and that performance at small hospitals that are in these programs, I would get – I would bet you are lagging substantially behind because a huge amount of education and outreach has gone on in the last five years to educate sites about the importance of starting statin therapy.

Bill Barsan: This is Bill Barsan. I just had one question and that was regarding the exclusions in the, you know, the Sparkle study that excludes patients with atrial fibrillation, cardiac emboli and those aren't exclusions on here. I mean, are you thinking you all just capture that under documental reasons for not prescribing statin.

Lee Schwamm: That's – it's a great question Bill. And actually, this relates to – so the Sparkle Trial did not include patients who had a stroke mechanism that explained their stroke in the absence of atherosclerotic disease.

Bill Barsan: Right.

Lee Schwamm: You have to have some evidence of atherosclerosis. And so originally, this measure was constructed that you had you have the sentence or the phrase, evidence of atherosclerosis to be in the measure.

Bill Barsan: OK.

Lee Schwamm: It became clear quickly from the joint commission's piloting that nobody writes that down.

Bill Barsan: Right.

Lee Schwamm: I mean, we infer that as physicians but nobody actually documents that. So now, more appropriately, given that 85 percent of our patients with ischemic stroke have atherosclerotic disease, if there is no evidence of athero, that is an exclusion to the measure. So patients with pure lone Afib, patients with dissection, patients with hypercoagulable state, they are excluded from the measure by a dent of contraindication so long as their medical record documents that there is no indication for statin therapy or that there's no evidence of athero.

Bill Barsan: Really?

Lee Schwamm: Yes.

Bill Barsan: I mean, if you read this, I don't read that. I mean I don't see that by reading that.

Lee Schwamm: So the – I'll refer to Ann and Karen as to how abstractors are guided by both the guidelines for abstractors as well the inclusion exclusion criteria and the coding instructions. Can you answer that, Ann?

(Karen): Yes. This is Karen at the joint commission. And what Lee just told you is correct. However, the actual data elements that would result in the exclusion in the algorithm flow logic is the reason for not prescribing statin medication at discharge.

Bill Barsan: OK. So you'd have to specifically say I didn't do it because they didn't…

(Karen): Correct.

Bill Barsan: They had atrial fibrillation.

Lee Schwamm: Exactly. And sites are actually pretty good about doing that now.

Bill Barsan: OK.

Lee Schwamm: And so, you know, this 90 percent is in the face of that. So we – it is possible that part of the performance gap reflects a lack of document but we've done a tremendous amount of training around this issue and I think – it's just like TPA. People now document why they don't give TPA; people now document why they don't give statin therapy.

And I think for the tremendous betterment of our patients, there's also, I think, increasingly data suggesting that patients on statin therapy before arrival may have better outcomes and milder strokes and that starting statins early may have benefits in the same way in which it does in acute coronary syndrome.

Bill Barsan: Right.

Karen Johnson: Great. Well, this is Karen from NQF and I want to thank you guys for really having a very lively discussion. I think you are liveliest group with the four workgroups for what's that worth.

So I'm going to hand it over now to Suzanne who will tell about next steps.

Suzanne Theberge: All right. Thank you everyone. We had excellent turnout on that survey, the preliminary measure evaluation survey who are actually the – had the most number of votes. But if anybody would like to change their ratings following the discussion, we're going to keep the surveys open through tomorrow, at close of business tomorrow.

So if you want to change your vote on any of the sub-criteria following this discussion, just go back in and fill out another survey and just write two after your name so we know that it's a new vote.

Male: Do what – write what now again?

Suzanne Theberge: Write a two. Just the number two after your name...

Male: OK. OK.

Suzanne Theberge: … so that we know if you're a new vote and then we'll – we're going to be compiling a document with all of the sub criteria ratings and sharing that with the committee next week as you prepare for the in-person meeting.

So the next steps for the committee are the in-person meeting is in two weeks from yesterday and today. And so we'll need you to review all the measures and come to that meeting prepared to discuss them all in depth. As we mentioned earlier, we have reopened some of the measures to allow the developers to make changes based on what's happened on some of the previous calls this week. So we'll be sharing those updated measures, hopefully, by Tuesday next week, we are going to give them a couple more days to make those changes. I'll be posting a revised versus on share point and marking them updated.

We're also asking them to give us a summary. So I sent you some summaries earlier today and that will just let you know exactly what was changed in case you've already reviewed the measure and then you don't have to go back and re-read everything.

Before we open up for a public comment, are there any questions on the next steps?

All right. Great. Operator, can you open the line for public comments.

Operator: Thank you. At this time, if you would like ask a question, please press star then the number one on your telephone keypad, we'll pause for just a moment to compile our Q&A roster. And again, that's star one to ask a question.

And there are no questions at this time.

Suzanne Theberge: Great. All right. Well, I think that concludes the call. If the steering committee members have any questions or comments, please feel free to e-mail us and we look forward to meeting you in a few weeks.

Thank you everybody and have a good afternoon.

Operator: Ladies and gentlemen, this concludes today's conference call you may now disconnect.

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