

## **NATIONAL QUALITY FORUM**

**Moderator: Caren Ginsberg**  
**September 22, 2011**  
**1:00 pm CT**

Operator: Welcome to the conference. Please know today's call is being recorded. Please standby.

Caren Ginsberg: Good afternoon everybody. Welcome to the follow-up call for the Palliative and End-of-Life Care Steering Committee to discuss measures that were - that needed extra attention as a follow-up from our meeting on July 20th, 21st and 22nd. I believe those were the dates.

We have a full agenda today. And before we get to discussing the agenda, I'd like Lindsey just to take roll and make sure we know who's on the call.

Lindsey Tighe: Okay, (Russell Activado).

Eduardo Bruera

(David Casarett).

Bob Fine.

Richard Goldstein.

Sarah Hill.

Sarah Hill: Here.

Lindsey Tighe: (Pam Kaylan).

(Naomi Clark).

Mark Leenay.

Mark Leenay: Here.

Lindsey Tighe: Michael LePore.

Michael LePore: Here.

Lindsey Tighe: Solomon Liao.

Solomon Liao: Here.

Lindsey Tighe: June Lunney.

June Lunney: Here.

Lindsey Tighe: Stephen Lutz.

Stephen Lutz: Here.

Lindsey Tighe: Helene Martel.

Helene Martel: Here.

Lindsey Tighe: Sean Morrison.

Sean Morrison.

Lindsey Tighe: Naomi Naierman.

Naomi Naierman: Here.

Lindsey Tighe: Douglas Nee.

Douglas Nee: Here.

Lindsey Tighe: Kathleen O'Malley.

Kathleen O'Malley: I'm here.

Lindsey Tighe: Tina Picchi.

Tina Picchi: Here.

Lindsey Tighe: Tracy Schroepfer.

Tracy Schroepfer: Here.

Lindsey Tighe: Douglas White.

Caren Ginsberg: And are there any other guests?

Bob Fine: Yes. Bob Fine. I've signed in so I think I missed roll call. Sorry.

Lindsey Tighe: Okay.

Caren Ginsberg: Okay.

Helen Burstin: And Helen Burstin from NQF as well.

Caren Ginsberg: Okay.

Martha Tecca: Martha Tecca.

Lindsey Tighe: Okay.

Caren Ginsberg: All right.

Tom Murray: Tom Murray, ASCO.

Caren Ginsberg: Welcome.

Mark Antman: Mark Antman, AMA.

Caren Ginsberg: Welcome.

Lindsey Tighe: Okay.

Cindy Morgan: Cindy ((inaudible)) North Carolina.

Caren Ginsberg: I'm sorry. Can you say that - your name again?

Cindy Morgan: Cindy Morgan at the Association for Home and Hospice Care, North Carolina.

Carol Spence: Carol Spence from NHPCL.

Rebecca Vanvorst: (Becky Vanvorst) with Data.

Caren Ginsberg: Welcome everybody. This is Caren Ginsberg from NQF. And I'm here with Lindsey Tighe, (Erika Tamero), Heidi Bossley and Angela Franklin.

And as I mentioned we do have a full agenda discussing first whether - there are two measures specifically that need to be reviewed for their status as competing and related measures. An issue having to do with reviewing harmonized pain measures.

And the committee review of four or five other measures for their updated information.

I just wanted to make a comment about process. We won't be voting on this call. You'll be - we'll be discussing the measures according to what the discussion criteria are for today and then Lindsey will send a survey monkey link for you to vote on the measures.

One measure will be voting pretty much in full the measure - the data measure on spiritual and religious concerns documentation, spiritual and religious concerns because we tabled the voting on that measure until we could discuss on this call.

And the others will be voting about whether the additions to the measure submission were satisfactory for the Steering Committee.

So I'm going to turn the floor or the phone over to our co-Chair Sean and June to lead the discussion of the measures. Sean, June.

Sean Morrison: Sure. Sorry. You know it's hard when you can't see June's face, whose going to take the lead so.

June Lunney: Come on Sean.

Sean Morrison: It's really - thank you all for joining us today. We have a relatively very busy agenda which I hope we'll be ought to move through on time.

I did before we move forward to - first of all does have the agenda in front of them?

Female: Yes.

Male: Yes.

Sean Morrison: Great. Okay, so before we move forward on really the task at hand, I did want to spend just 30 seconds because I know there's been a tremendous amount of email traffic, at least to June, to I and our NQF colleagues about the ASCO measures and some of the process that went along with that. So I just want to take the opportunity really just to explain again sort of where we are and where things stand with that. And really do that sort of briefly so people are on the same page.

As many of you recall at our face-to-face meeting there were a number of questions that came up in the morning with regards to the ASCO measures particularly with respect to were there data available that made these measures suitable for accountability.

And the committee went back to ASCO and to the developer on both on that call and on a subsequent call asking for really specific data elements that would allow this committee to make an informed decision about the measures being presented. Specifically were there normative standards that ASCO had that would allow these to be put - move forward as accountability measures and data that would allow these to move forward from that they were as surveillance measures which NQF no longer supports into measures that could be used for both quality improvement and accountability.

And unfortunately those data were not forthcoming. We at - both June and I and the NQF Staff really don't know whether those data A, exists within ASCO; and B, there were issues in terms of accessing them or whether the data don't exist at all.

And the measure developers were given the opportunity to again move the measures forward with appropriate support or withdraw them and they chose to withdraw them.

There isn't really an opportunity because of the timeline to readdress those on this particular call for measures. And I think a lot of us feel very badly about that.

On the other hand there will be a subsequent call for cancer specific measures that NQF is initiating. I think as - there will be as there was for this process an opportunity to put letters of support for appropriate representation on that Steering Committee and a call for measures.

And I think that that is a tremendous opportunity to ensure or at least potential to move this forward in a different avenue. In which they will become if they get through that process, they will become NQF endorsed measures just the same as if they had gone through this committee.

I know that's not an ideal situation. I suspect it's not what many of us would want. But I - unfortunately that is the situation we're in.

Certainly I can't direct anybody. But if people do have connections with ASCO and do have connections with measure developers around this certainly it wouldn't hurt to reach out.

Is that a fair - my NQF colleagues, is that a fair summary statement?

Heidi Bossley: This is - Heidi is on. Yes. And in fact I know Tom Murray from ASCO is on. And if he'd like to say anything, you know, we'd be welcome. If he doesn't that's fine.

Sean Morrison: Yes. I didn't want to put Tom on the spot.

Heidi Bossley: I know I did. I'm sorry. But I know Tom ((inaudible)).

Tom Murray: ((inaudible)) okay. We understand that situation and we are certainly willing to work with you however we can to get these measures through.

Sean Morrison: That would be fantastic Tom. And as I said I think all of us are, you know, both thankful that there will be an oncology call for measures; and B, you know, the opportunity to get some palliative care representation on that committee and as to, you know, speaking not as a chair but, you know, as a palliative care researcher to the extent that we can help get these together so that they can get through would be very, very beneficial for the field and for our patients so.

Tom Murray: Great. And we've gotten great NQF support from the staff and working with that and continue or plan to continue working closely with you all.

Sean Morrison: Thanks Tom. As I said, I did not want to put you on the spot but thank you.

Any burning issues or questions from fellow Steering Committee members before we move forward?

Naomi Naierman: Sean and everyone, this is Naomi. I just wanted to let you know that I'll have to leave the call around 3:10. I have a broken finger I need to get fixed. I apologize in advance.

Sean Morrison: I understand completely.

Naomi Naierman: Okay.

Sean Morrison: Any other medical issues or ASCO related issues?

All right, and again I realize that there's a lot of distress in the committee about these measures which I think - which I share. So we are going to try and do a different route or process forward.

So moving on, the first thing that we need to do on our agenda is the review of competing and related measures.

And my understanding and again from my NQF colleagues correct me if I'm wrong, ideally we would like to have one sort of measures that addresses the same area and not competing measures and splitting the field.

And there were two measures that have been - one which is already NQF endorsed which is the NCQA's steward and measure on the Advance Care Plan that looked very similar to the UNC Hospice and Palliative Care Treatment Preferences.

And all of you should have received a document, a side-by-side comparison about those two.

And what I'd like to do now is briefly turn things over either to (Helen) or Heidi just to explain the criteria by which we should think about harmonizing measures or perhaps selecting what would be the best in show or best in class measure. I guess its best in class.

Heidi, (Helen), I'm not sure which one of you I can turn to.

(Helen): Either. Heidi, what would you like? What's your ((inaudible))?

Sean Morrison: Just the criteria by which we look at harmonization of measures and what we should be thinking about as we look forward.

(Helen): Sure, I can...

Sean Morrison: If there's more to add to what I said I guess.

(Helen): Yes. I could take care of that. This is (Helen), so thanks to all of you.

Sean Morrison: Thanks (Helen).

(Helen): We generally prefer to have a single measure that can cover as large a population of people as possible. And we really do look towards the target of the measure as well as the focus of the measure.

We understand at times that it's not possible always to have a single measure address a given population and at times if it's necessary for data, underlying data issues or because of nuances to the population you need different measures, that's fine but we do ask that they be harmonized.

When we say harmonized we're really talking about the evidence of the measure focus, the approach the different developers are taking even if they might live in different data sources. The last thing we want to do is add to the copy that's already out there in terms of measures that are slightly different, slightly nuance but applicable to the same patient population.

So as you look towards this, these measures have already passed your criteria for endorsement, the overall criteria for endorsement, the question for you would be is there one that clearly has an advantage as you think about the four criteria; is one more evidence-based, is one more reliable, valid; is one more usable; is it applicable to a broader population. Is it on a data platform that might be broader and more applicable as well?

And then the feasibility issues would be a concern - a consideration as well. We recognize not all measures can be combined but that's certainly, you know, our preference would be to try to get the sort of maximal bang for the measure buck.

But, you know, I think it's really a discussion at this point for the committee to look at the pros and cons of those measures in that context. Really sticking to those criteria and help us see if there's a path forward.

Sean Morrison: Fantastic, thanks (Helen). That's very helpful and said much better than I did.

So I'd like to open it up for discussion for people who have thoughts, having used both of these. And see if we can get them harmonized for selected one versus the other.

June Lunney: So this is June. And I just want to toss out because interestingly I was in a conversation just yesterday trying to point out that there really are two different pieces of information as to whether someone has a surrogate decision maker versus someone having documentation preferences for life sustaining treatment.

Now so my concern with the Advance Care Plan versus the - you know, that one seems to be an or statement that they will - the numerator will include those who either have a surrogate decision maker documented or an Advance Care Plan.

The UNC measure on the other hand doesn't seem to document a legal document such as, you know, an appointed decision maker or an Advance Care Plan. But rather simply documents whether or not preferences have been stated so while I see them needing harmony I'm - I don't see them as the same.

Sean Morrison: Okay.

(Kate): This is (Kate). And I would tend to go toward the UNC measure and I picked up a little bit of what June was talking about in the Advance Care Plan.

And the surrogate decision making issues in California are ripe for some type of explosion because we don't really have any type of clear, definitive decision about who is considered the surrogate decision maker and this has actually come up around a lot of the work that we've done around physician orders for life sustaining treatment.

And some of the advocate groups in California have taken an issue with, you know, recruit the next of kin who's standing at the bedside who then becomes the surrogate decision maker.

And then how do you actually make that become consistent and standard so that it can be equally interpreted at the quality measure that you actually have the right surrogate decision maker?

So I think the NCQA-1 feels a little complicated to me. And the UNC approach feels a little bit more straightforward and maybe less open to interpretation. That's just my thoughts.

Solomon Liao: So this is Solomon. So along the same lines that (Kate) was mentioning, you know, the numerator instruction under the NCQA-1 where cultural or spiritual beliefs preclude, can I ask for a clarification of that? Is anybody able to?

Bob Rehm: Sure, what - this is Bob Rehm at NCQA.

Solomon Liao: So can you tell me what that means?

Bob Rehm: I think that the motive here is to be able to capture that patient has said, you know, my belief - you know you've had the discussion but I don't want to document it essentially is what it comes down to and there are codes that can capture that that are identified in the specification.

So the purpose here is to make sure that we are respectful of that patient choice.

Solomon Liao: Yes. The problem is that like (Kate) said, unfortunately that often times it was too common to use as an excuse.

Bob Rehm: Well I don't - I can't speak to the evidence of that. I'm sure that there is probably - that probably has occurred but again trying again to be patient centric here.

Sean Morrison: And I guess I would just - you know I would interject just a minute that unless Heidi tells me differently, the NCQA measure is already endorsed. So we're not - we don't - it's not about looking at endorsement issues for NCQA. We're really looking at whether these two measures can be harmonized, whether one should be recommended over the other.

Solomon Liao: Right Sean. So I'm sorry, I didn't mean to ((inaudible)).

Sean Morrison: And does that make sense?

Solomon Liao: Yes. I'm sorry, I'm not trying to criticize ((inaudible)) already endorsement...

Sean Morrison: I hear what you're saying. I just want to make sure that we're all on the same page.

Solomon Liao: ...but in terms of pointing out difference.

Sean Morrison: Yes.

Solomon Liao: I think like (Kate) was saying I think the UNC one is, what's the word, a more updated version I guess, so I would favor the UNC one in terms of it's just simpler, more straightforward and less complicated.

Bob Fine: This is Bob. I haven't heard anybody else comment on this, but I tend to favor the UNC one more. I don't know that I would want to give up the NCQA.

But, you know, the NCQA looks only at patients say 65 and older. And if I'm reading it right and I happen to be on call for our consultation service week. I've got 18 patients that I've seen so far. And 10 of them are below the age of 65.

Female: Yes.

Bob Fine: It seems to me that, and that's not unusual. I mean I think that I don't want to - I don't want my comments to mean I would take away the NCQA-1. I tend to favor the UNC measure. I think that we're trying to raise the quality of palliative care as it's practiced.

And I think first focusing on Palliative Care Teams who are providing that kind of secondary level of care beyond what maybe the primary oncologist or primary cardiologist is providing.

And I think that we capture more of our patients that way and we should be held to that standard as palliative care providers to make certain that we've done, you know, robust documentation of care planning and life sustaining preferences.

Mark Antman: This is Mark Antman at the AMA. I'll defer to Bob or other colleagues at NCQA if they were going to reply to this.

But since this measure was jointly developed between NCQA and PCPI I think I can clarify that age range if I may.

Bob Rehm: Sure Mark. I was going to comment. Go ahead and then I'll fill in if there's anything missing.

Mark Antman: Okay, thank you Bob. I was simply going to say that the context of this measure being developed in the first place was this was a geriatric measure set work group that convened to look at measures that would be appropriate for the geriatric population and so the work group was convened with the intent of focusing on that population specifically.

Since this measure and since that whole measure set was developed we have in fact believed developed measures that are comparable if not identical to this one in for other populations and with different age ranges.

So by all means we agree that provision of an Advance Care Plan shouldn't be limited to the geriatric population only. At this moment I can't tell you the exact other populations or age ranges that it has been applied to.

But we have used the same measure for other populations. And yes, for populations other than the geriatrics.

Bob, anything you would add to that?

Bob Rehm: Yes. And I think that just to recall that the measure of the NCQA, AMA PCPI measure was submitted under a completely different call for measures. It was not intended to be submitted under the Palliative Care End-of-Life. In fact the whole purpose and intent of the measure is to make sure that people at some marker point in time, in this case its 65, you know, think about and go through a process and have clinical support for Advance Care Planning well in front of any impending events that may come downstream.

So from a measure intent perspective the measure intent is quite distinct from the UNC measure which focuses much for the downstream.

So I think that with that mind we would have not even seen this measure as appropriate for an end-of-life palliative care call for measures because we see it as it's in fact one of our effective - it's a - very similar to one of our effectiveness of care measures in our HEDIS data.

And so therefore it's what should be done to a symptomatic population, you know, 65 and here are some things that need to happen.

And this was, you know, supported in great part by our work with CMS in our geriatric measurement development process.

So that's kind of the background if you will. And I think that's why these two measures are quite distinct and have two different purposes.

(Kate): Well this is (Kate). And I think that's very helpful. And I guess the question that I'm not quite clear about is given that this is already an endorsed measure...?

(Helen): Right.

(Kate): ...how do we then harmonize? I'm not quite sure of the mechanics of this.

(Helen): Yes. And I can help with that. This is (Helen).

So basically what we would really like you to do today is take a look at these two measures. The PCPI measure is up for maintenance in the coming year. And we'll have an opportunity to go through this exact, you know, a detailed dive on that measure as well. It just wasn't in time for this project.

And I think what we would like you to do is make recommendations for how you think the measure can be harmonized further if you think there's a benefit to having both. I mean certainly there are different populations. One is more focused on the ambulatory side. One is more focused on hospital/hospice.

So again I think the harmonization recommendations you make we will flow to the next group who will be looking at that measure.

Sean Morrison: (Helen), this is Sean. Can I take a crack at that?

(Helen): Sure, please.

Sean Morrison: Because this has been extraordinarily helpful. And actually June and I had a conversation of this if - on another call. And June's point was extremely helpful.

I actually think that these are two different measures looking at two different care processes. The Advance Care Planning really is and I think the emphasis here is on advanced as was just mentioned that it's focused on the hypothetical. It's focused on the what if and the key goal to that measure is identifying a proxy decision maker and at least identifying some big picture ideas about how people would want to be treated if the unforeseen happens.

(Helen): Right.

Sean Morrison: And it's really focused on Advance Care Plan. It's focused on what I call the worry well, those for whom serious illness is a hypothetical rather than a reality.

I look at the treatment preferences measure as much more focused not on the worry well but the actually seriously ill and it's a much more drilled down, real time measure that focuses on not what's going to happen 5, 10, 15 years out, but what's happening over the next day, week or six months.

And I think that they're both a different denominator and they get at a different concept. And that they harmonize in that way. The Advance Care Planning really is for the worry well and that

specific treatment preferences are people - for people who are really living with that serious illness.

(Helen): That's very helpful, Sean.

Sean Morrison: Is that helpful?

(Helen): Yes, it's very helpful. Although I do think it would be helpful given that you are a group of experts who know this area well to just offer if you think there are any ways perhaps that the NCQA PCPI measure could move sort of, you know, now that it's going to be up for maintenance as well, are there any suggestions this group would make that would help, you know, make the measure more relevant to 2012 and beyond?

Group and there may not be any, I just - just a question.

Naomi Naierman: This is Naomi Naierman. I need to always include my last name.

The surrogate representative is not so much a problem in the hospice setting it seems to me because more often than not we can identify a primary caregiver who at least is informed about what's going on.

But in other settings it may be a problem. So I think at least we need to have a definition of what the means that take us further, my question.

Female: Right.

(Kate): Yes, I would agree with that. That would address some of the concerns that we've been hearing in California related to Pulse work.

And another comment I would have in looking at the UNC measure is the specific inclusion of Pulse. It says documentation of preferences for life sustaining treatment of which that is what Pulse is.

So I don't know if there'd be any place to identify that specifically as if a Pulse form is completed following a discussion, etcetera, and the signatures that that would qualify for meeting this measure.

Female: (Okay).

Richard Goldstein: This is Rick Goldstein. I do think that the NCQA measure has one important element that we actually don't want to have in the UNC measure which is I think there's strength in trying to promote these discussions before you're in the situation. Not so much in the worry well but just that it's a sensible conversation to have with your normal doctor when you're healthy whatever age that your risks go up.

So to me it would be important either to completely differentiate or to make sure that if we do harmonize this that we don't undermine the importance of Advance Care Planning in kind of the ambulatory setting outside of sort of end-of-life decision making for what that's worth.

Female: (Yes).

Sean Morrison: Other thoughts for the group? And for my AMA and NCQA colleagues does that work for you gentlemen?

Bob Rehm: I mean, you know, we always take great interest to the Steering Committee recommendations around measures.

Again I do think that when we first looked at this and had a preliminary call with the NQF Team, we did see these as quite distinct. And I think from the conversations been able to more fully appreciate why these are addressing an important issue from different advantage points and that in fact the populations are quite different.

And where, you know, where in many ways for a measure to be feasible and the reason that this measure really does rely quite extensively on codes that clinicians have available, I don't know if clinicians have codes that are currently available to identify surrogate decision maker or even have definitions around that.

So while at a patient/clinician level understanding who and who is not a surrogate decision maker, you know, or, you know, one (that's been) given, you know, authority to make medical decisions in particular not just financial. You know this almost gets very esoteric quite quickly.

And again a lot of the (audit) measure development is in capturing what you can capture and making sure that that tells an important story and leads to higher quality and better patient outcome.

So this is a balancing act. And I'm sure, you know, as the Steering Committee Panel you face this all the time, trying to fully appreciate that there is a balance between great specificity and then usability and feasibility.

Sean Morrison: We agree.

Mark Antman: And this is Mark Antman at the AMA. I think Bob Rehm summarized things nicely. I would just add that we at the PCPI also value recommendations from the NQF Steering Committee.

So as (Helen) noted when this measure is up for maintenance we'll by all means take the recommendations of this committee into very careful consideration. Thank you.

Female: Thanks.

Sean Morrison: Is everybody okay if we move forward then?

Female: Yes.

Female: Yes.

Female: Yes.

Sean Morrison: And Heidi and (Helen) are you okay with this?

Female: Yes.

Sean Morrison: Okay.

Female: Yes. Yes.

Sean Morrison: (Great).

(Kate): Oh just one question though. I think the comment was we were going to make recommendations. Do you consider us as having made recommendations or is there a further written process that we will engage in?

Sean Morrison: I am sorry. Who is that?

(Kate): That was (Kate).

Sean Morrison: I'm sorry (Kate).

Female: We'd be happy to get formal written comments on the measure if you'd like and we'd be delighted to share that with NCQA and PCPI.

(Kate): Okay, thanks.

Female: Yes, because obviously the level of detail was pretty minimal on the call. I'm sure they'd appreciate that as they update the measure.

Sean Morrison: Yes. So if we could - if people have thoughts about that if you could drop that off to Lindsey and (Erika) that would be fabulous.

And could I just make a request that people identify themselves by name when they talk because it's just hard to put names to faces when the faces aren't in front of you.

Female: Agreed.

Sean Morrison: Thanks guys. Okay, so we're going to move onto the harmonized pain measures. This was - these were two measures, one submitted by (Rand) on patients with advanced cancer if that's their pain at an outpatient visit and the pain screening that had been proposed by the UNC Group. Again I hope that you've got a side-by-side document.

And the (Rand) and UNC Group have worked to update their non- numerators, harmonize them. And I guess the question is, is this okay with all of you folks?

And do you have any other concerns with the materials presented?

Did I miss anything from my NQF colleagues?

Female: No. I think you've nailed it. Thank you.

Richard Goldstein: It's Rick Goldstein. I have one concern if we're going to merge the two which is that from a primary care provider perspective an encounter for a flu shot would as I understand this be included so I wonder if we could have some language that would exclude low complexity visits either at 211 and at or at 212 that wouldn't be considered as part of a denominator. Does that sound legitimate?

Neil Wenger: This is Neil Wenger. Can I chime in?

Sean Morrison: Please.

Neil Wenger: So these are harmonized but not merged, right?

Sean Morrison: Yes.

Neil Wenger: And the denominator, I assume you're talking about the (Rand) measure, would require - it's a cancer related visit.

Richard Goldstein: Well it says with primary care. So it's...

Female: Well...

Richard Goldstein: And it would still be listed as their diagnosis, right?

Carol Spence: Neil, this is Carol. It does include primary care visits as well.

Neil Wenger: Right.

Carol Spence: Right. But I don't think - something that was just a flu shot generally isn't that usually a nurse visit?

Richard Goldstein: 211, it's an encounter that's billed for.

Neil Wenger: Well the...

Sean Morrison: Sorry, go ahead Neil.

Neil Wenger: ...the conceptualization of this is that it is a primary care visit that in some way would be related to a patient/physician interaction and not a visit for a vaccination.

Richard Goldstein: That's why I'm suggesting that if you like were to cut out all the visits just for a vaccine, maybe they come in for a pneumococcal - a pneumovax also because of their disease state but where you wouldn't expect that it was a complicated encounter or the (G tube needs) just a replacement. Those are lower level interactions where it wouldn't be fair to expect this kind of screening whereas any richer interaction in a primary care setting would be coded at a higher level of complexity so 91213 or above. Just I think it'll strengthen the measure.

You know I sort of - from a primary care perspective if, I mean if you include all those visits then a practice that's striving to be more of a medical home and a first stop for a lot of small things and

would then be sort of - it would look worse by this measure rather than better if we just kind of cut out those lower skilled visits.

Neil Wenger: Right. Well I mean it's certainly isn't the intention to include the very brief nurse visits. I'm actually trying to look to see whether we included codes in here and I don't see them, so maybe...

Female: Well and...

Neil Wenger: So maybe what you're saying is that when in fact the codes are included we should be careful to make sure that they don't include the lowest level.

Richard Goldstein: Low - even if they're five levels and I would exclude those two lowest complexity visits because I don't - there would - even if it's meeting with the physician there wouldn't be an opportunity necessarily to have that conversation.

Sean Morrison: So Neil, I guess what I'm hearing, I just want to - is when the codes are included moving forward if we just exclude the low complexity, you know, flu shot visits, is that going to be - is that okay with your group or do we - or they're unintended consequences of doing that that we should be aware of?

Neil Wenger: I'm not aware of any unintended consequences. In fact that statement is consistent with the way that we have implemented this from a chart perspective.

From using codes from a medical record - from a administrative data or encounter perspective that makes perfect sense.

I'm a little but unsure about the 90212 code.

Richard Goldstein: Yes. And I'm not sure about it either but it's a decision to be made about - it's actually  
- I think it's a decision about the specificity of the measure.

Neil Wenger: Right. It may very well make sense to exclude both or one - one and two.

Sean Morrison: Okay. Rick, that's very helpful. Thank you for testing that.

Any other questions about the harmonization that (Rand) and UNC have proposed?

Hearing none, Neil, thank you so much; and I'm not sure who's on from UNC. I didn't - but thank  
you very much and I would propose that we move forward if that's all right with people.

So I'm going to turn things over to June to go through really one, two, three, four, five; five  
measures and questions that we have to address from - for the next set.

June, is that all right?

June Lunney: Well all right. We'll go on.

Sean Morrison: Starting with spiritual concerns and I can jump in if need be.

June Lunney: Yes, thank you. Okay, so the first measure that we were not able to complete at the  
meeting was number 1647. That's a documentation of spiritual and religious concerns.

There apparently was some question about the reliability of that documentation and we did - did  
we request that information and it has not come? Is that the - my understanding of the meeting  
notes?

I'm looking at Page 16 of the meeting notes where it says that we're waiting response on two questions for the developer data on reliability testing and...

Female: This is the time for that response. They've updated the measure submission form and I think there's somebody from Data on the phone.

Martha Tecca: We are on the phone. And this is Martha Tecca from Data. (Becky Vanvorst) is also with us on the phone.

I was unaware that you had still open questions so I hope I'm prepared to answer them here.

Female: If you don't mind summarizing what you've provided additional into the form. I think that's really what we're looking for you to do here, just summarize if you don't mind.

Martha Tecca: Sure. And (Becky), I'm - since you - do you want to speak to that?

Sean Morrison: It's in (89) at the end.

Rebecca Vanvorst: Sure. I'm just trying to pull this up. It's just been a little while since...

Martha Tecca: Yes, sorry. We weren't sure exactly what you guys were doing. And don't have the specific documentation in front of us. I apologize.

Sean Morrison: My recollection was that we were interested in whether there was some relationship between the measure and an outcome.

Martha Tecca: Right. No, we remember the question. We - what we did we did a couple of different things. We did some clarification on the definition and background information with (Laura

Hanson). She - we had a conference call with the folks from NQF and it was (Laura Hanson) who provided some additional information.

We also looked at data that we had at - from our performance measurement database that included not only the measure in question which is did you have a documented conversation about spiritual concerns but also we looked at that alongside a measure that we also have for spiritual distress.

And that's measured at different time periods that shows, you know, change in spiritual distress over time.

And we did a quick analysis of that data and we presented the results of that that demonstrated for those folks who had a reduction in their spiritual distress, a higher percentage - I'm going to have said this wrong. A higher percentage of the folks who did have discussions - a documented discussion of spiritual concern, had a reduction in their spiritual distress scores.

Female: Yes.

Martha Tecca: Than the percentage of folks who did not have the discussion but had a reduction in spiritual distress scores.

So that's a sort of summary. (Becky), did you - have you got the data to support that in front of you?

Rebecca Vanvorst: Yes. No, that data I don't have in front of me. Though I can - let me see if I can pull it up.

Going back to the reliability question, my understanding is that Data itself did not have - did not do any reliability testing on this measure.

But this measure was tested in the (Piece) Project. And that was the data that we submitted.

Martha Tecca: It's (Laura). Yes.

Rebecca Vanvorst: (Hanson) had, correct.

Bob Fine: You know this is Bob Fine in Dallas. I was afraid maybe one of the lone people that really liked this in the beginning so I happen to have your analysis of the 652 records that you looked at.

And it's 63% of the patients whom you documented spiritual discussion had improvements in their spiritual distress score, 37% whom you documented discussion did not have an improvement in your distress score.

Female: ((inaudible)).

Bob Fine: And I like this measure along flawed though it is, I think it's a start. And I appreciate you gathering the data because I think it helps us or helps make for people like me that think we need to be doing this more, it helps make the case that it's beneficial and I realize this is not a randomized control trial and all but...

Martha Tecca: Right. Yes, and I want to be clear. We weren't...

Bob Fine: I know.

Martha Tecca: We're just trying to...

Bob Fine: Yes.

Martha Tecca: ...support what - the data that could, you know, lend some support in that direction.

Naomi Naierman: This is Naomi Naierman. I just wanted to comment that in the research we've done with consumers this is one of the pieces of information that they would like to know about hospice care in advance. Does the hospice do a good job with this particular service?

So it is - if we're discussing it all usability or importance, I'd like to add to that that it seems to us that it is.

Tina Picchi: This is Tina Picchi. And I wanted to express my appreciation to Data for the additional information that you did provide regarding the (Piece) Project and the AIM Project and the use of the spiritual distress score.

I was interested and perhaps my question was already answered about what percent of surveys actually included the spiritual distress as one of the documented symptoms since I know there are optional symptoms for them to report on that survey.

And then my other comment would be and, you know, my hope would be that this single measure could include palliative care consultations, not just hospice patients but perhaps that's beyond the reach of this particular measure.

And in the comments I noticed that there was a comment about if the measure was used for public reporting that it would be important to include a definition of spiritual needs and what constitutes that discussion of these needs and, you know, where that documentation would be located in the patient record.

And I would hope that that definition and what constitutes a discussion of spiritual needs would be spelled out whether or not it was being used for public reporting.

So those are just my comments.

June Lunney: Well this is June. And just to make sure we're on track in terms of where - what we still need to do as a group at the meeting we were able to vote on the importance and determine that it met the criteria for importance. It sounds certainly from the discussion today there's no one that's spoken up who has not - who has challenged whether or not this measure has importance.

So what we have left to vote on after our discussion is over today and we get the survey monkey, we'll be discussing or we'll be voting on the scientific acceptability, usability and feasibility of the measure.

We table that discussion at our face-to-face meeting waiting for the additional information on the measure. We have the additional information now.

Is there anyone present on the phone call from the Steering Committee who believes that there are any questions that we need answered from the developers before as individuals we'll be able to use the survey monkey and vote on this measure?

Solomon Liao: This is Solomon. Can I just ask an administrative question?

June Lunney: Please. That's what this is about.

Solomon Liao: Yes. So when we talk about scientific acceptability, can I ask sort of what the denominator is? Because I know we've had a little bit of a discussion at the in-person meeting, you know,

about the sort of relative availability of scientific evidence in palliative care compared to other areas of medicine.

You know so, you know, we've talked about the - especially like with this topic of spiritual care that, you know, we're never going to have randomized control trials.

So can you give us a little help in terms of what is the denominator of scientific acceptability?

June Lunney: I'm not quite sure what you're asking in terms of the denominator of scientific acceptability.

Solomon Liao: I mean what should we be comparing it to? I mean some - a topic like this.

June Lunney: I think and I may be misinterpreting your question. But I think perhaps what you're asking is related to since this may not be as sophisticated a tool as we might like to see for a topic is the fact that what we're proposing here is the documentation of a discussion is that, you know, sort of as a baseline, as a beginning measure, is that good enough?

Is that what you're asking?

Solomon Liao: Right. I guess my question is what is good enough? When we say this measure is going to be like you say, is a beginning first step going to be good enough, what do - I still don't understand what good enough is.

June Lunney: Well I think I mean my personal opinion on this and again it's June trying to make sure that I'm getting at what your question is about is that yes, it would be great if we had an accepted spiritual assessment tool and we were ready for that but we don't.

I think that having a quality measure that at sort of if you will, to use the word at least measures whether or not a spiritual discussion took place or whether it did not take place because it wasn't appropriate. At least measuring that occurrence or justification for nonoccurrence is better than nothing.

I think it is a first step that I would support. But that's and in some ways that's the discussion we had at the face-to-face meeting in that we agreed with the importance.

Bob Fine: This is Bob Fine. I thought at our face-to-face meeting though that I thought I heard Sean say and maybe somebody else said the committee could still vote, in essence vote our conscience if we thought we needed to go with the measure even if the science behind it was not optimal by NQF standards.

Now maybe I misunderstood that, but I thought we technically had the authority to vote ((inaudible)) for whatever we wanted.

Did I misunderstand that, Sean?

Sean Morrison: You know vote your conscience is clearly one of my taglines. But I don't know that I - I'm not sure that I said that specifically.

Bob Fine: All right.

Female: Just...

Sean Morrison: I think what - you know speaking - my concern is that I think it's very hard not to support a measure that is as, you know, motherhood and apple pie as spirituality.

I guess my concern though moving beyond the importance of this measure which we're going to be voting on in the future of that scientific acceptability, usability and feasibility is that I'm not sure that it's a straight documentation process measure without data that suggests that there's a link to an outcome that is beneficial.

And, you know, we do a lot of documentation in medicine for many reasons. And I'm not - and I guess my question is is simply documenting something enough to make this scientifically acceptable, usable and, you know, certainly feasible when there's not data behind it that suggests that leads to improved patient or family outcome.

Bob Fine: Well again Sean how much data? They've got their 652 retrospective analysis where of the ones they documented spiritual discussion; they showed two-thirds improved, one-third no improvement. And the ones where there was no documentation it was basically flat, 48% improved, 52% no improvement.

Look it's - that's not a randomized control trial. It's a retrospective analysis.

Female: Right.

Bob Fine: Of the - of a tool where they weren't planning on doing that in advance.

But again it gets to the point where we - I fear sometimes we may let the ideal be the enemy of the real and I know I'm being a bit of an advocate here. But I'm advocating this that this is not a bad first step. Doesn't mean it's the final step.

Sean Morrison: And I - this is why I would probably come back and say vote your conscience.

Female: Right and...

Sean Morrison: I think the issue, you know, the contralateral side to that is that any measurement - any time you ask people to measure it's at the expense of something else.

Bob Fine: Sure.

Sean Morrison: And so that's where again from my perspective is the issue of are there enough data and it certainly doesn't have to be RCT data but are there enough strong data to support doing that to the extent if something else is valuable?

And that's why I (probably say) vote your conscience.

Bob Fine: We lost our six ASCO measures or whatever so maybe we've got time.

(Keith): Well and actually. And this is (Keith). That was going to be my question is when we lost those six ASCO measures was that because of lack of data or was that because they didn't have in the proper format so it could be evaluated? Because part of the issue I still have is one of the folks that has, you know, end-of-life cancer care everyday is that I have no issue with this topic in terms of the spirituality.

But if we lost our six or seven ASCOs because they didn't have good data but we're going to say just vote your conscience on this one, then I want to go back to the oncology ones.

So if it was a formatting issue on those, fine. But if it was a data issue then it might seem to some of us like a little bit of a double standard.

June Lunney: Well this is June. I think that I don't quite apply it - see it as a double standard. The issue with ASCO, first of all they withdrew the measures. Second of all, the data that was missing was data to establish a benchmark so that they could be used for accountability.

And what that data if you will is not at issue here. The issue here is whether the data is adequate to demonstrate a link between the measurement and good patient outcome or, you know, a link between what we're saying is everybody should have documentation in their chart. And the data that they have provided us is the best data they have to demonstrate that if everyone had documentation in their chart those who were spiritually distressed would have a better chance of being less spiritually distressed.

So it's, you know, it's the case that we have some data here that suggests a link between the measurement and outcome. With the ASCO measures first of all ASCO had to withdraw them. Second of - or chose to withdraw them. Second of all, we were looking for data that we don't have but it was data about what constitutes a good benchmark, how many, what proportion of cancer patients appropriately should be in the ICU and what proportion shouldn't be.

So we had a very different data question for those two measures.

(Helen): And if I could just add something. This is (Helen). Just to put your vote your conscience in the context of our criteria, we do specifically have an option under the evidence ratings.

And we talked about this at the in-person meeting as well that, you know, in addition to looking at the quality or the quantity, consistency of the evidence, the task force can use their expert - the Steering Committee can use their expert judgment to say that they still think that the benefits significantly outweigh any downside risks for a given measure for a given population. I think that's what you're referring to so that was very appropriate here.

Bob Fine: That's very well stated. That was what I was recalling. Thank you.

Female: Good.

June Lunney: Okay, are we finished with questions...?

Solomon Liao: Well...

June Lunney: ...for the spirituality measure?

Solomon Liao: Well I'm sorry. This is Solomon. I'm not sure I still got a really good answer to my initial question.

So I'm happy to vote my conscience. But if we're all going to be voting on conscience like (Steve) pointed out, then what's the whole point of having a standardized NQF procedure?

Sean Morrison: No. You're voting your expert opinion Solomon.

Female: Yes.

Stephen Lutz: So I was wrong to say vote your conscience. I really was too flipped and that was incorrect of me, but I think what was stated just before then we are permitted to use our expert opinion on topics if we think maybe the other justification isn't optimal. But we think the topic is important enough.

And I think the Data people have reached out to us. They've not withdrawn the measure. They've done a retrospective analysis. They've tried to show us look, interestingly we went back and

looked at this and we think that there's a positive outcome from assessing people's spirituality, asking the question.

And, you know, we talk in pain management all the time. If we don't assess it we can't treat it. I'm just advocating that we start trying to hold ourselves and others to the standard of saying you ought to assess it.

And the preliminary retrospective analysis we have is that when you assess it you're more likely to have an improvement in spiritual distress score.

And my suspicion is that because if you assess it you start to talk about it. So I don't think it's just voting your conscience. I wish I hadn't said that and I apologize.

Solomon Liao: Well so I'm sorry. So, you know, I'm happy to vote based upon my background.

But I guess maybe to frame it or phrase it a different way, you know, when I asked about the denominator and numerator I kind of get more for myself a sense of, you know, the I guess relative percentage or ratio of what we have in front of us versus what we can in a perfect world like you said expect to eventually ever get.

So to maybe address (Steve)'s concern, you know, like with cancer, with ASCO the potential for getting data is a whole lot larger than the potential that we'll ever get much more data for spiritual care.

So I have no qualms asking ASCO to provide a whole lot more data than asking for data on spiritual care.

But my question is more of what's the relative scale? I mean is this, you know, is getting halfway there acceptable for us to say this is a good start? Is 80% the threshold?

I mean I just don't really have a good feel of what threshold should we be using to say this is an adequate first start.

June Lunney: I think this is where your expert opinion has to come into there. Given them - the - what this measure is purporting to capture, do we have adequate data to support that there's a link between measuring this and desirable patient outcomes.

And the definition of adequate has to be your definition in this case. This is a documentation measure. It's not a, you know, it's not a survey tool or any other kind of measure that would give us a score or anything like that. This is a measure of whether or not there's been a discussion.

And the developers have provided us with data that if there has been a discussion they find better outcomes.

And our expert opinion has to be whether or not the data they have provided us is adequate for this purpose.

Solomon Liao: And so again I'm, you know, happy to do that. But I'm just a little uncomfortable as a voting member to base it on just my own personal individual threshold or criteria.

I mean what I - I guess what I'm asking is, you know, can we have a discussion? Can the committee achieve some sort of consensus? Can staff provide us some guidance as to, you know, at least some ballpark of where that threshold should be so we have some sort of semblance of standardization as a committee...?

Female: (Yes).

Solomon Liao: ...rather than each of us voting whatever our own personal feelings are?

(Helen): Well let me try this one more time. This is (Helen). I think it's a very good discussion.

You will have the option of specifically looking at the quality, the quantity, the consistency of the evidence. You may vote those down.

But then you may also indicate that you think in spite of the fact that you rated those low you still think there's a specific question you're going to be asked about you still think that based on your expert opinion the measure benefits outweigh the risks. We'll describe that to the, you know the broader community when that measure goes out for comment.

This measure may not have met the criteria for evidence. But the expert panel felt strongly, and I'm just adding words here, that, you know, this should be endorsed in spite of the evidence available to date.

We'll have all that information. We'll feed all that back to you. And you can try to get more of a group consensus.

But at this point, I think it's just to try to get through the issues and allow you a chance to vote.

Naomi Naierman: This is Naomi Naierman. I just want to comment that first of all I'm not sure that we can say that this is a personal opinion. It's really more of a technical expertise opinion. That's a...

(Helen): Exactly, yes.

Naomi Naierman: ...distinction. But also expert opinion is acceptable in - as evidence when other data are not available especially in this context when random studies are very difficult, so I don't think it's out of...

Female: Yes.

Naomi Naierman: ...turn to think about this as an expert opinion.

Female: Agreed.

Stephen Lutz: And ultimately, I think it's our collective expert opinion. We will all cast a vote and we'll all live with the results of that. And none of it hinges upon any one vote. But it's the collective wisdom of the crowd sort of speak and again I realize I've been speaking as an advocate for this and at a second meeting.

But I don't think Solomon there's a ideal answer to your question. This is one of those areas of nuance and interpretation where I trust your expert judgment. I hope you trust mine.

And we may not agree with each other. But I would say that we're both expert in this field. And there are 20 other experts in the field. And we'll all vote and that'll be that.

I just I don't think there's a perfect answer to what you're asking personally.

Martha Tecca: This is Martha Tecca from Data. And just one more if I might, one more just piece of data. I'm not sure whether it was clear or was - is helpful about this again the importance of this and/or the link to the outcome.

But of - only 17% of the patients reported said they did not have spiritual distress. And, you know, with - of those with the spiritual discussion 80% of them with a documented spiritual discussion, 80% of them had - have spiritual distress.

So that's just again I guess we started saying that there was no real question about whether the concept of spiritual care or a spiritual discussion is important. But then the link to the kind of care seemed unclear.

So I'm not sure if that particular data is helpful or not but it's a big chunk of the patients who do experience, of course who do experience spiritual distress.

June Lunney: Okay, I think at this point unless there's a different question we need to accept the fact perhaps that this - our judgment of the adequacy of the data is something that we will be voting on.

But then separately we will also vote on whether or not the measure should be endorsed. And collectively all of our voting should according to - isn't it the Brown Prophecy Formula should come closer to the truth than if any one of us individually made that decision?

So I think we - unless we have a different question ought to go on to the next measure that we have to deal with today.

(Kate): June, this is (Kate). I just have a question about members who are not on the call but are still members of this committee, will everyone be voting on this measure or only the people who are on the call today to have the updated information and conversation?

June Lunney: Well everybody has got the updated information. Lindsey and Caren does everyone vote?

Lindsey Tighe: Yes. Everybody does vote. And we'll send out just a very brief bulleted summary of this conversation for the people who aren't able to make the call and send out a more detailed summary later on but just so that they have the information you all discuss.

(Kate): Okay, thank you.

Sean Morrison: And that's one of the reasons why we don't have voting on the call because we realize that every time works for everyone.

June Lunney: Okay, so moving onto measure 0208, ((inaudible)) evaluation of hospice care. We had a question about the numerator. That was clarified by the measure developers.

Is this clarification enough? Is everyone content that they now understand that the numerator, if you look at the information, the numerator statement is a composite score weighed from the responses of 17 items on the (text) survey, is everyone comfortable with this information?

And are we able to finish our voting on this item?

Somehow I've lost my copy of our report to see what aspects we have left to vote on.

Lindsey Tighe: Well there's nothing left to vote on this measure. You already made the recommendation for endorsement. It was just a clarification you asked for from the measure developer.

June Lunney: Okay.

Lindsey Tighe: Whether it was acceptable?

Female: Right. So part of the survey we'll just ask you if you want - you feel that they've met what you asked for and whether you want to continue to recommend.

Carol Spence: This is Carol Spence. Part of the updating that we did was because this was a measure that had approval so this is maintenance, I thought that in providing both the information on importance and in scientific acceptability session we focused primarily on the composite score.

And Dr. (Gentino) requested that we put additional information in on the original work that she did on reliability and validity in particular.

So those were the primary updating that was done was in relation to those plus a little additional information on disparity that was inadvertently left out of the original submission.

So this is mostly supplementary material as opposed to material that was directly addressing issues and concerns that the committee had.

June Lunney: Okay. Does anyone on the conversation have additional questions that were not resolved or are we in general - comfortable that the additional information has been helpful?

(Kate): No additional questions. This is (Kate).

June Lunney: Okay, hearing no additional questions, then our next item is the care, number 1632.

Again the evidence was updated and the numerator was clarified.

Are these changes acceptable and are there any questions that we have about this measure?

(Kate): This is (Kate). I don't have any additional questions.

June Lunney: Hearing no additional questions, we'll move on then to measure 1617, patients treated with an opioid who are given a bowel regimen and the evidence regarding the population targeted by this measure was updated.

Are we content with that and is there any other discussion around this measure that we need to have now?

Hearing no questions on that, are we just moving along because everybody's wanting to move along or are we finished with this?

(Kate): So June, these are - this is (Kate). So these are measures we've already approved but we just ask for additional information.

June Lunney: Yes.

Sean Morrison: That is correct.

(Kate): Okay, thank you.

Sean Morrison: And we just want to make sure the additional information meets everybody's needs.

(Kate): Okay.

Douglas Nee: Yes. And this is Douglas Nee. I actually did look at this in detail and reported on it in the meeting. And I highlighted the additional information relative to the summary of evidence that was provided as well and some information from the (Piece) Project and personal communication from Dr. (Hanson).

And it all looked, you know, very supportive in addition to the fact that we did vote in support of this measure.

June Lunney: Thank you for that reassurance for the rest of us.

Okay, and then our final measure to determine whether we're pleased with the updated information provided was on measure number 1625, those hospitalized patients who die an expected death with an ICD that has been deactivated.

Does anyone have any questions about the updated information that was provided?

Male: No, I think the measure - this is another case where the measure has really improved with updates.

June Lunney: Terrific. Terrific, okay, well if that is the completion of our review of updated materials we now are ahead of schedule but open for public comment.

Lindsey Tighe: And I think all lines are already open. Is that correct (Robbie)?

Operator: Yes, that is correct.

Lindsey Tighe: Okay. So if anyone has any comments.

Sean Morrison: So this is Sean. Hearing no more further comments and I turn things over to good Dr. Ginsberg for next steps.

June Lunney: Yes.

Caren Ginsberg: And I'm actually turning over to Lindsey who's going to be sending you an email soon.

Sean Morrison: Boy that was quite a quick handoff Caren.

Lindsey Tighe: So before the weekend we'll send you an email with a link to a survey monkey. We'll ask you for your vote.

The measure 1647, the Data spirituality measure will be the only measure that we ask for your vote all of the NQF criteria. So that'll be similar to what you've seen before prior to the in-person meeting, the longer survey where we do have room for you to input your own text as to justifying your vote. That would be particularly important for us as you're going through the importance two measure and report section just based on the conversation you've had today. Anything that you want to put in there in the free text space we would greatly appreciate as we go to write that draft report.

The competing and related measures if you have any information that you want to send to us over email for NCQA certainly feel free to.

The harmonized team measures will just be a simple are you okay with the harmonization that took place.

The remaining measure, also does the (ACU) still recommend these measures for endorsement based on the updated evidence or information that was provided by the measure developers.

We'll ask for you guys for a pretty quick turnaround on that survey response just because we are working on a timeline to get the draft report posted for our member and public comment on

October 7th. So don't be alarmed when we're asking for your responses probably by midweek next week.

Short of that we will be working to pull together a draft report which we'll send out to you all for your review and we're again looking to post that on October 7 for member and public comment which will be a 30 day period.

And then after that we'll be looking to schedule more calls with you all so you are not done yet.

Sean Morrison: But Lindsey this is Sean, just for the group just before we all say goodbye, after the 30 days public comment could you just remind us about the next stages of the process and where things go after that?

Lindsey Tighe: Sure. All the comments that we receive we'll either still throw out to the measure developers if they need (some time) to respond so if there are more for the Steering Committee we'll provide them to you all.

We'll have a conference call where we review the measure developers' responses to the comments received and also allow you all to come up with any additional responses.

Based on your recommendations from that call we'll make modifications to the draft report. And then at that point we'll post it for NQF members voting. And that'll be 15 days. And right now that is looking to fall in mid-November.

Female: ((inaudible)).

Lindsey Tighe: Right. After the voting is over or no, before the voting starts we'll be doing a quick webinar that allows people to come on and address any comments that they have about the draft report.

We'll ask Sean and June to be present on that webinar though the rest of the you are welcome to attend if you would like. And we'll have a member from our Consensus Standards Approval Committee on there. And it'll be open to the NQF members to address any questions or comments about they have about the report.

So and it'll be for 15 days. We see that - we have that ending - yes, I think early December is when it's ending now or mid-December and then after the report will go to the NQFC Staff and Board for endorsement recommendations on the measure.

Sean Morrison: Fantastic. Thanks Lindsey. I just wanted to - a lot of people have asked about what happens next. So I just thought it would be great for all the ((inaudible)).

So I think unless there are any things that June and I missed we can adjourn a little bit early today. And just again our profound thanks for all of your time and effort on this. I know it's been a very long process. But the end is fairly in sight. And again my personal thanks to everybody. NQF has made this just remarkably easy to get through. So thanks guys so much for that.

And any last comments or thoughts before we leave?

Female: Thanks everybody.

Female: Thank you.

Male: Thank you all.

Male: Thank you.

Female: Thank you.

Male: Thank you.

Sean Morrison: Have a great weekend everybody.

Male: Thanks so much.

Male: Bye.

Sean Morrison: Bye-bye.

END