NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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Lee Fleisher: Why don't we get started?

Melissa Marinelarena: Okay, while people are logging in, this is Melissa Marinelarena, Senior Director at the National Quality Forum and working on the Surgery Project. Welcome everyone. This is our third webinar for the Surgery Spring 2019 Measure Review Cycle. This is a continuation of last week's webinar and thank you everyone for calling in today, to the committee, to the developers, everyone who is listening online, my coworkers at NQF, and we sent out some additional materials on Saturday morning that STS has provided. I also sent out the recording, and then this morning we have the transcripts, which I know is last minute, but we got it this morning and forward it on to the committee.

So, I know that Bill got caught up because he was not able to make it last week so he listened to the recording over the weekend and he is going to be joining us today, but I didn't know if Bill, are you…

William Gunnar: Yes, I'm on. Yes, I'm on.

Melissa Marinelarena:…summary. Okay, hi Bill, great. So, Lee do you want to do a quick summary and then we'll do a roll call and then we can get started?

Lee Fleisher: Sure. Lee, I thank everybody for rejoining us for this one hour maximum phone call that our - last time we discussed three measures. Those measures were - tended to be structural in nature. We chose to go over all the issues because discussions about evidence and the fact that the committee can weigh in and that the NQF staff in many of the cases felt that it was unclear as opposed to it was insufficient. I think it was insufficient for them to make a determination so we asked the STS to provide us with additional information and today's call is really to discuss issues that we felt have been left out as well as discuss STS's response since we did go through all three measures.

Bill, do you have any comments from listening to it?

William Gunnar: No, I thought the - all aspects of the evidence issue were examined.

Lee Fleisher: Great, so, do you want to do roll call?

Melissa Marinelarena:Yes. Janaki?

Janaki Panchal: Yes, hi, good afternoon everyone, this is Janaki with NQF. I will go ahead and do the roll call. But before we do that, just wanted to remind everyone if you were not here on the first two calls and have not disclosed any conflicts, please let us know as I call your name, or if you have developed new conflicts, let us know as well. All right, Lee Fleisher?

Lee Fleischer: Yes and there are no new conflicts.

Janaki Panchal: William Gunnar?

William Gunnar: I am here. I have no conflicts.

Janaki Panchal: Robert Cima? Richard Dutton?

Richard Dutton: I'm here.

Janaki Panchal: TeMaya Eatmon? Elisabeth Erekson?

Elisabeth Erickson: I'm here, no conflicts.

Janaki Panchal: Fred Grover?

Fred Grover: I'm here, and the usual STS conflict.

Janaki Panchal: Okay. Thank you. John Handy? Mark Jarrett? Clifford Ko? Barb Levy? Barry Markman?

Barry Markman: Good afternoon. No conflicts.

Janaki Panchal: Thank you. Amy Moyer?

Amy Moyer: I'm here.

Janaki Panchal: Keith Olsen? Lynn Reede?

Lynn Reede: I'm here, no conflicts.

Janaki Panchal: Chris Saigal? Salvatore Scali?

Salvatore Scali: Yes, hi, I'm here, no conflicts.

Janaki Panchal: Thank you. Allan Siperstein?

Allan Siperstein: I'm here.

Janaki Panchal: Joshua Stein?

Joshua Stein: I'm here and no conflicts.

Janaki Panchal: Larissa Temple? Barbee Whitaker? AJ Yates?

AJ Yates: In the house.

Janaki Panchal: Thank you. So we have 12 people online, so we do not have quorum. We need 14 people but we can still go ahead and get started with the discussion. Melissa or Karen?

Karen Johnson: Melissa (unintelligible) but I can jump in if you need me to, Melissa.

Melissa Marinelarena: Actually, I'm going to pass it back to you, Karen, since you were leading the discussion last week, and yes I'll pass it over to you. And I think you wanted to discuss some evidence and maybe some testing some more for the three measures?

Karen Johnson: Just some of the evidence, so thank you Melissa. I did just want to point out this one thing I neglected to say, although we - the discussion did talk around this point but I didn't say it explicitly last week on the call.

And, that is to actually talk about what we're looking for in terms of evidence for structure measures. So, according to our current criteria and guidance, we are looking for a systematic assessment and grading of the quantity, quality and consistency of the body of evidence that the measured structure leads to a desired health outcome.

Now, there wasn't actually systematic assessment grading of evidence and that's okay, that's what we would love to see, but not all measures have that level of evidence behind them. But the developers did provide several articles so we have to think about - and this is where you guys definitely did have this conversation, is you have to think about whether what was provided, did that demonstrate that the, in two of the cases, participation in the registry leads to better health outcomes.

So, I think when you are thinking about the two participation measures, you have to think about this idea of the causal relationship and is it there. Do you feel like the evidence provided shows that or not. If it does, then I think you would - we did talk a little bit about how the evidence algorithm and where if you would be - where you would kind of focus your attention on the evidence algorithm and that would be probably in boxes 7 through 9.

Again, the grading, the systematic review, the grading that wasn't provided, I'm assuming that it doesn't exist if they did provide evidence. So if you feel like that the articles that were provided give you, kind of, that causal relationship between participation and improved outcomes, then you'd work your way through boxes 7 through 9.

If you feel like that the articles that were provided are a little bit more tangential to that basic question, then you would need to think about going further down the algorithm and starting to look at box 10, 11 and 12.

So, apologies for, sort of, leaving that out. There was conversation last week about that causal relationship so you guys did cover it, but again I was remiss in not being explicit.

In terms of the data that was provided for what we would call data element validity, in the materials that Melissa sent out on Saturday morning, the developers did provide some additional documentation that talked about the methodology that they used, and we specifically talked about the comparing information in the registry to the OR logs.

So, that, I think, has quashed our concerns about a methodology so if you agree to that methodology as a reasonable way to do it, then you would just kind of look at the results that they got from that exercise and maybe just think also just a little bit about the number of hospitals and records with that. And if you feel that that demonstrates sufficient data element reliability, you feel like that the completion rate for the two participation measures and really also for that volume measure. If you feel like that is adequate then I think, you know, that's how you would rate reliability, sorry validity, on those measures.

So, those were the two main things I think that we wanted to just point out to you. The developers did provide many of the articles and they provide a short summary of what some of these articles said, so I'll stop there and I guess hand it back to Lee.

Lee Fleisher: Yes, so that is very helpful to gain your insights. I guess I'd ask first if any of the reviewers, the primary reviewers, need further thoughts about these particular - the answers or Karen's comments before we move forward.
I forget who were the primary reviewers for - Janaki, do you have who those were, I can pull it out.

AJ Yates: This is Yates, I was one of the primary reviewers. I didn't present but I'm okay with going ahead.

Lee Fleisher: So, you feel the evidence - they did a good job from your perspective in presenting the evidence?

AJ Yates: Yes, I mean, for the purposes of a structural measure, yes.

Lee Fleisher: Okay, anybody else who was a primary reviewer and wants to comment just on the evidence? We have the second thing which I do think we need to discuss which was the gap and the - I thought we'd go further in discussions and Bill, I like your comments about whether or not we should continue to endorse these structural measures. But, any other concerns, comments regarding evidence?

Woman 2: This is…

Salvatore Scali: This is Sal, I was one of the primary reviewers for 734 which was the structural measure for the congenital heart surgery and the participation national database. Echoing what AJ said about his structural measure, when I looked through the evidence that was presented, I was - I had no concerns.

Lee Fleisher: Great. And AJ, which measure were you the primary reviewer?

Melissa Marinelarena: AJ was the primary reviewer for the participation in the general thoracic surgery database and Josh Stein, I know you're on and you were the - one of the primary reviewers for the surgical volume for pediatric and congenital heart surgery measure. Do you have any additional thoughts?

Joshua Stein: I thought the evidence was sufficient.

Lee Fleisher: So, yes, thank you. The other real issue that we got to - and maybe I'll turn this over to Bill since - was the whole question of - I guess it's in some ways gap and in some ways the priority of endorsing these - continued endorsing of structural measures was the other question that I thought we addressed towards the end. Am I remembering correctly, Janaki? Melissa and Karen?

Melissa Marinelarena: We did talk about and it and then the committee seemed, sort of, split between whether there was still a gap, whether there was still a need for them. And then there was talk about whether we had moved on beyond structure measures so it sort of all got sort of muddled between, sort of, evidence but then beyond.

And then there was discussion about burden as well, which is kind of part of feasibility and usability but with gaps, how much higher can you go and then I believe the developers did talk about - did send some documentation about penetration for some of these databases. But I don't think they're all equal.

Lee Fleisher: Melissa, thanks. I don't know, Bill, do you have any comments from your perspective and then I'm going to turn it over to the committee if they want to continue discussing what I think will be the key issue as people vote.

William Gunnar: Well, yes, I don't - these are - it really has to do with alignment with NQF intent. I mean, do they drive the NQF goals of quality, improvement and resolving performance concerns where they identify performance concerns then over time, improve the care that's provided.

So I don't know, is that - going back to - I hate to put NQF staff on the (unintelligible) does it - do structural measures, do they meet NQF intent?

Marine Marinelarena: Hold that thought and as a reminder again, there was questions about - there are other, similar measures that have been put into reserve status so there was talk about that and these measures do not meet the criteria for reserve status because they - for reserve status, measures have to be tested at the reliability and validity score level.

And then, Karen also mentioned that NQF is looking at reserve status in general to see if we are actually going to keep that. And then, I believe, starting next year, we're going to be bringing back all reserve status measures anyway instead of letting them sit there, and they'll have to go through the process and meet all of the criteria.

As far as structure measures, they have to meet - structure measures have to meet the same criteria that process measures meet. So we treat them the same as far as the requirements for evidence. Like Karen mentioned at the beginning, and when the original preliminary analysis that I did was they have to meet the same evidence standards that a process measure does.

Outcome measures have a little bit of a lower bar. The gap is the same and the testing is the same. Maintenance measure and feasibility is the same and the maintenance measure so the criteria is the same but they're not held to a different standard.

Lee Fleisher: So, we just wanted to give the committee time to discuss this because we ended the call abruptly. If anyone has any other thoughts before we go to voting. The issues are twofold. One, questions regarding STS response and STS is on the phone?

Mark Antman: Yes, this is Mark Antman with the STS. Drs. Jacob and Shahian were unfortunately not available to join today.

Lee Fleisher: Okay, did you - are you comfortable with the discussion or I'm certainly happy to give you a few minutes if you'd like, if that's okay with staff, to comment on at least the evidence that you gave us.

Melissa and Janaki, are you - Karen?

Woman 3: Sure.

Lee Fleisher: So, Mark, do you want to make any comments?

Mark Antman: Yes, just to add that we felt that the articles that we provided did meet the criteria that were discussed by the committee last week as to what they were looking for with respect to evidence. I did hear from Dr. Yates and others that what we provided did meet their expectations, it seems, with respect to demonstrating evidence as required for these measures, as articulated by Karen Johnson last week.

With respect to gap, I'll remind the committee that the penetration for the congenital - the STS Congenital Heart Surgery Database, is much greater than for the General Thoracic Surgery Database because, as discussed on the call last week by Dr. Jacobs, there are a great many lobectomy procedures which are the most - the single most performed procedure among - in general thoracic surgery.

There are many that are performed by general surgeons therefore the penetration of the STS General Thoracic Surgery Database is much lower than

for the Congenital Heart Surgery Database. So, there is a substantial gap there.

There is certainly still a gap for the Congenital Heart Surgery Database, even though we believe the penetration is greater than 90%. It's certainly not 100% but we can say with greater certainty exactly what the penetration is. From our perspective, there is still a gap there; there is still an opportunity for more congenital heart surgery practices to be using the STS database.

So, that's about the extent of the comments that I have at the moment. If there are questions, I'm happy to respond.

William Gunnar: Yes, this is Bill Gunnar, I have a question. So, that really frames how the two registry measures are different because participation in Pediatric Congenital Heart Surgery Database is going to be primarily from - well they're going to be board certified cardiac surgeons. And so, you could - that's just a fact. Whereas lobectomies are done by, as you stated, general surgeons and they weren't given privileges at a facility that has gone through general surgery residency and also gets thoracic privileges and that likely is happening in more rural settings than not because there's not enough thoracic surgeons to go around.

So, does the STS crosswalk its participants to thoracic surgery board certification? Do you know what participation you get from non-board certification thoracic surgeons performing lobectomies? Maybe I missed it. I didn't see it right off but …

Mark Antman: Dr. Gunnar, I don't think we - I don't think we routinely do the crosswalk that you're describing. Anecdotally, we know that there are, as we said, there are many general thoracic surgeons who do these procedures. There are some

that participate in the STS database. We could go through our participant database to meticulously identify those who are not certified - who are not, who are or who are not certified in thoracic surgery but do we track that routinely, no I don't believe we do.

William Gunnar: So, I guess the second (unintelligible) question is is there enough - and I apologize, you - is there enough evidence that would drive a facility, typically not in a - what would motivate that facility in a rural, or relatively rural, area that has one or two general surgeons doing thoracic surgery? It's sort of a philosophic question but that - are you really going to capture? I guess that's the intent of it to capture that, but what is the gap, what do we know about the gap of facilities performing thoracic surgery versus the numbers that are reporting and I'm sorry again if I don't have that. I'm sure you provided it. Is it - how many, is it 90% of facilities?

Man 1: It isn't provided. I don't think you have that data, correct?

Mark Antman: This is Mark again. Dr. Gunnar, when you say the percentage that are reporting …

William Gunnar: No, that they're not reporting. What's the - you've got - you know how many participating - because this at the hospital level, you know how many hospitals are participating, you know how many - and then there must be other data sets, CMS or whatever, that would be able to identify how many hospitals actually perform lobectomies. I guess the question is how big of a gap is that?

Mark Antman: So, certainly there are data sets that identify all the hospitals at which the procedure is performed, yes. I don't have specific data accessible to me at the moment as to what percentage of hospitals are represented by participants in

the General Thoracic Surgery Database. Again, we know there are many that don't. There are many sites, as you noted Dr. Gunnar, perhaps many rural surgical sites, where the surgeons do not participate in our database.

If I may go back, however, to your motivation question, your so-called philosophical question?

William Gunnar: Yes.

Mark Antman: Again, we believe that the documentation we've provided, the articles that we've provided, as well as the statements that Dr. Jacobs and Dr. Shahian made on the call last week, we have emphasized that participation in the STS databases in general has been shown and has been documented to have a very positive relationship to better outcomes.

So, our hope, and no we cannot prove this of course, but our hope is that non-participating surgeons may be motivated by the knowledge that there is a strong correlation if you will, between participation in any of the STS databases and improved outcomes. We - again, the Joint Commission article and the (L. Bardissi) article that we provided, and that I know have been shared with the committee, those particularly show a strong correlation at least between participation on the adult cardiac side, participation in the STS Adult Cardiac Surgery Database, and significantly improved outcomes for those patients.

So, in terms of motivation we would hope the knowledge that's there is a strong likelihood that better outcomes will ultimately be supported, or-and encouraged, and promoted through participations in our database we would hope that that would be motivation for non-participants to begin to participate in our databases.

William Gunnar: And just to follow - I don't mean to torture this, but I just - there is a - what's the motivation for - so the small - the program, the rural general surgery program, which might be very, you know - collectively, the general surgery, you know, team, whatever, group, individuals, whatever, they may be doing apparent number of general surgeries, you know the number of cases may be personally perfectly fine, but the number of thoracic cases to them - if they do 10 or 20 lobes a year, one every other week or so

Man 2: Yes, (unintelligible) not yourself so--

William Gunnar: What's the motivation to join an STS, I mean an STS registry? I guess the question is that in - if we, if you were to - if somehow we would prohibit or limit those individuals from doing - who were probably you know, for the most part doing just fine given the relatively - it's a relatively low complexity procedure that - with results, with good results, it would be an access issue right?

I mean if we - if those individuals weren't doing that out in the rural or moderately rural world, it would be an access issue. If we somehow remove that. Again, a philosophical question, I just - I'm not trying to in any way - I think if we - the substantive things I've gotten away from this conversation is that you - the STS recognizes that thoracic surgery is often performed particularly outside of urban settings by non-board-certified thoracic surgeons i.e. General surgeons.

And that there is the structural measure that you're - that's promoted actually is associated by the evidence you've provided with improvement. My only question back to that is that, is there a volume threshold in which you would then see improvements or are you looking at it, sort of, globally?

Mark Antman: So I thank you Doctor Gunnar, I don't think there is a volume - particular volume threshold that we would be looking at. I will note, if I may, which I - something that I think may have been mentioned on the call last week, but certainly not today as yet.

It's important to note that not only the surgeons who participate in the General Thoracic Surgery Database through public reporting which is roughly, currently about 34 percent of all participants in the database, not only those who publicly report, but all participants in the database do get periodic feedback reports which give them - which benchmark their data against the - excuse me their own participant data against STS participants' participation data as a whole throughout the database

And so it's an opportunity for them to see where they stand with respects to their outcomes, relative to the entire population of general thoracic surgeons participating in the database. So, that from, I think, in my mind, and certainly I believe from the STS perspective, is an additional benefit if you will of participating in the - in our database to go back to the terminology that you're using Doctor Gunnar, is that an additional motivation for them? Perhaps it is. To be able to see how their outcomes stack up if you will, or where they stand relative to their peers, relative to other surgeons performing the same procedure. And…

Lee Fleisher: Hi, can I ask a question? This is Lee and it's more to Karen. Is it - if we believe that the measure is valid, any measure, structural measure, but there isn't a program, you know what the STS measures part of it is the cost, et cetera. But, if one day, say CMS or hospital say you got to pay for it, and we think this would drive improvement. Is that a valid reason to approve it? In other words, the fact that there are certain - I guess, the use and usability -

what does that need from your perspective as far as whether a small hospital has two general surgeons doing thoracic? Is that part of the - how much is that part of the use and usability equation?

Karen Johnson: Hi Lee, this is Karen, I don't quite understand your question.

Lee Fleisher: The…

Karen Johnson: …for use and usability. Yes, go ahead and can you rephrase it? Maybe I'm just not…

Lee Fleisher: Yes, let me rephrase it.

Karen Johnson: …didn't hear it.

Lee Fleisher: As I've been listening to Bill and Mark discuss it, part of the question is, the barrier to national adoption of the thoracic measure, say, compared to the cardiac measure, is cardiac is only done by one type of surgeons and essentially it became the standard of care.

If we believe that a measure such as a thoracic measure, and I'm not saying we do or don't, I'm just giving you a hypothetical, that if one day, it became the standard that CMS said that anybody who's doing thoracic, you should have this sort of measure. And, it's usable, in other words, you can create the database, we know the elements, and it's valid. Let's make those assumptions.

Then, is the fact that there is potentially a financial barrier that this time, enough to say we should not approve it, because it's not routinely used throughout the country? It's sort of an interpretation of Bill's questions.

Karen Johnson: Yes, it's an interesting question Lee, and it kind of gets to three, I think of our criteria actually, so there's more nuance there than maybe even you realize. You know, we do think about cost and that sort of thing with feasibility. So, you know even small hospitals potentially could participate, and we talked last week about the cost involved, not just the direct cost of participation, but the extraction cost and those kinds of things. So, we consider that very directly under feasibility.

Under usability and use, we're actually looking to see if people are actually using the measures, and if there are any unintended consequences, and that sort of thing. So, I think that's mostly what we'd be looking at under usability and use. You know, both of those (unintelligible) these days.

Going back to validity, I think that mainly the question that you're trying to get to is is somehow or another the fact that maybe, smaller hospitals for example, who did not participate, does that in some way invalidate the measure? And I think that is a question that you would have to kind of weigh yourself.

It's a little bit different than just validity testing but you know, are the results invalid and I get that does get to gap, so how many people are getting - are being missed by not participating? But this is, kind of, a special measure because the measure itself is about participation.

So, you know, I think, you know, one of the things that you may want to just think about, in terms of usability, is do you feel that hospitals that participate are able - I mean at the end of the day, measurement is all about improvement. So you know, is this somehow or another lead to improved outcomes? You know, at the end of the day that's what we hope that happens, and we want to

make sure that we're not being unfair in comparison. So whoever is being looked at with this measure, is it, you know, an unfair comparison?

So, I don't know if I answered your question or not, but it's a little bit the beauty and a little bit the aggravation of our criteria because so many of these things are intertwined.

Salvatore Scali: Can I add a comment? This is Sal, I thought from the evidence perspective, when the STS presented their paper from (unintelligible) and Annals of Thoracic Surgery, it sort of hit on some of the questions that Doctor Gunnar had asked about the crosswalk between the Thoracic Surgery Database particiments (sic) versus non-participants.

I mean, at least they did it for a Medicare match and they did it for CMS patients, and they presented that paper that clearly shows the penetration is about 25%, and for hospitals that were not matching in the Thoracic Surgery Database when they looked at 30-day (unintelligible) and it--and hospital mortality, and length of stay, they were all much worse in people who were not participating in the registry. That was in their--the paper they sent us from Tong et al.

It's pretty robust analysis that was performed, so I don't know if that in anyway helps to further form or helps in the questions that were asked, but I'm looking at the paper currently again and I think it very much sort of at least supports this concept that participation in the registry versus those not participating in the registry at least globally--national perspective clearly shows differences (unintelligible).

William Gunnar: I think the only pushback I would have on that, and I appreciate that, is that most - there are very few high volume thoracic centers, it's not like

(unintelligible) surgery where at least you have 10% or 20% of the facilities or maybe even that are doing a substantial number right?

But, thoracic surgery is relatively low volume, and particularly in these rural areas. It's one thing because general surgeons are trying to credit and enable the credential privilege to do a lobectomy, they can do them, you know - these can occur in a far less complex center than where cardiac surgery is performed. And so, there is a - there's no doubt with low-volume procedure. You've got people that many, I understand the volume-outcome relationship, but part of that is, you can hide a lot of bad results in a high volume center because of the numbers.

On the other hand, you can have people doing very competent work and in the community, doing lobectomies, and they've never - their motivation for - they will not be motivated to join the STS registry for 20 or 30 cases a year, for the cost and what it takes to do the extraction, and all the rest. So there's a practical nature to this.

And there's also bang for the buck is that, from a public reporting point of view, it's one thing to say I got a, you know, I've got a four star rating at a cardiac surgical program that's low volume, and I can see that on the publicly reported STS Web site. It's another where you just statistically, from an (unintelligible) racial point of view, you'll never get to even three years of accumulated data to 400 cases. You know you'll never get to that number of cases where you get to be statistically valid, because an event - a death event, a pneumonia event, is actually one event, and a small number - a small denominator.

Sorry for the rant, it just I - this is where, you know, I appreciate the reason for presenting the registry and the good - and the well intention, but from a

pragmatic point of view, I'm struggling with the application. That's where the use and usability and Lee - I'm just restating what Lee was saying in a different way.

(Lee Fleisher): Any other comments from the Committee? Concerns, questions, things we should ensure we address? (Unintelligible) make sure we've discussed everything before people voted. So, from the staff perspective, are they comfortable that we had a robust discussion before we go to open it up to the public?

Karen Johnson: Before we do that, I think Maya is on the phone?

TeMaya Eatmon: Can you hear me?

Karen Johnson: Yes.

TeMaya Eatmon: Okay,

Karen Johnson: Is there anything that you would like to add from the patient's perspective?

(Lee Fleisher): Yes, oh right, Maya, unfortunately you left last time, so thank you - the value of having these databases remains endorsed because it's up for re-endorsement.

TeMaya Eatmon: Okay. For me, I look it at it two-fold. Sometimes too much information that the general public doesn't understand, and so the only concern I have with the databases period is, as long as there are some term and lay information that's provided to help them along the way.

Because, a lot of this stuff, the information it's there, and then it's research overload and then you're researching because you're in a particular state of diagnosis, and you're trying to get as much information so that you do know what to have conversations about, and you do understand your care yourself, however you don't understand it because it's not written for a lay-person to reference back to. So that's my only concern, I think the information is good, but I think the information also needs to be clearly defined as to how the information was gathered, and who was actually utilized for that information to be the standard per se.

Lee Fleisher: Thank you so much.

Mark Antman: Dr. Fleisher, this is Mark from the STS. May I respond briefly to what Ms. Eatmon just said?

Lee Fleisher: Yes, please.

Mark Antman: Ms. Eatmon, thank you for your comment. You may recall after the committee meeting in February of this year, where there was much discussion then about the adult cardiac measures. We took back some of the comments that you made and other members of the committee about unclear definitions on our Web site and we fairly quickly made some revisions to clarify some of those items.

We have in fact made an effort to clarify definitions and other elements that are on the public reporting side, not just for adult cardiac but for general thoracic and the congenital pediatric site as well.

We're currently - one of our task forces has taken on the challenge of looking at all of our publicly reported information and considering where there are

other improvements that can be made. So, I took some notes as you were just speaking, and I will share those - your comments with my colleagues.

STS is very anxious to continue to enhance what we have on our Web site and particularly on our public reporting Web site to make that information as transparent and understandable to patients as it can be. So, again, thank you for your comments. We're continuing to work on this and it's our intent to make the information there certainly useful for surgeons but also understandable to patients as well. So, again, thank you.

TeMaya Eatmon: Thank you for the changes that you guys made quickly, thank you.

Mark Antman: My pleasure.

Lee Fleisher: That actually would be a good story to socialize about the patient aspect of this committee and the response. Just how effectively we use the addition, so thank you.

Melissa Marinelarena: Thank you Mark.

Lee Fleisher: Any other comments?

Melissa Marinelarena: I have a quick question. Mark, the taskforce that is looking at your information, are there patients on the taskforce or is it surgeons?

Mark Antman: I don't believe we currently have patients on that taskforce. Was that Melissa speaking?

Melissa Marinelarena: Yes.

Mark Antman: Thank you. Melissa, no I don't believe we currently have patients on that taskforce. It is not all clinicians. It does include data managers who work for the surgical practices, and I believe other representatives as well.

Currently I don't believe there are patient representatives. Since we've not historically had patient representatives on our taskforces, it is an action that we're looking at, but we've not been able to make than change as yet; add patients to those taskforces.

Melissa Marinelarena: Okay. Thank you.

Mark Antman: Thank you.

Melissa Marinelarena: Is there anything else? Karen, is there anything else you want to discuss?

Karen Johnson: I don't think so on my part. I think we've hit all of the criteria either today or the other day and several things. I think the only thing that I would note is that, you know, structural measures as a whole, we still, you know, do see validity in structural measures.

So, kind of getting back to, someone's earlier question and I apologize as to who it was, but that - you know, right now NQF does still endorse structural measures. The question before you isn't so much is this a structure measure and therefore should we or should we not consider it, but you have to look at the individual criteria for each individual structure measure.

So, I hope that helps as well.

Lee Fleisher: Karen, thank you.

Mark Antman Lee, this is Mark at STS. May I make one additional comment, I don't want to prolong the discussion unnecessarily but may I?

Lee Fleisher: Sure.

Mark Antman: Thank you very much. Id o want to add just on a conceptual level. I appreciate and I know that Dr. Jacobs and Dr. Shahian last week, appreciated the rich and detail discussion by the committee. I do just want to add on a conceptual level, the STS does feel strongly that continuing to document and continuing to have NQF endorsement for database participation, we do feel is - continues to be an important foundation for the STS quality program.

We believe that articles and other information we provided does document that there's a strong correlation between database participation and improved outcomes. We cannot provide feedback reports to our participants nor can we offer them the opportunity to publicly report their data unless they participate, and we understand the concern about the direct connection between the participation measures and improved outcomes.

Our perspective is that even though they're structure measures, they are the foundation for the outcome measures that are publicly reported and that demonstrate the improved outcomes. And so, in that respect, we believe they remain important and remain worthy of endorsement.

Beyond that, we'll defer to the judgement of the committee. Thank you.

Lee Fleisher: Thank you so much. Bill, any last comments before we go to public comments?

William Gunnar: I have none, thankfully.

Lee Fleisher: So, for the staff, can we go to public comments? See if there is anyone who'd like to make a comment?

Melissa Marinelescarena: Absolutely. This is Melissa from NQF. Any members of the public would like to make a comment, you may do so. The lines are open. You can submit any comments via the tap box if you would like to. In the meantime, while you press to make a comment, I can ask Janaki to cover any next steps.

Janaki Panchal: Sure. So, in terms of next steps, we will be sending out - because we didn't have a quorum today, we will be sending out a survey monkey to get all the votes in and the committee members will have about 48 hours to submit their votes. So, we will be doing that by the end of the day today and then you will have 48 hours to submit the votes.

For those who were not able to attend, we will be posting the recording as well as the transcript so if you did miss previous web meetings, you'll have a chance to listen to that as well. But other than that, I think this is our last meeting and we'll have another web meeting sometime in September for the post-comment call.

Melissa Marinelarena: And I don't see - we didn't get any comments in the chat box, you still have the opportunity to raise your hand if you're on chat of just cut in.

Another reminder so the two outcome measures that you are going to be voting on which was 0733 Operative Mortality Stratified by 5 Stat Mortality Categories and 2683 Risk Adjustment Operative Mortality for Pediatric and Congenital Heart Surgery. A reminder that those are at the facility level of the analysis.

STS clarified last week that they made a mistake and it is not at the clinician level, it is at the facility level so that is what you are going to be voting on. I just wanted to make that clarification. And then again, the three structure measures we have been talking about for the past two webinars.

Are there any other questions or comments?

Lee Fleisher: No, I want to thank the committee for coming back on and I do want to thank Mark for preparing in a timely fashion a response and a discussion to help the committee vote.

Mark Antman: Thank you Lee.

Janaki Panchal: Thank you everyone. Bill?

William Gunnar: Yes, thanks Mark. (Unintelligible).

(Man 3): Take care (now).

Melissa Marinelarena: Okay everybody gets an hour of their Monday back and we will be in touch. If you have any questions or any trouble accessing the survey or recording, just shoot any one of us an email or give us a call.

Man: Thanks.

Melissa Marinelarena: All right, thank you. Have a good afternoon. Bye-bye.

END