**NATIONAL QUALITY FORUM**

**Moderator: Palliative Care**
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OPERATOR: This is Conference #: 87549542

Operator: Welcome, everyone. The webcast is about to begin. Please note today's conference is being recorded. Please standby.

Rachel Roiland: Thank you. All right, hello, everybody. This is Rachel Roiland with the National Quality Forum. And welcome to today's post-comment call of the Palliative and End-of-Life Care Standing Committee.

We have a bit of a packed agenda today just to address some remaining issues from our in-person meeting.

So, what I'll first do to get us started is just to do a quick roll call of the committee, so that we can determine whether or not we have quorum.

So when I say your name, please just say your tier and also let me know if you are able to get access to the webinar, able to vote to the web link that we sent you earlier this week.

So first off, Sean Morrison.

Sean Morrison: I'm here, and, yes, I have the access to the web link.

Rachel Roiland: OK. Deborah Waldrop? OK. Bob Archuleta? Margie Atkinson?

Margie Atkinson: Here.

Rachel Roiland: All right. And Margie, are you able to access the web link?

Margie Atkinson: Yes, I'm on it.

Rachel Roiland: OK. Amy Berman?

Amy Berman: I'm here. I couldn't get a separate e-mail with a different web link, but I am on the webinar. But I think I was supposed to receive a voting web link.

Rachel Roiland: Yes, there is an e-mail sent out yesterday from Shawnn Bittorie at CommPartners. But, we can forward it to you, Amy.

Amy Berman: Thank you so much.

Female: It's OK, Rachel, we have her all sent.

Rachel Roiland: Oh, you do, OK. Thank you.

All right, Eduardo Bruera? Cleanne Cass?

Cleanne Cass: I'm here. Hello.

Rachel Roiland: Hi, Cleanne.

Cleanne Cass: Hi, I'm here. I would think we're going to get my voting link set up. We're working on it right now.

Rachel Roiland: OK.

Cleanne Cass: OK, actually, I can vote, they tell me. I'm …

Rachel Roiland: OK.

Cleanne Cass: … I got my teenager here, so we're all set to go.

Rachel Roiland: OK.

(Off-Mic)

Cleanne Cass: Thank you.

Rachel Roiland: All right, Michelle Caughey?

Cleanne Cass: Everybody gets that.

Rachel Roiland: Arif Kamal?

Arif Kamal: I'm here. And I'm on.

Rachel Roiland: OK. Alice Lind?

Alice Lind: Hi, I'm here. And I'm on the webinar.

Rachel Roiland: OK. Ruth MacIntosh?

Ruth MacIntosh: Hi, Ruth MacIntosh is here. And I accessed the voting link …

Rachel Roiland: Great.

(Off-Mic)

Rachel Roiland: Thank you. Alvin Moss? Douglas Nee?

Douglas Nee: Here, and I do not have access to the voting link right now. And I'm actually on the way to the airport, so (Luke) and I actually talked earlier. He'd thought maybe there might be a MonkeySurvey that goes out after the call.

Rachel Roiland: Yes. We'll give you some details about that. If we don't get to quorum, we'll send out the survey. But, just – we'll keep working through this first.

(Crosstalk)

Douglas Nee: All right then.

Rachel Roiland: OK, Laura Porter?

Laura Porter: I'm here.

Rachel Roiland: And Laura, are you able to access the voting link?

Laura Porter: Well, I logged in on it, and it just has letter on it. So I'm assuming, is that the correct – it has …

Rachel Roiland: Yes.

Laura Porter: … the letter, so.

Rachel Roiland: OK. Yes.

Laura Porter: Yes, OK, great. Thanks.

Rachel Roiland: Cindi Pursley?

Cindi Pursley: Here.

(Off-Mic)

Female: No.

Rachel Roiland: And you're able to use the link?

Cindi Pursley: I'm trying to get in right now.

Rachel Roiland: OK. They'll work with you on that. Amy …

Cindi Pursley: OK, thanks.

Rachel Roiland: Yes. Amy Sanders?

Amy Sanders: Yes, I'm here. And I'm pretty sure I have the link.

Rachel Roiland: OK. Tracy Schroepfer?

Tracy Schroepfer: I'm here. And I have the link.

Rachel Roiland: Thank you. Linda Schwimmer?

(Off-Mic)

Rachel Roiland: Linda Schwimmer?

Female: For me.

(Off-Mic)

Rachel Roiland: OK. Christine Seel Ritchie?

(Off-Mic)

Female: OK.

(Off-Mic)

Female: OK.

Rachel Roiland: Robert Sidlow?

(Off-Mic)

Female: OK?

Female: Is that right?

Rachel Roiland: And for someone who has an open line, if you could just mute that while we do roll call, that'd be very helpful. Thank you.

Female: I need you.

Rachel Roiland: All right. We'll have to call out Robert Sidlow again just one more time.

All right. Karl Steinberg?

Female: (JA) called.

Female: Yes, I heard about that, I …

Female: Just working on your e-mail and I got busy on this.

Rachel Roiland: Could someone please mute their open line, please? We can hear you while we're trying to do roll call.

Karl Steinberg? Paul Tatum?

Paul Tatum: Present from Berlin. And having a little technical problem, can't find the e-mail, if someone could resend the links for voting.

Shawnn Bittorie It's OK, Paul. We've taken care of you in the backend. You're fine with your connection now.

Rachel Roiland: OK.

Paul Tatum: OK, thanks.

Shawnn Bittorie Thank you.

Rachel Roiland: Thank you, Shawnn.

Gregg VandeKieft?

Gregg VandeKieft: I'm here. And I have the link open.

Rachel Roiland: OK. And Debra Wiegand?

Debra Wiegand: Hi, I'm here. And I have the link.

Rachel Roiland: Great. Let me just do a recount.

(Off-Mic)

Rachel Roiland: OK, so we have 14 folks on who also have access to the web link, so it looks like we don't have quorum. So I think just for the sake of simplicity, we're just going to call it at that for right now, even if other folks come on. I think that'd be the best way to go.

So what will happen is we won't actually vote on the call today, but we drafted a survey just as a backup in case this happened, that we'll be sending out to you either tomorrow or late – or later on this week. That will have the voting options for the different criteria we'll have to vote on so that we can get some of these issues resolved around some of the measures.

So, we'll walk – we'll still go through the memo as we would have before and discuss the criteria that need to be vote on – voted on. But we will not be voting on them today, so.

George Handzo: Hello, Rachel.

Rachel Roiland: Yes?

George Handzo: This is George Handzo. I didn't hear my name called and therefore I didn't answer yes, if it was.

(Crosstalk)

George Handzo: I'm not sure if that makes it to count, but just to …

Rachel Roiland: I'm sorry, George. I, for some reason, marks you absent. No, I appreciate you trying to come in and save the day. But – so we're at 15 now, we're still short of a quorum. So, thank you, though. I apologize.

George Handzo: I just …

Robert Sidlow: I'm here, too, Rob Sidlow.

Female: Oh.

Rachel Roiland: Oh, we're at 16. Do you have access to the web link, Rob?

Robert Sidlow: Yes, I do.

Rachel Roiland: OK.

Karen Johnson: One more person. If anybody, we didn't call your name, is on and has access to our web voting, we need 17 for quorum.

Rachel Roiland: So if – Linda Schwimmer, are you on the line? OK.

Karen Johnson: I thought you were on, Linda, still.

Rachel Roiland: Yes. OK, let's just call it.

Karen Johnson: Yes. Well, we'll have a discussion when it gets time to vote, we may just check again, because it would be nice to be able to wrap things up on the call rather than make everybody drag it out for another week.

George Handzo: Yes. Rachel, this is George. I can click on the link, but I'm – all I'm seeing is a blank screen at the moment.

Linda Schwimmer: Hi, everyone. This is Linda Schwimmer. And I didn't hear you confirm. I think my computer was on mute, but I'm on and have voting capability as well.

Rachel Roiland: Oh.

Karen Johnson: All right, Linda, we thought you were on there. OK, I think you might be 17 if we can …

Female: Yes.

Rachel Roiland: … we get George cleared way.

Shawnn Bittorie Sorry, didn't mean to step on you there, Karen. Just also want to make other committee members aware, in case they were trying to communicate through their computer or the computer microphone, you do also need to be on the phone as well so that could have been why if you were trying to respond, you might not have been heard.

Rachel Roiland: OK, thank you …

Shawnn Bittorie And we're going to access George out and try to give him some help, so I'll be right back with you guys.

Rachel Roiland: OK.

Karen Johnson: OK.

Rachel Roiland: And I've also just received an e-mail, Karl Steinberg, you're on the line and area able to vote?

Karen Johnson: If you could send us a chat.

Rachel Roiland: Yes, if you could send us a chat message, that would be great. But I – we should be at quorum with 18 …

Karen Johnson: Yes. So, how exciting after all of that.

Rachel Roiland: OK. So we'll call – we'd say yes for the quorum.

Karen Johnson: We think we have quorum.

Rachel Roiland: And I thank you all for your patience.

Male: And Karl Steinberg just sent an e-mail.

Rachel Roiland: Yes, I just saw that. Thank you.

Cindi Pursley: Yes, this is Cindi and I'm not able to vote. I just have a blank screen also.

Rachel Roiland: All right. When Shawnn gets back on the line, we'll see if she can work with you. We're not going to be voting for a few minutes here. So …

(Off-Mic)

Rachel Roiland: Yes. So what we'll do is, if you have any trouble voting, you can put in a comment in the chat box and Shawnn will reach out to you on the backend and work with you to get your link up and running.

So what we'll do is we'll just go forward with the call and presume that we're voting and we'll see how the first vote goes. And then, we'll play it by ear after that.

Now after all that, I do also wanted to see if there's any measure developers on the line?

Carol Spence: This is Carol Spence from NHPCO.

Rachel Roiland: Hi, hello, Carol.

Carl Scheffey: And this is her colleague, Carl Scheffey, from NHPCO.

Rachel Roiland: OK, thank you.

Anne Walling: Anne Walling is here as well. And I'm expecting Neil around 12:30.

Rachel Roiland: OK, thank you, Anne.

Debra Dean-Whittaker: Debra Dean-Whittaker from CMS for Hospice CAHPS is on the phone.

Rachel Roiland: Thank you.

Is there anyone …

Jamie Koslosky: Jamie Koslosky from ASCO.

Rachel Roiland: Hi, Jaime.

Jamie Koslosky: I also have other colleagues with me as well. Do you need their names?

Rachel Roiland: No, no, I think we should be OK. Thank you, though.

Jamie Koslosky: OK.

Rachel Roiland: All right, are there any other measure developers?

Debra Dean-Whittaker: My colleague Lori Teichman is on from CMS. And we also have representation from RAND. This is Debra again.

Rachel Roiland: OK, thank you.

Kathryn Wessell: And Kathryn Wessell from UNC Chapel Hill, and Laura Hanson should be calling in as well.

Rachel Roiland: OK. Thank you, Kathryn.

All right. So I think with that, we have finished the roll call and declare the quorum. And I'll now turn it over to our senior director, Karen Johnson, who will get us rolling on the rest of our call.

Karen Johnson: Thanks, Rachel. And let's just make sure measure developers, you hopefully do not have voting privileges on this call, right? So …

Female: We do not.

Karen Johnson: Sorry about that. Sometimes the voting stuff can be a little challenging to get through. But, as I said, if we could vote today, that would be just absolutely superb. And I think we're going to be able to do that.

I just wanted – before I hand it over to Sean to facilitate the rest of the call, I just wanted to thank you guys again for joining us today. I know it's dog days of summer and people are on vacation and trying to have some fun in Berlin and other places. So, thanks for calling in.

The way that we set up this – the call will be the order that's in your memo. So, hopefully you have the memo that you can glance at. We have it on the screen, so we'll just be going through the memo. And the way the voting is going to work, it may seem a little puzzling to you so I did want to make sure that you understood what's going on. There's a couple of things that are a little bit different than how we did them in the in-person meeting.

First of all, some of the measures we're going to ask that you will revote. We're not going to give you a choice, we're just going to tell you that we need you to revote on certain things.

Those were the measures that, in the in-person meeting, consensus was not reached within that gray zone that we talked about, if you remember that.

So, our process dictates that we must have you revote on that – on those measures. And then if those measures passed those particular criteria, we would go on to do an overall vote for suitability.

There are a couple other measures that we're going to be looking at today, even starting out with 209. That one, in the meeting, the measure actually went down in terms of validity. But there was discussion back and forth between you guys as the committee and the developer hoping that the developer would be able to bring some step back to you to look at.

So, it was not a consensus not reached scenario, but it is another one of these scenarios where they have brought some information back to you. In this case, it's your choice after you look at the information and maybe hear from them if you need to hear more from them specifically. You can decide if you want to continue voting on that measure or not.

The same with one of the RAND measures. That one also went down in the in-person meeting, but the developer had asked for a reconsideration. So – and they have provided some additional information and (Anne) and possibly Neil are going to be on the phone later that they can answer some questions if you have any.

So, that will be another situation where if you choose to revote, you can. But we will (inaudible). So it'll be up to you to do that or not. So that's how we are setting up the call.

The other thing that's going to be different in this call in terms of your voting is, in the in-person meeting, we did allow for our must-pass criteria, we allowed what we call that gray zone. So, if the votes landed somewhere

between 40 and 60 of high or moderate inclusive, that was gray zone. And we put those measures out as "consensus not reached".

Now, for today's call, now that you have potentially additional information from developers, now that you have information and from the commenters, when we put the measures out for comment, you – we will ask you, when you vote on those things, the vote cannot be consensus not reached. So, basically, on those votes, the measure will actually have to pass with a greater than 60 percent margin, or otherwise, the measure would go down.

So don't worry about it, it just sounds pretty confusing. We will walk you through this and let you know as we go through which one is which, and that sort of thing. Just in thinking about the comments real quickly, that's laid out for you in the memo. One question you might have is, what are we supposed to do with these comments? Do we – you know, how much do we take these into account?

But I will tell you, and it's your personal choice, just to let you think, that we at NQF do take commenting process very seriously. That's why we released measures for public comment for the 30-day period.

So, we want to be sure that all the comments are looked at and considered by the committee. That it'll be your own decision as to how much you want to weigh the comments that come in.

For the most part, the commenters either express support or sometimes suppress non-support, if you will, for your decision. Depending on the project and the measure, sometimes commenters will have questions about specifications or they may have other kinds of things that you may need to react to. Every now and again, a commenter may bring additional information, maybe that even the developer didn't bring to a meeting, in which case, you would potentially want to consider that.

So, you will just consider the comments as they come. Those are all provided for you in the accompanying Excel file. Only a very few of the comments did we put verbatim in the memo.

I think that was all of the background that I wanted to cover, except you also may recall that in our in-person meeting for a few of the measures, we had to recuse certain committee members. For the measures that we are specifically discussing today, there are no committee members who need to be recused. So we just wanted to get that on the record that no one is being recused from any of the discussion or voting today.

So with that, let me stop real quickly to see if anybody has any questions and then if not, I'll hand it over to Sean.

OK, Sean. It's all yours.

Sean Morrison: Thanks, Karen. And thanks everybody for joining today. I know we have a very busy agenda and a limited amount of time.

I'll just want to walk people through what we're going to – how this is going to proceed. Everybody has the agenda in front of them, I hope. We're going to walk through that agenda. For each of the measures, I'm going to summarize very quickly the key issue raised by the committee. I'm going to turn it over to our discussants and I believe we have at least one of the two lead discussants from each of the measures on the call, who on – who will summarize the additional information provided by the developer if necessary or supplement the conversation from the information that we received.

I'll then open it up for the entire committee for discussion. And then we'll proceed with the action steps which we may be voting or not voting as we move forward.

And I know that everyone in this call has done more conference calls than they'd ever, ever want to. But just a couple of reminders for everybody, please if you're not speaking, keep yourself on mute so we minimize the background noise. Please, please, please don't put us on hold because for many institutions, that means that not only do we hear your music, but we can't speak as well.

Please if you're saying anything, please begin by identifying who you are because many of us know the voices but there are 18 people on the call, so please identify yourself when you start.

And then the last piece is, because we don't have tent cards and we can't do the (inaudible) a bit, putting tent cards up, please feel free to sort of step in when I open it up for conversation. But also just put your name in the chat box and I will make sure that I get to you or we get to you during the conversation if there's a heated conversation or a lot of people trying to speak.

Karen, did I miss anything?

Karen Johnson: You covered it, Sean. Thank you.

Sean Morrison: All right. So, off we go, guys. We're going to start with measure number 209, which was Comfortable Dying, Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment. The steward for this is NHPCO. And this measure came back to us because we requested additional information.

This was one of the few patient-reported outcome measures that we considered. And the issue that was raised by the committee was around risk adjustment that we had asked for more information demonstrating that either A, risk – what risk adjustment was, or B, why it wasn't needed.

In terms of public comment that came back from this, NQF received six evaluation comments that were specific to this measure, four of the comments essentially supported the committee's decisions and two agreed that additional analysis was needed. And two did not support the committee's decision and asked that we relook at this.

So that's the quick summary. And I'm going to turn things over to – so I have to go back and forth between my agendas. I think – I can't – are Doug or Debra on the call, Doug Nee or Debra Wiegand?

Douglas Nee: Yes, Sean, this is Douglas Nee.

Sean Morrison: Hey, Douglas, thank you.

Debra Wiegand: And I'm here, too. This is …

Sean Morrison: Oh, fantastic. Could one of you sort of just take the lead and summarize the additional information provided by the developer and what came back to us?

Douglas Nee: Deb, would you like me to go?

Debra Wiegand: Yes, go ahead, Doug, and I'll add as needed.

Douglas Nee: OK. All right. So …

Debra Wiegand: You're not driving, are you?

Douglas Nee: No, I'm not driving, I'm in the backseat. Or – yes, right.

Debra Wiegand: OK.

Douglas Nee: So …

(Crosstalk)

Debra Wiegand: OK.

Douglas Nee: … the NHPCO did come back with supplemental risk analysis on patients from 2012 and 2013. The request was to look at and do risk analysis or even see if there was even a need for it, for geographic location, service area, ownership, race, ethnicity, gender, age, principal diagnosis, et cetera, which they did.

And so they – we had asked them to look at these factors to assess whether there was a need for risk adjustment or that there wasn't. So in fact, the (inaudible) then included all the different risk factors, identified the median scores relative to comparative groups, those statistic – couple of different statistical analyses that were done and the results were that there were really was no statistically significant difference between all of the different factors that they requested to look at.

So in essence, when NHPCO said that a "risk adjustment for 209 is really not needed because the providers have an equal responsibility to provide timely pain management for all patients", the lack of a need for risk adjustment is supported by the supplemented analysis provided. That's kind of it in a nutshell.

Deb, did you want to add to that?

Debra Wiegand: Oh, no, I don't think so.

Sean Morrison: Thank you very much, Doug. That was perfect. And both in terms of the summary and in terms of time.

So let me open this up to the committee if there's questions, discussion. I know that Carol Spence from NHPCO is on the line representing the developer if there are questions for NHPCO.

No questions, OK. So, now, the next phase is, given what you have heard, the question becomes whether there is – because it as (failed) for validity, we need to raise whether we're going to revote. And so what I'm going to do is just ask the committee if there is anybody on the line who does not want to revote.

And hearing no, then I think I now turn things over to Jean-Luc to walk us through a revote on measure 209.

Jean-Luc Tilly: That's right, Sean. Thank you.

So, you'll see here you will be following on the slides, we have measure 0209. So the first thing we're going to vote on is the validity, you'll see your options there, you will able to select one for high, two for moderate, three for low, four for insufficient, just like at the in-person meeting.

And the polling is now open. So you can go ahead and select your answer choice and we'll see the results.

Shawnn Bittorie And if I may for a second, Jean-Luc, if the boxes to the side of the letters do not appear for you, just refresh your session by pressing F5 for a PC or command (R) for a Mac.

Jean-Luc Tilly: Thank you.

Douglas Nee: Jean-Luc, this is Doug Nee. I think I mentioned earlier that I don't have access to vote online.

Jean-Luc Tilly: That's right, yes, we've included that in our (slide), so. And so we have all the results in. We have 19 voting members. And the results are 17 voting moderate and two voting high, so the measure passes the validity subcriterion.

Karen Johnson: And let me make sure, Doug, did you send in your vote, no? OK.

Douglas Nee: No, I didn't, but it was – it's fine, it would be right in the mix with the others, so that's perfectly fine.

Karen Johnson: OK. I was going to say, if you wanted to send in votes afterwards, we can do that. I think where we get tricky is, you know, if it were kind of on the edge and we wouldn't know what to do.

So, if you're OK with not voting, I think that might be the safest way to go.

Douglas Nee: Yes, since you have a quorum and I can do that, that's perfectly fine. Just let me know if it needs to change and I can send an e-mail with my vote.

Karen Johnson: OK.

All right. So, sorry to interrupt you, Jean-Luc. So, it did pass validity. And what that means is that we can now go ahead to discuss feasibility. And now, I'm stepping on Sean's feet, so Sean, go ahead and facilitate the rest of the discussion on the measure.

Sean Morrison: I thought this is Jean-Luc's job. OK. We are now – since we passed validity, we now go to the feasibility on vote. Again, we've done this before. Again, voting high, moderate, low or insufficient on …

(Off-Mic)

Karen Johnson: And Sean, before we go to vote, I don't think in the in-person meeting that we actually talked about feasibility or usability and use for those measures. And maybe I'm misremembering.

Go and pull open the report. And it …

Sean Morrison: Let me …

Karen Johnson: … it's very possible that we did. I can't remember.

Sean Morrison: I can't remember either, Karen, I'm sorry. Do you have it in front of you?

Karen Johnson: I do have it in front of me. You know, we did not discuss feasibility or usability and use. So …

Sean Morrison: So, I need to turn that back over to either Debra or Doug, I'm afraid.

Douglas Nee: Yes, no, and that's – this is Doug. That's fine.

So what I – and I've got my original notes. The data were obtained through ongoing collection effort by NHPCO and submitted by hospices voluntarily, providing their aggregate data from 2004 to 2007. Hospices submitted data annually through NHPCO data analysis reporting tools. And by manual submission through raw data and CVS files from 2008 forward, which is saying hospices voluntarily submitted data on a quarterly basis only through the data analysis reporting tool.

Hospices evaluate their individual results for sub-par performance and comparing their percent of patients.

The score below national average or even below the 75th percentile generally indicates significant room for pain management care. And the measure seems feasible, data collection was relatively easy to record. No similar information indicated that I really don't have personal experience in doing this, although I've been with hospices that have discussed this as well.

I think, initially, NQF identified feasibility as moderate from a historical perspective.

Did you want me to talk about usability and use?

Sean Morrison: I think – why don't you while we're on a roll if that's all right with Karen …

Douglas Nee: Sure.

Sean Morrison: … and the NQF folks. But, yes, why don't we go through all of it at once. Thank you, Doug. That's perfect.

Douglas Nee: Yes.

(Off-Mic)

Douglas Nee: Sure, yes. And usability and use, the measure – it's not publicly reported as far as accountability goes that's included in a PQRS program and NHPCO benchmark reporting. There's no apparent data really shows improvement in measure scores, interesting enough, measures are reporting trending from 2013 to 2015 showing a little of reduction measure reporting by 77 percent.

That was actually came – kind of came up a little bit in discussion in the on-site meeting. There were no unexpected findings report as well. The only unintended consequence is that patient dies within 24 hours and wasn't able to do a follow-up report in the 48-hour period.

And I believe, historically, the NQF recommendation was low on usability and use.

Sean Morrison: It was – did your committee agree with that, Doug, or did you have different thoughts?

Douglas Nee: I'm …

Sean Morrison: And your workgroup staff.

Douglas Nee: Yes, correct me if I'm wrong, Deb, I think we kind of like agreed with that.

Debra Wiegand: Yes.

Douglas Nee: Usability and …

Debra Wiegand: I think we did.

Douglas Nee: … yes. Right.

Sean Morrison: Terrific. Open for discussion.

(Off-Mic)

Sean Morrison: Hearing none, Karen, I really miss you sitting right beside me and Rachel and nudging me. I think we now move to a vote, is that correct?

Karen Johnson: Right, if nobody has any questions or concerns, any questions …

Debra Wiegand: Karen, can I ask a question?

Karen Johnson: Yes.

Debra Wiegand: This is Deb Wiegand. So if we stay with your recommendation we do vote low for usability, does that influence the measure going forward?

Karen Johnson: Not necessarily. Usability and use is not what we call a must-pass criterion. So, you don't have to worry about that when necessarily killing the measure, so we're not at that greater than 60 percent. So what we would do …

Debra Wiegand: Thank you.

Karen Johnson: … and that's true also for feasibility. So, for both of those, those are not must-pass. We'll have the votes on feasibility and then on usability and use.

But then there's going to be one final up or down vote on suitability for endorsement, that when we'll have to have the greater than 60 in order to be able to go forward.

Debra Wiegand: Great. Thank you for the reminder.

Sean Morrison: Thank you, Karen. That's important and very helpful.

Anybody else want to make a comment before we move to voting? Jean-Luc.

Jean-Luc Tilly: OK, so the polling is now open for a vote on feasibility. Your options are selecting one for high, two for moderate, three for low and four for insufficient.

OK, so we received 18 votes. So we have 14 voting moderate and four voting low. So the measures passes the feasibility. And I think we'll move right into voting on use and usability.

(Off-Mic)

Sean Morrison: Yes, that'd be terrific.

Jean-Luc Tilly: And your options are the same, high, just pick one, two for moderate, three for low and four for insufficient information. So, the polling is now open.

OK. And we received 18 votes. Zero voting high, five voting moderate, 13 voting low and zero voting insufficient information. So the measure does not pass the usability, but as Karen mentioned, it's not a must-pass criterion.

Sean Morrison: OK, so finally, guys, we have one more vote. This is, as Karen said, the overall suitability vote for endorsement. It's either an up or down. And so, we're going to – let's move to that one. And that will be – that will complete the voting for this measure.

Jean-Luc Tilly: That's right, the polling is now open on overall suitability for endorsement, does the measure meet the NQF criteria for endorsement. And of course, pick one for yes and two for no.

(Off-Mic)

Jean-Luc Tilly: OK. We received 18 votes, so unanimous. Everyone voted yes.

The measure passes, and is recommended for endorsement.

Sean Morrison: Well done, group. That was a very efficient process. And we are going to move right on to the next measure that we requested …

Douglas Nee: Hey, Sean?

Sean Morrison: Hey, yes?

Douglas Nee: Sean, yes, this is Doug Nee again. Just one quick comment, sorry to interrupt you. But …

Sean Morrison: Yes.

Douglas Nee: … yes, so everything being said and the NHPCO representatives has listened in on the on-site meeting as well as this call here. I would encourage them in whatever way they can to bring up the whole usability and use process.

You know, I think in the on-site meeting as well as in the four out of the six comments that came in post-meeting, that people do really feel that this is a terrific measure. It's a much – it's a bit – provides a much needed gap and care. Patients consider it highly desirable.

And that being said, I really encourage, if that would be a good word here, where the folks at NHPCO to do whatever it is that they can to uplift the participation of the hospices nationally on this measure. Thanks.

Sean Morrison: Thanks, Doug, appreciate that.

I know Carol is on the phone and point taken. I realized that we can't go to the next measure yet because I have to turn it over to Karen because we need to have a discussion about related and competing measures at this point. Right, Karen?

Karen Johnson: Oh, right, you're on the ball, Sean.

Yes, let's just talk very quickly about related and competing measures. And Jean-Luc, if you would take us to appendix C. We try to put – the reason this

thing is 114 pages long is we try to put everything in here that we thought you might need to get you through this call.

So, appendix C as in – he went too far. You didn't just click on appendix C? Sorry, we'll get there.

All right, what I want to do is just remind everybody and maybe have – it doesn't have to be a long conversation, but really just to get your thoughts and, to some extent, check my boxes here for what we need to do at NQF.

But we have several measures. And I apologize, I just kind of cut and paste it from screens that we used in the in-person meeting here.

We have three measures right now that look at pain in the hospice setting. And we didn't have this conversation in the in-person meeting specifically, because at the time, the 0209 went down. So, you know, there was nothing to talk about. But now that you have recommended it for endorsement, we wanted to talk about, you know, the need for having in the hospice setting measures for screening for pain, assessment for pain and then this outcome measure, this PRO-PM outcome measure for pain being brought to a comfortable level.

Often, we would have this as a – trying to get you to select the best-in-class measure. I'm not going to do that today because the other two measures, 1634 to 1637, are specified not only for the hospice setting but also for the hospital setting for palliative care.

So, in that way, you know, that makes it a little bit of a different animal. But I do just want to get your thoughts as really the keepers of the portfolio, if you will, about having multiple kinds of measures for pain in the hospice setting. So I'll just open it up and let folks if you have thoughts about that.

Is there a need for it? Should we, at some point, get rid of the process measures and just keep the outcome measures? Those are the kinds of things I'd like you to opine upon.

Michelle Caughey: This is Michelle Caughey.

Sean Morrison: Go ahead, Michelle, sorry.

Michelle Caughey: I put my hand up, you can take it down now.

So the – these measures are different than the one that we just considered. They – and I would support continuing to measure these process measures. We strongly endorse them at the time and especially in our discussion.

And so, I think we need both. One looks at screening for pain and then the quality of the pain. As you mentioned, it's both in the hospice setting and the inpatient setting. And then this – the outcome measure is important too but different in that the pain has been reassessed and presumably treated and addressed.

So, I think for right now, I think we're stuck with all three measures and I would support maintaining all three.

Sean Morrison: And I've got Amy Berman next. Thanks, Michelle.

Amy Berman: Hi. I – well, I'm going to agree. I believe that we do need more than one of them. I don't know if we need two process measure and an outcome measure, but we do need (inaudible) process knowing whether or not we've screened to identify and assess the pain, and then we do separately need to know the outcome of that care whether or not we've been able to achieve a good outcome related to the pain brought to a comfortable level.

I actually had a – maybe a little off-track comment. But, my question is, given the fact that there is more dying in the hospital than in hospice, I was kind of curious why the last measure 209 was only in the hospice and not in the hospital as well.

Sean Morrison: Amy, this is Sean. I think I can answer that. That measure was only developed and tested within the hospice. NHPCO has been the steward of that measure. And so the denominator, by definition, was hospice and it's never been actually looked at within the hospital setting.

Amy Berman: Thank you, Sean.

Sean Morrison: That doesn't mean that it wouldn't be appropriate, there's just no data on that.

Additional comments for Karen on related and competing measures?

Karen, I think you're probably hearing both for the moment but to be determined in the future.

Karen Johnson: Great. I have to say I'm not too surprised. But, it's something that we will probably continue to ask you guys about over the next several years as you sit with us on this committee.

So, I think, Sean, back to – no, back to Rachel. This is like, you know …

Sean Morrison: Right.

(Off-Mic)

Karen Johnson: … here.

Rachel Roiland: I know. So, hi, everyone, this is Rachel. Sorry, let me just put on mute for a second.

So, hi, everyone, this is Rachel and I'm going to give you a quick update on measure 0211, the proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life. And the measure steward for this is the American Society of Clinical Oncology.

And if you remember during the in-person meeting, we have a lot of discussion around risk adjustment for this measure and the lack of risk adjustment as it was specified. And the committee actually decided to defer the measure and ask that the developers go back and do some risk adjustment analysis over the course of several months.

And so after the in-person meeting, we were in discussion with the developer about what some possible options might be. And ultimately, they decided to withdraw the measure for consideration this time around. So, we really won't

have much of a discussion around this measure. We just wanted to update you as to the measure status right now.

So, if anyone has any questions, we can try to address those right now. But that's just the update on measure 0211.

Sean Morrison: Thanks, Rachel.

Rachel Roiland: So over to you, Sean.

Sean Morrison: Back to me, I guess. OK.

Rachel Roiland: Yes.

Sean Morrison: So, we're going to move on then to 2651 on the CAHPS Hospice Survey, experience with care. This measure, we could not reach consensus on and we'd asked for some additional data information.

As you guys may recall, the CAHPS Survey is a collection of measures and we actually pulled out one of them, actually, I'm sorry I take that back. We had concerns with reliability for two of the measures and pulled those out, and we didn't reach consensus on the reliability of treating family members with respect.

The NQF received three comments about the overall measure all supported endorsement of these measures. And then the measure steward came back with some additional data. I know Amy is on the call, I didn't hear Eduardo, Woody. And Margie, I didn't know if you were here.

Margie Atkinson: Yes, I'm here.

Sean Morrison: So I will – oh, great. So you and Amy can find out if you'd like (inaudible) the discussion.

Margie Atkinson: OK, this is Margie. Amy, I'll take a stab at it and then you can add whatever you feel I'm missing on this.

First of all, I just wanted to – in the original data set, when – if I recall our discussion at our in-person meeting was that it was not a – it was only, I think, two quarters of data. I believe it was January to June, although this data on this – our sheet here says April to June, so maybe we're only looking at that one quarter.

So, CMS came back with additional updated data that added April to September 2015. And the updated data related to the treating family members with respect increased the ICC from 0.008 to 0.011 which puts it within the range of acceptable over 0.01.

The estimated reliability didn't quite make it to 0.70, which is the threshold, but it did increase from 0.61 to 0.68. And I think it could be noted that, you know several of the other measures that we did approve are under the 0.7 threshold.

Additionally, all the other measures with exception of one with this additional data also increased as well, which is interesting to note. So, clearly, having the greater amount of data made a difference in the evidence.

Sean Morrison: Thanks, Margie. Amy, anything to add, subtract?

Amy Berman: Margie did a great job. The only things that I would say is that the NQF staff also presented the measures to the Person- and Family-Centered Care Standing Committee for their feedback, because they also tend to evaluate the PRO-PMs from the CAHPS Survey.

And one member of the committee did express concern with the low ICC value. But as Margie said, it is now at the 0.011, which according to (Inaudible), makes this considered high, below 0.01 is low and above 0.01 is high, so the ICC score, in essence, you know, is not low. So, that's it.

Sean Morrison: Thank you both. Questions from the committee?

Hearing none and seeing no hands up in my little box, I think I turn I this over to Jean-Luc for voting. I think we need to vote (inaudible) both reliability (inaudible) Jean-Luc, and overall suitability for endorsement.

Jean-Luc Tilly: That is exactly right, Sean. So you've seen in front of you, we've move on to measure 2651, the CAHPS Hospice Survey.

So you'll first be voting on the reliability criterion. So your options will be one for high, two for moderate, three for low, four for insufficient, just click the box of your choice. And so the polling is now open.

So we received 18 votes, 17 voted moderate and one voted low, zero voted either high and insufficient, so the measure passes the, excuse me, the reliability criterion.

And that will take a – so we've already voted on the other criteria for this measure so that will take us right to the vote for overall suitability for endorsement.

So your options there are just two, yes or no. Does the measure meet NQF criteria for endorsement? And the polling is now open.

(Off-Mic)

Jean-Luc Tilly: All right, so we received 18 votes, the vote (has been) unanimous for overall suitability for endorsement. You all voted yes. So the measure passes, or it's – rather it's recommended by the committee for endorsement.

And then I'll turn it back over to Karen or Rachel.

Rachel Roiland: All right, hi, everyone again. This is Rachel.

And so I'm just going to lead you through the discussion on the other measure for which we had a criterion for which we did not reach consensus. And that is measure 1639 and – the Hospice and Palliative Care, Dyspnea Screening. And the measure steward for this measure is UNC-Chapel Hill.

And just a reminder of what happened at the in-person meeting. We do not reach consensus on the importance criteria. The measure developer in the original submission submitted facility-level data for – from the hospice item set for fiscal year '15. And this was – this data showed that the average

hospice facility data – facility-level performance rate was 97.3. But the committee noted that the developers did not provide clinician-level performance data for a palliative care setting in the hospital setting.

So I think this is sort of the issue that sort of brought – that may have led to us not reaching consensus on the importance criteria.

So, in addition to those committee discussions, we did receive some public comments on this measure as well. So we received five post-evaluation comments and four of which supported the continued endorsement of this measure, so.

And one commenter did express concern about the inclusion of short-stay patients for the length of less than seven days, or sorry, and recommended stratifying the calculation of the measure between individuals who had a length of stay of less than seven days and an exclusion of those who are – people who are imminently dying.

So that's a quick overview of our previous discussion as well as the comments we received on the measure after our in-person meeting.

And now, I'm going to turn it over to Ruth MacIntosh or Cindi Pursley if they're on the line, and they can lead us through an overview of the additional information submitted by the developer.

Ruth Maclntosh: Hi, this is Ruth Maclntosh. And the additional information provided was that the preliminary data for the measure in the hospital-based palliative care setting indicated that 81.8 percent of the patients were screened for dyspnea. So there is, you know, opportunity for improvement there. And that result is based on the data from 895 patients who were admitted to an acute care hospital for at least one day for that full year ('15).

So that combined with the little opportunity that we still saw for racial and ethnic disparities. My feeling is that we should endorse this measure to continue.

Rachel Roiland: All right, Cindi, did you have …

Cindi Pursley: This is Cindi. So this is Cindi and I agree.

Rachel Roiland: All right, thank you, Cindi.

Does anyone else from the committee have any comments or questions for the developer?

Or any other discussion on this measure?

OK, I'll turn it over to Jean-Luc and he's going to walk us to voting on opportunity for improvement. And then finally, overall suitability for endorsement.

So, over to you, Jean-Luc.

Jean-Luc Tilly: OK, so great. So, for measure 1639, we'll first vote for – on the importance to measure and report criterion, the subcriterion for performance gap. Your options are one for high, two for moderate, three for low and four for insufficient. And the polling is now open.

And we're actually just waiting for a couple more votes to come in, so if you're able to click the little box you're choosing, OK, so.

Karen Johnson: Shawnn Bittorie, do you have any idea, we're only seeing 16 votes. We thought we had 18 people voting. Any idea?

Shawnn Bittorie I actually do see 18 at the moment all votes for moderate.

Karen Johnson: OK. On our screen …

Sean Morrison: Yes.

Karen Johnson: … we're only seeing 16.

Sean Morrison: Yes. Karen, on my screen, I'm seeing 18, too. It's Sean Morrison.

Female: OK, OK.

Female: Yes, yes.

Karen Johnson: All right …

(Crosstalk)

Female: Everybody …

(Crosstalk)

Shawnn Bittorie OK. Oh, there it is, OK.

Karen Johnson: OK, it updated – OK, great.

(Crosstalk)

Shawnn Bittorie: … momentary lag in your Wi-Fi.

Karen Johnson: OK, great. All right.

Jean-Luc Tilly: Great. That's fantastic. So, as you all heard, the measure passes the particular subcriterion, and of course, we voted on the other criteria so we're not going to – criteria for endorsement.

Female: I'm sorry …

(Off-Mic)

Jean-Luc Tilly: Yes. So you have just two options, yes or no. Does the measure meet NQF criteria for endorsement? And the polling is now open.

All right, thanks so much. We received 18 votes, everyone voted yes. So the measure is recommended for endorsement.

(Off-Mic)

Jean-Luc Tilly: And well, please go ahead, Sean, for those. I'm going to turn it over to you.

Sean Morrison: So, the last measure that we need to discuss is measure 1626, which is patients admitted to an Intensive Care Unit who have care preferences documented. The steward for this is the RAND Corporation.

And I know that – I think this was perhaps the longest discussion with, I think, less than a clear understanding both around the numerator and the denominator of this issue. We did not reach consensus from the reliability of the measure and it didn't pass on validity measure.

With respect to the reliability, this was – the committee was concerned about the numerator specification and there was some confusion over how the numerator was computed if the patient had an advance directive available.

With respect to the validity, we didn't accept the face validity testing of the measure, although we accepted the face validity of all the other measures submitted by this group on the same voting.

NQF received six comments about this. One agreed with this not to continue endorsement. Two supported endorsement and then one requested that we consider the measure after we got additional data from RAND. And the developer of the measure formally requested on the consideration of the measure, because they believe that we had inappropriately applied the evaluation criteria.

And I think because – and Shawnn, if this is all right with you, I think because there was so much confusion about this, I'm just going to – I think Anne Walling is on the line as the measure developer. And I just was going to ask her to specifically address those points and then I'm going to turn it over to Amy and Tracy for discussion.

Karen, is that all right?

Karen Johnson: Absolutely, all right. And I think Anne, if you can really discuss to one of the questions with what happened, how does this measure get calculated, if there is an advance directive already in the record. So, if you could discuss that as well, I think that would be helpful.

Anne Walling: Right, OK, so, give me one second. I am going to – so, I don't know if everybody has the – you probably don't have the actual specifications for the indicator.

So this very same topic came up during the planning, the initial meeting. So, the part about having an advance directive, so – and this had been in the documentation that was submitted, is that having an advance directive alone doesn't satisfy the criterion. However, a notation within the proper timeframe in the record that showed that there was a – that that document had informed choices or that had been reviewed with the patient did satisfy the requirement.

The thought behind the reason why that was part of the determination is that, many people will have an advance directive and maybe scan in the record, but if it's not actually referred to during tier that that's not really what we were trying to get at. Does that make sense?

And in terms – I think the question that came up was whether that was able to be reliably abstracted from the record. And so, we did present inter-rater reliability in terms of a CAHPS statistic for a 2010 study, where the overall sample was 496 patients, 369 of those patients were actually admitted to the ICU and survived 48 hours, so.

And we had inter-reliability for 10 percent samples, the overall sample, and the eligibility kappa – now this is with (trainers) abstracters, that were provided these – the guidelines for abstraction and we were able to get an eligibility kappa of 0.95 and a specified care kappa, meaning the enumerator identified with a kappa of 0.87.

So, that's not to say that it isn't – doesn't require skilled abstraction because it certainly does. These were nurse abstracters. So I think that was one of issues.

The other issue that was brought up was about the validity, and I think the face validity of the measure versus empirical validity of the measure, I think, was a little bit confusing in the discussion from what I could tell from the transcript.

And if you look at – let me – the measure specifications that were provided, it – I think it was perhaps a little bit confusing about the way that it was written. So, for example, we talk about how the specific measure had not been tested empirically for the process outcome link, meaning that there hasn't been research that's link – specifically links that measure statistically to outcomes that were – that theoretically it is linked to for – however in aggregate, the measure has been associated with outcomes and that's documented, but that is not the face validity.

So, the face validity was – for this specific measure, was explicitly evaluated by the ACOVE, ACOVE-3 and the ASSIST expert panels. And the instructions for that panel is that they would review the relevant literature that was provided and we use the Modified Delphi Panel process of voting to determine the validity of the measure.

And in summary, each measure is rated on a scale of one to nine, where one is not valid, nine being the most valid, and basically as a median score in the seven to nine range meets the criteria. And there's not disagreement, meaning there might be slight differences between the way each expert panel was done, but in general, that means that nobody – that three people have not rated it as invalid in their one, two, three range.

So, basically, if they have a median score seven and no disagreement, then that's considered to have face validity. And so, in each of these panels, the indicator was rated separately for face validity just like the other three measures that we presented.

So, I think that – because of the way that that was presented in the documents, so that may have been confusing. But, those were the two, I think, main issues.

Tracy Schroepfer: So, this is Tracy Schroepfer, and I just have a question. I want to make sure that I understand. So I'm just going to repeat back what in terms of the numerator.

So, someone that's been admitted to the ICU, which means there – and it's within 48 hours after they're admitted. So they're actually in the ICU for 48 hours.

And that during that time period that the – that if possible that there's actually a conversation between nurse, doctor, whatever and the patient regarding preferences, if not feasible than the advance directive, but it can't just be that they just have one in the record but rather that there's a notation that advance directive was reviewed with the patient.

Anne Walling: Exactly. That would count – that would also count …

Neil Wenger: So, it doesn't have to be …

Anne Walling: Go ahead.

Neil Wenger: It doesn't have to be reviewed with the patients, right, a lot of these patients are comatose.

Tracy Schroepfer: Well, that's I'm wondering. So …

Neil Wenger: Right.

Tracy Schroepfer: … what's the notation then?

Neil Wenger: That's the acknowledgement that the advance directives – that the clinicians are aware that an advance directive exists …

Tracy Schroepfer: OK.

Neil Wenger: … within the record.

Tracy Schroepfer: OK.

Amy Sanders: This is Amy Sanders. And presumably, the content as well of that advance directive that if it's specified, they don't want a feeding tube, then there's no plan to arrange for a peg.

If I don't want antibiotics, then no antibiotics re prescribed. I mean, the document is present. It has been reviewed and stipulations, you know, acknowledged as sort of guiding the course of care. That's my understanding of how this is meant to be interpreted.

Neil Wenger: That is correct.

Debra Wiegand: So this is Deb Wiegand.

So, I practice on the critical care, and as someone commented, most patients can't communicate in the intensive care unit. Has there been any consideration to having the advance directive reviewed with the family because that is what's commonly done in practice?

Anne Walling: That would certainly satisfy the indicator.

Debra Wiegand: That would?

Neil Wenger: Yes. Yes. It certainly would satisfy the indicator, this should – this is Neil Wenger, working with Anne.

The issue is that we try not to be prescriptive looking for magic words within a record, because people will write many, many different things reflecting the fact that exempts your planning was attended to during this critical 48-hour period after ICU admission.

Tracy Schroepfer: So, if a family member of the patient is comatose and the family member is present and there is no advance directive, but the doctor talks with the family member about – in terms of advance care planning that would satisfy.

Anne Walling: Yes.

Tracy Schroepfer: OK.

Anne Walling: And then there's also and/or reason why it was not done. So, if there's – for example, documentation that, you know, we've identified the surrogate decision maker or can't find the surrogate decision maker, or the surrogate decision maker isn't answering the phone, that would all count as well.

Sean Morrison: Other questions from the committee?

So, let me just – before we go to the discussion, Anne and Neil, thank you so much for the additional information, this is Sean.

I just want to summarize this in my head, so I'm clear about it as I move in forward. So, the numerator is documentations about patients' preferences within 48 hours of the ICU admission. That that documentation can include recognition of a previously completed advance directives as was discussed. It can include a discussion with a surrogate family member about the patient's goals of care, if the patient is not able to participate.

Male: OK.

Sean Morrison: It could include discussion with the patient if they are able to participate. And it could include a comment note as to why that discussion didn't happen, the advance care plan wasn't followed or it wasn't indicated for some specific reason.

Is that – am I clear in my head on that one?

Anne Walling: Yes.

Neil Wenger: Correct.

Sean Morrison: OK. Correct.

And that you guys have provided data around the face validity, clarified our confusions about that, and that the reliability was tested and measured within the April study with trained chart abstracters. Is that your summary as well?

Anne Walling: Yes.

Sean Morrison: OK.

So, any other comments, discussion from the committee? I don't see any hands on my little chat box, but I just want to make sure.

Amy Sanders: This is Amy Sanders. I'm not sure whether I'm expected to discuss this in addition, but I do have one sort of lingering question.

The measure specifications called for review of a paper chart. Most hospitals these days, most ICUs have converted to an electronic medical record.

And from my memory of the discussion at the in-person meeting, there doesn't seem to be much from the measurement developers on whether this measure is – has been tested in the electronic medical record's environments, whether it is expected to just – sounds like seamlessly whether it needs to be tweaked in anyway. And so that's for me at least the lingering question.

And I don't know since we have the measure developers on the line if they're prepared to comment about that.

Sean Morrison: Guys, Anne, Neil, any thoughts?

Anne Walling: Yes. So, what I would say is in terms of the way that the most recent study that we did using the – this was – it was a cancer-specific study, but we applied the same criteria to the V.A., which is an electronic medical record. However, the process is very similar because the nurses have to look through every note just like they had to do with the paper record with – from the earlier study.

So, in terms of the specifications, it doesn't change the specifications very much as it's currently created. It's just – in some ways, it's a little bit easier because, you know, you don't have to go get the paper records to do the abstraction, if that answers the question.

Amy Sanders: So, it's expected to sort of translate without much modification. And that's – I mean, that's a common sense assumption, but there's not necessarily any data to back that up just yet.

Neil Wenger: Anne, in your V.A. study, it was in the H.R., right?

Anne Walling: Right. I don't have …

Neil Wenger: Yes.

Anne Walling: … yes. But I don't have quality indicator level kappas for that study, so. But yes, the idea – the message to abstract from the electronic record are similar, the same that what you're saying is true, if that make sense.

Neil Wenger: Yes, in other words, it has been done, but we don't have the kappas …

Anne Walling: Exactly.

Neil Wenger: … from the study.

Sean Morrison: Michelle, I see your hand up.

Michelle Caughey: Yes, thanks very much. This is Michelle.

You know, we had a long discussion about this measure for all those reasons. And then, in addition, the feasibility of doing it with the two nurse abstracters and the expense, and the ease of doing it not just in a paper record versus an electronic record, was there more thinking about that? Other committee members had more thoughts as they thought about over the many weeks. More of the feasibility issue.

Neil Wenger: So can we – I'm one of the measure people, can I comment on that?

Sean Morrison: Absolutely. Go ahead, Neil.

Neil Wenger: So, while we have not applied this measure yet using a mechanized system, it is – the reason that we're sort of doggedly pursuing this is that this measure, we believe, can be the kind that we can implement directly using an EHR with simple natural language processing mechanisms.

So, we're currently using that mechanism for our advance care planning dashboard here at UCLA. We have not implemented it for this measure, but that's certainly the expectation of the direction that we think that this will go.

Sean Morrison: Thanks, Neil. It's very helpful.

Any other comments? I don't see any other hands.

Rachel Roiland: Sean, this is Rachel. We actually have a question from Paul through the chat box, if I can read that out quick.

Sean Morrison: Please.

Rachel Roiland: OK. So, from Paul Tatum, the question is, from what setting is the data for abstraction by an R.N. of 400 plus charts for feasibility, a single institution and does this process work in a small hospital?

So I don't know if Anne and Neil have any …

Sean Morrison: Anne or Neil, do you have any thoughts on that?

Anne Walling: That study was …

Neil Wenger: I have to look …

Anne Walling: Oh.

Neil Wenger: Which study was it, Anne?

Anne Walling: That was – it was my – the ACOVE – it was a single institution UCLA (inaudible). It was the 2010 study.

Sean Morrison: Other – and so Anne was …

Neil Wenger: So, I mean …

Sean Morrison: Right, go ahead, Neil.

Neil Wenger: So there's two parts, I think, to that question. One is, a candid abstraction occur in a small hospital, which means could a small hospital find individuals to do a record abstraction, by either from paper, if it's a really small hospital perhaps, or based on an electronic record.

And the second question, I guess, would be, what a small hospital have enough of an (N) for a measure like this. And if the hospital has an ICU, the answer has to be yes.

So, there – I think there's little reason to believe that it wouldn't be feasible. And the size of the hospital really shouldn't matter as long as one can identify someone capable of doing an abstraction.

Sean Morrison: Thanks, Neil.

Any other thoughts or questions from the committee?

So, hearing none, I would suggest – the first thing is, does anybody have any objection to revoting on this measure now that the additional information about reliability has been provided, the validity has been clarified.

The developers have talked to us a little bit about the feasibility both within paper charting data that they have, although their kappa was within electronic health record. And questions about size of hospital and scope, which I think were the key issues that came up in our discussion before.

Does anybody have any objection to voting on this? Hearing none, Jean-Luc, I think that we will vote and this will be our last measure – our last measure.

Jean-Luc Tilly: That is exactly, right, Sean.

So, we are voting on 1626 for reliability, and you recall from our in-person meeting that for a few of these measures, there was a different set of testing.

In this case, only patient level data elements for test for reliability. You only have three options this time. So one for moderate, two for low and three for insufficient. So, the polling is now open.

Sean Morrison: Rachel …

Jean-Luc Tilly: All right.

Sean Morrison: … do we still have (ATM) – oh, OK, good. Sorry, go ahead.

Jean-Luc Tilly: Yes, so we received 17 votes, 12 voted moderate, five voted low. So the measure passes the reliability criteria.

So – and now, we move on to voting on validity and (inaudible), you know, we were only looking at data elements, they only had three options. One for moderate, two for low and three for insufficient. And the polling is now open.

All right, great. So, we received 18 votes on the validity testing. I received nine voting moderate, nine voting low, zero voting insufficient. So that means the measure doesn't pass the validity subcriterion, which is a must-pass criterion, the threshold we needed 60 percent and here we just had 50.

(Off-Mic)

Karen Johnson: OK. So, does anybody have any questions or any feedback to the developer?

Sean Morrison: Yes, this is Sean. And I guess – I do have a question, Karen, because it comes back to, as a committee, we approved the validity of three other measures that were tested exactly like this one.

So I'm not sure what feedback we, as a committee, can give to the developers that the validity of this measure given that we, ourselves, was schizophrenical. And I must admit that does trouble me as the chair of the committee.

Karen Johnson: Right. Maybe …

Sean Morrison: Because it raises questions if we need to, and I don't think we can. We look at all the other measures and I just – as I said, I don't know what to make of that.

Karen Johnson: It's puzzling to me. And I think it might be worth – and maybe we can ask maybe some of you who voted low on validity. Would you be willing to share what tipped you towards low, given the explanation of how the face validity was done for this measure?

We want to at least make sure that you understand, you know, that there's no misunderstanding to what was done, first of all. So – and I know that putting

folks on the spot, but would anybody be willing to talk about low versus moderate and why you voted that way.

Linda, it looks like your hand is up in the …

Sean Morrison: I'm sorry. I'm going to put it down. Yes.

Linda Schwimmer: Sure.

Sean Morrison: Linda and …

Linda Schwimmer: Sure.

Sean Morrison: … yes, and I have Michelle as well.

Linda Schwimmer: Sure. So, I think it – so I think part of this goes to the way the developers – for me, where the developers were talking about the fourth element where if there was not advance directive and they weren't able to reach a surrogate, but that an attempt was made and, you know, I just have some questions about the validity.

I think for some of these things, it's proving me negative of the things that didn't happen and whether that's going to be a process that is valid and that you could really test for validity, or whether that would be something that a box that could be checked, but I don't know how you could further evidence that a lot of those things really happened.

Sean Morrison: Others have comments before – I do think I want to address that one though. Amy?

Amy Sanders: No, I – when this topic is finished, then I'm willing …

Sean Morrison: OK.

Amy Sanders: … to opine on my own opinions.

Sean Morrison: OK. OK.

Are there others who might be willing to talk about why they might have voted low rather than moderate on this?

Amy Sanders: Oh, if the floor is open for that, then I'll just jump in now. I mean …

Sean Morrison: Yes.

Amy Sanders: … I think for me – and again, this is sort of, you know, my – based on my understanding of the definition of validity, the hierarchy of validity, by definition, face validity and sort of expert panel consensus, even if there's a modified Delphi process, you know, that – those are fairly low validity standards.

This measure was endorsed in 2012. And exactly the same information was presented asking us to do maintenance and there was no updated additional validity information that was presented. I think if I had – if there had been some additional validity testing given that the initial endorsement was on the basis of, by definition, low validity standards, if there had been additional validity testing, then I think it might have gotten differently at least in my head.

Sean Morrison: Karen, can you address both of those?

Karen Johnson: Yes. Yes, I can certainly do that. You know, right now, we do allow face validity as a one way to demonstrate validity, that may not always be the case, but it is currently our decision to go forward with that. And we also do not require that developers bring back additional testing. We would love to see additional testing and we would actually love to see testing at both levels of analysis. But that also is not a requirement.

So, you know, the face validity that they had the last time would still carry this time. Our criteria have not changed in terms of what we will accept for validity.

So, Sean, I don't know if you would add anything to that.

Sean Morrison: No, I think the only thing I would add was the other comment, while important really doesn't reflect what NQF is using when they talk about validity testing. And that actually may be more in the feasibility section, but it's not within the scope of what we talked about in terms of validity testing on this measure.

So, I'm not sure what to do with this. Again, Karen, I think I will leave this up to you guys, the staffers.

And again, I don't want to push this, but I am pushing it because as I've said, we made a decision very different on the same set of data on three of the measures.

So, what I'm hearing is that face validity is acceptable to NQF and there's no requirement that the measure developers present new data. It's passed on face validity before.

And again, I would – I think we all need to be very clear when NQF is talking about the validity testing, what that actually means and what the developers did.

And Karen, I turn it over to you.

Karen Johnson: OK. And Paul, it looks like your hand is up from where I'm sitting. All right, are you available to talk, Paul?

(Off-Mic)

Karen Johnson: OK. We have a comment from Paul. Hang on just a second.

Jean-Luc Tilly: Right. So Paul just sent us a comment. And I'll read that to you now.

So Paul said, "I voted moderate. I worry my question (re) small hospital might have persuaded others to vote low. But I think the comments of the developer and the standard we use for other measures have led me to think we approach moderate level. And we are right at 50-50 and I think this is an important measure. I know that during the voting, the number of moderate

seems to change a few times up and down. I wonder if there's an appropriate parliamentary procedure for me to ask for a recount to be sure."

And that's Paul's comments.

Karen Johnson: Thank you, Paul.

Sean Morrison: Amy Berman?

Karen Johnson: Oh, go ahead.

Sean Morrison: I'm sorry. I had Amy (hand up) unless you …

(Off-Mic)

Amy Berman: Oh, I'm sorry. I actually was going to ask also after this clarification, is there a process with which we could ask for a revote?

Sean Morrison: Karen.

Karen Johnson: Yes.

Female: I was going to ask the same thing in view of that it was pointed out that we were schizophrenic and that for those who've – that we voted three other measures using that criteria and could we consider a revote.

Karen Johnson: You know – this is Karen. Yes, we can. We don't have to be quite so formal as Paul with the rules of order. I think if folks are feeling more comfortable with, you know, what our criteria are and what we're looking for, and I thought it might be useful as well for me to just read out to you very quickly our requirements for face validity testing. So, bear with me.

Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process by identified experts and explicitly addresses whether performance score is resulting from the measure specified can be use to distinguish good from poor quality.

So, while face validity is the weakest form of validity testing, we put a little bit of a bar around it and say that, you know, it does need to be systematic and it needs to be transparent.

So, I think it is, you know, up to you to decide whether the Delphi processes that the developers did meet that requirement.

But with that, we can certainly do a revote. It sounds like there's appetite for that on the committee.

Before we do that, does anybody else have any questions or concerns that they would like to air before going forward?

Amy, go ahead.

Amy Sanders: So given my comments about validity, what I'm about to say next is probably going to come as a surprise. But, I would like to encourage, maybe even exhort RAND to consider redeveloping this measure or developing a new measure that grows from this measure that could be an outcome measure. I mean, this strikes me as a – the gestalt of this measure is incredibly important.

The last thing, you know, that any of us want is to be in an ICU having our wishes not noticed or otherwise ignored. And I think it would be very easy to convert this or to develop this further into an outcome measure based on, you know, what the advance directive said, what percentage of patients in ICUs actually did die with the treatment that was in accordance with their preferences.

And so, sort of going forward, you know, please, RAND, at least take into consideration the possibility of developing this as a really important outcome measure.

Sean Morrison: Amy, that's a really important comment. Thank you. Absolutely.

OK. Jean-Luc, I think I'm hearing that there's enough question for a revote. Can you clear and we can start again?

Jean-Luc Tilly: Excellent question, Sean. I will certainly try (inaudible) compliance use. OK, great.

So, I think – well, I thought – I think the voting results will automatically titrate from what you did last, but you are able to change your vote.

Female: That is correct. It will automatically recalculate.

Jean-Luc Tilly: Great. And a number of you are doing. So, as soon as that number stabilizes a little.

Karen Johnson: And sorry. Shawnn Bittorie, can you look at your …

Shawnn Bittorie I see, 15 and 14. 15 for moderate and – I'm sorry, 15 and four, 15 for moderate and four for low.

Karen Johnson: OK. That's what we're seeing, too. We weren't sure because that's 19, right?

Shawnn Bittorie That is correct.

Karen Johnson: I was a math major, believe it or not. And we're expecting 18.

Female: Yes, it's arithmetic.

Karen Johnson: I know.

Shawnn Bittorie We've had one that's kind of been on the bubble that has came and went on the meeting in (Philly), so I think they might have had a little connectivity issue.

Karen Johnson: OK, all right. Thank you so much.

Male: Got it.

Karen Johnson: OK. So Jean-Luc …

(Crosstalk)

Karen Johnson: … for the record …

(Crosstalk)

Jean-Luc Tilly: Yes, that's right. So, Shawnn just (serve it up) that 15 voted moderate, four voted low, so of course the measure passes the validity subcriterion, which (inaudible). So, that leads us now into the validity discussion, I think.

Karen Johnson: Right. And just to jump in here, you talked about feasibility would be the next one. And you talked about that a little bit.

Let's go ahead and finish if there's anything new on feasibility and then let's also, if you're willing, Sean, let's talk about usability and use because we – because the measure went down in the in-person meeting, we did not have that discussion in the in-person meeting.

And just so everybody is aware, the submission forms that you use are included in appendix G, as in Gary or go, G. So if you want to refresh yourselves with the feasibility and usability and use information through that measure, that's where you'll find that.

Sean Morrison: Terrific. And I think at this point, I have to turn it over to our committee discussants, Amy and Tracy, to just walk us quickly through feasibility and usability if that's all right.

And I'll take either of the two of you.

Amy Sanders: I'm trying to remember here. So I do not – I'm not in possession. This is Amy. I am not in possession of my notes from the in-person meeting, and I (suspect) by a lot of confirmation because I really don't know where they are.

But I think the feasibility question, the paper versus electronic chart is an obvious issue of feasibility that I think that's sort of already been asked and answered. And I think, you know, there are directives where there are directives and they're findable or they aren't. So, I mean, I think that the – for me, the feasibility is this measure is not really an issue.

Sean Morrison: Thanks, Amy.

I think that having scrolled through, that was also what the (workers) had recommended.

Karen, when you see anything else, I'm just scrolling through. I'm trying to read this as we go.

Karen Johnson: Right. I think feasibility, you just covered it. And Jean-Luc, if you could go down in the – this is still the P.A., but you see the preliminary analysis that we did for usability and use should be on the screen, actually (inaudible). Yes, if you can go back up a little bit.

Sean Morrison: Yes.

Karen Johnson: I think the staff preliminary analysis ranked at low and – I'm sorry, Jean-Luc, go back again. I think it's mainly, because unfortunately, this measure is not in use, which makes it difficult to have the information about improvement. So, that's why staff ranked it low. But, you know, maybe this is also another point that (inaudible) Anne or Carl could talk about – or sorry, Neil, could talk about any plans for use of this measure.

Sean Morrison: Right. And I just add that the staff rated the feasibility moderate and then the usability criterion was rated low. And one of the things that was noted was that there was plan used. And I wonder, Anne and Neil, if you could talk about plan used versus actual use.

Neil Wenger: Anne, do you have anything you want to say?

Anne Walling: So, the one piece that I can say that we included on the maintenance application was that while it hasn't been in use, it was referenced. So, as a important – it was referenced as part of the V.A.s LSP policy. So, that's – and I can't speak to if – how – if it's going to be applied or used in that setting. But also, we are currently doing work to try to apply the indicator and Neil mentioned this earlier using electronic record specifications.

So, I mean, I think it's pretty obvious with the discussion that's come up with the committee that, you know, because of the level of abstraction skills that it actually takes to get this measure and being able to apply it broadly as the

challenge. So, we're, you know, doing work now to be able to apply it using electronic specifications, so that it would be more feasible and be easier to be used in real time for quality improvement reasons.

Sean Morrison: Thank you, Anne.

Neil Wenger: Great. We can't …

(Crosstalk)

Neil Wenger: I'll just add on to what Anne was saying that those of you who use electronic records know that the advance care planning component for those records are very rudimentary, even the brand new (Epic) ACT mechanism doesn't begin to collect anything that could be used in this measure.

On the other hand, there are many EHRs around the country. In fact, UCSD and UCLA just this morning demonstrated the feasibility that our mechanisms are identical, where these notes are being captured in such a way that this measure could be applied electronically.

And that is what we're currently working on developing. The thought is that rather than a lot of places trying to do this by hand, that the next steps will be demonstrating that it's feasible to do in EHR systems that have a capability.

Sean Morrison: Thank you, Neil. Open to the committee for questions.

Amy, is your hand up or is it just …

(Crosstalk)

Amy Sanders: My hand is up. But I have rather more comments than a question, though. And I just…

Sean Morrison: Go ahead.

Amy Sanders: … in terms of the fact that CMS (with) Medicare have, since the beginning of this calendar year, been reimbursing physicians for conducting advance care planning sessions with patients and/or caregivers, you know, the so-called

death panels of the Affordable Care Act, really not. But, this is – the components of the Affordable Care Act, but I think got misconstrued in the public media as the death panels.

I think that that – there is potential, and this should be something that maybe should be sort of tracked or watched or monitored in some fashion that the number of patients who actually have advance care plans even if they're not as formalized as a POLST or a MOLST, but have some sort of advance care plan.

They've gone through the conversation. They have considered their alternatives, given certain situations. I mean, myself, I've conducted several of these sessions now because I take care primarily of dementia patients.

And dementia patients have, you know, particular needs at the end of life and, you know, some of the aggressive measures that would be appropriate in other settings are really just inappropriate and burdensome to patients at the end of a long dementia illness.

So, I think as advance care planning conversations take hold and become more common, the number of patients who actually would enter in the ICU with a preexisting document and/or some sort of, you know, declaration of their wishes is probably going to rise, and in my hopes and dreams, exponentially so.

Sean Morrison: Thank you. Any other comments from the group? Or, you know what, I would suggest we go to voting. Jean-Luc?

Jean-Luc Tilly: Yes. So, the poll is now open for a vote on the feasibility of the measure. So (inaudible) first, you have four options here, high, moderate, low and insufficient.

All right. So, we received 17 votes, 16 voting moderate and one voting low. So the measure passes – the measure 1626 passes the feasibility criterion.

So then we'll move right along to use and usability. And here, again, you have four options, one high, two moderate, three low, four insufficient information. The polling is now open on usability and use for 1626.

(Off-Mic)

Jean-Luc Tilly: All right. So, we received 18 votes, 11 voted moderate, seven voted low. So, the measure passes usability and use.

And I think our final vote for today, which is overall suitability for endorsement, so just two options, yes or no. Does the measure meet NQF criteria for endorsement?

(Off-Mic)

Jean-Luc Tilly: We're just (for) one more vote, please don't be afraid to – all right. Terrific, thank you so much. So, we got 18 votes, where everyone voted yes. So, the measure is recommended by the committee. The measure 1626 is recommended by the committee for endorsement.

Thank you so much. So I'll turn it to over to Karen now for the related and competing discussion.

Karen Johnson: Yes. So, related and competing, really, I wanted to get from you guys. And Jean-Luc, if you could take me to the related and competing link from the memo, that would help.

Just as reminder, we had this discussion for the most part in the in-person meeting. But it, really, was thinking about the treatment preferences measure versus the advance care plan measure.

Just a reminder, that advance care plan measure, you did not evaluate. We brought that in from another project to discuss.

So, basically, from that discussion, the committee noticed differences between care preferences and treatment preferences. And I just wanted to open it very quickly for any discussion.

The care preferences measure that we just discussed versus the treatment preferences measure that we talked about earlier. Is there anything in terms of harmonizing these measures or maybe justifying why two different kinds of measures with the similar views that may be a little bit different things are needed?

So I'll just open that for a couple of seconds for committee input on that question.

OK.

Sean Morrison: I guess, Karen, this is Sean. My only – the way that – the only way I would think about this is that the ICU represents a really different level of treatment for many individuals. And too often, we've seen advance care plans being – or patient preference has been noted and then forgotten as people transition through a complicated hospitalization.

And I think the idea that a care team thinks about this and readdresses this when there's a substantial change in treatment plan or clinical condition which really an admission to the ICU represents.

It means that it really is a different measure than 326. And certainly, the setting is very different than – the setting is different from 1641, which the denominator is only hospice or palliative care.

Karen Johnson: Thank you, Sean. That's very helpful. That'll help me complete the report as we write it up and address these issues. So, that's great.

Now, I noticed that, just like in our in-person meeting, I thought we would have tons of time and be done early. And once again, I made a mistake with that.

But I wanted to talk very, very quickly about the other comments and the disposition. And basically, them one was the general support for the comment – for the measures and for your work as the committee. There were a couple of comments that brought the idea of patient choice into the discussion, noting that there is a need for patient choice.

And that – particularly for this aggressive care measures from ASCO, noting that the 100 percent or the 0 percent performance is not the goal. And also the idea that preferences can change overtime.

So, what we, as staff, have done is drafted some committee responses. I'm not going to read those to you now. What I'd like for you to do is take a look at our draft responses to the comments. You could find those comments in their entirety in that Excel spreadsheet.

So, if you would take a look at those and just e-mail the project team, if you have any suggestions for changes or additions, or nuance that we need to add in to the proposed comment – or proposed response, we'd appreciate that.

And finally, them three, there were a lot of people who commented on gaps of measurement. And we had a chance in the in-person meeting to talk about that briefly. So, we came up with a list from you guys. And our commenters have added to that list. And I put those here. So, again, there's a little bit of post work for our meeting trying to be (inaudible) time here.

If you would look at that list and if anything – if you think that something on that list doesn't make sense to be added to the list of gaps, I appreciate it if you could just let us know.

And maybe if you could do that within the next, what is today, Wednesday. If you could get back to me by Friday, that would be wonderful on either of these two issues. And I'll let you know if there is substantial changes based on feedback from the committee.

Finally, the last thing that I'll ask of you as the committee, I had hoped to have some time to talk about our measurement framework. You may remember the rings and the grid. And we had talked a little bit about including concepts of cost and decision making and safety in there. And you see that I haven't done that yet because I didn't quite know how or where to put it. So, I have some questions in the memo that I'd like you to consider and maybe give some feedback, by Friday, if you could.

Monday, if you – I'll give you the weekend. How about COB Monday if you could get back to me on any of these things, any feedback about the measurement framework. Are there – are these the right rings, bringing the right order? We use the domains of care from the consensus guidelines. They sort of worked, mostly worked. But they – a couple of them are a little bit odd. So, maybe they don't work.

I went back and looked at dying in America and realized that they had (core) concepts – or sorry, (core) components for quality end-of-life care. They note that their (core) components actually do match up well with the domains from the national consensus guidelines. But, I just want to throw that out there.

So, any feedback that you have on those three things, patient choice, the gaps or our frameworks, if you could get back to us by COB Monday, that will be great. What we will be doing – well, I'll be handing this over to Jean-Luc in a minute to tell you about our next steps. But, we'll be taking your final comments and modifying the report as needed based on our conversations today.

So, Rachel, would you mind us to take us through public comments and then Jean-Luc as far as next steps.

Rachel Roiland: Sure. Thanks, Karen. Hi, everyone.

Operator, if you could open up the lines to see if we have any public comments, that would be great.

(Off-Mic)

Operator: If you would like to go – if you would like to ask a public comment, please press star one.

There are no public comments at this time.

Rachel Roiland: Thank you. All right. So we don't have anything in the chat. But I see, Cleanne, you have your hand raised?

Cleanne Cass: I do. Will this information be on this website for us to review and send back comments by Monday, or should we be looking on the homepage on our committee page?

Rachel Roiland: All the information is posted to the committee SharePoint page. So, if you have any questions, you can look through that. And if you're having trouble accessing that, I know it may have been a while since you looked at it, just feel free to give us a call or e-mail us and we'll help you out with that.

Cleanne Cass: OK. Sounds great. Thank you.

Rachel Roiland: Thank you. And I'll turn it over to Jean-Luc to walk us through some next steps.

Jean-Luc Tilly: Thanks, Rachel. So, it’s a bittersweet moment, of course, since this is our last meeting together. Thank you all so much for participating. You'll have a chance to follow some of our progress in the next few steps that are part of the NQF Consensus Development Process, where we give NQF members an opportunity to vote for about a month. So that will take up the month of August.

The next, our Consensus Standards Group, the CSAC, will review our measures on October 11th, a meeting that you're, of course, invited to attend. And listen in on.

And so, with their verdict, they'll consider your recommendations on either move forward with them or not. We'll give our Board of Directors a chance to review and ratify that CSAC decision. That'll be on October 27th.

So then, there's a kind of an appeals period. So, for any measure that has been endorsed, there's an opportunity for anyone, a member of the public, an NQF member to appeal the endorsement of that measure based on a few criterion. That doesn't imply to measures that were not endorsed. So, this never was a decision for non-endorsement.

The appeals period will last from October 21st through November 29th, a 30-day period.

Finally, once we have (inaudible) on hand, we'll assemble to them into a final draft report which will include, of course, your feedback today and your votes today. And then, we'll send you all an e-mail when it's done. And that'll be that. So, thank you so much.

Karen Johnson: And this is Karen. I thought I saw Paul's hand raised.

Paul, are you on and have a comment or question?

No? Let me open it up. I know we're a little bit past the hour. But, did anybody have any questions or comments, concerns, anything you'd like to say?

Sean Morrison: Karen, this is Sean. I just wanted to say thank you to you, Rachel, Jean-Luc, and the rest of your staff for really putting together and coordinating this …

Female: Can't hear.

Sean Morrison: … the rest of the – sorry, I said I just want to thank Karen, Jean-Luc, Rachel, and the rest of the NQF staff for really coordinating all of this and (hurting a lot of cats).

And most of all, I really want to thank all the members of the committee. I know how hard to stay focused on a conference call for two hours. And you guys did amazing. And I thought we had a very good discussion about some tough issues. So, thank you very much for that.

Karen Johnson: Yes. And we, from NQF, wholeheartedly agree. Thank you so much, Sean, for stepping in and taking over the facilitation of this.

We know Deborah wanted to be on the call. But she had something else that – I think she's in the air maybe right now …

(Off-Mic)

Karen Johnson: … join us. But, thanks, Sean, for being such a great co-chair. We very much appreciate it.

So, with that, we will be in touch with next steps. So, we look forward to hearing from you by COB Monday on anything if you have any suggestions. And we'll be talking to you later. Thanks.

Female: Thank you.

Female: Thank you.

Male: Thanks, guys.

Male: Yes.

Female: Thank you.

Female: Good night.

Operator: Bye-bye.

(Crosstalk)

Operator: You may now disconnect.

END