NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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2:00 p.m. ET

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

Wunmi Isijola: Hi. Hello, everyone and thank you for dialing in to our Surgery Post Meeting Call. I have here Reva Winkler, our Senior Director. We have Amaru Sanchez, Andrew Lyzenga, our Senior Product Manager, and myself, Wunmi Isijola.

Before we get started, we just want to get a sense of who on the line is on the call with us. And I'll just do kind of a brief roll call of those who are on the call.

Is Anthony Asher with us on the call? Robert Cima? Richard Dutton?

Female: Rich said he'd be late.

Wunmi Isijola: OK. Elizabeth Erekson?

Elizabeth Erekson: Yes, I'm here.

Wunmi Isijola: Great.

Lee Fleisher?

Female: Yes, he's here, OK.

Wunmi Isijola: Frederick Grover? William Gunnar? John Handy? Mark Jarrett?

Mark Jarrett: Present.

Wunmi Isijola: Great. Clifford Ko? Barbara Levy? Barry Markman? Kelsey McCarty?

Kelsey McCarty: Yes, here.

Wunmi Isijola: Great, thank you. Lawrence Moss? Amy Moyer?

Amy Moyer: I'm here.

Female: Great, thank you, Amy.

Wunmi Isijola: Keith Olsen?

Keith Olsen: Here.

Wunmi Isijola: Great. Colette Pitzen? Lynn Reede? Gary Roth? Christopher Saigal? Amber Slichta? Robert Sawin? Allan Siperstein?

Allan Siperstein: Yes, I'm here.

Wunmi Isijola: Great, thank you, Allan. Larissa Temple? And A.J. Yates?

A.J. Yates: Speaking.

Wunmi Isijola: Great, thank you, A.J. OK. So, thank you all again for your participation during the two-day meeting. We do have a host of things to kind of talk through today. I know we have four measures that we previously provided to you for your survey results.

At this point in time, we haven't identified and established voting forum which we need in order to move forward. But, given the interest of time in our agenda items, we would like to start off by discussing these measures. Then we will move into the related and competing piece of the meeting. And then we will have a discussion surrounding the gaps area within our portfolio.

To get this kind of piece started, we want the primary and secondary discussant to speak to each measure. So, if we have Dr. Moss and Dr. Saigal, if you can kind of speak to 0269.

The timing of prophylaxis antibiotics.

Reva Winkler: Hi, this is Reva. I think if you recall on this measure during the meeting, we began discussing this measure that came from ASA. And we got as far as evaluating the importance criteria. But then, there was a question about whether this measure has been tested and then the transfer of ownership of the measure from PCPI to ASA, somehow not all of the information transferred. So, we were able to find the testing result and provide them to you to allow you to finish your evaluation.

And so, this measure is a clinician level measure. It has been tested at the level – at the clinician level for reliability and validity. For those of you who've reviewed the measure and voted on it, did anybody have anything – any comments around the reliability and validity of this measure to bring up with your colleagues?

OK. Or either – who is it, John Handy and Chris Saigal? Or either of the discussants for this measure with us today?

John Handy: John Handy, (Alex) would not discuss to this. Mine was on antibiotics cessation.

Wunmi Isijola: Oh, OK. Oh, it's Dr. Moss, OK. And Dr. Saigal. So, unfortunately, we don't have that. But, those of you who've been submitting your votes, (inaudible) at least look at the information enough to be able to do so. Did anyone have any questions or any comments about the reliability and validity of this measure?

Barbara Levy: This is Barbara Levy. I do not have any issues.

Wunmi Isijola: OK thanks, Barbara, glad to hear from you. All right. Then …

A.J. Yates: This is A.J. Yates. No issues, I mean I thought that's reasonably valid and reliable.

Wunmi Isijola: OK. Thanks. That's helpful. And so, similarly, were there any concerns about usability or feasibility for this measure as you looked at it? Again, this is a measure that has been endorsed for a few years, yet has been – I believe used in the PQRS program. It is a clinician level measure. So is there any thing that the committee would like to discuss further to be able to complete your evaluation of this measure?

John Handy: Well, John Handy here. So, I put some comments when I took the survey a couple of days …

Wunmi Isijola: Right.

John Handy: And what I don't see in either this or the original is really any clear demarcation of the performance gap which is what killed all these antibiotic measurements or what led to lack of endorsement at the in-person meeting. So, the data that's been the updated applications from 2008, yet, we've been using this for quite a long time. So I could not determine from either application or endorsement and updated one of the prior one. What is the performance gap that we're talking about?

Christopher Saigal: Yes. This is Christopher Saigal, can you guys here me?

Wunmi Isijola: Yes. Hi Chris, welcome.

Christopher Saigal: Hi. Good. I'm in the clinic, so I'm a little bit intermittent here. But I think you're discussing the antibiotic measure, is that right?

Reva Winkler: Right. Correct.

Christopher Saigal: So, I was the secondary person to this. I couldn't get in to the SharePoint to read what you've posted. But I guess it's something like you had an adequate performance in those documents from what the group was saying. But also I couldn't find out where they said how well is being done and I think that this has been in a pretty high level in my impression.

Reva Winkler: OK.

Christopher Saigal: Maybe we could point to that if it's available in the record somewhere.

Reva Winkler: Sure. We'll try and bring up in the webinar and see if we can take a look. Do we have any measure developers on the line that could respond to the question?

Colette Pitzen: Reva?

Reva Winkler: Yes?

Colette Pitzen: This is Colette Pitzen. I'm sorry, I just have a question. Had we already – we're going down the track of voting for reserve status, correct?

Reva Winkler: I don't believe this …

Colette Pitzen: Or did we not even get that far?

Female: I don't believe you voted for reserve status.

Colette Pitzen: OK. Thank you.

Male: Reva, I agree with the previous post comment is that – I mean the performance gap on this should really, you know, this is one those PQRS. So that's probably a small percentage of people that are actually using it. And I couldn't find any data on how many people are actually using it because, you know, it could be like 50 percent of people are actually reporting it, something like that.

Reva Winkler: OK.

Male: But the other thing is this – yes, this is the performance of this is, you know, got to be if it's tied to the national performance on this measure, because somebody has to give the antibiotics then performing at 99 percent, 98 percent and, you know, that's – I agree, this is sort of what led us to top out the other ones.

Reva Winkler: Yes.

Male: So what are we adding here for this?

Allan Siperstein: Hi, Allan Siperstein here. I guess one of the other issues with this measure is that it's physician-level reporting, it's to the administering physician. And so, I have a question about, you know, appropriate attribution in the group setting.

Reva Winkler: Allan, this is Reva, just in terms of the PQRS program, those are steps self-reported. And I don't know if anyone can offer whether the measure is being used in other programs that perhaps attribution would be a huge issue.

Allan Siperstein: One person in essence is getting credit to reporting for what really is a team activity in the operating room.

Reva Winkler: Right.

Allan Siperstein: And the data was presented in the appendix on …

Reva Winkler: Right.

Allan Siperstein: … you know, how often the performance was "not met."

Reva Winkler: Right.

Allan Siperstein: And over the three years, 2010 to 2012, it was reported we're running, you know, between roughly 5 and 6 percent performance not met. And there was a comment somewhere in the text that a component of this was probably documentation rather than failure to actually administer.

Reva Winkler: So those of you on the webinar, we've pulled up the submission form and in the testing attachment, there was performance data reported in aggregate. If you recall, there were two sets of data that were looked at. One was the Medicare 5 percent data file and it's on page 36, there are performance results ranging in the performance rate as like 93.7, 94.7 percent. So, there is that data. And then also …

Male: Is there any data on how many people are using that it though, reporting.

Reva Winkler: Yes.

Male: I think on the same table, it says that, right? How about what the numerator was or denominator? Other were cases in reporting rates, so like 50 percent are reporting of 700 eligible cases?

Reva Winkler: Yes. This is from the Medicare data sets that they also have (Naycord) data. So, those actual case numbers are listed.

Male: No, but I thought nationally. That's what I couldn't find. So how many …

Reva Winkler: Do we have any of our measure developers on the line who can answer the question?

Gary Roth: Yes. Reva, this is Gary Roth. So I can't answer that question. I don't have the information about the actual per se. As I recall, they talked about it on the last call and it's relatively small proportion of physicians that are eligible, that are actually reporting the measure.

Male: Yes. Yes, that's what I'm trying to get at. If this is a really useful measure, are people actually using it to do anything and look from what I was able to figure out, it seems like it's a very small measure, very small number of people that's – and the people that are reporting it are already doing it in a very high level. So, that is why there was really no – there's not a significant fact measure because we have other measures that we've already decided should be retired that are in the same thing. And that's the number of people if it really impacts, is so small in a big scheme of things that I didn't know if it was really adding value.

Female: Excuse me? I don't know if you can hear me.

Reva Winkler: Yes.

(Sam Turney): OK. Sorry, I didn't know if we had (inaudible) on line. This is (Sam Turney) with the (PCPI). I think – I'm not sure if our colleagues at ASA are on the line as well but I know that this is – this was a (PCPI) measure and ASA has taken over the stewardship of it, but I can answer the question about the reporting rate, like how many professionals are actually reporting on this. And this is

some of the most recent PQRS experience report in 2012, 52.6 percent of the roughly 80,000 eligible professionals reported on this measure in 2012.

And in 2011, 2010 has gone up a little bit; it was 43 roughly in 2010 and 49 percent of eligible professionals reporting in 2011. So just to give you – just to answer the specific question that was asked.

Reva Winkler: Thank you, (Sam).

Male: Thank you.

Reva Winkler: OK.

Robert Sawin: This is Rob Sawin, I don't know if you can hear me. I'm at the airport.

Female: Hi Rob.

Robert Sawin: But the criteria for this excludes children, is that correct? Is there a compelling reason why we shouldn't include children?

Reva Winkler: Yes, this measure is specified for adults 18 years and older.

Robert Sawin: I understand. I'm just asking the question.

(Dale): This is (Dale). Good question that, you know, we can –also say the same thing about CMS measure. The performance measure was initially developed in the Medicare population for adults. There are few data that I've ever seen related to the PDF …

Female: I'll call in a minute.

(Dale): … and deliver the antibiotics.

(Off-mike)

Wunmi Isijola: OK. Are there any other comments?

Reva Winkler: So, in terms of getting a sufficient number of votes for the evaluation, I'm hoping that everybody who's joined us today has submitted your vote and we

will be encouraging your colleagues to complete, so that we have adequate numbers to meet the quorum for the evaluation. So, if you haven't submitted your votes on all of the measures, we really need you to do so.

If you want to change your votes based on this conversation, you can go back in the SurveyMonkey and submit your votes again and we'll be able to ignore your first set and use your second set. So, you are able to revise some if necessary. But is there any further discussion on this measure 269 about the prophylactic antibiotics?

Male: I have a question. On the SurveyMonkey, I don't see a place where you vote around on the performance gap has been demonstrated. They also ask about progress-demonstrated in 4B. So, I mean, basically maybe that's a place where we could comment on that or …

Reva Winkler: Sure. That would be great.

Male: Because it's pretty static in terms of – it's been – it's in a high use and it's been pretty static since they may have here.

Reva Winkler: OK.

A.J. Yates: This is …

(Crosstalk)

A.J. Yates: I'm sorry.

Reva Winkler: No, that's fine. Go ahead.

A.J. Yates: This is Yates. You know, I went through SurveyMonkey and did these voting – did these votes early yesterday or Sunday. And I'm clicking on them again and now it's letting me vote again.

Reva Winkler: Well, it will if you go in a second time.

A.J. Yates: Because when I did it the second time on the same day, it wouldn't let me do it. So it said, "Thank you for completing."

Reva Winkler: OK.

A.J. Yates: So, I'm safe to assume that if I did vote it was accepted?

Reva Winkler: Yes, correct.

A.J. Yates: OK. Thank you.

Male: Reva, I'm on the webinar one now. I'm seeing everything and I revote on that or do I have – because I don't have the link for the SurveyMonkey anymore.

Reva Winkler: No. You'd have to go into the link to the SurveyMonkey. They aren't connected, OK?

(Off-mike)

Female: We conducted …

(Off-mike)

Reva Winkler: We'll resend send it.

Wunmi Isijola: Yes.

Reva Winkler: We'll resend it.

Colette Pitzen: Reva, this is Collette Pitzen.

Reva Winkler: Hi Collette.

Collette Pitzen: I voted several days ago and my memory is not that good but I don't recall the initial under the importance to measure criteria and the gap being there. So I think I would …

Reva Winkler: It wasn't there because the committee had already voted during the meeting.

Collette Pitzen: OK.

Male: And what do we say Reva regarding the performance gap at the meeting?

Reva Winkler: I have to go back and we're digging through pieces of paper here.

Collette Pitzen: I wouldn't be surprised if we also at the gap was demonstrated but – this is Collette again, I'm sorry but I just might be confused.

Male: Right.

(Crosstalk)

Male: With the gap was demonstrated, don't we not proceed with the rest of the vote?

Reva Winkler: Yes. OK. Here is the result on the criterion 1B for this measure. It was too high, 12 moderate and 9 low. So, that actually just passed.

(Off-mike)

Wunmi Isijola: Is there any other comments (towards) …

Lawrence Moss: Hi. This is Larry Moss. Sorry to be late to the discussion. I've been on hold trying to get in the call. I just got in here a couple of minutes ago. And I'm sorry if I missed the survey, it happened before I got on but I – what I got out of our discussion in person was a move to consider moving this to reserved status. Has that been discussed on this call?

Male: Not yet.

Reva Winkler: So the question posted to the group would be, do you want to consider that forward status as we've done with quite a few of the other antibiotic measures?

Male: Yes definitely.

Female: I think we need to be consistent. I really do.

Reva Winkler: OK. Let's put it this way. For those on the phone, is there anybody who would be opposed to considering it for reserve status? It might be easier to count. All right …

Lawrence Moss: No objection for me.

Reva Winkler: OK. So it sounds like everyone would be comfortable with considering at the reserve status. So we will make that clear that that's what your votes are indicating, which is why we need the rest of the votes on your – the rest of the criteria.

William Gunnar: Reva, it's William and I've seen obviously, is a lot of people have developed the potential.

Reva Winkler: OK. Yes, thank you. All right, so are there any further discussion on this measure? Does everybody feel comfortable they have the information and discussion may need to complete voting on the criteria? For those of you who've submitted your votes on SurveyMonkey, if you want to change them, we're able to track that. If you haven't voted yet, could we please get you to vote so that we can get up to our necessary quorum for voting so that we can complete this task? But if there's nothing further, perhaps we can move on to the next measure. OK.

(Off-mike)

Female: All right, so we're going to move forward with measure 0113, participation in the systematic database for cardiac surgery. I know there were some discussions during the in-person meeting on this. And we did receive some of the voting for it but we want to actually point to the discussions for this, this measure as well. Dr. Jarrett and Dr. Dutton, are you on the call?

Mark Jarrett: I'm on the call. This is Mark Jarrett.

Female: Great.

Mark Jarrett: I'm trying to remember where we left focus when – we'll look at SharePoint, I could not find any additional stuff beyond what was originally available. We had the …

Female: No.

Mark Jarrett: It was just a question that, was this so – as I remember, a part of it was the fact that the 10 percent that were the performance gap reflected the VA and places like that and therefore would not ever in Kaiser, and therefore, you're not going to be getting much higher than 90 percent so we're pretty well-tapped out. If I'm not – again, that's what my notes indicate.

Reva Winkler: Yes. Mark, this is Reva. You're correct. What we did was have – because of short time, we did have a conversation with the developers around some basic things that did not get into the criteria.

Mark Jarrett: Right.

Reva Winkler: And so, we need to just finish the process for these three database measures. I do think there was sort of a sense. We were talking about them sort of as a group but things like the participation rate will be unique to each individual one. And so, again, this is – I think we only touched on the beginning of the conversation about how this measure meets the criteria so things like evidence.

The gap, I think is the one you spoke to, you know, reliability, validity, feasibility and usability to allow everyone to have an opportunity to discuss any of those criteria that applies to this measure.

Mark Jarrett: I mean, as I remember again looking back in my notes from the, you know, from that day, you know, and beforehand, I mean, I think, you know, the reliability, validity et cetera, although I was comfortable, the real question was does this need to be, you know, something that could be gained, could be on the reserve status because it's kind of out or not and – it's only a concern from the developers if I'm not mistaken that without this, they feel people will start dropping off because they won't feel the urge to participate in the registry that it helps. It helps them in terms of getting their administrative people to spend the money to participate. Otherwise, if it's not required by NQF, they may just say it may not be necessary, and therefore, that's a place they cut off the budget.

Allan Siperstein: Reva, Allan Siperstein here.

Reva Winkler: Yes.

Allan Siperstein: If you could just comment, I know you went through this before in terms of NQF philosophy on structural measures particularly when the same developer has process and outcomes measures in the same area.

Reva Winkler: Yes. I mean, in general, there has been a very deliberate move towards preference for outcome measures. And structural measures tend to be, you know, rather remote from those and rather limited and minimal. We do have and have endorsed structural measures so it's certainly possible if they need the criteria. But again, you know, there is a preference for the outcome measures.

John Handy: This is John Handy. So as a thoracic surgeon, I have to say I agree with the developer's comments is when you're struggling with resources within the system and so many of the outcome measures that the NQF has endorsed from the (STS center) on this, I do think that it makes it a no-brainer for the hospital to be able to support this. If it's an NQF endorsed (inaudible).

Reva Winkler: OK.

Kelsey McCarty: This is Kelsey McCarty. I just had a question about the idea of bundled metrics because I think we've talked about before. So this to me it would make sense if it were ought to – if they because they were bundled in with all of the other outcome and process measures we reviewed. But are we viewing it as a standalone because if it's a standalone structural measure, I do find that difficult to evaluate it.

Reva Winkler: This is a standalone measure. It is not part of the composite. I guess I would ask the question if you are calculating any of the outcome measures or the composite. In order to do that, you must be a participant in the database. So, the question is what is the additional value of the measure?

Male: Yes, that's the point. I mean, as we heard from STS multiple times during the meeting and all of the other measures, the ADR measures, the CABG measure, 90 percent capture, other ones are not going to be part of this, anyway, because they're either federal facilities or Kaiser. And there are all

those other outcome measures which really do add value, do measure something.

Then you're going to be using those, they come from this. So, just having another measure, that's another statement of the fact that we have a mechanism. So, you know, I think one of the things we should look at is get all these measures, you know, 600 and somewhat measures, 131 surgical measures. But if you got four measures that are measuring the same thing, do we need four measures?

So, if you got four outcome measures using the STS, what's the fifth one adding? Maybe we should (pair) the three a little bit here.

Lee Fleisher: This is Lee. I'm concerned that every society will now use this mechanism to say every registry needs to be endorsed …

Male: Right.

Lee Fleisher: … in the same way that you identify but in order to capture or meet the other measures, the mortality measure, you have to be part of the registry. So I also agree in that. I think it's becoming redundant and in fact, it's an interesting dichotomy that almost sets up a paradigm of going backwards to just say the registry as opposed to a registry that actually get to an outcome measure.

Anthony Asher: Well, this is Tony Asher. To follow up on that though, I think that at the beginning, there actually was an interesting rationale which is to say that were inherent value in finding every way possible to encourage individuals to participate in registries because, you know frankly, we needed to make individuals aware this is an important thing to do as part of standard practice. But, you know, STS has been so successful which was 95 percent plus penetration, it's harder for me to understand how that continues to have value aside from, you know, whatever value the NQF blessing of that participation, you know, adds with respect to hospitals.

I think it actually – it's a stronger argument for societies that are just starting to get into this game who need to encourage folks who maybe they only have 10 or 15 percent penetration in their specialty. So, I guess – I want to go back

to John because – John, when you were talking about the value of this in the eyes of the hospitals, exactly what value is there to the NQF recognizing participation? I'm just trying to see – if I was a hospital administrator and I knew that people were, you know, receiving some credit for this but it didn't really translate into dollars in a significant way.

Why would hospitals continue – flip it around. Why wouldn't hospitals continue to support this now that it seems that virtually every thoracic surgeon in the country is participating? It seems like I wouldn't want to be the odd man out.

John Handy: So, John Handy here. It's a good question Tony. First off, let's not confuse the databases because we're talking about the adult cardiac database now versus the thoracic …

Anthony Asher: Sure.

John Handy: … versus a congenital. And the penetrance in the thoracic is nothing close to the adult cardiac.

Anthony Asher: OK.

John Handy: But it is a resource allocation question. And so, kind of getting back to Lee's point, if you have a bunch of outcomes data or data or outcomes endorsement that are reliant on a database, do you really need to specify the database? Probably not because the hospitals have a vested interest in making sure that they meet the NQF-endorsed measures which are outcome measures and you have to have a database to be able to do it.

But it's not an insignificant problem for the hospital to run a resource allocation, so I'm establishing a thoracic survey not a cardiac survey database across a large health system in five western states. And depending on your case volume, it's anywhere from 37 to $72,000 a year for the institution that has to do with the software, the licensure, the uptake and primarily, the data personnel.

So, to ask your administrator for 37 or 72K is not a very easy asked nowadays. But if you – or if you already have a very integrated data system with lots of outcome dependent on – as the cardiac surgery database has, I think you can make a very cogent argument for not having this NQF-endorsed measure. Those things are not the case for the congenital or the thoracic surgery but I'll save my comments for those.

Anthony Asher: OK.

Christopher Saigal: Sounds like in a reserve status. I mean, this is Chris Saigal, given what we've talked about for the database.

Reva Winkler: So the question is …

A.J. Yates: This is A.J., this is Yates.

Reva Winkler: Yes. Go ahead.

A.J. Yates: You know, the argument that there's a carrot at the end of this tick for the administrators may have been stronger four or five years ago. But now, one of the mechanisms for enticing administrators to use registries and to be enrolled is the need to become a qualified clinical data registry which then makes it eligible for PQRS. And it may also be one of the avenues for reporting through CMS for – like reporting such as (misclips) used in public reporting on hospitalcompare.gov.

And so, now that there are reporting criteria and payment criteria tied into participation in a registry that makes them even more valuable than if they were just simply being a performance measure on paper for NQF, it seems like circular logic to not put this on reserve at least for this particular one.

Reva Winkler: Are there any other comments?

Amy Moyer: So this is Amy Moyer and for this measure and the other two database measures, I was a little confused by the reliability and validity section. It appears that they presented data on the validity of the data elements in the database itself which – well, it's appreciated, doesn't really get at the measure

we're evaluating. I was curious if anyone else had noticed that. I felt like there wasn't any data on the actual performance of the measure.

Reva Winkler: Do we have anybody from STS who can respond to her question?

Jeff Jacobs: Yes. Hi this is – yes, this is Jeff Jacobs from STS.

Female: Hi Jeff.

Jeff Jacobs: Can you guys hear me OK?

Reva Winkler: Yes, fine.

Jeff Jacobs: Great. So, what exactly is the question that's being asked because I'm not sure I understand it?

Amy Moyer: And I apologize. I took it by at lunch. On all three of the registry structure measures, and for the reliability and validity section, what's discussed is the validity of the data elements in the database itself versus the validity of the measure or the reliability of the measure was my reading of it.

Jeff Jacobs: Well, I think over the two days that we worked together face to face, there was ample data that documented the reliability and validity of a database as you said and I don't know if we need to go over that anymore as far as the reliability and the validity of the measure. I'm not really sure what the difference is myself. I don't know, I mean, the measure's participation in a database we've talked about the reliability and validity of the database.

I guess the other thing I could add is that there's publications that we have listed (inaudible) reference that shows that the active alone of participation in this database is those cardiac databases associated with improved compliance with performance and outcomes measures and those references that document that are in the packet for the reference. But I'm not sure exactly what else I could provide to answer that question.

Mark Jarrett: Yes. This is Mark, you know, when I was reviewing it, you know, is part one of the review is – basically, it's a binary answer, yes or no and, you know, to me, you know, the only thing could be is if somebody said they were

participating and never really seen the data but then I'm sure you guys wouldn't count them as a yes. So that's about the only way I think somebody can get and kind of slip through in terms of not being valid and I don't know where the reliability really comes in this case because it's just to participate or not participate.

Jeff Jacobs: Yes. That's kind of what I thought and I think that's why I was struggling with providing a more sophisticated (answer to the) question.

Mark Jarrett: Well, I'm not the writer of it so I could afford to say, even if I'm wrong.

Jeff Jacobs: Yes. The other comment I just wanted to add is that I think that one should not underestimate the value of being able to sit in a room with a hospital administrator and ask them to pay for the database and be able to show that it's an NQF measure to participate in a database.

I realize that 90 percent of the hospitals do participate but it's taking database endorsement away and really sends the wrong message and it wouldn't – if NQF takes the endorsement of this measure away, it wouldn't surprise me that there was going to be a heart surgeon sitting in, officers with the middle managers from hospitals who are then saying to them, "Well the NQF is not endorsing participation anymore so we're not going to pay to participate." And it's not …

(Off-mike)

Jeff Jacobs: … with database, it's paying for data entry personnel et cetera. And I know that the next thing that can be said is that well, you need the database to comply with other measures but sometimes, the logic that seems very obvious with that statement on this phone call and in a room that we're all together in a few days ago is not the same logic that plays out when we're sitting behind the desk of a middle manager who's trying to cut the budget so they can increase their bonus.

Reva Winkler: Dr. Jacobs, this is Reva. I just have a question about the data source for this.

Jeff Jacobs: OK.

Reva Winkler: (Inaudible) for the adult cardiac surgery database, STS would be the data source, do you – where would somebody find out whether a particular hospital or a surgeon participate? Is there – where is the data source and is that information available?

Jeff Jacobs: Yes. So, STS does publish a list of programs that's participating in the STS database.

Reva Winkler: OK.

Jeff Jacobs: And that information is available. It's in a number of places including in our annual meeting book that we distribute every year in our meeting every January. So – And, you know, a number of other places. This measure and the next two measures are not limited to participating in the STS database. One can comply by participating in any national multi-institutional database that allows for benchmarking and this is put forward by the STS because we have a database that does that but we're not saying that we could – we're necessarily the only database that could do that.

Male: So what are other …

Jeff Jacobs: Pardon?

Male: All right. So, let's say, I mean, so if you're asking us to support a database and, you know, because it makes them a mid-level manager feel like they have to but it's not tied to STS, couldn't they equally say, well, what other databases are there?

Jeff Jacobs: Sure.

Male: So are there other …

Jeff Jacobs: Yes, great question. So if one is at the VA hospital participating in the VA's multi-institutional registry which similarly allows multi-institutional benchmarking would meet this requirement because they're participating in a multi-institutional database that allows for benchmarking that includes all the VA hospitals across the country.

Right now, I would think that the two major possible ways to comply with this measure are the STS database and the VA database but nobody can predict what would be developed in the future.

Male: The VA database, we can talk about because that's the VA and that's the government. So for – out on the streets somewhere, private practice in Nebraska Hospital, what are their options?

Jeff Jacobs: Right now, their option is to participate in the STS database but this doesn't …

Male: So if they need the outcome measure, then this measure really doesn't add anything?

Jeff Jacobs: Well, I disagree. I think we're having a very circular discussion here now.

Reva Winkler: Right.

Jeff Jacobs: The point I'm making is that it does add something when one is in the room with a middle manager of the hospital trying to get them to release budgetary funds and support database participation.

Female: OK.

Jeff Jacobs: The other side of the circular argument is that well that's not true. You have to just tell them that you need it for the outcome measure. And I guess one could go back and forth with either of those discussions. I still think it's very important to have this endorsed when one has that discussion and it sends the wrong message to take the endorsement away.

And I think the other point I would address is when someone brought up – well, this could lead to a series of measures from a variety of subspecialties about database participation. And to be honest, I would think that would be a good thing because the more subspecialties, they create databases that allow multi-institutional benchmarking, the more we're going to be able to push quality of care forward. So I don't view that as a bad thing, I view that as a good thing.

Reva Winkler: OK. So I'm …

Collette Pitzen: This is Collette.

Reva Winkler: … yes, Collette. I'm just looking at time everybody.

Collette Pitzen: I just wanted to make a typical comment then because if the measure truly is participation in a database, then STS as the measure steward of this measure, who is collecting then the true numerator and the denominator, if the denominator could be any participation in a cardiac surgery database?

Jeff Jacobs: Well, any individual database could keep track of who's participating in their own database, STS keeps track of who's participating in the STS database.

Collette Pitzen: Right. But I just …

Jeff Jacobs: The denominator of all cardiac programs in the country is an illusive number. There is no source that I know that can give that exact number at any given time. There's a variety of strategies that can be used to estimate that number and we even, probably every one of them at one time or another but I don't think …

Collette Pitzen: This is Collette again. I'm just talking from purely within a numerator and a denominator …

Male: Collette?

Collette Pitzen: Yes?

Male: Collette, I think that would be measured by the person who is using the measure.

Jeff Jacobs: Right.

Male: So I don't know if the CMS picked this up for PQRS, you would be applying to CMS saying, "Hi, I'm meeting with this measure because I am participating in registry X."

Collette Pitzen: OK. Thanks for the clarification.

Jeff Jacobs: Agree.

Allan Siperstein: Yes. Allan Siperstein. I have a comment. I mean obviously, I see the value of participating in a registry but as we go through the individual criteria for measure endorsement, that kind of political nudge doesn't – I don't see that as one of our criteria for endorsing a measure and I would propose that if the structural measure were moved to "reserved status", it no way takes away from an NQF endorsement.

Jeff Jacobs: So, I agree that the argument of using this as a tool to advocate for resources or database participation within a hospital is certainly not in any way whatsoever a requirement for NQF endorsement or a piece of evidence for NQF endorsement. What it is, is an answer to the question of whether or not the measure is topped out and should be retired or not endorsed because it's topped out.

So I'm not putting this argument forward as a rationale for the scientific validity of the measure, I'm putting it forward as an argument to say that I don't think we should retire the measure because it's topped out because of the reasons that I explained in this argument.

Female: OK. All right …

Anthony Asher: This is Tony Asher. If you were going to make that argument though, it seems like that it would be valid with respect to the priority issue. So, if we want to make a statement that this was addressing a national priority, I think that that would be a reasonable argument to make.

Reva Winkler: OK, folks, do you think you have had enough discussion that you'll be able to, you know, finish voting or reconsider any of your votes so that we could move on to discussion of the next two measures? Is everybody OK with that?

Male: Yes.

Female: Yes.

Male: Yes.

Reva Winkler: OK. So the next measure …

Wunmi Isijola: 0456.

Reva Winkler: … 0456 is essentially the same concept but this is a database for general thoracic surgery.

Frederick Grover: Hey, this is Fred Grover. I just want to let you know I joined the call about 10 minutes ago. Sorry, I was late.

Reva Winkler: OK, Fred.

Frederick Grover: Yes.

Reva Winkler: Thanks. OK. So we have Dr. Markman and Dr. Sawin if you want to kind of speak to any of the concerns with this measure that you see unnecessary to speak to?

Male: Well, you know, this, I mean, the discussion on the cardiac registry or cardiac surgery, we, you know, on a work call. This is different because I think there is a performance gap here. And it is noted that there were only 244 participants in this registry and there was a varied mix between them, between the thoracic surgeons, this is a different type of surgery so I felt that the performance gap was not similar to cardiac surgery but it was high. And you discussed that during the work hall

So, you know, from the reliability and the priority and the feasibility, it's basically the same but this is a different issue because the small numbers are really participating and we did note that there were some significant outcome measures that were even generated from the small group. So those were my basic comments.

Robert Cima: And this is Bob Cima, I agree. I think the gap is considerable in the non-cardiac thoracic world will …

Reva Winkler: This is Reva. Are there other databases for which thoracic surgeons can participate? Does NSQIP take that kind of data?

John Handy: They do. The different – so John Handy here, so NSQIP does do this but NSQIP does sampling of sort of signature cases versus this is an all-inclusive entry via your entire thoracic surgical experience for the participants. And the participants are a minority in the nation.

Reva Winkler: OK.

Male: If the measure is saying it has to be all inclusive because I am under the impression it was again just like Dr. Jacobs says that any participation in a national registry would do benchmarking and so thoracic, well, there is a sample NSQIP, you know, over time, you build up and you'd have very good reliability and that's what the VA does and add sample for thoracic, it doesn't do 100 percent selection, it does a sample.

Male: You know, Bob is right. It does not – the part of the measure stipulation is not all inclusion but …

Male: Right. So that's what I'm saying. There are other processes of that allow thoracic surgeons that this measure (inaudible) participate in a national database with all the benefits of that because it does have benchmarking. And again, it's not inclusive of 100 percent which is unlike STS like adult cardiac and everything but it is participation in this systematic database and there is a big performance gap.

And so I agree, I mean, unlike the last one, I think this one right now, there is a performance gap. There are multiple opportunities to participate in systematic databases that are either all inclusive or sampling but still give you risk adjustments in an appropriate way.

Male: As Dr. Jacobs, now in this registry …

Jeff Jacobs: Yes.

Male: … it's only board certified thoracic but you can come from different specialties?

Jeff Jacobs: Yes. And it doesn't require board-certified – it does not require one to be a board-certified thoracic surgeon to participate in the STS thoracic database. Lobectomies are done by general surgeons and general surgeons who are not board-certified thoracic surgeons are more than welcome to participate in the STS database.

Male: OK. So then it goes across all specialties?

Jeff Jacobs: Correct.

Male: I think that's good.

Reva Winkler: Yes. Dr. Jacobs, is this measure being used in any program at this point? Are you aware?

Jeff Jacobs: As far as what type of program?

Reva Winkler: I don't know, I mean, is anybody using the measure?

Jeff Jacobs: I think it – I'm not sure. I don't know.

John Handy: John Handy. So I'm a little confused by that question, Reva. You mean, are there participants? I mean, yes, there is 256 of us.

Reva Winkler: No. I know but if somebody, you know, collecting this data and using it beyond just the database process itself …

(Off-mike)

Reva Winkler: … is this a measuring PQRS for instance? Is this a measure that's being used in any formal quality improvement program that kind of thing?

Jeff Jacobs: I think the best way I would answer is that this measure is used as the previous speaker said by a several hundred hospitals that participate in the general thoracic database. I'm sure it's used by a lot of us thoracic surgeons when they

justify the allocation of funding for database participation within their own hospital, the same argument that we talked about before.

And I think in a situation where the penetration if you'll ask, it becomes even more an argument …

Reva Winkler: Yes.

Jeff Jacobs: … that it's important to have that ability whether or not it's used for some other mechanism of outcome reporting down the road.

Reva Winkler: Is it publicly reported so that it's easy to find out who are participating and who's not?

Jeff Jacobs: Right now, the STS are the platform for public reporting for adult cardiac surgery database only. We're rolling out our public reporting platform for congenital cardiac surgery this year and for general thoracic surgery next year in early 2015. So right now, STS is only public reporting adult cardiac but that's soon to change.

Lee Fleisher: So can I ask a question Reva on both you and Jeff and that there's registry that are asking for sort of approval status or endorsement of the registry as opposed to a performance metric. And I think you're getting to that question. And how do you think NQF sees that the difference like currently, we have CMS approving registries for public reporting or, you know, would be – so I'm trying to put my hands around those – that difference.

Reva Winkler: Lee, this is Reva. I mean, the database measure for adult cardiac surgery has been endorsed by NQF for 12 years. It's a structural measure. You know, we've talked about the evolution of measures and the moving towards preference for outcomes measures. Beyond that, I don't think NQF has a specific position, so I think you're raising some very important questions that need to be considered.

Lee Fleisher: That's why I asked this question, because question is who are going to be the endorsers of a structure rather than structure elements. And the argument Jeff I'd like to know, is it fact that if NQF endorses it, it's not going to be a

measure in the classic sense. You think that will get more hospitals to approve it as opposed to getting it approved by CMS for some other organization for an ability to use as part of public reporting?

Jeff Jacobs: I think both are good and there's no good mechanisms to judge which is more important. I don't think one should underestimate the value of being able to say that participation in this database is endorsed by NQF. And I don't think one should underestimate the value of an NQF endorsement in a variety of scenarios, platforms and discussions. That's why I think – it's one of the many reasons why STS strives so hard to get so many measures endorsed because NQF endorsement has tremendous value in multiple domains. And I think even for this structure measure that arguments holds.

Reva Winkler: OK, any other discussion around the database measures? Yes?

Male: This is – pertinent to what was just said by Dr. Jacobs, the one thing that I would point out this is structural measures are sometimes of utility to other parties that are not CMS. We know NQF has a proximity and a very special role with CMS. But for instance, the ultimate structural reviewer of hospital processes would be JCAHO. And I don't know for – I don't know personally whether JCAHO expects hospitals of cardiac programs to be part of any kind of registry or thoracic programs to be part of a registry.

Another example would be third party carriers, like Aetna or HealthAmerica or some other large insurer may expect to see data or have access to reporting of data in these measures are from such structural measures. So, just off the cup, is anybody aware of whether or not insurance companies or JCAHO look to see whether somebody is participating in a registry or has data from registry? Because that – those of the other major stakeholders in healthcare that would want to know and would potentially take advantage of an NQF-endorsed measure asking for whether or not somebody is a participant. That's my two cents.

Male: I think it's in our scope.

Male: Why would it be out of the scope if those who are asking if they – we were talking the other day about the fact that STS is reported on consumer reports. I mean that there were scope too, but it maybe that the fact that it's NQF endorsed makes it an unavailable registry tool. That can be used to be required by other parties.

Reva Winkler: Yes. This is Reva. Just in response, I would say that this – some of this would apply to the usability and use criteria.

Male: Understood, but we've sort of (swarped) there a little bit already in terms of the use being – having a hammer over our administrator's head.

Reva Winkler: OK, all right. Does anybody want to discuss anything further on the general thoracic database measure? Because we do want to spend just a couple of minutes on the remaining database measure. Again, I think a lot of the issues are similar. But is there anything else before we move on?

Jeff Jacobs: This is Jeff Jacobs. I just wanted to ask a question with regards to both of these two measures we discussed so far. Is the group voting and considering this for reserve status now or for actual endorsement? I was a little unsure as to where we are in the whole process.

Reva Winkler: Well, it sounds like for the cardiac or the adult cardiac surgery database, there was a support for potential reserve status because that performance is so high but that was not part of the discussion for thoracic surgery because there is a performance gap.

Jeff Jacobs: So for the first one, what was actually voted on and then was …

Reva Winkler: It hasn't been voted on final yet.

Jeff Jacobs: OK. All right, understood.

Reva Winkler: OK.

Wunmi Isijola: So, if there's not anymore discussion when we'll report to the last measure 734, participation in the national database of pediatric and congenital heart surgeries? And do we have Dr. Sawin and Dr. Jarrett to speak to it?

Robert Sawin: Yes. This is Rob Sawin. All the similar issues as we're discussing the last year – aside from – I guess is about of 11 percent gap and I take this – that Dr. Jacobs can correct me but I think it is pretty well known how many institution actually perform congenital heart surgery.

Male: Right.

Robert Sawin: And so it does appear that there's little opportunities for improving the participation. But otherwise, all the issues discussed in the prior to proposals remains on this one.

Jeff Jacobs: Yes. This is Jeff Jacobs. I would agree with that. We have pretty solid evidence that there's 125 hospitals in the United States that have two pediatric heart surgery. So, we know, we know the denominator a lot better than we do for thoracic surgery for sure and even for adult cardiac where it's somewhat elusive.

Reva Winkler: OK.

Jeff Jacobs: And there is – the performance gap here is in the middle of the thoracic database in the adult cardiac database, but still certainly a lower percentage of participation that in adult cardiac. Otherwise, all of the remaining issues are basically identical.

Reva Winkler: OK. Are there any other comments?

Mark Jarrett: No, this is Mark. I agree the same issues.

Reva Winkler: OK. This is Reva, just a follow up on Dr. Jacob's comment. The votes that you're taking include the overall approval for endorsement. And does everyone agree that the measure for 113 for the adult cardiac surgery, you are talking about reserve status where the other two for general thoracic surgery and for pediatric surgery is just a regular endorsement? Can anybody disagree with that?

John Handy: John Handy here. I don't disagree with that, but on the SurveyMonkey …

Reva Winkler: Right.

John Handy: … that is one of the options.

Reva Winkler: Yes, I know. I know. That's why I'm trying to clarify with it now, so we can interpret it.

Jeff Jacobs: Thank you. That was exactly what else trying to ask, of course, but thank you.

Reva Winkler: OK. So anything before we move on for next agenda item? OK, thanks very much. So, if you haven't submitted your votes, we really need to do so, so that we can get a quorum of those and get some result and we'll get the results back out to you as quickly as possible. We're going also to do a quick summary of this discussion to send out to your colleagues who aren't able to attend the call to encourage them to also submit their evaluation.

So those are the next steps for this part of the agenda. OK. As we're going into the next agenda item, Andrew, are you in the line?

Andrew Lyzenga: I am. Can you hear me?

Reva Winkler: Great.

John Handy: Well Reva, John Handy here. Before we moved on, I just want to ask a procedural question. So, I did all my voting earlier and I haven't change anything, so there's no wiping of this late clean and starting over if that would still stand?

Reva Winkler: That will stand unless you …

John Handy: OK.

Reva Winkler: … want to wipe it clean.

John Handy: Right, got it. OK.

(Andrew): All right. So this is Andrew and I apologize that there's music in the background here. I'm sitting in a hotel lobby, (inaudible) but I hope that's not too disruptive.

But I just wanted to say a few words about competing measures discussions here. Just as a background – I'm sure you all know there's a proliferation of measures out there for a variety at programs purposes and I do hear a frequently that it creates a significant burden on providers in terms of data collection, reporting and so forth. And when there are multiple measures on the theme or a similar topic, they can also lead to confusion or a lack of alignment in terms of interpretation of results and prioritization of measurement efforts.

So when NQF receives measure submissions that could be considered duplicative or overlapping and presents as an opportunity to consider whether it's a need – a need for multiple measures in the area or alternatively a selection of one of the measures as superior would be appropriate with an eye toward reducing that measurement burden then simplifying the measurement landscape.

So along these lines, NQF has set out some guidance around committee consideration of related and competing measures. We've described this guidance in the memo that we sent out last week. But I'll, you know, just say a few more words here to sort of set the stage for the discussion again on the two CABG mortality measures.

Competing measures are measures that essentially address the same concepts in terms of a target process, condition or outcome, and in the same population, you know, the same target population that is using existing guidance from taskforces we've seen on this issue. NQF staff has identified the two CABG measures were discussing today as competing.

And so, in these cases what we asked you to do is to – first, what we'll ask is whether the committee thinks that a decision should be made on whether one of the measures was best in class, so that's sort of a yes-no answer, should had this is – best in class decision would be made.

If you answer yes to that question, we'll go ahead and consider which one of these measures should be considered best in class. If you determine that best in class decision is not necessary, that there is justification for having multiple measures in this area. And hopefully, you see the materials that CMS and STS had sent around, it's getting irrational for having both measures endorsed.

If you do find, that should be compelling argument and, you know, that there is justification for having two measures. Then we'll just ask you to sort of articulate your rationale for that. Tell us the justification for having two measures like the reasons or what the added value of the two measures are just so we can sort of explain that in our report and took somewhat why we've influenced two similar competing measures.

So, what we'll do is we will first give our developers a quick opportunity to make some statements about the measures, their position on how they think the committee should approach this. And now, we'll open it up for committee discussion and discuss whether or not we'd like to make a best in class decision. If we do, which one we would like to select or if not, again, how a better discussion and articulate that rationale for having both measures in that similar area. Do you have anything to add Reva to that?

Reva Winkler: No, that's fine. Nicely done.

(Andrew): OK. So with that, I guess we will ask our developers to see if you were – since we have them on the line, either CMS or STS first (inaudible).

Lein Han: Hi. This is Lein Han. I'm from CMS. I will speak …

Male: Hi, Lein.

Lein Han: … briefly and I'll pass on to STS and Yale for them to speak briefly as well.

Male: OK, great.

Lein Han: So, thank you for inviting us to this meeting. And I would like to clarify first that we don't see these two measures as competitive measure. We see them as measures that complement to each other. And we do see the need for both

measures. The two measures captured different but over population and – are using different data sources. However, these data sources – however, these two measures are harmonized as a result of the collaboration between CMS and STS.

The two measures, a good measure as the panel voted to recommend both for endorsement. The CMS use the claim-based measure because it is feasible and they're cost-effective at this point for nationwide implementation. But I would like to reiterate that CMS very much support development implementation of clinical database measures. Ultimately, we want to move to develop and implement measure based on EHR. But during the transition period of time, I mean, from claims to EHR, we support concurrent use of clinical database measures. As you know very well that CMS is not the only organization that develops and implement measure, we believe that registry based measure offer an alternative mechanism for quality measurements. Thank you.

Yale, STS want to …

Jeff Jacobs: Sure.

Lein Han: Can you?

Jeff Jacobs: Yes. This is Jeff Jacob from STS. And again, thank you for allowing us to present the – everything that we presented including our information about this discussion. I would just reiterate what Lein said. The STS views these two measures as complementary. They've been harmonized as much as possible given the different sources of data. They each fill gaps for the other measure.

And to briefly summarize those gaps, the administrative measure applies to patients that are – that have Medicare claims data. So, it's essentially patients over the age of 65 at all Medicare participating hospitals. The STS data augments that by filling in the gap of patients under the age of 65 that undergo coronary artery bypass grafting. On the other hand, the STS data currently captures 95 percent of the coronary artery bypass grafting operations in the CMS dataset. And potentially a little bit more but certainly not a 100 percent.

So, each of these two sources of data – I'm sorry each of two measures filled gaps that the other one cannot address and come from different data sources, but have been harmonized as much as possible by the developers given the fact that they do come from different data sources. And I realize most of what I said was in the documents that have been distributed to the group already but I just want to summarize those two brief points. Thank you.

Lisa Suter: And this is Lisa Suter from Yale. I just also wanted to add to Dr. Han and Dr. Jacobs' statements. I'm reiterating everything they said. And just further reassuring the committee that neither measure or the endorsement or support of both measures can concomitantly – does not create any additional provider burden. Hospitals are already collecting and reporting the STS mortality measure and the claims-based measure uses administrative claims that require no additional burden. So, there's no provider burden that moving forward with both measures that would be additionally placed on providers.

We have both organizations both CMS and STS have mechanisms for ensuring clarity of message and ensuring that providers are not confused about how these measures are presented. CMS enacts dry run processes before implementing measures where they give hospitals an opportunity to review their results confidentially and those results include patient level data.

They also do consumer level testing where they actually ask, interview patients about how to interpret the information that is post on the CMS website. STS has similar detailed processes for consumer testing for their own measure presentation that they can detail for you. And finally, I just want to reiterate, I do think that these measures both add significantly to the field as was discussed by the all cause admission/readmission committee that reviewed the two isolated CABG readmission measures that STS and CMS created as part of a collaborative efforts out of which the CMS mortality claims-based mortality measure arose.

We have talked about complementary ways in which these measures can and maybe reported in the future. Dr. Han mentioned nationwide Medicare reporting of the claims-based measure that could complement more rapid

cycle measuring, excuse me, reporting through the STS registry from – an under 65 in our all pair population. And similarly, this would be complementary and that one of the voluntary process although it captures a large majority of the nation's CABG patients and the other would be a mandated process that would ensure that the small fraction of hospitals that are not currently captured. And the benefits from additional measuring are also provided information. Thank you.

Male: Question, has there been a comparison of – between the STS over 65 patients captured which represent 95 percent, if not more of all 65 year old you get the CABG versus the measurement of the CMS for that same population. Are they similar, I mean, I'm just trying to understand if you all say they basically are the same in the sense of they are they looking at – they have, you know, subset STS has a subset with entire CMS one. Are the measurements the same? I mean …

Lisa Suter: So there has not been a direct comparison of performance assessment of hospitals by these two measures. We do know and I think STS shared with you earlier that they capture – I think it's 90 to 95 percent of hospitals in a similar project where we develop the readmission measures. We were able to match 90 percent hospitals and 85 percent patients between the Medicare data and the registry data which suggest that the vast majority of patients are captured by STS but somewhere between 10 and 15 percent of patients are not included in that.

Male: Well that's readmission which is always difficult to track because they may not be readmitted to the same place. But we're talking about an outcome measure of mortality which theoretic – doesn't matter where it happens, it should be tracked, it could be able – because STS is very good about that. And …

Lisa Suter: Yes.

Male: … Medicare is good too. So …

Jeff Jacobs: This is Jeff …

Lisa Suter: I'm sorry. Let me just clarify. That was not the readmissions. That was actually the cohort which is very similar although to be fair, not identical. The readmission cohort eliminates patients who die in the hospital because you need to be discharged alive to be eligible for the readmission measure. But that was the cohort not the outcome. So …

Male: So, just cohort?

Lisa Suter: Just cohort. We were able to match 90 percent of hospitals and 85 percent of patients for the readmission measure validation that was done with STS and Yale in conjunction. So, we know there's a large overlap between the two measures but we don't know exactly how hospitals look on the STS measures versus the Yale measure. And I think our points is that they can look different and it's fairly – can be fairly transparent hospitals why they might look different.

You have different patients that are captured. You have patients who are younger patients who have different insurance and patients who, you know, slightly different operative versus 30-day mortality definition of the outcome, so there will be slight discrepancies in how each hospital's performance is assessed. So we think that those are complementary pieces of information for a hospital.

Male: Yes. But I want to say, does the STS can also provide a sliced out 65 and older. I mean NSQIP does the same thing. They looked at 65 and older patients. So, what I'm saying is if you're getting 90 percent of all the 65 year olds in STS 90 to 95 percent. I just, you know, it doesn't matter if they – it's like an operation, does an 18-year old, if you'll exclude them and say we're only going to evaluate the 65-year old or greater, you would get the same – you should get the same data set, right?

Lisa Suter: Yes. And what I will say is this was mentioned by one of your committee members and I apologize that I can't recall the name off of the top of my head during our in-person interview which is that, in-person meeting which is perhaps a few hospitals who do not participate in the STS registry may benefit most for measurement. And so, well, we know those hospitals are likely

small. They may benefit most from getting a formal measurement of their performance. Even if they're too small to be considered, you know, different from the national average on a public reporting site. That hospital will receive, if it were publicly-reported through CMS, would receive hospital level report detailing their performance in comparison to their state and the nation that could be valuable to that hospital.

And I think there's been a lot of evidence presented by STS that measurement at any level and certainly voluntary measurement with STS and mandated measurements such has been done in California, have improved mortality rates. Even though they're low to begin with, they have improved with continued mandated measurements.

(Crosstalk)

Male: One of my concerns, I think this is brought up at the Washington meeting was if you're really looking at benchmarking hospital level performance, you'd rather have a measure that included all patients as opposed to the over 65 subset.

And I guess my question and for the developers is how many hospitals do not participate in STS but have Medicare patients? I mean obviously, VA would be a neither, Kaiser, so what – how many hospitals are there who do not participate currently in STS but would be – have data collected for this measure?

Lisa Suter: I can just tell you from what we understand from validating the claims-based measure cohort that there is somewhere between 10 and 15 percent of Medicare patients that are not captured by the STS measure. That we're not able to match to Medicare – we would not able to match Medicare claims data to the registry.

Male: I have a question. If I could interject.

Female: Yes.

Male: Question for Dr. Saigal and Dr. Jacobs. What is the time delay from the – say three months period or six months period of surgery and to the ventral recording. It was brought up the other day that we were meeting that obviously there's a delay in the CMS data because the hospitals are given a chance to contest or to fix or to make better their reporting. If there's discrepancies, what's the lag between say, the reporting of data from the same time periods or are they always going to be out of sync?

Male: So, within STS for the adult cardiac surgery database which this measure applies for data is harvested every three months. And for example the March 1st harvest will have data that includes all sort, I'm sorry, an April 1st harvest would have surgery that includes all surgery up to the previous January first. The July 1st harvest would have surgery, all surgery up to the previous April 1st harvest which means that there's a three-month lag from the date of surgery itself. But, a part of that is necessary because you need time for the patient to recover and be discharged alive or to have at least some measurable outcome.

Male: Are there quarterly every three months reporting?

Male: Correct, so there's feedback reports that are distributed to the STS participants every three months on a rolling window of annual and aggregated data. So, each participant can benchmark their individual outcomes against national aggregate data which can update and report every three months for the adult cardiac database.

Male: I guess I'm not being specific enough. How about public reporting?

(Crosstalk)

Male: The public reporting is updated twice a year.

Male: Twice a year. And how about for the …

(Crosstalk)

Male: The reason for that is that there's tremendous efforts that are made to make sure that there's absolute validity of what's put on the public reporting website.

(Crosstalk)

Male: Yes. And how about for STMS?

Female: So, certainly the – how these measures would be implemented is yet to be determined, but if they were implemented in a way in which other mortality measures have been implemented for CMS, they would be implemented on an annual basis using data that is 12 months I believe I said 18 months in the in-person meeting and I apologize I've been corrected since that time, a 12-months lag. So, and they would be a rolling three-year measures. So, it would generate usually every summer. They would update the measure results for public reporting. And include data hospital level data going back to the hospitals on an annual basis using the three prior years with the 12 months lag.

Female: Any other comments or questions from committee members about the issue?

John Handy: Well, John Handy here. So, I was interested in the letters of support that each organization wrote in favor of the other end for having simultaneous overlapping measures. That – they seem to be too identical to me to be able to account for that. I would not vote for that.

And when I look at the different measures that the STS accounts for all the patients versus the CMS which accounts for over 65 that's a clinical data system versus administrative data system, the forgoing arguments notwithstanding, there has been extensive risk adjustment period of publication out of the STS and despite the similar methodology from CMS, that does not have the same track record. And the STS accounts for all operative mortality versus the 30 day mortality which in cardiac surgery we do have multi-organ system failure possibilities and you – this can be a substantial cohort of patients who can date off the court after 30 days.

So to me, it doesn't seem like we need to, I would choose one which we feel superior. And I – to me, the STS one has more components that advocate for it.

Male: Great.

Male: I agree.

Lisa Suter: I'm sorry to interrupt. This is Lisa Suter from Yale. May I just add one additional comment? I think it was included in the letter which it seems like everybody is familiar with, but the all cause admission and readmission committee made a decision to recommend both the claims space and registry based readmission measures to go forward. That would enable both of these measures to exist as paired measures, with paired data sources for both readmission and mortality. And each measure is harmonized to align with not only the different data source measure, but also their own suite of measures. So, STS measures harmonized best to fit and be reported with the STS measures.

And the CMS measure is harmonized with the existing CMS mortality measures all of which adhere to AHA ACC outcome guidelines indicating a defined offer, excuse me, outcome time window. And I think I just wanted to reiterate that we are hopeful that you will see the benefit in both mortality measures considering that there's precedent for moving both readmission measures forward.

(Crosstalk)

Lein Han: Hi this is Lein from CMS. Yes, I do agree with that Lisa. We do – We have this readmission CABG readmission measure. And we developed measure in general to pair them up. And I do agree that, you know, the clinical database measures are more, sort of having the face validity.

And STS has good measures. But, at this point of a time that there's no other way for CMS to implement measure. But use this claim based measure to implement a measure in the most cost-effective way and a feasible way and

nationwide for very important clinical area. So I just want to put that out there to reiterate it. Why CMS uses claims based measures.

Colette Pitzen: This is Colette Pitzen. I have a comment. I just wanted to point out that I think both measures are valuable. They are using different data sources and they're not completely harmonized and that the numerator definition is a little bit different. But I just wanted to point out again with the claims based measure. That both specifications can be applied against an all-pair claim. It doesn't have to be limited to just the Medicare population. Thanks.

Amy Moyer: And this Amy Moyer. We've talked about the ability, the overlap in the patient population was different in the patient populations measured. But from a usability perspective, you know, CMS is looking for something that they can make broadly available through hospital compare. The results of the CMS measure for the, I'm sorry, the STS measure are reported from a voluntary basis. And well, organizations have a wide variety of reasons why they might choose not to share those measures. The claims based measure can be made available whether an organization consents to that or not which is much more usable from a purchaser and from a patient perspective.

Reva Winkler: Thoughts from anyone else?

Male: Reva?

Reva Winkler: Yes.

Male: NQF staff after evaluating them, have thought that they are competing measures. That's what I heard at the beginning, right? They meet …

Reva Winkler: They meet the definition for competing, yes.

Male: OK, so all this other stuff is slightly different. But they meet – they are considered competing measures which was a question to me which was (inaudible).

Reva Winkler: Right. But I think, you know, if you read through the memo, it described sort of the process of thinking about competing measures. And so, it is within this

steering committee's decision whether they want to accept multiple measures or not. So it isn't like you have to pick one or not. It really depends on the individual measures. Remember that we try and create definitions that we can apply across the boar, to all measures that get submitted to us.

And so, in that case, these are do meet our definition for competing. And which is why we're asking you to consider all of these issues. But, if you, you know, if you look through it, one of your – back to your first measure decision is, do you want to try and pick between them or is it acceptable to have two measures? Any other thoughts from anyone else? Because essentially at this point, that's the decision we need you need to make is whether you want to accept two measures or whether you want to, choose a best, you know, pick one of the two.

So that's the first question for you to vote on. And my questions to you …

(Crosstalk)

Reva Winkler: Yes?

Robert Sawin: I'm sorry this is Bob Sawin. The question was asked earlier. Is it reasonable for us to request that a comparative analysis be done at the STS data base patients over 65 and see if we're comparing apples to apples or whether they are additive to one another. They may actually show us the data.

Reva Winkler: This is Reva. I don't want to speak for either STS or CMS, but in terms of the time, we need to get this work done. It's unlikely there's time for any significant data analysis. So, I would post the question to both of them.

Lisa Suter: This is Lisa Suter, you know, we obviously want to be as responsive as possible to the committee. I guess my one question would be, what data would change their minds one way or another. Like what specific finding would – are they looking for – what specific question are they, do you want answered in order to and how would it change your decision.

Is it clearly the question of overlap or is it a question that do – does FTF identify the exact same high performers and lower performers as among

Medicare patients. I'm just trying to understand and I think we know some of our experiences with the readmission measures which were also identified as competing measures, that when you – in a match cohort of patients.

So in an identical set of patients, when you look at those hospitals using the two measures, you get slightly different results in terms of performance categorization. You get tremendous amount of correlation, both in the point estimates as well as in the uncertainty estimates around those point estimates of hospital performance.

But anytime you draw a hard line, there is some variability. And so, I just, I think it would be helpful to understand our a priori what the threshold would be that those analyses would respond to. And we're happy to work within the timeline if it's feasible for us to do so.

(Crosstalk)

Male: I think part of the discussion we've been having obviously is that there – the STS measure maybe a little richer in terms of its patient population. But what I've also heard is that the advantage of looking at the CMS population is number one it's effortless to collect. And number two, get a transparency advantage and that everybody would be reported.

Jeff Jacobs: So this is Jeff Jacobs, first of all, I think certainly, STS would be glad to collaborate with the group from Yale from the CMS to do an analysis that could look at the different classification of patient (inaudible) administrative data versus clinical data the way that we're talking about looking at the differential classification and how many hospitals would change their classification as outliers, whether they were set with clinical data versus administrative data.

And we would certainly be more than willing to collaborate with Yale and CMS to do that analysis. I think, we would agree with Yale and CMS if these are complementary measures that have been harmonized as much as possible and we can make a list of advantages and disadvantages of each measure.

Some of which includes coverage connecting Medicare populations over the age of 65 and the STS population is all ages. While only 95 percent of the patients that participate in Medicare have their data capture in the STS data base. But another important difference is the difference in the ability to identify a pure model using clinical data and to apply to that pure model clinical variables for risk adjustment.

And the enhanced clinical data and a clinical database rather than in a claims database allows one to do more sophisticated risk adjustment. And I think that that argument is an argument that's in favor of making the clinical measure available. While the hundred percent availability of public reporting of a measure from claims data is an argument that supports the claims measure that was presented nicely by the Yale group.

So, it's pretty clear that both of these measures have a set of complementary advantages and disadvantages. And if one is forced to choose one over the other for best of class decision, one is going to ultimately lose the complementary advantages from the alternative measure. So, while we could do this analysis and we'd happy to do this analysis.

It's not going to change the fact that neither group thinks it makes sense to choose one over the other because both groups feel that the alternative measure feels gapped.

Christopher Saigal: This is Chris Saigal. I think basically that if some of the STS measure is going to be richer and more robust. And that CMS itself is saying that it's a transitory measure, it's proposing that probably it won't be used as much as more doctors are reporting in registries and to their EMRs and data warehouses to their EMRs.

So, I mean, I think you're going to pick one pass the test measure and be the way to go – because they're everywhere, except for me, one of our four percent of the hospitals. I don't know that there's a huge value in using the Medicare measure, but I'm not entirely opposed to it.

A.J. Yates: This is Yates. The keyword in the last statement I think is transition and the question today would be whether or not that transition is complete and I would argue that it is not at this time. And I think it would be legitimate to not table but delay any decision-making on one of the other for one year. And actually let the data roll and see where it comes out in terms of the analysis that was proposed, but given enough time.

So, the analysis is actually a complete one. And I have a question for CMS if Dr. Han is still on the phone. But my question would be, would it be, since NSQIP data is now on a voluntary basis reported on hospitalcompare.gov, is it also likely that even with the (CMS) mortality data and readmission data for CABG is from their model, would they also allow STS reporting on hospitalcompare.gov since there is a lot of synergy between the two groups.

Lein Han: Hi. Our experience with the voluntary reporting is that is very – the participation rate is kind of low. Because it's not required and it's not part of the, any CMS initiative. So, that's why these are voluntary program.

Kelsey McCarty: Hi, this is ...

Lein Han: Yes.

Kelsey McCarty: This is Kelsey McCarty. I might be missing something, but I don't understand necessarily why we have to choose one or the other or why does – measures are tied supposedly to the database. Because on the data base side, I'm not sure that one is better than the other. One, you don't get patients under 65, the other one, you don't get all claims and you can't really make a justification maybe that one of those is less bad than the other.

So, why are the two measures high to those databases? How come we can't assume the measure outside of them and then each organization can apply the methodology to whatever claims database or registry they have access to.

Reva Winkler: This is Reva and, you know, the question I guess for the committee is what do you feel comfortable with in terms of decision making? Dr. Yates offered a proposal. We certainly need your cent of whether you want to go forward with two measures of you would prefer to select one over the other. Perhaps

those two can find the, you know, sort of a common ground proposal. What are your thoughts about where you'd like to go?

(Rick): This is (Rick), I move in here.

Allan Siperstein: So, you know, before I think there's value in both. I mean one maybe better than the other, but I think the CMS patient population has a, you know, a gap in terms of – in terms of guaranteeing transparency, or reporting all programs except the other one last, so I'm sorry, I see value in both.

Female: OK. (Rick), I mean Allan was that you who spoke up?

Allan Siperstein: Yes.

(Rick): That was Allen, this is (Rick) but so moved, how do we vote?

Reva Winkler: OK. We do if you're on your webinar, (Shawn) you need – we can certainly collect those through the webinar process, I think you all signed up. Most of you we need to know if any of you are not signed up through that process and then (Shawn), do you need to give them any instructions on voting?

Female: Reva, it looks like they are doing just what they need to do. You can …

Female: OK.

Female: Click in the box next to the answer of your choice. And it is for those folks that are voting company members only and we did check if you didn't use the project you were sent. We did take care of checking you on the back end so you should still be able to vote.

Reva Winkler: OK. Are there any ...

Male: Fred Grover (inaudible).

Reva Winkler: OK, great. I think, is there anybody on the line who is not on the webinar?

Robert Sawin: Yes. This is Bob Sawin and I am not on the webinar. I'm at the airport.

Reva Winkler: OK. Do you feel comfortable just by casting your vote verbally?

Robert Sawin: I do.

Reva Winkler: OK. Are you – the question is, does the best in class decision need to be made with respect to these two measures? Yes or no?

Robert Sawin: No.

Reva Winkler: Thank you. Is there anybody else like Bob who needs to vote outside the webinar?

Female: Sorry, Reva, I didn't mean to step on you. But just a reminder if you're on the tab, you can't register your vote on the tablet. So, we would need you to either send it through the chat box or speak it verbally if you were comfortable doing so.

Barry Markman: This is Dr. Markman.

Reva Winkler: Yes. Dr. Markman, did you speak and say that you are unable to vote or?

Barry Markman: Well, I'm unable to vote, but I don't think (inaudible), I'm voting no.

Reva Winkler: Thank you. Thank you, we'll record your vote. OK. We're just making sure everybody is on board here. So if everybody had a chance to vote either through the webinar or the couple of user online?

Male: Yes.

Reva Winkler: OK. All right. We have 19 of you that voted and the results are – OK, we have four Yes and 15 No. So, essentially you've decided as a group that you will put vote measures forward. You don't feel there's a need to pick one over the other. I think with the discussion you've had over the last half hour, we can certainly pull out the rationale and explain your decision going forward. Is everybody comfortable with that?

Male: Yes.

Male: Yes.

Male: Yes.

Reva Winkler: Super. OK, so we've actually finished the agenda item. And so we're nearing the end of the call. We did have one topic that we always like to check in with you all. You've had a chance to look at measures, you've had a chance to look at our portfolio.

During the in-person meeting, you mentioned a few things about gaps or areas where you think measurement is needed for surgery, specifically, I recall meeting good measures around bariatric surgery also perhaps better measures around surgical sight infection. But were there other, you know, gaps and measurements that you will have identified that you'd like to recommend need to be filled to make the portfolio as robust and meaningful and useful for a wide variety of stakeholders?

Frederick Grover: Hey Reva, this is Fred. I've thought about this a fair bit last night and I still believe that one of the best ways to improve quality is through specialty groups developed in their own databases with data that they know is clinically important. And then using that in their own settings after they see what the results are compared to a national cohort much as we have and this group has. I think the bariatric people are trying to do and others, cardiologists are doing and – a very good job to this.

And I think, I don't know if there's a way NQF can reach out again through its (inaudible) care committees through these clinical groups. It was great seeing the bariatric group come forward but, there are many, many other areas and that I think we could really improve the heath care and the quality of (inaudible) in the country. You know, if we get – if we really get the providers more involved.

Reva Winkler: OK.

(Rick): This is (Rick).

Reva Winkler: Yes?

(Rick): I'd like to see more development of shared accountability measures where perhaps two societies or different groups combine to look at bigger picture outcomes.

Reva Winkler: OK.

(Rick): So like appropriateness of care, yes, that could be patient satisfaction might fall into that in various ways. We're …

(Crosstalk)

(Rick): Return the function after joint replacement.

Male: Right.

Male: How about cost? I mean, there's – is that part of the new Affordable Care Act. Maybe we are asking groups that focus somewhere on that's requesting quality votes so they have a measure of value.

Colette Pitzen: This is Collette. I just like to type in. I think that there's a lot of opportunities for looking at patient reported outcome within the surgical population especially related to functional status at a certain time post-operatively. Thanks.

Male: Thanks a lot. Anybody else? Obviously, you've got a lot of great thought.

A.J. Yates: This is Yates. I'm going to be specialty centric and orthopedics is embarrassingly not represented very well in the portfolio other than the two EL course CMS complication and readmission measures which are claims-based data.

I would argue that there is a very strong need for multiple more measures in total, knee and total hip replacement since combined. They represent this segregator's cost center for procedures for CMS. I would also argue that there needs to be more performance measures for spine. And then in orthopedics in general, and I would agree that patient-reported outcomes should be something that we strive for in that process because those outcomes are

sometimes measured over months and years. And it's all well and good to have very few complications but you need to have – show that you're providing value.

The final thing is that, the risk adjustment has to be robust and has to be risk adjustment that can be reliably captured going into the measurement. As such, we will be having a – the American Academy of Orthopedic Surgeons is having a performance measure summit in July. And I am one of the people going to it, in participation with the American Association of Hip and Knee Surgeons.

So, I'll send word out in that regard but it might be appropriate for the National Quality Form to send a letter inviting such performance measures from the orthopedic community now that they have a specialty society committee dedicated to creating them and especially in advance of this meeting.

Reva Winkler: OK. Thank you. Sounds like a plan.

Christopher Saigal: I have one more if you have the time. This is Chris Saigal. I was thinking that in regards to, you know, preferences and decisions we're talking about the value. I think that a lot of surgical quality has to do with how good the decision making, whether they can measure the – whether, if your decision-making happened in the encounter of decision making, it would be interesting to look at.

Reva Winkler: Sure, sounds good. Thank you.

Anthony Asher: This is Tony Asher. I just wanted to follow up on some of these comments. I'm sorry, who was the head of an orthopedic team just a few minutes ago?

(Off-mike)

Anthony Asher: Hi. Yes, this is Tony Asher. And to the point of about, you've mentioned spine surgery is an example, you know, there are specialty societies now with the neurosurgery in this category where unfortunately, we haven't been in the scheme of developing quality measures precisely because we don't have

robust data across practice settings that allows to really, very specifically identify performance gaps and we're in the beginning stages of developing these registries.

In that regard, I do think that there is value in recognizing registry participation for a group that have not yet really gotten in this area. So, they can't evoke that information to inform development of more meaningful measures.

And I think particularly, with respect to degenerative diseases, I think we mentioned it a long ago, spine fits in that category, it's a $200 billion industry at least on the implant side that perhaps 20 percent of that share being wasted. It's actually, critical that there be cross especially participation in the development and meaningful measures and I think it is NQF who would encourage those types of alliances, it would be of extreme value.

(Bob): This is (Bob), just to follow up on that. But then to reflect on the discussion we had 15 minutes ago which if everybody comes and start making their own registry which are labor-intense, extremely expensive, but not open, completely transparent to the public, then CMS is going to feel the need to develop their own. And we're going to end up with the discussion of completing measures again. I'm just putting that out there.

NQF, you know, everybody wants – everybody is going to a measure because they are all measuring something and they were going to have this discussion of all these measure. And then they're going to be slightly different. We have no (inaudible).

I mean I'm just, I sort of the (inaudible) razor kind of guy who cut it down to the simplest and of course, yes, there needs to be hip and knee measures but should it be the orthopedic hip or knee, should it be CMS or hip or knee. We have that in Minnesota now where the State of Minnesota wants the functional outcome. They want to use a certain tool, the orthopedic society want to use a different tool. So, I mean it comes to a point where someone is going to say enough is enough. And one is going to sit down and decide one thing.

And so, I mean, we're going to – I'm so supportive of this but there's got to be some type of understanding that we're going to end up with all these discussions again about best in class, not best in class and eventually a final decision will be what we have. There's not best in class. So anybody can use anything so.

I mean, you know, this is just – and it's just a comment about looking at all these measures. Like I said, there's 131 surgical measures. And that's only limited to a very small slice of surgery. So now, we're going to end up with 600 to 700 eventually and that CMS is going to want another set to eventually, they're going to be meaningless.

Anthony Asher: Well, this is Tony Asher – OK, go ahead.

Kelsey McCarty: Oh, this is Kelsey McCarty. I completely agree and that was kind of my question earlier which I guess is a question directed to NQF in terms of the guidance that are given to the developers. And why, wherein the measures are constructed? Are they constructed around using a specific data base and not just around certain values and certain fields that could be analyzed with any database?

Now I know for the reliability and the validity testing. You have to test it on something. But then, can you only use that measure where the data base is effective on? I don't (inaudible) that's the part of the measure conflict.

A.J. Yates: This is Yates. I just want to comment on what was just said. My vision would be that STS registry and NSQIP as well would be the national models for which other sub specialties would or specialty groups would plot with the – they would use those as benchmarks in terms of the depth of data and the reliability of the data.

And I would argue that, you need to have a national platform and the recognized larger national specialty societies at least on those specialties which have one single very important voice. I think that those societies need to get on the ball and it would be – I'm speaking for myself, I think it would

be ideal if it was a robust registry such as which you see with NSQIP or STS. And I'm going to make that argument when I have an opportunity.

What you see now with the explosion of different things that people want recorded in terms of different patient-reported outcomes and different ways of adjudicating quality. You've seen that because there is a vacuum. You wouldn't see the same argument in cardiac surgery in Minnesota or other places because STS has filled the vacuum.

And ultimately, I think that – if it's transparent and it's publicly-reported, it's going to be a greater value if it's a national platform. And it has internal validity and governance that gives the participants the same sense of trust as the patient should have, if it's done right.

Reva Winkler: OK. Hold on a second.

Frederick Grover: Let me follow up with that. I just again, and I promise I'll shut up but, I mean, for a hundred years, I started being a (spouse) and the best way to get an improvement was to involve in quality was they get the people that are taking care of the patients involved in the process of how to improve, not have an oversight group do it. Not that there isn't a role for the oversight groups when the other things maybe failed. Don't get me wrong on that but involving the physicians and the nurses in their care, whoever is on the team in developing measures. And then, they bring themselves against national benchmarks and on the last two decades, we've seen the risk adjusted (albeit) mortality in CABG for up to 60 percent as an example. And it's just involvement of people and you have the clinical data which is accurate.

And I guess I hear what you're saying but we don't – it would be better if it was generated by the societies and eventually it evolves in the public or the (inaudible) has to be public and I guess, you know, that could be turned over right now or reporting, you know, half of our folks who are reporting publicly.

But, we saw this drop in quality before we land – in mean, drop in mortality, improve quality before we went into public reporting. And it is in the National Quality Forum and as I recall, when you do have an approved project

or a measure at it, you know, is the implication as I went on a certain period of time, you will try to get that into public reporting.

So, I think there is room for both and I think it would be great and having a lot of measures doesn't bother me too much but I – because there are for some different reasons but what I've struggled with in all my years with NQF is getting other specialty groups really on board and now I think we're starting to see that. I spend hours this last week just with the ophthalmologist for helping them with their first newsletter around – promoting the database that they're developing.

So, that's just some of my – I personally, I have a lot of passion for it obviously because I think it works. And I understand your other issues as well.

Reva Winkler: Thank you, Fred. Personally guys, I know, we're running out of time but something we absolutely have to do is take the opportunity to get any feedback or public comment.

So operator, could you see if there is anyone who wants to offer a comment, question or whatever from the audience?

Operator: If you have a question or comment, please press star one on you telephone keypad.

Again, to ask question or comment, please press star one.

We have no one at this time.

Reva Winkler: Thank you very much. Now, we're down to the end of our time and Wunmi wants to kind of tell you what the next steps are in terms of what we need to do to finish up the work and write up the reports that will go out for comment, a public comment in early July.

Wunmi Isijola: So, as Reva mentioned earlier, a lot of question that was to take place today. We will be summarizing those discussion points for individuals who were not necessarily on a call but also, to ensure that we're (capturing) all of the

discussions that took place today. And we will incorporate that into the draft report that will be posted on July 3rd.

At that point in time, we ask for any comment as it relates to the draft report and then we will have a post commenting period. Prior to that, there will be a 30-day commenting period in which the NQF membership and the public can make their comment as well as the committee. And as a committee, we will review those comments and respond accordingly on August 26th.

So, nest step really is, we will follow up in the next few days with kind of the discussion points but also we encourage those who have not voted to please to do so. And if you do in fact, want to change your vote (inaudible) you will be asked to do that as well. We will – I know there were some questions about the settings with the voting. Make those adjustments and you'll be able to get into that post this call.

And if there aren't any questions we will …

(Off-mike)

Wunmi Isijola: OK.

Male: Where was the outcome on the vote? I got in late on that 369, I missed that one.

Wunmi Isijola: We haven't talked about the result yet. We have …

Male: Oh, OK. OK.

Wunmi Isijola: But once that's finalized, we'll definitely distribute that to the committee.

Male: Thank you.

Wunmi Isijola: So, are there any other questions? OK. And with that being said, we will adjourn the call. We do appreciate everyone's participation today. So we'll be speaking with you soon.

Male: Great, thank you.

Female: Thank you.

END