National Quality Forum

Moderator: Jason Goldwater
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OPERATOR: This is Conference #: 28358659

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

Jason Goldwater: And thank you. Good afternoon everyone. This is Jason Goldwater. I'm joined by (Katy) Streeter. As we now go over the results of the work that you did with respect to medications and values of harmonization.

We're thrilled to have you this afternoon. Thank you all very much, not only for taking the time out today to talk to us, but taking the time out to go over the worksheets, submit your thoughts and comments to us. We found that incredibly helpful and really has helped us move forward with this project.

Just a brief glance at the agenda for today, as usual, we'll start with our welcome and our roll call. We'll briefly just summarize the pilot harmonization process, so that you sort of know where we are and where we will be going the next few months. Then we're going to basically recap the comments, and suggestions, and recommendations that we have had from all of you with respect to values and harmonization for medication. And then we'll talk about some next steps to conclude.

So what I'd like to do first is to do the roll call, and I'll turn it over to (Katy).

Kathryn Streeter: Hi, good afternoon everyone. Do we have James Case with us? Lynn Choromanski? Kendra Hanley?

Kendra Hanley: I'm here.

Kathryn Streeter: Rachael Howe?

Rachael Howe: I'm here.

Kathryn Streeter: Catherine Ivory?

Catherine Ivory: Here.

Kathryn Streeter: Jason Jones? Russell Leftwich?

Russell Leftwich: Here.

Kathryn Streeter: Kathryn Lesh?

Kathryn Lesh: Here.

Kathryn Streeter: Caroline Macumber?

Caroline Macumber: Here.

Kathryn Streeter: Priscilla Mark-Wilson?

Priscilla Mark-Wilson: Here.

Kathryn Streeter: Nick Mattison?

Nisk Mattison: Here.

Kathryn Streeter: Kristen McNiff? Deborah Sita?

Deborah Sita: I'm here.

Kathryn Streeter: Shelly Spiro? And Allison Weathers. OK.

Jason Goldwater: All right, thank you all very much.

Kathryn Streeter: Actually guys, do we have any folks from our federal partners on the line the have joined us? OK.

Jason Goldwater: OK. All right, so let's, I guess, just sort of talk about the process, the tools, the task. I know it's been a while since we took into all of you via webinar. Most of our communications over the last three months have been commuter mediated, so we thought we would just take a little bit of time to sort of go over again the process and discuss where we are at right now.

The idea, the objective of this is to determine a pilot harmonization process with the objective to determine the intent of the value set, identify an overlap, duplication and omission with value set within quality measures, and then look to classify from extensional to intentional, looking at developing classes of value sets that directly relate to the intent of the measure.

Some of the tools for harmonization – in this particular case, we were going to have resources, such as the Rx navigation tool to help you identify classes of medications. As you are now all well aware, we opted to move away from that, and instead, we looked at a worksheet really to show you the medications with respect to VTE and AMI, and have you look at the ones that had a particular Jaccard score to determine whether or not harmonization was needed or not. And that was the very first task. The first exercise was to look at value sets associated with medication.

The pilot process for harmonization really again looked at intent, looking at the intent of both the measure and the value set, and to use the Jaccard analysis as sort of a guidepost as to which ones had the highest possibility of overlap or redundancy. We used the 0.49 as the cutoff, and we did a manual review of the value sets as well as the Jaccard analysis to determine which ones we wanted you all to look at. And then once you looked at, we asked you for recommendations why you believe that change was needed and what improvements you believe will result from this.

Some changes in the last point, which most of you know, we did not ask for you to do – use the (RxNav), try it in (inaudible) classes that were redundant and overlapping. We will opt to take on that activity based upon the

conclusions of our discussion today. And that the charge of the TEP is really to examine the paired value sets to determine if harmonization was needed or not.

The first worksheet on value set for harmonizations for medications included, as you know, the measures for AMI and VTE, and both under meaningful use, the (steward) of both the measure and its intent, the value sets that could potentially be overlapping, the object identifier or the OID of those value sets along with the description, its (steward), and its intent.

We only used published value sets within the Value Set Authority Center. Those that we noticed were either draft or proposed, after some discussion with our value set committee, we opted to drop. We only wanted to focus on those that were published. And then in the last table, as you all know, on that worksheet, we listed paired value sets that were overlapping and the measures that they corresponded to.

We asked you to look at those paired value sets and examine the measures they come from, the intent of the value set and its description, and determine that they were either one, distinct enough that there was no overlapping and no harmonization was needed, that the value sets – two, the value sets were redundant, and they are overlapping, and harmonization was needed, or three, the information provided was too ambiguous, but is unknown as to whether harmonization is needed or not.

To no one's surprise, I guess, it was very evenly split amongst all of you. In each one of the value set pairs, half of you thought they needed to be harmonized, the other half of you thought they did not. We did not receive any comments indicating that there was too much ambiguity to proceed. Most of you had a very definite opinion one way or the other, so there was no clear cut...

(Off-mike)

... no clear cut answer as to whether we need to proceed, we're trying to device a harmonization by using classes of medications, or whether we could simply leave it as it is.

So that's going to be the focus of the discussion today is sort of to review the analysis that you all gave us. In some cases, we grouped comments together because they were somewhat similar. In some cases, there were very distinct comments that we wanted to point out to all of you. And then we'd like to facilitate some discussions to get better ideas as to whether the group as a whole feels like we need to move forward to see if we can identify classes of medications and try to come up with a new harmonization approach.

So the first one that we looked at was other anticoagulants for AMI. This generated a lot of responses, so we really had to look at grouping some of these so that we could try to identify some similarities without (inaudible) incredibly small. Like I said, this is evenly split. There were 10 responses in all, five of you said it should be harmonized, five of you said it should not be.

The reasons that were given for harmonization is that the other anticoagulant was compared to the oral factor, Xa inhibitor value set. And the reasons for harmonization included that all of the values in that oral factor set could be found in the value set for other anticoagulants for AMI. There were two medications, and the other anticoagulants value set that were not Xa inhibitors, the other anticoagulant is limited to the measure that is looking specifically for aspirin, yet this value set does not have aspirin as a value. There were some ambiguity, clinical, that is, about the indication for – I'm not going to be able to pronounce this medication – dabigatran for VTE prophylaxis. And although that medication is the only difference between both value sets, it's recommended mostly for atrial fibrillation and AMI, and it is an oral anticoagulant. For those reasons, some of you believed harmonization is needed.

Those of you that thought harmonization was not needed, the value sets have different uses which is why I think there's justification for them not needing to be harmonized. I should interject and say this is also a comment made by our value set committee, which they said there are different types of value sets in terms of meaning. And even though they have the same medications, their intention is different. And so as such, even thought there looks like there's

redundancy, ultimately they seem to be distinct. That of course is their interpretation, not necessarily yours.

dabigatran which is included in the other anticoagulant set value is not an oral factor Xa inhibitor. Also, those measures were oral factor Xa inhibitor not specifically stated that they only want this class of medication. It's distinct – the other anticoagulant is distinct from the oral factor inhibitor for VTE prophylaxis in those following measures. Other anticoagulants include that drug which is a direct (thrombotic) inhibitor, which is different from a Xa inhibitor. Thank goodness, I'm not a physician. dabigatran is not indicated for general VTE prophylaxis. It's only used for VTE prophylaxis, if the patient has atrial fibrillation or has a history of VTE.

So in looking at these comments, and I realize you've just seen these for the first time, but in taking the moment to look at these, does anyone really have a strong feeling, one way or the other, about this – the other anticoagulants for AMI and the oral factor Xa inhibitor value sets should be harmonized or should not be? And can you provide sort of a brief description as to why or why not? Independent of what you wrote, but just sort of looking at this, can you just express your feeling sort of succinctly?

Catherine Ivory: This is (Cathy) Ivory.

Jason Goldwater: Hi.

Catherine Ivory: Hi, how are you?

Jason Goldwater: I'm great.

Catherine Ivory: So I'm going to advocate for harmonization wherever we can harmonize for the sole purpose of minimizing the clutter and the noise among and within our value sets.

Jason Goldwater: OK.

Catherine Ivory: So wherever we can find commonality, we're going to ultimately, in my opinion, make any value set easier to use and get perhaps a clearer picture of

what medications are being used, what medications are not being used, and for what indication.

Jason Goldwater: OK. Thank you very well. Thank you very much, Catherine. Anyone else? So we have one vote for harmonize to reduce the clutter and noise as much as possible, which is sort of the intent of why we move from extensional to intentional. Are there any other thoughts? Because the idea that both of these value sets have different uses have any bearing onto the decision or not.

Kendra Hanley: So Jason, this is Kendra Hanley.

Jason Goldwater: Hi.

Kendra Hanley: I would say that they definitely have different uses, because the value sets for the other anticoagulant for AMI is used – the way that value set is used in the measure is as an exclusion. And so it's looking to identify medications that patients might already be on, and if they're already on those medications for a variety of reasons, you would not (should) also prescribe aspirin following an AMI.

Whereas oral factor value set and many of the other five value sets where we looked at, you know, kind of the pairs, it seems like those are more looking for things that were prescribed with the specific intent of VTE prophylaxis. So I see those as two very different use cases for the value sets.

Jason Goldwater: OK. Anyone else? Any other thoughts?

Caroline Macumber: Yes, this is Carol Macumber. I'll just kind of echo Kendra's sentiments here. I mean, in my review of this, it kind of seems like those who were using the oral factor Xa, the measures were much more granular in their attempt to capture drug classes with specific mechanisms of action. In particular, (CMS 73) has a specific or strong value sets for dabigatran that it captures separately.

That being said, I'm not familiar enough with the measures or their offering to say whether or not those two things have to be captured separately, because I also feel like where we could harmonize, we should, but I don't know whether

or not that these measures need to be as granular as they are. If they don't, because they actually do a union of these two, the oral factor Xa and dabigatran in the numerator, perhaps they could just say those two could become one, and therefore your ability to harmonize would be easier.

Jason Goldwater: OK, excellent point, thank you.

Deborah Sita: Hi, this is (Deby) Sita. I think part of the issue of here is that the QDE's themselves are not harmonized and sort or this (trickle down) problem. If you could harmonize at the quality data element level, it would be easier to harmonize this code sets. It's back to intent again.

Jason Goldwater: So what would your recommendation be on trying to tackle that? We have our own ideas obviously, but you know, what are your thoughts?

Deborah Sita: I don't have a thought on that. I mean...

Jason Goldwater: I understand.

Deborah Sita: ... that's a – you know, it's a big thing to tackle.

Jason Goldwater: Right, right. I thought maybe you had a magical solution, and we could just snap our fingers and it would happen, but all right.

Deborah Sita: I wish.

Jason Goldwater: I wish too. That's a great point, and I think that that's been – it's well stated and it's also been stated before that some of the misalignment occurs because at the higher QDE level, there is lack of coordination in some (facilities), so because of that, the codes themselves become misaligned. But how'd you tackle that problem is challenging, so...

Deborah Sita: Yes, I think that harmonization at the code level would naturally follow if you get those QDE's better aligned.

Jason Goldwater: Right, good point.

Kathryn Lesh: This is Kathy Lesh, I second that motion.

Jason Goldwater: OK. Great. OK, anybody else?

I mean, the comments on this first pair are great. I mean, they – on all of them, they were fantastic. There was really just a lot of very high level thinking that you all gave to really considering whether harmonization was needed, and examined the issues very thoroughly. And we're very grateful to you all for taking the time to do that.

And you know, I told the staff jokingly that we're probably going to bet back results where half of them are going to say yes and the other half are going to say now, and we're going to have to sort of like discuss what to do next. Sure enough, that's what happened. But I think that's great because it shows that even in the midst of having codes that are redundant and seemingly overlapping, that there is also the possibility that they're distinct which makes harmonization a little bit easier, rather than just being a complete mess where there – it's almost not sensical and you have to then rethink the value sets going all the way to the intent, and then trying to match that up. So I think that there is not as much of dire need at least when it comes to medications, at least with meaningful use, (that is).

All right, if there's no other comments on that, we'll move to the next one. Also a 50-50 split, and this was for the low dose unfractionated heparin for VTE prophylaxis. And your reasons for harmonization stated that the unfractionated heparin contains all but one item in the value set of low dose unfractionated heparin which was the value set it was being compared to. The unfractionated set includes four additional values that are not in the low dose unfractionated set.

And looking at the measures these value sets could be combined to the less specific less value set, unfractionated heparin, which is interesting because if we were actually to go through the harmonization process, that is probably what the value set would end up looking like. And we would look for classes that (would map) to that could apply to the measures that go to these values that it's a part of.

The reason to not harmonize is the measure developer had created smaller subsets of the different types of heparin, which allows them to reuse across multiple measures. The value set for low dose unfractionated heparin for VTE prophylaxis is meant to indicate subcutaneous administration, whereas unfractionated heparin is meant to indicate intravenous administration of heparin.

So I have two questions here for all of you. The first one is really which deals with that last bullet, which is, how significant is it to keep subcutaneous administration and intravenous administration separate as two distinct value sets, or is it possible to have is as one value set where both of those values and their root of administration is mentioned in the same category.

What are your thoughts?

Kendra Hanley: Jason, this is Kendra Hanley. I would say that's a question that really is most appropriately answered by the measure developer. The first comment on the reason to not harmonize is mine, and I sort of made some assumptions that they had a reason for why they segmented them this way.

Jason Goldwater: Right.

Kendra Hanley: And therefore if they're in fact maybe also used in these other measures – but maybe they're not because you did that analysis, but let's just say they are – then – and there's a reason to have them separate, then I think it makes sense why they provide us a fractionated from the unfractionated.

Jason Goldwater: OK.

Kendra Hanley: I think that is a question that the measure developer probably would need to answer, but I'd be interested in other (stuff).

Jason Goldwater: OK. Anyone else?

Kathryn Lesh: This is Kathy Lesh, and the second comment is mine. I just found it rather odd to have the distinction between subcutaneous and intravenous in the measured guidance and not in the logic. And it just didn't make sense to me to

create two separate value sets, one for each root of administration, when they could have included the root of administration in the measure of logic.

I tried to get some sense from the logic – some of the mightier logic people, but they're all on vacation last week, so. It goes back to the measure developer choice, but I'm – maybe it needs new guidance in the MAT. So this would be a better way to – I don't know whether it would be better – a better way to actually describe the logic.

Jason Goldwater: Right. Good point, very good point. Anyone else?

Catherine Ivory: This is (Cathy) Ivory, and again, I'm on the harmonization train, so I'm going to always advocate for those to be combined and to just differentiate the route.

Priscilla Mark-Wilson: This is Priscilla. I went back and forth, (and this is it). And – but actually just 0:22:51 (like both sides), but I ended up going with the reason not to harmonize mostly because of the root administration. So again, I agree with the earlier – with you who said that maybe the logic can be a bit more specific as to the root as opposed to having it here, because really the differences are not that much and you could combine them.

But if we're looking to harmonize, I mean, I've been on the developing end of trying to create this tool that can actually take into consideration this value sets, so I'm always for harmonization. But if the root of administration is the bigger issue here, then I'd be on the reason not to (do that).

Jason Goldwater: Right, I agree. I agree. But I think it's a very interesting point because clearly that the – I mean, so we have the advantage of the developer for this value sets, and the measures that they went into is on our value set committee. So I mean, we talked to (inaudible) frequently, and her comment was, you know, that they developed the root of administration, specifically the subdivide and create two distinct value sets. But I think that there is a point to stating what if that were put into the logic of the measure and you just had one harmonized heparin, in this case unfractionated heparin value set, so that might be worth considering as a pilot to see what (thoughts would be).

Deborah Sita: Hi, this is (Deby) Sita. The other – you know, for me, it came back to the quality data elements again. If you could combine those, and instead having all the separate ones for each type drug and just combine them into a parenteral and then oral anticoagulant, then the value sets would just harmonize real nicely. You know, it's, again, that QDE issue.

Jason Goldwater: Right. I think that's a good point. Anybody else?

OK, let's go on to the last one, which is, again, heparin. This time, it's low molecular weight heparin for VTE prophylaxis, and this was combined with the parenteral anticoagulant. So the reasons for harmonization that were given was the intent was different. However, looking at the codes there were issues. So for example, the low molecular weight heparin had not heparin medications in it. If this had heparin, it would make sense to keep them separated. The anticoagulant could be used instead, and low molecular heparin for VTE prophylaxis should be discontinue or remapped to only contained heparin medications. The anticoagulant value sets is much more robust than the low molecular weight heparin for VTE prophylaxis, so perhaps looking for classes of medication and wrapping those into a parenteral anticoagulant value set that would be used for VTE prophylaxis.

The reasons to not harmonize. The anticoagulant value set includes medications used for treatment of VTE. The other value set was used prophylactically. While there is overlap, all the meds in these are not appropriate in the other one. The CMS measures 108, 114 and 190 utilize a set of more granular drug value set including the low molecular weight heparin value set. Included in the anticoagulant value set are numerous drugs captured in one of the other value sets, thus, these two value sets are distinct as one is intended to be more granular than the other.

So this is where we found interest again. There was actually – out of the 10, it was six to four to harmonize. This is the only one where there was not a split. So the reasons for harmonizing were actually the reasons why some of you thought it shouldn't be harmonized, which is one value set was very granular, and the other value set was much more high level.

And so those of you that thought harmonization was needed thought why have a fairly high level value set, why not just combine the medications into one. Even though the intent might be different, is it possible to harmonize, rename, and then it would cross supply?

Or those of you that were not in favor of harmonization said the idea of being relatively high level, the other one being granular was done intentionally, which is also what the joint commission said, which is, we went into designing it for that specific reason. One was to be kept far more at a higher level medication, while the other one was supposed to be far, far, far more granular, such as the low molecular weight heparin.

So the question to post to all of you is even though it was six to four, that is still pretty evenly split, so what are your thoughts. I'm understanding that there are those of you that are really in favor of harmonization and those of you that are not, but do you think that having a value set that is very granular and one that is not warrant harmonization, or do you think it does not because it was done that way for a reason and the intent would be compromised otherwise?

Lynn Choromanski: This is Lynn Choromanski, and I think when you explain it that way that there was an intention behind, which I didn't gather from when I reviewed the documents, but with the intention that this was a joint commission request, that there was specific reasons why only these particular medications were called out in that value set, then I would change my mind and say then they should remain separate.

Jason Goldwater: OK. And so Lynn, it wasn't my intent to change you mind, but...

Lynn Choromanski: But I can...

Jason Goldwater: ... you well noted.

Lynn Choromanski: I can understand your logic though behind it.

Jason Goldwater: Right, right.

Lynn Choromanski: And some of that I don't – didn't get either through the documentation or don't have the background to understand that this was an intentional...

Jason Goldwater: Right.

Lynn Choromanski: ... pairing down of the list to make – for use in one particular area.

Jason Goldwater: Sure, sure.

Nick Mattison: I agree with that. If the purpose was to have a more paired down list specifically, I don't see why you could – why you would want to merge them into one.

Jason Goldwater: I mean, I think again, there might be ability to rectify this at the quality data level. But you know, we'll have to look and see. But that might make things a little clearer.

But you know, we've talked the joint commission about all of these, and you know, their claim has always been they're distinct, they're different, we have different reasons and purposes. That of course does not mean that we then, you know, not move forward with thinking if they need to be harmonized or not.

But this one in particular, you know, they said this is going to be sort of the issue you're going to come up with, and it was done for a reason. And then it's up to you to decide whether you think that reason is valid enough that harmonization need to not be done on this particular pair, which seems to me, I think, what most of you seem to be thinking, other than those who may think, you know, there should always be – if we should always go for the easiest root in terms of harmonizing, which is if there's redundancy, they can be removed to try.

But in this case, you know, there were two very distinct different – distinct reasons as to why the value sets were created.

Priscilla Mark-Wilson: OK. So this is Priscilla. I'm going to put it another way at this (inaudible) of really even making it look like it – yes, let me think (inaudible).

I look it more like that each of it worked – each of these measures and value sets have (definitely sense). But sometimes, it's like looking at the big picture. We're trying to get an end result, but there's so many ways to get there.

We can clarify a lot of (system) and logic, and the logic – but then the tools that we use in having these codes harmonized will probably be the easiest way, and the logic will use – we'll use the logic to narrow down the actual cause that go with the particular measure.

So if we say – I mean, I can't figure how to say it properly here. And in my mind, when I look at all the value sets, OK, looking at it also from the I.T. end of it, you can – then we can narrow down the codes that (there actually is), that come through. The clinicians do not use these to provide care. They provide the care we get that (inaudible) and we try...

(Off-mike)

... what is being done and measured quality and all that.

So when you get it to that level of – if we're using it for this intent or that intent, it's not being used really by clinicians but rather we're taking what the clinicians have done, how it's been coded, and we're using that information to analyze what they have done.

Jason Goldwater: Right.

Priscilla Mark-Wilson: So for me, having so many different value sets, especially in a case like this where never mind (inaudible) low molecular weight versus just throwing it into one big (heading), just – I don't know, I feel like we're creating more work (inaudible) at this level, because we have other ways of conducting that analysis and (sticking) through that whole bunch of codes and saying, "OK, these are the ones that actually make sense here." So that's what we're looking for, whether to exclude or include.

Jason Goldwater: Right.

Priscilla Mark-Wilson. You know, so...

Jason Goldwater: Right.

Priscilla Mark-Wilson: ... I don't know if what I was trying to say came through the...

Jason Goldwater: No, no, no. That makes perfect sense, Priscilla. Any other thoughts?

OK, so I think what we're going to do is – and again, as I've said before, and we'll probably say profusely many times before we reach the end of this project, to thank all of you again for the time taking to look at this, and for your thoughts this afternoon – is to sort of go back, sort of just steal your thoughts in thinking across each pair of the values set, and then sort of determine from our standpoint what course of action we'd like to follow. We'll bring that up with our value set committee next week and then proceed accordingly. And we will of course keep you all posted on this as we move forward.

So next steps. So before we get on with the next webinar, so we'll have one on the ninth of September and then another one on October, but here's in terms, I think, of the work of what will happen next. So when we see you and when we talk to you in September, there'll be two things we'll be talking about.

One is the results of what we just discussed today. If we have actually gone through and decide that we want to harmonize one of more pairs of these value sets that we've discussed, it will go through that process by looking at classes of medication in (RxNorm), developing an intentional value set, and talking that through with you, and talking that through with the value set committee in the month of September to see if it's sort of aligns with what our intent was in terms of creating a harmonized and intentional value set across quality measures.

And if we opt that we do not want to harmonize any of them, and think that we don't need to because after discussions with you and with the TEP – or the (BSC) rather, that harmonization was not necessary, we'll discuss that as well and give you our reasons as to why.

We'll also start prepping you for the second level of analysis – or the next set of analysis rather, which is to talk about encounters. And that's going to be the next thing. And so we're going to try to move away from medications and into encounters and specifically encounters as they relate to depression and behavioral health within the meaningful use measures. And those would be SNOMED codes specifically.

The instructions from (ONC) was not, at this moment, to talk about ICD-9 or ICD-10, but only to focus on the SNOMED-CT codes that are used in the value sets for behavioral health, which is where in our pre-work analysis, we noticed there was significant overlap.

How the methodology will go, and how that will be done, and what we'll need you to do, we will discuss in September. And shortly after that discussion, we'll have another worksheet for you all to examine, fill out, and offer your thoughts, which we will greatly look forward to. That will be the next thing we will do, is to sort of review what our final analysis was in terms of the medications and to start prepping you for what will be coming in terms of encounters.

When we see and talk to you in October, hopefully the analysis on the encounters will be done, and we'll have a discussion very similar to the one we've just had this afternoon, where we'll get your thoughts and decide how to proceed. We'll bring that up with the value set committee and then follow accordingly.

And then in November, we'll actually be having an in-person meeting with our value set committee to review the progress to date, determine additional recommendations that we want to move forward with, also discussing governance models for values of harmonization as we move forward.

We will give you some more details about that November meeting. If any of you would like to attend, you certainly have an open invitation to do so. We'd love to see if you could. I'm understanding of course that is a commitment of time for that particular day.

Are there any questions on anything that I've said so far?

OK, that's it, then this is public comment time. OK, so we can now open it up for public comment.

Operator: And to make a public comment, please press star, then the number one on your telephone keypad.

And there are no public comment for this time.

Jason Goldwater: OK, thank you so much, and thank you all very, very much. If you have any additional thoughts or things you'd like to discuss offline from this conference call, our information is listed there. You're free to contact either myself, (Katy) or Ann at anytime. We're happy to speak with you privately if you'd like. Other than that, we will be talking to you all in September.

Thank you all very, very much again for your time, not only this afternoon, but in the time that you used for the analysis. It is greatly, greatly appreciated. We will talk to you all very soon. Thank you very much.

Female: Thank you.

Male: Thank you.

Female: Bye.

Jason Goldwater: Bye-bye.

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