NATIONAL QUALITY FORUM

Moderator: Kim Patterson
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2:00 pm ET

(Robin): Okay. It is 2 o'clock. Ms. Kim will get the call started and use every minute that we have. My name is (Robin) Project Manager. I'm going to go ahead and kick it off with (Sam) to welcome you all and start the call.

(Sam): All right. Hello, and welcome everyone. This is our second call and hopefully, the second of two. We had two measures that we're considering this fall 2019 cycle for the Patient Experience and Function Standing Committee. And the second measure, we're going to be talking about is Measures 0291, the Emergency Transfer Communication Measure.

As you probably can guess from the number, the NQF number, this is a measure that's been around the table for quite some time. So delighted that we have, I think I heard (Jill Joanne) join from University of Minnesota. And we're delighted to have you. Thank you for joining. And do we have (Ira) joined as well?

(Ira): Yes, I'm on.

(Sam): Excellent. Oh Ira, welcome. We appreciate the two of you joining us today. I think Lee Partridge is the only one of our co-chairs that is on, either Chris or Jerry is set to join.

Lee Partridge: This is Lee. I know Chris is on, I know Jerry is unable to join us because he's presenting at another meeting. And Chris hopes to chime in.

(Sam): Okay, very good. Thank you. This is just a slide to show to our staff, I think you all are familiar with us, except for (Udobi), who recently joined as a project analyst. So welcome too, (Udobi). She's going to be a permanent addition to this team.

And so our agenda is pretty straightforward. We're just going to move straight from our welcome into a roll call. And then we'll cover some things briefly just to remind you of how the order of operation runs. Then we'll move into the consideration of our measure. So (Robin), did you want to walk us through our roll call?

(Robin): Absolutely. So I'll call your name and so you could state if you are here. Gerri Lamb? Lee Partridge?

Lee Partridge: I'm here.

(Robin): (Chris Daly)? (Richard Ansanelli)? (Adrian Boise)? Donald Casey?

Donald Casey: Hi, I'm here.

(Robin): Great, thank you. (Ariel Cole)? (Ryan Kohler)?

(Ryan Kohler): I'm here.

(Robin): Thank you. Sharon Cross? (Christopher Dezi).

(Christopher Dezi): Yes.

Woman: Thank you. Shari Erickson? John Paul.

John Paul: Here.

(Robin): Thank you. (Sheri Kaplan)?

(Sheri Kaplan): Here.

(Robin): Great. (Brenda Liz)?

(Brenda Liz): I'm here.

(Robin): Excellent. Brian Lindberg?

Brian Lindberg: Here.

(Robin): Thank you. Ann Monroe? (Lisa Mores)?

(Lisa Mores): I'm here.

(Robin): Great, great. And then I know, (Randy Oster).

(Randy Oster): Yes.

(Robin): (Clarissa Casella)? Lenard Parisi? Debra Saliba? (Ellen Shod)? Lisa Suter? Peter Thomas.

Peter Thomas: Present.

(Robin): Thank you. Tracy Wong.

Tracy Wong: Hi, I'm here.

(Robin): Excellent. Thank you. And I know during the roll call, we had a couple of beeps. Is there anybody who entered the call and did not state their attendance?

Okay, great. Anyone, please enter a comment in the chat box if your name was not called and we're going to try to get started and use all the time that we have. All right, let's kick it back.

Man: May I ask a quick question? Do we have a quorum?

(Robin): One moment, let's confirm that. Okay. So at this time, we have 12 committee members on the line. So we have at least 50%. However, we are not at quorum. We required 16 members on the call for quorum. So moving on, from this point, we will hold the call. But we will have to do voting offline.

And I will defer to (Sam) to kind of continue with the process details. But just want to let you all know that we currently have 12 committee members on the line, which means we have to use the offline voting survey.

(Sam): Okay. So let's go ahead and send out the survey and allow folks who are on the call to vote in real time. That way, you don't need to revisit it. Once we send out the recording to the rest of the committee members, what we'll need to do is get at least four more of the committee members to weigh in via the survey instruments in order for us to tally the votes. So that'll allow us to get the quorum.

Unfortunately, we didn't reach that over the call. But it does allow us to do a little bit faster to the voting process. And since we don't need to wait for all the votes to come in, we can just move forward. So with that being said, let's go ahead and just advance through a couple of reminders on how this is going to move.

And do to next slide, please. Okay, thanks. So, just a reminder, we have five voting and we're going to be voting on five endorsement criteria. The first is important to measure and report that includes both evidence and gap. We have scientific accessibility.

We'll be voting for the reliability and validity of the measure. Then we'll consider its feasibility, usability in use. And we also have the related to competing but then we'll also vote on the overall suitability for endorsements.

Next slide. So as was noted, we need to have 16 people to achieve quorum. But in order for our measure to pass greater than 60%, not inclusive have to vote Yes, of the current voting members. We have a consensus. Now, in this situation is 40 to 60% vote Yes. And it is of course, if it's less than 40%, voting less than the estimate means that the measure does not pass.

So, we should be sending the link to the SurveyMonkey, if it hasn't been sent already. You can vote during the course of the webinar. But once again,

since we don't have quorum, this is the way that we have to do it. When we actually moved to our discussion of the measure, we'll start by allowing the measure developer to give a three to five-minute introduction of the measure.

And then we'll pivot to our lead discussion and have the lead discussion first, highlight things around the evidence and gap and also pivot to discussing, and then the rest of the committee to continue on evidence and gap.

And then we'll move in a stepwise fashion to allow time for you to lock in your vote, if you wish, as we're having the conversation. And then move to the subsequent criteria as we continue our discussion.

So try to stay focus initially on evidence. And then we'll move to gap and then onto scientific acceptability et cetera. Next slide. Any questions on how we're going to be going through our process today?

Man: The voting mechanism was sent by email correctly. Is that correct?

(Robin): Yes. It was sent literally a couple of seconds ago. So you should be receiving that shortly. But definitely let us know if you don't have it.

Man: Okay. And is it electronic or do we print it and…?

(Robin): It'll be an electronic survey. So you can actively vote inside this link.

Man: Okay, thank you.

Woman: Do we ignore the vote one?

(Robin): Yes, exactly. That's not working anymore.

Woman: Okay.

(Robin): Exactly.

(Sam): All right. So we won't be using the poll everywhere, method that we usually use for live voting. Our offline voting platform, we simply use SurveyMonkey. So if you open that up, it should - the link that (Robin) just sent out, it should be the SurveyMonkey link. And that'll allow you to vote as we go through our measured discussion. Any other questions?

(Sheri Kaplan): This is (Sheri). Can I ask a question about the measure? Is this a maintenance or a new measure?

(Sam): It's a maintenance measure.

(Sheri Kaplan): Okay, thanks.

(Sam): Okay, very good. Well, let's move to our discussion here, the consideration of the candidate measure. Our next slide please. So this is Measure 0291, The Emergency Transfer Communication Measure. The Measure dealt with the University of Minnesota and both (Ira) and Jill are on the line to give an introduction.

I'll hand it over to the two of them to kick things off. And then we'll go directly to Lee to lead our discussion. Let's hand it over to the stewards Jill and (Ira).

(Clarissa Casella): This is (Clarissa Casella). I apologize. I am here too. I just left that clinical encounter.

(Sam): Oh, thanks for joining.

Jill Klinger: Okay. This is Jill Klinger calling and I'll give it a start. As you know, lapses in transition of care can lead to increased costs and errors. The EDTC is one of the very few measures that address transition directly. It was developed at the University of Minnesota Rural Health Research staff in 2003, with the focus towards providing a measure that was relevant to rural hospitals in particular.

It also addresses patient group transfers to our increased risk of medical errors and who are excluded from most quality measures. The measures have been piloted across the US, since 2003. The major difference across these pilots have been the training methods.

To me, UM, RHRC and to Stratis Health, initially trained hospital as practice face to face, then they train you with webinar. They've trained hospital staff with the struggler staff with rural hospital network staff and with QIO personnel across the U.S.

The measures were significantly revamped in 2018 to reflect the improvements that have been made an inter-facility communication. The measure now has only eight elements of the original 27. These changes were made using technical expert panel of rural measurement and quality experts. These changes are being rolled out starting this First Quarter of 2020.

Currently, the measure is supported by the state plus coordinators with Stratis hospital staff, Robyn Carlson as the touch point. This support is provided as part of our RQITA, which is Rural Quality Improvement Technical Assistance Program, which is a cooperative agreement between Stratis and the Federal Office of Rural Health Policy.

Many of the state's Flex Coordinators who are responsible for shepherding their hospital, use contractors or private vendors, like Adventist, Chartis, Stroudwater or Cynosure to support their hospital staff with the reporting of the EDTC measures to FORHP. These contractors and vendors may not be sufficiently attentive to the exact specifications. And that's where we find many of our IIR issues coming from.

So there are inconsistencies because of the way the measure has been spread. The reporting of EDTC HCAHPS and some of the CMS measures by Critical Access Hospital are supported as part of the requirements to receive MBQIP funding for Flex critical access hospital improvement project.

Right now, about 1300 Critical Access Hospital already are currently and have for the past couple of years reporting these EDTC measures quarterly to their Flex coordinators, who then submit those measures to the Federal Office of Rural Health Policy.

We do understand that there are issues with the reliability and we will address those issues when we get to that area of this discussion. (Ira), you wanted to add something?

(Ira): Yes. I would just say, you know, given the comments that were quite helpful, that was sent to us. There are very few care coordination measures that have been endorsed by the National Quality Forum. And the process that we developed was not quite two decades, about 17 years ago, really got to trying to start work in the area of care coordination, particularly in the rural environment.

And we view this as a three-step process, really. What we looked at was, if the appropriate information being sent out from the emergency department of these small rural hospitals to a facility that a patient was being transferred to. Several of the comments that came back to us, they just said, well, they have not linked this to outcome, patient outcomes, or while these measures being sent, is it being used on the other end, we don't know.

And as I say, this is a three-step process. We think the first part is, is the right information being sent out. The second part is, is it actually being used. The third part is, if it's being used, is it having an impact on outcome. It took us a huge amount of effort to get all of these hospitals to be collecting this information in terms of what's being sent out.

And it would be a very large effort also to get to the two other parts of process that I described. They're important. But I really view this, we really view this as a three-step process. And we think this measure is a really good measure for the first step of the process. And it is important, I think to have NQF endorsement.

And I would say that the fact that we have over 95% of all Critical Access Hospitals are now, uniformly reporting this on a quarterly basis to the federal government, the Federal Office of Rural Health Policy.

And then this measure is currently being used to evaluate the quality of Critical Access Hospital. That's one of several measures just understates its importance, certainly to the individual hospitals into the Federal government that oversees the program. So I'll just offer that.

(Sam): Why should this be confined to rural -- small rural hospitals? Are these transitions just as important for larger hospitals?

(Ira): That's a good question and we've certainly received that over the years and the answer is absolutely. We feel it's important to urban hospitals also. We've had a federally-funded Rural Health Research Center for three decades now. And this was one of the projects that started back in the early 2000.

And so the funding for this came from our Rural Health Research Center funding, which focuses on rural household. But absolutely, we think these kinds of efforts could be expanded to urban. It would just, once again, take additional resources to do that.

(Sam) Are there other measures that are similar to this that might be used by larger or urban hospitals, or is this really the only measure of which you're aware that really measures this process?

(Ira): I think this is the best measure that measures this. I think the work of (Coleman) out at the University of Colorado probably is the most important work in terms of care coordination. But we think this is the most comprehensive measure that's looked at all the right elements being sent, so that people on the receiving end can make good decisions about the next steps and treatment of care for patients that are transferred.

(Sam): Thank you.

Jill Klinger: CMS has looked at this measure several times. It's been in preliminary state several times for its expansion to all hospital. And it just hasn't jumped at to that level yet, because of some current concerns about the burden, which we have reduced in which most hospitals that are using it could feel that it's not an urgent issue. I mean that is not a burden.

(Sam): Okay, thank you.

(Christopher Dezi): This is Chris, (Chris Dezi). Just quick, a quick question, if I may. I appreciate the three steps, the three phases, that's much appreciated. In the brief description of the measure, it says indicated that all required information was communicated. Here's what I'm thinking of when I read that. Are we talking about, do we want to frame this as required to be sent or required in use, to be used? Do you follow what I'm saying there?

Jill Klinger: Yes, I do. This is required for the measure. During our evaluation in 2018 with the expert panel, the vital signs were removed because evidence has suggested that they are being communicated on a regular basis.

The flow sheet from the emergency department is set. The part of the vital signs, the neurological status is not as routinely said until that vital signs has been saved in the new elements. But the vital signs sheet is always sent.

(Christopher Dezi): All right. Thanks.

(Ryan Kohler): This is Ryan. Since we're bringing up a question about the measure. Maybe I'll ask one that I was going to bring up later. Can the measure developer just clarify the distinction between one of the elements that has to be included, which is the plan of care? And how that differs from the ED provider note?

Jill Klinger: The plan of care is usually in the provider notes. So that would be saying, that's where the abstractors would look for the plan of care.

(Ryan Kohler): Okay, thanks.

Donald Casey: Hey, this is Don Casey. I just wanted to historically say that we have been working with this group, NQF for a number of years. I know that when we initially saw their measures, it was submitted actually as separate measures. And so they did a nice job of bringing those together based upon our feedback, I think, maybe about six years ago.

So I know a lot of work has been done in this. I have a lot of experience with Critical Access Hospitals and rural health. And I do think that the notion of having timely information is critical. The quick question here is, is the 60 minutes just something that you think is expert opinion?

Did you have any other than, let's say, strokes and MI, whereby there are, you know, or perhaps serious drama with a critical time elements to it is in general, the 60 minutes sort of a rule of thumb by expert opinion?

Jill Klinger: Yes, that is exactly right. It's by rule of thumb, knowing that, as you said, ongoing MI and rhythm strokes and acute trauma, emergency deliveries would all have a different timeline. But this is for all the rest of the patient, exactly.

Donald Casey: Thank you.

(Sheri Kaplan): This is (Sheri Kaplan). Can I ask you – sorry. I had cold, that has nothing to do with the coronavirus. Can I ask you a quick question to developers? So it's my understanding that how does this work exactly with respect to the follow up on the 60 businesses?

So you have to get each one of these pieces of the elements of this measure and the numerator, both documented communicated and received within 60 minutes.

So every single one of those has to be within. So my question is, which all of the elements are required to be documented and communicated and received within 60 minutes? In other words, if I was doing the algorithm, how would this come in? Do I have to get all of the first and then go back and look at which ones were received within 60 minutes and which weren't?

Jill Klinger: Received is not part of this process. As Ira said earlier, this is to be what's being sent. So, you have to have these elements and it has to be documented that they were sent within the 60 minutes.

(Sheri Kaplan): Each one of them within 60 minutes. So if one of them fall out, the whole numerator gets a fail?

Jill Klinger: Yes.

(Sheri Kaplan): Okay. Thanks.

(Randy Oster): And this is (Randy Oster). In terms of a patient is being transferred in a rural hospital, many times, it could take longer than 60 minutes to get to where the patient is transferred there. If the patient is in an ambulance with the ambulance driver, does that ambulatory service count as a transfer if they are holding the medical records at that time? And it says two hours, you know, travel time to get to the next facility?

Jill Klinger: Yes, that does count if the information is sent with the patient. And if you give me a couple of seconds, I can read you the exact specification for what we mean by sense, because that's reiterated throughout the specification several times. Would you like me to get that for you?

(Randy Oster): No, I think you've answered the question. The question does the EMT count as sent and then EMT then hands it over to the hospital?

Jill Klinger: Yes.

Donald Casey: This is Don, again. I just had recalling my input here. You know, I think it's pretty clear that especially the smaller or remote hospitals are in the tail end of being sophisticated in terms of EHR and other technology adoption. I know there are different areas of the country that have health information exchanges, which actually facilitate this well.

But for the most part, I would bet that there's a large number of fax machines still running, like, you know, the trains, in many of these places. And that's just the way it is. But do you have a sense of variability in terms of access to technology, you know, all the way from immediate virtual to using the slower sort of, 20th century technologies. How does that ferry us for hospitals?

Jill Klinger: Ira would you fill this one?

(Ira): Yes. So we've done other studies that have looked at that technology diffusion issue. And I think as you just said (Don), there still exists significant, I would say sophistication and access to recent technologies. Having said that, people recognize, this is an important aspect of keeping rural hospitals viable and open and of use to the community.

And what we've seen in recent years are substantial federal and state funding going to improve those kinds of capacities, not just having a really good electronic health records, whether it's using telemedicine, whether in some rural communities, it's just having access to broadband. There are still

reasonable number of rural communities that don't have good access to broadband capacity in their community.

So I think little by little, what we're seeing is that variation is getting smaller. But we still have a ways to go, that's for sure. And I agree with you. Once again, in terms of, we're just looking where the hospital is sending this information at this point. Ideally, you'd like it to get there quicker by electronic means. But you're probably right, some of these facilities are still using faxes to accomplish this.

Donald Casey: What I'm getting at, of course, is the disparity. And this is, you know, more than just getting a grant, right? You've got capital requirements that are substantial, especially for some of the resource constrained places that are basically day-to-day, trying to keep the lights on.

So I just throw that into the mix here, in terms of the notion of accountability and how the rates may reflect potentially, disadvantaged organizations that can't afford not just the expensive and application. But the people power to put that into place maintain it connected, you know, troubleshoot it, et cetera, et cetera, which as you know, is in the gazillions of dollars across the country now, so just saying that?

Lee Partridge: This is Lee. If there are more questions for the developers?

(Tracy Wong): Yes. This is (Tracy Wong). I have a question somewhat related to the previous one, which is, do you, either of you have a sense for the cost of reporting. So not the cost of actually providing that documentation within 60 minutes but the cost for abstraction and self-reporting of these measures?

Jill Klinger: Sure. We have for the quarter. We've asked hospitals to report up to 45 cases. So that's 15 cases a month. If they have less than 45 cases, they're asked to report all of them. And if they have more than 45 cases, they can contribute, do some sampling and report just the 45 or up to as many as they would like to. So go ahead, (Ira).

(Ira): Now, just the thing I would add to that is in rural facilities, you know, they don't have a 16-person quality improvement group. And so when we develop these measures, we really in our pilot tests, et cetera, worked with the staff who are involved both in terms of the training but also in terms of follow-up. And the staff that are providing information are wearing multiple hats in their facility in terms of their responsibilities.

And this led us to really, when we brought a technical expert panel together. The one thing we were asked constantly overtime was, is there a way that we could try to scale the original measure down so that we really collected the information where there was variation and that are really important.

And that's why, one of the reasons that we scale the measure down from 27 to less than 10 elements and so the burden issue is important. We really haven't measured costs per se. But as Jill said, what we've done is we've tried to take into account. The time burden on the staff, particularly the nursing staff, and record staff who would be collecting this.

Jill Klinger: Lot of this that, most of the emergency department records are quite short. So in terms of the time to audit, it's often very clear in the record whether things have been sent or not, whether it's documented that they've been sent, whether they've been collected and then sent.

(Ira): I think one other point that is important to note is we have, as Jill said, not quite 1300 Critical Access Hospital, which is more than 90% of them reporting this to the federal government. That's not mandatory, okay?

And so they're doing this in the efforts of the Federal Office of Rural Health Policy to really try to assure high quality and to help improve the quality in these facilities. So the fact that that many hospitals are currently submitting this information really, I think, speaks to the fact that this is doable and they continued to do it overtime, which points out that they're finding it useful.

Jill Klinger: Randy, did you have a question?

(Randy Oster): Yes. When you scale that down to the 10 on the screening, but can you confirm that that includes things like CT scans and X-rays, that any pictures or that type of data is also included in the transfer?

Jill Klinger: Yes. Out of the eight, seven is tests and procedures done. And eight is the tests and procedures results sent.

(Randy Oster): Very good.

Jill Klinger: Okay. Any further…

((Crosstalk))

(Clarissa Casella): This is (Clarissa Casella). Can I ask a question also?

(Ira): Sure.

(Clarissa Casella): So, this background, I'm an emergency department physician at a quaternary care center, where 40% of our patients arrive as transfers. And we have a number of rural transfer centers. So that's my perspective. I know that from being, from participating with the NQF that we endorse measures that are based on things like expert consensus at the outset.

But my thought would be that five years downstream, we should be looking for, okay, where's the associated outcome data? So we endorsed this on the premise that, you know, the underlying ideas of fewer ET tests and so forth, were supported. It surprises me since that seems like, relatively easy sort of billing data and stuff to get that we wouldn't be looking for, have we done fewer ET test, have we done to fewer scans.

So it gives me great angst the idea of a measure like this being deployed and more in our region. And I say that only because I say, it looks like it would be a lot of extra work on smaller hospitals with fewer resources, potentially, just to check the boxes and then would not benefit me at all on the receiving end.

So that's why I feel like one of the big gaps is in the outcomes. And I understand the three-phase part. And I'm, you know, it seems to be working well in the system there. I just was wondering about, you know, if any outcomes are being looked at or measured?

(Robin): Because this, the information is being sent from the rural hospital. We would have to, in order to link that up, to go to the receiving hospital, match the identity of the patients, and then collect the data from there. And logistically, in terms of getting the data, it's mind-boggling.

And that's why we think that perhaps, complimentary measures of did they receive, you know, looking at the coordinates of the tertiary hospitals, did they

receive information from their transfers? Do they have a transfer agreement in place with what information is required and what the timing should be required?

And then taking those transfer patients at the tertiary, quaternary hospital and looking at the outcomes, linking it all at that particular hospital. (Ira), your thought?

(Ira): Yes. It's a fair question. It was asked in the comments, being asked again. And I think it would be as Jill said, quite challenging from a resource perspective to do that.

I think it's fair to ask after 15 years, hey, have you, you know, started the process to do this? We haven't, it's something we could talk about with Stratis Health colleagues, who we've been working with in terms of training and pilot testing, et cetera.

I think it's important to understand our unit of analysis, what we were proposing here and has been in the field for 17 years. Our unit of analysis is the critical access hospitals, not the patient. So we don't receive patient records. We don't have the IDs of patients.

And so, as Jill was saying to match them up, would really involve a very different process. Some would be doable but we really, we'd have to go through a whole bunch of activities related to patient identification as compared to right now, it's aggregated to the hospital level.

And fair question, the answer is we have not had the funding to do that. It would take a very large effort to support that.

Donald Casey: Yes. This is Don.

(Sam): Hello. Did we lose you Don?

Man: I think we lost him.

(Sam): (Unintelligible)

Jill Klinger: Well, if Don gets back, we'll let him in. If we don't have any more questions, Sam, who's our lead discussing, discussion on this measure?

(Sam): We had (Clarissa Casella) as the lead. And (Ryan Kohler) as the other discussing. So Clarissa, if you wanted to take the initial go at discussing the evidence, it would be a good place to start?

(Clarissa Casella): I am getting to the correct page here. Okay. So the preliminary reading for evidence as previously reviewed based on the criteria was insufficient. I'm assuming that based on the prior endorsements that it was rated as insufficient evidence with exception. Is that a correct assumption of the prior rating?

(Sam): That is correct. But just a brief explanation there, this is Sam. Our process is that if we do rate something as insufficient that technically fails to measure. However, with evidence, we as a committee can elect to grant an exception to that if the committee feels that that is the appropriate course.

And in instances where that might be inappropriate thing if it's something that is remarkably challenging or unethical to structure a randomized controlled trial around or any sort of study around that we know is the best practice or if it's just very challenging to gather the sort of evidence, so we'd back it up.

But there is strong indicators in the mind of the committee that this would still be an industry best practice then evidence exceptions can be granted by the committee as your purview.

(Lisa Mores): This is (Lisa Mores). This may seem like a strange question. But since we don't have quorum, how do we vote on whether or not, we can grant an exception with evidence and know that we could go on for table the whole issue?

(Sam): Thanks for that question. We have staff then participated this, given that this was the way that the measure was passed last time. So it's actually structured into the SurveyMonkey. So everyone who answers the question about evidence, I guess with rating, will be given the option.

And I think the phraseology is something to the effect of if the committee votes to rate this as insufficient, would you like to grant an exception to evidence. So everyone will have that question at their disposal.

(Sheri Kaplan): This is (Sheri). I'd just follow up on that, if they – in a full approval exception or can it be provisional in a time interval that's before when it would come up for maintenance the next time? Then I'm thinking of an observational study with hospital level outcomes, not patient level outcomes, which would be plausible to do, right?

I think it would be plausible - certainly plausible to do with the existing information systems. Could we offer a provisional exception that's not time - that's not such a long-time interval?

(Sam): I actually don't have a good answer for that, Sheri. I think the answer is no. If we are granting an evidence, an exception to evidence, we could say, well,

when this comes back for maintenance, here's the requirement or what the committee would request if there's a consensus around that. And happy to include that inside of the report as well.

(Sheri): Okay. Thanks.

(Randy Oster): So, this is (Randy Oster). Part of what we get by this discussion is sort of a consensus and how we are all thinking. It is then to agree that there was an exception to evidence it's warranted because we had these conversations, but the other four people weren't a part of that. And then, they don't agree, right? Isn't that, you know, they are making a decision without the information that we had. And so, how do we get around that or do you see that as a problem?

(Sam): Thanks for the question, (Randy). So the process that we follow here is that, whomever is not present on the call will have access to both the recording and the transcript of the call for them to be able to review. So they'll be able to see where the discussion went and why the committee determined in their minds that an exception was warranted.

So if they agree with the rationale that you put forward and it has a cogent backing behind it, then they'll be able to hear what those arguments are and agree or disagree with them.

Brenda Lee: This is Lee again, I'm mindful of the time of what happened to us last time. So as I'm looking at the SurveyMonkey, as I understand that Sam, our threshold question is to build on whether we think the evidence on 1A is sufficient.

And if we don't, then we'd move down to the exception. Is that right?

Man: It is.

Brenda Lee: One, two. So, do we have any discussion about the first question that is, are people comfortable that the evidence that's been provided is whatever it is moderate, lower, insufficient. And any further discussion questions about that one? If not then we could proceed to vote.

Woman: Do we submit each question individually even though they are all on one page?

Brenda Lee: Yes, Sam does - do the answers come back to you so you see them? The way you do on vote?

(Sam): I'll defer to remind on this one.

Woman: Thank you for the question. So the way the SurveyMonday work, we will not be able to see the vote until the entire survey is complete. So it does cause the question how do we determine, you know, the additional question. But the survey has to be completed in its entirety in order to see a result.

Brenda Lee: Well, because I think that there are questions on this one. And there are - I know from the comments of earlier discussions that there are some questions on the gap, part of this question. And if we voted, no on the exception we wouldn't have go on any further. Sam, I'm a little stuck on the process.

(Sam): So, the process when we don't have quorum is to move through the entire measure to discuss the additive, each section would continue as of…

Brenda Lee: All right. So we are going to assume, therefore that the answer is we go on. Okay. If everybody's clear on that.

(Lisa): Well, I'm confused again. I'm sorry, this is Lisa. Because…

Brenda Lee: No, it is confusing.

(Lisa): When I vote, I'm not apt to then decide if we want to grant an exception. Is that something that doesn't pop up until the end of voting?

(Sam): No, it's Question 3.

Man: It's Question 3, yes.

Woman: Well, actually, Question 2.

(Lisa): That's not the Question 3 that I'm getting. Oh, important to measure potential exception?

Man: Yes.

(Lisa): Okay. I see. Thank you.

Brenda Lee: Okay.

(Sam): You are welcome.

Brenda Lee: So further discussion on the first step, Importance to Measure 1A. If not, I guess we just each record our vote and then everybody's comfortable. We will discuss 1B, is that right Sam?

(Sam): That is correct. (Clarissa) did you finish everything that you wanted to say about the evidence?

Woman: Yes.

(Sam): Okay.

Woman: There are no other question, I'm good with that.

Woman: But, we are going to vote on both. We are going to just, 21A question.

Woman: That's right. Well, if you vote insufficient…

Man: Then you qualify.

Woman: Then I think you go on to the next one.

Man: Yes. Even if you don't vote insufficient though, please answer question three. Actually it will require you to answer question three.

Woman: All right. Okay, all right. Is everybody comfortable moving on to 1B?

Man: Yes.

Woman: Okay. (Chris), performance gap?

(Chris): Yes. So, the comments in this section are varied and primarily go to the quality of evidence and outcome on data suggesting that as a process metric, there was not – I'm sorry, that go back in the evidence section, sorry.

That the – that in terms of performance gap, there appears to be a performance gap that was, you know, demonstrable on the documentation of the measure and if the issues were more in the reliability section. So, I will leave those.

Woman: Okay.

(Chris): There was a demonstrable gap based on the data presented here. And that was rated as moderate in the initial review.

Woman: Are there questions from the committee? If not, I have one. As I read this admission, the evidence on performance gap is based on the old measure, i.e., It is the 27. And not on the new measure which now has only eight elements.

I am – I guess I'd like the developers or (Sam) or somebody to help me understand whether or not, if you really significantly changed a measure which you have here. In the absence of evidence, the gap in performance of the revised measure, can we make adjustment?

Woman: This is still in response to how we have changed it. The eight elements that remained were part of the 27 original. The mental status and orientation was clarified, the specifications were clarified. But otherwise, the other seven are exactly the same as they were in the original 27.

And that's why we felt that the gap going forward we have, I think, the information from 2017 that was submitted. So, that information does reflect the eight measures that have carried forward.

We have pulled out different values across the 27 to reflect the eight. Does that make sense?

Woman: That's right – well, if you're under the old measure, couldn't you have flunk passed on eight, most of these but flunk ones now don't exist? And so, I think the difficulties with saying old data works for revised measure?

Woman: Sure. So, in the old data, we had seven sub measures. And the reporting was by those sub measures. And so, one of the sub measures was including the three medication elements that are still included. So, we looked at that one sub measure. And then we looked at the provider note and reason for transfer or plan of care.

And those were both in the same sub category as well. Then tests and procedures done versus results, sent. Those two were in the same category as well. So, we could look at those particular sub measures and be able to say going forward, the remains gaps in those sections of the sub measures.

(Ryan): This is (Ryan). Can I also clarify that might speak to this? So, there's data presented from 2017 from two quarters with performance of 75% on the measure with an IQR of 65 to 97, which I think was arguing in favor of the performance gap. Was that based on calculating from the eight items or from the 27 items?

Woman: From the eight.

(Ryan): Which I think, I think that was what I was making my judgment based on assuming that that is the measure as intended to be specified. And that, those were the data that we were trying to sort of make our judgment about performance gap from that inconsistent with others.

Woman: If that's what you did, it essentially] went back and looked at the scores on those eight and that's uncomfortable. I just had difficulty from the submission understanding that.

Woman: Yes. I'm sorry for being unclear.

Woman: When you say we, you know, the new data won't be used until 2020. I think it probably put up the flag for some of us. Anybody else have questions?

(Ryan): This is (Ryan) again. Is there going to be an attempt or opportunity to look at disparity data in the future, that was the one other piece I think that was commented on by folks.

(Ira): So, this is (Ira). It's a good suggestion. As I said earlier, our unit of analysis is the hospital and not the patient that would – we've been trying to reduce the burden on rural hospital staff.

So, we had – it's not that we forgot about this. It's just that we don't have patient level data that who would have do that, that would imply that at the individual patient level, they would have to, you know, collect information on race, et cetera.

And that's not something that once again, this is not required. This is voluntary reporting this information and we have not included that in the past. I understand the interest in this.

And there's a lot of good potential future research projects that have been suggested here, but we haven't had the resources up enough to do that.

Woman: Any further discussion of performance gap? If not, moving on to scientific sensibility.

Woman: And our first category there is reliability. And this is one of the areas where there were a number of important concerns raised based on the reliability data and Kappa scores.

In particular, that the level of reliability we're seeing suggested it would be concerning to use it more broadly. And that there is sort of substantial, inter-rater reliability. And that as a process measure that's fairly integral to the performance and presumably you might want to see the outcome.

(Jill): So, can I respond to that? This is (Jill). Okay, that's great. We really understand that the statistics suggest us the desirable reliability. And since our initial inter-rater reliability for the first set, the first part of the 27 hospitals, we haven't had a specific set of funding to do systematic IRR.

And with this various training methods across the programs and projects and geography, there's been a significant challenge to this. So, we have in the past two years, at least we have really addressed this enthusiastically.

Currently, there's an opportunity for what they call abstraction for accuracy, that Stratis has part of their or our key to cooperative with the Federal office have offered. This is a voluntary thing for hospitals to stand in and do an active IRR with Robin Carlson again the abstract lead at Stratis Health.

About 25 hospitals have taken advantage of this since May – early of May 2019. We would really like for this to become part of the requirements going forward, for participation in MBQIP, which of course allows of the Flex coordinators at the state level to have funding for improvement projects.

So, Stratis is working with their FORHP context towards that end. We did an IRR this past fall that tested the clarity of the new specification. And element level agreement was fairly significant, but a major failure noted by the Stratis staff was the failure to follow the population specification. So, they did not include the non-acute transfers which we feel is really an opportunity for improvement.

So, they didn't include patients who are discharged or transferred to non-acute settings. For example, patients who returned home to the nursing home. So, they live in the nursing home and they returned to the nursing home. And many hospitals code that as going home as opposed to go into another facility.

And the specification states that any discharge to a facility where a licensed professional is the caregiver must be included in this measure, and they have not been doing it. So, we're working hard on that.

Going forward, Stratis Health had recently concluded three webinars for Hospital Staff Flex coordinators and vendors to explain to them there are modifications and means for that nursing home on non-acute population requirement.

So, just note that that population, that suggestion is not a new modification. That has been in place since about 2006. About 600 people participated in those webinars. So, if you're thinking about 600 participants that we have, 1300 hospitals reporting, that's a good start. The recording of the webinar is available on the Stratis website.

Additionally, information about the measures and specifications and resources for abstractors are available on the website. And we understand the Federal

Office Stratis and the event, really understand that reliability is essential. And we'll be working to find a better process in order to get a more accurate reporting of the IRR.

(Ira), do you have any other comments about that?

(Ira): Yes. The only thing I would like to add is ideally, it would have been quite helpful if the Federal Government could have designated the one group to provide the technical support to the sides for this. But the Flex program and resource for this come to the state level, to the Federal – to the state officer, will have policy.

And it has been opened to them to decide who was going to provide the technical assistance. And that is what has led to the issue with specifying the right population for the analysis.

I think a lot easier to get that, let's make sure that the denominators specify correctly as compared to looking at the elements of the individual, the individual items on the measure not being understood.

We've always had good acceptance of that, good reliability. And Stratis Health working with us has really put some real effort into this now. And we think next time we do the inter-rater reliability, it'll reflect that effort on Stratis Health.

Woman: Further comments or questions?

(Terry) This is (Terry). It's hard for me to look at (campus) like this, especially if this measure's been around for 15 to 20 years. And one study was done in 2009,

which is now over 10 years ago. And this very unsettling (campus) statistic honestly.

And say, "Okay, it's not reliable, but we'll go forward because it doesn't really look like reliable and you explain a lot of reasons why, you know, not enough support for substantial research not, you know, specifications are optimized, et cetera".

But we're still staring at really not very convincing evidence that this is – this can be the data elements and can be reliably abstracted. And that's a real concern for me.

Woman: Okay. Can we can we move on to validity? If we are ready to vote on reliability. Just record your vote, John. So, the comments under validity testing which was rated in the initial review as moderate, primarily echo some of the same concerns that appeared in the reliability testing without too many additional specific, unrelated concerns.

Were there specific questions for the developers related to that? One of the comments seemed like it would bear a little bit of explaining in terms of the rationale for conducting a comparison between communication processes and appropriate care processes being a little bit unclear.

Woman: The reason we chose gross measures were because they were outpatient measures. And they were reported by the same exact hospitals that we were looking at their (unintelligible) measures. So, these are hospitals that have submitted different measures to the MBQIP program or process.

And so, those were the only measures that the – there were no communication measures to compare to that are submitted by the critical access hospitals

under this process. And so, we chose the emergency department matters to compare them too.

Woman: Thank you. I think that's a helpful clarification. Are there other questions related to validity and threats to validity?

(Randy Aster): So, this is (Randy Aster). So, if we were to rate the validity low and the liability low, you know, or insufficient, right? But we also recognize the importance of the measure.

I'm just curious what the outcome is like, you know, because it is an important measure of the patient perspective and everything if we're ready. And so, I just want to understand how individual metrics for validity and reliability could impact the overall decision or if it does at all.

Woman: I think (Randy) did the answer to your question, Sam. Even you have to pass this too.

(Sam): That's correct. So, just for clarity sake, there's a several criteria that NQF has which we have to determine our month pass. And reliability and validity are included inside of those. So, if you rate this as low, that would be considered of not passing the measure and it will not maintain endorsement.

(Randy Aster): Okay. And the thought process there is if we pass something that's not valid or has high reliability, we're just subtracting the institutions to burden some work, right? Versus what's important from the patient perspective, which is they need their data, right? They needed in the nursing home. They need it when they get transferred.

And so, if it doesn't pass, then the question is do they come up with a new measures? A new way to do it? Is that what would happen or does it just go away?

(Sam): If it list as endorsement, then the onus is on the measure developer to bring forward either a new set of evidence or a new set of testing that would satisfy the committee for them to continue to endorse the measure.

So, but as for our purposes today, we would just – for voting to for the measure to not continue to have NQF endorsement, then at the end of this cycle, the measure would lose its endorsement status. And the measure developer would need to go through the process again if they wanted to seek endorsement.

(Randy Aster): Thank you.

Woman: (Ira), do you want to make a comment about that?

(Ira): No, I think it's pretty clear. I think the only we can say is when we did the most recent IRR testing and we saw there was not acceptable results, we have instituted three different efforts to try to improve that process.

And we've had more than 50% of the hospitals that are currently reporting, participate in one of those three efforts. And we are working with the Federal Government to try to get them to require the grantees to participate in this.

But we still have some ways to go in terms of getting complete participation. Once they participate in that, we do believe that the IRR will go up substantially, but that's going to take some time to measure.

(Ryan) This is (Ryan). Can you all speak to the change in the reliability of the measure as it went from the 27 items down to the eight items? I'm just wanting to understand a little bit more of the impact of that change on maybe what we're seeing as well.

Woman: Are you asking the developers?

(Ryan): Yes.

Woman: Okay. So, the change in the number of elements I don't think will impact the reliability. We believe that the process of IRR measurement is with that issue. So, all of the 27 measure elements were adequately reliable. And the early testing, when we had control of the training and had direct contact with all of the hospitals.

So, we're trying to get closer to the hospitals and to the actual abstractors. And then, also to those who are giving them direction, the Flex coordinators and the developers. But we don't expect that there would be any difference in the reliability from the 27 to the eight because these eight are included in the 27.

(Ryan): I see. In the – so, folks who did the abstraction for the IRR testing, are those the same that do the measure reporting, the actual performance measurement in the measures use or is that a separate group?

Woman: No, it was the hospital coordinators, the ones who are doing the abstraction. They did the abstraction and then sent in the records to Stratis Health for that initial IRR.

(Ryan): Thanks.

Woman: Okay. Further discussion on validity? If not, we're moving on feasibility.

Woman: So, there were a few comments related to feasibility. The preliminary reading again for this aspect of the evaluation was high. We have some competing comments, including on the one side that there are no concerns about data collection or undue burden, and a few things to be routinely collected.

And on the opposite side, that it's a fairly high burden simply on the basis of requiring manual abstraction and documentation. And I think the only other, you know, this is clearly developed with a particular subset of facilities in mind.

I guess my only other comment would be, I think there is potential that this is a measure that would be easily met by some large health system that had multiple hospitals and had people on the EHR.

And my disadvantage, smaller hospitals that weren't part of, you know, electronic consortium as it were and that especially in terms of feasibility. So, we already talked about, you know, manual abstraction and then also, you know, dedicated education of the abstractors that's required to abstract us. It's not something you can just walk into and do reliably, it wouldn't seem.

So, I raised those concerns. I welcome comments, discussion and probably – and then maybe any other questions and then response from the developers?

(Tracy): Hi, this is (Tracy). The only comment that I had around this one is - it's kind of hard for me to really gauge feasibility when the comments are only from those who have volunteered to participate. So naturally, I think they would

rate it more feasible and less burdensome. And people have potentially self-selected to not report because it is burdensome.

(Randy Aster): And this is (Randy Aster). My point of view is that as we put together these measures, it's not necessarily because it has to always be feasible or easy, or for them to do. It's almost there's a true north of what it takes to have best practices and also the ability for management to realize where they might need to streamline or change some of their processes.

So, in my mind, if the measure is useful, then whether they at this point have the ability to make it feasible for them to do is not why we should accept or not accept it. We have to – if it is a best practice and helpful, then it's something that we need to support. That's a much more process there.

Woman: Further comments? Go ahead.

(Jill): This is (Jill). And I just wanted to reiterate what (Ira) had said earlier, that this is a voluntary measure and we have reluctant participants and, you know, more enthusiastic participants. But the bottom line is we have 1300 out of 1400 reporting, and it's not required.

And so, as you're choosing how to expand your quality improvement and reporting energies, 1300 are choosing to report this measures. So, I think that might be an indication of its feasibility.

Woman: Thank you, (Jill). Anybody else? If not, can we move on to usability and use?

Woman: Absolutely said…

Woman: Go ahead.

Woman: The first part is accountability and transparency for the use of accountability within three years and public reporting within six years. And then feedback on the measure by those being measured. And it looks like this is a path, not path, and from the documentation, we've received it looks like those criteria have been met. Is that an accurate reflection?

Woman: Does anybody disagree?

Man: I do not.

Woman: Okay. Then, can we move on to usability?

Woman: Absolutely. We're moving at lightning speed now. So, it is really the news is it currently in public use in Minnesota. And there's – we've already heard multiple facilities even with voluntary adoption, the vast majority have chosen to participate. I do think that speaks highly to use in usability.

Concerns raised relates – related primarily to the burden to collect and document. I think those were the main concerns that are raised in the comments.

Woman: I had a question for the developer on that one. In the worksheet, I was looking for the progress demonstrated. Am I looking in the right place that the newest data you have is from Q3 of 2016?

Woman: No, the newest data that we have is from 2017. And if I'm looking at the same area that you are, I don't know why subsequent – I'm thinking it might have fallen off that the submission part, because you do have data through –

actually, now, I think we have it through 2018. So, I apologize for that but showing the increase, but yes.

Woman: Could you speak to the performance improvement?

Woman: You know, as you see there, we have each of the sub measures. And so, we're really looking at (EDTCO) because it is an all or nothing measure. And so, there's still improvements to be made on the all elements that we have in 2015 when MBQIP started collecting. It was at 51% and it has improved 25% up to 74% by quarter three of 2017.

I don't have the other information in front of me. But I believe that it has improved since then, although at a slower rate. Many of the hospitals, I guess, the Flex at the State level, they share different tools that they have developed in order to – like the checklist so that each of the elements are included so that it's a more streamlined process for the reporting.

And then the other elements, number of – I think it's elements six, which is the nursing elements, which included the orientation and mental status, you can see that's still a little bit lower than the other elements.

So, you can see that there has been a lot of progress made in the other elements, but not as much. In the overall measure, they're still missing one or two at different places but I believe that it has improved since then.

Knowing that most of these reports are from acute to acute, emergency department to acute because there was a failure to include some of the non-acute. So, we really believe that the gap remains at some of the non-acute level.

And if we separate that out, which is another thing that we have suggested to FORHP is that they changed the reporting level, so that they would report their elements as transfers to non-acute and transfers to acute settings. So that we could observe that improvement better.

Woman: Does anybody have any further questions or comments on usability? If not, record your vote and go on. Record your vote for overall suitability for endorsements.

(Peter): May I please ask a question.

Woman: Any discussion on that one? Go ahead, (Peter)?

(Peter): Before we get the overall suitability, could someone please – I must have missed the memo, when it came to question three. In terms of the – no, maybe it was, hold on, I'm sorry, let me go back. I guess it was question one, two. It's the issue about the no exception or insufficient evidence for exception, with exception. I don't quite understand that.

Woman: Sam?

(Sam): Sorry, could you repeat the question? I didn't quite get that.

(Peter): I'm sorry, I botched the question. It says number three, but it's the second question we're asked in this form, in this kind of electronic form. As importance to measure and report evidence potential, exception to empirical evidence, insufficient evidence with exception are no exception. I just don't – I didn't track that. I'm afraid I must have missed the meaning when we talked about that?

(Sam): Oh, yes, no problem. So, let me just clarify that real quick. So, because insufficient with exception with the last way that this measure was passed when we reviewed it the last time. We thought that it was likely that the committee would require an exception to evidence again in order for the measure to move forward.

So, question three is simply saying if the measure lamps that's insufficient, meaning greater than 60% of the committee votes insufficient. Would you like to grant an exception to evidence?

Man: Okay.

(Sam): If that's the case, then click insufficient evidence with the exception. And if not, then say no exception grant.

(Peter): Okay. So, if you feel like this is maintenance measure, this has been an out in the field, this is important for rural hospitals and other health systems. And even though the evidence is not, you know, high, I'm willing to kind of hold my nose and make an exception in this case. That's kind of what we're saying there?

(Sam): Right. Yes, I think that's a fair way of putting it.

Woman: Yes, right.

(Peter): Okay. Thank you. Sorry to interrupt.

Woman: Is everybody else clear on that? It is tricky. Okay. Then I think if there are no other questions, people were ready to record the final vote and hit the done box. Sam, we turn it back to you.

(Sam): Okay. Was there anything for the related and competing discussion? I don't think that we've found anything as that. So, if we want to discuss anything on that end?

Woman: Nothing was identified as relating and – related or competing that we could find.

(Sam): All right. Well, if everyone's going to have any questions from the committee at this point or from the measure developers?

(Ira): Oh yes, this is (Ira). And this issue was raised before and we had a robust discussion. It's pretty clear where the committee is or at least where folks would like to see improvement. But people also – many people feel it's an important measure. I'm just wondering about the – at least four other people who have to join this to make a decision.

Are they really – I mean, are they going to really be able to get a real feel for discussion today that make their own decisions? Will they take the time to actually read the transcript of this, which is almost an hour and a half, et cetera, et cetera?

Is there any way that we can try to let the remaining folks know the importance of really looking at the details of our conversation, which has been a good conversation before they make a vote?

(Sam): Yes. So, when the staff sends out our margin surveys to the remainder of the committee along with the recording, we will absolutely emphasize importance of adhering to the process.

We're actually carefully reviewing this transcript, carefully considering each of the criteria and scrutinize the measure according to the criteria. And to really listen closely to the discussion that occurred in the context in which they're being asked to vote.

So, with some degree stress and I apologize (Ira) and (Jill) of course, this is not the ideal situation. This is not how we prefer to review measures. And it's kind of, it is kind of tricky but this is on the last – the best option that we have.

Woman: Thank you for the conversation. I love you. I miss you so much. You need to come and visit me to meet my new boyfriend.

Lee: (Jill) and (Ira) this is Lee. I want to assure you that my co-chairs are certainly going to check back and read the transcript. (Unintelligible) with me because we have been talking about some measures among ourselves, the three of us for several weeks. And I think other members of the committee (unintelligible)

(Ira): I appreciate that.

Woman: We didn't get a chance to hear your conversations with – from the questions from all of them.

(Jill): Yes, thank you. We appreciate that.

Woman: Yes. This is not an ideal process, but it is what it is. Sam, do you want to open up for public comments?

Woman: Okay. So, the line is now open for public comment. If there are any members on the line who are representing the public, please use this time now to speak.

(Randy Asters): I just want to ask, this is (Randy Asters) and I'm tend to be a consumer representative. And my comment is from the patient perspective. The data is important to the patient and as we look at a patient having the data they need at the next facility, whether it's burdensome or not, I think the process is important.

Woman: Great. Thank you, Randy. We will be sure to capture that comment. Are there any other comments from the public or members?

Man: No.

Woman: Okay, great. We'll move on to the next step. Again, thank you everyone for being available for this call. What you can expect next is the draft report comment period, which will take place on March 18 and we'll continue through April 16. So, that will be a 30-day comment period, where we will host the draft report on the web and allow the public and members.

Following that is the committee post comment web meeting, which will take place on May 8, 2020 from 12:00 to 2:00. And everyone should have a calendar invites for those. So, please stay tune for more updates on that.

Woman: May 8?

Woman: And before we go, just a reminder that there are several ways to reach us. If you have any questions or concerns or comments, please reach us at patientexperience@qualityforum.org. You can call us by phone. And you

can also access all information related to this project on our online project page.

And of course, for committee members, you have access to the SharePoint as well. And just a point to that, we will upload the recording to SharePoint site. And we will also email the recording directly to you all.

Peter Thomas: Just to clarify, did you send out a calendar invitation for the May meeting or just an email, because I don't have it on my calendar.

Woman: Yes, the calendar invitation has been sent. But who is speaking?

Peter Thomas: Peter Thomas, I don't know why it wouldn't be there. I get all your stuff.

Woman: Okay. We will double-check the invite and make sure that you are on there. If you are missing, we will add you today.

Peter Thomas: Great. Can I ask one more follow-up?

Woman: Sure.

Peter Thomas: If you otherwise finished?

Woman: Oh, absolutely. Go ahead?

Peter Thomas: Could you give us a sense – could you give patient experience and function, a committee, a sense for what else is on the docket for this year, if anything?

Woman: Absolutely. So, there are two key dates to keep in mind for the rest of this cycle. March 18 through April 16 will be our 30-day draft report commenting

period, that will not involve an online sort of web meeting or convenient of the committee.

However, we just want to notify you that that will be the 30-day allotted to report out on the evaluation thus far, and to receive comments on the evaluation of both measures. On May 8, we will convene again if we receive comments during that commenting period.

So, if we receive even one comment during that March 18 to April 16 period, we will hold the call and we'll be sure to communicate that to you all. If we do not receive comments, we will cancel that call on May 8.

Brenda Lee: This is Brenda Lee. I also don't have the May 8 calendar meeting event.

Woman: I believe it's on May 6. That's what is on my calendar is for Wednesday, not Friday.

Brenda Lee: Okay.

Woman: Okay. So, the product team will double-check the calendar invitation and make sure that everyone has it and that the correct date is reflected. So, if there are others on the call who are experiencing the same issue, we will make sure to correct that and you will receive the correct meeting invitation.

Peter Thomas: Yes, I've got it scheduled for…

Woman: I've got it for the 6.

Peter Thomas: Specific altitude.

Woman: Okay. So, that may have been a slight error or typo in the slide deck. If you do have that on your calendar, that is correct. So again, we'll follow-up just to make sure everybody's included in that meeting invite and to make sure the date align. Thank you for bringing that point up.

Woman: Thank you.

Woman: Okay. Any additional questions? All right, well, that wraps up today's call. Thank you so much to the committee. Please complete your…

Woman: Thank you everybody.

Woman: Please complete your survey and let us know if you have any questions.

Woman: Thank you.

Woman: Bye.

Man: Thank you. Bye.

END