

NATIONAL QUALITY FORUM

+ + + + +

ALL CAUSE ADMISSIONS AND READMISSIONS
STEERING COMMITTEE

+ + + + +

MONDAY
May 5, 2014

+ + + + +

The Steering Committee met at the
National Quality Forum, 9th Floor Conference
Room, 1030 15th Street, N.W., Washington,
D.C., at 8:00 a.m., Bruce Hall and Sherrie
Kaplan, Co-Chairs, presiding.

PRESENT:

BRUCE HALL, MD, PhD, MBA, Co-Chair
SHERRIE KAPLAN, PhD, Co-Chair
KATHERINE AUGER, MD, MSc, Cincinnati
Children's Hospital
FRANK BRIGGS, PharmD, MPH, West Virginia
University Healthcare
JO ANN BROOKS, PhD, RN, Indiana
University System
JOHN BULGER, DO, MBA, Geisinger Health System
MAE CENTENO, DNP, RN, CCRN, CCNS, ACNS-BC,
Baylor Health Care System
HELEN CHEN, MD, Hebrew Senior Life
ROSS EDMUNDSON, MD, Adventist Health System
W. WESLEY FIELDS, MD, FACEP, CEP America
STEVEN FISHBANE, MD, North Shore
University Hospital and LIJ Medical
Center
LAURENT GLANCE, MD, University of Rochester
ANTHONY GRIGONIS, PhD, Select Medical
LESLIE KELLY HALL, Healthwise
PAUL HEIDENREICH, MD, MS, FACC, FAHA, Stanford
University School of Medicine

KAREN JOYNT, MD, MPH, Brigham and Women's
Hospital
PAULA MINTON-FOLTZ, RN, MSN, Harborview
Medical Center; UW Medicine
PAULETTE NIEWCZYK, PhD, MPH, Uniform Data
System for Medical Rehabilitation*
CAROL RAPHAEL, MPA, Subject Matter Expert
PAMELA ROBERTS, PhD, MSHA, ORT/L, SCFES,
FAOTA, CPHQ, Cedars-Sinai Medical Center
ALISON SHIPPY, MPH, Consumer-Purchaser
Alliance, National Partnership for Women
& Families
THOMAS SMITH, MD, FAPA, American Psychiatric
Association
RONALD STETTLER, United Health Group
CRISTIE TRAVIS, MHA, Memphis Business Group
on Health

NQF STAFF:

TAROON AMIN, Special Assistant to the
President and CEO
HELEN BURSTIN, Senior Vice President,
Performance Measurement
ANNE HAMMERSMITH, General Counsel
ANDREW LYZENGA, Senior Project Manager,
Performance Measurement
ADEELA KHAN, Project Manager, Performance
Measurement
KAREN PACE, PhD, RN, Senior Director,
Performance Measurement
ZEHRA SHAHAB, Project Analyst

ALSO PRESENT:

JANE BROCK, MD, MSPH, Colorado Foundation for
Medical Care

KEZIAH COOK, PhD, Acumen

LAURIE COOTS, RTI

DEBORAH DIETZ, Acumen*

DAVID GIFFORD, MD, MPH, American Health Care
Association

MELVIN INGBER, PhD, RTI

JACK KALBFLEISCH, PhD, University of Michigan
Kidney Epidemiology and Cost Center

EUGENE KROCH, PhD, Premier, Inc.

YI LI, PhD, MS, University of Michigan Kidney
Epidemiology and Cost Center

JOSEPH MESSANA, MD, University of Michigan
Kidney Epidemiology and Cost Center

LAURA SMITH, PhD, RTI

URVI SHAW, MPH, American Health Care
Association BETH STEVENS, MS, Colorado
Foundation for
Medical Care

* present by teleconference

TABLE OF CONTENTS

Welcome	6
Bruce Hall, MD, PhD, MBA, Co Chair	
Sherrie Kaplan, PhD, Co Chair	
Taroon Amin, MA, MPH, Senior Director	
Introductions and Disclosure of Interest	9
Ann Hammersmith, JD, General Counsel	
Project Introduction and Overview of Evaluation, Process	36
Taroon Amin	
Committee Update: Risk Adjustment/SES	
Karen Pace	44
Portfolio Review	68
Andrew Lyzenga	
Consideration of Candidate Measures	
2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) (RTI)	78
2512: All Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) (RTI)	160
2375: PointRight OnPoint 30 SNF Rehospitalizations (American Healthcare Association)	214
2510: Skilled Nursing Facility 30- Day All-Cause Readmission Measure (SNFRM) (RTI)	260
2496: Standardized Readmission Ratio (SRR) for dialysis facilities (University of Michigan)	302

2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries (Colorado Foundation for Medical Care)	351
2504:30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries (Colorado Foundation for Medical Care)	417
0327: Risk-Adjusted Average Length of Inpatient Hospital Stay (Premier)	474
2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (Acumen)	509
2380: Rehospitalization During the First 30 Days of Home Health (Acumen)	519
NQF Member and Public Comment	520
Adjourn	

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

P-R-O-C-E-E-D-I-N-G-S

8:03 a.m.

MR. AMIN: Good morning, everyone
and welcome to the National Quality Forum.
Thank you all for all of the time that you
have spent up to this point and for the two
days that we'll spend on these complex
measures, so it will be a very filled agenda,
so we appreciate everyone's time in sort of
keeping their comments directed and to help us
keep moving the conversation along. Again,
thank you for being here. And I'll turn it
over to our two co-chairs for their welcome
from Sherrie Kaplan and Bruce Hall.

CO-CHAIR HALL: Welcome. I don't
have a lot else to say.

(Laughter.)

CO-CHAIR KAPLAN: Ditto. Moving
on. Seriously, this is a beautiful day in
Washington and thank everybody for -- many of
you made a long journey to get here and we're
all very appreciative of the hard work we're

1 about to do and we do want to make sure that
2 we keep to the schedule. We've got a lot of
3 measures to review in a fairly compressed
4 amount of time to do it in, so we appreciate
5 the spirit of conciseness.

6 MR. AMIN: Adeela, take it away.

7 MS. KHAN: Good morning, everyone.
8 My name is Adeela. I'm the project manager on
9 this project. I just wanted to quickly go
10 over some housekeeping items for you all.

11 The restrooms are at the end of
12 this hallway to the right, men and women.
13 We'll have three breaks during this meeting,
14 one at 10:45; lunch will be at 12:30 and then
15 at 3:30. For those of you who have your
16 laptops and cell phones, the WiFi information
17 is also up there. The user name is guest and
18 our password is capital NQF and lower case
19 guest. And we do ask that you please mute
20 your cell phones during the meeting.

21 MR. AMIN: Adeela, one other thing
22 if we can -- for administrative purposes. If

1 everybody can turn their name tag to the front
2 so that we can -- so the co-chairs know, can
3 see everybody and make sure that they can
4 recognize you by name. And as is sort of NQF
5 tradition, if you would like to speak, just
6 raise your placard to the side in this fashion
7 and the chairs will note the order in which
8 they've been raised and do their best to make
9 sure that we go in order.

10 The second housekeeping item is
11 that we can only have two microphones on at
12 the same time, so please remember to turn off
13 your microphone when you're done speaking.
14 And secondly, it's really important to use
15 your microphone because the meeting will be
16 transcribed and obviously the meeting is open
17 to the public and is webcasted. So thanks,
18 Adeela.

19 MS. KHAN: Sure. And just to
20 introduce our staff really quickly, I'm
21 Adeela. I'm the Project Manager. We have
22 Zehra Shahab, our Project Analyst over here.

1 Andrew Lyzenga is our Senior Project Manager.
2 And then, of course, Taroon Amin is our Senior
3 Director.

4 I'm going to turn it over to Anne
5 who is going to be going over our
6 introductions and disclosure of interest.

7 MS. HAMMERSMITH: Thanks, Adeela.
8 I'm Anne Hammersmith and NQF's General
9 Counsel. And for those of you who have been
10 on any of our committees before and probably
11 a familiar face as I do the disclosures at the
12 first meeting of each committee.

13 I'm going to run through some
14 introductory remarks to remind you of a few
15 things and then we'll go around the table and
16 you can introduce yourselves and tell us if
17 you have anything to disclose.

18 If you recall, when you were
19 nominated for this committee, you received a
20 lengthy form that asked you about your
21 professional activities. So what we'd like to
22 do here today is have you disclose matters

1 that you believe are relevant to the subject
2 matter that the committee will deal with today
3 and tomorrow. We're not looking for you to
4 recount your resume, but just to disclose
5 things that are relevant to the subject matter
6 of the committee today and tomorrow.

7 I want to remind you that you sit
8 as an individual on this committee. You are
9 here because you're an expert. You do not
10 represent your employer. You do not represent
11 any entity that may have nominated you to
12 serve on this committee.

13 Another reminder is that
14 disclosures aren't limited to financial
15 disclosures or conflicts. NQF's conflict of
16 interest process is a little bit different in
17 that regard. It's because of the nature of
18 the work that we do. You may have served on
19 a committee as a volunteer for a professional
20 society or some other group where the work
21 that that committee did was relevant to what
22 you're doing here today. It's not necessarily

1 a conflict, but we look to you to disclose
2 that. And I want to stress that disclosure
3 does not equal conflict. Part of the idea
4 here is to be open and transparent for each of
5 you to know where people are coming from for
6 the public to know that. So just because you
7 disclose does not mean that you have a
8 conflict.

9 As I said, we are only looking for
10 you to disclose things that are relevant to
11 the work the committee will do today and
12 tomorrow. We are particularly interested in
13 your disclosure of grants, research, or
14 consulting, but only if it is related to the
15 subject matter of the committee.

16 So with that, let's go around the
17 table, tell us who you are, who you are with,
18 and if you have anything you would like to
19 disclose. I always start with the chairs.

20 CO-CHAIR KAPLAN: My name is
21 Sherrie Kaplan. I am Assistant Vice
22 Chancellor for HealthCare Measurement and

1 Evaluation at University of California Irvine.
2 I used to say I was a psychometrician by
3 training, but then I got into trouble with the
4 clinometric psychometrics kind of distinction,
5 so now I say I'm a measurement scientist. It
6 has clarified nothing.

7 So my prior NQF service, I co-
8 chaired the All Cause Readmissions, Measure
9 789. I also served on the Composite Measures
10 Advisory Group. And I am now a member of the
11 Family and Patient Centered Measures Committee
12 for NQF as well.

13 Since the last reporting period,
14 two things have come up. I've received a
15 grant from Patient Centered Outcomes Research
16 Institute to measure children ages 4 to 12
17 functional status and well being using an
18 animated touch screen based measure
19 performance for use in perioperative anxiety
20 in children. And I also serve on the
21 Physician Compare Advisory Committee that has
22 as one of its contractors Acumen.

1 CO-CHAIR HALL: Bruce Hall.
2 Welcome again, everybody. I'm a Professor of
3 Surgery at Washington University in St. Louis
4 and a Professor of Healthcare Management for
5 our Business School as well. I serve as a
6 Vice President for our healthcare corporation,
7 BJC Healthcare. I'm the Associate Director of
8 the National Surgical Quality Improvement
9 Program for the American College of Surgeons
10 out of Chicago. And I've served the NQF on a
11 number of different projects and committees in
12 the past. Like Sherrie, I assisted
13 with the 789 measure that was not too long ago
14 reviewed. I've served as a measure developer
15 for NQF on behalf of American College of
16 Surgeons. No measures in front of us for this
17 session have I been a developer on and one
18 measure of the vascular surgery measure I was
19 an expert for. We'll discuss that tomorrow.
20 So as far as I know, I have no other issues or
21 conflicts.
22 DR. AUGER: I am Kathy Auger. I

1 am an Assistant Professor at Cincinnati
2 Children's Hospital. I'm a pediatric
3 hospitalist and health services researcher.
4 My primary interests are in pediatric
5 readmission and this is my first NQF
6 experience. And the only past funding that
7 might be relevant is I received a grant from
8 Blue Cross Blue Shield Foundation of Michigan
9 to look at problems of pediatric readmission
10 and risk factors for pediatric readmission.
11 But no stake in the current measures.

12 DR. EDMUNDSON: Good morning. I'm
13 Ross Edmundson. I'm a VP Medical Director in
14 the Florida hospital system which is the
15 Adventist Healthcare System. I'm not a
16 researcher and this is my first time in NQF.
17 I'm actually quite nervous, but honored to be
18 here. I appreciate the opportunity.

19 In my capacity, I do -- it's a
20 large hospital system, seven hospitals with
21 about 2200 beds total and a large tertiary
22 hospital, so I get intimately involved with

1 the readmission and admission related, on the
2 ground, boots on the ground type of issues.
3 But I have otherwise, I believe, nothing to
4 disclose.

5 DR. GRIGONIS: I'm Tony Grigonis.
6 Currently Vice President of Quality
7 Improvement for Select Medical Corporation
8 which is a for-profit, post-acute healthcare
9 organization and I don't have any grants or
10 any other committees that I've been on that
11 would constitute a conflict of interest.

12 Our healthcare organizations owns
13 long-term acute care hospitals and in-patient
14 rehabilitation hospitals, so we have sort of
15 a direct good purpose for having me on this
16 committee. Thank you.

17 DR. ROBERTS: I'm name is Pam
18 Roberts and I work at Cedars-Sinai Medical
19 Center in Los Angeles, California and I am in
20 charge of rehabilitation there. And I have
21 served on the Member Application Partnership
22 for Post-Acute Care and Long-Term Care for

1 NQF. I also was a tapped member for the
2 Readmissions IRF Group and I recently received
3 funding for the Centers for Rehabilitation and
4 Research using large databases to study
5 readmissions and stroke.

6 DR. HEIDENREICH: I'm Paul
7 Heidenreich, a cardiologist and Vice Chair for
8 Quality at Stanford, Department of Medicine.
9 I also work at the Palo Alto VA and I'm chair
10 of the Task Force on Performance Measures for
11 the American College of Cardiology and
12 American Health Association, but none of -- we
13 did not address any of the measures that are
14 going to be presented this week.

15 DR. BROOKS: Hi. My name is Jo
16 Ann Brooks. I'm Assistant Vice President for
17 Indiana University Health for Quality and
18 Safety and we are based in Indianapolis,
19 Indiana. We're a fairly large system.

20 I served on the previous All Cause
21 Readmission Committee with NQF and I have no
22 potential or other conflicts of interest for

1 this meeting.

2 MR. STETTLER: Ron Stettler. I'm
3 Vice President for Healthcare Economics for
4 UnitedHealth Group. And I have nothing to
5 disclose.

6 MS. TRAVIS: I'm Cristie Travis.
7 I'm the CEO of the Memphis Business Group on
8 Health in Memphis, Tennessee and I work with
9 the major public and private employer
10 purchasers in our market. I also served on
11 the other All Cause Readmission Committee for
12 NQF. I serve on the Consensus Standards
13 Approval Committee for NQF as well as the MAP
14 Hospital Work Group. And I have no conflicts
15 to disclose.

16 MS. MINTON-FOLTZ: Good morning.
17 I'm Paula Minton-Foltz, and I'm an Assistant
18 Administrator with the University of
19 Washington Health System. Specifically, I'm
20 at Harbor View which is the Trauma Level 1
21 there. We have eight entities in our system
22 in Seattle, Washington.

1 I was on the 2011 All Cause
2 Readmission also. So I recognize quite a
3 number of you. I also am on the Washington
4 State Hospital Association's HEN specifically
5 for readmissions, but it's implementation and
6 also the Governor's BREE Committee which is
7 also representing in payers' interest in
8 implementing some of these measures. Thank
9 you.

10 DR. JOYNT: Good morning. I'm
11 Karen Joynt. I'm an instructor in Medicine at
12 Harvard Medical School in Health Policy at the
13 Harvard School of Public Health. I'm also a
14 practicing cardiologist in the VA. This is my
15 first time at NQF and I don't have any
16 disclosures. Thanks.

17 DR. FISHBANE: Good morning, Steve
18 Fishbane. I'm a nephrologist, Vice President
19 and Director of Research for the North Shore-
20 LIJ Health System. We have two current grants
21 to study readmissions. One of them is to look
22 for methodology for avoidable readmission

1 testing for dialysis patients. The other is
2 just related to risk factors for readmissions.
3 I haven't worked previously with NQF.

4 DR. FIELDS: My name is Wes
5 Fields. This is my second go round. I was
6 part of the Regionalization of Emergency
7 Services. It turned out to be a real
8 interesting activity. My academic appointment
9 is with the Clinical Faculty of the University
10 of Irvine Emergency Medicine. I kind of split
11 my time between Northern and Southern
12 California. My main sort of industry handle
13 is past chair and long-serving member of the
14 largest partnership in acute care, so my
15 group, my partners in hospital medicine have
16 a lot of exposure to the readmission problem
17 at about a hundred locations or so, primarily
18 on the West Coast, but in other regions as
19 well and I very much appreciate the chance to
20 be with you.

21 MS. CENTENO: Good Morning, my
22 name is Mae Centeno and I'm a Corporate

1 Director for the Baylor Healthcare System. I
2 co-chair the Readmission Reduction Task Force
3 for across 11 facilities and I'm involved in
4 a grant right now that's about to complete
5 looking at risk stratification and
6 implementation of interventions for patients
7 with heart failure and pneumonia. Thank you.

8 DR. SMITH: Hi, everybody. I'm
9 Tom Smith. I'm a psychiatrist at Columbia
10 University and the New York State Psychiatric
11 Institute in New York. I'm a clinical
12 researcher and mental health services
13 researcher. We do a lot of work with the New
14 York State Office of Mental Health. Our main
15 project right now is developing the
16 performance metrics for the behavioral health,
17 public health Medicaid-managed care program
18 that's being implemented in New York State.
19 I have no other outside funding relevant to
20 this work.

21 This is my first Measures
22 Committee with NQF. I am on the American

1 Psychiatric Association Quality Council which
2 is how I was referred here, although I do also
3 sit on the NQF Readmissions Action Team at
4 present.

5 MS. SHIPPY: Good morning, Alison
6 Shippy with the National Partnership for Women
7 and Families. It's an advocacy organization
8 here in Washington, D.C. I don't have any
9 disclosures to note. I do sit on the MAP
10 Coordinating Committee though.

11 MS. HALL: Leslie Kelly Hall from
12 Healthwise and I am a consumer advocate and
13 spend time mostly in the meaningful use space
14 and in Health Information Technology Standards
15 Committee. I have nothing to disclose.

16 DR. GLANCE: Good morning. My
17 name is Larry Glance. I am a cardiac
18 anesthesiologist and a health outcomes
19 researcher. My appointments are at the
20 University of Rochester. I'm Professor and
21 Vice Chair for Research. I also am Professor
22 at Public Health Sciences and have a secondary

1 appointment as a senior scientist at RAND
2 Health.

3 I have previously served at NQF.
4 I was also a member of the prior Readmission
5 Steering Committee. And I don't have any
6 conflicts of interest, although I do serve on
7 the American Society of Anesthesiologists
8 Committee for Performance and Outcomes
9 Measures. Thank you.

10 DR. CHEN: Good morning. I'm
11 Helen Chen. I'm the Chief Medical Officer of
12 Hebrew Senior Life which is an integrated
13 senior healthcare organization located in
14 Boston, Massachusetts. We're the largest
15 provider of post-acute care in New England and
16 we serve about 2,000 lives across the
17 continuum of care from outpatient through
18 inpatient rehabilitation through long-term
19 acute care hospitals.

20 In my previous academic career, I
21 was actually a Professor at UCSF. Recently
22 joined Hebrew Senior Life and otherwise have

1 no other disclosures.

2 MS. HAMMERSMITH: Thank you. I
3 understand there's a committee member on the
4 phone, Paulette Niewczyk. Is Paulette
5 Niewczyk on the phone?

6 DR. BULGER: John Bulger. I'm the
7 Chief Quality Officer for the Geisinger Health
8 System. I don't believe I have any conflicts
9 at the moment.

10 MS. HAMMERSMITH: Thank you for
11 those disclosures. I just want to remind you
12 of a few things before I leave, one of which
13 is that we rely on all of you to have a
14 successful conflict of interest disclosure
15 process. So if you are sitting here and you
16 think you may have a conflict, you think one
17 of your fellow committee members has a
18 conflict, you think someone is behaving in a
19 biased fashion, please do speak up. We don't
20 want you sitting in silence if you think
21 something is up.

22 If you do want to raise something

1 like this, you can bring it up openly in a
2 meeting at any time. You can go to your co-
3 chairs who will go to NQF staff or you can go
4 directly to NQF staff. So based upon the
5 disclosures that have been made this morning,
6 do you have any questions of each other,
7 anything that you want to discuss or raise?

8 CO-CHAIR HALL: I note that two
9 members are unaccounted for. Has NQF
10 accounted for them? Have they said they would
11 not be present? Frank will be here, okay.
12 And Carol, okay.

13 MS. HAMMERSMITH: Okay, anybody
14 else? Thank you.

15 MR. AMIN: Thank you very much,
16 Anne. I just also would like to introduce
17 Helen Burstin, our Senior Vice President in
18 our Performance Measures Group.

19 DR. BURSTIN: Good morning,
20 everybody. I just want to add my welcome and
21 say thank you, especially for those of you
22 willing to come back. Last time was a pretty

1 intense committee. I suspect this will be as
2 well. This is obviously very high profile,
3 but really, really important and I just want
4 to thank you.

5 I also just want to mention that
6 it's a thrill to have so many of you back
7 including Sherrie as co-chair. We actually
8 had a co-chair with Sherrie, Eliot Lazar, who
9 some of you may know who is the Chief Medical
10 Officer at Columbia who passed away. So I
11 wanted to at least recognize his great service
12 to both New York and to NQF and he's
13 definitely missed. We are in excellent hands
14 between Sherrie and Bruce and thanks for your
15 support in advance for what will probably be
16 an interesting process. Thanks.

17 MS. KHAN: Okay, so I guess it's
18 back to me. So I wanted to talk a little bit
19 about the role of the standing committee.
20 You'll be chosen to either serve a two- or
21 three-year term. During that two- or three-
22 year term, you'll be working with NQF staff to

1 achieve the goals of the project which is to
2 review all the measures, evaluate each measure
3 against each criteria, indicate the extent to
4 which each criteria is met and the rationale
5 for the rating.

6 You'll also be making
7 recommendations to the NQF membership for
8 endorsement and you'll be responding to
9 comments submitted during the review period.
10 You'll also be responding to any directions
11 from the CSAC which is our Consensus Standards
12 Approval Committee and you'll also be
13 overseeing the portfolio of should be
14 readmission measures.

15 MR. AMIN: Adeela, before you move
16 on on that, I just wanted to note for the
17 committee that this is a change to the NQF
18 process. For those that are new to NQF, and
19 those that are returning, we are instituting
20 standing committees so you'll be asked to be
21 sort of supporting NQF in this area of
22 readmissions for the next two to three years

1 and that will include to the extent that
2 you're willing, obviously, that will include
3 measure review, but also will include elements
4 of follow-up activities, for instance,
5 reviewing dry run results or reviewing updates
6 to NQF guidance.

7 And so part of what we'll do today
8 is review the portfolio because this will be
9 an area that we would expect some level of
10 input from the committee and then also
11 relevant guidance related to technical issues
12 related to measures. So we've also invited
13 Karen Pace, our lead methodologist to walk
14 through some relevant information that won't
15 necessarily be relevant to the measures in
16 front of you, but will be relevant in future
17 efforts related to readmissions and
18 admissions.

19 MS. SHIPPY: So just to clarify
20 for the committee, over that two to three year
21 course, conflicts can change. People get
22 grants, things happen, interests are kind of

1 pursued, blah, blah, blah, blah, blah. So can
2 you clarify for us what happens in how to deal
3 with those conflicts as they occur?

4 DR. BURSTIN: So we recognize that
5 and that's fine and that's -- we have actually
6 as part of this process of moving to standing
7 committees, also have a policy of recusal. So
8 you no longer -- we used to have people if you
9 had a conflict you couldn't even be on the
10 committee at all. And now what we do is you
11 can be on the committee, you just have to
12 recuse yourself and not participate in any
13 discussions or vote on any measures for which
14 you have had a role. So it's actually -- it
15 should work out fine. I mean if it works out
16 that you are, in fact, on the overwhelming
17 majority of the measures and you would be
18 silent, we would probably ask you to just sit
19 that one out, but pretty unlikely, I think,
20 particularly in this space. Thanks.

21 MR. AMIN: So one thing that we
22 neglected to do is during the introductions,

1 but we want to make sure that this is in the
2 record, so we're going to around and ask you
3 to draw a term and if you could just say your
4 name and your term as we walk around the room.
5 We'll try to do this as quickly as we can.

6 Your term, you'll either select a
7 two or three-year term. It will be randomly
8 selected.

9 DR. BURSTIN: And the terms are
10 renewable. So even if you get a two-year
11 term, we'd be delighted to have you for four
12 years.

13 MR. AMIN: So Steve, if you don't
14 mind, just starting with the term that you've
15 selected just so that we have it in the
16 record.

17 DR. FISHBANE: Yes, Steve
18 Fishbane. It's a 30-year term.

19 (Laughter.)

20 It's a three-year term. Three-
21 year term.

22 DR. FIELDS: Wes Fields. Three-

1 year term.

2 MS. CENTENO: Mae Centeno. Three-
3 year term.

4 DR. SMITH: Tom Smith. Two-year
5 term.

6 MS. SHIPPY: Alison Shippy. Two-
7 year term.

8 MS. HALL: Leslie Kelly Hall.
9 Three-year term.

10 DR. GLANCE: Larry Glance. Two-
11 year term.

12 DR. CHEN: Helen Chen. Three-year
13 term.

14 CO-CHAIR HALL: Bruce. Two.

15 DR. BURSTIN: I got a three-year
16 term.

17 DR. BULGER: John Bulger. Three-
18 year term.

19 DR. AUGER: Kathy Auger. Two-year
20 term.

21 DR. EDMUNDSON: Ross Edmundson.
22 Three-year term.

1 DR. GRIGONIS: Tony Grigonis.

2 Two-year term.

3 DR. ROBERTS: Pam Roberts. Three-

4 year term.

5 DR. HEIDENREICH: Paul

6 Heidenreich. Two-year term.

7 DR. BROOKS: Jo Ann Brooks. Two-

8 year term.

9 MR. STETTLER: Ron Stettler. Two-

10 year term.

11 MS. TRAVIS: Cristie Travis.

12 Three-year term.

13 MS. MINTON-FOLTZ: Paula Minton-

14 Foltz. Three-year term.

15 DR. JOYNT: Karen Joynt. Two-year

16 term.

17 CO-CHAIR HALL: Tonight after

18 dinner, there's going to be a tug-of-war

19 between the Twos and the Threes.

20 (Laughter.)

21 CO-CHAIR KAPLAN: Frank Briggs

22 will have a three-year term. Carol Raphael,

1 a two-year term. And Paulette Niewczyk will
2 have a two-year term as well.

3 MS. KHAN: So, going back to our
4 meeting expectations, I just wanted to talk
5 about some of the expectations for today's
6 meeting. NQF is continuing to improve our
7 committee meetings based on input from our
8 multi-stakeholder membership. And we've made
9 a few changes since some of you may have been
10 here to our meeting process.

11 We want to recognize that we have
12 our measure developers present and we'll be
13 asking them to briefly introduce their
14 measures for discussion. Once they've done
15 that, selected work group members will then
16 begin discussion of the measures in relation
17 to the measure evaluation criteria.

18 We've provided the developers two
19 seats up front. If you have other people from
20 your team who would like to join us, you can
21 actually go to the back table back there.
22 We've provided the designated place for the

1 developers at the main table during the
2 introduction and discussion of the measures.
3 Here, they are easily able to respond to
4 questions from the committee and correct any
5 misunderstandings about their measures during
6 our discussion.

7 Developers can put up their cards
8 to indicate when they wish to respond to
9 questions raised or correct any statements
10 about their measures. During the measure
11 evaluation, committee members often offer
12 suggestions for improvement to the measures.
13 It's important to note that these suggestions
14 can be considered by the developer for future
15 improvements. However, the committee is
16 expected to evaluate and make recommendations
17 on the measures for the submitted
18 specifications and testing.

19 This multi-stakeholder group
20 brings various perspectives, values and
21 priorities, so the discussion and respect for
22 differences of opinions and a collegial

1 interaction among the committee members and
2 measure developers is expected.

3 Again, some ground rules for
4 today's meeting. The agenda is quite full.
5 All the committee members, developers, and
6 staff are responsible for ensuring that the
7 work of the committee is completed during the
8 time allotted. During the discussion,
9 committee members are expected to be prepared,
10 having reviewed the measures beforehand.
11 They're expected to base the evaluation and
12 recommendation on the measure evaluation
13 criteria and the guidance. We've actually
14 provided the guidance tables for you. It's
15 that colored document that's on the table.

16 Remain engaged in the discussion
17 without distractions. Attend the meeting at
18 all times except during the breaks. Keep
19 comments concise and focused and avoid
20 dominating the discussion and allow others to
21 contribute and indicate agreement without
22 repeating what's already been said.

1 Does anyone have any questions?

2 This is just a timeline for
3 activities. So we have our in-person meeting
4 today and tomorrow, May 5th and 6th. We'll be
5 drafting our report after the meeting and
6 we'll be posting it for NQF member and public
7 comment, June 6th through July 7th. After
8 that, the world can be in the steering
9 committee again to respond to all of our
10 comments. Once the committee has responded to
11 all of the comments, we'll be posting our
12 draft report to our website and the measures
13 will go out for NQF member vote. They'll be
14 reviewed by the CSAC in August and then we
15 hope for the Board to endorse the measures by
16 September. And we'll have a 30-day appears
17 period as we do with all NQF projects in
18 October. We'll have more specific dates for
19 you as the project moves on.

20 I'm going to turn it over to
21 Taroon now to go over the overview and
22 evaluation process.

1 MR. AMIN: Thank you, Adeela.

2 DR. SMITH: Could I interrupt?

3 MR. AMIN: Yes, please.

4 DR. SMITH: Maybe I'm the only
5 person that cannot get the WiFi access, but if
6 I am, is there any IT Supporters, someone that
7 could look at my computer?

8 MS. KHAN: Sure, we'll get you
9 someone.

10 DR. SMITH: Thank you.

11 MR. AMIN: Yes, thanks. Actually,
12 I was just going to ask, are there any
13 questions from the panel? I know we're trying
14 to move things along. However, also
15 recognizing that a number of new folks joining
16 us, so please, feel free to ask any questions
17 that you may have. We want to make sure that
18 you're able to fully participate in the
19 conversation.

20 So I'll just go through a very,
21 very brief introduction of what we're going to
22 do throughout the course of this process. As

1 you know, we've gone through a call for
2 nominations process that was open to across
3 all stakeholders. We've had a comment period
4 on your nomination to this committee. And
5 we've gone through adjudicating those
6 comments. We've had a call for the consensus
7 standards which are the standards that are in
8 front of you today.

9 Today, we are looking at the
10 standards review which include the review of
11 submitted and maintenance measures.
12 Maintenance are measures that are currently
13 endorsed and we require a three-year review of
14 any endorsed measure for updated evidence or
15 testing, and testing.

16 The committee deliberations during
17 today's discussion and tomorrow's discussion
18 will have a number of public comment periods
19 in which we'll invite members of the public to
20 provide input to not only the measures, but
21 also the committee's deliberations. And we'll
22 go to a formal 30-day comment period where

1 members of NQF and the public will be asked to
2 comment on the committee's decisions and the
3 recommendations of the group.

4 And we will have an adjudication
5 call for those comments. We do expect that
6 this project will generate a significant
7 amount of interest. And so we'll have a
8 significant amount of comments to review.

9 We go through a member voting
10 process which we ask our members to vote on
11 the measures that are in front of you. And
12 then this information will go to our Consensus
13 Standards Approval Committee which is a
14 governing committee which will review the
15 recommendations of the committee and then we
16 go to the Board of Directors which ultimately
17 ratifies the decisions of the committee.

18 Any of the measures in front of us
19 can go through an appeals process if
20 stakeholders feel that there has been a
21 significant change in the field requiring a
22 re-review of these measures. And the NQF

1 staff generally review these appeal requests
2 and also the Consensus Standards Approval
3 Committee.

4 So that's the general process that
5 we'll be going through. That's typically what
6 we call our CDP project. This is what we do
7 for our general measures and this is what
8 we'll be doing over the course of the few
9 months that we'll be working together on this
10 particular effort.

11 What you'll be doing today on the
12 next slide is -- yes, please?

13 CO-CHAIR KAPLAN: So for those who
14 haven't served before on the NQF committees,
15 can you clarify the three year review process
16 and how much wiggle room there is if someone
17 wants to shorten that, for example, or if the
18 committee feels like there should be a shorter
19 length than three year.

20 And the second thing is is how
21 public is public? Can John Q. Public dial in
22 to these meetings, etcetera, etcetera?

1 MR. AMIN: Yes, so I'll start with
2 the second one first. So these meetings are
3 completely open to the public. The dial-in
4 information is available on our website so it
5 really could be any member of the public.
6 Your friends could call in and listen in on
7 the committee deliberations if they're so
8 interested. And we would welcome comments
9 from them.

10 And the three year maintenance
11 cycle is that if there are no changes in the
12 evidence or in the -- I would just say let's
13 just say the evidence, we would have a three-
14 year cycle and that's generally -- we try to
15 have projects that fit within that three-year
16 cycle, although they could span between two
17 and four years at times. But if there is any
18 significant change in the field or evidence
19 with the measures in front of you, any member
20 of the public can request an appeal, ad hoc
21 review, sorry, thank you, Helen. An ad hoc
22 review of any of the measures that are in

1 front of us.

2 Now as a standing committee, if
3 there is, for example, in the last project
4 there was some questions around threats to
5 validity for some of the measures that were in
6 front of you. You asked the developer and
7 they agreed to provide some information back
8 to the committee related to the dry run
9 results of the measure, meaning as the measure
10 was being implemented since it hadn't been
11 implemented prior. If that is an agreement
12 between the committee and the developer, that
13 type of information can be brought back to the
14 committee during their next review.

15 So in some ways, some of you are
16 already acting in the spirit of the standing
17 committee, but typically, it's a three-year
18 cycle.

19 Are there any other questions from
20 members of the committee on this?

21 Okay, thanks. So I'll just finish
22 on this slide. Obviously, you guys have been

1 a very committee through our work group calls.
2 I won't really spend a lot of time on the
3 criteria, but again, just as a reminder, we
4 have conditions for consideration before the
5 measures are able to come to the committee
6 requiring essentially a number of conditions.
7 And then we have four main criteria importance
8 to measure and report: scientific
9 acceptability of measure properties,
10 feasibility, use, and usability. We would
11 expect for these measures since the majority
12 of the measures that are in front of you are
13 outcome measures that the bulk of the
14 discussion will be in the scientific
15 acceptability section of the evaluation.

16 Generally, for our more
17 clinically-oriented process measures, the
18 importance of the measure and report criteria
19 involves a review of the evidence, the
20 quality, quantity, and consistency of the
21 evidence, justifying the measure focus. In
22 the case of the measures that are in front of

1 you, since they are outcome measures, we will
2 generally move pretty quickly through the
3 importance to measure and report portions of
4 the discussion. However, if there are
5 comments that you have, feel free to raise
6 them. But we'll likely move through that
7 section of the evaluation relatively quickly.

8 Scientific acceptability include
9 reliability and validity which is again,
10 generally the area of most heavy discussion.
11 And then finally, I don't believe we have a
12 discussion in this panel related to
13 harmonization. And I think that's all I
14 wanted to point out here.

15 Is there anything else, Andrew, or
16 Adeela that you want to raise?

17 Okay, so in the spirit of the
18 standing committee, we wanted to have a quick
19 discussion -- there's two sections of the
20 discussion that we wanted to add now as we're
21 moving more toward a standing committee. The
22 first is to give you more of a macro

1 understanding of some of the other work that's
2 going on at NQF and that's related to this
3 work, but not corely related to the measures
4 that are in front of you.

5 And we have invited Karen Pace,
6 our lead methodologist, to give you a quick
7 update on our work related to risk adjustment
8 and SES. And then following that, I'll turn
9 it over to Andrew, who will walk through the
10 measures that are in the portfolio that
11 ultimately the committee will be responsible
12 for which include various different types of
13 readmissions and admission measures. So we'll
14 do a quick walk through of the measures that
15 are currently in the portfolio that are within
16 the purview of the standing committee.

17 So Karen, I welcome you to begin.

18 MS. PACE: Good morning, everyone.

19 So probably many of you already aware that
20 we're in the midst of a project where we're
21 looking at the question of whether outcome
22 measures and potentially some process measures

1 could include adjustment for socio-demographic
2 factors. So initially, the project was
3 labeled socio-economic status. Actually
4 that's a key element, but also could
5 potentially be other socio-demographic
6 factors. That project is currently in motion.
7 We just completed our 30 day public comment
8 period. The expert panel will be reviewing
9 those comments actually this Friday and
10 deciding whether there are any adjustments to
11 be made to their recommendations. And then it
12 will go to the Consensus Standards Approval
13 Committee and Board. So we don't anticipate
14 that project really being completed until the
15 end of June, potentially beginning of July,
16 depending on how things go.

17 But I wanted to just mention where
18 we're at, where the expert panel's
19 recommendations fall, and some of the issues
20 that we'll be confronting. But as Taroon
21 said, you know, it's important to keep in
22 perspective that the measures that you'll be

1 looking at today and tomorrow, you really are
2 being asked to judge them against our current
3 criteria. So I know that that's hard to do
4 sometimes, but we do have to kind of move
5 things along in a systematic way so that
6 everybody knows what they're being held to.

7 That being said, the expert
8 panel's recommendations are that outcome
9 measures and potentially some process measures
10 could be adjusted for socio-demographic
11 factors. And I think it's important to
12 realize that there's several conditions upon
13 that. The first is and the recommendations
14 are actually stated, when there is a
15 conceptual and empirical relationship between
16 the factor and the outcome of our process of
17 interest. So the point is that it's not a
18 blanket every measure should be adjusted for
19 socio-demographic factors, that just as for
20 clinical risk factors, one has to follow good,
21 systematic, sound methods. And the first step
22 is is there a conceptual reason that that

1 factor might be related to the outcome of
2 interest? And when you look at those
3 variables reflecting that factor, is there an
4 actual empirical relationship with the outcome
5 or process of interest and then to follow all
6 of the other guidelines for developing a risk
7 model.

8 Another key point is whether the
9 distribution of that factor across providers
10 varies and then you start looking at using
11 these factors in risk models with your other
12 factors and seeing what really works in terms
13 of a risk model. So I just want to clarify
14 because some have interpreted that the
15 recommendation is that every measure should be
16 adjusted for socio-demographic factors and
17 that is not what the recommendation is.

18 The other thing that I think is
19 important to clarify is that the expert panel
20 did not abandon stratification for
21 identification of disparities. Their
22 recommendation is really two part, basically

1 to look at if you're having one computed score
2 of a performance measure, they're recommending
3 that if it's relevant, all the caveats I just
4 mentioned, then it could include socio-
5 demographic factors. But very much identify
6 that if we want to identify disparities and
7 actually work to improve them, that we will
8 need to be doing risk adjustment -- or I'm
9 sorry, stratification so that we look at the
10 outcomes by the various factors, you know, it
11 could be income, it could be homelessness,
12 whatever the socio-demographic factor that's
13 in play for that particular performance
14 measure.

15 So I think those are the key
16 recommendations. Certainly what follows from
17 those is that the NQF criteria which currently
18 states that statistical risk models should not
19 include socio-demographic factors -- or
20 basically it says should not include factors
21 that are related to disparities. And the
22 guidance is that stratification is preferred.

1 So that kind of prohibition against having
2 socio-demographic factors would be removed
3 from the criteria.

4 The committee also made specific
5 recommendations about measure submission and
6 the information that steering committees such
7 as yourself, would need to have available to
8 really look at the adjustment process, what
9 factors were included, how that decision was
10 made, what those contribute to the model,
11 etcetera.

12 And then there are some -- and
13 that the guidelines that are used for
14 selecting risk factors apply to the socio-
15 demographic factors, so again, the emphasis on
16 sound methods. And then there's some
17 additional recommendations related to
18 improving data collection, some suggestion
19 that NQF look at its stance and potentially
20 start looking at providing implementation
21 guidance for endorsed measures and some other
22 clarifications. But the key things were

1 related to socio-demographic factors. So I'm
2 going to stop.

3 Helen, is there anything you want
4 to add to that?

5 DR. BURSTIN: No, that was a great
6 summary. The only thing I'd add is again
7 considering that it is still in draft form, it
8 is not going to be finalized until July,
9 that's not the principles under which we are
10 operating for this group. We may need to
11 return to these measures, if that moves
12 forward, but at least to just keep in mind
13 that is still draft. We've got 670 comments.
14 So it wasn't a report that sort of people
15 didn't notice. There's a lot of discussion.
16 The committee has a four-hour call on Friday
17 to review those comments and see if there
18 might be some modifications in some of those
19 recommendations to seek common ground.

20 Again, as a consensus-based
21 organization, our goal is not to have reports
22 that move forward with -- where we don't, in

1 fact, try to reach consensus. We will try our
2 best over the next couple of months to reach
3 that, but we are still operating under our
4 current guidance for now.

5 MS. SHAHAB: Right, so as Helen
6 said, you know, our process is to attempt to
7 resolve objections. And so we will be
8 addressing the comments that came in that were
9 opposed to some of the recommendations and
10 seeing, as Helen said, if there's any way to
11 resolve those and have the expert panel really
12 examine those and identify whether there are
13 any potential modifications before they move
14 forward with their recommendations to the
15 Consensus Standards Approval Committee.

16 MR. AMIN: So I will turn it over
17 to the chairs, if you have any introductory
18 comments, then welcome some discussion on the
19 topic.

20 CO-CHAIR HALL: Thank you. I'll
21 actually ask two questions of Karen.

22 Karen, as you stated a minute ago,

1 there's more or less a prohibition currently
2 on such adjustments, but we know that one or
3 more of our measures in consideration to today
4 or tomorrow, is adjusted or has a form of
5 adjustment. So are we to consider that
6 actually still prohibited?

7 MS. SHAHAB: Good question. So we
8 actually, NQF actually has endorsed some
9 measures that have socio-demographic factors
10 in the adjustment model and those have to be
11 well justified. You know, I think we'll have
12 to look at them on an individual basis and
13 really try to sort that out. But it has been
14 -- as the criteria state that it should not
15 include factors related to disparities and the
16 preference is to stratify, but as you all are
17 well aware, different situations may call for
18 different considerations and that happens on
19 a measure by measure basis, but we try to
20 stick to the criteria as closely as possible.
21 And we'll certainly be interested in your
22 questions about that and discussion with the

1 developers so that we can try to resolve that.

2 CO-CHAIR HALL: Okay, thank you.

3 My second question is let's pretend that the
4 new recommendations would be finalized in
5 July. Will the NQF make a statement that this
6 group of measures should be examined or will
7 it invite developers to submit any comments or
8 should this group be thinking about some sort
9 of statement in the process of our work today
10 and tomorrow saying if such recommendations
11 were to be finalized, we would recommend that
12 one or more measures be reexamined?

13 MS. SHAHAB: Yes, I think that
14 would be certainly within your purview and
15 would be of interest to NQF. Some of the
16 comments that came in that is probably more
17 for NQF than the expert panel is what -- if
18 these recommendations are upheld and approved
19 by NQF, what would be the process of looking
20 at previously endorsed measures. So that is
21 something that NQF with the CSAC will need to
22 grapple with, but I think, you know,

1 statements from this committee, if they think
2 that's a primary issue that we would certainly
3 welcome those.

4 DR. BURSTIN: And to that,
5 obviously, the way they're -- assuming they
6 stay the way they are, it does require a
7 conceptual and empiric relationship so some of
8 it is you'll be looking at it today without
9 the information, in fact, on whether there is
10 at least an empirical relationship. You would
11 probably infer something about the conceptual
12 relationship. So it would really just be that
13 these might be measures that you would want to
14 think about asking for those additional
15 analyses, but you certainly look at it and say
16 yes, it should be or shouldn't be because you
17 don't, in fact, have that data.

18 CO-CHAIR HALL: And I would add to
19 that in reading the recommendations, as
20 they've existed so far, that they're actually
21 pretty burdensome. So they actually grate on
22 the developers quite a bit of demand for their

1 work and I think it would be unfair to expect
2 the developers to have reacted to something
3 that is not finalized yet.

4 CO-CHAIR KAPLAN: Let me just
5 reiterate what I heard so we're all clear.
6 This is going to come up. It's come up in the
7 all cause for admissions discussion as well.
8 So one is that we will evaluate the measures
9 under consideration as presented by the
10 measures developer currently. So what you see
11 is what you get. And the guidance yet coming
12 from the Socio-economic Status Committee isn't
13 there yet. It's on the horizon.

14 So we are not to consider socio-
15 demographic adjustment for any of the measures
16 unless specified in the document by the
17 measures developer, one. And two, the
18 stratification by hospital type, I just want
19 to -- whatever the unit of comparison is is
20 okay to consider for the purposes of
21 enveloping in that stratification of hospital
22 type, comparisons that are fair, but not based

1 on socio-demographics, based on other
2 considerations like hospital size or whatever
3 the stratification. But it still has to be as
4 presented by the measures developers. Is that
5 so?

6 MS. PACE: Right, so when you're
7 talking about stratification of the hospitals,
8 let me make sure I'm understanding. I think
9 the committee last year recommended for
10 implementation that like hospitals be
11 compared. And last year MEDPAC came out with
12 a recommendation specifically about I think it
13 was all cause admissions and looking at --
14 comparing hospitals within deciles of income
15 that they're serving.

16 So that type of implementation
17 guidance, the steering committee can make some
18 statements, but as you're well aware and that
19 is one of the recommendations from the panel
20 for NQF to consider what is the role of NQF in
21 making implementation guidance.

22 So certainly the committee can

1 talk about that. It doesn't necessarily --
2 it's not part of the measure specifications
3 that are being endorsed and so that it's not
4 something that is hard and fast in terms of
5 part of the endorsement, but the committee can
6 certainly make those kinds of statements.

7 Taroon, did you want to add
8 something?

9 MR. AMIN: No. I think the
10 committee has done that in the past and
11 specifically in terms of evaluating the dry
12 run results along certain criteria in the
13 past. So if that type of future analysis is
14 needed and agreed upon by the developer, that
15 might be --

16 MS. PACE: But I think getting
17 more at your -- maybe the real specifics of
18 your question is since we currently say that
19 generally we don't expect those to be in the
20 risk model, is it fair game then to say to do
21 something about that post-measure score
22 development? It's a gray area. So I think it

1 really relates more to what Helen was saying.

2 Since you're not going to have the
3 empirical information, you can make some
4 statements about what you think the conceptual
5 relationship is and what would follow from
6 that, but it would be hard to make more
7 specific recommendations, not knowing exactly
8 how that will play out. But ask again. It's
9 a gray area. It's hard to give black and
10 white answers.

11 MR. AMIN: Alison?

12 MS. SHIPPY: Thanks. I have a
13 question from a historical perspective. So
14 you did acknowledge that there are some
15 measures that have been endorsed when those
16 variables have been included in the risk
17 adjustment model. How does that kind of play
18 into the CSAC? I mean they're kind of
19 considered the stewards of the evaluation
20 criteria. Is that kind of flagged as a
21 deviation from the evaluation criteria? I'm
22 just curious from that perspective?

1 MS. PACE: It's been pretty
2 infrequent and the ones that come to mind,
3 that was flagged for the committee, they asked
4 for specific analyses for justification and so
5 that kind of information would then also go to
6 the CSAC.

7 CO-CHAIR HALL: Kathy?

8 DR. AUGER: Thank you. Could you
9 just give some guidance about how broad of a
10 net socio-demographics really encompasses?
11 There are certainly things like race and
12 income, but what about things like payer
13 status? Because dual eligibles or Medicaid
14 patients are indicative of socio-economics as
15 well?

16 MS. PACE: Right, so it's pretty
17 broad. So for example, of course, the kind of
18 three major aspects of socio-economic status
19 are income, education, and employment or
20 occupation. And there's a recognition that we
21 don't really collect on a standard way income
22 and it's probably not individual income. It's

1 household income and so we do tend to use at
2 least in the current environment and the data
3 available, use things like Medicaid status,
4 dual eligibility, insurance coverage status.
5 There's also been some work done with address
6 and geocoding to census track or census
7 information which actually has gotten pretty
8 good traction and results. But I think the --
9 so all of that is fair game, but in terms of
10 the expert panel's recommendations, there's
11 also the reality check that what data are
12 currently available. And that's why one of
13 the recommendations is that NQF, along with
14 other stakeholders such as IOM, who has been
15 doing work in this area, ARC, CMS, really need
16 to come up with some standard core data,
17 definitions, and collection process and so
18 what is even possible is going to change over
19 time. So right now should these
20 recommendations move forward, the first step
21 might be using insurance status. The next
22 step might be more broad implementation of

1 address and geocoding and probably the longer
2 term is really having good standard data
3 collection.

4 So the expert panel recognizes
5 this is going to be evolving and like many
6 areas of measurement, it's not going to be
7 perfect, especially starting, but they also
8 kind of saw it as a chicken and egg thing.
9 That actually, this could have an impetus for
10 better data collection for us really
11 identifying disparities and doing something
12 with this data as well. So it's going to
13 evolve over time.

14 CO-CHAIR HALL: Wes.

15 DR. FIELDS: Yes, I just want to
16 point out a couple of obvious things. First
17 of all, I really appreciate the interim
18 report, very useful for an emergency
19 physician. But just a couple of specific
20 examples. You now have a country where
21 Medicaid eligibility varies dramatically
22 across blue and red states, something like 26

1 states have yet to pick up the extension of
2 Medicaid that was part of the Affordable Care
3 Act. That's essentially a political activity
4 and so using insurance status as a metric is
5 problematic. It suggests that you need
6 another way to stratify that may actually be
7 based on income, since the income variation is
8 so radical between states these days.

9 The same thing to a lesser extent
10 is probably true about people with private
11 insurance purchased through exchanges. Young
12 adults who opt not to purchase it because they
13 can come to my emergency department, that's
14 another way of suggesting or thinking that
15 insurance status may not be truly useful as a
16 way to differentiate strata, patient, and
17 problems.

18 MS. PACE: All good points and
19 things that the expert panel discussed
20 especially about the Medicaid status and the
21 insurance status as you mentioned. So you
22 know, it's definitely something that's going

1 to have to evolve over time. We can't use
2 data that don't exist and we have to continue
3 to move forward and try to get better data,
4 but definitely good points need to be
5 considered.

6 CO-CHAIR KAPLAN: Yes, I just want
7 to underscore that the committee is still
8 working on the report and that we will go over
9 some like disproportionate share hospital
10 status and other kinds of variables that have
11 attempted to address this issue in the dry run
12 results tomorrow. So we're going to get a
13 little bit of a chance to see how these
14 various use of different indicators -- we can
15 argue more or less satisfactory indicators of
16 socio-economic status -- have played out
17 empirically in the all-cause readmissions data
18 dry run for tomorrow.

19 So keeping us on track, where are
20 we now?

21 MS. KHAN: I just want to note
22 that we have all of our committee members, so

1 I would like Frank and Carol to introduce
2 themselves and we also have Paulette on the
3 phone. So if you could do an introduction and
4 just do a quick disclosure if you have
5 anything to disclose to the committee.

6 So why don't we start with Carol.

7 MS. RAPHAEL: I'm Carol Raphael
8 and I'm actually the chair of the MAP Post-
9 Acute Care, Long-Term Care, Hospice and
10 Palliative Care Work Group at the National
11 Quality Forum. And was for more than 20 years
12 the CEO of the Visiting Nurse Service of New
13 York and after that a Fellow at Harvard
14 University. And I'm currently a Senior
15 Advisor at Manatt Health Solutions and the
16 Chair Elect of the Board of AARP and was
17 appointed by President Obama to the Bipartisan
18 Commission on Long Term Care and on a number
19 of other boards.

20 So in terms of I guess what I
21 should disclose, I'm the Chair of the Board of
22 Long Term Quality Alliance which is an

1 alliance that tries to promote and raise the
2 bar on quality in the field of long term
3 services and supports. And at Manatt Health
4 Solutions, I'm working with a number of
5 systems on how they can better integrate post-
6 acute care into their service delivery.

7 And the other thing I should just
8 mention is that I'm the Chair of the Health
9 Information Technology Board in New York State
10 and we are working as well to try to integrate
11 care across the state and set up an
12 information highway. And I'm on the National
13 Quality Forum, the group that is looking at
14 measures and bringing technology to bear.

15 MS. KHAN: Thank you. Frank.

16 DR. BRIGGS: Good morning. Frank
17 Briggs from West Virginia University
18 Healthcare. I'm Vice President of Quality and
19 Patient Safety at the hospital for 12 years
20 now.

21 MS. KHAN: Nothing to disclose,
22 I'm assuming?

1 DR. BRIGGS: Right, nothing to
2 disclose.

3 MS. KHAN: Thank you. Paulette,
4 are you on the phone?

5 DR. NIEWCZYK: Yes, hi. I'm
6 Paulette Niewczyk. And I'm with Uniformed
7 Data Systems for Medical Rehabilitation in
8 Buffalo, New York. I'm also with the
9 University of Buffalo. And I'm their Director
10 of Research and responsible for establishing
11 and developing the psychometric properties and
12 some of the same derivatives as well as
13 managing the inpatient rehab data associated
14 with the (inaudible) as well as some of the
15 outpatients as well as skilled nursing and
16 other large data repositories that use our
17 tools.

18 In addition, I am a Professor at
19 Daeman College which is one of the local
20 private colleges in the Buffalo, New York
21 area. And my background is in public health
22 and epidemiology and I also have a doctorate

1 in sociology where my research is focused
2 heavily on access to healthcare.

3 My only disclosure is I'm employed
4 at UDSMR.

5 CO-CHAIR HALL: Thank you,
6 Paulette. So why don't we have --

7 CO-CHAIR KAPLAN: I have one more
8 thing.

9 CO-CHAIR HALL: Yes.

10 CO-CHAIR KAPLAN: First of all,
11 thank you, Karen. That was a nice summary of
12 -- on behalf of the committee of where we are
13 and where we aren't with respect to SES
14 guidance. But for the group, if we have
15 specific queries that the committee feels
16 strongly should be sent to the SES Guidance
17 Committee, it's okay for us, I understand to
18 sort of summarize our issues and forward them
19 on to that group so that we don't leave
20 ourselves terribly, terribly frustrated with
21 respect to where we are right now with respect
22 to the SES issues, is that correct?

1 MS. PACE: Yes, that would be
2 great and you know, you're going to be in the
3 midst of it over the next two days, so I think
4 it would be very relevant and helpful for us.

5 CO-CHAIR HALL: And I was just
6 going to ask if any other committee members
7 have any questions for Karen? Not seeing any.

8 MR. LYZENGA: Great, thanks.

9 I'm now going to quickly run
10 through the admissions and readmissions
11 portfolio. As Adeela and Taroon mentioned, we
12 have transitioned to a standing committee
13 system. This is as opposed to seating a new
14 committee every time we started up a project.
15 This was done for a number of reasons, among
16 those increasing the consistency of decision
17 making across time, achieving some
18 efficiencies at the process level in terms of
19 project startup, but also so that the standing
20 committees can gain a familiarity with the
21 topic area and the measures in the portfolio
22 and start to kind of steward that portfolio

1 over time and provide input into the
2 sufficiency of the portfolio in terms of
3 addressing the topic area.

4 So what we'd like you to do is to
5 just sort of keep that in mind as you're
6 reviewing the measures today and tomorrow,
7 provide input on the measures that are under
8 review, that are included in the portfolio,
9 consider issues of standardization and
10 parsimony when considering measures in the
11 portfolio as a whole. Identify measurement
12 gaps. Raise awareness of other measurement
13 activities for the committee and other
14 stakeholders. Be open to external input and
15 provide some feedback to us on how the
16 portfolio should evolve over time and for
17 developers as well.

18 Right now we have about 27
19 endorsed measures that are related to
20 admissions, readmissions, or length of stay.
21 In terms of this committee's purview, for the
22 purposes of maintenance, we've classified ten

1 measures, currently endorsed measures, as
2 being in this group's purview. Three of those
3 measures, three of those ten are up for
4 maintenance under this project and we've
5 gotten 15 new measures for review and
6 endorsement so that will sort of bump the --
7 if we do pass those measures, that will bump
8 the number of measures in the portfolio up
9 significantly.

10 Just to give you sort of a visual
11 depiction of the framework we're using here,
12 admissions are sort of -- can be considered in
13 that sphere on the left side. From the
14 community or non-hospital setting, post-acute
15 care, decline in health status, so a need for
16 a higher intensity of care leads to a
17 hospitalization. That's one sort of area of
18 measurement, that movement from a lower
19 intensity care to higher intensity care. Then
20 we have measures down there at the bottom
21 measuring length of stay in the hospital. And
22 then once discharge occurs, patients go back

1 to the community or post-acute care and you
2 have that readmission on the right side there.
3 That's what we're measuring with readmissions
4 measures, the decline in health status that
5 requires a higher intensity of care, return to
6 acute care of the inpatient setting.

7 I'll run through these pretty
8 quickly just in the interest of time. I know
9 we've got a lot to get through today, but I
10 just wanted to give you sort of a quick sense
11 of the nature and scope of the measures
12 currently in the portfolio. The ones in
13 orange are measures that are up for review in
14 this project, so today and tomorrow. Is that
15 right, Adeela? Okay.

16 So just -- we've broken these down
17 into a few broad categories, one being what
18 are sometimes called all-cause. I prefer to
19 call them all-condition measures. I think all
20 the measures that were being considered today
21 are all-cause, actually, but that sort of
22 becomes the lingo for it. But these are sort

1 of agnostic in terms of the condition or
2 procedure that a patient has undergone and
3 just measure admission. These are sort of
4 addressing issues at a public health level.
5 We'll skip out to the next.

6 Here's a few of the measures in
7 the portfolio. I think many of these have
8 actually been assigned to the Health and Well-
9 Being Committee, not as opposed to this one.

10 Length of stay, sort of the second
11 broad category. A few measures here, one of
12 which we're considering today. Readmissions.
13 Again, we have a few broad categories, all
14 condition measures. Condition or procedure
15 specific. Some of the groups of those are
16 cardiovascular pulmonary conditions, surgical
17 conditions or procedures.

18 Then we have a number that are
19 setting specific, that are looking at
20 readmissions from a particular setting back to
21 the hospital and those settings include
22 skilled nursing facilities, home health, long-

1 term care hospitals, inpatient rehab
2 facilities, dialysis facilities, ASCs,
3 etcetera.

4 So I would open it up at this
5 point to any initial thoughts on the portfolio
6 or questions or comments that you'd like to
7 raise as we move forward into evaluation
8 today.

9 DR. BURSTIN: I was just going to
10 say, Andrew, just one perspective. I'd be
11 curious if Cristie or others from the MAP, but
12 there was also a lot of discussion at the
13 Measures Application Partnership when they
14 discussed the readmission measures in the past
15 that there was a desire to, in fact, get
16 readmission measures across the broad spectrum
17 of settings, so it's actually very positive to
18 see that movement towards looking at
19 readmissions, not just from a purely to a
20 hospital setting, back and forth between
21 hospital to home, the other settings included
22 as well.

1 MR. LYZENGA: Any other questions
2 or comments? Leslie.

3 MS. HALL: Helen, you had
4 mentioned harmonization earlier. Is that
5 something we need to consider in our
6 deliberation today?

7 DR. BURSTIN: Probably not today.
8 We'll see how -- what we usually do is go
9 through the measures on their own, the right
10 first. If they both make it through well then
11 the staff will walk you through an exercise to
12 look at issues of harmonization. We usually
13 don't do that because sometimes one of them
14 doesn't make it through, so why invest energy
15 to do that in advance. And we'll also have an
16 opportunity to do that after this meeting and
17 I'm sure others will help you through that.

18 MR. LYZENGA: Paul?

19 DR. HEIDENREICH: Yes. I noticed
20 that some of the admission measures are dealt
21 by other committees, and going forward though
22 will this committee address those?

1 MR. LYZENGA: My understanding is
2 that they actually will remain split across
3 some other committees. This is an issue in a
4 number of other topic areas as well. I work
5 on patient safety and that's kind of an issue,
6 a cross-cutting issue and there are a number
7 of measures that are in other committees
8 including surgery, long-term care, other
9 things. It's sort of an artifact of our
10 process of categorizing measures and we would
11 certainly welcome input from you as well if
12 you think that some of these measures would be
13 more appropriately considered by this
14 committee. We can certainly consider that.

15 DR. BURSTIN: And just to add,
16 these ARC measures that you see listed here,
17 they're prevention quality indicators are
18 community level measures at the community MSA
19 level and they have traditionally been looked
20 at as part of our more population health
21 focus. But again, I think you're looking at
22 some today that are sort of on that border as

1 well, so we'll try to reconcile those going
2 forward. Logically, they would probably go
3 together in the future.

4 MR. LYZENGA: Paula?

5 MS. MINTON-FOLTZ: Thank you. I
6 was curious about the length of stay measure
7 that was put in here. Is that counter
8 measure? I understand your Venn diagram and
9 that there's a relationship, but you know, it
10 kind of just feels like an odd duck in this
11 admission or readmission. So I was wondering
12 about that inclusion?

13 MR. LYZENGA: I don't know if
14 Helen, you want to speak to why this was
15 assigned to this --

16 MR. AMIN: Yes, I'd like to say
17 that there is -- that the way that every
18 measure has been assigned to a project is
19 conceptually appropriate. I would say that
20 we've gone through a process with the new
21 standing committee process of really just
22 trying to figure out who best and how best to

1 assign some of these measures. And I think
2 the length of stay measure in this group is
3 sort of a reflection of that. It's not -- we
4 have to make some artificial decisions when
5 some areas are between two projects and some
6 don't necessarily have a clear home. And so
7 I think that might be potentially part of the
8 reason. So we've adopted them.

9 CO-CHAIR KAPLAN: Helen, with
10 respect to the title of this committee as a
11 standing committee, because it includes
12 admissions and if some of these are
13 preventable admissions and that's a community-
14 based measure, and some of them are hospital
15 -- could we work on the title of this?
16 Otherwise, the volume of measures coming to
17 this committee could get daunting.

18 DR. BURSTIN: Again, we look to
19 the committee to give us some suggestions,
20 what is the right framing of this, I mean to
21 the question as well about length of stay. I
22 think we wanted to have something that

1 collectively embodied this set of measures
2 that are often highly related, but you know,
3 artificial separations don't help either. So
4 --

5 MR. LYZENGA: Okay, so moving on.
6 I think, Adeela, you're just going to give
7 some general notes before we jump into the
8 actual measures that are in front of us?

9 MS. KHAN: Yes. So we have a list
10 of the measures that we will be going over
11 today. I won't read them off to you. They're
12 actually listed out in your agenda, but I
13 guess we can start off with 2502. So I
14 believe our developers, RTI, if you want to
15 bring your team up here.

16 CO-CHAIR HALL: So while they come
17 up to the table any final opening questions or
18 concerns from any committee members while we
19 welcome our first developer up to the table?
20 Looks like we're good to go.

21 MS. KHAN: I do want to add,
22 actually, that we have an outline for everyone

1 to kind of follow further discussion and so if
2 we could sort of stick to that structure.
3 That would be the best way to kind of be able
4 to evaluate each criteria independently and
5 then we'll be voting on each criteria as well.
6 You should have a copy at your table. If you
7 don't, let me know. It looks like -- I
8 actually don't have a copy.

9 CO-CHAIR KAPLAN: It looks like
10 this. Two pages. So you can kind of follow
11 along and make any relevant notes to yourself
12 as we go along.

13 CO-CHAIR HALL: And just to
14 reiterate what Adeela just said, this is a bit
15 of a departure from some previous committees.
16 We'd like to walk through each criteria
17 individually and then take a vote on it and
18 then move to the next criterion and vote on
19 that and so on as opposed to having the full
20 discussion and then voting all at one at the
21 end.

22 With that, we will invite RTI to

1 introduce themselves and introduce their first
2 measure.

3 DR. INGBER: There it is. My name
4 is Mel Ingber with RTI and we're discussing
5 the inpatient rehab facility measure.

6 MS. COOTS: And my name is Laurie
7 Coots, also at RTI.

8 DR. INGBER: You've already heard
9 a lot about the family of measures that are
10 readmission measures. So this is a member, a
11 first cousin to some of the others, but -- and
12 the name of it is long enough to tell you
13 everything about it. It uses up my entire
14 time. all cause, unplanned readmissions
15 measures for 30 days, post discharge from an
16 inpatient rehab facility.

17 It's in the all cause family that
18 was discussed, but with a little extra part
19 about the unplanned part of it. There is an
20 attempt to account for readmissions that are,
21 in fact, are expected for this population.
22 There are often things left in people that

1 have to be removed and things that have to be
2 adjusted and we're trying to remove some of
3 those and that's been done with some of the
4 other readmission measures as well.

5 The focus is on the 30 days post-
6 discharge, so I think fairly clearly we're
7 dealing with the period in which people are
8 transitioning from a relatively high intensity
9 situation, inpatient, to a less intense often
10 not inpatient at all situation. These
11 transitions, coordination of care are clearly
12 what's going on in addition to whether or not
13 they got good or bad care in the hospital, but
14 the focus is what happens afterwards.

15 There's been, of course, the
16 hospital -- the acute hospital version of this
17 which you're going to be reviewing again
18 tomorrow and we're in the post-acute part of
19 the world in this case.

20 We attempted to make it "no-
21 burden-able" and that means we're using the
22 claims-based measure in Medicare. And

1 Medicare counts for vast, vast majority of
2 these patients, so it's not going to be a bad
3 measure of what's going on in these IRFs.
4 There are very few exclusions to this. When
5 we use -- once we go beyond the part of it
6 being Medicare, we do have an exclusion which
7 is for patients who received only nonsurgical
8 care for cancer. And that was carefully
9 researched by the acute group. And we went
10 and used their information to exclude them
11 here, too. They have a very different
12 trajectory of their condition afterwards. So
13 that was excluded. So generally speaking,
14 aside from pediatric patients, pretty few,
15 everybody is there.

16 And the planned readmissions were
17 basically reviewed by our technical expert
18 panel and they're in a state of evolution.
19 There's a pretty good list of them now and as
20 you all are aware with ICD-10 upon us, we're
21 reviewing the next generation of codes for
22 these conditions. So we're not -- we actually

1 were expecting to have to do that, but now
2 it's been pushed off officially by a year.

3 The measure is a risk-adjusted
4 measure and that means we take into account a
5 reasonable set of patient characteristics that
6 we can get out of claims data and eligibility
7 data from the Medicare system. We use
8 diagnoses. We use whether or not they were
9 surgical patients. We use length of stay,
10 ICU. There's a bunch of patient-specific
11 things that we use. And for the IRFS, we
12 actually make use of the fact that they're
13 already case-mixed groups that the IRFs
14 themselves classify patients into and those
15 have proven to be fairly useful as well. So
16 each readmission measure has similarities, but
17 they're all specifically addressing a
18 particular facility when specific forms of
19 information become available. Reviews the
20 prior acute stay as a source of a lot of the
21 medical information and even information from
22 acute stays prior to that.

1 A lot of the post-acute care data
2 when you look at claims are coded with a
3 different mindset than what's in the more
4 acute facilities. So we picked up a lot of
5 other kinds of information than we would have
6 if we just used the IRF claims themselves as
7 a source of information.

8 So we're picking up with the risk
9 adjustment, the morbidity of the patients and
10 trying to level the playing field quite a lot
11 across facilities. The statistical approach
12 is similar to what we've seen in some of the
13 others. Those of you who haven't looked at
14 these before it's not one of these. We look
15 at the observed readmission during the period
16 divided by some expected or some number like
17 that. It uses a model in which you estimate
18 the probability of a patient being admitted or
19 readmitted in a period. And that model
20 contains in it all these patient
21 characteristics, plus indicators for what
22 facility you were in. The patients are

1 clustered in the facilities.

2 Then when you try to account for
3 what's happening, what's the facility's piece
4 in all of this, you take the ratio of what
5 you're predicting for the facility including
6 all those characteristics, including the
7 estimate of what the facility effect is and
8 then you divide that by what it would be in
9 the average facility. So it's a different
10 kind of numerator denominator, but it does
11 make some sort of sense. The facility effect
12 is included in the numerator and then removed
13 in the denominator. That ratio is then
14 multiplied by the average readmission rate
15 across this population of facilities, so that
16 you get a number like 1.1 times 13 percent or
17 .8 times -- that would be a good place, .8
18 times 13 percent, some number like that.

19 The risk adjusters then are set up
20 in one equation. The facility is in there
21 along with the patient characteristics. The
22 one interesting thing about the modeling which

1 we're using is that it's the hierarchical,
2 multi-level model statistically. And there is
3 a tendency for this ratio to be a little
4 compressed, depending on the strength of
5 evidence. And what I mean by strength of
6 evidence is that if you don't have very many
7 patients, it's not going to take your raw
8 number which is likely to have a lot of
9 variability because we have very little data
10 on and it will combine that with the average
11 to produce this, what they call -- well,
12 shrunk meaning -- there's a shrinkage
13 estimator that's involved here. And it isn't
14 terribly unusual. We didn't bring it in from
15 outer space. It's certainly been used before.

16 And the whole thing then is
17 expressed as the standardized readmission
18 rates. We've looked at the rates. Obviously,
19 we look at the actual rates that come out. We
20 look at their distributions. You have
21 probably seen them in our thousand pages of
22 material here. And we have pretty good

1 differences in the high and the low
2 predictions. You can get very high
3 predictions for patients, very low ones. It's
4 pretty good discriminatory power on that
5 basis. And there is not an unreasonable
6 spread across facilities, although not as wide
7 as you get in some other kinds of facilities.
8 But once you get past that middle quarter,
9 inter-quartile range, they do kind of spread
10 out. So you can see ones that are doing a
11 fair amount better than others. And we are
12 looking for that in the measure.

13 So that said, that's the overall
14 picture of what we've got. And we're open for
15 discussion.

16 CO-CHAIR HALL: Thank you. Thank
17 you very much.

18 Sherrie, you were listed as a
19 discussant. Do you want to take over?

20 CO-CHAIR KAPLAN: Yes. I was
21 primary reviewer of this and I have a couple
22 of quick questions. First, with respect to

1 the varying shrinkage estimation modeling
2 problems, your data actually do show evidence
3 that there is a varying shrinkage problem for
4 low-volume hospitals. That is, your low-
5 volume hospitals more closely approximate the
6 national average as opposed to your high
7 volume -- 82 percent of your high-volume
8 hospitals don't fall close to the national
9 average. So that's one and it's come up again
10 and there's a fair amount of controversy as
11 you're aware of how that works out and what
12 the issues are, but can you at least speak to
13 that. I'm going to make a list here for you.
14 So varying-shrinkage estimations is one that
15 I'd like you to at least talk to the committee
16 about, alternatives that you may have tested
17 and not shown us, whatever, that --
18 alternative approaches.

19 Second thing is the C statistic.
20 For those of you who don't know, 50 percent is
21 like chance. So you've got 19 percent over
22 chance. Can you tell the committee how common

1 that -- because you look at that and say whoa,
2 you're only 19 percent better than chance.
3 Tell us a little bit about how those C
4 statistics -- is that normal statistics? Is
5 that normal? It is, because we want you to
6 talk to us about that.

7 The third thing is in
8 distributional scoring somebody always loses,
9 so you can be 95 percent and if the average is
10 95 percent and the standard deviation is 5
11 percent, somebody in that bottom five percent
12 is going to lose. So can you talk to us about
13 the wisdom of distributional scoring?

14 And finally, dual eligible --
15 well, your inter-quartile range is 13.0 to
16 13.9. That's not after risk adjustment. So
17 your risk adjustment did something big to
18 tighten the variance around the mean. And
19 your actual range is 11.1 to 16.1. So that's
20 five percent after adjustment. That means
21 that we don't have a lot of room here to kind
22 of look at who's good and who's bad after risk

1 adjustment. Five percent sounds like a lot,
2 but in fact, it tightened up considerably
3 after your risk adjustment.

4 And, finally, dual eligibility
5 looked like it moved your marker around as
6 well. Dual eligibility looked like it had an
7 impact, and the group is concerned about
8 socio-economic status and even though you
9 elected not to include dual eligibility as a
10 risk adjuster since you did look at it, can
11 you guide the committee a little bit about
12 what you would do if it was your zoo for the
13 next round of comments?

14 MR. LYZENGA: Just a point of
15 process here. I may ask you to hold off on
16 answering a few of those questions for the
17 time being. We'd like to really kind of focus
18 on each criterion as we go through the
19 measure, so we want start off -- I know a few
20 of those issues can probably be covered under
21 scientific acceptability, and a couple of them
22 can probably go under importance as well.

1 But right now, we'd like the
2 committee to consider the question of whether
3 there is a credible rationale linking the
4 outcome being measured to specific processes
5 of care or care interventions. So that's the
6 sort of question for discussion at this
7 particular moment. The evidence behind the
8 measure.

9 CO-CHAIR KAPLAN: Okay, I goofed
10 right away.

11 (Laughter.)

12 Just to own it.

13 CO-CHAIR HALL: That's my bad. I
14 told you to start talking --

15 CO-CHAIR KAPLAN: Yes, don't ever
16 ask -- so yeah, so with respect to the
17 evidence then, the evidence is all based on
18 inpatient readmissions, as opposed to
19 readmissions to the inpatient rehabilitation
20 facility. So you, kind of, cite the same
21 studies over and over and over again. So
22 could you talk to us a little bit about the

1 evidence?

2 DR. INGBER: I can't invent it.
3 The evidence pretty much has been where people
4 look, you know. There's a street lamp, and
5 that's where you look, because that's where
6 the light is. People have not spent a lot of
7 time looking at readmissions after post-acute
8 care. It doesn't mean that post-acute care,
9 inpatient care, you should just take the
10 patients and throw them on the street, of
11 course. There's something to be said for
12 transitioning from a high intensity -- and so
13 it's not an acute hospital, but if you go into
14 an IRF, they're going to do stuff to you.

15 It's a high-intensity program and
16 then you go out and you have to be
17 transitioned somewhere else. And IRFs, in
18 particular, have a very wide range of
19 patients. They have a wide range in the sense
20 that you have stroke patients, TBI patients at
21 the same time you have hip and knee patients
22 that have actually very different

1 characteristics. The question is, when you
2 send them out the door, you expect them to be
3 discharged to a location appropriate for the
4 kind of patient they are.

5 So I don't have any particular
6 evidence to show anything, but I think common
7 sense, kind of, tells us there's going to be
8 some sensitivity to how you transition
9 patients, and certainly in other work that I
10 have done which hasn't been distinctly related
11 to this, in which we're working with long term
12 care patients, and the way their decisions are
13 made of who gets readmitted back to hospitals
14 and all that, there's a lot going on in
15 process once you move the patient out. So no,
16 I don't have any information, just words.

17 CO-CHAIR KAPLAN: So any comments
18 from the rest of the committee?

19 DR. FISHBANE: Yes, I wonder,
20 since this is the first measure for today if
21 we might speak a little bit about threshold of
22 evidence. I'm concerned. I mean this will

1 apply, I think, to a number of measures and I
2 don't want to keep beating the same drum.

3 Maybe we can deal with it now?
4 That, you know, there's a classical article
5 from the New England Journal Of Medicine in
6 2010 by Chassin et al. This was on using
7 measurement to promote quality improvement,
8 and I thought that there was a lot of wisdom
9 there. They speak to things like the need for
10 a strong foundation of research showing that
11 the process addressed by the measure, when
12 performed correctly, leads to improved
13 clinical outcomes. Strong foundation means
14 more than one study, not an expectation that
15 it will come from randomized trials, or that
16 most of them will.

17 And the opinion of the authors,
18 and this was a review piece, was that there
19 should be a high bar, one that exceeds the
20 typical standard used, for example, in
21 clinical practice guideline development, which
22 a lot of us have been involved with. So what

1 exactly is the threshold for the voting on
2 evidence that we'll be doing throughout the
3 day today?

4 MR. AMIN: Do you want me to take
5 that? Okay. In the Importance to Measure and
6 Report section of the evaluation, so this
7 evidence area, what we're really looking for
8 in terms of evidence is: first, there's the
9 primary bifurcation is whether we're looking
10 at outcome measures or process measures. For
11 readmission measures that are in front of you,
12 we consider those outcome measures. And so
13 all we're really looking for is that there is
14 a process or structure that the accountable
15 entity can have to influence the outcome, that
16 there's a rationale. So we're not looking for
17 a full quantity, quality, and consistency
18 review of the body of evidence.

19 We're really looking for, simply,
20 a rationale that the facility that you're
21 holding accountable can have some type of
22 intervention that would influence the outcome.

1 For instance, if you're looking at hospital
2 readmissions that proper discharge planning
3 has demonstrated that that would reduce
4 readmissions. So that's the bar and it's
5 relatively low, I would say, in terms of what
6 we're actually looking for in terms of
7 evidence.

8 For more process measures, we're
9 looking for a systematic review of the
10 evidence which would include an evaluation of
11 the quantity, quality, and consistency of the
12 evidence that exists to justify the
13 relationship between that process and an
14 outcome that's important to patients.

15 So for the purposes of our
16 evaluation here, the evidence review should be
17 actually pretty straight forward, and from the
18 fact that if there's an agreed-upon rationale
19 that's provided by the developer, we should be
20 able to move on from this section of the
21 evaluation.

22 MS. KHAN: You can also, just to

1 interject, use your algorithms that we printed
2 out for you to kind of understand a little bit
3 better what we're talking about when we are
4 looking at outcome measures for evidence.

5 DR. FISHBANE: Can I just ask one
6 follow-up question? So are you saying that
7 there's not a need for evidence, but just a
8 need for rationale?

9 MR. AMIN: Yes. For outcome
10 measures. For outcome measures that are
11 important to patients, we're not looking for
12 a systematic review of the evidence. Karen or
13 Ellen, if you want to add to that?

14 MS. PACE: No, I just want to
15 maybe explain a little bit of the basis for
16 that. NQF really does have a hierarchical
17 preference for outcome performance measures,
18 because those are generally the things that
19 patients are seeking and providers are seeking
20 to do. And we ask that there be a rationale
21 that outcome is related to at least one
22 healthcare structure process, intervention, or

1 service.

2 So the idea is that for outcome
3 performance measures, that there is a
4 relationship to healthcare service and that
5 that is the criteria for NQF endorsement,
6 versus, as Taroon has already pointed out, for
7 the process measures.

8 DR. FISHBANE: I'm sorry, I'm
9 going to follow up again on this. So a
10 rationale, even if there has been no study of
11 that rationale would be sufficient evidence?

12 MS. PACE: Yes. I mean most of
13 the rationale that is going to be that there's
14 -- have been some evidence. It's not going to
15 be necessarily a large body of evidence. But
16 the evidence that readmission, for example,
17 and rationale, that readmissions are
18 influenced by discharge planning practices,
19 connecting people to primary sources of care,
20 discharging them in a clinically stable
21 situation versus not. There are a variety of
22 things that are either evidence based or

1 strongly -- strong rationale that there is
2 some connection and that is what is required
3 for an outcome performance measure.

4 DR. FISHBANE: I'll be quiet after
5 this one.

6 CO-CHAIR HALL: Please don't.

7 DR. FISHBANE: What I'm hearing is
8 then that you do expect studies that
9 demonstrate a relationship. You're not
10 looking for a systematic review necessarily of
11 a large number of studies that have been
12 conducted, but you do want a demonstration of
13 evidence that indicates that there is a
14 linkage between process and improved outcomes.

15 MS. PACE: So we don't require
16 that they submit that. That obviously makes
17 it stronger. But we do require that they
18 present to you the rationale, the things that
19 they think influence that outcome, and
20 obviously if there are references to cite,
21 studies to cite to include those if possible,
22 but it's not required. Helen?

1 DR. BURSTIN: To build on that,
2 and some of the logical of this, when this
3 went to our evidence task force a few years
4 ago, was that, in fact, at times outcomes
5 measures come forward, are put out for public
6 reporting and in fact processes follow that
7 focus. And so the idea that you would always,
8 in fact, know the processes up front to
9 influence the outcome as a requirement to
10 putting forward an outcome that's important
11 for the nation was something that,
12 particularly, our Board felt strongly we
13 shouldn't do.

14 People often cite the example of
15 center line associated blood stream infections,
16 where in fact, the public reporting preceded
17 a lot of the evidence-based processes and in
18 some ways perhaps spurred on the search for
19 some of those evidence-based processes.

20 So the rationale, at least gives
21 the committee an opportunity to talk those
22 issues through, but we don't want to make it

1 such that you can't move forward a really
2 important outcome measure unless you actually
3 know for sure exactly what processes will
4 influence that. We recognize that's
5 uncomfortable, particularly for some providers
6 and clinicians among us, but I think that
7 we've seen enough evidence that, in fact,
8 pushing forward the outcome at times could be
9 a really important impact as well.

10 CO-CHAIR HALL: Paul.

11 DR. HEIDENREICH: I guess I want
12 to also discuss, I think, what is going to be
13 an issue for most of these measures, and that
14 is first stating this as an outcome measure,
15 I think is a little problematic. I say --
16 while I agree with the central line infection,
17 I think all patients are going to avoid that,
18 there are some admissions that are good,
19 probably some readmissions that are good, and
20 I think most patients and I would view this as
21 an intermediate clinical outcome. And to the
22 extent it's associated with mortality or

1 health status, it's a good thing. And so we
2 would want more evidence and say we would want
3 for a true -- which I wouldn't consider this
4 a true outcome measure.

5 Having said that, I agree that we
6 always can't wait for data if there's a
7 compelling indication. In this case,
8 especially when we're looking at 30-day
9 readmissions, I think there now is some data,
10 and I think it's concerning. I know this
11 application discussed the 24-week Naylor
12 Article Readmission rate that was reduced, but
13 there was a meta-analysis or a systematic
14 review of 30-day readmission published by
15 Hansen Annals of Internal Medicine 2011 of 16
16 randomized trials. I think four were
17 significant in reducing all cause readmission,
18 but the problem was there wasn't consistent
19 pattern. There wasn't a reproduction that if
20 one study did, say, home-monitoring, the other
21 studies couldn't show it.

22 And their conclusion was that

1 there was no particular process that now
2 having been tested was consistently associated
3 with improving readmissions. So I think there
4 actually is some evidence. I just think that
5 it's poor, and I think that -- I'm not sure
6 exactly how to weight that, but I think that
7 -- I think that's going to be an issue for all
8 of these.

9 CO-CHAIR HALL: Larry.

10 DR. GLANCE: So just as a comment,
11 an additional comment, I think that beyond
12 looking for a rationale to measure, I think
13 that if you accept that readmission, hospital
14 readmissions, or readmissions to other
15 facilities is a reasonable outcome to measure,
16 and if you can demonstrate, and I think there
17 is evidence demonstrating this in many cases,
18 that there is significant variability across
19 hospitals or across facilities in
20 readmissions, then the fact that you have that
21 variation, after accounting for differences in
22 patient case mix suggests that there's an

1 opportunity for improvement.

2 And I would suggest that that is
3 probably the strongest rationale for going
4 forward with the measure. If you think it
5 captures a dimension of quality, and if
6 there's variation in quality across hospitals,
7 then that presents an opportunity for quality
8 and performance improvement.

9 CO-CHAIR HALL: Leslie.

10 MS. HALL: Actually, follow up to
11 that is Sherrie's initial comment about the
12 five percent differential doesn't leave a lot
13 of opportunity when the processes are vaguely
14 identified or not pinpointed in a way. So
15 therefore is there evidence enough to
16 determine whether or not this promotes
17 effective change?

18 CO-CHAIR KAPLAN: I think the
19 performance gap criteria gets to the latter,
20 establishing how much of the variability is
21 mutable is kind of tucked underneath that
22 performance gap criterion, as opposed to the

1 strength of the evidence. But I think that
2 the concern is that the threshold, the
3 criteria is a body of evidence that would at
4 least suggest a causal link between process
5 and outcome. And for those of us for whom
6 that constitutes a fairly high bar, the
7 evidence is probably not going to be there for
8 -- well, it's going to be stronger for some of
9 these measures in making imprints across
10 hospital readmissions to some part of the --
11 readmission to some part of the hospital is
12 probably less of a gap than -- a conceptual
13 gap than between, for example, home health
14 care and some of the other kinds of measures
15 we may be considering today.

16 So I think that moving the target
17 of inference still within the hospital is not
18 as much of a leap as it is for some of these
19 others, and therefore I was sort of interested
20 in how that worked for people who were
21 developing the measure, what kinds of evidence
22 they're really relying on the readmission to

1 the hospital, versus readmission to one part
2 of the hospital in the evidence basis for
3 their analysis, a little more development
4 about the thinking about the causality link
5 there. But again, that is sort of beyond now.

6 We're taking it a little bit
7 beyond what NQF guidance is giving us. They
8 really want us to look at some plausible link
9 between process and outcome, and even if the
10 evidence, what we would consider causal,
11 statistical evidence may or may not be there.

12 CO-CHAIR HALL: Paula?

13 MS. MINTON-FOLTZ: Just a point of
14 clarification. Is the accountable party the
15 discharging hospital? Because there's quite
16 a rigorous -- or is the accountable party the
17 rehab? Because there's quite a rigorous
18 vetting of facilities to even take these
19 patients from hospitals. Thanks.

20 CO-CHAIR HALL: I don't know --
21 actually clarification with our NQF
22 colleagues: I know we're supposed to be

1 talking about evidence. It's hard in my head.
2 I feel like we're talking about everything,
3 which is hard to avoid. So I don't know how
4 we move forward voting category by category,
5 versus open discussion.

6 MR. AMIN: Yes. I think, again,
7 for the purposes of kind of keeping things
8 structured and making sure that the committee
9 can move along in a pretty structured way, the
10 important thing to keep in mind is that the
11 Importance to Measure criteria is more really
12 not necessarily into the measure
13 specifications, but that the measure outcome,
14 which is looking at inpatient rehab facilities
15 into the hospital is that -- that is a help
16 outcome, and is there credible rationale for
17 the relationship between the structure,
18 process and that outcome. And I think we
19 should just kind of discuss that.

20 If there's any more comments, or
21 go to vote and look at whether there's a
22 performance gap, conceptually, and then vote

1 on that. And then we can get into the science
2 of acceptability, which is where the majority
3 of these comments are really focused.

4 CO-CHAIR HALL: And so Paula, the
5 accountable entity is the inpatient rehab
6 facility, but it almost feels like that's part
7 of the scientific specification. So we'll
8 return to that.

9 I certainly endorse everyone's
10 concerns. There are 23 of us here in the room
11 as experts and another on the phone, and in
12 many ways we are to sit here like a jury using
13 our best judgment and finding some reasonable
14 level of comfort. That's about the only
15 guidance I can pull out of having done this
16 several times before. So we'll try to refocus
17 on the category of evidence, but Carol, I see
18 that you have a question.

19 MS. RAPHAEL: I just wanted to say
20 two things from the point of view of the MAP
21 Coordinating Committee and Work Group that has
22 struggled with this. One is I do believe that

1 there is great variation in performance and
2 there is an opportunity for significant
3 improvement. And it isn't one process that's
4 the key to unlock this door. We have to work
5 in many dimensions. It has to do with
6 communication. It has to do with how
7 medications are managed. It has to do with
8 followup, with primary care and specialty care
9 as well as the discharge process and the
10 degree to which the patient and family are
11 prepared for what comes after.

12
13 And secondly, this may not be
14 methodologically correct, so I plead guilty,
15 but from the work group's point of view, we
16 really need to move toward uniform measures,
17 because in the post-acute care sector there
18 are different assessment instruments. There
19 are different case mix adjustments. There are
20 different payment systems and when we're
21 trying to rationalize why people get placed in
22 certain places and what's the clinically

1 appropriate place for them to be, we have to
2 begin to have some uniform way of measuring
3 these different sites and the performance of
4 the different sites.

5 And when we looked at readmission
6 measures they were all over the place and it
7 really handicapped and inhibited our ability
8 to take a look and compare the different sites
9 of service. So those are my comments before
10 we move ahead here.

11 CO-CHAIR HALL: Thank you, Carol.
12 Points well taken.

13 So before us we are asked to judge
14 whether there's evidence that this
15 intermediate outcome as Paul has highlighted,
16 this outcome, which is also an intermediate
17 outcome, has an adequate conceptual link in
18 our heads to something that the accountable
19 entities can do to improve this. And that
20 will be tightly linked to the second category
21 of vote, which is whether there's also an
22 opportunity to improve that. I think that's

1 where we are. We will get back to the
2 scientific acceptability shortly as well.

3 I know Sherrie has questions. I
4 have some scientific-type questions. I'm sure
5 many of you do as well.

6 MR. AMIN: Yes, let's move to
7 voting. Zehra

8 MS. SHAHAB: So before we start,
9 just a few, I guess, like instructions.
10 Please point the clicker towards me, towards
11 this laptop when we're voting. Does everyone
12 have clickers? I believe I handed it to
13 everyone.

14 Just click on the number for the
15 vote. You don't need to click send. And you
16 will have 60 seconds to vote. You may click
17 the button multiple times, but it will only
18 register once.

19 (Laughter.)

20 CO-CHAIR HALL: Zehra, is it going
21 to register your last click or your first
22 click?

1 MS. SHAHAB: Yes, your last one.

2 CO-CHAIR HALL: And are you going
3 to tell us what numbers mean what?

4 MS. SHAHAB: Yes. I will read out
5 the numbers. I will read out what we are
6 voting for, and if anyone has any questions.

7 CO-CHAIR HALL: And then will you
8 ask Paula for her vote or will she be sending
9 that separately?

10 MS. SHAHAB: Paula is going to be
11 sending to me via the chat and I will enter it
12 for her.

13 CO-CHAIR HALL: Thank you.

14 MS. SHAHAB: So is everyone ready
15 to start? First, we're going to vote on
16 importance to measure and report, 1a,
17 evidence. One is yes and two is no. So I'm
18 going to start the timer and --

19 CO-CHAIR KAPLAN: And that means
20 that the evidence criterion is met in this
21 case for the health outcome that there's a
22 rationale that there's a healthcare structure

1 process, intervention, or service linked to
2 that.

3 MS. SHAHAB: Does everybody have
4 that? One is yes, the criteria is met; and
5 two is no.

6 CO-CHAIR HALL: Paul.

7 DR. HEIDENREICH: It sounds like
8 you're saying we should not -- we should only
9 be going on number one, healthcare rationale
10 and the second line should be removed from the
11 slide. Is that basically what you're saying?
12 That this is a mistake slide?

13 CO-CHAIR KAPLAN: Yes, yes.

14 MS. SHAHAB: So, 60 seconds begins
15 now.

16 (Pause.)

17 CO-CHAIR KAPLAN: When you send, a
18 green light shows up in the upper left corner.

19 MS. SHAHAB: So we're waiting for
20 one more. That is all votes and voting will
21 close now.

22 So 21 people voted yes and 3 no.

1 So we will move on to the next vote.

2 CO-CHAIR KAPLAN: So now we're on
3 to performance gap. And I'm going to just
4 query the measures developer about the after-
5 adjustment issue. So initially, your range
6 was considerably greater. After adjustment
7 your range went to 11.1 to 16.1. And the
8 inter-quartile range is after adjustment 13.0
9 to 13.9. So help us understand, because this
10 gets at the issue of causality and mutability.
11 Now you've got after adjustment, 5 percent
12 difference between the lowest and highest
13 folks.

14 Is that credible, in terms of --
15 in your opinion from the data you've looked
16 at, etcetera? Is that credible with respect
17 to how much variation is mutable? Is there a
18 big performance gap here? Are we looking at,
19 still, noise and if we were only able to risk
20 adjust tighten we would sit everybody right
21 around -- right up against the mean?

22 DR. INGBER: There are judgments

1 to be made here, of course, when you say big
2 and small, that term is relative to what, of
3 course. And I will point out that this
4 particular facility type has a relatively low
5 readmission rate. The nature of their patient
6 mix is very different from the one we're going
7 to see a little bit later, the long-term care
8 hospitals.

9 And so the range you're going to
10 see will be reflective, to some degree, of
11 where that mean is. And the mean at 13
12 percent is a good deal lower than the roughly
13 16 percent for acute care hospitals and 20X
14 percent for the LTCHs.

15 So you have to put it into that
16 context, as to how much it can be moved. Five
17 points, is it big or small? I don't think
18 that if we were to say the difference of five
19 percent of the patients is -- and that's not
20 everybody. But the difference is not
21 negligible and does allow for some people to
22 be doing a lot more in that period,

1 apparently, to lower their rates, assuming
2 that the risk adjustment is working properly,
3 that we could have some of the others move up,
4 if not to the top, at least to the middle two
5 points. And two points, I don't sneeze at
6 when it comes to readmission rates.

7 As a percentage of the 13'ish
8 number we're talking about, it isn't totally
9 insignificant. So I mean I can't convince you
10 of what's good and what's bad. The other
11 issue will come about later, which is,
12 relative to how you use the measure and the
13 distribution in terms of saying oh, you're
14 going to get unrewarded and you're going to
15 get rewarded. There are lots of ways to use
16 the numbers that don't just arbitrarily, and
17 I really dislike the method of just looking at
18 your decile, because deciles can cover 1 point
19 or 10 points or 50 points. So without getting
20 into that right now, the issue of how narrow
21 it is is somewhat related to the fact that you
22 can use the information in different ways.

1 You're not fixated necessarily on one quartile
2 or another quartile.

3 CO-CHAIR KAPLAN: Questions from
4 the group? Thank you for that. Questions
5 from the group? Wes?

6 DR. FIELDS: Just a quick point.
7 I think if you adopt this as is, with a narrow
8 spread, and you endorse the concept that it's
9 really a measure of the facility's overall
10 performance, which I think is what we're
11 getting at, if I was only one or -- if I were
12 one or two quartiles below the hospital, the
13 acute rehab facility and I wound up a quartile
14 or two below my competitor, the rational
15 response would probably be to change the
16 cohort of patients we accepted into our acute
17 rehab facility, which really wouldn't be a
18 process improvement. It would be a way of
19 managing service lines.

20 I think, ultimately, part of my
21 distaste for this one, or my discomfort with
22 it, is that I really would love to know how

1 facilities are doing by service line. I think
2 you've got a better chance of getting at what
3 you want from this in terms of performance and
4 reducing of variation. So I'm speaking with
5 some level of discomfort about having this as
6 an outcome measure for facilities with such a
7 narrow spread, when the easiest way to perform
8 at higher level in the future, if we adopt
9 this as is, would be to actually restrain
10 access to higher risk rehab services, say, for
11 stroke patients.

12 I mean if I want to do well, I
13 probably just kind of rehab hips and knees and
14 make the hospital across town deal with the
15 strokes. And I don't think that's the intent
16 of NQF, or CMS for that matter.

17 CO-CHAIR HALL: I know our
18 developer wants to comment, so please make a
19 note. But Steve, do you want to --

20 DR. FISHBANE: Just a brief
21 comment. When you have a measure, from any
22 source, where from the unadjusted to making

1 adjustments for covariates and there's a lot
2 of movement after that adjustment. I'm very
3 concerned that because we don't measure all
4 variables or the richness of all variables
5 that, with a lot of movement, it indicates
6 that there is a high probability that there's
7 a lot of residual confounding that's probably
8 not being captured. And I'd just be curious
9 in this case about what the developers'
10 comments might be.

11 CO-CHAIR HALL: Before we invite
12 that, and I think your point is correct, and
13 it's an example of a point that addresses not
14 just the performance gap that we're presented
15 with, but then also the scientific spec of the
16 measure. So we'll certainly return to your
17 concern, Steve. I know Taroon wanted to make
18 a clarifying --

19 MR. AMIN: Just a quick
20 clarification, Chris, in terms of the criteria
21 that we're looking at variation in the
22 performance, but we're also looking at whether

1 there's an overall lesson, optimal performance
2 at an absolute level as well. So it's not
3 purely just variation, but I just wanted to
4 add that into the discussion.

5 CO-CHAIR KAPLAN: Could you also
6 comment, or Helen, about the policy with
7 respect to NQF on the use of these measures
8 following approval and endorsement, versus how
9 they're implemented and used etcetera versus
10 the endorsement process itself?

11 DR. BURSTIN: Yes. That is an
12 important issue. And actually, it's very
13 helpful today, because you have several
14 members of the MAP at the table so the
15 Measures Application Partnership, at least
16 currently, is the group that after you guys do
17 the okay on the scientific acceptability of
18 these measures, we'll then make a
19 determination about which programs they're
20 appropriate for, in terms of use. So we try
21 to keep them separate, try to keep you guys
22 really focused on the science. It is often a

1 very difficult task.

2 I will also say that one of these
3 were actually actively doing which, Taroon is
4 helping us lead because we actually are doing
5 an internal lean effort to try to, in fact,
6 better integrate the work between those
7 groups, so that it's very clear when things
8 reach the MAP exactly what the science is and
9 try to make it less about an artificial
10 divide, and even considering something moving
11 forward where we will actually move away from
12 binary yes-no endorsement and look towards
13 some way of differentiating levels of
14 endorsement for intended use. That's still a
15 work in progress.

16 CO-CHAIR HALL: I don't see any
17 other cards up, so I'll ask our developers if
18 they want to make any brief comments about
19 what they've heard on this topic, please,
20 performance gap.

21 DR. INGBER: Yes, on the topic of
22 gaming the system, as it were, by picking only

1 the patients who can play football or
2 whatever, we did attempt to address it by
3 actually including the service lines in the
4 model, so that the stroke patients, or the
5 traumatic brain injury patients, we take into
6 account their probabilities, and to the extent
7 that the hip and knee folks have a much lower
8 probability of readmission, it will self
9 adjust and so it's easy to game as it would
10 appear.

11 Now, let's see, the other issue
12 was, I thought, somewhat related, but I think
13 a lot of it has to do with the risk adjustment
14 approach of things. And the fact that there
15 is randomness left. I don't know about you
16 guys, but I've been modeling health stuff for
17 a long time. There's a lot of randomness.
18 You cannot adjust for it all. We don't have
19 the luxury of having everybody's lab values,
20 DNA, and everything else we can have in the
21 system right now, and so the measure is using
22 what information it does have and some of the

1 uncertainty is, of course, taken care of by
2 the very nature of the modeling which has to
3 do somewhat with the fact that small
4 facilities look like they're near the mean,
5 but even if you didn't make them near the mean
6 by using another statistical approach, which
7 we can talk about, they would come out with
8 such large standard errors that you wouldn't
9 know what they were no matter what. You
10 couldn't say that they were very different one
11 way or the other from the mean.

12 So there are different ways of
13 getting to the conclusion that says, I don't
14 know. There's not enough information here.
15 So we do adjust for what we can and I mean
16 it's my judgment this particular measure fits
17 in the acceptable range from what I've seen of
18 models that work in this dimension.

19 So I think the risk adjustment
20 such as it is, we put in a lot of variables
21 and we went through a lot of clinical review
22 and what not. So all of that is in our pages,

1 but it's working. I will not say it's working
2 perfectly. And I certainly have not had the
3 experience of any modeling yet that did.

4 CO-CHAIR KAPLAN: We're going to
5 come back to this, the scientific
6 acceptability. This was on performance gap.
7 So your position is that there is a
8 performance gap, and even though there is a
9 fairly tighter mean for these kinds of
10 facilities, there remains a performance gap
11 between good and poor and high quality
12 facilities. Okay, so are we ready to vote?
13 Okay, so.

14 MS. SHAHAB: So we will vote on
15 1b, performance gap. Data demonstrated
16 considerable variation or overall less than
17 optimal performance across providers and-or
18 population groups. One is high. Two is
19 moderate. Three is low. Four is
20 insufficient. And the time begins now.

21 (Pause.)

22 We're waiting for one more

1 response. CO-CHAIR KAPLAN: Do it
2 again really fast just to make sure you got
3 your thing in.

4 MS. SHAHAB: So we have all 24
5 votes and I'll close the voting. Three voted
6 high; 13 moderate; 8 low, and zero
7 insufficient.

8 MR. AMIN: Again, I'll just point
9 out for this next section on high priority,
10 this is really a conceptual question of
11 whether or not the measure addresses a high
12 priority area of looking at readmissions from
13 inpatient rehab facility. Again, it's much
14 more of a conceptual question, and I think
15 we've had some of these discussions already,
16 but if there are other conversations I welcome
17 them.

18 CO-CHAIR HALL: So comments on
19 whether this is a high priority. I'm not
20 seeing any comments. Questions? So we'll
21 move to vote.

22 MS. SHAHAB: We're going to begin

1 voting on 1c, high priority. Addresses a
2 specific national health goal priority or data
3 demonstrated a high impact aspect of
4 healthcare. One is high. Two is moderate.
5 Three is low. Four is insufficient. Time
6 begins now.

7 (Pause.)

8 We're waiting for two more
9 responses.

10 (Pause.)

11 Ten seconds.

12 So we didn't get all 24 votes. So
13 we will have to revote.

14 CO-CHAIR HALL: Paulette, don't
15 forget to send in your vote.

16 MS. SHAHAB: I know. We're
17 missing two votes. The results are 6 high, 13
18 moderate, 3 low, zero insufficient.

19 CO-CHAIR HALL: So we'll return
20 now to scientific acceptability and Sherrie,
21 you might want to start by restating your
22 concerns or questions.

1 CO-CHAIR KAPLAN: I think I'm
2 probably going to restate some of what's
3 already been said, but one is the varying
4 shrinkage estimates potentially overestimate
5 the low- volume hospitals and your data sort
6 of show evidence of that, so can you come back
7 to like 40 percent, like twice as many of
8 those have an estimate that was near the
9 national average, as opposed to 82 percent of
10 the high volume hospitals were way away from
11 the average. So can you come back to the
12 varying shrinkage?

13 I know we're not going to resolve
14 this, but if you have some information that
15 would help us understand, as you said, the
16 low-volume hospitals are going to have a huge
17 standard error around their means, so
18 interpreting their differences is going to be
19 problematic, but maybe did you look at them
20 compared to each other?

21 The second thing is is the
22 performance adjustment, you know, it's going

1 to shrink and just what you were talking about
2 earlier how much is in this. I think you had
3 204 variables in your risk adjustment model,
4 so I mean adding the 205th, 6th, and 7th may
5 not be a plausible thing to do, and may not
6 have helped us understand what residual
7 remains after you've adjusted for everything
8 else. Is it true score variation.

9 And finally, distributional
10 scoring is always going to put somebody on the
11 bottom, so if you were indicating that you may
12 have done some threshold analysis or something
13 like it, if you could give us a sense of if
14 you do those kinds of analyses are we getting
15 around to the point where the distribution is
16 so tight that we might want to consider some
17 other kind of scoring than distributional
18 scoring?

19 DR. INGBER: The issue of what
20 happens when you use these kinds of models, it
21 is the nature of these multi-level models to
22 assume that the cluster, which is the

1 facility, is distributed in a bell-shaped
2 curve around some average and by building that
3 in, you basically have statistically said
4 well, this particular facility -- I was using
5 the word strength of evidence earlier -- that
6 has only 27 patients and this other one has
7 got 300 and what not.

8 And so what's the probability that
9 they're really out as far as they appear to
10 be? And we had some pretty pictures that we
11 did submit to you on what the raw
12 distributions were and there was some with 100
13 percent and some with zero percent, and none
14 of which did we find believable as a good
15 characterization of a facility.

16 So the nature of this kind of
17 estimation is to say we're going to take into
18 account how little evidence there really is
19 for you being that far out and bring you in.
20 So the numbers do tend to bring them.

21 There's a danger, then, if you use
22 a pure distributional that some larger

1 hospital that's out here is declared to be
2 particularly good or bad. This other little
3 one has been made to look better or worse. It
4 goes both directions. And so therefore,
5 you're making a bad judgment.

6 So the question really is: how do
7 you apply what you've got? And nothing in the
8 measure tells you how to use it. What we did
9 find, if you look at the section that talks
10 about who is statistically different from the
11 mean, is that fewer of the small facilities
12 are -- not all of them are out there, but
13 fewer of them make it to be statistically
14 different from the mean. And the bigger ones,
15 justifiably, you can say are different from
16 the mean. Now is the mean your ideal in any
17 way? It becomes a different question.

18 So where is your benchmark for
19 what you're going to consider good or bad or
20 how are you going to make use of this
21 information? And one way that it has been
22 used. I don't know, I mean CMS has to decide

1 from a policy point of view, and I don't know
2 if Paul wants to speak about it, but how these
3 are going to be applied. But, naively, you
4 don't want to just rank folks and say you're
5 good, you're bad, when you know you have
6 confidence intervals that are saying well, you
7 look good, but the confidence interval is a
8 mile wide and so we're not so sure.

9 So how you use it has to be done
10 carefully, and I can't tell CMS what to do
11 with it. I just work for them. So -- they
12 pay me, really.

13 (Laughter.)

14 So at any rate, yes, I say use
15 these things with caution and understanding
16 how the numbers are derived. We did supply
17 for you a whole little section that was a
18 supplementary doohickey, and it had in it a
19 picture of what if I used the different
20 measure? And it shows what the raw rates are
21 for the smaller, the middle size and the
22 bigger ones. I didn't take the smallest or

1 the biggest to do these.

2 And then what happened with a so-
3 called fixed effect model which makes no
4 assumption as to what the distribution of the
5 facilities is, it just says whatever it is,
6 that's -- after we risk adjust you, where does
7 it go? And these measly-looking charts that
8 you have do show that there's a very wide
9 spread of raw rates that are kind of all over
10 the place. And that risk adjustment does tend
11 to bring them toward the center. In some
12 cases it even crosses the line from a below
13 average to an above average, or vice versa.
14 So the risk adjustment is fairly effective
15 working with it.

16 Now, if you wanted to use a pure
17 fixed effect model we don't have in here the
18 sort of error bars that that tell you that
19 yeah, you see a different number than we're
20 telling you as the final number with the
21 shrinkage estimator, but that error bar would
22 be very, very large. And you can't quite see

1 that. So whether you would actually draw a
2 very different conclusion about a facility
3 from this, you can just see there are
4 differences and you can see that the shrinkage
5 is much greater for the smaller facilities, as
6 just what you'd expect because they have
7 relatively weak evidence.

8 We are using two years of data
9 which made the facility sample sizes larger.
10 We hesitated to use three years, because
11 there's always the straight off between
12 timeliness --

13 CO-CHAIR KAPLAN: Sorry, for the
14 record, can you tell us which page you were
15 looking at when you were looking at the
16 diagram?

17 DR. INGBER: Okay, this particular
18 area is in something called "Assessing the
19 Impacts of Risk Adjustment and Shrinkage," and
20 it's a relatively small addition that we sent.

21 And in there we have lots of
22 numbers which say how much change was caused

1 by pure risk adjustment and how much change
2 was caused by the shrinkage in addition. So
3 we do present to you with some information on
4 that to work with and we do present the
5 differences between what's going on with the
6 larger facilities and the smaller facilities
7 so you can say yes, of course, there is small
8 evidence, you get larger shrinkage and you
9 also, sometimes, have wilder raw effects. You
10 have to be really careful with raw effects.
11 So the risk adjustment is helpful.

12 CO-CHAIR KAPLAN: Thank you very
13 much. Other comments from the committee?

14 Larry, did you have issue?

15 DR. GLANCE: I think that the use
16 of shrinkage estimators is really a cross-
17 cutting issue, and we went over this and spent
18 a lot of time on this last time around.
19 Certainly, the use of shrinkage estimators
20 gives you more stable estimates of
21 performance, possibly more reliable as well.

22 The disadvantage of using

1 shrinkage estimators is that you are
2 implicitly or explicitly making the assumption
3 that low volume providers are performing in an
4 average way. So that from the standpoint of
5 public reporting and accountability, shrinkage
6 estimators may not be completely ideal,
7 because we know that in many cases there is a
8 volume outcome association, and that low
9 volume providers have worse outcomes than
10 higher volume providers. We also know that
11 there is some literature in the case of
12 readmissions to suggest that is the case.

13 On the other hand, if you don't
14 use shrinkage estimators, you can get some
15 fairly wild estimates of provider in hospital
16 quality. So you're kind of stuck between and
17 this is a very technical term, between a rock
18 and a hard place.

19 (Laughter.)

20 And we spent hours talking about
21 this last time. So --

22 CO-CHAIR HALL: And I'd like to

1 build on that, what we're building on Larry's
2 comments. When you think about using
3 shrinkage in this type of application,
4 performance assessment potentially for reward
5 and punishment, what we're really saying is
6 we're less willing to penalize people when the
7 information, quality or volume is low. Now
8 that comes at a cost. The cost is, as Larry
9 said, that means some people who might, should
10 be penalized are not going to be penalized.
11 That's equivalent to Larry saying we're going
12 to give those small-volume hospitals the
13 benefit of the doubt and push them back to the
14 average. What we're really doing is saying,
15 because the volume or quality of the
16 information about those facilities is low,
17 we're not willing to penalize them at present
18 time. That's the implication of what we're
19 saying.

20 CO-CHAIR KAPLAN: And this again
21 transitions over into the use of these
22 measures after the fact and I think, Helen, is

1 that accurate the MAP folks have and are
2 dealing with this issue? So what we're
3 looking at is basically for the measure as
4 proposed, is it scientifically sound? Any
5 other comments from the group on what that
6 constitutes?

7 CO-CHAIR HALL: I don't see any
8 cards up yet, so I'll throw up a couple of my
9 concerns where first of all, just to
10 highlight, this is unplanned readmissions.
11 The algorithm is very similar to the unplanned
12 algorithm that applies to several other
13 measures coming out of the CMS, so that's a
14 pretty common algorithm that we have some
15 exposure to and if you have any questions
16 about that, please feel free to ask our
17 developer.

18 The time period here is proposed
19 to be 24 months and in the past deliberations
20 people have raised whether a 24-month
21 evaluation is really an evaluation that you
22 can act on in a timely fashion. So that's one

1 concern. Obviously, that's done so that the
2 volume numbers will be higher than they would
3 otherwise be. But that's a tradeoff.

4 This also in the information
5 submitted by the developers, the reliability
6 is really adjusted with split sample
7 consistency, rather than sort of a signal to
8 noise emphasis, if you will. The split sample
9 consistency seems good. The correlation, the
10 inter-class correlation numbers are only
11 moderate at best.

12 And then perhaps the one question
13 that I do need answered, which is open for me,
14 is why transfers from the IRF to short stays
15 were excluded within a day? So in other
16 words, we're saying if you're discharged from
17 the IRF, and you go home and you're home for
18 more than a day, you're not eligible to be
19 readmitted. But if you're transferred
20 directly from the IRF, or if you go home and
21 within a day go to a short stay care, you are
22 excluded. Those seem to me to be just as

1 powerful indicators that something went wrong.
2 So I was curious as to why the immediate
3 transfers back to short stay or the transfers
4 after only one day or up to one day were
5 excluded?

6 DR. INGBER: Yes, on that: one day
7 is a standard way of handling the issue of
8 Medicare data where sometimes you cross to
9 midnight and it's really a transfer, and we
10 didn't want to get into that debate about
11 whether or not it was really a transfer, but
12 the clock ticked and it went over.

13 CO-CHAIR HALL: Then it reduces to
14 why your transfers are excluded?

15 DR. INGBER: Yes, exactly. And
16 you can think that maybe there's another
17 measure that might be in the works to take
18 care of that. But we wanted to make sure that
19 we were looking with people demonstrably in
20 the community one way or another.

21 DR. AUGER: So a couple of
22 questions. One is about the planned exclusion

1 criteria. There's something that mentions
2 that they were modified, I believe, so I
3 didn't know how so or what the justification
4 was for that, and then how we know whether or
5 not it remains to be a valid sort of algorithm
6 for the modification?

7 DR. INGBER: The modification was
8 done having started from what was done from
9 the acute hospital measure. They had done a
10 lot of work looking at planned readmissions
11 and we don't throw out perfectly good work.
12 But we did bring it to our own technical
13 expert panel and they know what patients they
14 see. They know what patients they're sending
15 back to hospitals, so we did add, and what
16 happened subsequent to that is that the other
17 measure, which we'll be seeing this afternoon,
18 actually, in their considerations came up with
19 some of the same things we do. So it's
20 something that is always a judgment call, and
21 our folks just added a few more procedures to
22 the ones that were excluded to begin with.

1 And it is understood that if some
2 of these procedures occur in the context of an
3 acute admission, as noted by the diagnosis on
4 that next inpatient readmission, you can have
5 something done just incident to some acute
6 admission, and because it's done that way it
7 doesn't get you off the hook. So if you
8 really went back for your heart attack or
9 whatever it was that happened to you, and you
10 happened to have some wound debridement done,
11 that wouldn't take you off the hook. So it
12 was kind of done by just a technical panel.
13 There's no magic to working this one out.

14 CO-CHAIR KAPLAN: Thank you,
15 Helen, and we're ten minutes into our break
16 here, so just for those of you who need
17 caffeine, we're going to work through this and
18 be a bit more concise as we go on. This is
19 kind of our first measure so we're working a
20 little bit harder here.

21 Helen?

22 DR. CHEN: Just quickly. I

1 understand that the issue of transfer, going
2 back to Bruce's comment might need to be
3 evaluated as a separate measure. However,
4 this exclusion, and similarly in the LTAC
5 measure troubled me, because I think it could
6 actually lead to some potential for people
7 transferring patients who are marginal in
8 terms of their ability to be safely discharged
9 towards the end of their stay, knowing that it
10 wouldn't count against them as a readmission.
11 So there's a potential for an unintended
12 consequence and some degree of gaming the
13 measure.

14 CO-CHAIR KAPLAN: Thank you,
15 Helen. I think monitoring that might come, if
16 approved, that might come under what gets
17 monitored in the endorsement in the three-year
18 run. Kathy, did you still have an issue?

19 DR. AUGER: One other quick
20 question is about the heterogeneity of ages.
21 So clearly Medicare eligibility, over 65 is
22 included, but also younger people with

1 disabilities, therefore there might be more
2 younger people that have been in inpatient
3 rehab facilities. I believe you guys adjusted
4 for age, but I'm wondering if this sets up
5 sort of a situation where you may have some
6 rehab facilities where you're comparing some
7 rehab facilities that primarily deal with
8 things like stroke rehab, and that kind of
9 thing, to facilities which are very different
10 which primarily deal with rehab for like
11 younger patients with other sorts of
12 disabilities.

13 And I guess part of it is, sort
14 of, a I don't know whether or not there are
15 different types of facilities like that, but
16 also are those appropriate hospitals to
17 compare?

18 DR. INGBER: Assuming that's a
19 question, we do have the risk adjustment that,
20 as you said, does have age in it per se. But
21 if they tend to fall into one of the CMGs that
22 is more characteristic for younger people --

1 we are doing our best to adjust for what kind
2 of patient are you, on top of just how old are
3 you, and not only that, but what your
4 diagnoses were. We mentioned 200 risk
5 adjusters. We actually worked very hard to
6 pull in -- there are over 100 CMGs out there
7 in the world.

8 So and most of them came out, we
9 had to condense a few because they're quite
10 small, some of them even in the national data.
11 Guillain-Barre is not exactly your most
12 popular disease. So we did collapse a few of
13 them. But to the extent that particular age
14 groups of patients are found in certain CMGs
15 or have certain things, we attempted, I can't
16 swear to you that we have taken all the
17 variants out, but we tried.

18 CO-CHAIR KAPLAN: Thank you. I
19 have just one more quick question for you and
20 that is would it be your guidance, for
21 example, the standard error of measurement is
22 the standard deviation times the square root

1 of one minus the reliability. And what it
2 does is it gives you guidance, like a
3 confidence interval does, on how much noise
4 there is in a measure. Would it be possible if
5 this measure is endorsed to kind of, as we go
6 forward, start providing the standard error of
7 measurements around these measures for
8 whatever groups we're kind of comparing?

9 DR. INGBER: It's just a little
10 tricky, because you can produce standard
11 errors. But these kinds of measures, the way
12 we got confidence intervals was entirely
13 differently, because the very nature of the
14 ratio estimator led us to have to do the
15 bootstrap because it doesn't lend itself well
16 to the standard calculation. So we could
17 produce numbers, but we'll have to be careful
18 about how we use them.

19 CO-CHAIR KAPLAN: Any other
20 comments? Are we ready to vote? So what are
21 we voting on first? So first we're voting on
22 reliability.

1 MS. SHAHAB: 2a, reliability
2 including precise specifications, and 2a2
3 testing. So one is high. Two is moderate.
4 Three is low. Four is insufficient. And the
5 time will begin now.

6 (Pause.)

7 Will everyone just press it one
8 more time, please? We're trying to get to 24.

9 (Pause.)

10 So we have 23 votes and the
11 results are 3 high, 16 moderate, 4 low, and
12 zero insufficient.

13 CO-CHAIR KAPLAN: Okay, now
14 reliability spoke to the issue of consistency,
15 reproducibility, etcetera, etcetera.
16 Reliability is consistency. Validity is
17 accuracy. So reliability: is it reproducible.
18 And I love to give the example of my bathroom
19 scale. I step on my bathroom scale every
20 morning. It tells me exactly the same answer.
21 I love my bathroom scale. It is completely
22 wrong. But I love the answer it gives me. So

1 validity speaks to the issue of was my
2 bathroom scale correct? Which is different
3 from reproducible. So we're about to vote on
4 validity.

5 MS. PACE: And validity also
6 includes the -- what we talk about as threats
7 to validity, so issues about exclusions, risk
8 adjustments, etcetera come in this section.

9 CO-CHAIR KAPLAN: So is it right
10 or is it wrong?

11 MS. SHAHAB: So now we're going to
12 vote on 2b, validity. One is high. Two is
13 moderate. Three is low. And four is
14 insufficient. Voting will begin now.

15 (Pause.)

16 CO-CHAIR KAPLAN: Do it again.

17 (Pause.)

18 MS. SHAHAB: Okay, so we have all
19 24 votes. One, high; 16, moderate; 6, low;
20 and 1, insufficient.

21 CO-CHAIR KAPLAN: Okay, now we're
22 going to talk about feasibility, and I,

1 basically, don't have any comments about
2 feasibility, other than they use the data that
3 was existing, so at least we know with those
4 data you can do something. But if there's any
5 other comments from the committee or
6 questions, is it feasible? Okay, we'll vote.
7 Let's vote.

8 MS. SHAHAB: Voting will be open
9 for feasibility. One, high; two, moderate;
10 three, low; four, insufficient. Time begins
11 now.

12 (Pause.)

13 We have all 24 responses.
14 Eighteen, high; 6, moderate; zero, low; and
15 zero insufficient.

16 CO-CHAIR KAPLAN: Okay, we're on
17 to usability and use. I did lie to you. We
18 are not ten minutes into our break. The break
19 is actually 10:45, but it was a strategic
20 move. I'm going to declare it as a strategic
21 move.

22 (Laughter.)

1 Technically, as Bruce pointed out,
2 we are behind, because we started early at
3 9:20, so okay. So on usability and use, it's
4 sort of where potential usability and use are,
5 are public reporting, quality improvement, and
6 quality improvement both for purposes of
7 benchmarking and for institutional internal
8 use where the potential uses of this thing --
9 I think they were specified, but if not, in
10 the document itself. Other comments on
11 usability and use? Tony?

12 DR. GRIGONIS: Yes. I think in
13 your response to one of the issues that was
14 raised in the preliminary analysis, you've
15 noted that these measures, and this will come
16 up -- I'll be doing the LTAC one,, so it will
17 come up in the long term acute care hospital
18 measure also. And that is this measure is not
19 really intended to track change over time.
20 And if that's correct, is that really
21 problematic, since what we're trying to
22 endorse is a quality measure that can measure

1 improvement?

2 DR. INGBER: Whereas it does not
3 track change over time explicitly, you just
4 can't take the number in Year 1, Year 2, Year
5 3, and easily track it for a facility. It has
6 the virtue of accommodating itself to changes
7 in the way people are treated over time,
8 because each time you're looking at a new
9 world each year and new treatments come up,
10 new ways of doing things come up, so that it
11 actually allows you to say, given the current
12 situation, you're doing a lot better over --
13 whatever, than other people.

14 The way you can track time is a
15 little bit different because it requires sort
16 of tracking that raw number, because that raw
17 number of 13 percent could go down to 12
18 percent let's say, and then everybody is
19 clustered around this new mean. So you get
20 kind of relative to the mean of what's
21 happening, how are you doing? So yes, each
22 facility over time, if you just track the

1 numbers without knowing what's going on
2 overall, it's not really great, but it does
3 accommodate.

4 For instance, I'll just make this
5 because it's an obvious one. You mentioned
6 LTACs. Something strange is going to happen
7 in the LTAC world in 2016, according to the
8 new rule that just came out this week. And
9 it's going to change the patient mix. Well,
10 the measure will accommodate that because it
11 gets reestimated each time, so that you don't
12 worry that the patient mix is suddenly
13 changing, and the same thing could happen in
14 the world of IRFs in which they have some
15 administrative change in some of the rules, 60
16 percent of this or that, you know.

17 And it accommodates itself to
18 that. So there are pluses and minuses. I
19 can't say it's great for tracking over time,
20 but I can say, because of the way it works, it
21 accommodates itself to the change in the
22 universe over time.

1 DR. GRIGONIS: But just to
2 clarify, that universe would be a two-year
3 time period. So, I'm bringing this up as a
4 cautionary note of how the measure may be used
5 after it's implemented. For example, if it's
6 used to change payment structure or penalty or
7 something like that, I wouldn't want to see it
8 misused by shrinking it to a year or six month
9 time period or something like that, when
10 you've clearly established that its utility is
11 based on a two-year sample.

12 DR. INGBER: Utility is based on
13 having enough data. Whether -- you want to do
14 it for one year, you can do it on half the
15 facilities reliably, and say anyone with fewer
16 than N patients we can't really do this, and
17 so administratively we're going to throw you
18 out of the picture. There are a lot of ways
19 of sort of dealing with that.

20 We estimated it to get the full
21 distribution and to get their sample sizes up
22 and actually, we don't have a lot of tiny

1 facilities. We managed to get a bunch of them
2 up, and that's why we have as many as we do
3 that are statistically significant from the
4 mean, even in the small group. We were kind
5 of surprised to see that the confidence
6 intervals actually said they're not average to
7 20 or 30 percent of that little group at the
8 bottom, as opposed to everybody down there is
9 average looking.

10 We don't really mean they're
11 average when we say they're average. We mean
12 we can't differentiate them from the average.
13 So I do want to be a little careful.

14 CO-CHAIR KAPLAN: Paul.

15 DR. HEIDENREICH: Just in the
16 voting on 4c with the term evidence, and it's
17 in the further description, evidence of
18 unintended consequences. Now in the cases
19 where we haven't actually implemented it and
20 we don't have the evidence yet, does that mean
21 you don't consider it, or would it be if
22 there's a rationale for unintended

1 consequences that we should consider, even if
2 there is no evidence?

3 MS. PACE: This really applies
4 mostly to measures that are coming back for
5 endorsement maintenance, rather than initial
6 measures. But certainly it's something that
7 you can talk about if you think there's a big
8 issue with potential unintended consequences.

9 DR. HEIDENREICH: The reason I
10 bring it up is because the way 4c is
11 described, it really is sort of a summary of
12 your overall view of it is the benefit of
13 having this measure. Does that outweigh the
14 potential harms of having the measure? So in
15 some ways it could very well apply to all the
16 measures. Maybe that wasn't the intent.

17 MS. PACE: The intent, and you're
18 right, you specifically noted that it said
19 evidence, so it was mostly intended for
20 endorsement maintenance. But again, you know,
21 if there's particular issue you can certainly
22 raise it, but overall, after you go through

1 each of the criteria you'll do an overall vote
2 on the measure, but certainly this would be
3 the place to discuss it, but that criterion is
4 mostly relevant for the endorsement
5 maintenance measures.

6 CO-CHAIR KAPLAN: So by that you
7 mean empirical evidence after the application
8 of the measure of unintended consequences, not
9 anticipated unintended consequences that we
10 could all conceptually kind of --

11 CO-CHAIR HALL: I don't know. I
12 think that we're all called upon to use our
13 judgment, and if there are concerning
14 potential unintended consequences in your
15 mind, then you're obliged to consider them in
16 your voting. That's how I feel. Pam?

17 DR. ROBERTS: I just have a
18 clarification question, based on what Tony
19 said. So if it went forward, it would go to
20 the MAP for the implementation issues, is that
21 correct? So the issue that Tony brought up
22 would be, if this does get endorsed, it would

1 be a really important issue for facilities to
2 understand for future implications because
3 it's buried in there and it's not something
4 that people readily think about.

5 DR. BURSTIN: When measures go
6 forward to the MAP, we'll, of course, we do
7 try to make sure they stay true to the
8 endorsement, and if the endorsement is around
9 24 months of date, then that would need to
10 stay true to that.

11 CO-CHAIR KAPLAN: So the committee
12 could make a recommendation to MAP that they
13 consider the issue that Tony raised or no?

14 CO-CHAIR HALL: Tom?

15 DR. SMITH: I think I'm
16 summarizing what people are saying, so for 4a
17 and 4b, it doesn't say if new credible
18 rationale or plan. So wouldn't the
19 implication be for 4c that potential
20 unintended consequences ought to be considered
21 as well?

22 CO-CHAIR KAPLAN: I think that's

1 reasonable. That's fine. Any other comments?
2 Ready to vote?

3 MS. SHAHAB: We're going to vote
4 on usability and use. One, high; two,
5 moderate; three, low; four, insufficient
6 information. And the time starts now.

7 (Pause.)

8 CO-CHAIR KAPLAN: Do it again.

9 (Pause.)

10 MS. SHAHAB: Okay, we have all 24
11 votes. One, high; 14, moderate; 8, low; and
12 1, insufficient information.

13 We can go ahead and also vote of
14 overall suitability for endorsement. Does
15 this measure meet NQF criteria for
16 endorsement. And note, this may not yet be a
17 recommendation for endorsement. Final
18 recommendation for endorsement may depend on
19 assessment of any related and competing
20 measures. So one is yes and two is no. Time
21 begins now.

22 (Pause.)

1 Two more.

2 CO-CHAIR KAPLAN: Do it again.

3 (Pause.)

4 MS. SHAHAB: We have all 24 votes.

5 Sixteen voted yes and eight voted no for
6 measure 2502, all cause unplanned readmission
7 measure for 30 days post discharge from
8 inpatient rehabilitation facilities.

9 MR. AMIN: Before we break, I just
10 wanted to point out one thing related to
11 voting, because I assume we're going to get
12 here at some point. Adeela, could we scroll
13 back to the slide related to the gray zone
14 voting?

15 So one of the enhancements that
16 we've done in NQF over the last year and a
17 half is -- one of the challenges that we have
18 is sometimes when the measure just falls right
19 below the 50 percent threshold, the
20 conversation on the measure didn't move
21 forward and the measure didn't go out for
22 public comment. And so what you'll find is

1 that what we've implemented now and approved
2 by the Board is that if it falls between the
3 40 and 60 percent range, we'll continue to
4 move the measure forward to the evaluation of
5 the remaining criteria and we'll move the
6 measure forward for public comment, just so
7 that there's not an absolute 50 percent
8 threshold.

9 Obviously, this process includes
10 this committee deliberation, public comment,
11 voting by the members, and then we'll
12 ultimately make a decision with CSAC on the
13 measures if there are measures that fall
14 within that range going forward. So you will
15 hear, potentially, over the next day, I'd be
16 surprised if you didn't, if we describe
17 something as falling in the gray zone if a
18 consensus is not reached.

19 CO-CHAIR KAPLAN: We were on track
20 for our break until that last comment.

21 (Laughter.)

22 DR. FISHBANE: Gosh, I'm costing

1 us the break. Just the second one, 40 percent
2 combined for high and moderate, so that's kind
3 of a composite of taking all of the votes
4 together. Thanks.

5 MR. AMIN: Thank you.

6 CO-CHAIR KAPLAN: Break. Eleven
7 o'clock, start again.

8 (Whereupon, the above-entitled
9 matter briefly went off the record.)

10 MR. AMIN: On the next measure,
11 which is 2512.

12 (Pause.)

13 CO-CHAIR HALL: So we will move on
14 with Measure 2512, All-Cause Unplanned
15 Readmission, 30 days post-discharge from LTCH.
16 We'll invite RTI to give their two minute
17 introduction to this measure.

18 MS. COOTS: Thank you. My name is
19 Laurie Coots from RTI, and I'm going to give
20 a brief overview of the measure. So this next
21 measure, the All-Cause Unplanned Readmission
22 measure for 30 days post-discharge from long-

1 term care hospitals or LTCHs, is also among
2 the same set of readmission measures specific
3 to post-acute care that RTI is the measure
4 developer on behalf of the Centers for
5 Medicare and Medicaid Services.

6 So this particular measure is
7 quite similar to the last measure that we
8 reviewed, in terms of the methods and the
9 statistical approach. In terms of the
10 background, given the large proportion of
11 readmissions among the Medicare population,
12 and in particular for beneficiaries post-
13 discharge from long-term care hospitals, CMS
14 has proposed to monitor the readmission rates
15 in order to reduce rates that are
16 inappropriately high, with the aims of
17 improving patient safety and quality of care.

18 This particular measure estimates
19 the risk standardized rate of unplanned all-
20 cause hospital readmissions for Medicare fee
21 for service beneficiaries discharged from
22 LTCHs who are readmitted to a less intense

1 setting, or back to another --

2 I'm sorry, readmitted to a short
3 stay acute-care hospital, or back to an LTCH,
4 within 30 days of the LTCH discharge. So
5 again to clarify, this is post-LTCH discharge
6 measure. It's based on inpatient Medicare
7 claims data, and again we use a rolling two
8 years of LTCH discharges, the measure
9 exclusions here were also minimal and most
10 often related to data limitations.

11 The risk adjustment variables
12 include demographic and eligibility
13 characteristics, principle diagnoses, types of
14 surgery or procedure from the prior short-term
15 stay, comorbidities, prior acute length of
16 stay and ICU utilization, again from the
17 immediately prior acute term stay, as well as
18 number of prior acute admissions in the year
19 preceding the LTCH admission.

20 Specific to this measure is also a
21 claims-based indicator for long-term
22 ventilator use in the LTCH. Again, we

1 performed a variety of statistical tests to
2 evaluate this measure, and found that the
3 measure demonstrated good reliability, and our
4 risk adjustment model had good model fit and
5 reasonable predictive ability overall.

6 So for example, we conducted
7 test-retest analyses using a split sample. We
8 also evaluated the models by computing several
9 summary statistics, including tests for the
10 calibration, discrimination including
11 predictive ability and c-statistics,
12 distribution of residuals and the model's chi
13 square.

14 We conducted bootstrapping in
15 order to obtain multiple estimates for LTCH's
16 risk-standardized readmission rate, or RSRR,
17 and estimate confidence intervals around
18 facility's RSRRs.

19 Results of the bootstrapping
20 analyses suggest the ability to discriminate
21 between providers with higher and lower than
22 average readmission rates. So in closing,

1 this is an important measure for this patient
2 population. There are no current-- there no
3 competing measures, and this measure was
4 harmonized to the greatest extent with similar
5 measures.

6 The measure will provide
7 information to providers and patients that is
8 not easily available to them currently.

9 CO-CHAIR HALL: Thank you very
10 much. I just want to note that whereas we had
11 90 plus minutes on the last measure, we have
12 35 this time around, and I'll invite Tony and
13 Carol to kick off the discussion as
14 discussants.

15 DR. GRIGONIS: Thank you.
16 Obviously the first area we had discussed
17 extensively for the inpatient rehab measure
18 and that is the evidence or lack thereof,
19 showing any kind of process improvement change
20 relating to the change in readmission rates,
21 and similarly there were really no studies
22 done in LTCHs on this issue. But I'm just

1 opening it up. If anyone has any further
2 comment, we could probably vote on that
3 initial. Yes, Steve.

4 DR. FISHBANE: Yes. Just one
5 suggestion for the National Quality Forum
6 here. What we're talking about with the
7 definition that we're using for voting is not
8 clinical evidence. It's not scientific
9 evidence, and I think that if we use that term
10 as we put forth the results of our voting to
11 the public, we may be accidentally misleading
12 to suggest that we voted based on evidence.

13 In fact, what we're asked to vote
14 on here is that there's a reasonable construct
15 that exists, which is fair. I mean that's
16 acceptable. But I think, you know, in the
17 interest of transparency and clarity of
18 definition, that the word evidence shouldn't
19 be used, in terms of the specific criterion
20 for outcome measures.

21 CO-CHAIR HALL: Thank you, Steve.
22 So again, are we going to -- do we want to

1 move just with evidence? We'll take a vote.
 2 But any other comments, more or less limited
 3 to the topic of evidence?

4 CO-CHAIR KAPLAN: Carol.

5 CO-CHAIR HALL: I know I'll ask
 6 Tony and Carol just to raise their hands
 7 whenever they see fit, because they're the
 8 main discussants. But others. Wes?

9 MS. RAPHAEL: Are the other -- I
 10 guess Tony you can comment on this as well,
 11 that I think was discussed was whether 30 days
 12 was the right time frame, because these are
 13 very sick people. They don't have short-term
 14 episodes. But I have to say to be consistent
 15 in really looking for uniform measures, I
 16 think we came back to the 30 days.

17 CO-CHAIR HALL: Wes.

18 DR. FIELDS: I'm sorry. I'm used
 19 to yelling at people, I'm sorry. What is the
 20 evidence that a readmission to an acute-care
 21 hospital is the same outcome in terms of
 22 measurement to readmission to an LTCH? To me,

1 those seem like very different interventions
2 for different problem sets. So why are we
3 treating them as if they're comparable in
4 value as outcomes?

5 CO-CHAIR HALL: Wes, can you
6 clarify what you mean? I mean, this is a
7 measure about LTCHs being readmitted to short
8 stay acute care. We considered a separate
9 measure --

10 DR. FIELDS: I'm just reading
11 this, so forgive me if I'm wrong. But what it
12 says is discharge from a long-term care
13 hospital. Let's see. Readmitted to a short
14 stay acute care hospital or an LTCH within 30
15 days.

16 CO-CHAIR HALL: Right, I'm sorry.
17 I misunderstood your comment. I thought you
18 were comparing this to the last. So your
19 comment is well-placed now. Others, or Tony,
20 do you want to add to that? Were you trying
21 to raise your hand Tony or no?

22 DR. GRIGONIS: Pam.

1 CO-CHAIR HALL: Pam, I'm sorry. I
2 missed somebody. Okay. All right, great. I
3 apologize. Anyone who can comment on Wes'
4 concern? Developers.

5 DR. INGBER: Yeah. I just want to
6 say that to a degree that it's parallel to an
7 acute hospital, I think a readmission to an
8 acute hospital where we have an LTCH, which we
9 take somewhat seriously the LTCH terminology,
10 although we don't always use it.

11 They are treating very ill
12 patients, and we're treating the readmission
13 back to that facility as being also an
14 unfortunate circumstance which comes after
15 discharge, equally bad to having to go back.
16 I mean most patients, if they do go back, will
17 go to the acute from the community. That's
18 where they're going to get sent first.

19 But we have some who go back to
20 the LTCH, and we wanted to make sure that that
21 was taken care of in a measure.

22 DR. GRIGONIS: I think you bring

1 up a good -- I think you bring up a good
2 point. I don't think there's evidence in the
3 data to suggest what kinds of patients would
4 be different. It was no stratification done.
5 That speaks, I think, more to the scientific
6 part. So we may want to bring that up during
7 that segment.

8 CO-CHAIR HALL: Any other comments
9 or concerns before we vote on evidence?

10 (No response.)

11 CO-CHAIR HALL: I'm not seeing
12 any.

13 MS. SHAHAB: So we're going to
14 vote on 1A, Evidence. Rational supports the
15 relationship of health outcome to at least one
16 health care structure, process, intervention
17 or service. One is yes, two is no. Voting
18 begins now.

19 MS. SHAHAB: We have all 24 votes.
20 20 said yes, and 4 said no.

21 DR. GRIGONIS: Okay. The next
22 area is opportunity for improvement. The

1 assessment of the performance was made using
2 the retrospective data. No analysis was
3 conducted for any current use of the measure.
4 Does anyone have any issues related to the,
5 sort of the ability of the measure,
6 performance gaps?

7 CO-CHAIR KAPLAN: Actually, I
8 think that in this case, the range is much
9 more impressive in terms of, you know, how
10 much the risk adjustment spreads people out in
11 the distribution, and it makes it more,
12 considerably, in my mind, a more compelling
13 argument compared to the previous measure we
14 just discussed.

15 DR. GRIGONIS: Right, and also the
16 rates are higher, a lot higher than they were
17 in the inpatient rehab facility.

18 CO-CHAIR HALL: Any other
19 questions before vote?

20 (No response.)

21 MS. SHAHAB: We're going to vote
22 on 1B, Performance Gap. Data demonstrated

1 considerable variation, or over all less than
2 optimal performance across providers and/or
3 population groups. 1 is high, 2 is moderate,
4 3 is low, 4 is insufficient, and voting begins
5 now.

6 MS. SHAHAB: We have all 24 votes.
7 14 is high, 10 is moderate, 0 is low, 0
8 insufficient.

9 DR. GRIGONIS: The next area is
10 Priority, that this measure is an important
11 issue related to health care quality and-or
12 the cost of care. Any comments? I think it's
13 similar to the previous inpatient rehab
14 measure, as far as importance.

15 (No response.)

16 CO-CHAIR HALL: I don't see any
17 questions raised. Questions? None.

18 MS. SHAHAB: 1C, High Priority.
19 Addresses a specific national health goal
20 priority, or data demonstrated a high impact
21 aspect of health care. 1 is high, 2 is
22 moderate, 3 is low, 4 is insufficient. Time

1 starts now.

2 MS. SHAHAB: We have all 24 votes.
3 12 high, 12 moderate, 0 low, 0 insufficient.

4 CO-CHAIR KAPLAN: We're getting
5 better at the voting process, you notice how?
6 Yeah. We can make the thing connect with
7 them. We were pretty normally distributed
8 there for a while. Now we're kind of skewed.

9 DR. GRIGONIS: Okay. Now we move
10 on to the Scientific Acceptability
11 specifications.

12 CO-CHAIR HALL: I'll ask Tony and
13 Carol to make their initial comments about
14 Scientific Acceptability.

15 DR. GRIGONIS: One comment I had
16 about the planned versus unplanned, are you
17 still taking suggestions as far as what would
18 constitute a planned category, because some of
19 my colleagues across many hospitals have made
20 suggestions.

21 So there's not a big list, but
22 maybe four or five more that could be looked

1 at, could be examined as a potential. We see
2 a lot of our patients being sent back for
3 certain procedures that we know that they
4 would have to go back for. So it's not really
5 an unplanned situation.

6 DR. INGBER: From the developer's
7 point of view, we are certainly open to
8 improvement all the time. So we expect
9 actually, just talking generally about these
10 measures, they have to evolve over time, and
11 that's one of the pieces of the evolution,
12 yeah.

13 CO-CHAIR HALL: Tom.

14 DR. SMITH: Just to make sure I've
15 got it clear in my head: so these are people
16 in a long-term care facility, discharged
17 presumably to the community but not
18 transferred to a hospital, but in the
19 community, and then are either admitted to an
20 acute care hospital, or back into a long-term
21 care facility within 30 days. And if they go
22 to an acute care hospital and they're not

1 transferred back to a nursing home, they don't
2 get counted twice?

3 DR. INGBER: That's correct. We
4 look for the first event to occur, and then we
5 stop looking past that. And any other kind of
6 post-acute care facility we're not looking at
7 here. It's just, are you having another
8 admission to either the LTCH or the short-term
9 acute.

10 DR. SMITH: Within 30 days of
11 leaving the long-term care?

12 DR. INGBER: Yes.

13 DR. SMITH: Okay, and I still -- I
14 struggle with the, I think it was Wes, the
15 conceptual issue of equating an admission back
16 into a long-term care facility with an
17 admission to an acute care facility.

18 CO-CHAIR HALL: And keep in mind
19 that as specified, transfers directly into
20 care are excluded. You have to be sent home,
21 discharged first, and then readmitted. So
22 Tony was going to, I think, respond. No?

1 DR. GRIGONIS: I was just going to
2 ask if you knew what the relative proportion
3 was of patients who readmitted back to the
4 LTCH, versus short-term acute case hospital?

5 DR. INGBER: I must confess
6 ignorance as to the actual number. However,
7 as I speculated before, if you're having a
8 problem and people send you to the acute
9 hospital off the street or wherever you are,
10 they're not normally going to send you to the
11 LTCH directly. But no, I can't give you the
12 number in actuality.

13 CO-CHAIR HALL: Kathy and Ron, was
14 that your question? Yes, okay.

15 MS. HALL: I just have a follow-up
16 to that.

17 CO-CHAIR HALL: Leslie.

18 MS. HALL: So if the patient is
19 sent to the emergency room for observation and
20 then discharged to the long-term post acute
21 care hospital again, is that in this group?

22 DR. INGBER: Yeah. The

1 observation stay, if it's a pure observation,
2 would not be detected. But the readmission to
3 the LTCH would be.

4 DR. GRIGONIS: I just had one
5 question about that lookback period. I think
6 you did address it, but if you could just
7 comment on the fact that prior to the long-
8 term acute-care hospital stay, you're
9 considering the comorbidities associated with
10 the short-term acute care stay up to 30 days
11 prior to that LTCH admission. Now the fact
12 is, that only represents about five percent of
13 the patients. I was just curious why that was
14 left into your model?

15 DR. INGBER: It's certainly
16 possible to lop it off and make it one day.
17 I mean it's not a technical issue here. It's
18 certainly doable. We were trying to be more
19 inclusive of the population of LTCH patients,
20 and the question was: do we have reasonably
21 good information about the patient from a stay
22 which would normally have a lot of --

1 nowadays, you can have 25 diagnoses and all of
2 that. So that lookback of 30 days was to be
3 more inclusive, rather than less inclusive.
4 It isn't a huge number, and if the world were
5 to fall on us, we could chop off the five
6 percent.

7 But we don't have a lot of LTCH
8 patients to begin with, so we try to retain
9 them.

10 CO-CHAIR KAPLAN: Can I ask a
11 question about missing data? What did you do
12 with missing data?

13 DR. INGBER: We were having
14 trouble figuring out what data would be
15 missing, in the sense that either we detect
16 these stays in the administrative data or we
17 don't. The data problems we had were: some of
18 the stays we had turned out to be for managed
19 care people and we excluded them, or some of
20 the people did not have Part A coverage for
21 the period we needed to collect it.

22 So that's the nature of the

1 missing data we have. It's not a systematic
2 kind of missing data.

3 CO-CHAIR KAPLAN: So in your
4 adjusters model, some of those data obviously
5 were not, you know, you couldn't find all
6 those. You'd just assume that they --

7 DR. INGBER: We would eliminate
8 those patients who didn't have good data, and
9 good data meant, you know, useful data.

10 CO-CHAIR KAPLAN: Right, and what
11 -- do you have a sense of how many folks that
12 was?

13 DR. INGBER: Oh yeah. We actually
14 have a chart. We had a sort of flow chart in
15 here. Let's see. I mean it's a small number.
16 Let me put it that way. It's not a major
17 issue.

18 CO-CHAIR KAPLAN: It's under five
19 percent, yes.

20 DR. INGBER: The thing is that for
21 some kinds of measures -- oh, there it is.
22 Page 12 of something. The nature of the LTCH

1 patients, you don't get a lot of new Medicare
2 patients who are missing data because they
3 just came in. So it tends to be a relatively
4 small number. There are also -- we find
5 people who sometimes who change sex in the
6 Medicare data, and there are some things we
7 just have to lose, because it's unreliable and
8 we exclude them.

9 CO-CHAIR HALL: Larry.

10 DR. GLANCE: One of the other
11 cross-cutting things that I think we could
12 maybe spend about two minutes with, and that
13 I find that is particularly different about
14 this, our meeting today as it was two years
15 ago, is in discussing the scientific validity
16 of these measures and looking at the
17 statistical performance, in the past we've
18 focused primarily on looking at
19 discrimination, how well these measures
20 discriminate between high and low quality
21 performers, calibration on how well the model
22 fits the actual data.

1 But one thing that we didn't
2 really look at in the past and that we're
3 looking at now, and I think it's actually very
4 important, is the ability of a quality signal
5 to predict future performance. This is
6 something that all of our measure developers
7 are being asked to look at.

8 So essentially, what they're doing
9 is they're saying okay, we're going to look at
10 the performance of our hospitals in one time
11 period, and see how well that predicts future
12 performance.

13 We're measuring that using the
14 inter-class correlation coefficient, and what
15 we're finding is that, at least for this
16 measure, there's actually a very, very high
17 correlation between past performance and
18 future performance. I think the correlation
19 coefficient was .08.

20 And that's something to bring out,
21 and that's something that we should look at in
22 all the measures that we're evaluating, in

1 terms of examining the scientific validity of
2 these measures. I think that's very
3 important.

4 DR. INGBER: I think you wouldn't
5 want the correlation to be too high, because
6 that means that nobody ever changed. But yes,
7 it's -- when we look from one set of year's
8 data to the next, it showed a reasonably high
9 correlation of the facility measure.

10 CO-CHAIR HALL: Karen, and then
11 Tom.

12 MS. PACE: Yeah. I just want to
13 clarify that NQF does not really ask the
14 correlation from one time period to another as
15 a reliability test, often because the fact
16 that we are looking at these in the context of
17 performance improvement, as what you just
18 heard.

19 I mean it's -- I'm not sure how to
20 interpret that when you have high correlation
21 from one time period to the next. Does it
22 mean that the measure's reliable, or does it

1 mean that no one's changing? So, typically,
2 what our testing task force had recommended is
3 signal-to-noise reliability, or the split half
4 reliability.

5 So I just want to put that in
6 context, that it's not something specific that
7 NQF asks for, because of the kind of
8 contextual ideas about improvement over time.

9 CO-CHAIR HALL: Larry, do you want
10 to respond before we let Tom respond?

11 DR. GLANCE: Thank you very much
12 for that clarification. I guess to me when a
13 quality signal predicts future performance in
14 the next, the following year, that just has a
15 tremendous amount of face validity, as opposed
16 to if the quality measurement was just picking
17 up a lot of noise. Then you would expect very
18 little correlation year to year.

19 CO-CHAIR HALL: Tom.

20 DR. SMITH: Just, I'm not as
21 familiar with Medicare claims data, so just
22 going backwards, and this may be an easy

1 question that's addressed. I don't remember.
2 A lot of people leave long-term care
3 facilities when they die, and are you
4 confident that those people are accurately
5 identified and managed in this measure?

6 DR. INGBER: Measuring death, we
7 actually are using the discharge status from
8 the LTCH itself. There's a potential
9 discrepancy when you use either Social
10 Security or Railroad Board death dates. So we
11 think the hospital knows when somebody has
12 expired, and we trust them for that.

13 I can -- at the risk of
14 expatiating here, the Railroad Board death
15 dates are almost, that I've seen in the data,
16 are almost the last day of a month, which is
17 quite a coincidence. So you know, depending
18 on the source. We're using the hospital, in
19 this case the LTCH, as the source of that.

20 CO-CHAIR HALL: Thanks. Can you
21 clarify? The 30-day, the short stay prior
22 lookback is 30 days prior to the LTCH

1 admission?

2 DR. INGBER: Yes.

3 DR. HEIDENREICH: Is there any
4 evidence on how many discharges are influenced
5 strongly by patient and family preference, as
6 opposed to clinical decisions?

7 DR. INGBER: Using the admission
8 -- I mean using the claims data only, we
9 really don't have any idea.

10 DR. HEIDENREICH: I think that was
11 for -- I don't know if there's any clinical
12 experts in the room who deal in these centers.

13 DR. GRIGONIS: I should just speak
14 to that a little bit. I think most of the
15 decisions are made by physicians. The family
16 members may choose, for example, if they're
17 sending them to a facility, that they might
18 choose different facilities. But it's not
19 usually the case that the patient's family
20 would make a decision, unless it's to hospice,
21 whether not to go back, for example, to an
22 acute care hospital.

1 CO-CHAIR HALL: Leslie.

2 MS. HALL: Maybe it's the
3 unintended consequences section, but it's a
4 follow-up to this theme, that we have such
5 disparity.

6 Oregon has more people dying at
7 home, twice as many as they do in
8 Massachusetts, and we do not want the
9 unintended consequences of this measure
10 reducing the ability for the family to make
11 decisions with more autonomy, because there's
12 pressure to perform in any particular way.

13 CO-CHAIR HALL: Leslie, are you
14 saying you see a potential here, the way this
15 is specified?

16 MS. HALL: I think the question
17 comes up is if we have no way to determine
18 whether this was at the will and desire. I
19 mean, the family's decision-making vacillates
20 often, and so coming home and then not having
21 follow-up care, because we're now -- we're in
22 a comfort care only, and then changes of mind.

1 Now readmitted back through the emergency
2 room, then back through the whole cycle again.

3 So we want to encourage shared
4 decision-making and encourage patient
5 discussion, and not end up creating unintended
6 consequences of this cycle. So I don't know
7 whether this is the appropriate time to talk
8 about it, or whether this is the appropriate
9 measure, or how that reflects it.

10 I just think this is a social
11 issue that's emerging more and more, as we get
12 more aware of polls and more aware of advance
13 directives, and we would not want to reward
14 the wrong thing.

15 CO-CHAIR HALL: Kathy.

16 DR. AUGER: The follow-up on that
17 is do you have information of whether any of
18 these patients are discharged to a hospice
19 service? Is that in there compared to home,
20 and if so, then maybe that's one way to say
21 like, potentially, we shouldn't be counting
22 readmissions from hospice, because maybe it

1 was the family just changing their mind. You
2 don't know.

3 DR. INGBER: We don't take count
4 of where the patient actually goes. The
5 notion is you'll send them to the best place
6 they should go, if you're doing this right.
7 The actual bias, if you want to call it that,
8 if we're going to discuss this, is in the
9 favor of Oregon, because if you go into
10 hospice or palliative care and what-not,
11 you're less likely to get admitted, and
12 therefore your rates will go down.

13 So even though you're being
14 predicted at a national level to be having
15 readmissions, if you have more patients dying
16 at home, your scores will improve, compared to
17 everybody else. So you're safe.

18 CO-CHAIR KAPLAN: So when we talk
19 about reliability, I want us to kind of
20 separate, and it comes back to Larry's point,
21 inter-class correlations tell you the ratio of
22 between facility variation over between, plus

1 within facility variability. So in terms of
2 single item measures, it's often used as a
3 reliability estimate. So is there more, you
4 know, between facility differences in these
5 measures than there is a thumbprint across
6 patients within a facility?

7 But in terms of validity testing,
8 what Larry was talking about is, is there
9 discriminate validity? Are we looking at the
10 ability of these institutions? Can we
11 distinguish one institution from another, and
12 it gets a little confusing when you're talking
13 about inter-class correlation.

14 I think where Larry was getting at
15 is, when you shift over into a validity, kind
16 of are we right, do we have these measures
17 right, then the question is: can you pick
18 another measure that should give you more or
19 less the same information, that either you can
20 predict a state in the future, or for example,
21 with mortality rates or other kinds of things,
22 can you find another measure that institutions

1 that deliver good care should also be showing
2 positive results on?

3 That gets a little more dodgy when
4 we're talking about these kind of facility
5 issues, until we've had a chance to use the
6 measure. So I just wanted to sort of clarify
7 when you're voting on the reliability versus
8 validity what you're talking about, what we as
9 a group are talking about.

10 CO-CHAIR HALL: So within
11 reliability, just to beat a dead horse, and
12 not to offend any of you who know this inside
13 and out, within the topic of reliability, with
14 the guidance that NQF has provided in prior
15 white papers, there are really two concepts.

16 One is that signal to noise
17 concept, right, how much error is there in
18 measuring this provider, versus the variation
19 we see across providers. That's the signal to
20 noise concept. That's an acceptable thing to
21 report upon by NQF guidance.

22 The other acceptable thing to

1 report upon is really reproducibility,
2 consistency of getting a particular result,
3 which that again, as Sherry has indicated,
4 that result may be wrong. But is it
5 consistently obtained, and that's really
6 consistency of testing, split sample testing,
7 reproducibility of a finding over time or
8 using different testing modes.

9 So either of those two larger
10 topics, either the signal to noise area or the
11 reproducibility area, NQF has said are
12 acceptable under this topic of reliability.

13 DR. GRIGONIS: And also --

14 CO-CHAIR HALL: Yes.

15 DR. GRIGONIS: I was just going to
16 add, as far as the validity, a more sensitive
17 test of validity would be the c-statistic.
18 Could you just comment on the fact that it was
19 fairly low? I know health care models
20 typically don't have really high c-statistics,
21 but this was, I believe, .63. So there's a
22 probability of predicting an outcome above

1 chance?

2 DR. INGBER: Right. The c-
3 statistic is fairly low on this, and it was
4 disappointing, because you always like to see
5 a higher number. The IRF number was much
6 higher, relatively speaking in this world.

7 This number is indicative to me of
8 the fact that we have a population of multiply
9 comorbid, sick people, and with the randomness
10 factor added in all health care predictions,
11 this is a tough group to tease apart.

12 The model itself actually has a
13 good range of predicting people, from over 40
14 percent on the average on the high end, and I
15 think it was 13 percent or something like that
16 at the low end. It was actually able to have
17 a range, when you look at the people.

18 So it is teasing them apart, and
19 the predictive ratios indicating over and
20 under-prediction were quite good. But the C
21 statistic is the one statistic that is not so
22 beautiful, indicating that specificity and

1 sensitivity don't give you the kind of
2 precision you'd really like.

3 I find that the fact that it still
4 seems to be able to tease apart the facilities
5 pretty well, and that it has a good range of
6 prediction for individuals, that it's not all
7 squinched in and everybody's got a 24 percent
8 probability, means there's something good
9 happening in here, and the c-statistic,
10 however, is just not backing that up, you
11 know. There's no saying that it's bigger than
12 it is. It's better than chance, but not huge.

13 CO-CHAIR HALL: Thank you. So
14 we're at our time limit. I'll ask Karen to
15 make whatever comment she's burning to make,
16 and then we'll move to vote.

17 MS. PACE: I was just gong to say
18 on the c-statistic, the other thing to keep in
19 mind is for risk modeling, you don't expect it
20 to be one, because you're purposely leaving
21 out some of the explanatory variables, meaning
22 the actual care provided.

1 So if it were approaching one, it
2 would really be saying that the outcome is
3 only predicted by patient characteristics. So
4 just to put that in context, even though that
5 range can go up to one, when we're only
6 including the patient factors available at the
7 start of care, we don't expect it to be that
8 high. But obviously somewhere higher is nice.

9 CO-CHAIR HALL: So Cristie, quick
10 comment.

11 MS. TRAVIS: It would help me to
12 have an understanding of what's considered
13 good with some of these statistical, you know,
14 testing, both on the reliability side and on
15 the validity side. So if there's somebody who
16 could quickly tell us that, that would be very
17 helpful to me.

18 CO-CHAIR HALL: Well, I wish there
19 were an answer to that, Cristie.

20 MS. TRAVIS: Well then I don't
21 know what it's low.

22 CO-CHAIR HALL: I'll tell you.

1 With respect to C statistic, you're asking
2 whether you can tell an event from a non-
3 event, and anything better than .05 means
4 you've improved over a random guess.

5 MS. TRAVIS: Right.

6 CO-CHAIR HALL: So the economist
7 would say if you can explain two percent of a
8 phenomenon, you know, you're going to win a
9 Nobel Prize. In our lives, we say we want,
10 you know, 30 percent of the residual
11 explained, so that your c-statistic is, you
12 know, remarkably high.

13 But the real problem is that when
14 you have a homogeneous patient population,
15 your c-statistic's going to look horrible, and
16 as Karen said, when you're expecting there to
17 be an event from the therapy applied, that's
18 going to make your c-statistic look kind of
19 odd as well. So there's not one answer to c-
20 statistic. Usually, we like to be dealing in
21 the .07 range. But in this case, we're in the
22 .06 range and so be it.

1 CO-CHAIR KAPLAN: The same thing
2 is true by the way, not to interrupt you, with
3 inter-class correlation coefficients, because
4 it totally depends on the sample you're
5 looking at. For some of these things, where
6 there's not very much variation to work with,
7 they tend to be in the range of .025, .22,
8 which is not great.

9 I mean some of us would not
10 consider that very reasonable at all. On the
11 other hand, that's what you get in these kinds
12 of -- many of these kinds of comparisons,
13 especially when the variation is tight.

14 CO-CHAIR HALL: And for the ICC
15 type of reliability measurements, that is
16 currently controversial, but many people would
17 say .04 is a minimum. We call it moderate,
18 but it's really considered minimum. Many
19 people are saying it should be .07 if you're
20 paying people or not paying people, but there
21 are very, very few models that reach that
22 level of reliability in practice. So

1 unfortunately, there's not one answer.

2 I was about to say that Sherry and
3 I are in this unfortunate position of needing
4 to move the voting along. At the same time,
5 as a scientist myself and as a provider
6 myself, I don't like the notion that we would
7 vote before people have a comfort level to
8 vote.

9 So we will move a vote along, and
10 you all have to raise your hand and say I'm
11 not comfortable with that, if that's the case,
12 and if we don't get our work done in the next
13 two days, we'll make up for it. So I'll call
14 for a vote, unless people raise their hand and
15 say we are not comfortable. Larry.

16 DR. GLANCE: One ten second
17 comment. When you're considering the
18 statistical performance of all these models,
19 you have to consider it within the framework
20 of all the other models. For readmission
21 measures, c-statistics of .06 to .065
22 extremely common. There is nothing unusual

1 about this one.

2 CO-CHAIR KAPLAN: Exactly, thank
3 you. And the same thing is true, by the way,
4 with inter-class correlation coefficients.

5 MS. SHAHAB: So we're going to
6 vote on 2a, Reliability, which includes
7 precise specifications and testing,
8 appropriate method and scope with adequate
9 results. 1 is high, 2 is moderate, 3 is low,
10 4 is insufficient, and the time starts now.

11 MS. SHAHAB: We have all 24 votes.
12 4 is high, 19 moderate, 1 low and 0
13 insufficient. So we can go ahead and vote on
14 2B, validity, which includes specifications
15 consistent with evidence, testing, exclusions,
16 risk adjustment, stratification, meaningful
17 differences and comparability, multiple
18 specifications, missing data.

19 1 is high, 2 is moderate, 3 is
20 low, 4 is insufficient. The time starts now.

21 MS. SHAHAB: We have all 24 votes.
22 0 high, 17 moderate, 7 low and 0 insufficient.

1 CO-CHAIR HALL: Any specific
2 comments on the area of Feasibility. Karen,
3 is your card up? I got you. I don't see any
4 comments. Wait, Wes.

5 DR. FIELDS: Just real quick. I
6 think in terms of the CMS, the Medicare
7 population, it would be highly desirable to
8 know what the outcome following discharge from
9 LT facilities is. I think it's very much
10 about palliative care, hospice care and really
11 above average community care, or family care
12 for that matter. So although it wouldn't be
13 -- it may or may not reflect directly on the
14 facility, but it would say a lot about the
15 community's ability to really do what's often
16 necessary for these very complex, chronically
17 ill patients. So speaking in favor of looking
18 at disposition, at least at some point in the
19 future on this measure, if approved.

20 CO-CHAIR HALL: Thank you. Any
21 other comments? Not seeing any.

22 MS. SHAHAB: We can vote on

1 Feasibility, which is 3A, data generated
2 during care, 3B, electronic sources and 3C,
3 data collection could be implemented, e-
4 measure feasibility, assessment of data
5 elements and logic. 1 is high, 2 is moderate,
6 3 is low, 4 is insufficient, and the time
7 starts now.

8 MS. SHAHAB: We have all 24 votes.
9 13 high, 10 moderate, 1 low and 0
10 insufficient. We can go ahead and vote on
11 Usability and Use now.

12 CO-CHAIR HALL: One second, Zehra.
13 Any comments on Usability? Leslie.

14 MS. HALL: Back to the flow of
15 care, going into the observation area and then
16 back out to the facility. My only concern
17 would be is that there are so many limited
18 numbers of beds, and is this another
19 opportunity to redirect a patient, because of
20 the potential negative consequences of
21 readmitting to my facility. So my concern is,
22 as a consumer advocate, are we just making it

1 harder to get people back to the right care as
2 a result, as an unintended consequence?

3 CO-CHAIR HALL: Other comments or
4 concerns? Yes, Tony.

5 DR. GRIGONIS: I just want to
6 reiterate the same comment I made before about
7 adapting this for an actual improvement
8 measure, instead of a static two-year time
9 period. Also, I just want to add in terms of
10 Usability and Use, and that is it will be
11 important, I think, when this becomes a public
12 measure that's reported, that some kind of
13 education is added to this measure. Because
14 you'll have facilities, for example, that had
15 very low readmission, who would now look like
16 they're higher because of the movement toward
17 the mean. So I would strongly encourage that
18 that would become part of this measure, so
19 that the public can interpret it correctly.

20 CO-CHAIR HALL: Helen.

21 MS. SHIPPY: Just really quickly.
22 So the LTCH is actually the responsible party

1 here, right? So in terms of Leslie's comment,
2 you know, someone who goes back for an ob
3 stay, who has been discharged from LTCH, the
4 LTCH has no ability to tell the -- or when
5 they go to the ER and the acute care, they
6 have no ability to tell the acute care whether
7 or not to admit this person or not.

8 It's very rare, actually, when
9 people go out to the community. I think
10 someone made this point before, that patients
11 would be directly admitted to an LTCH from the
12 community. It's actually incredibly -- it's
13 very rare.

14 MS. HALL: So the observations
15 still go back to the LTCH, versus an
16 inpatient? I'm talking about going back to
17 the long-term plus acute readmission, versus
18 their going into the hospital, direct from
19 observation.

20 Find a bed, send the patient. Are
21 we negatively reincenting that readmission
22 when we have such a sparse amount of beds

1 available, especially in a highly complex
2 patient? At my facility, we don't have
3 ventilators, except in one facility. So this
4 is a big problem for us.

5 CO-CHAIR HALL: So there are two
6 aspects, Leslie. One is you might feel so
7 strongly about this that you would be advising
8 the developer to respecify, and the other is
9 that you would just be voicing to all of us
10 that you think there's a potential unintended
11 consequence that you want all of us factoring
12 into our decision.

13 MS. HALL: Uh-huh.

14 CO-CHAIR HALL: Russ.

15 DR. EDMUNDSON: Just a question.
16 Is it possible that the same patient would be
17 discharged from an acute care hospital into a
18 long-term acute care, get discharged, get
19 readmitted back to an acute care and that same
20 patient gets counted as a readmission both in
21 the hospital and the LTCH counts?

22 CO-CHAIR HALL: Yes. You mean in

1 separate measures, could a hospital be double
2 jeopardy, separate measures? Absolutely,
3 yeah. Not within ths measure, no. I
4 understand, yeah. But across measures, double
5 jeopardy can happen. If the developers want
6 to express anything contrary to that?

7 DR. INGBER: Not exactly contrary,
8 but yeah, it's certainly possible. But given
9 the lengths of stay in LTCHs before they tend
10 to discharge, the fact of it being within 30
11 days of that initial hospital discharge is a
12 little bit unusual, but possible.

13 CO-CHAIR HALL: Paula.

14 MS. MINTON-FOLTZ: My question is
15 does the three-day rule apply to LTCH
16 readmissions or admission to LTCH? If anybody
17 knows, because I guess you could come back as
18 an observation patient and be missed in this
19 readmission, but really don't meet acute care
20 criteria. But if the three-day rule is in
21 place, then you artificially have to be
22 readmitted in order to gain access. Does that

1 make sense? Observation, no. That's whole
2 another task force.

3 CO-CHAIR HALL: It's a good
4 question.

5 DR. INGBER: Yeah. I'm not
6 positive myself about whether it applies. I
7 thought it applied to all of the inpatient
8 stays. But that may not be the case. I'm
9 sorry, yeah, you're right. I don't know for
10 sure.

11 CO-CHAIR HALL: Wes?

12 DR. FIELDS: I just want to
13 support Paula's question, because it sort of
14 gets back to the one I asked about the science
15 of this.

16 The paradox is a lot of this isn't
17 science; it's CMS policy, rules and regs,
18 admission criteria. They're quite different
19 for acute care facilities and for long-term
20 care facilities, and I believe that that's
21 probably the primary driver of where these
22 patients get readmitted.

1 The other is whether or not they
2 have any remaining eligibility in -- I guess
3 it's Part A, for long-term care. I think it's
4 very likely that there's actually a
5 substantial number of patients that do get
6 readmitted, because they clearly are failing
7 in the community after a recent long-term care
8 stay, and readmitted to the hospital sort of
9 by default, so that you can restart the clock
10 on the three-day rule.

11 I could be wrong about that, but
12 if so, somebody would need -- you know, from
13 CMS would need to tell me which part of it I'm
14 getting wrong. But I think that's really the
15 practice in community settings wherever CMS
16 patients are served.

17 CO-CHAIR HALL: So again, Wes,
18 what I'm hearing is either an advisement to
19 the developer, that you feel this measure is
20 spec'd inappropriately because of that
21 concern, or at a minimum, you're raising your
22 own concern for unintended biased behaviors,

1 and thus unintended consequences.

2 DR. FIELDS: Yeah. I think the
3 way I would phrase that is that back to the
4 science of this. I think that there's plenty
5 of reasons to distinguish between these
6 outcomes, because I don't think they're the
7 same. I think a patient being readmitted to
8 the hospital is a fundamentally different
9 patient.

10 Even though they may share a lot
11 of comorbidity. But the reasons they get
12 readmitted to the hospital for acute care are
13 categorically different under CMS criteria, as
14 well as clinical, you know, cognitive stuff,
15 versus the beneficiaries being readmitted to
16 an LTCH. So I just -- to me, this is another
17 example of us lumping what I think we need to
18 be splitting. I'd be much more comfortable
19 with this as two separate measures, looking at
20 each as separate outcomes.

21 CO-CHAIR HALL: Or if we had a
22 number about the frequency of this readmission

1 to the LTCH, if it's really a contaminant. I
2 mean if it's a tiny number, it's really not
3 much of a contaminant, right, and not only --
4 again, that readmission to the LTCH also, no,
5 it does not have to have a 30-day lookback
6 short stay, no. So if we knew something about
7 how big of a contaminant this is, we'd be able
8 to make a better judgment. Do we have the
9 ability to ask the developers to provide that
10 information tomorrow?

11 MR. AMIN: That's a question for
12 the developer, as to whether that could really
13 realistically be produced.

14 DR. INGBER: Or reproduced within
15 how many days? No, we can come up with a
16 number. We know where people are readmitted
17 in our data. We just haven't bothered to
18 isolate that. So in a few days, we could pull
19 that out.

20 MR. AMIN: But not by tomorrow.

21 CO-CHAIR HALL: So do we have a
22 comfort level to move to voting on Usability?

1 Oh, I'm sorry, Pam.

2 DR. ROBERTS: I just have a
3 question for the developers. How are
4 interrupted stays dealt with within the data?
5 Are they -- if interrupted stay is within the
6 LTCH?

7 DR. INGBER: The interruptions
8 don't really count in here because they have
9 to be discharged discharged. You know, when
10 you have the interruption and they're
11 effectively readmitted and the discharge is
12 effectively cancelled because it's one stay
13 they're going to get paid for.

14 So we're not looking until after
15 that discharge is a discharge, as opposed to
16 a temporary discharge.

17 DR. ROBERTS: Okay. So they're
18 excluded?

19 DR. INGBER: I'm sorry?

20 DR. ROBERTS: So they're excluded
21 from your analysis?

22 DR. INGBER: Yes, right.

1 CO-CHAIR HALL: They're ignored as
2 much as excluded, yes. Frank.

3 DR. BRIGGS: I was just going to
4 comment. It's my understanding that the
5 three-day rule is applicable to skilled
6 nursing facilities, not for inpatient rehabs
7 or LTACHs.

8 CO-CHAIR HALL: Maybe I
9 misunderstood the question. Paula, wasn't
10 your question when a patient goes back to a
11 short stay hospital, they have to be there
12 three days now to be considered a readmission,
13 and so therefore it's not considered an event
14 in this model?

15 MS. MINTON-FOLTZ: That was my
16 question. I know for a fact that applies to
17 SNFs. I don't know whether it's LTACH or
18 inpatient rehab.

19 DR. INGBER: What, the three-day
20 rule?

21 MS. MINTON-FOLTZ: It's a three
22 day --

1 DR. INGBER: The three-day rule
2 that I've seen --

3 MS. MINTON-FOLTZ: Yes. It's a
4 mandatory three day rule before you can gain
5 admission. You can't just go right into a
6 nursing home from -- skilled nursing right
7 from home or from the clinic. So but I don't
8 know whether -- so it will apply in the next
9 measure for sure, but I don't know if it
10 applies on this one.

11 DR. INGBER: I don't think it
12 does. I don't think it applies to anything
13 but nursing homes. I'm sorry, I was a little
14 confused the last time around. But the three-
15 day rule is only a SNF rule, and that's it.

16 MS. MINTON-FOLTZ: I think that
17 when I Googled it, it looks like that's
18 considered an interrupted stay and not --

19 (Off microphone comment.)

20 DR. INGBER: I mean, you can --

21 MS. MINTON-FOLTZ: Yes, which is
22 different.

1 DR. INGBER: You can walk in off
2 the street to any of the post-acute cares, and
3 there are LTACH admissions off the street and
4 there are ERF admissions off the street. It's
5 just that they're not a high proportion of
6 them. So the three days does not get mixed up
7 in this measure.

8 CO-CHAIR HALL: So I think we have
9 to move forward. Obviously, some of you may
10 have some level of uncertainty or discomfort
11 around various aspects, and I think you have
12 to express that when you vote. So unless
13 anyone wants to throw up a stop sign, I think
14 we'll move to a vote.

15 MS. SHAHAB: We're going to vote
16 on Usability and Use. 4A, Accountability and
17 Transparency. It's used in accountability
18 within three years, public reporting within
19 six years, or if it's new, credible plan. 4B,
20 Improvement. Progress demonstrated and if
21 new, credible rationale, and 4C, benefits
22 outweigh evidence of unintended negative

1 consequences to patients and populations.

2 1 is high, 2 is moderate, 3 is
3 low, 4 is insufficient information. Time
4 begins now.

5 We have all 24 votes. 0 high, 9
6 moderate, 10 low, 5 insufficient information.
7 So we can go ahead and vote for overall
8 suitability for endorsement. Does this
9 measure meet NQF criteria for endorsement? 1
10 is yes, 2 is no. Time begins now.

11 CO-CHAIR KAPLAN: Can everyone do
12 it one more time, please?

13 MS. SHAHAB: We have all 24 votes.
14 10 yes, 14 no. For Measure No. 2512, All-
15 Cause Unplanned Readmission for 30 days post-
16 discharge from long-term care hospitals.

17 MR. AMIN: So this is an example
18 of a measure that's sort of fallen into our
19 gray zone, where consensus hasn't been
20 reached. So this measure will continue to
21 move forward in terms of the comment period,
22 and we'll revisit this during the comment

1 call, and yes.

2 DR. INGBER: Just to ask a
3 question. If that number of readmissions to
4 LTACHs was a key to any of this, we can call
5 the programmer and have a number for you
6 either this afternoon or tomorrow.

7 CO-CHAIR HALL: Well, I think what
8 you've heard now is that that expresses our
9 group's opinion for now. The measure is not
10 prevented from moving into the next phases, so
11 if I were you, I would be prepared to comment
12 on those figures in the next phases. Thus, I
13 don't think it's necessary to comment on it
14 tomorrow.

15 MS. KHAN: Yes. We'll follow up
16 with you with more steps after the meeting.

17 CO-CHAIR HALL: And I believe
18 we're about a half hour behind schedule now,
19 so we succeeded in reaching that goal pretty
20 quickly.

21 (Laughter.)

22 CO-CHAIR HALL: We will move on to

1 2375, and our invited discussant to kick off
2 a brief description of their measure will be
3 the American HealthCare Association, and then
4 I'll ask Helen and Frank to kick off on the
5 group side. We thank RTI so far. We think
6 we'll have them back shortly.

7 So when ready, we'll ask American
8 HealthCare Association to introduce themselves
9 and briefly describe their measure.

10 MS. KHAN: Do you have anyone on
11 the phone who needs an open line?

12 DR. GIFFORD: My name is David
13 Gifford. I'm a geriatrician and the senior
14 vice president for Quality and Regulatory
15 Affairs at the American HealthCare
16 Association, NCAL. We represent about 10,000
17 of the 15,000 nursing homes across the
18 country.

19 MS. SHAW: I'm Urvi Shaw, and I
20 work for the American HealthCare Association
21 as their senior manager of Quality
22 Improvement.

1 CO-CHAIR HALL: So please, briefly
2 describe your measure if you would.

3 DR. GIFFORD: So our measure is
4 an all-cause rehospitalization measure for
5 individuals admitted from a hospital to a SNF,
6 regardless of payer status, regardless of
7 condition, regardless of issue. It looks at
8 any readmission that occurs within 30 days
9 during their SNF stay.

10 If they leave the SNF before 30
11 days and are then hospitalized after
12 discharge, they're not counted. We utilize
13 the MDS record. Therefore, we capture any
14 stay in the hospital, whether it be an
15 inpatient Medicare stay or an observation
16 stay, whatever other insurers might include
17 out there for the overall measure.

18 The measure is a rolling 12-month
19 measure. It has a minimum denominator size of
20 30. It has no exclusions and is calculated
21 for all the nursing homes in the country.
22 Currently, four ACOs are using this measure on

1 a regular basis. An MCO is using this data
2 and we are in the process of sending the
3 entire state of New Jersey, all the nursing
4 homes in New Jersey's data to a couple of ACOs
5 in New Jersey for their use as well.

6 And probably since you're behind
7 schedule and the more important thing is to
8 answer your questions, I'll stop there, or I
9 could keep describing in detail.

10 CO-CHAIR HALL: All right, thank
11 you very much. So I think the group is
12 getting used to the sense that we're going to
13 first discuss the evidence, and I'll ask Helen
14 and Frank to kick off the discussion.

15 DR. BRIGGS: So there's a
16 considerable gap in the variation across the
17 country. I think we have some statistics
18 included by state provider, from lows of 13 up
19 to 22 percent by state. I think there's
20 considerable variability there, that points to
21 the overall need. This is again, an outcome
22 measure in terms of readmissions.

1 DR. CHEN: And just as a comment,
2 you know, it sort of -- the evidence is a
3 little bit of a gamish in terms of what the
4 literature that's reported out there. Some of
5 it is really conflated between long-term care,
6 true long-term care versus people who are in
7 post-acute SNF.

8 It probably doesn't make a huge
9 amount of difference regarding this measure,
10 but just so you know, the literature out there
11 is very mixed on this topic, although
12 technically I would say that there probably
13 are process measures that do impact whether
14 people do have a higher or lower rate of acute
15 care utilization in nursing home facilities.

16 CO-CHAIR HALL: Others with
17 comments or concerns on the topic of evidence?
18 If not, we'll move to vote.

19 MS. SHAHAB: Voting is going to be
20 open for 1A, Evidence. Rationale supports the
21 relationship of health outcomes, at least one
22 health care structure, process, intervention

1 or service. 1 is yes, 2 is no. Time begins
2 now.

3 MR. AMIN: Paulette, I think
4 we're waiting on your vote.

5 MS. SHAHAB: Voting is now closed.
6 22 yes and 1 no.

7 So now there's 23 yes and 1 no.

8 CO-CHAIR HALL: Gap, performance
9 gap. Helen or Frank, anything else to add?

10 DR. CHEN: No. I think Frank
11 spoke to that.

12 DR. BRIGGS: I think when you look
13 at the actual readmission rates, the average
14 in this range is 18 as compared to the
15 inpatient rehabs and the long-term acute
16 centers, both having lower. So I think there
17 is a larger issue with the skilled nursing.

18 MS. SHAHAB: 1B, Performance Gap.
19 1 is high, 2 is moderate, 3 is low, 4 is
20 insufficient. Time begins now.

21 MS. SHAHAB: We have all 24 votes,
22 so voting is closed. 15 high, 9 moderate, 0

1 low, 0 insufficient.

2 CO-CHAIR HALL: Priority, high
3 priority. Any comments? Seeing none.

4 MS. SHAHAB: Voting is open for
5 High Priority, 1C. 1 is high, 2 is moderate,
6 3 is low, 4 is insufficient, and your time
7 begins now. We're missing a few
8 votes. Just one more.

9 For High Priority, 19 voted high,
10 4 moderate, 0 low, 0 insufficient.

11 CO-CHAIR HALL: Let's open the
12 discussion on Scientific Acceptability,
13 Reliability, Validity. We'll again invite
14 Frank and Helen to start.

15 DR. CHEN: I had a question
16 regarding why planned readmissions were not
17 excluded from this measure because my question
18 would be, how would this be actionable at a
19 facility level, you know, to be held
20 accountable for that?

21 DR. GIFFORD: So when we
22 developed this measure, it's based off MDS

1 data. So we don't know and it wasn't a
2 variable in the MDS to collect
3 planned/unplanned. Subsequent to the
4 development of the measure in the last year,
5 CMS has added that as a variable.

6 It is missing data 82 percent of
7 the time, and so we do not want to use a
8 claims-based component of this because it (a),
9 restricts the population down to only Medicare
10 fee for service, and this is out of the huge,
11 growing population of managed care.

12 We worked under the assumption,
13 looking at some of the broader data, that
14 other than a handful of facilities, this would
15 not affect the overall rate at a facility
16 level measure, certainly at individual levels.
17 It is probably one of the more common
18 questions we get from many of our members when
19 they're exploring the data that's out there.

20 We are looking at whether we can
21 utilize that MDS data, but it's been a new
22 item. So the reliability and validity of it

1 is not tested, so we didn't feel comfortable
2 using that measure overall.

3 DR. CHEN: Along the lines with
4 missing data, I noticed that in your
5 discussing regarding missing data, you provide
6 some description of the relative low
7 prevalence of missing data, but then you add
8 a statement saying that it would be useful to
9 calculate its effect on the numerator. I
10 wondered if you could flesh that statement out
11 more.

12 DR. GIFFORD: So we calculate
13 this based on the admission MDS assessment as
14 to whether they were admitted from a hospital
15 or not, and then the requirement is that all
16 discharges, whether they die or not, go home,
17 or any acute care setting, a discharge MDS
18 assessment be completed.

19 We are able to look then out to
20 see if discharge assessments are being filled
21 out consistently. If overall, 97 percent of
22 discharge assessments are being filled out

1 that we can assess, if we have less than 95
2 percent completion rate, we do not report the
3 data for an individual facility that's out
4 there, going forward.

5 We have not looked specifically at
6 what the impact of say 90 percent or 92
7 percent would have on the overall, but we felt
8 the greater than five percent missing data for
9 that key element might have -- we would drop
10 them and not report the data.

11 We do suggest and recommend that a
12 flag be provided back to the providers, that
13 they have high missing data on the district
14 assessment form. It tends to cluster in
15 certain facilities, and therefore they would
16 hopefully improve their data collection piece
17 of that process.

18 DR. CHEN: There was a request for
19 a clarification during the work group call
20 regarding the ability to stratify based on MA,
21 MCO organizations, and my understanding is
22 that even though they're included in the data

1 set, that we don't really have a very reliable
2 way of looking at the overall measure based on
3 payer class.

4 DR. GIFFORD: There is a data
5 element in the admission MDS assessment, where
6 the nursing homes are to indicate what is the
7 payer status. It is very unreliable data.
8 Sometimes the portrayal from families or from
9 the hospital as to what the insurer is is not
10 really true, so you discover it after the
11 fact. It's hard to believe.

12 The other is actually, payer
13 status actually changes a lot because of
14 eligibility and various issues. You were
15 talking before about a three-day rule. You
16 often don't discover the three-day observation
17 rule until after you fill in your first MDS
18 assessment. So we don't feel comfortable
19 breaking it out by payer status to stratify
20 that. Though when you look at the SNF claims
21 overall, about two-thirds of all the
22 admissions are, on average, are coming from

1 Medicare fee-for-service.

2 But that again varies by region of
3 the country and it varies by facility, such at
4 some places have very few Medicare fee-for-
5 service altogether if you use that as a
6 metric. So we do not stratify it by payer
7 status.

8 DR. BRIGGS: So in terms of the
9 data collection on the MDS, have you looked or
10 do you know the outliers in terms of -- I know
11 on the hospital sides, having looked at
12 thousands of our discharges recently, we
13 certainly get it right in terms of deaths.

14 But in terms of discharge status
15 to a skilled facility or home, home with home
16 health and things like that, we have certainly
17 a lot of variation between the person who is
18 doing that registration task.

19 So I was wondering if you had any
20 information in terms of outliers. You have
21 missing data, but then do you have a lot of
22 variation between sites?

1 DR. GIFFORD: I'm following up to
2 the very last question. Variation on the
3 sites on what, missing data or --

4 DR. BRIGGS: In terms of their
5 admission sources. Are you seeing a lot more
6 coming from saying that they're being admitted
7 directly from the hospitals, and then on the
8 discharges, are you seeing patients going
9 home, patients being transferred?

10 DR. BRIGGS: It really varies by
11 region of the country, as far as whether
12 people are coming, say Medicare fee for
13 service and managed care or what issues, and
14 also whether they're being directly admitted
15 from the ER without a stay or coming from home
16 into the facility.

17 Clearly, those areas with much
18 higher penetration of managed care, those are
19 some areas with more ACOs. We're anecdotally
20 hearing that. When you look at the data
21 overall, like Arizona, which is all managed
22 care, you can really see some differences out

1 there in Arizona.

2 It also varies by the observation
3 status issue that's out there going forward on
4 it. We have looked at the sensitivity and
5 specificity of the MDS against Medicare claims
6 for those who have just Medicare claims, and
7 it's got a pretty reasonable sense of
8 specificity, same as most diagnostic tests
9 that we use out there.

10 84 percent sensitivity, about 97
11 percent specificity with about -- when you
12 look at the overall measure itself, it's about
13 96, 97 percent in agreement with the measure
14 itself, because you're aggregating at the
15 facility level. I think I -- did I answer
16 your question? Okay.

17 CO-CHAIR HALL: Paula.

18 MS. MINTON-FOLTZ: Thank you.
19 Just a comment regarding the planned
20 readmission question before. It's becoming a
21 very common tactic for the length of stay in
22 hospitals, for orthopedic, trauma and burn

1 stage procedures, to use the intermittent and
2 planned readmission. So I just -- that might
3 be in the Feasibility, but thought I'd make
4 that comment.

5 DR. GIFFORD: We would actually -
6 - I mean, if the hospitals are trying to game
7 the system, we wouldn't pick that up. It's
8 really the facility; it's the SNF. They send
9 the person out. They don't know whether, how
10 they're going to be admitted or what they're
11 going to be admitted for.

12 They will be documented as they
13 went to an acute care hospital and will be
14 admitted, whether it was an observation stay
15 or not.

16 MS. MINTON-FOLTZ: Well, that's my
17 point.

18 DR. GIFFORD: If they came back,
19 they would get them there.

20 MS. MINTON-FOLTZ: I think that's
21 my point. It's a common tactic, in
22 partnership with SNFs, to send people for

1 well, waiting for the swelling to go down, why
2 should they wait for their orthopedic
3 procedure.

4 But I think SNFs would be more
5 reluctant to partner with hospitals, and we'd
6 see a shift in length of stay, if we were not
7 able to like somehow weed out that planned
8 admission.

9 DR. GIFFORD: No, I fully agree
10 that we don't capture planned/unplanned. I
11 would say that hypothesis is very unlikely
12 because the hospitals are so much trying to
13 get people out, and SNFs are so dependent on
14 the volume to come in. They're not willing to
15 criticize hospitals for anything.

16 I mean, the quality of the
17 transfer information, for example, has been
18 historically abysmal when they show up on the
19 doorstep of a SNF from a hospital. But that
20 has improved dramatically since the hospitals
21 are now being held accountable for the 30-day
22 readmission rate.

1 Our broad membership has seen that
2 as a huge bonus, and a much more closer
3 partnership. But you're also seeing an
4 alignment, where you have to sort of take
5 everything. So in the areas where there's
6 ACOs that are really actively going on,
7 they're forming tight networks and they're
8 using this data for network selection, but
9 they're also using it to sort of drive all the
10 volume there.

11 So it would be hard to sort of
12 play, I think, that gaming process that you're
13 describing.

14 CO-CHAIR HALL: I guess even
15 within an ACO, if you want a tighter
16 coordination between hospital and SNFs so that
17 people could move back and forth as
18 appropriate, this measure would defeat that,
19 or it would be a counter-incentive.

20 I think in the broader sense, if
21 we as a profession have moved over time toward
22 the notion that certain things that are

1 planned should be considered separately, which
2 we have for a number of measures in front of
3 us today, and which we have for measures in
4 the past, I'm wondering why we wouldn't ask
5 the same of this measure in front of us today.
6 Leslie.

7 MS. HALL: I'm sorry. I don't
8 know your data source. I'm not familiar with
9 that, and so I have a question about whether
10 patients' goals or directions are included in
11 your data set, to accommodate for what their
12 desires are for appropriate care, that
13 question.

14 And then just also understand, in
15 an area where there's a natural decline and a
16 defined scope of practice, what are the
17 alternatives? Are we rewarding or penalizing
18 the wrong thing? So it's my ignorance, if I
19 don't --

20 DR. GIFFORD: I'm going to answer
21 your first question, and then I'm not sure I
22 understood your second question. The minimum

1 data set can only be described by the
2 government as minimum. It's been in use for
3 almost, I don't know, 15, 20 years now in the
4 nursing home.

5 It was required in OBRA-87, so I
6 guess 87 forward. It has over almost 600 data
7 elements in it for standardized data elements.
8 They're on Version 3.0 right now. Every
9 admission to a Medicare or a Medicaid-
10 certified building, which is about 96 percent
11 of all the 15,000 SNFs in the country, are
12 required to collect that at admission, and
13 then every 90 days thereafter significant
14 change in status.

15 If you are Medicare fee-for-
16 service and most Medicare Advantage plans and
17 a lot of commercial now require you also
18 collect it at admission, and then about every
19 7 to 14 days thereafter, until they're
20 discharged from that acute care episode.

21 It collects a robust set of
22 information around ADL function and cognitive

1 status, pressure ulcers, it's a long list. It
2 goes on and on and on. It's been shown to be
3 pretty reliable and valid.

4 All other quality measures that
5 are currently used on five star public
6 reported measures and in the payment systems
7 that CMS uses rely on the MDS data collection
8 that's out there. It's collected on everyone,
9 regardless of their payer status. It's a
10 requirement. And the second part of your
11 question?

12 MS. HALL: And short answers. No,
13 their patient goals and directions are not in
14 that data set?

15 DR. GIFFORD: There's a couple of
16 questions in there about whether they plan to
17 be discharged home, and what some other goals
18 are. But no, not at a robust level like you
19 might see in a more standard type of rehab
20 center.

21 MS. HALL: Then my second question
22 is my clinical ignorance, but when is a

1 decline a readmission, and when is a decline
2 simply a scope of practice that can't be done
3 inside the skilled nursing facility?

4 DR. GIFFORD: We elected to go
5 with all-cause, to avoid the gameability in
6 that gray zone of when you determine it, and
7 you know, we're using it as a feedback report.
8 So we actually provide it to all 10,000 of our
9 members on a quarterly basis, so they can see
10 the report. Hospitals are using it. At least
11 they had some sense of where they're going on
12 that angle.

13 I would never want to set a goal
14 of zero for this issue, but I think as pointed
15 out by Frank, 18 percent, I think most of us
16 who practice in the setting would agree it's
17 a little bit high.

18 CO-CHAIR HALL: Pam and then
19 Karen.

20 DR. ROBERTS: Could there be any
21 unintended consequence of not having planned
22 events that go back, that could hold the event

1 until after 30 days so that they're not at
2 risk, especially on like, two-stage
3 procedures?

4 DR. GIFFORD: I guess that would
5 apply to any -- I mean any potential provider
6 could try to game the system. Whether it's a
7 claims-based measure or MDS measure, whether
8 it's included or not and how it's defined out
9 there. So I guess if it is, they'd have to
10 hold them a long time to get there.

11 CO-CHAIR HALL: Karen.

12 DR. GIFFORD: I just can't see it
13 happening a lot, to affect the overall
14 measure. These are definitely, as we know and
15 as we see, we've heard before, gender changes
16 on claims all the time. But it's not at a
17 large enough rate to affect the overall
18 metric.

19 DR. JOYNT: I just wanted to
20 comment that I think it's interesting that
21 this is -- oh, it's on. Oh, sorry. I just
22 wanted to comment that I think it's actually

1 interesting that I think the strengths of this
2 measure are almost opposite some of the other
3 ones that we've considered.

4 I don't think we're going to come
5 up with a perfect measure, but I just think
6 there's a few things worth pointing out about
7 why this is different from some of our claims-
8 based metrics, that I think to me makes it an
9 interesting complement, which is that it's a
10 lot more timely than claims-based measures.

11 It's all payer, which I think is
12 really important for understanding disparities
13 and for other patterns of care that we may
14 miss, and we're thinking about only folks who
15 have one particular type of insurance
16 coverage.

17 It doesn't use the shrinkage model
18 from what I can tell from the measure
19 specifications, which may be my own personal
20 bias, which I think is a strength, and it
21 actually -- the data on here would suggest
22 that it runs with other metrics of quality

1 measured at the nursing home level, which many
2 of the other readmission metrics actually
3 don't. So I don't think that this measure is
4 perfect, but I think it's worth noting the
5 ways in which it differs from claims-based
6 measures that might be important for this
7 group.

8 CO-CHAIR HALL: Thank you, Karen.
9 Larry.

10 DR. GLANCE: I think that, I'm
11 probably echoing what a lot of people on this
12 committee feel, that one of the major
13 limitations of this measure is the inability
14 to exclude planned readmissions, and that's --
15 I think it's a significant limitation.

16 Most of all of the other measures
17 that we're looking at today, for better or for
18 worse, are based on Medicare data, and I
19 wonder if you would go back and reconsider the
20 decision to link your MDS data with Medicare
21 data and to maybe reconfigure your measure in
22 such a way that at least, for a certain

1 segment of your patient population, you're
2 able to measure and to exclude planned
3 readmissions.

4 DR. GIFFORD: It is certainly
5 technically possible to do it. It will only
6 apply for the Medicare fee-for-service, where
7 you have the claims, until we have an all-
8 payer national claims database.

9 The trade-off for that slight
10 increase in accuracy, because I don't believe
11 it's that significant in accuracy overall, is
12 that we go from having results within three to
13 four months, within the close of a quarter to
14 having results probably 16 months later. Our
15 membership, the number one complaint is that
16 the data is not timely enough.

17 Basically, they find claims data
18 useless because it comes so late. They don't
19 believe it anymore. They all have their own
20 internal data they're trying to track anyway,
21 and I've seen that with a lot of the hospitals
22 too.

1 I mean, certainly it's based on
2 payments, so people will pay attention to it.
3 But it's so long in coming that we explicitly
4 elected to lose some of the ability for
5 improved risk adjustment and some of this
6 addition for there. I would rather drive it
7 through the reporting of the MDS data for
8 that.

9 But if we did that, it would make
10 the measure not useful for our membership or
11 the SNF community. I would hazard to guess
12 that at the -- seeing some of the data at the
13 hospital end, that the percentage of planned
14 versus unplanned and the variation of that
15 across hospitals is so little that I can't
16 imagine it as a significant variation overall
17 for the overall measures, and that that trade-
18 off is not one that I think we would make with
19 the measure.

20 DR. GLANCE: Really quick follow-
21 up. Do you have empiric data to show that the
22 number of planned admissions is a very, very

1 small fraction of your overall readmissions?

2 DR. GIFFORD: Can I turn to the
3 -- can I ask another contractor? So Karen, do
4 you guys wait? You guys exclude
5 planned/unplanned using the hospital stuff in
6 your SNF RM. What is the number of exclusions
7 of planned readmissions overall, on average?

8 (Off microphone comment.)

9 DR. GLANCE: So I'm asking RTI,
10 who has developed the other measure after
11 lunch, which is the next measure, which is a
12 SNF 30-day readmission measure that's based
13 off Medicare fee-for-service claims.

14 DR. SMITH: Can you hear me?
15 Okay. This is Laura Smith. I'm from RTI
16 International. So what I was saying, before
17 you guys could hear me, was that so our
18 unplanned rate for 2011 of readmissions is
19 21.1 percent.

20 If we were to have included
21 planned readmissions, that would have added
22 1.3 percent, two percentage points to that

1 total, and that 1.3 percent is about five
2 percent of readmissions.

3 DR. GLANCE: Does the relative
4 ranking -- I mean really, the issue is
5 relative ranking and change and --

6 CO-CHAIR HALL: Yes, but I'm not
7 sure we can get into that with respect to your
8 measure, since we -- I don't know that we know
9 as a committee whether all the data are
10 comparable and would apply equally to your
11 measure. We certainly can appreciate that we
12 think on the order of five percent of
13 readmissions in this environment are planned,
14 correct?

15 DR. GIFFORD: If you use the MDS
16 data, as I said out there, right now the ratio
17 is about two percent are labeled as planned
18 versus unplanned, and that's about -- that's
19 being filled out for about 20 percent. So if
20 you assume that 20 percent is represented
21 nationally, it's about two percent, which
22 would correspond approximately to what they

1 just sort of mentioned.

2 CO-CHAIR HALL: So a reasonable
3 guesstimate for now is two to five percent?

4 DR. GIFFORD: Yes. I mean we
5 could certainly try to go back and look at,
6 because we have the claims linked.

7 CO-CHAIR HALL: Understood. So
8 for what's in front of us now, I think we just
9 have to push forward. We all have some
10 uncertainty again, which I think unless
11 somebody needs to throw up a stop sign, we're
12 pretty far behind. So please do throw up a
13 stop sign if you need to, but otherwise, I
14 think we need to move and vote based on
15 whatever uncertainties we might have.

16 Again, it's uncomfortable for us
17 to push to a vote because these are great
18 discussions, very insightful comments from all
19 directions. But we don't have the liberty of
20 staying on one topic all afternoon. So all
21 right, we'll push for a vote on Scientific
22 Acceptability and Reliability on this measure.

1 MS. SHAHAB: We're going to vote
2 on 2A, Reliability. 1 is high, 2 is moderate,
3 3 is low, 4 is insufficient, and time starts
4 now.

5 We have all 24 votes. 4 high, 13
6 moderate, 5 low and 2 insufficient.

7 CO-CHAIR HALL: We'll go on with
8 Validity.

9 MS. SHAHAB: 2B, Validity. 1 is
10 high, 2 is moderate, 3 is low, 4 is
11 insufficient. Time begins now.

12 All votes are in. Voting is now
13 closed. 1 high, 17 moderate, 6 low and 0
14 insufficient.

15 CO-CHAIR HALL: Any specific
16 comments on Feasibility?

17 DR. BRIGGS: Whether it's under
18 Feasibility or not would be -- so this data
19 source actually includes readmissions, both to
20 the inpatient setting and observation setting.
21 The area that it doesn't capture that's very
22 high use by the SNF patients is ER visits,

1 where the patient goes to the ER, is
2 reassessed, is sent home.

3 It still places lots of burden on
4 both the patients and the health care setting.
5 Don't know if there's really any data out
6 there perhaps that should become a balancing
7 measure at some point. But do want to point
8 out that this measure does include both
9 inpatient and observation, which had come up
10 in previous discussions.

11 CO-CHAIR HALL: Thanks, Frank.
12 Helen, anything to add? No. Anyone else.
13 Okay. We'll move to vote.

14 MS. SHAHAB: 3, Feasibility. 1 is
15 high, 2 is moderate, 3 is low, 4 is
16 insufficient, and time begins now.

17 We have all 24 votes. 14 voted
18 high, 8 moderate, 2 low, 0 insufficient for
19 Feasibility.

20 CO-CHAIR HALL: Any specific
21 comments on Usability?

22 DR. BRIGGS: I think this kind of

1 cuts across both this measure and the next
2 measure, but the impact of the CMS 2-Midnight
3 rule, making more people observation status,
4 therefore not qualifying for that three-day
5 rule potentially.

6 I think that has the potential to
7 be not an unintended consequence of this
8 measure, but unintentionally impact the
9 outcome of this measure as we go down the
10 road.

11 MS. PACE: But they're not
12 differentiating, Frank, you know, for people
13 who go back. Irrespective of whether they
14 meet the 2-Midnight rule or not, they're still
15 captured in this data set. So the op stays
16 are actually counted, you know. The
17 facilities are held accountable for people who
18 go back, even if they don't meet the 2-
19 Midnight rule.

20 DR. GIFFORD: Yeah. Since it's
21 not Medicare claims, the three-day rule only
22 affects your ability of whether you're going

1 to qualify to be a Medicare fee-for-service or
2 not. If you don't meet the three-day
3 qualification, you will not have a Medicare
4 fee-for-service.

5 So even if you had, you know, one
6 or two observation days and then you had two
7 inpatient days and you came to a SNF, you
8 wouldn't qualify for Medicare Part A and you'd
9 be using some other insurance. So you
10 couldn't use a claim for that. But ours is
11 anyone coming in from a hospital.

12 CO-CHAIR KAPLAN: I have one quick
13 question about it. Different from claims
14 data, this measure may be more vulnerable to
15 things like are you measuring improved
16 documentation? Are you actually measuring
17 improved quality of care?

18 So could you just give us a little
19 sense of the potential unintended consequences
20 of yes, you've improved documentation and then
21 your quality went in the wrong direction?

22 DR. GIFFORD: Certainly with any

1 claims or any measure, you can change how you
2 code anything. So anything's gameable out
3 there. The MDS data is used for payment
4 purposes. It's used for quality measure
5 purposes.

6 CMS has done some checks in the
7 past but not -- but they just announced last
8 week they're going to start doing more audits
9 of the MDS for the quality measures because
10 they're also about to start using it more for
11 payment and looking at the quality that's out
12 there.

13 But you know, yes, it's gameable,
14 just like any other measure is gameable.

15 CO-CHAIR HALL: Paula.

16 MS. MINTON-FOLTZ: I would just --
17 sorry. I just need to revisit the planned and
18 the observation stay because I think as we
19 move forward in where people should be in the
20 affordability of care at certain levels, I
21 think observation state is a better option to
22 tune somebody up very quickly, as opposed to

1 an admission and that again, it's not a game.
2 It's just making sense of where patients
3 should be.

4 And again, planned readmissions,
5 why should -- patients' recovery between
6 surgical procedures, if they don't need trauma
7 level care, why would we pay for that? So
8 again, I think those are two measures that or
9 two things I just can't get past.

10 CO-CHAIR HALL: Thank you, Paula.
11 Helen.

12 DR. CHEN: Two comments, the first
13 one being regarding the MDS coding intensity
14 issues, for lack of a better term. I think --
15 I'm not sure that this measure actually
16 promotes that per se.

17 I mean, I think organizations who
18 are using MDS and it's tied to reimbursement
19 have already had a huge push already, in terms
20 of improving the documentation. So I don't
21 think this measure per se would actually
22 facilitate that.

1 I think frankly, tying it to
2 reimbursement has pushed that for a lot of
3 facilities. But it is certainly a concern,
4 just like in the MA world, coding intensity is
5 certainly a concern. So just to speak to
6 that. And then regarding -- and then I've
7 lost my train of thought, so I'll just stop
8 here.

9 CO-CHAIR HALL: Yes.

10 DR. GIFFORD: Can I just respond
11 to that? I'd say the bigger area or the
12 problem is not the admissions, whether they
13 came from the hospital or not.

14 It's whether they use a discharge
15 assessment, saying they went to the hospital
16 or not. That's why we ended up setting the 95
17 percent limit, where they're missing the data
18 and they decide not to report that.

19 Because it's hard -- I mean, to
20 actually say they didn't go to the hospital
21 when they really did, you have an audit trail
22 that's in trouble. More than any other health

1 care setting, we get audited and in trouble a
2 lot.

3 CO-CHAIR HALL: The good news is
4 the folks that are not filling out their forms
5 are probably not going to -- are probably
6 going to change that behavior soon.

7 DR. GIFFORD: Yes.

8 CO-CHAIR HALL: There's a number
9 of pressures on them to change that behavior.

10 DR. GIFFORD: And they wouldn't
11 have a data result, and for the observation
12 stays, we would capture them. But for the
13 planned, as we've said, we've beat that dead
14 horse.

15 CO-CHAIR HALL: Thank you, all
16 right. I don't see any other cards up, so
17 let's move into voting Usability.

18 MS. SHAHAB: We're going to vote
19 for Usability and Use. 1 is high, 2 is
20 moderate, 3 is low, 4 is insufficient. Time
21 begins now.

22 Just one more.

1 We have all 24 votes. 5 voted
2 high, 14 moderate, 5 low and 0 insufficient
3 information.

4 CO-CHAIR HALL: All right. Any
5 final comments before overall? I do not see
6 any cards raised. Okay.

7 MS. SHAHAB: Voting is open for
8 overall suitability for endorsement. Does the
9 measure meet NQF criteria for endorsement? 1
10 is yes, 2 is no, time begins now.

11 Just one more vote, please. Okay.
12 We have all 24 votes. For Measure 2375, point
13 right on point, 30 SNF rehospitalizations, 22
14 voted yes and 2 voted no.

15 CO-CHAIR HALL: Thank you for that
16 conversation. It continues to be an
17 incredibly educational one as we go. We'll
18 now open public and member comment.

19 MS. KHAN: Operator, can you open
20 the lines for public comment please.

21 DR. GIFFORD: Thank you all very
22 much.

1 OPERATOR: Thank you. At this
2 time, if you have a question or a comment,
3 please press star and the number one on your
4 telephone.

5 (No audible response.)

6 And there are no public comments
7 at this time.

8 MS. KHAN: Anyone in the room who
9 would like to make a public comment?

10 DR. KRISHNAN: Thank you. My name
11 is Dr. Mahesh Krishnan. I am the vice
12 president for Clinical Innovation and Public
13 Policy for DaVita Healthcare Partners. We
14 serve approximately one-third of the U.S.
15 dialysis patient population. We have 170,000
16 ESRD patients in our 2,220 clinics.

17 The purpose of my visit this
18 morning is to comment on Measure 2496, which
19 you will comment on soon, standardized
20 readmission ratio for dialysis clinics. We
21 are actually opposed to this all-cause measure
22 for both usability and scientific validity and

1 acceptability reasons.

2 We do believe it's important to
3 align incentives to reduce admissions and thus
4 readmissions to the ESRD population, but feel
5 that the measure as constructed has
6 significant issues. There are four specific
7 issues for usability.

8 With regards to usability, we
9 believe that the first reason is that many of
10 the admissions for all-cause are not actually
11 within control of the dialysis unit. Based on
12 an analysis of 2011 Medicare claims data, ESRD
13 patients have an admission rate of 1.88 admits
14 per patient per year.

15 The percentage, however, of those
16 admissions that is attributable to factors
17 directly influenceable by the dialysis unit is
18 significantly much lower. Five percent of
19 admissions were due to vascular access
20 infections, and 27 percent were attributable
21 for all cardiovascular disease, which includes
22 fluid overload, which is something that could

1 be attributable to the dialysis unit.

2 That 27 percent included things
3 outside of the realm of the dialysis unit,
4 such as coronary artery disease, acute MI and
5 many others. The majority, then, of
6 admissions and presumably readmissions then
7 are due to other effects and organ
8 manifestations of chronic disease, most of
9 which are beyond the ability of the dialysis
10 unit to impact.

11 This is actually unique, as
12 opposed to the other measures which are being
13 presented today, where hospitals may have 100
14 percent accountability of admissions and
15 therefore have 100 percent accountability of
16 readmissions. That's different for dialysis
17 units.

18 Secondly, 17 percent of our
19 patients in our data sets -- and we have
20 significant disease measure experience with a
21 skilled nursing plan for dialysis patients as
22 well as a disease measure group. In that

1 analysis, 17 percent of our patients had a
2 readmission within three days post-discharge.

3 That three days represents a time
4 period before the patient has even encountered
5 the outpatient dialysis setting. Again,
6 dialysis is done Monday, Wednesday and Friday.
7 So if you leave the hospital Friday afternoon
8 and you're readmitted over the weekend,
9 there's not a hell of a lot the dialysis unit
10 can actually do to fix that.

11 Within dialysis units themselves,
12 we do not receive timely data, nor are
13 hospitals required to provide such data to
14 dialysis units to coordinate care. Despite a
15 large program, which we enacted approximately
16 three years ago in the past, where six percent
17 of our payments, six percent of all payments
18 were dependent on finding case mix adjusters
19 through discharge summaries, which means we
20 were highly, highly motivated, at one year
21 after the original discharge, index discharge,
22 less than 50 percent of those discharge

1 summaries were available to us despite that,
2 making care coordination difficult over that
3 long time period, let alone a shorter time
4 period.

5 The CMS recently conducted a dry
6 run of the SRR with its dialysis facilities,
7 and the feedback that I received when that
8 closed on Friday was our dialysis units had no
9 idea what to say, because they didn't know
10 what admissions or readmissions they had
11 because of the data gap mentioned above.

12 Lastly, kind of more related to
13 the MAC. In our special needs plan, as I
14 said, we have actually significantly reduced
15 readmissions across the board for all cause,
16 but that required significant resources. We
17 had to embed case managers within hospitals.
18 We had to expend vast amount of efforts and
19 money on IT systems to coordinate that care.

20 The current mechanism for
21 enactment, and I know this is sort of out of
22 the scope of this but more in the MAC, is to

1 include, potentially include this metric for
2 the dialysis unit, to withhold this two
3 percent that would fund the actions to
4 actually improve this, and that is amongst ten
5 other, eight to ten other different
6 initiatives.

7 With regards to validity and
8 methodological issues, there are two major
9 points. First, the statistical model used to
10 risk-adjust this measure has not been
11 subjected to peer review, which is problematic
12 for us.

13 But secondly and perhaps most
14 importantly, recently two weeks ago, the NQF
15 noted that socioeconomic status may affect
16 quality outcomes, and socioeconomic status is
17 by definition not taken into account in this
18 model.

19 Because CMS releases this data on
20 readmission rates, we were able to aggregate
21 all data for dialysis units across the United
22 States, all 5,400 dialysis units, cross-map

1 those with zip code-based census data for
2 extreme poverty versus not.

3 We found there's a correlation
4 between socioeconomic status and readmission
5 rates, that patients who are in units with the
6 lower decile of readmission rates tend to
7 always have high socioeconomic status be
8 associated with low readmission rates, and
9 vice-versa. So we believe that this is really
10 important to take into account.

11 Secondly, there are hospital-based
12 dialysis units, some of which are operated by
13 acute care hospitals, very similar to the
14 discussion you all just had on inpatient rehab
15 facilities. Again, we would assume that
16 readmission rates will be significantly higher
17 than readmission rates in the non-hospital
18 based dialysis units.

19 In summary, we do believe that
20 it's important to incentivize the alignment
21 between reducing admissions and readmissions
22 for the ESRD population. We believe this

1 current measure may be more suited for
2 hospital measures, since they are accountable
3 for 100 percent of the discharges, which may
4 then prompt them to give us the data so we
5 could actually coordinate care.

6 We do believe that if an ESRD-
7 specific measure should be contemplated, that
8 cause-specific hospitalization may be thought
9 about. So it's potentially vascular access-
10 related infections, fluid-related infections,
11 those sort of things, and that that model
12 should be peer-reviewed, risk-adjusted and
13 SES-adjusted as well. Thank you.

14 CO-CHAIR HALL: Thank you, Dr.
15 Krishnan, for those well-thought, well-spoken
16 comments. I'll remind our group that those
17 comments will apply to the second measure you
18 will hear after lunch. Other public
19 commentary?

20 (No audible response.)

21 CO-CHAIR HALL: It's 12:45. Helen
22 has ordered me to allow only 20 minutes for

1 lunch. We will reconvene at 1:05.

2 CO-CHAIR KAPLAN: Yes, wait a
3 minute. Helen, I don't know. We need to get
4 the business of this committee, absolutely
5 full-throated discussion, so we need to eat
6 fast.

7 CO-CHAIR HALL: 1:05 please, 1:05.
8 And just a quick housekeeping note. Not to be
9 draconian about this, but we would ask members
10 of the audience to wait until the committee
11 has eaten or gotten their food before getting
12 food themselves. Thank you.

13 (Whereupon, the above-entitled
14 matter went off the record at 12:45 p.m. and
15 resumed at 1:40 p.m.)

16

17

18

19

20

21

22

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:04 p.m.)

CO-CHAIR HALL: Thank you all for
returning to the table. Some of us are still
chewing away. That's all right.

We will move on with the agenda,
Measure 2510, skilled nursing facility, 30-day
all-cause readmission. Developer is RTI.
We'll have RTI open the discussion with a
brief introduction to this measure, please.

DR. LAURA SMITH: Thank you. My
name is Laura Smith. I am from RTI
International, and thank you for the
opportunity to speak about our measure.

This is a claims-based measure
that estimates the 30-day risk standardized
rate of all-cause unplanned hospital
readmissions for Medicare fee-for-service
patients who have been admitted to skilled
nursing facilities. The risk window for this
measure is similar to the last one that we
talked about. It looks at the 30 days after

1 discharge, but in this case it tracks the
2 patient for that full 30 days because we are
3 using claims to identify the readmissions.
4 This measure is based on 12 months of SNF
5 admissions. It's the calendar year.

6 I am going to skip through my
7 discussion of the importance of the measure.
8 I think quite a bit of that was covered in the
9 prior discussion. So this measure was
10 designed to harmonize with the CMS hospital-
11 wide readmission measure and the other CMS
12 post-acute care measures to the extent
13 possible to promote shared accountability for
14 improving care transitions. This measure can
15 be used by providers for quality improvement
16 and by patients for decisionmaking.

17 The statistical methods for the
18 model development are very similar to those
19 that you heard about for the in-patient rehab
20 facility measure and the long-term care
21 hospital measure. It's a random effects risk
22 adjustment model, and it includes

1 comorbidities and primary diagnoses and
2 demographic information identified on the
3 claims from that prior acute hospital
4 discharge claim that occurred previous to the
5 SNF admission.

6 We also include prior utilization
7 measures. I just want to note here there was
8 a question that had come from the panel that
9 if people received our written responses there
10 was a question about the ICU days and whether
11 or not we had evaluated days in ICU. And I
12 just wanted to correct the written response.
13 Right now, we only have a yes or no whether or
14 not there were any ICU days in the model.

15 We do have a set of dummy
16 variables for days in the prior acute
17 hospitalizations or the length of stay, but
18 just an indicator of the days in ICU. Despite
19 not having that -- days in ICU, we do find
20 that our model statistics demonstrate good
21 model fit and discrimination.

22 Measure reliability and stability

1 testing showed covariate values remained
2 stable over time, and our split sample
3 test/retest reliability results yielded an
4 overall interclass correlation coefficient of
5 .56.

6 In regard to validity testing, we
7 did find low correlations with other quality
8 measures as expected, but the higher
9 correlations with the vaccination and RN
10 staffing measures support the validity of the
11 measure. The measure shows variability across
12 facilities nationally and the ability to
13 differentiate facility scores from the
14 national mean.

15 For a special issue regarding our
16 measure, observation stays are an important
17 issue to monitor, but our analyses suggests
18 that the exclusion of observation stays from
19 the measure numerator have -- will have little
20 impact on the measure right now. We have new
21 results looking at 2011 data where we found
22 that had we included observation stays

1 occurring in that 30-day window, it would have
2 only added .5 percentage points to the
3 national average, so going from 21.1 percent
4 up to 21.6 percent.

5 In summary, this measure is
6 designed for quality reporting purposes and
7 monitoring of fee-for-service provided to
8 skilled nursing facility beneficiaries. It
9 focuses on unplanned readmission measures,
10 which are more likely to be attributable to
11 the quality of care being provided in the
12 facility. The measure will provide valuable
13 information to patients and families about the
14 quality of care in the SNF and encourage
15 shared accountability across providers.

16 Thank you.

17 CO-CHAIR HALL: Thank you. I'm
18 going to ask Helen and Carol to open group
19 comments. And, again, at the moment we're in
20 the category of evidence.

21 DR. CHEN: So I think we are
22 actually traversing territory we have

1 traversed earlier today and probably will
2 continue to traverse over the next day or so
3 regarding the evidence. I think it's clear
4 that this is -- there is some degree of
5 performance gap here. And also, in terms of
6 the evidence, a number of the workgroup
7 members were concerned about the inference
8 that some of the evidence presented was
9 related to studies done about acute care
10 transfers, not NSF care.

11 But, nonetheless, it is pretty
12 clear that there are processes that would
13 improve transitions, communication, and actual
14 SNF care, for example, nurse staffing ratios,
15 as the developers have mentioned in their
16 measure report.

17 MS. RAPHAEL: Well, there are
18 different studies. I think the consensus is
19 that there are a significant number of
20 unplanned admissions to hospitals coming from
21 nursing homes and that we can make headway in
22 this area. So I think our group decided to

1 forge ahead here.

2 I think there is one thing I
3 wanted to raise in sort of looking this over.
4 We have an overall exclusion rate of 20
5 percent. That seems like a high exclusion
6 rate, but I just would like you to comment on
7 that exclusion rate.

8 DR. LAURA SMITH: So we have -- we
9 do have multiple exclusion criteria for this.
10 I believe that the major exclusion criteria
11 that impacts this measure is the requirement
12 for having 12 months of claims in the prior --
13 prior to the acute hospitalization.

14 And so this was one of the
15 decisions that we had made in terms of
16 identifying comorbidities that you -- there is
17 prior literature showing that you get a far
18 more effective prediction using 12 months of
19 data compared to just the most current, most
20 recent hospitalization. So that was the -- I
21 believe that's the criteria that drops the
22 most. Yes.

1 CO-CHAIR HALL: I don't see any
2 other cards up yet, so I'll start with a
3 question myself. The time horizon is 30 days
4 from the hospital discharge prior to SNF, and
5 so I'm not expert enough to know whether all
6 SNFs happen immediately, all SNF admissions
7 happen immediately. But you could have the
8 sense that there is a different number of days
9 at risk for different patients because the
10 time horizon does end at 30 days from hospital
11 discharge. Does the model account for that
12 concern?

13 DR. LAURA SMITH: So because we
14 track every individual who has a qualifying
15 SNF stay for that full 30-day period, because
16 we are using the claims to identify
17 readmissions, we don't have the same issue of
18 there being variable time at risk that
19 everyone has 30 days at risk.

20 CO-CHAIR HALL: I understand. So
21 the assumption, then, is that everyone moves
22 from their acute care hospital discharge

1 directly to a SNF.

2 DR. LAURA SMITH: Oh. Yes. And
3 so it's not an assumption as -- because that's
4 one of our other exclusion criteria, which is
5 that we require that the admission to the SNF
6 be within one day.

7 CO-CHAIR HALL: Right. Okay.
8 Great. Thank you.

9 Any other concerns or questions
10 around the group?

11 (No response.)

12 Not seeing anything, we'll move to
13 vote on evidence.

14 MS. SHAHAB: Voting is open for
15 1a, evidence. One is yes; two is no. And the
16 time begins now.

17 (Pause.)

18 We are just waiting for one more
19 response.

20 (Pause.)

21 Voting is now closed for 1a. It
22 was 23 yes, zero no.

1 DR. CHEN: So moving on to the
2 performance gap, it did seem that there was a
3 fairly measurable performance gap in the data
4 that was presented with a standardized
5 readmission rate range for the 2011 data set
6 of 11.9 to 41.9 percent, which is a pretty big
7 swing in comparison to some of the other
8 measures that we have talked about today and
9 an opportunity for quality improvement across
10 facilities.

11 CO-CHAIR KAPLAN: So based on
12 Vince Moore's study, the estimate is that 20
13 percent of readmissions -- 78 percent, so 20
14 percent overall readmissions are preventable
15 of the 26 percent. So that seems like a very,
16 very -- I mean, 78 percent of these
17 readmissions are preventable. That seems like
18 a fairly incredible statement. Is there any
19 -- do you have any evidence from the data that
20 -- or other evidence that you would cite that
21 supports that number? Thank you.

22 DR. LAURA SMITH: So my

1 recollection of that paper has a lot to do
2 with the fact that there are a lot of sort of
3 chronic conditions like CHF and COPD that are
4 showing up as reasons for admission. That was
5 -- in truth, that is our major citation that
6 we were using. I think that we do see
7 variation in readmission rates by facility
8 characteristics that have been identified in
9 other studies as being associated with quality
10 of care like staffing ratios and other sort of
11 managerial characteristics.

12 So I -- it is not as direct as
13 sort of giving you a percent that are
14 avoidable, but I think that we do see
15 variation from other -- in other studies that
16 are associated with things that are associated
17 with quality. So --

18 DR. CHEN: I also found those
19 statistics in Vince Moore's study kind of
20 astonishing as well, anecdotally, as an n of
21 1 experience. For whatever it's worth, we do
22 100 percent case review of all readmissions

1 from our post-acute care facilities, and I
2 would say our readmission rates are fairly
3 low. But, on the other hand, the percentage
4 of potentially avoidable readmissions probably
5 runs in the 25 percent range.

6 MS. RAPHAEL: I was just going to
7 say that anecdotally what you observe, at
8 least at acute care hospitals, is that you
9 have high readmission rates for UTIs and
10 pneumonia, and sort of the hypothesis being
11 that with different staffing that nursing
12 homes could handle those cases at their
13 facility and not send them to the ED or to be
14 readmitted. That's more anecdotal than
15 scientific evidence.

16 CO-CHAIR KAPLAN: Other comments?

17 (No response.)

18 Okay. We are ready to vote.

19 MS. SHAHAB: For performance gap,
20 one is high, two is moderate, three is low,
21 four is insufficient. And your time begins
22 now.

1 (Pause.)

2 We have all 24 votes. For 1b,
3 performance gap, 18 voted high, six voted
4 moderate, zero low, and zero insufficient.

5 CO-CHAIR KAPLAN: Great. So now
6 is this a high priority? Any comments before
7 we vote? Oh, yes. Sorry.

8 DR. FIELDS: This is maybe more of
9 a point of information. I would just be
10 curious about whether we would assign this
11 measure a different priority than the one we
12 did before lunch, and maybe talk a little bit
13 about process. I am kind of assuming we are
14 going to stick to our knitting and not compare
15 the two measures or think about how they would
16 both be implemented or whether one would be
17 implemented. But can you help me out a little
18 bit about how process would work if we wind up
19 approving both?

20 CO-CHAIR KAPLAN: Can you give him
21 the harmonization, homogenization, whatever it
22 is?

1 DR. AMIN: Yes. Thanks, Sherrie.
2 We have a harmonization and competings
3 measures discussion. So NQF has an algorithm.
4 We, obviously, need to be respectful of the
5 concerns around measurement burden. If there
6 are measures that address the same measure
7 focus and the same target population, we will
8 have to go through an evaluation of whether or
9 not the measures have been harmonized to the
10 extent possible.

11 This measure and the measure
12 before it would obviously fall in that
13 category, and we have alerted the developers
14 of this prior to -- prior to this meeting.
15 Obviously, they have differences. They have
16 differences in data source and other elements
17 to it. So we would have more of a
18 conversation around what elements of the
19 measures can be harmonized going forward.

20 Karen, did you have something?

21 MS. PACE: But it would also be a
22 competing measures issue, right? Not just

1 harmonized?

2 MR. AMIN: We could talk about
3 that. But we don't get to that discussion
4 until the measures are recommended for
5 endorsement. And, also, I would just caveat
6 as, you know, we might have to -- that might
7 be a conversation for after the in-person
8 meeting, depending on how much we're actually
9 able to get through during this discussion.

10 CO-CHAIR KAPLAN: Leslie?

11 MS. HALL: Just follow up on that
12 and maybe have the same -- added to that
13 discussion is, what is the total number that
14 constitutes a burden? If you have five that
15 are on one item, or two on one item, or 20
16 overall, what are the definitions of burden?
17 So that we don't just keep adding and adding
18 because individually they are sound, but
19 collectively they create burdens. So in the
20 harmonization process, do we have a calling
21 process as well?

22 MR. AMIN: Not necessarily. I

1 mean, the way we're thinking about it is over
2 -- the overarching question is, if there are
3 measures that do address high priorities that
4 they still have a performance gap, that these
5 are still areas of measurement that are
6 important.

7 So we don't have an overall target
8 of what the overall portfolio should be in
9 terms of terms, but -- you know, so what we're
10 really trying to do is when there's cases that
11 the measured focus and the target population
12 are similar, we -- that's the area where we
13 are going to really have more of a head-to-
14 head discussion.

15 MS. HALL: But you do have a best
16 in class process, right?

17 MR. AMIN: Yes.

18 CO-CHAIR HALL: Yes. So if I may,
19 I mean, two measures could be too many if you
20 decide that that's the case and you think that
21 the two measures are competing and there is
22 only a need for one.

1 CO-CHAIR KAPLAN: Other
2 conversation? Alison?

3 MS. SHIPPY: I just wanted to
4 piggyback on the comments about measured
5 burden. I just would also want to throw out
6 the consumer interpretation is something to
7 take into account.

8 CO-CHAIR KAPLAN: Good point.
9 Anything else?

10 (No response.)

11 Okay. We are going to vote on
12 high priority.

13 MS. SHAHAB: For high priority,
14 one is high, two is moderate, three is low,
15 four is insufficient. And the time starts
16 now.

17 (Pause.)

18 We have all 24 votes. For 1c,
19 high priority, 19 high, five moderate, zero
20 low, zero insufficient.

21 CO-CHAIR KAPLAN: Excellent.
22 Scientific acceptability for reliability.

1 Helen?

2 DR. CHEN: So as mentioned in the
3 presentation, the overall ICC was 0.56, which
4 I believe is a little low-ish even for
5 readmissions, measures, as we have discussed
6 earlier today. But what concerned me was the
7 range. So the range of the ICCs that you
8 reported was 0.3 to 0.7. So some worse than
9 chance or some -- you know, not even chance.
10 And I just wondered if you could speak to that
11 a little bit.

12 DR. LAURA SMITH: Sure. So the
13 results that we are talking about right now
14 are of the split sample test/retest where we
15 combine the 2009 and 2010 data, split it
16 randomly, and then look to add the agreement
17 between the facility scores. So the .56 is
18 for the overall ICC for the measure, and then
19 the range that was reported, what we did was
20 we stratified by facility size and so we were
21 seeing ICCs of .7 for our largest category.
22 I am trying to pull out my table here, so I

1 can give you a little more specifics.

2 The one thing that we did do when
3 we did that analysis -- I just want to see
4 whether -- for some of our analyses we did not
5 exclude small facilities. We actually
6 included all facilities, regardless of how
7 many -- how many stays were included. And so
8 I believe that that is part of why you're
9 seeing -- okay.

10 So there were -- for that smallest
11 range, the .30 was for SNFs that had one to 44
12 stays in the denominator. So a certain amount
13 of those are going to end up most likely not
14 reported because there tends to be a 25 stays
15 cutoff for the size that would be reported
16 publicly.

17 And so the -- for SNFs that are 45
18 to 91 stays, the ICC was .45, to give you the
19 next level up, and then 92 to 171 is .53. And
20 SNFs with 172 to over 1,000 was .70.

21 DR. INGBER: Let me just add that
22 when you talk about chance this isn't the same

1 kind of a measure. What we're talking about
2 is when you have a relatively small population
3 and you just randomize it into two buckets.
4 The chances are those buckets are going to
5 look pretty different. So you're not going to
6 get the same picture, even if you risk adjust
7 it really well. Some of them just randomly
8 will have gone to the hospital and others not
9 and, you know, so the numbers, especially in
10 the smaller facilities, do look funny in all
11 the measures.

12 CO-CHAIR KAPLAN: So with respect
13 to reliability, just to clarify, as expected,
14 your reliability of your estimates for low
15 volume hospitals is crummy, right? Not to put
16 too fine a statistical point on it, but that's
17 what the -- that's what that means.

18 DR. INGBER: Yes. Because
19 reliability, in the sense of every time you
20 shake up the patient pool and look at it again
21 you're likely to get a somewhat different
22 measure. Yeah.

1 DR. CHEN: I think you -- for the
2 IRF measure, you talked some about the effect
3 of shrinkage, and I know you sent the
4 additional information to the group regarding
5 that, the effect on this particular measure.
6 Can you delineate that some more for the
7 discussion?

8 DR. INGBER: The shrinkage effect
9 in terms of the SNF measure?

10 DR. CHEN: Yes.

11 DR. LAURA SMITH: So for the SNF
12 measure, our results were similar, I believe,
13 to what we saw with the IRF and LTCH, except
14 for the impact of the shrinkage in the smaller
15 stay sizes. So we have stratified it by
16 decile of the number of stays. We had a
17 fairly small decile, one to 21 stays, and so
18 we were definitely seeing a fair amount of the
19 score that was being explained by shrinkage.

20 And we did see some shrinkage also
21 at the highest end of the distribution as
22 well, but otherwise fairly consistent with

1 what we had seen in other -- for the other
2 measures. Mel, did you want to add anything?

3 DR. INGBER: Well, what I was just
4 going to add is that there is some shrinkage
5 even at the high end, but it isn't a lot.
6 It's relatively small compared to what the
7 risk adjustment is doing. The risk adjustment
8 is doing its job irrespective of size. But,
9 yes, as soon as you get to the small ones,
10 risk adjustment moves it, and then shrinkage
11 says no -- not a lot of data here.

12 One to 21 is much lower than we
13 even had in these other measures that we
14 presented earlier. That's really pretty tiny
15 and very unlikely to show up on anybody's
16 measure list of reporting.

17 CO-CHAIR KAPLAN: Frank?

18 DR. BRIGGS: So in terms of the
19 obs patients, and the shift to obs versus in-
20 patient, say, with the two-minute rule, I
21 think that has the potential to have a big
22 impact on your data set. One thing I'd be

1 concerned about would be having more hospitals
2 now falling into that smaller range, because
3 you're excluding these patients who aren't
4 being admitted back into observation, or being
5 admitted into observation rather than in-
6 patient status.

7 Any sense -- is there any data
8 around the use of observation status from SNF
9 as opposed to the general population? You
10 know, is it an issue, or is it not an issue?

11 DR. LAURA SMITH: So we have -- in
12 the measure submission form, we do cite some
13 somewhat older analyses where what was seen in
14 the 2009 data was that the vast majority of
15 observation stays were coming from the
16 community and also not being discharged to
17 SNF, that that was -- I can't remember the
18 number off the top of my head, but discharge
19 to SNF was not one of the major destinations
20 now. Of course, that is a bit older data, and
21 we know from the GAO report that that -- the
22 patterns have been changing.

1 The analysis that I was just
2 referencing, we are really just looking at our
3 samples that are in the 2011 SNF RM measure
4 sample. We are not seeing a large proportion
5 of that set of individuals getting sent back
6 to the hospital for observation stays. So it
7 still seems relatively small at the moment,
8 but it certainly seems like something that
9 would bear ongoing monitoring, and certainly
10 with the change in the policy forthcoming.

11 CO-CHAIR KAPLAN: Thank you.

12 Other comments? Wes?

13 DR. FIELDS: Well, there are some
14 recent data, Frank. I'm not sure if it's
15 somewhere in the packet. It actually came
16 from CMS from recent morbidity and mortality
17 reports, kind of intriguing really. So it's
18 much more recent claims data, and it suggests
19 that readmission rates are falling, as you
20 would expect, as hospitals change behavior.

21 What is kind of interesting about
22 it is that the rate of observation services,

1 according to the CMS analysis, isn't rapidly
2 rising. But the other thing that's sort of
3 curious is that emergency department visits
4 aren't rising either. So the question
5 becomes, how much of that improvement and
6 readmission rate is happening in community
7 settings, primary care, case management? And
8 how much of it is happening around what --
9 depending on the measure and the context we're
10 calling ED visit that is actually an
11 observation stay that could be 24 or 48 hours
12 long, but less than, you know, to midnight.

13 So I think this is a huge moving
14 target, and I think the ultimate answer to
15 your question is really important.

16 CO-CHAIR KAPLAN: Paula?

17 MS. MINTON-FOLTZ: I'm curious
18 about the inclusion of psychiatric hospitals
19 in the measure. Psych patients are really one
20 of those groups that are really hard to place
21 already in SNFs, and so I'd be interested if
22 other people thought that that might result in

1 less access for these patients in SNF.

2 DR. LAURA SMITH: I think we might
3 have to get back to you on the -- it's a small
4 proportion of who we are seeing in the sample,
5 but I don't remember, so I would have to get
6 back to you on that.

7 CO-CHAIR KAPLAN: Paul, and then
8 Thomas.

9 DR. HEIDENREICH: In terms of the
10 distribution, the timing of readmission, do
11 you know what percent happens, say, on the
12 first 24 hours? And, you know, what's the
13 thought in terms of the nursing facility being
14 able to influence that as opposed to the
15 transferring facility?

16 DR. LAURA SMITH: So as you would
17 probably expect, there are -- there is a
18 fairly large proportion that take place within
19 the first 48 hours. I don't have a percent
20 here. There were some supplemental responses
21 that we can get you a copy of.

22 It looks like the peak is more

1 around the second or third day. So, I mean,
2 we -- this is something that we talked about
3 with our technical expert panel, that
4 certainly there was some discussion about,
5 should those first 48 hours not be included in
6 the measure.

7 We got a really strong message
8 from our experts that they should be included
9 because that's really part of this idea of
10 shared accountability in terms of the quality
11 of the transition. I think there could be
12 some debate about sort of how much flexibility
13 do SNFs actually have in choosing to accept or
14 not accept someone into their care. But the
15 message that we got was that we should be
16 holding the SNFs also accountable for the
17 services provided in this first 48 hours.

18 CO-CHAIR KAPLAN: Okay. We have
19 five minutes left to discuss this measure.
20 So, Thomas, do you want to give us a concise
21 question/comment?

22 DR. THOMAS SMITH: Uh-oh.

1 (Laughter.)

2 Well, just back to the psychiatric
3 admissions. So why not exclude admissions to
4 psychiatric hospitals, given that it's a
5 different population and the circumstances
6 around admissions are often so very different?

7 DR. LAURA SMITH: Oh. So I should
8 clarify. So the psych admissions -- the
9 admissions to psychiatric hospitals are -- we
10 basically consider them to be planned. They
11 are not counted in our numerator. It was that
12 you could be included in the measure if you
13 had -- your prior hospitalization was from a
14 psych hospital.

15 DR. THOMAS SMITH: I'm not
16 following.

17 DR. LAURA SMITH: So --

18 DR. THOMAS SMITH: You're in the -
19 - when are you in the numerator, and when are
20 you in the denominator if you're a psych
21 patient?

22 DR. LAURA SMITH: You're in the

1 denominator if you are a psych patient. But
 2 if you are -- if your readmission is to a
 3 psych hospital, that is not counted in the
 4 numerator.

5 DR. THOMAS SMITH: At all.

6 DR. LAURA SMITH: Not for this
 7 measure.

8 CO-CHAIR KAPLAN: All right.
 9 Comments on reliability? Because I think some
 10 of these issues touch on validity, but we are
 11 going to -- first we are going to vote on
 12 reliability, unless there is any further
 13 discussion. Ready/set?

14 MS. SHAHAB: So for reliability,
 15 one is high, two is moderate, three is low,
 16 four is insufficient. And your time begins
 17 now.

18 (Pause.)

19 We have all 24 votes now. For 2a,
 20 reliability, five were high, 18 voted
 21 moderate, one low, and zero insufficient.

22 CO-CHAIR KAPLAN: Thank you.

1 Now, with respect to validity,
2 Helen, do you want to make some comments?

3 DR. CHEN: I appreciated that the
4 developers actually tried to do some construct
5 validity using other measures of quality.
6 That was both reassuring and also comforting
7 to me, that there was a reasonable low
8 correlation in the expected directions with
9 the exception of pain management. So that was
10 good. Thank you.

11 In terms of discrimination
12 calibration, the C statistic was 0.67, which
13 is in range.

14 And the one concern I had was
15 regarding the exclusions. Although the
16 relative -- the standardized risk readmission
17 measure didn't seem to change much in terms of
18 looking at your exclusions in terms of the
19 absolute change, there were some changes in
20 the quintile ranking in terms of people going
21 up or down, and that was a bit of a concern to
22 me. Can you speak to that, please?

1 DR. LAURA SMITH: So the quintile
2 ranking I believe changed the most when it
3 came to the gap exclusion criteria. So we
4 talked about that a little bit earlier, that
5 if a patient had a gap of more than a day they
6 were excluded from the measure. And so we
7 were sort of -- we were torn in terms of that
8 issue of there being differences in the risk
9 for readmission based on the time since the
10 prior acute discharge, that you do see a
11 declining risk in readmission over time, and
12 so we went with a day gap for that exclusion.

13 I think part of the other reason
14 why we -- you potentially see some of the
15 quintile rank changes has to do with there
16 being somewhat of a smaller range in the
17 quality measure. So if you have -- even with
18 a small -- we only had a change of more than
19 one percent absolute change for 30 facilities,
20 that if they were in the middle of that range
21 of the distribution that it would be fairly
22 easy to potentially move in quintiles, if

1 you're in that mid-range, just because you
2 might have -- there's some clustering in the
3 center of the range for our measure.

4 CO-CHAIR KAPLAN: Thank you.
5 Other comments?

6 (No response.)

7 I have two quick questions, and
8 really quick. One is the -- 90 percent of the
9 facilities were significantly different from
10 the national mean. And, therefore, does it
11 make sense to use the national -- you point
12 out a lot of geographic variability, and then
13 you use the national mean. Can you help us
14 really quickly and concisely understand what
15 the advantages of that would be?

16 DR. LAURA SMITH: I think that our
17 using that as the national -- as the thing to
18 compare it to isn't necessarily an endorsement
19 of using that. But I think it's a useful way
20 of trying to determine whether or not you can
21 discriminate amongst providers. I think that
22 is a good point, that it becomes less

1 meaningful if everybody is different from it.

2 CO-CHAIR KAPLAN: That's more of a
3 use question, so that's not fair. So the
4 largest correlation, however, was with RN
5 staffing, and that was a negative .13. So 1.7
6 percent of the variability is attributable to
7 -- the largest variation in validity is
8 attributable to staffing of the variables you
9 tested. That's not -- that's pretty weak.
10 That's not -- and that was the strongest
11 variable. Can you help us understand all of
12 these correlations are weak -- or what would
13 you grade your validity evidence as?

14 DR. LAURA SMITH: So in terms of
15 our validity results, they are consistent with
16 prior studies of these quality measures, that
17 we tend to see low correlation for -- and
18 particularly the MDS-based ones. I do think
19 the best that we can do is sort of look at,
20 did they go in the hypothesized direction?

21 CO-CHAIR KAPLAN: Thank you. Any
22 other comments?

1 (No response.)

2 Okay. Can we vote a validity
3 score?

4 MS. SHAHAB: For criteria 2b,
5 validity, one is high, two is moderate, three
6 is low, four is insufficient. And your time
7 begins now.

8 (Pause.)

9 We have all 24 votes. For 2b, validity,
10 zero high, 17 moderate, seven low, and zero
11 insufficient.

12 CO-CHAIR KAPLAN: Thank you. Now
13 we're on to feasibility. Comments?

14 (No response.)

15 Okay. Let's vote.

16 MS. SHAHAB: Haven't started yet.
17 For feasibility? Okay. Three, feasibility.
18 One is high, two is moderate, three is low,
19 four is insufficient. Time starts now.

20 (Pause.)

21 Still need two more. We have all
22 24 votes. For feasibility, 14 voted high, 10

1 voted moderate, zero low, and zero
2 insufficient.

3 CO-CHAIR KAPLAN: Thank you. On
4 to usability and use.

5 DR. CHEN: This gets at the issue
6 that you were raising, Sherrie, and I think
7 that others have raised in other measures
8 discussions regarding, what does this mean?
9 And what is the consumer going to -- how is
10 the consumer going to interpret this?

11 And in terms of using the
12 expected, better than expected, worse than
13 expected, and thinking about, you know,
14 benchmarking for this particular measure, I
15 think that's a challenge not just for this
16 measure but for other measures in terms of the
17 overall use for this.

18 And, again, if people are very
19 different from the mean, what does it mean?

20 CO-CHAIR KAPLAN: Karen?

21 DR. JOYNT: I'd like to second
22 that, and also say I think it gets back,

1 again, to the whole shrinkage issue, which is
2 that if there are hospitals about which you
3 don't have very much information, it seems to
4 me like labeling them that they are the same
5 as everybody else, is actually pretty
6 misleading.

7 Now, in this case it looks like
8 the small facilities actually had lower
9 readmission rates than the large facilities,
10 unless I'm misreading the supplemental
11 information. So this is not to say that I
12 pretend to understand enough about nursing
13 facility care to know which direction it
14 should go in.

15 But I do think from a usability
16 standpoint that telling the consumer that
17 we're certain that the -- that a place is not
18 bad is potentially problematic. And so I
19 would just encourage as we think about the
20 usability of these measures to consider really
21 how certain we're willing to say we are about
22 low volume facilities and how we would

1 communicate that to the consumer.

2 CO-CHAIR KAPLAN: Larry?

3 DR. GLANCE: So I agree with
4 Karen's point. I think it's an important
5 point. It's one that we spent a lot of time
6 talking about last time around, the whole
7 issue of shrinkage coefficients and shrinking
8 low volume providers back to average. But
9 having said that, since virtually all -- well,
10 not all, but the vast majority of the measures
11 that we are looking at today are based on
12 hierarchical modeling, I don't think we should
13 -- I hate to use the word, but penalize this
14 particular measure because of that, because
15 most of the other measures also use this same
16 methodology.

17 CO-CHAIR KAPLAN: Leslie? Thank
18 you.

19 MS. HALL: I would just echo on
20 the consumer side -- and this relates to all
21 of them, but we don't want to send the message
22 that being hospitalized longer is better, and

1 that consumers could be confused by all of
2 this pushback against other areas of
3 admitting.

4 CO-CHAIR KAPLAN: Thank you.
5 Other comments?

6 (No response.)

7 Okay. Are we ready to vote? Oh,
8 sorry.

9 DR. INGBER: Just wondering, some
10 of the comments seem to be confusing me as to
11 what we are looking at. To say something is
12 -- you can't tell if it's different from the
13 average or not different from the average,
14 let's be very careful. Most of these people
15 you can't say are different from any number
16 you would pick out of a hat, because they have
17 a very wide confidence interval.

18 So the idea is not to tell
19 everybody that they are average. It's to tell
20 them something about them that we can't tell
21 that -- whether they are average or not
22 average or express it in a way that doesn't

1 say these guys are average because we can't
2 tell, because we could just as well say, well,
3 they're not 20 percent below or 20 percent
4 above because we can't tell.

5 So it depends on how you use the
6 measure and what benchmark you use. It's not
7 a bad thing about the measure; it's how you
8 use it. I just wanted to make sure that was
9 clear.

10 CO-CHAIR KAPLAN: Right. The
11 implementation issues, obviously, are -- and
12 the same issue is going to come up over and
13 over and over again with regard to how
14 confident we are in your estimate at a given
15 point in time, and that is true across
16 measures and is partly the job, right, Helen,
17 of the map group?

18 DR. BURSTIN: Yes.

19 CO-CHAIR KAPLAN: So for now, as
20 written, we have to vote on use -- I'm sorry.
21 Any other comments?

22 (No response.)

1 Okay. We can vote a score.

2 MS. SHAHAB: For criteria 4,
3 usability and use, one is high, two is
4 moderate, three is low, four is insufficient
5 information. And time starts now.

6 (Pause.)

7 We have all 24 votes now for
8 criteria 4, usability and use. One high, 16
9 moderate, seven low, zero insufficient
10 information.

11 CO-CHAIR KAPLAN: Overall
12 suitability for endorsement. Discussion?

13 (No response.)

14 Hearing none?

15 MS. SHAHAB: One is yes, two is
16 no. The vote is now open.

17 (Pause.)

18 All 24 votes are in. For
19 Measure 2510, skilled nursing facility, 30-day
20 all-cause readmission measure, 19 voted yes,
21 five voted no.

22 MS. TRAVIS: Can I make a comment

1 before we get to the next one?

2 CO-CHAIR KAPLAN: Go ahead.

3 MS. TRAVIS: In the discussion
4 about use and usability about a number of
5 these measures, we have brought up the map
6 process. And having been part of the map
7 process, I just would like to ask that perhaps
8 one of the improvement initiatives we can put
9 into the map process is to have a better
10 understanding of the use and usability
11 discussion that goes on in these standing
12 committees, because it is an endorsed measure,
13 it's in the set. It is not necessarily
14 transparent and apparent to people that these
15 kinds of conversations have gone on.

16 So I think as we continue to have
17 this, that's just one of the loops that might
18 be better to pay some more attention to at the
19 map.

20 MR. AMIN: Thanks, Cristie. Well,
21 this certainly is an area that we are working
22 on internally to be more robust.

1 For the general committee, just
2 want to make sure we are all sort of on the
3 same page. The measures application
4 partnership, which NQF convenes, makes
5 recommendations to HHS around selection
6 measures for various different federal
7 programs. And we will be bringing the
8 recommendation guidance here on the use and
9 usability of these measures to the appropriate
10 workgroups that are making recommendations on
11 these measures.

12 And there are many of you around
13 the table who are obviously playing leadership
14 roles on those committees. So we'll make sure
15 that that is connected as best we can going
16 forward. But it certainly is another area
17 that we are focused on. Thanks, Cristie.

18 CO-CHAIR HALL: Thank you all.
19 Another great discussion. Thank you, our
20 developers from RTI.

21 So we're a few minutes behind
22 after our first measure. You may think you

1 are seeing a meaner version of Bruce Hall now
2 that lunch is over, and I keep harping on
3 time. But one of my concerns is that we do
4 have folks in the room who have come into the
5 room to discuss as developers and to
6 contribute. And if we don't stick on our
7 timeframe, we may lose some of their expert
8 input.

9 So we'll ask right now for our
10 developers from University of Michigan to
11 introduce their measure, Measure 2496, around
12 dialysis. Please introduce yourselves and
13 basically introduce your measure.

14 DR. MESSANA: My name is Joe
15 Messina. I'm a clinical nephrologist on the
16 faculty at University of Michigan. I work at
17 KECC, U of M KECC.

18 DR. KALBFLEISCH: My name is Jack
19 Kalbfleisch, or John it says here. And I'm a
20 professor of biostatistics and statistics at
21 the University of Michigan and also work at UM
22 KECC.

1 So on the -- what we're talking
2 about is a 30-day unplanned readmission
3 measure for dialysis facilities. So it's
4 looking at patients who are discharged from an
5 acute care hospital to dialysis facilities and
6 the rate at which they are readmitted to the
7 hospital within 30 days. It is a measure of
8 dialysis facilities and not of hospitals.

9 The measure is in the form of a
10 ratio, so it's a bit different than some of
11 the other measures. It's looking at -- it is
12 relating the given dialysis facility to the
13 national norm basically, to a national average
14 and ratio, so the numerator of the ratio is
15 the number of readmissions and the denominator
16 is the expected number of readmissions, which
17 comes from a logistic model. So that based on
18 the number of discharges that there are and
19 the type of discharges and the patients
20 involved, patient characteristics and the
21 hospital discharging are taken into account in
22 getting that expectation.

1 Modality variation radiation is
2 substantial among dialysis facilities with
3 about 10 percent having a readmission ratio 30
4 percent above the national norm and about an
5 equal number 30 percent less than the national
6 norm, for example.

7 Patients at dialysis facilities
8 have on average about two hospitalizations per
9 year. And following a discharge from a
10 hospital, about 35 percent are readmitted
11 within 30 days. So it is a population where
12 the burden of hospitalization is quite high,
13 and so it's a population where there is
14 potential for substantial gain, both in terms
15 of patient quality of life and also in terms
16 of cost.

17 The measure has been
18 underdeveloped for some time, and we are
19 currently just finishing a dry run of all --
20 of the measure in all dialysis facilities in
21 the country, and it has been subject to
22 feedback of various sorts over that period.

1 So I guess, like other measures,
2 the SRR is really motivated in part by the aim
3 to -- aim to encourage health care providers
4 to work together to coordinate care. And in
5 some settings there is substantial evidence
6 that that works, and the general concept
7 carries a great deal of face validity I think.

8 There is, however, relatively
9 little direct evidence for dialysis facilities
10 as for some other facilities that we have been
11 discussing today. There is some. There is a
12 paper looking directly at that question and an
13 observational study, and looking at
14 interventions within the first week following
15 discharge and showing that those interventions
16 are useful.

17 There is also a fair bit of
18 opinion and qualitative studies looking at the
19 issue, and in particular an excellent
20 editorial in the Clinical Journal of the
21 American Society of Nephrologists by Jay Wish,
22 looking at that question and pointing out the

1 potential for gain through the involvement of
2 nephrologists in the first week following
3 discharge, talking in particular about getting
4 away from a paradigm of resumed previous
5 quarters at the end of discharge.

6 So at the preliminary meeting of
7 NQF, and at other times, this measure has
8 received many comments, a number of which were
9 unique to it, although the measure itself is
10 somewhat similar to many other measures that
11 are being discussed. We have submitted
12 through CMS a written response to the main
13 points raised, and of course no doubt some of
14 them will rise again. My time is certainly not
15 sufficient to review them here.

16 I would like to -- just quickly on
17 two comments, one which was made earlier this
18 morning by Dr. Krishnan which related to peer
19 review of the measure. In fact, it is based
20 on statistical methods which are quite old and
21 there are books on the subject, and it's the
22 same kind of statistical method that is being

1 used in all of the measures that have been
2 discussed so far today.

3 The particular measure itself
4 actually was published. There was a report on
5 it published in the -- in a statistical
6 journal, statistics and the biosciences, which
7 details the methods that are being used here
8 and is a peer-reviewed journal.

9 Second comment I guess is the
10 concern about potential adjustment for
11 physicians, and I think that was something
12 that came up with a great deal of discussion
13 at the last meeting of this group. And so I
14 guess one question being also whether there
15 really was the regulatory framework in which
16 dialysis facilities could actually control or
17 exert influence on the physicians that are
18 working at them.

19 So we note in the response that
20 the regulatory framework exists, that there is
21 such a framework. That was also noted on the
22 call. And one of the primary purposes of this

1 measure really is to promote coordination and
2 promote the kind of involvement at dialysis
3 facilities with their physicians in the
4 handling of patients following hospital
5 discharge.

6 So including an adjustment for
7 physicians we feel would -- may reduce the
8 incentive to coordinate care, and it also
9 would create a very large lack of
10 harmonization with many other measures that
11 are being considered here.

12 So, anyway, thanks for the
13 opportunity, and look forward to the
14 discussion.

15 CO-CHAIR HALL: So, again, we are
16 in the category of evidence still. And our
17 discussants Steve and Sherrie. Steve, do you
18 have any specific comments on this category of
19 evidence?

20 DR. FISHBANE: Yes. You know, if
21 I might, because we are moving into a very
22 different world here, the dialysis unit, I do

1 want to make some overriding comments which
2 will apply really to every criterion that we
3 look at. And then I promise I will get
4 directly to evidence.

5 But, you know, I think what the
6 TEP here really struggled with was, where
7 should this reside? Should it be at the
8 hospital, the physician, or the dialysis unit?
9 And they kept coming up with ways of combining
10 them because the ultimate struggle here is
11 that it is just very hard to understand how
12 the dialysis unit could have any process that
13 would be able to influence this specific
14 measure.

15 So I would like to remind
16 everybody that this is not nursing home care.
17 This is episodic care. Out of the 168 hours
18 in a week, 12 hours are spent in a dialysis
19 unit. The structure of a dialysis unit,
20 there's nurses, there's technicians, there are
21 dieticians and social workers. There is a
22 medical director, and the medical director is

1 generally a .25 FTE. And that time is not
2 necessarily spent in the dialysis unit. But
3 even in the dialysis unit, they may have a few
4 of their patients that they see in the unit,
5 but they don't take care of other patients in
6 the dialysis unit.

7 The treating nephrologist here is
8 really key, because that's where the
9 opportunity is to prevent readmissions. And
10 this is really different than some of the
11 processes that we have talked about so far.
12 Yet the treating physician is only required to
13 see the patient once per month, and there is
14 no structure that provides the medical
15 director or the governing body of the dialysis
16 unit to compel nephrologists to see patients
17 immediately after discharge, which is why I
18 think there has been such a struggle with this
19 measure in terms of, how do you put the
20 dialysis unit as the resident that owns this.

21 Now, CMS has an incredibly
22 positive record in dialysis, both through the

1 conditions for coverage, the regulatory
2 authority, and through the quality measures
3 that have been put forth to date of really
4 substantively improving the quality of care.
5 So if I'm going to be negative on this
6 measure, which I will be on a number of facets
7 of it, it doesn't reflect what is the overall
8 great record that they have had. And, you
9 know, I certainly have written a number of
10 articles supportive of that.

11 So the structure of the unit isn't
12 -- and the current regulatory structure, not
13 set up to empower the dialysis unit to really
14 be able to have any control over any processes
15 where we can prevent rehospitalizations.

16 The hospital dialysis unit
17 relationship is really important to understand
18 here. It is not like other types of
19 relationships. You heard Dr. Krishnan speak
20 about that for DaVita only 50 percent of the
21 time do they have any information that comes
22 to them from the hospital prior to discharge.

1 You need to I think understand that there is
2 no organic relationship between the dialysis
3 units and the hospitals.

4 I run a hospital-owned dialysis
5 unit, and we have some relationship, of
6 course, with the hospital because of that, but
7 that's the minority of American dialysis
8 units. It's a many-to-one relationship. So
9 it's not just one hospital that it returns
10 their patients after discharge to the dialysis
11 unit. You may have 10 or 15 different
12 hospitals. And it's impossible -- usually we
13 don't have information that comes from the
14 hospital. When we do have information, it's
15 only because they happen to be at that one
16 specific hospital.

17 The power to prevent readmissions
18 here is based on processes that the
19 nephrologist controls. So very clearly
20 reassessment of volume status leads to a lot
21 of readmissions here. And if you can get the
22 nephrologist to see the patient within a

1 couple of days after discharge, I think that
2 would be the most powerful thing that could
3 take place.

4 Medication reconciliation here is
5 very important. Reassessment of the patient's
6 medical status and reassessment of the
7 patient's dialysis prescription, the
8 developers here that spoke to Jay Wish's
9 editorial -- and Jay's point was exactly this,
10 that if you don't get the nephrologist
11 involved early and not doing what happens
12 mostly in the United States, which is just
13 resume previous orders, you don't have the
14 ability -- here you've got social workers,
15 nurses, technicians. There really is no setup
16 to be able to prevent readmissions.

17 So, you know, we speak of trying
18 to improve coordination of care, and I agree
19 that that sounds good, but there really is no
20 natural ability that we have here to improve
21 coordination of care. The hospitals are not
22 pushing out information to dialysis units, and

1 most American dialysis units have no way of
2 pulling the information. You would have to be
3 making calls to a number of different
4 hospitals asking them for information of what
5 took place during the hospital stay.

6 Sometimes it will happen to be the
7 same treating nephrologist in the hospital as
8 in the dialysis unit, and that will make it
9 easier. But that's very often not the case.

10 We talk about the
11 interdisciplinary team. In the response of
12 CMS, we certainly thought a lot about that.
13 It gives the impression that there is a team
14 that is waiting at the dialysis unit ready to
15 reassess the patient and work together. In
16 fact, that is not the case.

17 It is a virtual team, and what
18 current relations are through the conditions
19 for coverage -- that is our regulatory
20 authority -- is that the interdisciplinary
21 team once per year has to assess and develop
22 a plan of care for a patient. For unstable

1 patients, you compel the nephrologist once a
2 year to work with the interdisciplinary team.
3 For the unstable patient, which means a 17-day
4 hospitalization or three hospitalizations in
5 one month, you compel the nephrologist within
6 one month, not within a couple of days, to be
7 able to see the patient.

8 So, you know, I think I will get
9 straight to evidence, but we really worry
10 about -- here about where this measure
11 resides. I mean, I would say first there
12 should be a measure for physicians; secondly,
13 for hospitals. And it just doesn't seem like
14 there is any actual process that under current
15 regulation or practical structure that the
16 dialysis unit would be able to change a
17 process here to work.

18 You first need the right
19 regulations and structure. If not in place,
20 I can't see how you would have a quality
21 measure. But as for evidence, as the way that
22 we are defining it today, it is -- you know,

1 two issues that I would make here, and I'll
2 keep it, you know, very limited.

3 There is only one study that has
4 been done in dialysis units. It is pointed
5 out by the developers. It was by Chan et al.
6 from Priscinius. It was an observational
7 study, and really very trivial results. They
8 showed association between, for example,
9 measuring a parathyroid hormone level and a
10 reduced incidence of hospitalizations. I
11 think it is really a surrogate for the fact
12 that if you get the nephrologist in, if you're
13 able to do that, you can reduce the
14 readmissions.

15 But the way that we're defining
16 evidence today, which is that there is a
17 probable linkage between the ability to adjust
18 to effect processes to improved outcomes,
19 without having the ability, the right people
20 in the unit and the ability to compel the
21 nephrologist to see the patient, it is unclear
22 for me with the evidence how that would

1 happen.

2 And I will, as a final point,
3 simply point out here that there are current
4 studies that are going on to try to look at
5 preventing readmissions, including one by our
6 group that is funded by New York State. And
7 if you look at clinicaltrials.gov, all of them
8 would require -- so the interventions that are
9 being tested would require new models of care,
10 which would require a change in regulation and
11 a change in structure.

12 I'll stop there.

13 CO-CHAIR HALL: Thank you, Steve.

14 I'll ask Sherrie to make any
15 specific comments in this category of
16 evidence.

17 CO-CHAIR KAPLAN: I'm just going
18 to add one comment. This is about where we
19 were with the readmissions for congestive
20 heart failure when we got pushback saying, you
21 know, the hospitals have absolutely no control
22 over primary care providers where, you know,

1 they are supposed to see patients within a
2 certain amount of time.

3 So in terms of evidence building
4 and evidence base, yes, there is only one
5 study here, but this is pretty much where we
6 were when we were looking at all costs -- or
7 readmissions for specific conditions -- some
8 of the specific conditions and the issues
9 raised at the time. Now there are tons of
10 studies out there. We are building an
11 evidence based on kind of where we were then.

12 But I am not in any way defending
13 this measure from that perspective. I am just
14 noting that this is exactly the questions and
15 the concerns that were raised some time ago
16 with respect to readmission for congestive
17 heart failure.

18 CO-CHAIR HALL: Thank you.

19 Kathy?

20 DR. AUGER: Thank you. So with
21 the caveat that this is way outside of my
22 sphere, listening to, you know, your arguments

1 sort of against this being in the locus of
2 control for the dialysis unit, I hear you, but
3 you are also sort of making an argument that
4 potentially if this went on and became an
5 endorsed metric and then maybe payment was in
6 some way tied to it in the future, that that
7 might be the impetus to actually get a
8 nephrologist to see patients right after
9 discharge or to get that care coordination to
10 be much better.

11 So I understand that it's not the
12 usual locus of control right now, but it might
13 make it become one. I don't know.

14 DR. FISHBANE: Yes. I mean, I
15 think that's a fair statement. But, you know,
16 I'd like, you know, to just remind you of one
17 point on this, which is that there is no
18 regulatory structure to do that right now. So
19 as a medical director -- and I've been, you
20 know, in 20 years a medical director of six
21 different dialysis units -- one of the
22 frustrations we have is that if you don't

1 change what are the conditions for coverage,
2 our regulatory authority, there simply is --
3 I could put a policy in place in my dialysis
4 unit that says the doctor needs to see the
5 patient within 48 hours.

6 The problem with that is that they
7 are just not going to admit patients. And we
8 have pretty tough policies in our units. They
9 just won't admit patients to our unit. So
10 without having the right regulation through
11 the conditions for coverage, it would be
12 wonderful to be able to push the doctor into
13 that position.

14 I think a much more likely outcome
15 here is going to be some type of change in
16 structure where our nurse practitioners are
17 put into dialysis units, and that we have some
18 regulation and perhaps payment in order to
19 have a clinical encounter, because I do think
20 it's an important subject.

21 CO-CHAIR HALL: Thank you.

22 Frank?

1 DR. BRIGGS: Just a question,
2 because I don't know. But having been on the
3 hospital side with medical staff affairs for
4 years, one of the most powerful things that
5 the hospitals have over the head of the
6 individual providers is credentialing
7 privileging.

8 So are the nephrologists
9 credentialed to practice and admit at the
10 individual dialysis centers? Or is it just
11 strictly a contract of employment of some
12 sort?

13 DR. FISHBANE: Right. Good
14 question. And, sure, they are privileged and
15 credentialed to work in the unit. But, again,
16 under the -- so we are very highly regulated
17 under the conditions for coverage. We can
18 compel in annual assessments of patients a
19 monthly visit from the doctor.

20 We don't have any way of
21 compelling a visit right after
22 hospitalization, and that really is what is

1 needed in order to be able to reduce
2 readmissions. And I think that that is where
3 this will ultimately come from. But you're
4 going to need a change in regulation and
5 structure in order to have a quality measure
6 that there is any action-ability on.

7 CO-CHAIR HALL: Carol, I'll have
8 you make a quick comment, and then we'll have
9 Dr. Messina from the developer side reply.

10 MS. RAPHAEL: How much time during
11 a week does a dialysis patient spend in a
12 facility?

13 DR. FISHBANE: Yes. So it's
14 between nine and 12 hours during the week.

15 MS. RAPHAEL: That seems to me
16 like a substantial amount of time, more than
17 is usually spent at a doctor's visit or an
18 outpatient clinic. What other levers do you
19 have besides the lever of regulation to try to
20 change the paradigm here during those 10 to 12
21 hours?

22 DR. FISHBANE: Yes. So the

1 conditions for coverage, as written right now,
2 and, you know, I think you will hear some
3 rebuttal on this, but they are very clear.
4 And, you know, it's a frustration of medical
5 directors throughout the United States, 6,000
6 medical directors. We wish we had the power
7 to compel the physician.

8 Now, we're paying, so we're paying
9 out of our practice to have a nurse -- not the
10 dialysis unit, but a nurse practitioner in the
11 unit who we're creating a checklist-based
12 encounter immediately post-discharge. There
13 is a number of dialysis units in the United
14 States that have physician practice owned,
15 hired, nurse practitioners in the dialysis
16 units, and that gives you that opportunity.

17 But, for example, you know, in one
18 of my units I've got 200 patients. We get
19 about six discharges out of the hospital per
20 week. I could get the nurse practitioner to
21 see the patient, but the only leverage I would
22 have is if I created a policy, which I'm

1 allowed to do, which says that physicians must
2 see patients within 48 hours of discharge.

3 The physicians would argue that
4 it's just not possible. They go to three
5 different hospitals, three different dialysis
6 units. We have rural units that are 80 miles
7 away from, 160 miles away from a center. So
8 that we really don't have leverage that is
9 specifically on the physician.

10 We do have a medical director,
11 which is a .25 FTE. The medical director,
12 though, I think it would be inappropriate for
13 them to see well patients who are discharged,
14 because they don't have established
15 therapeutic relationships with most of them.

16 CO-CHAIR HALL: Dr. Messana, do
17 you want to reply to some of the concerns
18 you've heard?

19 DR. MESSANA: Well, I just wanted
20 to make three brief comments. I'm cognizant
21 of the time. One, the comments that I have
22 heard from Dr. Krishnan and Dr. Fishbane sound

1 to me generally like endorsements of the
2 performance gap and opportunities for
3 improvement. So I would echo a comment made
4 earlier.

5 Secondly, I don't entirely agree
6 with Dr. Fishbane's interpretation of the
7 interpretive guidance. Having 15 to 20 years
8 of experience in medical director roles in
9 multiple institutions myself, I believe there
10 is probably more leverage in those regulations
11 than has been described, but that's an opinion
12 piece.

13 In our response, we included the
14 specific regulations for your perusal related
15 to governance of the facility, the scope and
16 performance of the interdisciplinary team,
17 which is by regulation supposed to include a
18 physician, not necessarily in the context or
19 using the same paradigm that Dr. Fishbane
20 describes where the physician -- the physician
21 centric perspective that he has described,
22 where the only real change that occurs in a

1 patient's plan of care is when a physician
2 lays hands on, right?

3 That seems a little bit of a
4 caricature of how we practice health care
5 nowadays, certainly how I practice health
6 care.

7 Now, the dialysis unit has to have
8 a charge nurse to assess every patient before
9 every dialysis treatment. The patients come
10 in thrice weekly for an average of nine to 12
11 hours total per week, but they are seen three
12 times a week in the dialysis facility for an
13 in-center patient.

14 So there is great opportunity for
15 there to be interaction between the dialysis
16 staff and the patient, and the requirement
17 that a registered nurse performs that
18 assessment is in the regulations. And some
19 states have even higher standards, but we will
20 stick with the federal criteria.

21 And there is nothing that keeps
22 that charge nurse or another member of the IDT

1 from communicating with the physician and
2 asking for updated telephone orders until the
3 physician can come in and evaluate the
4 patient. So if you want to think in terms of
5 a physician centric perspective in
6 interpreting those regulations, that until I
7 lay hands on them, lay a stethoscope on them,
8 no changes can be made. Then, that is a huge
9 performance gap and an opportunity for
10 improvement.

11 If you think that it's up to the
12 team, which is clearly under the control of
13 the medical director and the governing body of
14 the dialysis facility, as stated in the
15 regulations, then you might develop a
16 different caricature.

17 DR. FISHBANE: Yes. I would just
18 like to respond to that. I would agree that
19 there is improvement, and you'll hear me very
20 strongly support that there is a performance
21 gap and an opportunity for improvement. So I
22 would agree with Dr. Messana's point on that.

1 Secondly, in terms of the charge
2 nurse's ability to change any of the processes
3 here that would leverage readmission rates, I
4 might, you know, disagree in pretty strong
5 terms with that. That is simply not the
6 responsibility of the charge nurse, and it's
7 not -- these are not processes of care,
8 assessment of stability after hospitalization,
9 a look at the patient's dialysis prescription
10 and readjusting it. And, most importantly,
11 the patient's volume status as it changes
12 dramatically and it leads to
13 rehospitalizations for volume overload at a
14 high rate, that a charge nurse can work.

15 And, third, in terms of the
16 conditions for coverage -- I mean, I could
17 read them here chapter and verse. They, you
18 know, simply -- they could be changed and they
19 are wonderful conditions. But this is just
20 one area. I mean, CMS has done so much great
21 here that has improved care dramatically.
22 This is just not a measure that the conditions

1 give us the ability to really move the
2 physician into place. But I appreciate, you
3 know, the very wise comments of Dr. Messana.

4 CO-CHAIR HALL: Thank you. We've
5 got five minutes to get through this measure.
6 Right now we are on evidence. Larry?

7 DR. GLANCE: I'll take 60 seconds.
8 If you believe that performance measurement
9 drives performance improvement -- and I think
10 we all do here -- I think that measuring
11 performance at a facility level has a lot of
12 advantages over measuring at the physician
13 level. And the advantage is sample size. If
14 you don't have the sample size, and you won't
15 have it at the physician level, you will not
16 be able to discriminate between high quality
17 and low quality providers. So you won't be
18 able to drive performance improvement.

19 CO-CHAIR HALL: Okay. Well, we
20 will have more categories that we can raise
21 comments in. Let's move to vote on evidence.

22 MS. SHAHAB: For 1a, evidence, one

1 is yes, two is no. And time begins now.

2 Just one more vote, please. Okay.

3 So for evidence, 17 voted yes, six voted no.

4 DR. FISHBANE: The second category
5 is the opportunity for improvement, and here,
6 you know, I think there is an opportunity for
7 improvement. The overall readmission rate is
8 30 percent, 36 percent for hemodialysis
9 patients. And that certainly there is
10 demonstrated by CMS in UMICH that there is
11 variability between units. So, you know, I
12 don't see any problems here.

13 CO-CHAIR HALL: Any additional
14 comments?

15 (No response.)

16 I don't see any immediate ones.
17 We'll vote.

18 MS. SHAHAB: 1b, performance gap,
19 one is high, two is moderate, three is low,
20 four is insufficient. And time begins now.

21 We have all the votes. For 1b,
22 performance gap, 15 high, eight moderate, zero

1 low, zero insufficient.

2 DR. FISHBANE: And, again, for
3 priority, I do think there is an important
4 priority area. You've got about 596,000
5 patients, high costs, so that's 38 percent of
6 Medicare payments here are related to
7 hospitalizations in general. So it seems like
8 it's a large enough population, big
9 opportunity, so the priority is probably
10 fairly high.

11 MS. SHAHAB: Voting for 1c, high
12 priority. One is high, two is moderate, three
13 is low, four is insufficient. Time is on.

14 We have all 23 votes. For 1c,
15 high priority, 20 voted high, three moderate,
16 zero low, zero insufficient.

17 DR. FISHBANE: I'm going to handle
18 reliability and validity separately here.
19 Reliability I think is a little bit easier to
20 deal with. The approach that was used was a
21 bootstrap approach with resampling. The
22 inter-unit reliability was measured to be

1 0.55, which, you know, I understand it's not
2 tremendously high, but it seems like for most
3 of our quality measures it is essentially what
4 we get.

5 You know, I'm going to have to
6 defer here to Sherrie, not being an expert on
7 psychometrics, but it seemed to me that this
8 was fairly reasonable.

9 CO-CHAIR KAPLAN: I agree.

10 MS. SHAHAB: If there are no other
11 comments, we can vote on 2a, reliability. One
12 is high, two is moderate, three is low, four
13 is insufficient. Time begins now.

14 We have 23 votes. For 2a,
15 reliability, five is high, 17 moderate, one
16 low and zero insufficient.

17 CO-CHAIR HALL: Any commentary
18 specifically to validity?

19 DR. FISHBANE: Yes. On validity,
20 and, you know, here I'll have a number of
21 comments, because I think, you know, the
22 threats to validity here are the same kind of

1 comments I've been speaking about, which
2 relate to first, again, the ability of any
3 action-ability of the dialysis unit under
4 current structure and practice and regulation
5 to be able to actually move this measure.

6 I do want to remind people here
7 that the early readmissions is about 16
8 percent. These are not people that are living
9 in a dialysis unit. Of patients discharged
10 Friday, dialysis unit doesn't see the patient
11 until Monday, and there is no way to be able
12 to touch the patient early.

13 Again, the TEP here spends a lot
14 of time on validity talking about the fact
15 that their dialysis unit shouldn't be holding
16 this measure, that it should, at the very
17 least, be accommodation of the hospital, the
18 M.D., understand some of the practical issues
19 in doing that. And we probably just have to
20 yield to that. But, again, it's the lack of
21 action-ability at the level of the unit.

22 The TEP voted seven out of eight

1 low or insufficient on this one. I think
2 there is a lot of issues. The heterogeneity
3 of dialysis units is important. So that in
4 many American dialysis units there are no
5 peritoneal dialysis patients. It is
6 hemodialysis where there is a 36 percent rate
7 of readmissions. In our main unit, we have 25
8 percent peritoneal dialysis patients, so I
9 shouldn't argue on this because we are going
10 to look very good on this measure, peritoneal
11 dialysis patients having the lower measure for
12 readmissions.

13 But there would need to be -- and
14 I may just have missed it in the
15 specifications. I'll turn to the developer on
16 this one, if in fact there is adjustment for
17 that. A lot of facility-related issues here.
18 There great heterogeneity in terms of American
19 dialysis units, so you've got units that
20 reside -- that are free-standing units, you've
21 got nurses that are nursing home based units.

22 The nursing home based units tend

1 to have very bad quality measures, and for
2 readmissions, where the patients are
3 rehabbing, they are very sick patients, they
4 are going to get readmitted at a very high
5 rate, and the SRR would be very difficult
6 there.

7 The size of their dialysis units
8 is tremendously different. We've got units
9 that are 200 patient, units that are 20
10 patients, and it's very hard to account for
11 that. We see very difficult problems in terms
12 of what is going on right now where dialysis
13 units are blocking discharges, more related to
14 financial issues than to quality measurement,
15 but what is happening is if the patient is
16 still on antibiotics or the patient has other
17 medical conditions going on, the hospitals
18 will try to pitch these complex patients to
19 dialysis units where they are blocked. I
20 would really be concerned here about the
21 tradeoff between length of stay.

22 Fifth, I will, you know, remind

1 you that in Washington, D.C. or New York there
2 is a lot of dialysis units close to physician
3 providers. However, many American dialysis
4 units are rural, and doctors may travel, you
5 know, once a month, sometimes by plane, 300
6 miles to get to a dialysis unit and see
7 patients.

8 And so there are a lot of threats
9 to validity here. I think a lot of it gets
10 back to the same question of, you know, how
11 can this unit -- how could this particular
12 measurement reside where there just isn't the
13 ability to push the physician to be able to
14 see a patient and whether -- is there validity
15 present.

16 CO-CHAIR HALL: Kathy?

17 DR. AUGER: One other follow-up
18 question on heterogeneity of dialysis units.
19 Since pediatric patients aren't covered by
20 Medicare, are they included in this? Are
21 pediatric dialysis units included? And can
22 you comment on, should they be compared in the

1 same metric as the adults, since the reason
2 for dialysis in pediatric patients is just so
3 different than for adults.

4 CO-CHAIR HALL: I'll ask the
5 developer to make a note of that. Sherrie?

6 CO-CHAIR KAPLAN: With respect to
7 sort of issues about staffing, et cetera,
8 et cetera, et cetera, I was hearing
9 opportunities for quality improvement as well.
10 And attribution to a physician versus facility
11 is also -- you know, nursing homes, and having
12 physicians visit patients in nursing homes,
13 et cetera, et cetera, one actually could make
14 the same kind of argument for many, many, many
15 of these measures, including -- and I was
16 harkening back to the congestive heart failure
17 readmissions measure, because that was also
18 pushed back on well, as I said, with respect
19 to being able to control the feeders into and
20 who is going to see patients after they leave
21 the hospital.

22 And yet what we are seeing is a

1 fair amount of attention to outreach for
2 telemedicine, for nursing calls, for people
3 that the hospital employs that now try and
4 reach out to those patients to make sure they
5 are not gaining weight in that first 48 hours,
6 et cetera, et cetera, that actually have done
7 a lot to help out with reducing the risk for
8 readmission.

9 So I was -- one concern that we
10 are holding -- I understand the unique issues
11 of the dialysis facilities, but I was
12 concerned that we are holding this measure to
13 a different standard, and may be missing an
14 opportunity to actually start getting the
15 message out there that this could be an
16 opportunity for us to really restructure how
17 we -- those linkages and continuities and
18 everything else that the quality improvement
19 would suggest is -- would really help patients
20 out.

21 DR. FISHBANE: Yes. And I would
22 only, you know, say to that -- but I do think

1 that this is critically important, is that
2 when you look at the studies that have been
3 put forth here by the developer, so many of
4 them relate to hospitals calling patients
5 after discharge to CHF centers that have been
6 set up, usually by hospitals in order to be
7 able to prevent CHF discharges and telephone
8 calls that are made.

9 And I think a lot of this, you
10 know, Sherrie, falls into what you are saying.
11 The dialysis unit having the very different
12 structure of being the receiver on this end,
13 and not -- you know, the skilled nursing
14 facility has an incredibly organic
15 relationship through all that communication
16 that takes place from the hospital to be able
17 to actually get a patient to a skilled nursing
18 facility.

19 We heard the representative of a
20 company that treats 40 percent of American
21 dialysis patients that they don't get any
22 discharge information in 50 percent of cases.

1 And where I have a more natural relationship
2 is hospital-owned dialysis units. Because of
3 the many-to-one relationship, we don't really
4 have the ability. So what would be the
5 performance improvement initiative?

6 And, again, I would just like to
7 point out that what you see being studied in
8 the United States right now are changes to the
9 model of care that would require changes in
10 regulation, because you'd be forcing
11 nephrology practices, for example, to pay for
12 and put a nurse practitioner into the unit to
13 be able to see the patient early on. So I do
14 think it's different than many of the
15 measures. But, you know I appreciate your
16 point.

17 CO-CHAIR HALL: I'm going to ask
18 Karen and Paul, and then we will have our
19 developer respond quickly to what they've
20 heard.

21 DR. JOYNT: I just had a couple of
22 quick points. One, I think that it is worth

1 thinking about how this is different from
2 heart failure and other conditions, because we
3 are talking about putting the onus on,
4 primarily on, the outpatient provider. And
5 for heart failure we still kept you in the
6 hospital.

7 So this is actually a bigger shift
8 than just shifting conditions. It is actually
9 shifting to a completely different -- it is
10 almost more like shifting to a patient-
11 centered medical home accountability for
12 readmissions, as opposed to shifting to a
13 condition-specific thing, but keeping it with
14 the hospital. That said, I think that is sort
15 of where we're going in general, right?

16 So I don't know that I think
17 that's a bad thing, but I do think we should
18 be thinking about it in terms of how we are
19 restructuring in terms of, sort of, ACOs and
20 patient-centered medical homes and making a
21 responsibility for our population.

22 Dialysis may be the best place to

1 start that experiment. Whether or not it's
2 ready for prime time as a quality measure
3 versus a demonstration project, not being a
4 nephrologist, I can't comment on some of the
5 financial arrangements.

6 The other sort of validity concern
7 I would just like to bring up, though, is the
8 competing -- two issues. The competing risks
9 issue of things like mortality and the, I
10 guess, competing risks of things like
11 admission. So if you're a dialysis unit that
12 does a great job keeping your patients out of
13 the hospital, your readmission rate may go up
14 as you get better. And that, to me, is a real
15 threat to validity for something like this
16 where you are talking about a population whose
17 denominator will get higher if they do it that
18 way. You know what I mean. If you do worse
19 on admissions, you might look better on
20 readmissions, and so just how you guys have
21 thought about that would be helpful.

22 DR. HEIDENREICH: As a

1 cardiologist, I'm a little uncomfortable
2 holding up heart failure as a success for
3 readmissions. I will say, making it a
4 performance measure, and particularly tying
5 reimbursement to it, has made a lot of
6 hospitals do a lot of things we hope -- I
7 think that are good. I think the jury is
8 still out, though, on how effective they were
9 and whether overall health was improved.

10 And, particularly, since we see
11 hospitals with high readmission rates have a
12 slightly better mortality rate, which is true
13 for -- not true for MI or pneumonia, but seems
14 to be true for heart failure, so I think you
15 definitely can force action by making this a
16 measure. I'm not -- you know, I think it
17 would be nice to be more confident that that
18 action will lead to improvements.

19 CO-CHAIR HALL: Thank you all.
20 We're 10 minutes behind. We'll have our
21 developers respond to what they've heard.

22 DR. KALBFLEISCH: Okay. I heard a

1 lot, but I will try to be brief. I mean, I
2 think we do see the measure, I think, as being
3 one which could promote changes in patterns of
4 care. That is perhaps its largest aim,
5 really, is to try and bring about change. And
6 I think a lot of the comments that related to
7 that, and that have been -- they have been
8 very good comments about the potential for
9 that as well.

10 Early readmissions, I guess, was
11 one that is measured. That is one that we
12 have wrestled with a bit, and we commented in
13 our response actually about that, because, as
14 dialysis facilities currently are structured,
15 I think it is hard to see how they can -- they
16 can easily address admissions within the first
17 three days of hospitalization. And to some
18 degree, there is sort of a policy issue there
19 I think that -- is the measure trying to
20 change the pattern of care there, and I think
21 that's -- I think that's really the policy
22 question. And I think it's -- we suggested

1 that we should probably think of it as
2 including that, with the aim of making that
3 kind of change. And I think that's the policy
4 that CMS wishes to pursue.

5 DR. MESSANA: So the only thing I
6 will add on that point, though, is that, as we
7 have demonstrated in the followup materials
8 from the last call, we can identify those
9 hospital readmissions that occur within that
10 time period, and we have done analyses
11 comparing, calculating the measure both ways.

12 DR. KALBFLEISCH: Yes. The
13 measure certainly could be defined either way.
14 I mean, we have dealt with that in some --
15 they are the highest -- days of highest
16 readmissions, actually, are the first three or
17 four days of the period following discharge.
18 Peritoneal dialysis was mentioned. We don't
19 adjust for that in the model. We have looked
20 at it, and overall they have a slightly higher
21 readmission rate than the -- than hemodialysis
22 patients, but not really much difference.

1 Let's see. Oh, the question of
2 readmissions and admissions is a very
3 interesting point, because I think when one
4 looks at readmissions the denominator really
5 is a random quantity, but it's the number of
6 discharges from the hospital. And if you
7 reduce the number of hospitalizations, you
8 reduce the number of discharges, so you change
9 the denominator.

10 And that is an issue I think with
11 readmission measures like this. I think that
12 in the context of dialysis facilities,
13 probably in SNFs as well, and other such
14 secondary care facilities, I guess our view is
15 we have as well a measure of hospitalizations,
16 the standard hospitalization rate, which is
17 actually looking at the rate at which
18 admissions occur in dialysis facilities.

19 And we really think of looking at
20 those two together, so the one is telling us
21 about the overall use of hospitalization by
22 the facility; the other is trying to look more

1 specifically at the readmission process, so
2 looking at two different aspects of
3 hospitalization. That is -- so taking the two
4 together, I think, is sort of something that
5 is -- we recommend and I think makes a lot of
6 sense.

7 Pediatric patients are included,
8 and they are adjusted for in an age adjustment
9 in the model. I think that's -- oh, geography
10 was another one that was mentioned I think,
11 and we haven't seen I think specific
12 differences in rural versus urban. But I'm
13 sure that the challenges those facilities face
14 are quite different.

15 DR. MESSANA: I would add one
16 additional comment, or a little bit of
17 additional detail about the pediatrics.
18 Patients under age 18 account for on the order
19 of 1,400 or 1,500 dialysis patients in the
20 United States out of a denominator of perhaps
21 450,000. The majority of those patients are
22 dialyzed in adult-predominant facilities.

1 There are some or a handful, less
2 than 100, probably in the twenties or
3 thirties, facilities that are predominantly or
4 completely pediatric. Generally, they tend to
5 be small units. They tend to take care of a
6 lot more infants. And since there are a
7 minimum number of observations, criteria built
8 in as exclusions, many of those facilities
9 would not be reported on just because of such
10 small numbers. So the pediatric picture is
11 small, no pun intended.

12 CO-CHAIR HALL: Karen?

13 DR. JOYNT: Sorry. That was left
14 there from --

15 CO-CHAIR HALL: Okay. I see no
16 other comments, so let's move to a vote for
17 validity.

18 MS. SHAHAB: For 2b, validity, one
19 is high, two is moderate, three is low, and
20 four is insufficient. And the time starts
21 now.

22 (Pause.)

1 We have all 24 votes. For
2 validity, one high, 16 moderate, seven voted
3 low, and zero voted insufficient.

4 CO-CHAIR HALL: Any specific
5 comments on feasibility?

6 (No response.)

7 Seeing none.

8 MS. SHAHAB: For criteria 3,
9 feasibility, one is high, two is moderate,
10 three is low, four insufficient. And the time
11 starts now.

12 (Pause.)

13 We have all 24 votes. For
14 feasibility, 11 voted high, nine moderate,
15 four low, and zero insufficient.

16 CO-CHAIR HALL: Specific comments
17 on usability use? Realizing that many
18 comments have overlapped so far.

19 MS. SHAHAB: For criteria 4,
20 usability and use, one is high, two is
21 moderate, three is low, four insufficient
22 information. And the time starts now.

1 (Pause.)

2 We have all 24 votes. Three high,
3 11 moderate, 10 low, and zero insufficient
4 information. So we can also -- if there is no
5 other comments, we can go ahead and vote on
6 overall suitability for endorsement.

7

8 CO-CHAIR HALL: Any other
9 comments?

10 (No response.)

11 No.

12 MS. SHAHAB: One is yes, two is
13 no, and the time starts now.

14 (Pause.)

15 Okay. We have all 24 votes now.
16 For Measure 2496, standardized readmission
17 ratio for dialysis facilities, 13 voted yes,
18 and 11 voted no.

19 CO-CHAIR HALL: So that this
20 particular measure falls, again, into the
21 40/60 percent category. So it will move
22 forward through the additional phases of this

1 process.

2 CO-CHAIR KAPLAN: Just for the
3 record, I don't count CHF a huge success.

4 (Laughter.)

5 I just wanted to make sure
6 everybody knew that.

7 CO-CHAIR HALL: Too late. Thank
8 our colleagues from Michigan, and move on to
9 the next measure, where we are about 20
10 minutes behind schedule. We are considering
11 rejuggling the end of the schedule to try to
12 make sure that anybody who needs to leave town
13 and catch a flight can do so. So please bear
14 with us as we move forward, and we will
15 continue to try to be as timely as we possibly
16 can with these critical discussions.

17 The next measure is 2503,
18 hospitalizations per thousand Medicare fee-
19 for-service beneficiaries, developer Colorado
20 Foundation for Medical Care. And our first
21 discussants will be Leslie and Tom. We'll
22 invite the developers to introduce themselves

1 and briefly introduce the measure.

2 DR. BROCK: I'm Jane Brock from
3 CFMC, not Teligent. We just changed our
4 corporate identity.

5 MS. STEVENS: I'm Beth Stevens.
6 I'm a statistician on the project.

7 DR. BROCK: So I feel like I
8 should thank the university for -- the team
9 from the University of Michigan for already
10 making some of our points. So thank you.

11 I want to give a little background
12 about both of our measures. So we have a
13 hospitalizations per thousand measure, and a
14 readmissions per thousand measure. And I just
15 want to talk a little bit about the background
16 of both of them together, and then that will
17 be all the background that we need.

18 In 2008, CMS funded 14 QIOs to do
19 population improvement with regard to K
20 transitions as measured by hospital -- 30-day
21 hospital readmission rates. So we started out
22 working with hospitals but very quickly we

1 were being asked to reduce the readmission
2 experience of a population. That population
3 was defined by geography, so the population of
4 fee-for-service beneficiaries within a
5 community, and we defined those communities as
6 a series of zip codes.

7 So this was based on where the
8 Medicare beneficiaries lived, so it didn't
9 take very long to realize that we had to work
10 with hospitals, so this very quickly grew into
11 community collaborative and collective action
12 type interventions, with a wide range of
13 providers, and then pretty quickly went beyond
14 medical service providers to involve home and
15 community service providers.

16 So it was pretty clear within the
17 first year of the project that the measures
18 that we had available to us at the time, which
19 were based on readmissions per discharges, we
20 were not capturing the improvements that were
21 being made. So the interventions that reduced
22 30-day readmissions, reduced 31-day

1 readmissions, and 45-day readmissions, and
2 which go straight into the denominator. So we
3 had communities that were not capturing the
4 benefits of, say, improving referrals to
5 palliative care, or home community services
6 and, even worse, were almost putting
7 themselves at risk of failure by potentially
8 reducing the denominator faster than the
9 numerator.

10 So we went to measure just
11 admissions per population and readmissions per
12 population, and that is where these measures
13 come from. So they were being used -- when we
14 first started using them, there were 14
15 communities, now we are working with about 400
16 communities. This work is going to expand
17 again next year. With QIOs, we will be
18 working with a lot of rural communities. And
19 we think there is urgency around this message,
20 around this type of measure, because it is not
21 just us. So with all the focus on population
22 health, we think that there is an urgent need

1 for a way of measuring the readmissions
2 attributable to the population, not defined by
3 their relationship to an existing medical
4 service provider.

5 So, the numerator is just number
6 of admissions, and we'll talk about the
7 hospitalization measure. Number of admissions
8 divided by the number of fee-for-service
9 Medicare beneficiaries in the target
10 geographic region. So this is not risk
11 adjusted. When we start to work with
12 everybody in the community, it's hard to stick
13 with a definition of avoidable or risk that is
14 valid. So, for instance, some of the
15 communities now are working, say, with our
16 housing authority, so it really gets to the
17 question that started out today around social
18 instruments of health. So when you go to a
19 community initiative, potentially the
20 community can solve all of those problems. So
21 we do not risk adjust this measure. Should I
22 go through validity now, or --

1 CO-CHAIR KAPLAN: Anything
2 relevant to the -- I think we need an overall
3 description, and then we will go through by
4 criterion and ask you, I think is the best way
5 to do it.

6 DR. BROCK: Okay. Well, so the
7 description is just hospitalizations per
8 thousand beneficiaries. We calculate that per
9 year and per quarter.

10 CO-CHAIR KAPLAN: Thank you.
11 Discussion of the evidence? Leslie, and then
12 Tom.

13 DR. THOMAS SMITH: Yes. Leslie
14 and I are the reviewers, and we decided I
15 would start and you'll jump in to help out.
16 So I think in terms of the evidence, the story
17 and the background are compelling. The
18 evidence is drawn largely from the prior work
19 on rehospitalizations, and certainly that is
20 an important area for performance measuring
21 and performance initiatives.

22 The logic is that through some of

1 the research we have about, for example,
2 transitional care interventions, and also
3 patient activation, things like that, that
4 what happens in the community often has a more
5 profound impact on whether people are
6 hospitalized than what happens in the
7 hospital.

8 So, therefore, we need a
9 community-based measure of admissions. And we
10 should take that step from just focusing on
11 readmissions to focusing on all admissions to
12 broaden the denominator and really create a
13 measure that is applicable for community-based
14 initiatives, for example, public health
15 prevention initiatives.

16 So the evidence, again, is drawn
17 upon a more limited sample of
18 rehospitalizations, and that work --
19 readmissions. But the story is compelling,
20 and I think the evidence supports moving
21 forward.

22 CO-CHAIR KAPLAN: Leslie?

1 MS. HALL: I don't have a comment.

2 CO-CHAIR KAPLAN: Other comments?

3 Are we ready to vote or -- oops. Okay.

4 MS. CENTENO: I just need to

5 clarify. Are we holding the hospital

6 accountable for this measure, or the

7 community?

8 CO-CHAIR KAPLAN: Good question.

9 Who is the accountable entity?

10 DR. BROCK: So the accountable

11 entity is an initiative that seeks to improve

12 community-based readmission rates. So it is

13 not a provider accountability measure.

14 DR. THOMAS SMITH: This touches on

15 a fundamental question, which we will get to

16 I think in the validity discussion.

17 CO-CHAIR KAPLAN: Thank you.

18 Okay. Oh, Karen.

19 DR. JOYNT: Just a brief comment

20 about this. I think the developer has

21 actually really undersold the evidence behind

22 this. There is a lot of evidence for how

1 better primary care and other community-based
2 interventions can improve health outcomes.
3 And the background was completely focused on
4 rehospitalizations. So I don't know that we
5 saw the evidence, but I think this is a
6 scenario which, because this is an outcome and
7 not a process, that there I think is fairly
8 good sort of theoretical basis for
9 understanding that if we do better as a
10 community we will reduce people's likelihood
11 of being hospitalized.

12 CO-CHAIR KAPLAN: Again, we will
13 come back to this discussion in the usability
14 issue, too, in terms of implementation, but
15 for now we are talking about evidence. Are we
16 ready to vote? Any other comments? Going
17 once, going twice.

18 (No response.)

19 Okay.

20 MS. SHAHAB: Voting for 1a,
21 evidence. One is yes, and two is no. And the
22 time begins now.

1 (Pause.)

2 Just one more vote. We have all
3 24 votes. For 1a, evidence, 22 voted yes, and
4 two voted no.

5 CO-CHAIR KAPLAN: Performance gap?
6 Thomas or Leslie?

7 DR. THOMAS SMITH: Sure. Yes, I
8 think this is fairly straightforward, too. I
9 think the answer is yes, there is a gap and an
10 opportunity there. If you're looking at
11 admissions per thousand Medicare
12 beneficiaries, and the measure is calculated
13 at the level of states and communities, it is
14 also calculated annually and quarterly with
15 seasonal correction.

16 So if you look at it -- at annual
17 levels, 270 or so, around there, admissions
18 per thousand beneficiaries, the quarterly
19 metric is 65, 70 per thousand beneficiaries.
20 Standard deviations are around 20 percent.
21 So, really, significant variability and a real
22 opportunity. Again, one of the main reasons

1 is the denominator is so large.

2 CO-CHAIR KAPLAN: Other comments?
3 Are you ready to vote?

4 (No response.)

5 MS. SHAHAB: For 1b, performance
6 gap, one is high, two is moderate, three is
7 low, four insufficient. And voting is open
8 now.

9 (Pause.)

10 We have all 24 votes. For 1b,
11 performance gap, 19 high, three moderate, two
12 low, and zero insufficient.

13 CO-CHAIR KAPLAN: Okay. High
14 priority. Oops, sorry.

15 DR. THOMAS SMITH: Yes. I was
16 going to say we can move on to priority. This
17 also I think is straightforward. Admissions
18 of the Medicare population are a priority.
19 That's a substantial population. It is all
20 beneficiaries. Why not, right?

21 (Laughter.)

22 Maybe that's not --

1 CO-CHAIR KAPLAN: Any comments
2 beyond "why not?"

3 (Laughter.)

4 Leslie?

5 MS. HALL: I'd just like to add
6 that this could be an opportunity for
7 something of a baseline for us to use in other
8 measures in the community, and so a beginning
9 of harmonization and a really good building
10 block. So --

11 CO-CHAIR KAPLAN: Why not second
12 it?

13 (Laughter.)

14 Ready to vote?

15 (No response.)

16 MS. SHAHAB: 1c, high priority.
17 One is high, two moderate, three low, four
18 insufficient. And voting begins now.

19 (Pause.)

20 Two more votes.

21 (Pause.)

22 We have all 24 votes. For 1c,

1 high priority, 20 high, three moderate, one
2 low, and zero insufficient.

3 CO-CHAIR KAPLAN: Moving on to
4 reliability and validity. Thomas?

5 DR. THOMAS SMITH: Again, good. I
6 think they presented data from Medicare claims
7 for five or six years, I believe, so a total
8 of 40 million beneficiaries' data were
9 presented. They did use a split sample and
10 their reliability reproducibility was very
11 high. Weighted cap is where -- .8, .9, very,
12 very high. So that was it. I mean, those
13 were your reliability data right there, so I
14 think that's pretty straightforward.

15 CO-CHAIR KAPLAN: Any comments?
16 Leslie, anything?

17 (No response.)

18 Negative. Okay. Ready to vote?

19 (No response.)

20 MS. SHAHAB: For 2a, reliability,
21 one is --

22 CO-CHAIR KAPLAN: Oops. Who said

1 -- Wes. Sorry.

2 DR. FIELDS: I just want to send
3 my compliments to the measure developer. This
4 is my favorite measure of both days. And
5 since we are pretty good at mixing science and
6 empiricism, I just want to point out that
7 after a premium per-member, per-month for any
8 prepaid group contracting with Medicare
9 Advantage contractor, this is the single most
10 important metric for the single largest cost
11 center.

12 And find it, really, you know,
13 entertaining and amusing, that it is coming at
14 us looking like a community initiative. What
15 it really is is your best single benchmark
16 between the difference between the fee-for-
17 service program and the Medicare Advantage
18 program.

19 So I'm speaking in favor of its
20 reliability as a metric.

21 CO-CHAIR KAPLAN: Thank you.
22 Other comments?

1 (No response.)

2 Okay. Now voting.

3 MS. SHAHAB: For 2a, reliability,
4 voting is open now.

5 (Pause.)

6 One more vote? We have all 24
7 votes now. For 2a, reliability. 18 high, six
8 moderate, zero low, zero insufficient.

9 CO-CHAIR KAPLAN: Thank you.
10 Validity?

11 CO-CHAIR HALL: Wes, are you still
12 up?

13 CO-CHAIR KAPLAN: Oh.

14 DR. FIELDS: No.

15 CO-CHAIR KAPLAN: Sorry. Thomas?

16 DR. THOMAS SMITH: So I think here
17 is -- with validity and usability is where we
18 have to have some discussion, and there are
19 some fundamental issues and questions that
20 come up. They present limited validity data,
21 face and construct validity.

22 They mention the Atul Gawande

1 paper on the hotspotters, right, the
2 communities, the four communities around the
3 country -- Newark, Camden, El Paso, the other
4 two, that are known to have high rates of
5 inpatient use. And they compared -- and they
6 looked at those four cities using this
7 measure, and sure enough found high rates of
8 admissions per thousand beneficiaries, which
9 gives some validity, some face validity.

10 They also mentioned a Commonwealth
11 Fund study of potentially preventable
12 admissions, and they compared communities --
13 I think it was community rates of potentially
14 preventable admissions to rates on this
15 measure and did I think quintile or quartile
16 analyses. And the cap is -- were moderate.

17 So those are sort of decent face
18 construct validity studies, although it does
19 -- a question was noted that both of these
20 other studies, whether it's Gawande's report
21 or the Commonwealth study, also relied on
22 Medicare claims data, which I guess ultimately

1 is the same data set that the stewards
2 developed the measure off of. So there are
3 questions there.

4 There is good control for seasonal
5 variation, we should mention that, for the
6 quarterly measure. Other than that, there is
7 no other validity data, and there is no -- one
8 of the bigger issues here is there is no risk
9 adjustment. That was a conscious decision.
10 The idea here is that this is a community-
11 based measure that communities can use, for
12 example, to track process and outcomes in
13 prevention initiatives. But it does raise a
14 question of how the data would be used and
15 comparability across communities or
16 comparability across providers within a
17 community.

18 And I think the response -- you
19 guys should speak to this -- I think the
20 answer is that this is a measure that would be
21 put out there with the proviso, or with the
22 note, that it's only for communities to

1 compare to themselves and not to be used for
2 other comparison purposes. So because of the
3 absence of risk adjustment questions about
4 validity, therefore, and given that -- how can
5 NQF control how people use other measures when
6 they're out there, it raises some important
7 questions for discussion.

8 So I'll stop with that. I don't
9 know if --

10 DR. BROCK: Yes. So this measure
11 is developed for a community, a specific place
12 to track their own progress over time. We use
13 it in the program to compare sort of relative
14 improvement among different communities, but
15 comparing one community's hospitalization or
16 rehospitalization rate per thousand to another
17 is not what the measure is designed for.

18 CO-CHAIR KAPLAN: Bruce? Oops.
19 Karen?

20 DR. JOYNT: Yes. I wanted to
21 speak to the issue of risk adjustment as well.
22 I think it's an interesting question, because

1 some of the -- some of the high rates of
2 hospitalization are a marker of poor quality
3 care. It is not just that things are, like,
4 somehow different in some part of the country
5 than others, and some of that is propensity to
6 use hospital services, some of it is
7 availability of hospital services. Some of it
8 is just bad outpatient care.

9 And so I think it is -- this is a
10 tricky space to decide what to adjust and not,
11 and it gets a little bit, I think, probably
12 into the discussions that were happening in
13 the other committee about, what do you want to
14 hide versus adjust for? And is it enough for
15 people just to compare relative to themselves
16 or is there some bar we should be, sort, of
17 holding people to? So this is another place
18 where I think the use and usability will
19 matter.

20 One set of validity testing that I
21 would have liked to see is, as opposed -- I
22 agree the validity testing was all sort of to

1 itself, which is fine, but, you know, Atul
2 chose those communities based on their high
3 utilization. So if that didn't match, then
4 there would have been very something very
5 wrong.

6 But what we don't know is how
7 other constructs might affect this. What
8 about supply of services? What about rurality?
9 I think there is a lot of other stuff. If we
10 wanted to go down the risk adjustment path, we
11 would need to think about more than just
12 sickness. We'd need to think about
13 infrastructure. And if that's not where we
14 want to go with this measure, that's fine.
15 But I do think that it bears considering that
16 it's about more than just whether or not
17 someone has diabetes.

18 CO-CHAIR KAPLAN: By the way, the
19 independence of purpose of measurement makes
20 a psychometrician insane, because the measures
21 are only good for the purpose you are putting
22 them to. So I have been mute on that topic,

1 because it comes up beyond the imprimatur of
2 the committee in terms of how measures are
3 actually being used. But, believe me, many of
4 us consider the purpose of measurement an
5 important property of how you interpret its
6 validity and reliability, for example. So
7 thank you, Karen.

8 Paula?

9 MS. MINTON-FOLTZ: Yes. Thank
10 you. And I also want to talk about just the
11 academic medical center, because those do --
12 I mean, you have communities that do have
13 academic medical centers, but the community
14 feeds into the tertiary piece of that. And
15 those usually do have a higher case mix and
16 would be more ill and more apt to readmit.
17 But I -- because they are not always from that
18 community, they may -- but it's a small
19 proportion, I think, of the overall.

20 CO-CHAIR KAPLAN: Thank you.

21 DR. BROCK: So I just want to
22 point out, though, that -- so if the

1 readmission is assigned to the place that the
2 patient lives, so a tertiary referral center
3 that gets a bunch of patients from someplace
4 else, if they were readmitted, that would be
5 assigned to the community that the patient
6 came from.

7 CO-CHAIR KAPLAN: Thanks for that
8 clarification. We are going to just come
9 right up and go right around. So, Ron?

10 MR. STETTLER: Yes. So I agree
11 with Wes. This is probably the single most
12 important metric, as a health plan, that we
13 use for measuring our performance. I think my
14 problem with it is not so much that if you
15 could control people from comparing community
16 to community, you could get away with not
17 doing the risk adjustment. But you have to if
18 they are ever going to compare communities.
19 But even within a community the population
20 changes. And this doesn't adjust for that.

21 So Medicare, there is age in to
22 Medicare. It is changing over time.

1 Populations are probably getting younger over
2 time. And I honestly think you would have a
3 miss in the metric. You would be, you know,
4 demonstrating something that doesn't exist
5 just because you are not controlling for that
6 case mix over time, without doing the risk
7 adjustment for age, for sex, for other
8 characteristics, even within the community.

9 MS. STEVENS: We have looked into
10 that some. The change over time for a
11 relatively short period of time is pretty
12 minimal. I think if we were comparing now to
13 five years ago, the change maybe in age would
14 have kind of changed within a community. But
15 within a community over the life of the
16 quality improvement project, the demographics
17 and risk doesn't change very much.

18 MR. STETTLER: Then I guess my
19 point would be, why not control for it? I
20 mean, I think you are just missing out on an
21 opportunity to eliminate the controversy, and
22 just adjust for it, and be done with it.

1 CO-CHAIR KAPLAN: Thank you.

2 Paul?

3 MR. HEIDENREICH: Yes. I have a
4 similar concern with not including the risk
5 adjustment. Without it, you are basically
6 saying, well, all hospitals can improve -- I
7 mean, all communities can improve. They all
8 can improve the same amount, without some
9 standard.

10 And like the Colorado group --
11 community I think from that article, they were
12 I think the best, or they are very good. So
13 when they -- next year, when they are not any
14 better, do we say, "Wow, you guys have
15 failed," while some of these other places
16 improved? If we are truly not comparing -- I
17 think in the end we are comparing. I think
18 people are going to compare. So I would urge
19 you to add that.

20 DR. BROCK: So we found --
21 certainly, in the initial 14 communities, we
22 found that the capability to improve was not

1 a reflection of where people started, if you
2 looked at proportion improvement or reduction
3 in failure rate, so we had some very high-
4 performing communities that improved the same
5 amount as some very low-performing
6 communities. So --

7 CO-CHAIR KAPLAN: Pam?

8 DR. ROBERTS: Just in addition to
9 looking at the -- adjusting for case mix over
10 time, also looking for hospital services,
11 change over time, too, and I think that that's
12 an important piece that would need to be
13 looked at for adjustment.

14 CO-CHAIR KAPLAN: Thank you.
15 Bruce?

16 CO-CHAIR HALL: Well, I had some
17 concerns, many of which have been expressed.
18 It is not clear to me in reading the
19 denominator spec how we're defining the state
20 or community. So, obviously, somebody later
21 on is -- I mean, state, obvious. But somebody
22 later on is going to define the community, and

1 then -- and I can see it now, we have already
2 probably seen it already, that, you know, this
3 is just going to be front page USA Today,
4 every single community flagged with their
5 rate.

6 So I think the notion that we're
7 not going to be comparing across facilities is
8 a false one. I also think the attribution of
9 the patients' care to a home zip code, perhaps
10 different than where they're actually treated,
11 to me is a problem, because then you would be
12 arguing not to have that community feed into
13 the treatment center that might be in a
14 different zip code.

15 I think controlling across
16 communities, controlling across time, are
17 critical aspects. And how do we think of --
18 it's not clear to me how we think a community
19 makes use of this information, but maybe
20 that's my feeling.

21 A question I have, though, is what
22 are we really approving? It seems like CMS

1 could and probably already has published this
2 in USA Today already. What are we actually
3 approving? We are approving calculation of
4 discharge per thousand fee-for-service
5 Medicare without risk adjustment, without some
6 of the other issues. I'm not even sure how
7 much this is really a measure, versus a
8 simpler statistic. And it's not clear to me
9 why we need to approve this.

10 DR. BROCK: So, let's see, there
11 are several questions in there. So I do think
12 it's worth standardizing approach to defining
13 readmission and admission and measuring that,
14 and assigning that to place. So I don't
15 understand your concern about the role of the
16 place there treated, in that the place that
17 they live generates the admission, and the
18 place they are discharged to, in a sense,
19 generates the readmission.

20 So it has a lot more overlay with
21 the social determines of health, which is part
22 of why they are useful. So if a community

1 knows, yes, everything is terrible in this
2 neighborhood, and that's why when you go to
3 this zip code or -- we are increasingly using
4 census tracks, you know, all of us are taking
5 a hit on quality measures, because we need to
6 solve some of the situations that are involved
7 with living in this place.

8 And that's why, as part of a wider
9 community initiative, it is so useful. And
10 that is also part of why we don't risk adjust
11 it, because you don't want to set parameters
12 around what a community can and can't solve.
13 You know, so if your housing authority
14 provides good housing to people after
15 discharge, then you can stop wringing your
16 hands about, oh, gosh, the problem is housing.

17 So that's a lot of why we wanted
18 to just display it as a rate that could be
19 reproduced across places, not necessarily to
20 be compared across places but to know that we
21 can calculate it the same everywhere and track
22 it the same everywhere. Does that answer your

1 question?

2 CO-CHAIR HALL: I think it gets to
3 some of the aspects, yeah. I think, again,
4 I'm not sure why we need to approve a simpler
5 calculation, but I do still feel that
6 comparing a community to itself over time and
7 -- is important, and inevitably it's going to
8 appear front page newspaper, and communities
9 will be compared with each other.

10 DR. BROCK: So, in the end, the
11 answer to that is kind of easy, I think. So
12 if you look at, you know, South Chicago, they
13 can say, of course we have a readmission
14 problem. We have terrible, you know, poverty
15 and housing, and, you know, that's probably
16 all true. But what the community needs to
17 think about is what can we do about that, you
18 know, not like wow, things would be better if
19 we were Grand Junction. You know, what we
20 want them to think about is what should we do
21 now, given this situation.

22 In terms of defining the actual

1 measure, it is more important for readmissions
2 than for admissions, I think, so -- I know we
3 are not discussing that yet, but there is a
4 number of ways to define what is a readmission
5 and how to calculate that numerator, you know,
6 number, which is -- we think it's important to
7 standardize that.

8 CO-CHAIR KAPLAN: Jane, could --
9 it's Jane, right? Could you just clarify for
10 me because I think maybe I misunderstood the
11 answer to Bruce's question based on what you
12 said before. The community the patient lives
13 in is the community that gets attributed the
14 discharge, correct?

15 DR. BROCK: Yes.

16 CO-CHAIR KAPLAN: Okay.

17 DR. BROCK: So if they are
18 discharged from a Denver hospital and they go
19 to Miami and get readmitted in Miami, that
20 goes on their Denver zip code.

21 CO-CHAIR KAPLAN: Thank you.
22 Larry?

1 DR. GLANCE: So I agree that there
2 is a tremendous amount of useful information
3 that could be obtained from this particular
4 measure. I am also concerned that there is
5 the potential for some very real, unintended
6 consequences. Namely, I could see a Dartmouth
7 Atlas type of publication where you could very
8 easily look at a map and using color coding,
9 identify areas that, as a Fortune 500 company
10 CEO, I might not want to have my company.

11 Maybe as an upwardly mobile yuppie
12 or something of that type, I would look at
13 that map and say, I don't want to live there.
14 Now, you might say that some of those things
15 are pretty obvious without that map, but I
16 would say maybe not all of them. And so
17 people might start moving around, companies
18 might start thinking about where they're going
19 to locate their headquarters based on this
20 kind of map.

21 So although I think there is a lot
22 of utility for -- within community comparisons

1 for longitudinal-type comparisons, I think
2 that there is some risk with -- between
3 community comparisons with this kind of
4 measure.

5 CO-CHAIR KAPLAN: Thank you. Now
6 remember, we are still on the topic of
7 validity, not usability yet, although purpose
8 of measurement shapes validity, so it's hard
9 for me also to kind of make that call.

10 But, Leslie? Thank you.

11 MS. HALL: And I would encourage
12 that kind of difference that you describe,
13 Larry, because -- and when we do community
14 needs assessments, in many communities
15 reporting back to our governors or our city
16 mayors about what our needs are there, it
17 gives providers and others an opportunity to
18 demonstrate and identify infrastructure
19 issues, access issues, disparity issues,
20 rather than just having single points of
21 failure aimed at hospitals.

22 So I think it's an important

1 equalizer, and transparency is a first step in
2 quality improvement. So I think this is an
3 important effort and quite valid, even though
4 the use cases that we might think of are
5 typically outside of the hospital.

6 CO-CHAIR KAPLAN: Thank you. This
7 has been a very rich discussion. Karen, did
8 you have something to add?

9 MS. PACE: Yes. I just wanted to
10 make a comment about the use of the measure.
11 I think one of the ways, at least currently,
12 that NQF is thinking about that is that the
13 way the measure is specified puts some
14 parameters around use in that it should
15 identify the patient population, the setting
16 or the accountable entity, the level of
17 analysis, and that should be the use that is
18 represented in the measure testing as well.

19 Now, the other overlay is that NQF
20 endorses measures that are expected to be used
21 in accountability applications, but at least
22 currently, we don't make a distinction of

1 whether that's pay-for-performance or public
2 reporting. But I think there is some element
3 of the use case in terms of how the measure is
4 specified, and just wanted to offer that.

5 DR. BURSTIN: Let me follow up on
6 that. So the measures we saw earlier in the
7 day, the prevention of quality indicators from
8 ARC I think are very analogous. They are also
9 at the community level. Those are endorsed.
10 But they are actually, just to -- you know,
11 for full transparency, they are adjusted for
12 age and gender specifically because of
13 concerns about differences across communities.

14 Those are displayed across
15 communities and are very much thought to
16 reflect the quality potentially of ambulatory
17 care available to avoid those
18 hospitalizations. So just to put that there.

19 CO-CHAIR KAPLAN: I think this --
20 clarification of this use and utility business
21 gets a little bit confusing for people when
22 you start talking about unintended

1 consequences. And so people are reacting to,
2 well, how could this go wrong? Any time you
3 measure something and put it out there, people
4 can use it for something you didn't plan. So
5 I think that language gets us a little bit
6 confused about, you know, exactly how this is
7 going to be used.

8 Also, with respect to populations,
9 it gets -- people like me go, population?
10 What are you doing with statistics? That's a
11 population. You just declare it. You know,
12 come on. So it's a little confusing and it
13 brings in a few -- a little bit more
14 discussion.

15 We have had some rich discussion
16 now about validity, and I think we are --
17 unless there's any other issues, I know Karen
18 and Wes wanted to bring something up. But
19 unless we -- can we vote?

20 (No audible response.)

21 Good.

22 MS. SHAHAB: So we're going to

1 vote on 2b, validity. One is high, two
2 moderate, three low, four insufficient. And
3 time begins now.

4 We have all 24 votes. For 2b,
5 validity, two high, 13 moderate, eight low,
6 one insufficient.

7 CO-CHAIR KAPLAN: Thank you.
8 Feasibility. Thomas?

9 DR. THOMAS SMITH: I don't think
10 there are significant concerns here. I don't
11 have anything to say.

12 CO-CHAIR KAPLAN: Wes?

13 DR. FIELDS: Yes. I have been
14 flipping that thing open now for about five
15 minutes. This is a situation, I believe,
16 where a really good idea coming from a
17 community trying to do the right thing has
18 potentially allowed us to face one of the most
19 important longer-term issues for the Medicare
20 program.

21 And if for no other reason than
22 that, and if for no other reason than there's

1 thousands of communities around this country,
2 you do need to risk adjust this data. Without
3 the risk adjustment, it probably would be
4 tougher for me to vote in favor of it because
5 although I very clearly understand their
6 intent, and it's a valid intent, the larger
7 issues that confront the program and the trust
8 funds are well-understood.

9 And you would be doing not just
10 communities but Congress a huge favor if you
11 do this with risk adjustment so that it could
12 become more and more clear whether or not
13 there should be a differential in payment per
14 member per month between Medicare Advantage
15 and the traditional program or not.

16 It would also probably help us if
17 -- in a drilldown, to understand where are the
18 gaps in case management and care coordination
19 where we can make investments that really will
20 make a difference in outcome by looking at
21 what Advantage can do versus the traditional
22 program cannot.

1 So speaking very strongly in favor
2 of doing the risk adjustment and the validity,
3 I just wanted to point out, is I don't think
4 of us believe that CMS pays exactly the same
5 amount per member per month in every single
6 geo zip in this country. It is already risk-
7 adjusted.

8 You know, what they pay plans is
9 already a matter of a whole other body of work
10 that goes on all the time. It would be I
11 think a minor tragedy if you didn't use
12 technology and analysis that already exists
13 and apply it to this population. For me,
14 ultimately, even though this is community-
15 driven, I think all of us feel driven to make
16 sure this population can be served well and
17 that the services that we provide are
18 sustainable. And you won't get there without
19 risk adjustment when you look at this measure.

20 CO-CHAIR KAPLAN: Thank you. You
21 know, I am hearing things that speak more to
22 usability and use and a little bit less to

1 feasibility because the feasibility I think
2 answers the question, can it be done? And
3 then usability is, how should it be done and
4 can it be used in the form proposed?

5 But are there any other comments
6 on feasibility? Go ahead.

7 DR. BULGER: Yes. And it's
8 probably used, but it speaks to what -- this
9 data is already on the Dartmouth Atlas for,
10 you know, it's hospital discharges per
11 thousand Medicare enrollees by gender and type
12 of admission and by hospital referral region,
13 state, and hospital area. So I mean, you
14 know, it's already to some extent there.

15 Now, it's different than this
16 measure is, but, you know, this type of data
17 is already available, and it's not -- it's
18 risk-adjusted, so it's risk-adjusted by age,
19 sex, and race, but that's it. And I'm just
20 playing on the Dartmouth Atlas right now,
21 pulling it up, so I mean, you can -- and
22 that's exactly what will happen with this. It

1 will be out there just the same way.

2 CO-CHAIR KAPLAN: In terms of
3 feasibility, though, because it's already out
4 there, it is doable, right?

5 (Laughter.)

6 CO-CHAIR KAPLAN: So it is -- so
7 whether it should be is a whole different
8 story. But for feasibility we need to kind of
9 vote how feasible it is unless there is
10 another issue. Hearing none?

11 MS. SHAHAB: For criteria number
12 3, feasibility, one is high, two moderate,
13 three low, four insufficient. And the time
14 begins now.

15 For feasibility, 22 high and one
16 moderate, zero low, zero insufficient.

17 CO-CHAIR KAPLAN: Okay. With
18 respect to usability and use, we've already
19 had some discussions about the implications of
20 risk adjustment and so on. Again, you know,
21 that -- that may go on to address the issues
22 that are going to be moved to the MAP group.

1 But if there is anybody else who wants to make
2 a comment on usability and use? Go ahead,
3 Leslie.

4 MS. HALL: I would just advocate
5 that with -- if we're thinking about using
6 this to compare for payment and other types of
7 health care-related issues by thinking that
8 the risk adjustment addresses that better,
9 perhaps. But if we are thinking that this
10 might be used to say, do we have deserts of
11 food? Do we have good transportation
12 infrastructure? Do we have other root causes
13 that are not related to this? Those are not
14 risk adjusted.

15 So I think that it is an apples to
16 apples consideration, and this gives us a
17 chance to look at other causes of admissions
18 in hospitals and an opportunity to work with
19 community partners to advance and improve
20 health care in our community for unrelated
21 issues that -- to our hospitalization and care
22 that also provides other opportunities for

1 funding sources and community outreach.

2 So I would advocate that non-risk
3 adjustment gives us better opportunity for
4 usability.

5 CO-CHAIR KAPLAN: Thank you very
6 much. In terms of just use and usability, I
7 am hearing a fair amount of concern about risk
8 adjustment. And something -- I mean, Karen
9 brought up the issue of rural-urban and
10 limited accessibility, for example. And
11 Leslie brought up the issue of needs
12 assessment. And to the extent that it --
13 maybe a more helpful/useful measure might be
14 adjusted for need, how many -- you know, how
15 much are we accommodating the need, et cetera.

16 All interesting and useful points.
17 We are voting on the measure we got under the
18 microscope right now.

19 DR. BROCK: Can I comment?

20 CO-CHAIR KAPLAN: Sure.

21 DR. BROCK: So our measure is
22 intended to be used as you have described. So

1 the problem with the Dartmouth Atlas HRR work
2 -- and it's excellent work; we don't have a
3 problem with the Dartmouth Atlas. But the
4 hospital referral region really reflects the
5 case patterns of medical service providers.

6 And what we find consistently in
7 working with readmissions particularly, which
8 is just a subset of admissions, it doesn't
9 reflect 100 percent what medical service
10 providers do. I mean, I'm beginning to
11 wonder, what is the impact of medical service
12 providers at times?

13 So to me, the measure is -- it's
14 an alternative way to look at what are the
15 roots of unnecessary admissions and
16 readmissions? And those are often rooted in
17 community realities that we would like to not
18 adjust away.

19 So, for instance, if a rural
20 community knows, well gosh, yeah, we have a
21 problem because we're like rural, well, but
22 our risk adjusted measure is okay. I mean,

1 that doesn't help them track whether they're
2 doing the right things to improve the outcomes
3 for the folks that live there.

4 CO-CHAIR KAPLAN: Thank you.

5 So again, for the purposes
6 declared in the measure as specified
7 currently, we are voting on -- unless there
8 are any other comments?

9 (No audible response.)

10 CO-CHAIR KAPLAN: We are voting on
11 usability and use.

12 MS. SHAHAB: For voting on
13 usability and use, one is high, two moderate,
14 three low, four insufficient information. And
15 time begins now.

16 One more vote. We have all 24
17 votes. For usability and use, five high,
18 seven moderate, 12 low, and zero insufficient
19 information.

20 CO-CHAIR KAPLAN: So now the
21 overall suitability for endorsement.
22 Comments? None? Yes? No?

1 DR. THOMAS SMITH: No. I think --
2 I don't have any.

3 CO-CHAIR KAPLAN: Good.

4 (Laughter.)

5 CO-CHAIR KAPLAN: Any other
6 discussion? Karen.

7 DR. JOYNT: I will just say I
8 think that this metric does not fit the same
9 paradigm as a lot of the other ones that maybe
10 we are more used to looking at. I don't think
11 that's necessarily bad. It's being asked to
12 do something different. It's being asked to
13 put our focus on where people live and not
14 where they are hospitalized. And national
15 data would suggest, even with the Dartmouth
16 Atlas stuff, only about half of the people are
17 really hospitalized in their HSA. So it's not
18 really clear what that tells you about
19 someone's home.

20 And I totally get all the concerns
21 about risk adjustment, and everyone is
22 certainly entitled to their opinion about each

1 piece of that. But I don't think this should
2 be about -- this isn't about a hospital, and
3 it is fundamentally supposed to be different
4 because it's about a community. So I would
5 just sort of throw that out there for
6 consideration.

7 CO-CHAIR KAPLAN: Thank you. Very
8 helpful. Other comments?

9 (No audible response.)

10 CO-CHAIR KAPLAN: Excellent. We
11 vote a score.

12 MS. SHAHAB: For overall
13 suitability for endorsement, one is yes, two
14 is no. And time begins now.

15 We have all 24 votes. For overall
16 suitability for endorsement, 12 yes, 12 no,
17 for Measure 2503, hospitalizations per
18 thousand Medicare fee-for-service
19 beneficiaries.

20 MR. AMIN: Again, this measure
21 falls in our gray zone, very clearly. And so
22 the measure will continue to move forward in

1 the process, and we look forward to getting
2 public comments on this measure. There is a
3 lot of gray here.

4 MS. KHAN: We have three measures
5 so far where consensus hasn't been reached.
6 That's 2512, the LTACH readmission measure;
7 the dialysis facilities readmission measure;
8 and this one.

9 MS. SHIPPY: So I think with the
10 split-vote measures, I'm seeing a little bit
11 of a trend, but I would love to hear NQF
12 report back whether the use and usability
13 feels like that's the closest, and that that's
14 leading into the kind of gray zone. Are you
15 able to report back just on those three that
16 are in the gray zone what the use and
17 usability votes were?

18 CO-CHAIR HALL: You're sort of --
19 I don't mean to put words in your mouth.
20 You're saying that you think the use and
21 usability and the overall votes are mirroring
22 each other?

1 MS. SHIPPY: They seem like it.

2 CO-CHAIR HALL: So is that a
3 problem?

4 MR. AMIN: I mean, the way that we
5 sort of think about this is the criteria are
6 hierarchical in the fact that importance
7 measure is the most important, scientific
8 acceptability. I don't -- I mean, the votes
9 aren't always this sensitive to predict the
10 outcome, but it sounds like validity and the
11 concern around unintended consequences seem to
12 be what's described in the votes in the
13 majority of these, although I don't want to
14 hypothesize because I think every one of the
15 measures is a bit different.

16 CO-CHAIR HALL: It does appear
17 that. And looking back, I can -- the
18 usability votes are, in terms of going one way
19 or the other, are reflecting which ones are
20 not having consensus reached.

21 MS. SHIPPY: You're saying the
22 usability or the feasibility?

1 CO-CHAIR HALL: Usability.

2 MS. SHIPPY: Usability.

3 CO-CHAIR HALL: And, again, just a
4 question for NQF colleagues. We will not be
5 asked to comment on the public comment, right?
6 Our discussions and the public comments
7 together, separately but together, go forward
8 the next --

9 Dr. BURSTIN: So what will go
10 forward is will this measure out, like the
11 couple of others we have had like this that
12 say, consensus not reached. We'll lay out the
13 discussion, the pros and the cons.

14 You'll then get public comment.
15 You'll have an opportunity to reassess it. We
16 have now built in any gray zone measures
17 automatically. The committee can reassess
18 post-comment. Again, just an opportunity to
19 gather more input.

20 And I have to say, in general,
21 over the last few months of steering
22 committees, it has generally been validity

1 that has tended to be more of a split. That
2 leads to the -- to the split at the end, but
3 also certainly I think unintended consequences
4 is another one in particular, which is part of
5 usability, I think is what you're seeing.

6 CO-CHAIR HALL: Challenges. So we
7 remain somewhat behind and we will ask CFMC to
8 proceed with introducing the next measure.

9 DR. BROCK: So the next measure is
10 readmissions per thousand, and it's -- you
11 know the background. So in this one, the
12 numerator is the number of readmissions within
13 30 days of a previous discharge from acute
14 care hospital divided by the number of people
15 in the geographic region of interest pro-rated
16 by day for their participation in the Medicare
17 program. That most often, in fee-for-service,
18 means censoring for death. So it's an
19 incidence rate. It's occurrence per person-
20 day.

21 So we developed this measure, like
22 I said before, you know, hospitalization --

1 rehospitalizations are prevalent and costly.
2 It is very difficult to track community
3 improvement if you are only assessing the
4 denominator of recent discharges because that,
5 in fact, varies a great deal by community
6 capacity to not hospitalize people. So with
7 regard to tracking change, a community can
8 lose on the readmissions per discharge measure
9 by reducing their hospital admissions faster
10 than they reduce their readmissions. In terms
11 of the validity and reliability, we have
12 already described that. It's the same
13 process. We did a split sample reliability,
14 and it was very high. The caps were .8, .9.

15 We compared to the Commonwealth
16 study of avoidable hospitalizations to compare
17 the quintiles -- I think it was quintiles, and
18 the caps on that were high -- .7.

19 So we note that we have proposed
20 this measure as both a quarterly and an annual
21 readmissions per thousand. They are also very
22 highly correlated, like .99 or something like

1 that between quarterly and annual.

2 CO-CHAIR HALL: Thank you. We
3 will invite Paul and Karen for initial
4 comments. We are back into the category of
5 evidence.

6 DR. JOYNT: So a lot of this is
7 very similar to the one right before this, so
8 I will be brief. Again, there is not a ton of
9 evidence other than the sort of major study
10 which I think probably drove the development
11 of all these measures. But I think there is
12 a good face validity that much of the
13 promising work around readmissions reduction
14 is taking place out of the hospital, and this
15 is a good way to acknowledge that.

16 CO-CHAIR HALL: Anyone else,
17 comments on evidence?

18 (No audible response.)

19 CO-CHAIR HALL: Seeing none, we
20 will vote on evidence.

21 MS. SHAHAB: For 1a, evidence, one
22 is yes, two no. And the time starts now.

1 For 1a, evidence, 21 yes, one no.

2 CO-CHAIR HALL: Any specific
3 comments on opportunity or performance gap?

4 (No audible response.)

5 CO-CHAIR HALL: Not seeing any.

6 MS. SHAHAB: 1b, performance gap,
7 one high, two moderate, three low, four
8 insufficient. Time starts now.

9 We have 23 votes. For 1b,
10 performance gap, 17 high, four moderate, two
11 low, zero insufficient.

12 CO-CHAIR HALL: And priority,
13 specific comments?

14 (No audible response.)

15 MS. SHAHAB: 1c, high priority,
16 one high, two moderate, three low, four
17 insufficient. Time begins now.

18 We have 23 votes. 1c, high
19 priority, 15 high, six moderate, two low, and
20 zero insufficient.

21 CO-CHAIR HALL: And back to
22 science, reliability and validity? Paul or

1 Karen, any specific concerns that we didn't
2 touch on last time?

3 DR. JOYNT: I think the
4 reliability of this one is, again, excellent.
5 But the numbers are huge. So there is really
6 fairly good correlation. I don't think we're
7 measuring things wrong.

8 CO-CHAIR HALL: Any other
9 comments?

10 (No audible response.)

11 CO-CHAIR HALL: Not seeing any.

12 MS. SHAHAB: Voting is open now
13 for 2a, reliability. One is high, two
14 moderate, three low, and four insufficient.

15 Two more votes.

16 We have all 24 votes. For 2a,
17 reliability, 18 high, six moderate, zero low,
18 zero insufficient.

19 CO-CHAIR HALL: So we're back to
20 validity.

21 DR. JOYNT: I'll just add one
22 additional thing, which is an interesting

1 thing about this metric is that the racial and
2 ethnic disparities are particularly high in
3 this measure, which I think is in part because
4 it's not risk-adjusted. It actually shows you
5 the real differences in health outcomes,
6 particularly when you think -- when you
7 realize that the actual prevalence of disease
8 is one big driver of disparities. That sort
9 of leaves in all the disparity, which I found
10 to be a useful thing here.

11 The other thing that I thought was
12 particularly useful about this metric, which
13 was a fact that was brought up by the
14 developers, which is that it won't -- it will
15 fall if admission rate falls. So if
16 communities -- if we're sticking with the
17 community improvement, it will go in the same
18 direction as admissions if a community
19 intervention is done that improves outpatient
20 care. I think all the other issues around
21 sort of risk adjustment and all that are
22 probably as -- I don't have anything

1 additional to propose.

2 CO-CHAIR HALL: Paul?

3 DR. HEIDENREICH: I think a new
4 issue here is, at least in prior studies I
5 have seen like this, that admission rate drove
6 this measure much more than readmission rate.
7 And I'm not sure if that's -- I'm not sure
8 what the correlation is, but it was incredibly
9 high. And that hospitals would change their
10 admission rate, and because of that there
11 would be some percentage of readmissions;
12 therefore, they would have a change in
13 readmission rate. And I think this study was
14 trying to show that, oh look, readmission
15 rates have dropped with some community
16 intervention. Actually, what they really
17 dropped were admission rates.

18 So as long as you have them both
19 together, I think they're useful. If you only
20 approve this one, I think it could be very --
21 I'm not sure it has the validity.

22 CO-CHAIR HALL: Do the developers

1 want to respond to that?

2 DR. BROCK: Yes. So if I can
3 comment, so we -- we actually published this,
4 the results of the 14 community pilots, which
5 defined and used these metrics. So, you know,
6 we found them to correlate almost exactly, but
7 we felt it was the other way around.

8 So you know, if you think about
9 it, if you go into a hospital where 20 percent
10 of the people in their beds are 30-day
11 readmissions, and you take those people out of
12 the admissions pool for 30 days from now, then
13 they have dropped their admission rate at the
14 same -- you know, they do very much go
15 together at first.

16 We subsequently have seen
17 admission rates slow down in their decline,
18 while readmission rates continue to decline,
19 which we assume has part to do with influx of
20 new beneficiaries. But we haven't done full
21 testing of that.

22 So anyway, we did see that

1 relationship but assumed it was the other way
2 around.

3 CO-CHAIR HALL: Any other concerns
4 or questions, or does anyone feel the need for
5 clarification around anything we mentioned on
6 the last measure? Tony.

7 DR. GRIGONIS: Yes. Do you adjust
8 -- or do you have an idea of how many
9 beneficiaries readmit within that 30 days, the
10 same beneficiary? And is that an issue that
11 could influence the result, in addition to the
12 fact that since you're not looking at planned
13 or unplanned, there may be a lot of situations
14 where they have to come back?

15 DR. BROCK: We did not look at
16 planned or unplanned. So we -- just to be
17 clear, we count every admission within 30 days
18 of a discharge as a readmission event that
19 goes into the numerator as opposed to, you
20 know, what's on the hospital compare measures
21 where they require a 30-day interval free of
22 readmissions to count the next admission as an

1 index admission that can take a readmission.

2 So in terms of how many of them
3 were very frequent, like being readmitted
4 within 10 days, 14 times in a row, we did look
5 at that. We did look at that, but in a way
6 the issue is to interrupt that cycle of
7 inappropriate acute care support and see that
8 reflected in the numbers.

9 In terms of taking out planned
10 readmissions, we did not do that.

11 CO-CHAIR HALL: Sherrie?

12 CO-CHAIR KAPLAN: I just wanted a
13 quick clarification from the statistician. So
14 on the readmission side, there is not
15 independence of measurements for the
16 admissions. You have to be admitted to be
17 readmitted.

18 MS. STEVENS: Correct. So if we
19 had -- if a person had five admissions in a
20 month, in the admission measure that we have
21 already talked about they would have five in
22 the numerator, and four of those would count

1 as readmissions. So they would have four for
2 the readmission in the numerator. I think
3 that's what you're asking.

4 CO-CHAIR KAPLAN: Yes. With
5 respect to modeling, you would not -- you
6 know, that's a non-independence issue. You
7 cannot put -- you know, those two measures are
8 not -- on the readmission side, it's not
9 possible to be readmitted without having been
10 admitted.

11 CO-CHAIR HALL: That's true. But
12 I think -- it's true, but we're saying that
13 that's a favorable aspect/attribute of this
14 measure is that you can reduce your
15 readmission by reducing your admission, as
16 well as by reducing your readmissions. So
17 it's true, they're not independent in any way,
18 shape, or form, and it could be viewed as a
19 favorable attribute.

20 MS. STEVENS: Right. And a
21 readmission counts as an admission, and then
22 we look 30 days out from that. So that is a

1 little bit different than the hospital compare
2 measures.

3 CO-CHAIR HALL: Absolutely. Other
4 comments?

5 (No audible response.)

6 CO-CHAIR HALL: Okay. Move to
7 voting?

8 MS. SHAHAB: For 2b, validity, one
9 is high, two moderate, three low, four
10 insufficient. And time begins now.

11 We have all 24 votes. For 2b,
12 validity, four high, 12 moderate, seven low,
13 and one insufficient.

14 CO-CHAIR HALL: Comments on
15 feasibility?

16 (No audible response.)

17 CO-CHAIR HALL: Seeing no new
18 comments on feasibility.

19 MS. SHAHAB: Voting for criteria 3,
20 feasibility, one is high, two moderate, three
21 low, four insufficient. Time starts now.

22 One more vote.

1 We have all 24 votes for
2 feasibility, 20 high, two moderate, two low,
3 and zero insufficient.

4 CO-CHAIR HALL: And usability. And
5 Kathy, do you want to open up?

6 DR. AUGER: So I think even putting
7 aside the risk adjustments, which I think we
8 have already talked about quite a bit, I think
9 the one part of the readmission metric that
10 bothers me a bit here is the fact that the
11 planned aren't excluded; therefore, one way to
12 potentially game the system is to actually
13 delay, like what would otherwise be necessary
14 care. And so just by putting it beyond 30
15 days, then you would not have that readmission
16 count against your community.

17 CO-CHAIR HALL: Other concerns?
18 Paula?

19 MS. MINTON-FOLTZ: I just want to
20 point out that the -- I think it was 2011, we
21 were here the last time for all-cause
22 admission. The health of the community was a

1 big topic there. You know, how much is the
2 community responsible versus the hospital? So
3 I think this is a way of really getting at
4 some of that.

5 CO-CHAIR HALL: Thank you. John?

6 DR. BULGER: Yes. The only comment
7 I would make is I think it's a good measure,
8 and I think it -- it measures a completely
9 different thing that we are already measuring.
10 But I think if it gets out there it is going
11 to be extremely important, that that's
12 highlighted very well, because I think there
13 is already confusion amongst providers and the
14 public about what the readmission numbers
15 mean.

16 And I think, you know, this is
17 going to have -- be a completely different
18 number from anything we have, and it will be
19 real easy for people to say -- to throw this
20 number out and try to compare it to this --
21 the possible compare numbers that you talk
22 about and create more confusion.

1 So I think, you know, its usability
2 is completely different from anything we have.
3 And making sure that everybody understands
4 that very well is going to be extremely
5 important.

6 DR. BROCK: So I agree with that.
7 And I know I have spent some time on the CDC's
8 website, and a lot of the statistics they put
9 out. And they always have a link how to use
10 this -- how to use these measures. And I
11 think it should be accompanied by that kind of
12 a thing.

13 Also, I just -- these numbers are
14 out, and they're mapped to zip codes and
15 they're on our website. They've been being
16 updated quarterly for four or five years, and
17 we haven't had -- we haven't seen people hurt
18 themselves with them yet. So, you know,
19 improvement initiatives use them.

20 CO-CHAIR HALL: You aren't aware of
21 any people hurting themselves.

22 (Laughter.)

1 DR. BROCK: They didn't call me.

2 CO-CHAIR HALL: Any other -- any
3 other comments on usability?

4 (No audible response.)

5 CO-CHAIR HALL: Seeing none.

6 MS. SHAHAB: For criteria number 4,
7 usability and use, one high, two moderate,
8 three low, and four insufficient information.
9 Voting is open now.

10 We have all 24 votes. For
11 usability and use, four high, 11 moderate,
12 nine low, and zero insufficient information.

13 CO-CHAIR HALL: Before the overall
14 vote, any additional comments?

15 (No audible response.)

16 CO-CHAIR HALL: It's curious to me
17 that we are -- we are reaching a different
18 conclusion than we did last measure, but
19 that's just a curiosity. There were -- risk
20 adjustment considerations still apply, but any
21 other comments before overall? Wes?

22 DR. FIELDS: It is really just a

1 question. It's not clear to me -- if NQF
2 approves this measure on readmission, would
3 the effect be for it to be done in Colorado or
4 in all 50 states and Puerto Rico, et cetera?

5 CO-CHAIR HALL: So again, what
6 bodies would choose to implement a program
7 based on this? It's not --

8 DR. FIELDS: Well, I guess maybe,
9 what is the intent of the developers?

10 DR. BROCK: It's already mapped for
11 every zip code in the U.S. and Puerto Rico and
12 the Virgin Islands.

13 CO-CHAIR HALL: Does that answer
14 your question?

15 DR. BROCK: Well, okay. So Puerto
16 Rico and the Virgin Islands are interested in
17 each other, just because they perceive
18 themselves as similar markets. So people do
19 use it to locate who they think has similar
20 problems.

21 I know in Colorado, our resort
22 communities always want to talk to each other

1 because they have a lot of temporary residents
2 and substance abuse issues and things like
3 that. So, I mean, people do use it to find
4 where they think are similar places.

5 CO-CHAIR HALL: Okay. Any other
6 comments before our vote on overall?

7 (No audible response.)

8 CO-CHAIR HALL: Seeing no cards
9 raised.

10 MS. SHAHAB: Voting for overall
11 suitability for endorsement, one is yes, two
12 is no. And time is open.

13 We have all 24 votes. For overall
14 suitability for endorsement for Measure 2504,
15 30-day rehospitalizations per 1,000 Medicare
16 fee-for-service beneficiaries, 14 yes, 10 no.

17 MS. KHAN: So just a process check.
18 This is also in the gray zone. So it will be
19 going out for public/member comment.

20 CO-CHAIR HALL: Okay. We will
21 break. Thank you very much, CFMC.

22 And what are we scheduled for, 15

1 minutes? So, let's say 4:05. We will cut it
2 short to about 12 minutes. 4:05, please.

3 (Whereupon, the proceedings in the foregoing
4 matter went off the record 3:52 p.m. and went
5 back on the record at 4:04 p.m.)

6 MS. KHAN: Let's go onto the next
7 measure.

8 MR. AMIN: We can send out an email
9 with that information as well, just so you
10 have it.

11 CO-CHAIR HALL: We're going to move
12 to -- slightly out of order -- to Measure 327,
13 Risk Adjusted Average Length of Inpatient
14 Hospital Stay. The developer is Premier. In
15 order to accommodate their schedule, we're
16 going to move them up in order. And I've
17 notified our primary discussants of that
18 change. So our colleague from Premier, Gene,
19 do you want to introduce yourself and briefly
20 introduce your measure.

21 DR. KROCH: I think it's on now,
22 right? Yes, I'm Gene Kroch. I'm at Premier.

1 I'm chief scientist and do a lot of different
2 things for Premier in regard to health
3 services research.

4 I have a secondary appointment at
5 the Wharton school and the University of
6 Pennsylvania. So Philadelphia is my hometown.
7 You can't hear me? That's not usually my
8 problem. Okay, let me know if I have to
9 repeat myself. Okay, sorry about that.

10 I'm chief scientist at Premier,
11 Inc. Which is located, by the way, in
12 Charlotte, North Carolina. But I live in
13 Philadelphia. I'm health services research.
14 I do a lot of measurement work.

15 And I'm affiliated with the Leonard
16 Davis Institute of Health Economics. And I
17 have an adjunct over at the Wharton School in
18 Healthcare Systems. So I don't know, there's
19 not much for me to say about this measure,
20 really, because it's kind of been out there
21 for so long. I've been working with this
22 measure personally for over 20 years. But

1 it's not been something that's been out in the
2 public sector very much.

3 It was endorsed by NQF back in --
4 I thought it was 2006, but the notes I saw
5 said 2008. But it, as you probably know,
6 measure stewardship involves updating on a
7 regular basis, the measure in case there are
8 any changes that are relevant to it's
9 properties. And we were doing that on a
10 regular basis.

11 Risk adjustment, as it says up on
12 the screen, it's risk adjustment, average
13 length of stay using a geometric mean. Given
14 the distribution of length of stay and the
15 properties of length of stay, as you can
16 imagine, it has a very large positive skew.
17 And so using geometric mean allowed us to use
18 the general linear model with a log link,
19 which improved the fit and reliability of the
20 measure. The main thing I want to emphasize
21 is that it is designed to allow a lot of
22 flexibility and sub-setting.

1 Although it's set up here that it's
2 about measuring at the hospital level, which
3 it certainly does. Our users, that's to say
4 the 850 or so hospitals that subscribe to
5 Premier System, for this and other reasons,
6 they generally are not all that interested in
7 the overall length of stay, because they're
8 doing this for performance improvement. And
9 they're looking for where are they -- where
10 are they insufficient or where do they need to
11 focus more, in terms of making sure that the
12 processes are followed in an efficient way.

13 So it's designed to allow flexible
14 sub-setting so you can look at it at the
15 diagnosis code level. It's a model that's
16 stratified by diagnosis code. At the
17 procedure code level, at the level of the
18 attending physician's specialty, at the age
19 category, at the DRG, look at hospital lists
20 relative to other attending physicians. It
21 has that attribute.

22 It is a measure that is very widely

1 tracked by again, the folks that I know in the
2 Premier Alliance, they're looking at it all
3 the time. In fact, they are not all that keen
4 on the value of whatever costs measures out
5 there.

6 So they much prefer to look at
7 themselves and benchmark themselves using
8 length of stay. And indeed, length of stay
9 is, as you might expect, highly correlated
10 with patient-hospital costs. The model itself
11 fits very, very well. We have a generalized
12 model that we use for other outcomes, like
13 mortality and morbidity and complications,
14 that doesn't nearly get to this level of
15 power. It explains about 60 percent of the
16 variation based on exogenous patient factors.

17 It's -- as you might imagine, we
18 found a high correlation between this measure
19 and various different measures of cost of care
20 that we looked at. Procedurally based cost of
21 care, cost accounting based cost of care,
22 using HCRIS reports for the cost to charge

1 ratio to turn charges into costs.

2 They all are sort of different
3 variations and have their own peculiarities.
4 And as you might expect, as you drill down
5 they look different, but overall, they're very
6 highly correlated with, as you might expect,
7 length of stay. The other thing that I think
8 this measure is, is it's obviously very easy
9 to understand. I mean how long -- and of
10 course we define a hospital stay based on
11 whether you were admitted or not.

12 So the shortest possible hospital
13 stay is a day. You can't have a fraction of
14 a day. And -- but it's sort of, kind of a no
15 brainer as to how you would compare your
16 numbers to somebody else's numbers.

17 We've found that in our validation
18 studies, that when we wanted to explain
19 variations in length of stay, that among the
20 factors that were driving variations in length
21 of stay, we found comorbidities certainly.
22 But complications importantly.

1 And right now we just put out a
2 paper about the financial consequences of
3 inpatient complications, making use of the
4 information on whether the or not the
5 conditions present at admission are not.
6 Performance gaps, I guess that will get talked
7 about by the committee. But there are clearly
8 effects. And not all of them go in the same
9 -- in the direction you might expect. But
10 there's an income effect, there's a age
11 effect. There's a race effect. And a whole
12 bunch of others that I guess, I don't have it
13 written down in front of me right now.

14 The -- we did a study quite a while
15 ago. As I said, this measure's over 20 years
16 old. We did a study for the Commonwealth fund
17 in which we found an inexorable decline in
18 risk adjusted length of stay over the study
19 period. Now that ended in the mid-2000s.
20 That trend has begun to look very convoluted,
21 in the sense that it started to flatten out.
22 It actually went the other direction. And now

1 it's going down again.

2 So length of stay seems to reflect
3 some of the forces that are going on. And
4 most people sort of say well, what's driving
5 length of stay more or less by hospitals is
6 they're trying to improve their bottom line
7 effectively.

8 Especially in A DRG environment
9 where it's not really the payer that's
10 benefitting from shorter length of stay, but
11 the provider that does. So let me -- I think
12 I -- oh, the only thing else I should say
13 about it is, this things been around for so
14 long. We have applied to almost every data
15 set you can imagine.

16 The hospital alliance of Premier,
17 which is now 850 hospitals, MedPar data, the
18 National Inpatient sample that's put out by
19 AHRQ through HCUP. It's -- you know the point
20 I wanted to make about that is just that it's
21 a model or a measure that's easily applicable
22 to almost any kind of data you might have.

1 Whether or not it's the HR data. Or whether
2 or not it's administrative data. Or however
3 you get the data.

4 And the other point I would make
5 too is that -- this will be my last point.
6 That we do use the sufficient statistics from
7 the calibration of the model to establish
8 confidence intervals around length of stay,
9 so you can test hypothesis about whether your
10 length of stay's indeed higher or lower than
11 you would expect. The -- I'm forgetting what
12 I was going to say.

13 CO-CHAIR HALL: Okay, we will
14 probably invite you to respond to some
15 additional comments.

16 DR. KROCH: Yeah, let me end there.

17 CO-CHAIR HALL: So no worries.

18 DR. KROCH: Thank you.

19 CO-CHAIR HALL: No worries, thank
20 you Gene. We'll turn to Allison and Ron for
21 initial comments. We're on the category of
22 evidence.

1 MS. SHIPPY: So Ron and I are going
2 to kind of ping pong back and forth. I'll
3 start with evidence. So I think I want to
4 start with a question related to the -- how
5 the forms will filled out. And there seemed
6 to be some inconsistencies as to whether it is
7 defined as an outcome. And there are some
8 times in the forms that it's defined, or
9 selected, as an intermediate outcome. So I
10 would like to first start with Eric, because
11 I think that help take us through the
12 algorithm.

13 DR. KROCH: Right. And what I
14 didn't mention is that the origin of this
15 measure actually was something called the
16 Corporate Hospital Rating Project, which was
17 conducted at the Wharton School, between about
18 1988 and 1992 or 93. And the principal
19 investigator on that study was Mark Pauly, who
20 basically said this isn't an outcome, it's an
21 input. And to economists, that's what we
22 think of.

1 When I was filling out the renewal
2 information for this measure, I tried to slip
3 that one past and I was caught. No, no, no,
4 no. You're not an efficiency measure. You're
5 an outcome measure. That's how we have you
6 listed. So you have to respond to that as you
7 seen it. I think that our -- as I implied in
8 my opening comments, our members used this as
9 an efficiency measure. They don't really use
10 it as an outcome measure. And in fact, when
11 we do profiling, it's a separate dimension.
12 It falls into cost dimension as opposed to the
13 quality dimension. But --

14 CO-CHAIR HALL: Alison, did you get
15 your questions answered?

16 MS. SHIPPY: Sure, yeah. So I
17 think it does leave me a little perplexed in
18 that the use -- the evidence base that you're
19 noting within your membership, that has kind
20 of driven why you're using this measure, if
21 they themselves are defining it as an
22 efficiency measure.

1 I think that is a little perplexing
2 for me. But think the rationale does merit
3 the focus. So --

4 DR. KROCH: Yeah, and there's also
5 the related issue is implication is that lower
6 risk of adjusted length of stay is better.
7 And we can all think about reasons why that
8 might be necessarily true.

9 CO-CHAIR HALL: Any additional
10 comments on evidence? Paul?

11 DR. HEIDENREICH: Okay. So in
12 terms -- since this is a re-endorsement, I
13 assumed we'd be looking to see if there was
14 evidence that -- if things had changed over
15 time. And were the things that were present
16 in 2008 when it was first, or whenever it was
17 endorsed, have we succeeded? And are we now
18 in a place we no longer need it? Because
19 that's from staff. Is that a way to be
20 considering this, or is it --

21 MS. PACE: That would be definitely
22 under performance gap. So that is a

1 consideration for endorsement maintenance, if
2 there's really no longer an issue with
3 performance gap. That's the relevant
4 question. Does it need to continue
5 endorsement?

6 DR. HEIDENREICH: Yeah. It just
7 seems that this should have gone to a group
8 that was considering efficiency or cost
9 measures. Because if we want -- I mean we can
10 kind of put that hat on briefly and do that,
11 if that's what you know.

12 MS. PACE: Yes, and basically we
13 just tried to bucket these measures as best we
14 thought we could. Since people oftentimes
15 talk about length of stay and readmission
16 together as being sometimes related, we
17 thought it would be logical for a group
18 looking at admissions and readmissions to look
19 at it. It is a bit of a lone wolf, to be
20 honest, in our portfolio. So kind of anywhere
21 we put it, the committee would have gone, why
22 is it with costs measures? Or why is it with

1 this?

2 So it landed with you. But there's
3 no expectation that measures necessarily need
4 to outlive their usefulness, if they're
5 proving to be useful and driving improvement,
6 then they should remain endorsed.

7 DR. KROCH: You could ask something
8 a little different, which is, has the model
9 changed sufficiently to warrant reexamination?
10 And the answer to that is yes. And the main
11 reason it has changed is because of reporting
12 requirements on the part of CMS. So we now
13 have information that we didn't have before.
14 That's very important when you're trying to
15 control for patient variation and looking at
16 risk adjusted length of stay.

17 CO-CHAIR HALL: Ron?

18 MR. STETTLER: Yes, and I'd say
19 based on looking at the submission, there's
20 still a lot of that that is for variation.
21 Right, so the gaps between different
22 hospitals, different regions, as you said,

1 sex, and age and various other demographic
2 variables that you have in your model are
3 definitely present. So whether or not overall
4 length of stay has changed over time, I would
5 say there's still a big gap and large
6 variation across different groups that you're
7 being measured on.

8 CO-CHAIR HALL: Leslie?

9 MS. HALL: I just had questions
10 about -- have things changed? Years ago it
11 was always based upon a midnight census
12 discharge and then risk adjusted. And so now
13 with electronic health records and we can
14 actually get when a bed is vacated. Or that
15 orders are placed, versus orders executed,
16 versus bed vacated. Are we looking to improve
17 the data collection to actually get a more
18 accurate length of stay that might be more
19 helpful?

20 DR. KROCH: Yes. I mean we started
21 out -- the whole purpose of the measurement
22 was to look at acute care. But actually, as

1 you can see in the write up, we actually look
2 at other care settings. And it plays a very
3 different role. And as you might imagine in
4 SNFs and in rehab facilities, the whole issue
5 of observation stays is one that we're now, I
6 think, taking time to sort out. And what's
7 kept us from sorting it out is because the
8 government can't make up it's mind what the
9 rule is. So we're going to wait for that to
10 happen and then we're going to try to model
11 it, as another dimension to this measure.

12 CO-CHAIR HALL: Steve?

13 DR. FISHBANE: Yes, two questions
14 on definition. One, is it's mean not median,
15 so what do you do with patients that are in
16 the hospital for 150 days? It's very unlikely
17 that it's the process of the hospital. Are
18 outliers excluded?

19 And second question is just
20 heterogeneity, you know when these global, as
21 opposed to close, specific measures for
22 hospitals, when it's global length of stay for

1 the hospital, if you have one hospital that
2 ten percent of their cases are OBs with one or
3 two day length of stays for the baby and the
4 mom. Other hospital are doing no OB, mostly
5 cardiac stuff. How do you deal with that?

6 DR. KROCH: Well, first of all,
7 it's -- the model is stratified, so you're not
8 directly comparing OB patients to cardiac
9 patients. And that gets back to my other
10 point, which is for practical purposes, that
11 comparison doesn't usually help at all in
12 trying to improve your processes. As far as
13 outliers are concerned, this came up, I think,
14 in the group that reviewed it. Their question
15 was why did you choose 100 days, which was
16 what we did choose.

17 And precisely because we discovered
18 that doing geometric means does help with
19 problems in the details, but not enough in
20 cases where it looks like there are -- the
21 number of days is so large that it is more
22 likely that it's a data coding error than it

1 is a real number.

2 And so that's why we said okay.

3 And that we did through validation testing
4 over the years. And 100 turned out to be
5 about the right number. Now in terms of sigma
6 variation, it's well beyond six sigma, so.

7 CO-CHAIR HALL: We okay to vote on
8 evidence?

9 MS. SHAHAB: Voting for 1a,
10 evidence. 1 is yes and 2 is no. And the time
11 starts now.

12 We have all 24 votes. 1a evidence.
13 23 yes. 1 no.

14 CO-CHAIR HALL: Opportunity to
15 improve, or performance gap. Comments or
16 questions?

17 MS. SHIPPY: I can start. So as
18 Ron noted, there is some variation. I think
19 the range is 2.1 to 6.8, and that was observed
20 from 2010 to 2012. But I think the overall
21 aggregate number, we haven't seen that much
22 improvement on. So I do thank that there is

1 just a larger question that we have, or that
2 I have, about is this the right lever for
3 enforcing any sort of change or improvement?

4 DR. KROCH: Yes, its value, as I
5 said before, in aggregate is not all that
6 useful, not to the people who have been using
7 the measure. It's being used for quality
8 improvement. And it's very helpful there.

9 MS. SHIPPY: But just a follow up,
10 I think there's multiple users that we would
11 like to see use this measure information,
12 beyond the internal purposes.

13 DR. KROCH: Yeah, I mean when you
14 start looking at the aggregate data, and we've
15 done this, done looking at hospitals for
16 regions or counties or states or anything. We
17 start to get into an analysis where you
18 quickly find out that discharge policy plays
19 a big role, and not entirely under the control
20 of the hospital.

21 Because community resources turns
22 out to be a big issues. And where we found

1 hospitals that were flagged with excessive
2 lengths of stay, they were in places where
3 they didn't have any place to send the
4 patient. And that showed up.

5 Now that's again, from their point
6 of view, that's what they wanted to know. You
7 know, and of course I -- you can argue, at
8 least I argue, that the hospital has a role in
9 that. You know, the adequacy of community
10 resources, the hospital should be applying the
11 appropriate pressure.

12 MS. SHIPPY: Right, and there is
13 question about whether it should be paired
14 with another measure, but there was no
15 recommendation that it should, to better
16 provide a fuller quality picture. And that it
17 was just possible to pair it with another
18 measure and save readmissions and length. So
19 I don't know if you can speak to that?

20 DR. KROCH: Yeah, it's possible to
21 pair it with, obviously, readmissions.

22 CO-CHAIR HALL: I think we can

1 reexamine that question under some of the
2 later categories as well. Any other
3 performance gap questions?

4 Seeing none.

5 MS. SHAHAB: Voting for 1b.
6 Performance gap. 1 high, 2 moderate, 3 low,
7 4 insufficient. Voting begins now.

8 We have all 24 votes. For 1b
9 performance gap. 10 high. 11 moderate. 3
10 low and 0 insufficient.

11 CO-CHAIR HALL: Topic of priority.
12 Allison or Ron?

13 MS. SHIPPY: Sure. We noted that
14 it does represent a priority as defined by the
15 evaluation criteria. And that it -- high
16 numbers.

17 CO-CHAIR HALL: Other comments or
18 questions?

19 Not seeing any.

20 MS. SHAHAB: Voting for 1c, high
21 priority. 1 high, 2 moderate, 3 low, 4
22 insufficient. Time begins now.

1 One more vote.

2 For 1c, high priority. 12 voted
3 high. 10 voted moderate. 1 low and 0
4 insufficient.

5 CO-CHAIR HALL: Scientific
6 reliability and validity. Ron?

7 MR. STETTLER: So when I looked at
8 the submission, the -- there seemed to be
9 discussion about the reliability, explaining
10 60 percent of the variability was explained
11 that's a lot. But I didn't see a lot of
12 statistics actually in the document, a lot of
13 statistics over time showing it was
14 consistent. And had you know, time based
15 reliability. But can you just talk a little
16 bit more about your reliability measures.

17 DR. KROCH: Yeah, I, again, the
18 model -- the measure's been around for a long
19 time. So we didn't -- we don't do split
20 sample analysis for example, which is one way
21 to get to reliability. Because we have a
22 natural split sample.

1 Which is to say, we have the
2 history with the measure. And we can -- every
3 time we re-calibrate the model, which we do
4 every year, based on two years worth of data
5 -- that's about nine million discharges -- we
6 first look at whether if we run the new data
7 on the old model, what do we get for
8 readmission scores? Then we'd run the new
9 model on the new model and what do we get for
10 readmission scores?

11 And how much do they agree? And
12 the answer you might not be surprised to hear
13 is that these days, it doesn't change very
14 much. So we don't think we've over fitted the
15 model. That's a concern when you're working
16 with general limiting models. We don't think
17 it's over fitted.

18 MR. SETTLER: I guess the same
19 question though goes back to you know, there's
20 no c-statistics, there's not R-squared's.
21 There's not a lot of information about the
22 accuracy of the model other than your

1 statement of 60 percent.

2 So I don't -- without the evidence
3 and the submission, it's -- I guess I talked
4 to the staff, I don't know exactly how to
5 review this.

6 DR. KROCH: Well, we're not talking
7 about discrimination here, so c-statistic is
8 not relevant to this particular measure. But
9 when I refer to the 60 percent, what I was
10 referring to was the R-squared.

11 Now that's the overall R-squared
12 across 142 strata. Which I mean, obviously,
13 we have an R-squared for each of those 142
14 strata. And that's in the detailed
15 literature. I mean we you know, we have a
16 document that's basically a large spreadsheet
17 which gets updated every year, that shows all
18 the parameter estimates and all of the
19 sufficient statistics, and the quality of the
20 fit. Since it's a general linear model, R-
21 squared is a perfectly descent information
22 criteria.

1 MR. STETTLER: And that wasn't
2 supplied, so. Even the R-squared wasn't
3 supplied. I guess you're saying the 60
4 percent was your low -- average R-squared
5 across the 142 strata?

6 DR. KROCH: Well the way you do it
7 when you have a stratified model is -- the
8 simplest way to think about it is: imagine
9 correlating the actual length of stay with the
10 expected length of stay as predicted by the
11 model. And taking that correlation and
12 squaring it. That's an ordinary, unadjusted
13 R-square. Yeah, I mean one thing that could
14 have been in there would have been some -- I
15 mean there clearly are strata that don't fit
16 very well. And have R-squared's that --

17 When you -- first of all, let me
18 make this point. The 60 percent is clearly
19 big. And that's because it's taking into
20 account the explanatory power of the principal
21 diagnosis, which it's stratified by.

22 So if you then go down and look

1 within, you're going to get a lower R-squared.
2 So none of the R-squared's for the individual,
3 like heart failure or AMI, or whatever it
4 might be, none of them are as high as 60
5 percent. They're all I would say they're in
6 the 30 to 40 percent range at most.

7 CO-CHAIR HALL: I'm not sure if Ron
8 wants to follow up, but Taroon wants to make
9 a comment.

10 MR. AMIN: Ron, one of the
11 questions you asked was you know, one of the
12 questions was for staff effectively, how to
13 evaluate this. I would just continue -- I
14 know it's getting late, but I just want to
15 continue to remind you that we have this
16 guidance document here that has a little bit
17 of an algorithm.

18 And if I may, you know, NQF,
19 particularly for reliability and validity
20 testing, requires empirical analysis. And you
21 know, as you work through the algorithm down
22 from the boxes, the first question is really,

1 having some testing of the statistical test,
2 and not just descriptive analysis -- not just
3 descriptive statistics.

4 And so I would encourage you to use
5 this algorithm in the way you're sort of
6 thinking about this. And there's other
7 components here that might be relevant.

8 MS. PACE: Right. And the rating
9 scale has a category for insufficient. So if
10 there's insufficient information for you to
11 evaluate according to the criteria, that's the
12 rating you would use.

13 MR. SETTLER: Thank you.

14 CO-CHAIR HALL: And right now we're
15 on reliability. Trying our best to stick to
16 our guns on reliability. Any questions? We
17 can vote on reliability and move to validity.
18 Is that a question Sherrie?

19 CO-CHAIR KAPLAN: Yes, I have a --
20 so reproducibility, in terms of the way you
21 were discussing it, because R-square wouldn't
22 necessarily guide you along those lines. It

1 means, we just say that's the amount of
2 variation explained? It doesn't say how much
3 of that variation's reliable, how much -- and
4 what's the error variance, the residuals may
5 tell you something about that. But the
6 explained variance does not.

7 And that's why I'm a little bit
8 still perplexed. And do we know enough about
9 the precision of the estimates, or exactly
10 what it is you're comparing? Are you
11 comparing models over time? Are you comparing
12 the beta coefficients for the -- for what --
13 help us understand the reproducibility issue.
14 Not just the explain variance.

15 DR. KROCH: Okay, so the really
16 issue -- the really -- the issue is what the
17 specification is. And whether or not, if you
18 hold the specification constant and apply it
19 to a new set of observations, do you see
20 things move as a result of the fact that your
21 parameters are shifting? And that's what I
22 was describing.

1 CO-CHAIR KAPLAN: And you're --
2 So you are considering that as true score
3 variation, not error? Right? Because error
4 gives you a sense of trying to estimate how
5 much of the score's actually moving in
6 response to change, and how much of the score
7 is actually moving in response to errors in
8 measurement.

9 DR. KROCH: Right. And errors of
10 measurement, not that depends on what you --
11 there's -- of course the errors in measurement
12 for the raw rates could -- for the raw length
13 of stay are very minimal. There's very
14 reliable reporting on that. The error
15 associated with the model, that's what I was
16 referring to the sufficient statistics. So
17 when I -- you want to answer the question, is
18 your average length of stay higher than you
19 expect? That's where the error variance comes
20 in. And that comes from the model.

21 CO-CHAIR HALL: I see no cards
22 raised. Let's vote on reliability.

1 MS. SHAHAB: For 2a reliability.
2 1 is high, 2 moderate, 3 low, 4 insufficient.
3 Your time begins now.

4 One more vote.

5 We have all 24 votes. For 2a
6 reliability. 1 high. 11 moderate. 6 low.
7 6 insufficient.

8 MS. KHAN: So this is in the gray
9 zone. We're going to keep going.

10 MR. SETTLER: All right, I think we
11 did start -- oh, go ahead.

12 So I think we did start to cover
13 validity earlier with the fitting. I don't
14 know if this is the right place to bring it
15 up, but it does have socioeconomic in it, as
16 an adjuster. And I think we need to bring
17 that up. From what we heard this morning, I
18 think that's conceptually okay at this point.
19 Even though historically it wasn't. But in
20 some instances we can have it in.

21 MS. PACE: Right. I think the
22 question would be: what's the justification

1 for it? And you would want to see how that
2 actually plays out in the analysis, with and
3 without it. And you know, so.

4 MR. STETTLER: So I guess the
5 question is, can you talk about your
6 socioeconomic adjuster and the genesis of it.
7 I don't think it was in the original model
8 that was originally approved by NQF.

9 DR. KROCH: Actually it was. And
10 I was part of the process, because I was the
11 one who was submitted the work on it. And the
12 subject of socioeconomic status wasn't
13 discussed at all in 2008 or 2006. This issue
14 has come up since. And as you noted, the --
15 I don't know how to call it, the guideline
16 that NQF is going by, and other organizations
17 as well, has shifted.

18 We have been using socioeconomic
19 status for all of our outcome measures since
20 the inception. But it's very straight
21 forward. It's what information we have on the
22 individual patient that we can either get

1 indirectly through where the patient lives.
2 Or directly, which we can, for our proprietary
3 data. So what's in there? Well, obviously
4 race is in there. Income. We actually use
5 distance as a proxy measure. Relative
6 distance traveled. And --

7 MR. STETTLER: Payer class?

8 DR. KROCH: Payer class, yes. Well
9 you know, payer class is yes, it is
10 socioeconomic in many ways, yes. So it's in
11 there.

12 CO-CHAIR HALL: So I guess, to your
13 question, Ron, it's incumbent on us as a group
14 to develop -- to develop whether we feel that
15 this is justified that this needs to be here
16 for this purpose, versus the rest of the
17 measures we've discussed all day.

18 MR. STETTLER: Correct. I think
19 the other -- I still am troubled by the 100
20 length of stay cutoff and, scientifically, how
21 it was determined. So you simply have
22 observed over time that it's about the right

1 level to exclude?

2 DR. KROCH: Well, at one point we
3 weren't -- we weren't excluding outliers at
4 all. And the argument was, we're using a
5 semi-logged model, so we don't need to.

6 Turned out that that led to some
7 false positives and false negatives that we
8 felt was -- and that what was showing up, as
9 we were doing the analysis, was that when we
10 got stays that were that long, as I said
11 before, in most cases the data were incorrect.
12 The misplaced decimal point if you will, I
13 don't know what.

14 So there was a real gap there. And
15 in fact, there -- if you look at the
16 distribution of raw lengths of stay, it's at
17 -- well at about 50 or 60 days it falls off
18 enough that you don't really have enough data
19 to be able to do much analysis with the other
20 points anyway.

21 But they do -- they can be very
22 crazy and so they can then sort of wreck the

1 actual computation. 100 is -- is I agree, is
2 somewhat arbitrary. I mean, it's based on
3 just experience over years. We've played with
4 different ones. At one point we had the
5 outlier, was if you had a length of stay of at
6 least a year, you would be considered an
7 outlier. And we discovered that that led to
8 reports that in some cases, again not usually,
9 but in some cases, that didn't look right.

10 CO-CHAIR HALL: Thanks. I don't --
11 oh, I'm sorry, Steve?

12 DR. FISHBANE: Yes, I'm sorry to
13 harp on the outlier thing, but you know it
14 still doesn't make a whole lot of sense to me.
15 You know, for looking at the efficiency of
16 hospital operations and management of most
17 diagnoses. So for the most typical diagnosis
18 that are treated in the hospital, congestive
19 heart failure, pneumonia, or COPD on the
20 medical side, and the typical surgical
21 diagnoses, you know an inefficient hospital
22 will have length of stays that instead of

1 being five days will be seven or eight days.

2 A more efficient hospital will be
3 three or four days. The admissions that go
4 over 20, 30 days, tend to be problems that
5 occur with a patient that usually, sometimes
6 can be under the control of the hospital, but
7 usually aren't. So that for our 17 hospitals,
8 we, you know, usually we'll look at an outlier
9 as being something longer than 30 days. And
10 unfortunately you do have hospitalizations
11 that go into the 50, 60, 70, or 150 day range.

12 When you're using a mean, it would
13 just seem to me as something that the
14 developer should consider, at least on an
15 ongoing basis for the future, that you're no
16 longer capturing the efficiency of hospital
17 care, when you're allowing outliers at 100
18 days, or 80 days, or 60 days, I would just
19 encourage something shorter.

20 CO-CHAIR HALL: Thank you. So this
21 is a geometric mean, right, the comparison?

22 DR. KROCH: Yes, it's ending.

1 CO-CHAIR HALL: And it's stated
2 differently in a couple of places in your
3 document. But in one point it says this is
4 reported as the days above the average. Is it
5 those opportunity days you're recording, or
6 the actual average length of stay adjusted?

7 DR. KROCH: Yes, that was -- that
8 was incorrect. I think I corrected it in the
9 documentation. It's not the number of days
10 above -- excessive days. It is literally --
11 there's an OE ratio, just you might have for
12 mortality.

13 CO-CHAIR HALL: Okay. So documents
14 that are posted still state days above
15 average, so we'll tend to that.

16 Kathy?

17 DR. AUGER: So just a point of
18 clarification from the intern and the staff.
19 I'm not totally sure how we still figure out
20 the socioeconomic risk adjustment, but even
21 so, like where do we consider that? Do we
22 consider that in validation? Do we, the

1 validity? Okay.

2 CO-CHAIR HALL: So I have one other
3 question as well. Intermediate complications,
4 in the category of what you know about that's
5 driving these. Are your intermediate
6 complications in the hospital adjusted for?

7 DR. KROCH: Yes. They're risk
8 adjusted complications.

9 CO-CHAIR HALL: All right. Steve
10 do you still have a question? Or are you
11 okay? You're all right.

12 Larry?

13 DR. GLANCE: Since we're talking
14 about the scientific validity, we're talking
15 about the validity of the risk adjustment.
16 And so we're looking at the model and the
17 model performance, if the R-squared is .6, it
18 really is pretty phenomenal. And so I think
19 we should go back to that concept, because we
20 are evaluating the validity of the model. So
21 R-squared of .6 is very, very good.

22 CO-CHAIR HALL: I would like to

1 hear whether anyone has any thoughts or
2 concerns about the race, income, distance,
3 payer class variables. Do we feel that
4 there's adequate justification that those
5 belong in this model, since this is the first
6 time we've run into this issue. Allison?

7 MS. SHIPPY: I'm not compelled to
8 have it included. I know that there's been
9 discussion about other risk adjustment issues
10 in previous measures. So it's difficult for
11 me to rectify how this one's going to be
12 different.

13 CO-CHAIR HALL: Wes?

14 DR. FIELDS: I think there's a
15 tremendous, you know, volume of literature
16 across the medical specialties that makes it
17 pretty clear that low economic status, low
18 income, and some racial attributes all result
19 in higher -- results in patients presenting to
20 the hospital in a later stage of their illness
21 or injury. And that they have higher rates of
22 comorbidities.

1 So I think SES is pretty
2 fundamental to length of stay. And I think
3 you know, without having an expert opinion
4 about how it was formulated in this measure,
5 you know, I think it does belong in the
6 conversation on length of stay.

7 CO-CHAIR HALL: Frank?

8 DR. BRIGGS: I don't know the data
9 in terms of how it impacts when they present.
10 But certainly from the hospital's perspective,
11 in getting them out and getting them
12 placement, socioeconomic status, distance
13 traveled, certainly impact the discharge
14 timing. And you're more inclined to keep them
15 an extra day, two days, things of that nature.

16 So it certainly impacts length of
17 stay.

18 CO-CHAIR HALL: Larry?

19 DR. GLANCE: So, when I think of
20 SES, I think of it boiling down to two issues.
21 If you include SES in a model, you potentially
22 adjust away racial disparities, which is bad.

1 On the other hand, if you don't include SES in
2 the model, then you disadvantage hospitals and
3 providers that take care of low SES patients.
4 And with current approach to value based
5 purchasing, those hospitals will get fewer
6 resources.

7 And those are the hospitals that
8 are in the worst possible positions to get
9 fewer resources, because if your goal is to
10 improve population health, you don't want to
11 take resources away from those hospitals. I
12 don't think there's a good answer to this. I
13 don't think we're going to resolve it today.
14 But I don't think it's unreasonable to include
15 it in the model.

16 CO-CHAIR HALL: Cristie?

17 MS. TRAVIS: Well, I think this is
18 what the entire SES project is supposed to be
19 focusing on. And all of the same thoughts
20 that are being shared here, are thoughts that
21 are being shared in that process.

22 And it would seem to me that the

1 guidance from NQF at this point is not to use
2 SES in risk adjustment. We've got the project
3 going underway, which is supposed to develop
4 a consensus around that, and therefore, it
5 would be my position that we should wait and
6 see what the project comes out with on the
7 other end. And therefore I would not be
8 supportive of including those in this
9 particular measure.

10 CO-CHAIR HALL: Karen, are you
11 wanting to make a comment? Your care is up.

12 MS. PACE: Oh, not about this
13 though. So I don't know Helen what your
14 thoughts are about process? I -- you know the
15 difficult part with this performance measure
16 is that it did originally -- it was originally
17 endorsed prior to the guidance that we're
18 talking about that's under question.

19 So I don't see any -- I don't know
20 if there's any specific information about how
21 -- what coefficient that gets, or what it's
22 you know, contribution is to the model, that

1 might be useful information. But I don't
2 think there's a right or a wrong answer at
3 this point, in terms of the committee's action
4 on this.

5 You know, depending on what happens
6 with the risk adjustment process, we may be
7 looking at other things as well. But you
8 know, I -- I'm sorry I can't give you more
9 guidance. And I don't know, Helen, if you
10 have anything more to add.

11 DR. BURSTIN: No, it's -- Jean's
12 right. This measure came in before the
13 guidance that said don't do it. So they're in
14 a bit of a funny place, compared to other
15 measures that have come subsequently. So I
16 feel like you know, part of our process is to
17 evaluate measures based on what has been put
18 before you. Guidance has changed since then.
19 So I think -- I think it really is up to you
20 guys, and the Chairs to make a decision. We
21 can always revisit it post-comment. We'll get
22 better clarity as we move forward.

1 But I you know, I think -- just
2 want to emphasize the fact that this measure
3 was in fact put forward when there was not
4 this guidance by the developer.

5 MS. PACE: I just had -- wanted to
6 make sure I understood, because I didn't.
7 What is happening with the long episodes?
8 Because it's not listed in your specifications
9 as an exclusion. What are you doing if the
10 episode is over 100 days, what are you doing
11 with them? Are you ex --

12 DR. KROCH: They're being excluded,
13 yes.

14 MS. PACE: Okay. Because it's not
15 listed as an exclusion, and there's no
16 analysis as excluded, so.

17 DR. KROCH: Oh, it should be, okay.

18 CO-CHAIR KAPLAN: Let me just jump
19 in real quickly and say when you -- anytime
20 you modify a measure in the way it's kind of
21 framed, especially one that's been in the
22 works for a while, then anything you look at

1 could be the way you modify the measure, as
2 opposed to actual changes. So you face this
3 tension between do we fix the problem now and
4 in advance of this guidance, or do we change
5 it, and then you compromise comparability.

6 So inevitably there are all of
7 these trade offs between when you change
8 something to make it more reasonable. And
9 then lose all that information that you've
10 been tracking over time, because you've
11 actually change the measure and you can't see
12 differences between actual variability and
13 things that you did with the measure itself.

14 CO-CHAIR HALL: Paula?

15 MS. MINTON-FOLTZ: Yes, I was
16 wondering if there was any risk adjustment
17 thought about like obesity, like history of
18 substance abuse? Those are the ones that we
19 can't, as hospitals, they're not attractive to
20 post-acute. So if they need post-acute care,
21 we can't get folks out of the hospital with
22 that.

1 So I didn't know if there was a way
2 -- 100 days, they could be on variance. I
3 mean we could be ready to discharge them way
4 before 100 days. But there's no access to
5 post-acute care. So again, that kind of goes
6 back to health of the community.

7 CO-CHAIR HALL: Allison?

8 DR. KROCH: Is that a question I
9 was supposed to answer? Or --

10 CO-CHAIR HALL: That's all right.

11 MS. MINTON-FOLTZ: Well I think it
12 -- yeah, it's just that the risk adjustment
13 needs to be more than just probably CMI.

14 CO-CHAIR HALL: Okay, we will move
15 to vote on validity.

16 MS. SHAHAB: Voting for 2b
17 validity. 1 is high, 2 moderate, 3 low, 4
18 insufficient. Time begins now.

19 Just one more vote.

20 We have all 24 votes for 2b
21 validity. 3 high. 16 moderate. 4 low. 1
22 insufficient.

1 CO-CHAIR HALL: Feasibility
2 specific comments?

3 CO-CHAIR KAPLAN: Actually I don't
4 think we had any comments on feasibility.

5 MR. STETTLER: I mean it seems that
6 it's pretty straight forward. He's been doing
7 it for a long time.

8 CO-CHAIR HALL: All right, we'll
9 move to vote.

10 MS. SHAHAB: Voting for 3
11 feasibility. 1 high, 2 moderate, 3 low, 4
12 insufficient.

13 We have all 24 votes for
14 feasibility. 22 high. 2 moderate. 0 low.
15 0 insufficient.

16 CO-CHAIR HALL: Usability comments?

17 MR. STETTLER: This is where I
18 think we mostly focused on the proprietary
19 nature of the model. I know it's not
20 conceptually proprietary. But help me
21 understand how others can use it without
22 actually going through the coalition.

1 DR. KROCH: Without actually going
2 through what?

3 MR. STETTLER: Whatever you call
4 your 850 hospitals.

5 DR. KROCH: Oh, yes, right. So the
6 best thing I can say about that is that there
7 have been a number of systems that basically
8 took the measure and fitted it themselves.
9 But these were relatively large hospital
10 systems.

11 So there is an issue there. If
12 you're small, it's an awful lot of work to
13 actually apply the model in a reliable way to
14 your data.

15 So it's you know, I think you --
16 it's a legitimate point. It's a big model.
17 And you have -- there are a lot of parameters
18 to keep track of. Can it be done? Yes it's
19 been done by a number of people.

20 And it's not conceptually
21 difficult. It's just that's a lot of data.

22 CO-CHAIR HALL: Leslie?

1 MS. HALL: I'm sorry, I thought
2 that I read that it was -- although it was
3 proprietary, there would be no licensing fees
4 associated with this for others to use?

5 DR. KROCH: Yes, well we -- we made
6 -- that's always been understood.

7 MS. HALL: Okay.

8 DR. KROCH: If we made this measure
9 that could be used, that we would -- I mean
10 we've applied the -- what we use to do is we
11 used to apply a number of measures, and the
12 length of stay was one of them to the MedPar
13 data. And we just posted it on the website.
14 And anybody who wanted to look up how they
15 were doing could just look it up.

16 So --

17 MS. HALL: The instrument itself
18 requires licensing, but the reports are not?

19 DR. KROCH: Well the -- If you
20 don't -- there's an interface that requires
21 licensing that let's you do all kinds of kind
22 of cool things that you can't do just by

1 running straight reports.

2 So it allows you more flexibility
3 in how you subset and that sort of thing.

4 CO-CHAIR HALL: Allison?

5 MS. SHIPPY: I think we talked
6 about this on the conference call a couple of
7 weeks ago. I'm harking back to the 4a, the
8 accountability within three year -- yeah,
9 accountability use within three years and
10 public reporting within six.

11 And this has been endorsed for six,
12 maybe eight years. And there was some mention
13 of a brief conversation with OCSQ about having
14 this publically reported. But if you could
15 speak more to your plan.

16 I take it seriously that NQF is you
17 know, working as a purveyor of a public good,
18 so.

19 DR. KROCH: So you mean our plan
20 for making it publically available? Well --

21 MS. SHIPPY: An accountability
22 program, or any other transparent way.

1 DR. KROCH: So, I was referring to
2 the actual guts of the model are organized in
3 a multi-tabbed spreadsheet that let's you
4 essentially take some data and insert it in
5 the data provision tab and actually get the
6 risk adjusted length of stay out of it.

7 I mean so that model has been
8 around for a while. It -- the thing is that
9 you -- well, again, it really depends on what
10 kind of an organization you are in terms of
11 how comfortable you are with the patient-level
12 data.

13 Because the one aspect of this
14 model is that the unit of analysis is the
15 patient. So you have to be working at that
16 level. And therefore you're working as I
17 said, with it's large not just in the sense
18 that there are a lot of parameters, it's large
19 in the sense that there are a lot of
20 observations.

21 So -- but it will fit, but --

22 CO-CHAIR HALL: Larry?

1 DR. GLANCE: Quick question of
2 clarification. Is the model in the public
3 domain? In other words are the risk factors
4 and the beta values in the public domain?

5 DR. KROCH: Yes.

6 DR. GLANCE: Okay.

7 DR. KROCH: Yes, they are. That's
8 what that spreadsheet is about.

9 DR. GLANCE: Okay.

10 CO-CHAIR HALL: Kathy?

11 DR. AUGER: And is that the NQF,
12 what they -- is that the NQF official, that
13 just the measure, like the betas have to be in
14 public domain, is that what the requirements
15 are?

16 MR. AMIN: I would say the
17 specifications need to be clear enough for
18 somebody to be able to pick up the measure and
19 be able to run it. Reproduce it, yes.

20 CO-CHAIR HALL: Along the lines of
21 this topic though is the question of
22 improvement. And you've actually shown some

1 pretty remarkably stable numbers over time.
2 With as you mentioned previously, maybe some
3 hiccups lately.

4 But do we meet this criteria that
5 use of this information is enabling
6 organizations to improve over time? Is that
7 demonstrated to us?

8 Because if it's been in play for
9 six, seven or eight years, it feels like we
10 should know by now.

11 DR. KROCH: Yes. The numbers are
12 used routinely for looking for opportunities
13 to improve care. Usually from the point of
14 view of streamlining the focus of operations.

15 So and I don't know if I'm
16 answering your question.

17 CO-CHAIR HALL: So some of the
18 information you report for instance, over a
19 years and years, shows length of stay and the
20 3.1, 3.2 region, pretty darn stable. Then you
21 mention that some sub-models demonstrate more
22 improvement over time than others.

1 That raises the questions should
2 those sub-models be up for approval and should
3 everything else be dropped?

4 DR. KROCH: Oh, I see, I see. Yes,
5 because where we've seen -- there are
6 definitely areas that you might expect have
7 improved. Orthopedics is one. Cardiovascular
8 treatment is another.

9 There are a few categories like
10 that where there have been quite a bit of
11 movement in length of stay. But when you look
12 at the whole hospital, the number doesn't
13 change much.

14 CO-CHAIR HALL: Understood. But
15 one of the criteria in front of us is that
16 when a measure has been in play for a period
17 of time, we are expected to see, as it says,
18 progress on improvement.

19 Sherrie?

20 CO-CHAIR KAPLAN: Just to follow up
21 on that. If you did an interrupted time
22 series analysis or just a straight forward

1 time series analysis over like you know, from
2 2008 forward, would you see a trend that would
3 be significant? Or would you see a flat line?

4 DR. KROCH: There -- you're talking
5 about overall at the hospital level? There is
6 a trend. And it's been downward.

7 But there have been some surprises
8 some years where that trend did not carry
9 through. And we've always -- looking for the
10 fact that is there a natural, if you will,
11 asymptote if you will, is there something that
12 basically you know, you're not going to get
13 below that.

14 And at some point when you have a
15 length -- an average length of stay, a
16 geometric length of stay -- geometric mean
17 length of stay of three days, you can see why
18 that can be an issue.

19 CO-CHAIR HALL: Thank you folks.
20 We've passed an hour on this measure.

21 Cristie?

22 MS. TRAVIS: Well I guess I just

1 need another little bit of clarification.
2 Because 4a up there says that it needs to be
3 used in accountability within three years, or
4 public reporting within six years. And so I'm
5 thinking that the results are what we're
6 talking about.

7 In other words, and I guess I
8 didn't hear that these results were being used
9 in public reporting. Something that the
10 public could go get access to these results.

11 So I guess I just need a little bit
12 of clarification. Not the model itself being
13 in the public domain, but the results of who's
14 reporting on these results publicly for use by
15 the public?

16 DR. KROCH: Yes, and we've made it
17 available publicly for public data. That's
18 what I mean by MedPar and NIS.

19 MS. TRAVIS: Okay, thank you.
20 Thank you.

21 CO-CHAIR HALL: Frank?

22 DR. BRIGGS: So, having been in

1 Premier and having our data in there, Premier
2 is one of multiple organizations that have
3 tools like this. All of them I think, without
4 exception, produce their own modeling around
5 these similar things such as cost of care,
6 length of stay, mortality.

7 So I'd be very surprised if any one
8 of them would ever get to the point that it
9 would be for accountability or public
10 reporting.

11 Now I can tell you, like I said, as
12 a previous member in Premier, and our system
13 still is, we do use it and we have done
14 demonstration projects around different
15 disease populations using the data to look at
16 one of our measures.

17 So if we wanted to look at how we
18 care for COPD, we would use the data set and
19 look over a period of time before and after
20 intervention if their length of stay
21 shortened.

22 I think there's lots of evidence in

1 terms of that as presented at their annual
2 conference every year at the Premier
3 Breakthroughs Conference, of people using the
4 data to drive improvements.

5 CO-CHAIR HALL: Okay. Great
6 discussion. We will vote on usability.

7 MS. SHAHAB: For usability and use,
8 1 is high, 2 moderate, 3 low and 4
9 insufficient. Time begins now.

10 Just one more.

11 Now we have 23 responses for
12 usability and use. 1 high. 14 moderate. 6
13 low. 2 insufficient information.

14 CO-CHAIR HALL: So we'll take an
15 overall vote. Any additional comments or
16 concerns before the overall? Not seeing any.

17 MS. SHAHAB: For overall
18 suitability for endorsement, 1 yes, 2 no.
19 Time begins now.

20 We have all the votes for overall
21 suitability for endorsement. For measure
22 0327, Risk-Adjusted Average Length of

1 Inpatient Hospital Stay, 13 yes and 10 no.

2 CO-CHAIR HALL: All right, that's
3 in 40/60 zone, so you're all familiar with
4 that. We thank you Gene from Premier.

5 And we will invite our next
6 developers up from Acumen. So we -- yes, so
7 we need to do a public comment at 5:15. But
8 since it's 5:10, we have to allow for people
9 to be jumping on the phone at exactly 5:15.

10 So we'll have our developers come
11 to the table for the next two measures, 2505
12 and 2380. And -- ah, they're on the phone.
13 They're on the phone, okay.

14 So let's just -- before we embark
15 on that discussion -- all right, we're
16 organizing here. Great.

17 MS. KHAN: I believe Deborah Dietz
18 is also on the phone.

19 CO-CHAIR HALL: Operator, could we
20 open Deborah Dietz' line.

21 MS. DIETZ: Oh, that was me. I was
22 on mute. Deborah Dietz is here, hello.

1 CO-CHAIR HALL: So can we enter --
2 can we ask now if there's any public comment
3 in the room? Okay, let's do that.

4 MS. KHAN: Is there any public
5 comment in the room?

6 CO-CHAIR HALL: We're not seeing
7 any public comment in the room. So we'll ask
8 our colleagues from Acumen to go ahead and
9 introduce themselves and we may do one more
10 check on public comment in a few minutes.

11 So please introduce yourselves and
12 a brief introduction of your measure.

13 DR. COOK: Sure. In the interest
14 of time, would you like me to introduce both
15 of our measures at once?

16 CO-CHAIR HALL: Let's do the first.
17 Let's stick to our guns here.

18 DR. COOK: Okay. No problem.

19 CO-CHAIR HALL: In case there
20 should be any disagreement between the two,
21 let's not muddy the waters. So let's --

22 DR. COOK: All right. My name's

1 Keziah Cook. And I'm an Associate Policy
2 Researcher at Acumen, LLC.

3 We are developing claims-based
4 quality measures for home health agencies
5 under contract with CMS. And these complement
6 some claims based measures of hospitalization
7 that are -- were previously developed and NQF
8 endorsed and publically reported.

9 So the first measure we're
10 discussing is the emergency department use
11 without hospital readmission during the first
12 30 days of home health.

13 This applies to all home health
14 patients who begin home health within five
15 days of hospital discharge. And measures the
16 occurrence of any emergency department use
17 that does not result in an admission to the
18 hospital during the first 30 days of the home
19 health stay.

20 About nine percent of home health
21 stays involve a emergency department use of
22 this type during the 30 day period. And those

1 stays -- or those emergency department visits
2 account for about \$45 million dollars per year
3 in expenditures.

4 We propose to publically report
5 this measure using categories. So each home
6 health agency would be categorized as better
7 then expected, same as expected, or worse then
8 expected, using a statistical test.

9 And based on about three years of
10 data, those results would be publically
11 reported on the Home Health Compare website.

12 This measure complements the re-
13 hospitalization measure that we'll be
14 discussing in a little bit in that both
15 measure, acute care usage by previously
16 hospitalized home health patients. And it
17 also complements a measure that's currently
18 publically reported called emergency
19 department use without hospitalization, which
20 applies to all home health patients, not just
21 those who were previously hospitalized.

22 The measure is risk adjusted using

1 a patient level multinomial logistic model.
2 And that patient level model is what allows us
3 to calculate an expected distribution of rates
4 for each home health agency.

5 So when we're saying a home health
6 agency is better than expected, we're saying
7 that based on the expected distribution of
8 rates per their patients' individual health
9 characteristics, that agency was in the lower
10 tail. So they had significantly fewer
11 emergency department visits without
12 readmission than anticipated.

13 So happy to just stop there.

14 CO-CHAIR HALL: Do we want to
15 invite public comment again at this point?
16 Okay. So we'll break for one second.

17 MR. AMIN: Operator are there any
18 public comments on the line?

19 OPERATOR: If you would like to
20 leave ask a comment at this -- question or
21 comment at this time, please press star 1.

22 CO-CHAIR HALL: Can you clarify

1 public comment on any item discussed, not just
2 this.

3 OPERATOR: There are no public
4 comments at this time.

5 MR. AMIN: We'll take any public
6 comments on any of the measures discussed in
7 the room or on the phone. So are there any
8 public comments on the phone?

9 OPERATOR: Again, please press star
10 1. There are none at this time.

11 MR. AMIN: Okay, thank you.

12 CO-CHAIR HALL: Okay, thank you.

13 So thank you for that brief
14 introduction. We'll ask Wes and Pam if they
15 would like to kick off the discussion for
16 evidence.

17 DR. ROBERTS: Okay. One of the
18 issues that had come up on one of the calls
19 was that the measure developer was going to
20 provide a categorization of agencies by region
21 at the median. So I don't know if you want to
22 --

1 DR. COOK: Interested, or I can
2 just briefly describe the findings and if
3 anyone wants to see the tables.

4 DR. ROBERTS: Can you briefly
5 describe it.

6 DR. COOK: Sure. There were
7 variations across regions. The observed rate
8 across CMS regions, so the 10 CMS
9 administrative regions, range from 7.4 percent
10 in the New York region to 11.1 percent in the
11 Seattle region.

12 And as one might anticipate based
13 on that, the New York region had the most
14 agencies who are categorized as better than
15 expected, with 27 percent of agencies in the
16 New York region categorized as better than
17 expected. And the Seattle region had the
18 largest number of agencies categorized as
19 worse then expected, with 29.3 percent
20 categorized as worse then expected.

21 The other variation across regions
22 that stands out here is the fraction of

1 agencies across regions categorized as same as
2 expected, differs fairly substantially from a
3 low of about 70 percent of agencies who are
4 same as expected in Seattle, New York and a
5 few others. Up to a high of 88 percent of
6 agencies in the Dallas region that are
7 characterized as same as expected.

8 And what's really going on there is
9 the Dallas region, so Texas and surrounding
10 states have a predominance of very small
11 agencies where it's difficult to make a
12 statistically significant statement about
13 whether your know their performance caring for
14 25 patients differs from expected.

15 CO-CHAIR HALL: Okay, thank you.
16 That feels a little bit like evidence and
17 performance gap. So we'll hit both of those
18 very quickly.

19 Any other specific comments on
20 evidence? Yes, Karen?

21 DR. JOYNT: I just didn't see much
22 evidence that we have any idea that home

1 health does anything for readmissions. Or
2 that they have the -- I mean home health at
3 least in my experience discharging patients
4 from the hospital can range from someone going
5 to draw blood next week to someone providing
6 really pretty comprehensive care.

7 And the evidence -- I mean the data
8 on readmissions is not great in general at
9 showing that any intervention can work. And
10 there's certainly not a particularly robust
11 amount of data suggesting what structure and
12 type, and set up and cost, and arrangement and
13 providers for home health can.

14 So I'm a little confused about the
15 evidence base.

16 CO-CHAIR HALL: Great. Thank you
17 for those comments. Anyone else what to chime
18 in? Wes were you -- you were also a primary
19 discussant. Any other concerns you want to --
20 or points?

21 DR. FIELDS: Yes, I just want to
22 follow what Karen said. The evidence as I

1 recall, it really was about innovations in
2 some home health services. With different
3 kinds of home monitoring, home surveillance.

4 And there's a lot of activity in
5 paramedical care. And different ways of
6 extending care into the home environment or
7 those kinds of things.

8 But I think that it's really kind
9 of an underwhelming amount of evidence in
10 terms of peer-reviewed literature. And what
11 was there to me didn't speak for the need to
12 have this metric and this particular measure
13 as a way of driving innovation.

14 The other one, if I heard right, if
15 the total number of ED visits that are in this
16 category cost \$45 million, in the Dirksen
17 School of Economics, that you know, applies in
18 this town, that's the -- that's very -- that's
19 a rounding error.

20 So I just don't see that there's a
21 huge amount of resources to be saved here.
22 And I guess fundamentally I see this as most

1 likely to be a failure discharge planning, or
2 a case management or a care coordination.

3 And that's supposed to happen
4 before folks leave the hospital. And in many
5 cases, as Karen said, the services that would
6 make a difference probably aren't services
7 directly provided by home health agency.

8 So I was a little at a loss for
9 this one.

10 CO-CHAIR HALL: Anyone else
11 comments about evidence. Yes Paul?

12 DR. HEIDENREICH: I'm just
13 wondering, technically do we need to have any
14 evidence at all since this is an outcome
15 measure? And we just need a plausible
16 rationale that might be you know, might have
17 some evidence someday?

18 CO-CHAIR HALL: Yes. That's the
19 specification of the guidance that's in front
20 of us.

21 Karen?

22 DR. JOYNT: I'm not sure the -- I

1 think the thing -- we have plausible evidence
2 that things that take place outside the
3 hospital prevent readmission. But I don't
4 know that we have evidence that home health
5 agencies control what they do that prevent
6 readmission. Right?

7 I mean I don't know how it works
8 for everybody else's clinical experience. But
9 in my experience, when we send someone home,
10 the inpatient team makes the decision what
11 they're sending them home with.

12 So I'm just confused about the
13 structure under which a home health agency
14 would be working with an inpatient setting or
15 with -- I just don't totally understand how
16 the home health agency themselves are the ones
17 who are actually making any decisions about
18 what's delivered I guess.

19 That's the plausibility that I
20 don't quite understand. That may just be my
21 misunderstanding of the system, but --

22 MS. DIETZ: This is Deborah Dietz

1 from the developer. Do you want any input n
2 that?

3 CO-CHAIR HALL: One second Deborah.
4 Let's take one question that's raised here and
5 then we will ask you.

6 MS. DIETZ: Sure.

7 CO-CHAIR HALL: Thank you.

8 MS. DIETZ: Okay.

9 CO-CHAIR HALL: Kathy?

10 DR. AUGER: I was just going to say
11 that I think there is a bit of heterogeneity
12 in terms of what home health offers. And then
13 there's some decisions by home health
14 companies about when to escalate versus not.

15 And so I think that you get some
16 variability there. But then I also think that
17 the fact that we're seeing variability in
18 performance sort of argues that there may be
19 things that home health can do to sort of move
20 this metric because we are seeing variability
21 in performance.

22 CO-CHAIR HALL: Thank you.

1 Deborah do you want to respond to some of what
2 you've heard?

3 MS. DIETZ: Yeah, I just want to,
4 you know bring up that there are a lot of best
5 practice guidelines that are -- have been
6 promulgated by the quality improvement
7 organizations and that agencies use in order
8 to reduce their rehospitalization rate.

9 And it has to do everything from
10 when they schedule visits in terms of front
11 loading visits. So that when a patient is
12 perceived to be a risk for rehospitalization,
13 that they're out there quite a bit right at
14 the beginning.

15 Medication reconciliation where
16 they're working with the patient to make sure
17 that the meds that they were prescribed at the
18 hospital are actually in their home. And the
19 patient knows how to take them and isn't
20 taking two of the same thing.

21 Education, looking to see when the
22 patient -- what the home environment is like

1 so that if the patient perhaps is at risk for
2 falls, that they're doing things to try to
3 minimize that. Getting PT in there when it's
4 appropriate.

5 So agencies in general recognize
6 that there are things that they can do and
7 should do in order to minimize
8 rehospitalization.

9 CO-CHAIR HALL: Okay, thank you.
10 I don't see any additional cards raised.
11 Let's --

12 DR. BURSTIN: Quickly, I believe
13 there's actually been a long standing measure,
14 correct me if I'm wrong, of ED's for home
15 health patients.

16 DR. COOK: There is. There is a
17 current measure that's publically reported
18 that applies to all home health patients.
19 This measure applies specifically to those
20 patients who come to home health from an
21 inpatient setting, who are discharged from a
22 hospital and then begin home health within

1 five days of that discharge.

2 So the existing measure applies to
3 the entire home health population and this
4 applies to a more narrow population that may
5 be at particular risk.

6 DR. BURSTIN: Okay, I understand
7 there's been a very long standing focus on
8 reducing ED use broadly among the home health
9 community. I wanted to emphasize, and there
10 had been.

11 I mean again as primary care doc,
12 perhaps different, lots of interventions that
13 home health takes to in fact try to reduce
14 that bumping back into the hospital.

15 DR. JOYNT: It think that would be
16 a really helpful thing to read. I just didn't
17 -- I was not even aware that existed in the
18 evidence or I would be happy to read it.

19 CO-CHAIR HALL: All right, we'll
20 move forward with a vote on evidence.

21 MS. SHAHAB: Voting for 1a,
22 evidence. 1 yes, 2 no. Time begins now.

1 We have all the votes for 1a
2 evidence. 16 voted yes. 6 voted no.

3 CO-CHAIR HALL: Well move on with
4 performance gap or opportunity to improve.
5 Pam or Wes did you have specific concerns?

6 DR. FIELDS: I'll defer.

7 CO-CHAIR HALL: Can you hit your
8 mic Pam.

9 DR. ROBERTS: There was a 9.1
10 percent rehospitalization to ED, which was one
11 of the priorities and leads to homes gaps.
12 And that there was -- there was concern and I
13 think we've already talked about with the care
14 coordination with the hospital of follow up
15 and access.

16 CO-CHAIR KAPLAN: Can I just
17 comment on something. This is the biggest
18 difference I've seen I think in that worse
19 then expected variability by geographic
20 region. It grows from 3.9 percent to 29.3
21 percent.

22 So in terms of a performance gap,

1 you know, that is rather major. I was --
2 again that's -- I think amongst the measures
3 that we've considered so far, the biggest gap.

4 And the question is what percent of
5 that is mutable, blah, blah, blah, blah, blah.
6 But at least for the gap, looks to me really
7 impressive. I don't know if anybody else had
8 gotten that.

9 CO-CHAIR HALL: Any other comments?
10 We'll move to vote on this opportunity.

11 MS. SHAHAB: Voting for 1b,
12 performance gap. 1 high, 2 moderate, 3 low,
13 4 insufficient. And time begins now.

14 We just need one more vote.

15 All votes are in for 1b performance
16 gap. 12 high. 8 moderate. 1 low. 1
17 insufficient.

18 CO-CHAIR HALL: Priority. High
19 priority area.

20 DR. ROBERTS: There was a study
21 that was provided that ED visits and inpatient
22 hospitalization showed an importance for the

1 coordination of care. 54 percent of all ED
2 use after inpatient stay was utilized. And
3 then we've already mentioned the 12 percent
4 readmission. And the geographic disparity.

5 MS. SHAHAB: Are there any
6 additional comments?

7 CO-CHAIR HALL: Wes?

8 DR. FIELDS: Yes, I think really
9 for me, the priority you place on this really
10 depends a whole lot on the specifics about how
11 you define the emergency department visit.

12 And this is where if we really are
13 talking about bad discharge planning or
14 inadequate discharge planning, or inadequate
15 community resources, to me there's a big
16 difference between a you know, a home care
17 patient coming back for a skin tear and
18 getting a Steri-Strip and going home. And one
19 that's going to be in the hospital for two
20 midnights because of something like COPD or
21 diabetes, or you know pick your cost, your
22 Medicare cost center.

1 So one of the things that I was not
2 comfortable with was I didn't see anything in
3 the structure, the measure, that would
4 distinguish between really, what would amount
5 to a trivial ED encounter with a patient
6 rapidly being returned back to the community.
7 And one that was probably unstable for
8 discharge home in the first place, and who's
9 bouncing back because they're clearly beyond
10 the scope of the home care agency to deal
11 with.

12 And I just didn't see in the
13 definition of this measure that we would be
14 able to identify the difference between those
15 two encounters in the emergency department.

16 CO-CHAIR HALL: And that's in the
17 context of their not being a readmission,
18 right?

19 DR. FIELDS: Yes, so I think this
20 one will be entangled in whatever the outcome
21 is from the two midnight rule, and the future
22 definition of observation services. And it

1 relates a little bit I think to that M&M
2 report I mentioned earlier, which is also the
3 leading edge of the health service research.

4 So it's tough for me to give you an
5 up or down vote on this because if I really am
6 not sure if we're talking about Steri-Strips
7 or acute coronary symptoms. It's tough.

8 CO-CHAIR HALL: Other thoughts?
9 Larry?

10 DR. GLANCE: So, I think that's a
11 really great point. But I think that same
12 limitation that you're describing for this
13 particular measure is probably shared by a lot
14 of the other measures as well.

15 And clearly if somebody is
16 readmitted within 48 hours of discharge,
17 whether it be because of home health err --
18 whether it be the home health care measure,
19 the dialysis measure, a lot of other measures
20 that we've considered.

21 Clearly a readmission with a very
22 short -- within a very short time frame is

1 probably I think something to do with what
2 happened during the hospitalization. Versus
3 if it's seven or ten days out, it is more
4 likely related to what's happened
5 subsequently.

6 I don't think it's really been
7 dealt very well with any of the measures that
8 we've considered today. But I think it's a
9 very interesting point that you make.

10 CO-CHAIR HALL: Other thoughts or
11 comments? Well vote on priority.

12 MS. SHAHAB: Voting for 1c, high
13 priority. 1 is high, 2 moderate, 3 low, 4
14 insufficient. Time begins now.

15 Two more votes.

16 We have all of the votes for 1c,
17 high priority. 2 high. 14 moderate. 5 low.
18 1 insufficient.

19 CO-CHAIR HALL: Reliability,
20 validity. Opening comments? Microphone.

21 DR. ROBERTS: There was -- they
22 used the -- conducted the split half

1 reliability test that we discussed before.
2 They did have, the result showed a high level
3 of internal consistency.

4 And they did find that the
5 transitions between better than expected and
6 worse than expected are extremely rare, which
7 shows that categorizations seem to be robust.

8 And I'll open. That was
9 reliability.

10 CO-CHAIR KAPLAN: Pam, can you move
11 a little closer to your mic because we're
12 having trouble.

13 DR. ROBERTS: Right. Do I need to
14 repeat what I said?

15 And then for validity. They looked
16 at --

17 CO-CHAIR HALL: Pam, let's hang on
18 reliability just one sec. Any other comment
19 on reliability? Let's vote reliability.

20 MS. SHAHAB: For 2a reliability.
21 1 is high, 2 moderate, 3 low, 4 insufficient.
22 Time begins now.

1 We need one more vote.

2 We have all 22 votes for 2a
3 reliability. 4 high. 14 moderate. 3 low.
4 1 insufficient.

5 CO-CHAIR HALL: Pam why don't you
6 pick up with validity.

7 DR. ROBERTS: So validity, they
8 looked at Medicare certified agencies with at
9 least 20 home health stays from July of 2010
10 to June of 2013. They did use a risk
11 adjustment model and developed this using 80
12 percent random sample.

13 And they had some -- they did have
14 exclusions on their risk adjustment analysis.
15 And they used OASIS measures, which is their
16 measure used in home health. It was used in
17 validity testing. And also without home
18 health readmissions, were associated with
19 underlying quality for readmissions.

20 So I'll open it up from there.

21 CO-CHAIR HALL: Other group members
22 with comments? Seeing none -- oh, wait,

1 Karen.

2 DR. JOYNT: A couple of things.

3 One, I don't totally understand the exclusion
4 of cancer. And the second thing is I don't
5 totally understand how we can account for the
6 selection into this exposure.

7 Which is true for any of our
8 metrics. There's a selection into a
9 hospitalization, I get that. But this seems
10 to be one in which the use of home health is
11 so different that the selection into the
12 exposure actually makes a big difference in
13 what your rates -- your expected rates are
14 going to be.

15 And unless the risk adjustment
16 model here is a lot better than our other
17 ones, I'm not sure that we can really account
18 for sort of that selection bias into the
19 metric. But I'd be interested in hearing the
20 thoughts.

21 I'm trying to read this, but I
22 haven't gotten to that yet at this end.

1 CO-CHAIR HALL: Any group member
2 comments? Does our developer want to reply to
3 that?

4 DR. COOK: Sure. So I mean I think
5 just -- you know home health is a different
6 population. You know different types of
7 patients are discharged home with home health
8 care then those who are discharged to a SNF
9 for instance.

10 In terms for how we account for
11 those differences. First of all you know this
12 is a measure that specific home health
13 agencies, we're not trying to compare home
14 health agencies to SNFs or to other care
15 settings.

16 We also account in our risk
17 adjustment model for the Medicare HCCs that
18 the patient experienced in the six months
19 prior to home health. And also we use the DRG
20 from the hospital discharge as one of our risk
21 factors.

22 And then finally, we use the length

1 of stay of the proceeding hospital stay.

2 To answer your question about why
3 cancer's excluded, that's actually for
4 consistency with the hospital wide readmission
5 measure that's calculated as part of the
6 hospital value based purchasing program. That
7 measure excludes certain kinds of index
8 hospitalizations and also certain kinds of
9 rehospitalizations.

10 So we mimic their exclusions of
11 index hospitalizations for this measure.

12 CO-CHAIR HALL: Wes?

13 DR. FIELDS: Yes, here too, I do
14 have qualms about validity. I think my
15 clinical experience and my 2000 partners is
16 that often people are referred to home health
17 because it's the only post-discharge service
18 they're eligible for in terms of criteria.

19 In many cases these are low income
20 persons, families that have other issues or
21 struggles and as often as not, having done
22 this 30 years and 90 thousand times and across

1 the street from Leisure World, these patients
2 can come back with non-trivial issues that are
3 a reflection really an inadequate community
4 care plan.

5 And I guess what I'm troubled by is
6 that it winds up looking like a measure of our
7 performance, the emergency department, for
8 referrals we didn't make, for discharge
9 decisions we didn't make. And for resources
10 we can't provide.

11 CO-CHAIR HALL: Question Helen?

12 DR. BURSTIN: I guess my
13 interpretation of this is it actually reflects
14 the quality of the home health agency, not the
15 ED. Did they do everything they could to
16 avoid having the patient go to an ED?

17 Obviously when patients are sick
18 enough, they're going to go anyway.

19 DR. FIELDS: We'll wait for the
20 headline in USA Today.

21 DR. BURSTIN: It's very clearly and
22 if you just look at -- I mean again, we're

1 just being, does the care, you know, the level
2 analysis does -- when you say facility here,
3 do you mean home health agency just to
4 clarify?

5 DR. COOK: I mean home health
6 agency. It's a little bit of a misnomer with
7 home health because they don't have an actual
8 building or anything.

9 DR. BURSTIN: So again if endorsed
10 measures are used that the level of analysis
11 that have been tested and endorsed, so I think
12 that's confusing because it says facility and
13 so your immediate mind goes to hospital. It's
14 in fact the home health agency if that helps
15 any.

16 CO-CHAIR HALL: Sherrie?

17 CO-CHAIR KAPLAN: Can you -- can
18 you help me clarify a little bit. Because
19 when I read this application, it said the
20 percent differences between better and same or
21 worse agencies was like 3.5 to 6.5 percent
22 depending on which validity variable you use.

1 And on one hand everybody was about
2 as expected, so the model did a good job. On
3 the other hand, that's not a real good you
4 know, evidence of discriminate validity for
5 example.

6 But then when I looked at the data
7 you provided in table three, it looks like on
8 average there's a lot more better and worse
9 then expected, which would suggest that there
10 is some discriminate validity.

11 So can you help us understand what
12 those data are about.

13 DR. COOK: Sure. So I think
14 biggest difference is that in our original
15 submission, we also included analysis of the
16 agencies who have between 1 and 19 stays. In
17 this regional breakdown we already excluded
18 those because we're not intending to publicly
19 report that information.

20 I think the -- you know the kind of
21 most interesting discrimination that this
22 measure can do is actually for the larger

1 agencies. So the agencies with 200 plus or
2 even 1000 plus patients. Which is certainly
3 only a subset of agencies, but they do account
4 for treatment of the majority of home health
5 patients.

6 CO-CHAIR HALL: Other comments?
7 Validity. Seeing none.

8 MS. SHAHAB: Voting for 2b,
9 validity. 1 is high, 2 moderate, 3 low, 4
10 insufficient. Time begins now.

11 Still waiting for two votes.

12 For 2b validity, 0 high. 17
13 moderate. 4 low and 0 insufficient.

14 CO-CHAIR HALL: Specific comments
15 on feasibility? Going once, going twice.

16 MS. SHAHAB: Voting for
17 feasibility, 1 high, 2 moderate, 3 low, 4
18 insufficient. Time begins now.

19 Just one more.

20 Voting for number 3, feasibility.
21 10 high. 10 moderate. 1 low. 0
22 insufficient.

1 CO-CHAIR HALL: Usability.

2 Specific comments? Karen?

3 DR. JOYNT: Sorry, but once again
4 I just think the best way to get better at
5 this is to select lower risk people into home
6 health.

7 And we see that, if you look at the
8 differences in utilization of home health in
9 Florida versus here. They send people home
10 with a bag of IV fluids you know, because
11 they're not quite hydrated yet late in the
12 stay.

13 And those people are never going to
14 come back. They're healthy people who had
15 their appendix out or something like that.

16 At least from what I understand of
17 the home health data, there's such a big
18 difference in utilization that I think it's a
19 really tricky denominator and a really easy
20 way to improve this is to send more people
21 home with pretty minimal services.

22 CO-CHAIR HALL: And your fear is

1 that that's not captured in the diagnosis that
2 are adjusted?

3 DR. JOYNT: I can't tell. It
4 doesn't look like it. I mean I might just be
5 reading it wrong.

6 But it seems to me like home health
7 is just -- it's a very selected service that
8 can be very different in it's intensity. So
9 maybe I'm just misunderstanding how well the
10 model captures the intensity of service
11 delivered.

12 I certainly happy to be pushed back
13 on if I'm getting it wrong.

14 CO-CHAIR HALL: Fair enough. Wes?

15 DR. FIELDS: Really nothing else.

16 CO-CHAIR HALL: Pam?

17 DR. ROBERTS: If I remember
18 correctly, weren't the low level LUPAs
19 excluded? So that would take care of the real
20 short stay ones?

21 DR. COOK: That's right. LUPAs are
22 sort of home health encounters that involve

1 four or fewer visits.

2 So we did exclude those. It
3 actually only has a very minimal effect on the
4 agency level outcomes. But it sort of seems
5 to get at this point, that if someone's only
6 providing very minimal services, perhaps it's
7 not appropriate to include them in this
8 measure.

9 CO-CHAIR HALL: Any additional
10 comments? Not seeing any.

11 MS. SHAHAB: Voting for criteria 4,
12 usability and use. 1 high, 2 moderate, 3 low,
13 4 insufficient information.

14 We have all 22 votes for usability
15 and use. 1 high. 13 moderate. 6 low and 2
16 insufficient information.

17 CO-CHAIR HALL: Any comments before
18 the overall vote? All right, we'll vote
19 overall.

20 MS. SHAHAB: For overall
21 suitability for endorsement, 1 yes, 2 no.
22 Time begins now.

1 We have all the votes for overall
2 suitability for endorsement for measure 2505,
3 Emergency Department Use without Hospital
4 Readmission During the First 30 Days of Home
5 Health. 15 Yes. 7 No.

6 CO-CHAIR HALL: Thank you. So we
7 are potentially going to lose our conference
8 lines and our sound at 6:00 o'clock.

9 Sherrie and I would like to argue
10 that we should push forward with the next
11 measure because they're parallel in some
12 sense. And our developer is here. We don't
13 want to make them come back again tomorrow
14 morning.

15 Is everybody -- or are most people
16 okay with that? Okay, all right. We're not
17 going to --

18 CO-CHAIR KAPLAN: Yes. Let me make
19 a bid for -- yes.

20 CO-CHAIR HALL: No, 1 high, 2 low.
21 No, no. For the sake of time then, can we ask
22 our developer to call our attention to the

1 highlighted differences between what we just
2 discussed and the next measure.

3 CO-CHAIR KAPLAN: And let me make
4 a bid please for really concise, sharp -- I
5 know everyone's worked really hard all day
6 long. So it's really a tribute to you that
7 you're all still firing on all your cognitive
8 cylinders.

9 But if you can just sharpen up the
10 you know, comments. And really make them
11 concise. And the response from the developer
12 --

13 CO-CHAIR HALL: And where were you
14 like eight hours ago?

15 Okay, developer.

16 DR. COOK: Sure. So in a lot of
17 ways this measure is actually very similar to
18 the measure we just finished discussing. The
19 rate of rehospitalization among home health
20 patients is a bit higher. It's about 13.5
21 percent within the 30 day time frame.

22 The denominator of this measure and

1 of the measures we just discussed are
2 identical. So that's identical.

3 The numerator is capturing you
4 know, those patients who are rehospitalized
5 either through the emergency room or direct
6 hospital admission.

7 The interventions that we
8 anticipate the agencies can take to prevent
9 rehospitalization are parallel to those that
10 they take to prevent emergency department use
11 without readmission. Although again, they may
12 be targeting those more severe kinds of
13 conditions.

14 So for instance a patient who's
15 surgical wounds are deteriorating, they
16 require hospitalization. Where as a patient
17 who you know, skins their knee, might only
18 need emergency department visit.

19 But overall, we're thinking that
20 the home health agency is working to prevent
21 the escalation of care to the next level. And
22 that once the care is escalated to the next

1 level, in some sense it's out of their hands,
2 whether the doctors in the emergency room feel
3 that it's best to admit the patient or whether
4 they can stabilize the patient and then return
5 the patient home.

6 Again the proposed public reporting
7 is categorical. You know overall, I think
8 we're a little less good at categorizing on
9 this measure than the other measure. Although
10 in large part that's because our risk
11 adjustment model does a little bit better on
12 this measure than on the ED.

13 So we have more same as expected's
14 because our risk model is capturing a little
15 more of that -- of those nuanced differences
16 between patients.

17 But still among the largest
18 agencies, we are able to categorize a
19 substantial faction of those largest agencies
20 as better than average or worse than average.
21 And we do see the variation across regions in
22 the fraction of agencies that are categorized

1 as better or worse then expected as we did on
2 the previous measure.

3 CO-CHAIR HALL: Pam you're listed
4 as discussant. Do you have any specific
5 comments on the evidence?

6 DR. ROBERTS: For sake of time,
7 it's very similar to the other measure.

8 CO-CHAIR HALL: Okay, any other --
9 yes, Wes?

10 DR. FIELDS: Yes, I actually -- I
11 think the rationale here is stronger. I mean
12 if this encounter results in admission to the
13 hospital, I think that speaks for itself.

14 The other thing that I find
15 curious, but it maybe supports my earlier
16 contention, is that the rate of readmission is
17 actually higher than the rate of ED visits
18 without hospitalization.

19 So I find that somewhat
20 counterintuitive. If you think about
21 admission ratios in general -- I'm running out
22 of time. But I -- so in general I have fewer

1 concerns and problems with this then the
2 other.

3 CO-CHAIR HALL: Okay, we'll vote on
4 evidence.

5 MS. SHAHAB: 1a, evidence. 1 yes,
6 2 no. Time starts now.

7 We have all 22 votes. 1a evidence.
8 18 yes. 4 no.

9 CO-CHAIR HALL: Performance gap,
10 opportunity to improve. Any specific
11 questions or comments? None.

12 MS. SHAHAB: 1b, performance gap.
13 1 high, 2 moderate, 3 low, 4 insufficient.
14 Time begins now.

15 Just one more.

16 We have all the votes for 1b,
17 performance gap. 7 high. 13 moderate. 0
18 low. 2 insufficient.

19 CO-CHAIR HALL: Priority. Comments
20 above and beyond what we've heard. Not seeing
21 any.

22 MS. SHAHAB: 1c, high priority. 1

1 high, 2 moderate, 3 low, 4 insufficient. Time
2 begins now.

3 One. Just one more.

4 We have all 22 votes for 1c, high
5 priority. 8 high. 14 moderate. 0 low. 0
6 insufficient.

7 CO-CHAIR HALL: Scientific,
8 reliability, validity. Pam?

9 DR. ROBERTS: There was a comment
10 that came up during the calls regarding
11 interclass correlation testing not being done.
12 And the developer did respond regarding why
13 that was not appropriate.

14 And that it was more -- and they
15 did use a split half test to assess measure
16 reliability.

17 CO-CHAIR HALL: Wes?

18 DR. FIELDS: This would actually
19 fit better in the next category. But I'll
20 just briefly suggest that I think that there's
21 a pretty decent chance that the readmissions
22 probably are not always related to the reason

1 they were referred to home health services.

2 So I -- just again I think the
3 scope of services available for most types of
4 agencies probably is not adequate if the
5 assumption is they can deal with all those
6 chronic conditions that those patients
7 typically have.

8 So that's the part of this that's
9 not intuitive for me.

10 CO-CHAIR HALL: Thank you. Any
11 other comments? Let's vote on reliability.

12 MS. SHAHAB: For 2a, reliability.
13 1 high, 2 moderate, 3 low, 4 insufficient.
14 The time begins now.

15 We have all 22 votes for 2a,
16 reliability. 2 high. 17 moderate. 3 low.
17 0 insufficient.

18 CO-CHAIR HALL: On validity we just
19 heard Wes express a concern that bleeds over
20 into validity. Are there any others? Above
21 and beyond what we've discussed? I'm not
22 seeing any.

1 MS. SHAHAB: For 2b, validity. 1
2 high, 2 moderate, 3 low, 4 insufficient. Time
3 begins now.

4 We have all 22 responses for 2b,
5 validity. 0 high. 18 moderate. 4 low. 0
6 insufficient.

7 DR. FIELDS: Chairpersons, point of
8 personal privilege. Is there -- there's no
9 filibuster privilege at NQF? I just wanted to
10 make sure. Because I can keep you here all
11 night if you know --

12 CO-CHAIR HALL: There actually is,
13 but no one else has to stay.

14 CO-CHAIR KAPLAN: And the lines
15 over are off, okay.

16 DR. FIELDS: Never mind, never
17 mind.

18 CO-CHAIR KAPLAN: Feasibility.
19 Specific comments? Feasibility, specific
20 comments? Not seeing anything.

21 MS. SHAHAB: Voting for number 3,
22 feasibility. 1 high, 2 moderate, 3 low, 4

1 insufficient. Time begins now.

2 We have all the votes for
3 feasibility. 10 high. 10 moderate. 1 low.
4 1 insufficient.

5 CO-CHAIR HALL: And usability.
6 Karen?

7 DR. JOYNT: I do worry a little bit
8 with this one on unintended consequences. We
9 already have a really hard time doing home
10 health agencies to go into some of our most
11 troubled neighborhoods.

12 And I think this is -- if we don't
13 deal with some of that stuff, again, awaiting
14 socioeconomic decisions from the other panel
15 and all that stuff, I just worry a about it a
16 little.

17 CO-CHAIR HALL: Good sentiment.
18 Anyone else? Yes, Helen?

19 DR. CHEN: Just keep in mind we're
20 already reporting this. So home health
21 already reports this. This is the only
22 difference is this is within 30 days.

1 So you know we're already reporting
2 acute utilization.

3 CO-CHAIR HALL: I don't see any other
4 comments.

5 MS. SHAHAB: For criteria number 4,
6 usability and use. 1 high, 2 moderate, 3 low,
7 4 insufficient information. And the time
8 begins now.

9 2 high. 15 moderate. 4 low and 0
10 insufficient information.

11 CO-CHAIR HALL: And overall. Any
12 additional comments? None.

13 MS. SHAHAB: Voting for overall
14 suitability for endorsement. 1 yes, 2 no.
15 Time begins now.

16 Just one more vote.

17 All votes are in for overall
18 suitability for endorsement for measure 2380,
19 Rehospitalization During the First 30 Days of
20 Home Health. 16 yes and 6 no.

21 CO-CHAIR KAPLAN: I think in
22 general the cognitive fatigue sort of is

1 sharpening up the gray area.

2 CO-CHAIR HALL: So we thank you for
3 your efforts so far. And we look forward to
4 reconvening these discussions tomorrow.

5 We ended a half hour late, which is
6 somewhat on the back of our last developer.
7 We pushed them and cut their discussions
8 short. Hopefully they will not prosecute us
9 for that.

10 So NQF colleagues any additional
11 remarks?

12 MS. KHAN: Operator -- oh, did you
13 want? Oh, we can end the call now. Thank
14 you.

15 MR. AMIN: So beginning tomorrow we
16 have 7:30 breakfast. We'll get started
17 promptly at 8:00 o'clock tomorrow morning.

18 Hopefully we'll see some of you in
19 a half an hour at Neo for dinner.

20 CO-CHAIR KAPLAN: I'd just like to
21 add a great thank you. Because I know that
22 this is arduous. You know it is really tough

1 to get through as many measures as you all
2 did.

3 So to Bruce's thank you, I would
4 like to add my thank you. Because I really do
5 know how hard this is.

6 Thanks again.

7 CO-CHAIR HALL: Just leave
8 everything. Leave the clickers and whatnot on
9 the tables.

10 CO-CHAIR KAPLAN: Can they leave
11 their personal stuff?

12 MS. KHAN: Yes, you can leave your
13 clickers and your name tags at your tables.
14 Please don't leave anything valuable in the
15 room. I can't guarantee it's safety. But if
16 you have papers, you can leave those.

17 (Whereupon, the above-entitled
18 proceeding was concluded at 6:01 p.m.)
19
20
21
22

A				
\$45 478:2 484:16	accept 103:13	383:21 466:8,9,21	315:14 379:22	347:15 362:5
A-F-T-E-R-N-O-...	286:13,14	472:3 473:9	405:7 442:9 451:1	374:19 383:8
260:1	acceptability 42:9	accountable 95:14	453:6 461:2,12	404:21 459:10
a.m 1:9 6:2	42:15 43:8 90:21	95:21 106:14,16	467:2 503:7	520:21 521:4
AARP 64:16	108:2 111:2	108:5 110:18	actuality 175:12	added 140:21
abandon 47:20	120:17 124:6	219:20 228:21	Acumen 3:3,5 5:13	191:10 200:13
ability 110:7 142:8	126:20 172:10,14	244:17 258:2	5:17 12:22 475:6	220:5 239:21
163:5,11,20 170:5	219:12 241:22	286:16 358:6,9,10	476:8 477:2	264:2 274:12
180:4 185:10	252:1 276:22	383:16	acute 15:13 19:14	adding 128:4
188:10 198:15	398:8	accounted 24:10	22:19 64:9 65:6	274:17,17
201:4,6 207:9	acceptable 123:17	accounting 103:21	71:6 81:16 82:9	addition 66:18
222:20 238:4	165:16 189:20,22	422:21	83:20,22 84:4	81:12 133:20
244:22 253:9	190:12	accuracy 146:17	92:13 115:13	134:2 238:6 375:8
263:12 313:14,20	accepted 117:16	237:10,11 440:22	117:13,16 140:9	408:11
316:17,19,20	access 36:5 67:2	accurate 137:1	141:3,5 149:17	additional 49:17
328:2 329:1 333:2	118:10 203:22	432:18	162:15,17,18	54:14 103:11
336:13 340:4	252:19 258:9	accurately 183:4	167:8,14 168:7,8	280:4 330:13
able 33:3 36:18	285:1 382:19	achieve 26:1	168:17 173:20,22	347:16,17 350:22
42:5 79:3 96:20	462:4 472:10	achieving 68:17	174:9,17 175:4,8	404:22 406:1
114:19 191:16	491:15	acknowledge 58:14	175:20 176:10	415:14 426:15
192:4 207:7	accessibility 392:10	402:15	184:22 201:5,6,17	429:9 474:15
221:19 228:7	ACNS-BC 1:16	ACNS-BC 1:16	202:17,18,19	489:10 493:6
237:2 256:20	accidentally 165:11	ACO 229:15	203:19 204:19	508:9 519:12
274:9 285:14	accommodate	ACOs 215:22	206:12 217:14	520:10
309:13 311:14	151:3,10 230:11	216:4 225:19	218:15 221:17	address 16:13 60:5
313:16 315:7,16	418:15	229:6 341:19	227:13 231:20	61:1 63:11 74:22
316:13 320:12	accommodates	act 62:3 137:22	253:4 257:13	122:2 176:6 273:6
322:1 329:16,18	151:17,21	acting 41:16	262:3,16 265:9	275:3 344:16
333:5,11 336:13	accommodating	action 21:3 343:15	266:13 267:22	390:21
337:19 339:7,16	150:6 392:15	343:18 353:11	271:8 290:10	addressed 94:11
340:13 397:15	accommodation	459:3	303:5 400:13	183:1
450:19 468:18,19	333:17	action-ability	409:7 432:22	addresses 119:13
494:14 512:18	accompanied	322:6 333:3,21	478:15 495:7	125:11 126:1
above-entitled	414:11	actionable 219:18	519:2	171:19 391:8
160:8 259:13	account 80:20 83:4	actions 256:3	acute-care 162:3	addressing 51:8
521:17	85:2 122:6 129:18	activation 357:3	166:20 176:8	69:3 72:4 83:17
absence 368:3	256:17 257:10	actively 121:3	ad 40:20,21	Adeela 2:14 7:6,8
absolute 120:2	267:11 276:7	229:6	adapting 200:7	7:21 8:18,21 9:7
159:7 289:19	303:21 335:10	activities 9:21 27:4	add 24:20 43:20	26:15 36:1 43:16
290:19	347:18 442:20	35:3 69:13	50:4,6 54:18 57:7	68:11 71:15 78:6
absolutely 203:2	478:2 499:5,17	activity 19:8 62:3	75:15 78:21 97:13	79:14 158:12
259:4 317:21	500:10,16 505:3	484:4	120:4 140:15	adequacy 437:9
411:3	accountability	actual 47:4 78:8	167:20 190:16	adequate 110:17
abuse 417:2 461:18	135:5 211:16,17	86:19 89:19 175:6	200:9 218:9 221:7	197:8 455:4 516:4
abysmal 228:18	253:14,15 261:13	179:22 187:7	243:12 277:16	Adjourn 5:21
academic 19:8	264:15 286:10	192:22 200:7	278:21 281:2,4	adjudicating 37:5
	341:11 358:13	218:13 265:13	317:18 345:6	adjudication 38:4

adjunct 419:17	374:5 375:13	68:10 69:20 70:12	advisement 205:18	agnostic 72:1
adjust 114:20	377:5 387:3,11	77:12,13 101:18	advising 202:7	ago 13:13 51:22
122:9,18 123:15	388:2,19 390:20	162:18 211:3,4	Advisor 64:15	100:4 179:15
132:6 144:1 279:6	391:8 392:3,8	223:22 238:22	Advisory 12:10,21	254:16 256:14
316:17 345:19	395:21 405:21	248:12 252:3,10	advocacy 21:7	318:15 373:13
355:21 369:10,14	415:20 420:11,12	252:16,19 253:6	advocate 21:12	424:15 432:10
372:20 373:22	453:20 454:15	253:14 255:10	199:22 391:4	466:7 510:14
378:10 387:2	455:9 458:2 459:6	257:21 261:5	392:2	agree 101:16 102:5
393:18 408:7	461:16 462:12	265:20 267:6	affairs 214:15	228:9 233:16
456:22	498:11,14 499:15	287:3,3,6,8,9	321:3	296:3 313:18
adjusted 46:10,18	500:17 512:11	342:19 344:16	affect 220:15	325:5 327:18,22
47:16 52:4 81:2	Adjustment/SES	346:2,18 354:11	234:13,17 256:15	332:9 369:22
128:7 138:6 143:3	4:8	355:6,7 357:9,11	370:7	372:10 381:1
347:8 355:11	adjustments 45:10	360:11,17 361:17	affiliated 419:15	414:6 440:11
384:11 388:7	52:2 109:19 119:1	366:8,12,14 380:2	affordability	451:1
391:14 392:14	147:8 412:7	391:17 393:8,15	246:20	agreed 41:7 57:14
393:22 418:13	ADL 231:22	401:9 405:18	Affordable 62:2	agreed-upon 96:18
424:18 429:6	administrative	407:12 409:16,19	afternoon 140:17	agreement 34:21
431:16 432:12	7:22 151:15	430:18 452:3	213:6 241:20	41:11 226:13
453:6 454:6,8	177:16 426:2	admit 201:7 320:7	254:7	277:16
467:6 478:22	481:9	320:9 321:9 512:3	age 143:4,20	ah 475:12
507:2	administratively	admits 252:13	144:13 347:8,18	ahead 110:10
adjuster 90:10	152:17	admitted 84:18	372:21 373:7,13	157:13 197:13
447:16 448:6	Administrator	173:19 187:11	384:12 389:18	199:10 212:7
adjusters 85:19	17:18	201:11 215:5	421:18 424:10	266:1 300:2 350:5
144:5 178:4	admission 15:1	221:14 225:6,14	432:1	389:6 391:2
254:18	44:13 72:3 74:20	227:10,11,14	agencies 477:4	447:11 476:8
adjusting 375:9	76:11 141:3,6	260:19 282:4,5	480:20 481:14,15	AHRQ 425:19
adjustment 44:7	162:19 174:8,15	409:16 410:10	481:18 482:1,3,6	aim 305:2,3 344:4
45:1 48:8 49:8	174:17 176:11	423:11	482:11 486:5	345:2
52:5,10 55:15	184:1,7 203:16	admitting 297:3	488:7 489:5 498:8	aimed 382:21
58:17 84:9 89:16	204:18 210:5	adopt 117:7 118:8	500:13,14 503:21	aims 161:16
89:17,20 90:1,3	221:13 223:5	adopted 77:8	504:16 505:1,1,3	al 94:6 316:5
114:5,6,8,11	225:5 228:8 231:9	adult-predomina...	511:8 512:18,19	alerted 273:13
116:2 119:2	231:12,18 247:1	347:22	512:22 516:4	algorithm 137:11
122:13 123:19	252:13 262:5	adults 62:12 337:1	518:10	137:12,14 140:5
127:22 128:3	268:5 270:4	337:3	agency 478:6 479:4	273:3 427:12
132:10,14 133:19	342:11 377:13,17	advance 25:15	479:6,9 485:7	443:17,21 444:5
134:1,11 143:19	389:12 405:15	74:15 186:12	486:13,16 494:10	algorithms 97:1
162:11 163:4	406:5,10,17	391:19 461:4	502:14 503:3,6,14	align 252:3
170:10 197:16	407:13,17 408:17	advantage 231:16	508:4 511:20	alignment 229:4
238:5 261:22	408:22 409:1,20	329:13 364:9,17	agenda 6:8 34:4	257:20
281:7,7,10 307:10	410:15,21 412:22	387:14,21	78:12 260:6	Alison 2:5 21:5
308:6 334:16	424:5 477:17	advantages 291:15	ages 12:16 142:20	30:6 58:11 276:2
347:8 367:9 368:3	511:6 513:12,21	329:12	aggregate 256:20	428:14
368:21 370:10	admissions 1:3	Adventist 1:18	435:21 436:5,14	all-cause 4:12,19
372:17 373:7	27:18 55:7 56:13	14:15	aggregating 226:14	63:17 71:18,21

160:14,21 215:4 233:5 251:21 252:10 260:8,17 299:20 412:21 all-condition 71:19 alliance 2:6 64:22 65:1 422:2 425:16 Allison 426:20 438:12 455:6 462:7 466:4 allotted 34:8 allow 34:20 115:21 258:22 420:21 421:13 475:8 allowed 324:1 386:18 420:17 allowing 452:17 allows 150:11 466:2 479:2 alternative 88:18 393:14 alternatives 88:16 230:17 Alto 16:9 altogether 224:5 ambulatory 384:16 America 1:18 American 2:7 3:6 3:17 4:17 13:9,15 16:11,12 20:22 22:7 214:3,7,15 214:20 305:21 312:7 314:1 334:4 334:18 336:3 339:20 AMI 443:3 Amin 2:11 4:3,7 6:3 7:6,21 9:2 24:15 26:15 28:21 29:13 36:1,3,11 40:1 51:16 57:9 58:11 76:16 95:4 97:9 107:6 111:6 119:19 125:8 158:9 160:5,10 207:11,20 212:17 218:3 273:1 274:2	274:22 275:17 300:20 396:20 398:4 418:8 443:10 468:16 479:17 480:5,11 520:15 amount 7:4 38:7,8 87:11 88:10 182:15 201:22 217:9 255:18 278:12 280:18 318:2 322:16 338:1 374:8 375:5 381:2 388:5 392:7 445:1 483:11 484:9,21 494:4 amusing 364:13 analogous 384:8 analyses 54:15 59:4 128:14 163:7,20 263:17 278:4 282:13 345:10 366:16 analysis 57:13 106:3 128:12 149:14 170:2 208:21 252:12 254:1 278:3 283:1 284:1 383:17 388:12 436:17 439:20 443:20 444:2 448:2 450:9 450:19 460:16 467:14 470:22 471:1 498:14 503:2,10 504:15 Analyst 2:16 8:22 and-or 124:17 171:11 and/or 171:2 Andrew 2:13 4:10 9:1 43:15 44:9 73:10 anecdotal 271:14 anecdotally 225:19 270:20 271:7 anesthesiologist	21:18 Anesthesiologists 22:7 Angeles 15:19 angle 233:12 animated 12:18 Ann 1:15 4:5 16:16 31:7 Annals 102:15 Anne 2:13 9:4,8 24:16 announced 246:7 annual 321:18 360:16 401:20 402:1 474:1 annually 360:14 answer 146:20,22 193:19 194:19 196:1 216:8 226:15 230:20 284:14 360:9 367:20 378:22 379:11 380:11 416:13 431:10 440:12 446:17 457:12 459:2 462:9 501:2 answered 138:13 428:15 answering 90:16 469:16 answers 58:10 232:12 389:2 ANTHONY 1:21 antibiotics 335:16 anticipate 45:13 481:12 511:8 anticipated 155:9 479:12 anxiety 12:19 anybody 24:13 203:16 351:12 391:1 465:14 492:7 anybody's 281:15 anymore 237:19 anything's 246:2	anytime 460:19 anyway 237:20 308:12 407:22 450:20 502:18 apart 191:11,18 192:4 apologize 168:3 apparent 300:14 apparently 116:1 appeal 39:1 40:20 appeals 38:19 appear 122:10 129:9 379:8 398:16 appears 35:16 appendix 506:15 apples 391:15,16 applicable 209:5 357:13 425:21 application 15:21 73:13 102:11 120:15 136:3 155:7 301:3 503:19 applications 383:21 applied 131:3 194:17 204:7 425:14 465:10 applies 137:12 154:3 204:6 209:16 210:10,12 477:13 478:20 484:17 489:18,19 490:2,4 apply 49:14 94:1 130:7 154:15 203:15 210:8 234:5 237:6 240:10 258:17 309:2 388:13 415:20 445:18 464:13 465:11 applying 437:10 appointed 64:17 appointment 19:8 22:1 419:4	appointments 21:19 appreciate 6:9 7:4 14:18 19:19 61:17 240:11 329:2 340:15 appreciated 289:3 appreciative 6:22 approach 84:11 122:14 123:6 161:9 331:20,21 377:12 457:4 approaches 88:18 approaching 193:1 appropriate 76:19 93:3 110:1 120:20 143:16 186:7,8 197:8 229:18 230:12 301:9 437:11 489:4 508:7 515:13 appropriately 75:13 approval 17:13 26:12 38:13 39:2 45:12 51:15 120:8 470:2 approve 377:9 379:4 406:20 approved 53:18 142:16 159:1 198:19 448:8 approves 416:2 approving 272:19 376:22 377:3,3 approximate 88:5 approximately 240:22 251:14 254:15 apt 371:16 arbitrarily 116:16 arbitrary 451:2 ARC 60:15 75:16 384:8 arduous 520:22 area 26:21 27:9 43:10 57:22 58:9
---	--	--	--	---

60:15 66:21 68:21 69:3 70:17 95:7 125:12 133:18 164:16 169:22 171:9 190:10,11 198:2 199:15 230:15 242:21 248:11 265:22 275:12 300:21 301:16 328:20 331:4 356:20 389:13 492:19 520:1 areas 61:6 75:4 77:5 225:17,19 229:5 275:5 297:2 381:9 470:6 argue 63:15 324:3 334:9 437:7,8 509:9 argues 487:18 arguing 376:12 argument 170:13 319:3 337:14 450:4 arguments 318:22 Arizona 225:21 226:1 arrangement 483:12 arrangements 342:5 artery 253:4 article 94:4 102:12 374:11 articles 311:10 artifact 75:9 artificial 77:4 78:3 121:9 artificially 203:21 ASCs 73:2 aside 82:14 412:7 asked 9:20 26:20 38:1 41:6 46:2 59:3 110:13 165:13 180:7 204:14 353:1	395:11,12 399:5 443:11 asking 32:13 54:14 194:1 239:9 314:4 327:2 410:3 asks 182:7 aspect 126:3 171:21 467:13 aspect/attribute 410:13 aspects 59:18 202:6 211:11 347:2 376:17 379:3 assess 222:1 314:21 326:8 515:15 assessing 133:18 401:3 assessment 109:18 136:4 157:19 170:1 199:4 221:13,18 222:14 223:5,18 248:15 326:18 328:8 392:12 assessments 221:20 221:22 321:18 382:14 assign 77:1 272:10 assigned 72:8 76:15,18 372:1,5 assigning 377:14 Assistant 2:11 11:21 14:1 16:16 17:17 assisted 13:12 Associate 13:7 477:1 associated 66:13 100:15 101:22 103:2 176:9 257:8 270:9,16,16 446:15 465:4 498:18 association 2:7 3:7 3:18 4:18 16:12 21:1 135:8 214:3 214:8,16,20 316:8	Association's 18:4 assume 128:22 158:11 178:6 240:20 257:15 407:19 assumed 408:1 429:13 assuming 54:5 65:22 116:1 143:18 272:13 assumption 132:4 135:2 220:12 267:21 268:3 516:5 astonishing 270:20 asymptote 471:11 Atlas 381:7 389:9 389:20 393:1,3 395:16 attack 141:8 attempt 51:6 80:20 122:2 attempted 63:11 81:20 144:15 Attend 34:17 attending 421:18 421:20 attention 238:2 300:18 338:1 509:22 attractive 461:19 attributable 252:16 252:20 253:1 264:10 292:6,8 355:2 attribute 410:19 421:21 attributed 380:13 attributes 455:18 attribution 337:10 376:8 Atul 365:22 370:1 audible 251:5 258:20 385:20 394:9 396:9 402:18 403:4,14 404:10 411:5,16	415:4,15 417:7 audience 259:10 audit 248:21 audited 249:1 audits 246:8 Auger 1:13 13:22 13:22 30:19,19 59:8 139:21 142:19 186:16 318:20 336:17 412:6 453:17 468:11 487:10 August 35:14 authority 311:2 314:20 320:2 355:16 378:13 authors 94:17 automatically 399:17 autonomy 185:11 availability 369:7 available 40:4 49:7 60:3,12 83:19 164:8 193:6 202:1 255:1 353:18 384:17 389:17 466:20 472:17 516:3 average 5:6 85:9,14 86:10 88:6,9 89:9 127:9,11 129:2 132:13,13 135:4 136:14 153:6,9,11 153:11,12 163:22 191:14 198:11 218:13 223:22 239:7 264:3 296:8 297:13,13,19,21 297:22 298:1 303:13 304:8 326:10 418:13 420:12 442:4 446:18 453:4,6,15 471:15 474:22 504:8 512:20,20 avoid 34:19 101:17 107:3 233:5	384:17 502:16 avoidable 18:22 270:14 271:4 355:13 401:16 awaiting 518:13 aware 44:19 52:17 56:18 82:20 88:11 186:12,12 414:20 490:17 awareness 69:12 awful 464:12 <hr/> B <hr/> baby 434:3 back 24:22 25:6,18 32:3,21,21 41:7 41:13 70:22 72:20 73:20 93:13 111:1 124:5 127:6,11 136:13 139:3 140:15 141:8 142:2 154:4 158:13 162:1,3 166:16 168:13,15 168:16,19 173:2,4 173:20 174:1,15 175:3 184:21 186:1,2 187:20 199:14,16 200:1 201:2,15,16 202:19 203:17 204:14 206:3 209:10 214:6 222:12 227:18 229:17 233:22 236:19 241:5 244:13,18 282:4 283:5 285:3,6 287:2 294:22 296:8 336:10 337:16,18 359:13 382:15 397:12,15 398:17 402:4 403:21 404:19 408:14 418:5 420:3 427:2 434:9 440:19 454:19
---	---	---	--	---

462:6 466:7	423:10 431:19	293:7 330:1,20	353:4,8 355:9	253:9 353:13
490:14 493:17	432:11 439:14	332:13 359:22	356:8 360:12,18	362:2 371:1
494:6,9 502:2	440:4 451:2 457:4	362:18 386:3	360:19 361:20	412:14 435:6
506:14 507:12	459:17 477:6	390:14 394:15	363:8 366:8	436:12 494:9
509:13 520:6	478:9 479:7	396:14 403:17	396:19 407:20	514:20 516:21
background 66:21	481:12 501:6	411:10 438:7,22	408:9 417:16	bias 187:7 235:20
161:10 352:11,15	baseline 362:7	447:3 462:18	beneficiary 408:10	499:18
352:17 356:17	basically 47:22	474:9,19 490:22	benefit 136:13	biased 23:19
359:3 400:11	48:20 82:17	492:13 496:14	154:12	205:22
backing 192:10	113:11 129:3	497:22 505:10,18	benefits 211:21	bid 509:19 510:4
backwards 182:22	137:3 148:1	508:22 514:14	354:4	bifurcation 95:9
bad 81:13 82:2	237:17 287:10	515:2 516:14	benefitting 425:10	big 89:17 114:18
89:22 91:13	302:13 303:13	517:3 518:1 519:8	best 8:8 51:2 76:22	115:1,17 154:7
116:10 130:2,5,19	374:5 427:20	519:15	76:22 79:3 108:13	172:21 202:4
131:5 168:15	430:12 441:16	begun 424:20	138:11 144:1	207:7 269:6
295:18 298:7	464:7 471:12	behalf 13:15 67:12	187:5 275:15	281:21 331:8
335:1 341:17	basis 52:12,19 87:5	161:4	292:19 301:15	405:8 413:1 432:5
369:8 395:11	97:15 106:2 216:1	behaving 23:18	341:22 356:4	436:19,22 442:19
456:22 493:13	233:9 359:8 420:7	behavior 249:6,9	364:15 374:12	464:16 493:15
bag 506:10	420:10 452:15	283:20	430:13 444:15	499:12 506:17
balancing 243:6	bathroom 146:18	behavioral 20:16	464:6 488:4 506:4	bigger 130:14
bar 65:2 94:19 96:4	146:19,21 147:2	behaviors 205:22	512:3	131:22 192:11
105:6 132:21	Baylor 1:17 20:1	believable 129:14	beta 445:12 468:4	248:11 341:7
369:16	bear 65:14 283:9	believe 10:1 15:3	betas 468:13	367:8
bars 132:18	351:13	23:8 43:11 78:14	Beth 3:18 352:5	biggest 132:1
base 34:11 318:4	bears 370:15	108:22 111:12	better 61:10 63:3	491:17 492:3
428:18 483:15	beat 189:11 249:13	140:2 143:3	65:5 87:11 89:2	504:14
based 12:18 16:18	beating 94:2	190:21 204:20	97:3 118:2 121:6	binary 121:12
24:4 32:7 55:22	beautiful 6:19	213:17 223:11	130:3 150:12	biosciences 307:6
56:1 62:7 77:14	191:22	237:10,19 252:2,9	172:5 192:12	biostatistics 302:20
91:17 98:22	becoming 226:20	257:9,19,22 258:6	194:3 207:8	Bipartisan 64:17
152:11,12 155:18	bed 201:20 432:14	266:10,21 277:4	236:17 246:21	bit 10:16 25:18
162:6 165:12	432:16	278:8 280:12	247:14 294:12	54:22 63:13 79:14
219:22 221:13	beds 14:21 199:18	290:2 325:9 329:8	296:22 300:9,18	89:3 90:11 91:22
222:20 223:2	201:22 407:10	363:7 371:3	319:10 342:14,19	93:21 97:2,15
235:8 236:18	beginning 45:15	386:15 388:4	343:12 359:1,9	106:6 115:7
238:1 239:12	362:8 393:10	475:17 489:12	374:14 379:18	141:18,20 150:15
241:14 252:11	488:14 520:15	bell-shaped 129:1	391:8 392:3 429:6	184:14 203:12
257:18 261:4	begins 113:14	belong 455:5 456:5	437:15 459:22	217:3 233:17
269:11 290:9	124:20 126:6	benchmark 130:18	478:6 479:6	261:8 272:12,18
296:11 303:17	148:10 157:21	298:6 364:15	481:14,16 497:5	277:11 282:20
306:19 312:18	169:18 171:4	422:7	499:16 503:20	289:21 290:4
318:11 334:21,22	212:4,10 218:1,20	benchmarking	504:8 506:4	303:10 305:17
353:7,19 367:11	219:7 242:11	149:7 294:14	512:11,20 513:1	326:3 331:19
370:2 380:11	243:16 249:21	beneficiaries 5:2,4	515:19	344:12 347:16
381:19 416:7	250:10 268:16	161:12,21 206:15	beyond 82:5	352:15 369:11
422:16,20,21	271:21 288:16	264:8 351:19	103:11 106:5,7	384:21 385:5,13

388:22 397:10	boxes 443:22	60:22 71:17 72:11	276:5 304:12	call 37:1,6 38:5
398:15 411:1	brain 122:5	72:13 73:16 229:1	burden-able 81:21	39:6 40:6 50:16
412:8,10 430:19	brainer 423:15	broaden 357:12	burdens 274:19	52:17 71:19 86:11
439:16 443:16	break 141:15	broader 220:13	burdensome 54:21	140:20 187:7
445:7 459:14	148:18,18 158:9	229:20	buried 156:3	195:17 196:13
470:10 472:1,11	159:20 160:1,6	broadly 490:8	burn 226:22	213:1,4 222:19
478:14 482:16	417:21 479:16	Brock 3:2 352:2,2	burning 192:15	307:22 345:8
487:11 488:13	breakdown 504:17	352:7 356:6	Burstin 2:12 24:17	382:9 415:1
495:1 503:6,18	breakfast 520:16	358:10 368:10	24:19 28:4 29:9	448:15 464:3
510:20 512:11	breaking 223:19	371:21 374:20	30:15 50:5 54:4	466:6 509:22
518:7	breaks 7:13 34:18	377:10 379:10	73:9 74:7 75:15	520:13
BJC 13:7	Breakthroughs	380:15,17 392:19	77:18 100:1	called 71:18 132:3
black 58:9	474:3	392:21 400:9	120:11 156:5	133:18 155:12
blah 28:1,1,1,1,1	BREE 18:6	407:2 408:15	298:18 384:5	427:15 478:18
492:5,5,5,5,5	brief 36:21 118:20	414:6 415:1	399:9 459:11	calling 274:20
blanket 46:18	121:18 160:20	416:10,15	489:12 490:6	284:10 339:4
bleeds 516:19	214:2 260:10	broken 71:16	502:12,21 503:9	calls 42:1 314:3
block 362:10	324:20 344:1	Brooks 1:15 16:15	business 2:8 13:5	338:2 339:8
blocked 335:19	358:19 402:8	16:16 31:7,7	17:7 259:4 384:20	480:18 515:10
blocking 335:13	466:13 476:12	brought 41:13	button 111:17	Camden 366:3
blood 100:15 483:5	480:13	155:21 300:5		cancelled 208:12
blue 14:8,8 61:22	briefly 32:13 160:9	392:9,11 405:13	C	cancer 82:8 499:4
board 35:15 38:16	214:9 215:1 352:1	Bruce 1:9,12 4:2	c 88:19 89:3 191:2	cancer's 501:3
45:13 64:16,21	418:19 430:10	6:14 13:1 25:14	191:20 194:1,19	Candidate 4:11
65:9 100:12 159:2	481:2,4 515:20	30:14 149:1 302:1	289:12	cant 521:15
183:10,14 255:15	Briggs 1:14 31:21	368:18 375:15	c-statistic 190:17	cap 363:11 366:16
boards 64:19	65:16,17 66:1	Bruce's 142:2	192:9,18 194:11	capability 374:22
bodies 416:6	209:3 216:15	380:11 521:3	194:18 441:7	capacity 14:19
body 95:18 98:15	218:12 224:8	bucket 430:13	c-statistic's 194:15	401:6
105:3 310:15	225:4,10 242:17	buckets 279:3,4	c-statistics 163:11	capital 7:18
327:13 388:9	243:22 281:18	Buffalo 66:8,9,20	190:20 196:21	caps 401:14,18
boiling 456:20	321:1 456:8	build 100:1 136:1	440:20	capture 215:13
bonus 229:2	472:22	building 129:2	caffeine 141:17	228:10 242:21
books 306:21	Brigham 2:1	136:1 231:10	calculate 221:9,12	249:12
boots 15:2	bring 24:1 78:15	318:3,10 362:9	356:8 378:21	captured 119:8
bootstrap 145:15	86:14 129:19,20	503:8	380:5 479:3	244:15 507:1
331:21	132:11 140:12	built 348:7 399:16	calculated 215:20	captures 104:5
bootstrapping	154:10 168:22	Bulger 1:16 23:6,6	360:12,14 501:5	507:10
163:14,19	169:1,6 180:20	30:17,17 389:7	calculating 345:11	capturing 353:20
border 75:22	342:7 344:5	413:6	calculation 145:16	354:3 452:16
Boston 22:14	385:18 447:14,16	bulk 42:13	377:3 379:5	511:3 512:14
bothered 207:17	488:4	bump 70:6,7	calendar 261:5	card 198:3
bothers 412:10	bringing 65:14	bumping 490:14	calibration 163:10	cardiac 21:17
bottom 70:20 89:11	152:3 301:7	bunch 83:10 153:1	179:21 289:12	434:5,8
128:11 153:8	brings 33:20	372:3 424:12	426:7	cardiologist 16:7
425:6	385:13	burden 243:3	California 12:1	18:14 343:1
bouncing 494:9	broad 59:9,17	273:5 274:14,16	15:19 19:12	Cardiology 16:11

cardiovascular 72:16 252:21 470:7	249:1 254:14 255:2,19 257:13 258:5 261:12,14 261:20 264:11,14 265:9,10,14 267:22 270:10 271:1,8 284:7 286:14 295:13 303:5 305:3,4 308:8 309:16,17 310:5 311:4 313:18,21 314:22 317:9,22 319:9 326:1,4,6 328:7 328:21 340:9 344:4,20 346:14 348:5 351:20 354:5 357:2 359:1 369:3,8 376:9 384:17 387:18 391:20,21 400:14 405:20 409:7 412:14 422:19,21 422:21 432:22 433:2 452:17 457:3 458:11 461:20 462:5 469:13 473:5,18 478:15 483:6 484:5,6 485:2 490:11 491:13 493:1,16 494:10 495:18 500:8,14 502:4 503:1 507:19 511:21,22	31:22 64:1,6,7 108:17 110:11 164:13 166:4,6 172:13 264:18 322:7 Carolina 419:12 carries 305:7 carry 471:8 case 7:18 42:22 81:19 102:7 103:22 109:19 112:21 119:9 135:11,12 170:8 175:4 183:19 184:19 194:21 196:11 204:8 254:18 255:17 261:1 270:22 275:20 284:7 295:7 314:9,16 371:15 373:6 375:9 384:3 387:18 393:5 420:7 476:19 485:2 case-mixed 83:13 cases 103:17 132:12 135:7 153:18 271:12 275:10 339:22 383:4 434:2,20 450:11 451:8,9 485:5 501:19 catch 351:13 categorical 512:7 categorically 206:13 categories 71:17 72:13 329:20 438:2 470:9 478:5 categorization 480:20 categorizations 497:7 categorize 512:18 categorized 478:6 481:14,16,18,20	482:1 512:22 categorizing 75:10 512:8 category 72:11 107:4,4 108:17 110:20 172:18 264:20 273:13 277:21 308:16,18 317:15 330:4 350:21 402:4 421:19 426:21 444:9 454:4 484:16 515:19 caught 428:3 causal 105:4 106:10 causality 106:4 114:10 cause 1:3 4:14 12:8 16:20 17:11 18:1 55:7 56:13 80:14 80:17 102:17 158:6 161:20 212:15 255:15 cause-specific 258:8 caused 133:22 134:2 causes 391:12,17 caution 131:15 cautionary 152:4 caveat 274:5 318:21 caveats 48:3 CCNS 1:16 CCRN 1:16 CDC's 414:7 CDP 39:6 Cedars-Sinai 2:5 15:18 cell 7:16,20 censoring 400:18 census 60:6,6 257:1 378:4 432:11 Centeno 1:16 19:21 19:22 30:2,2 358:4	center 1:20 2:2,5 3:10,13,15 15:19 100:15 132:11 232:20 291:3 324:7 364:11 371:11 372:2 376:13 493:22 centered 12:11,15 341:11 centers 16:3 161:4 184:12 218:16 321:10 339:5 371:13 central 101:16 centric 325:21 327:5 CEO 2:11 17:7 64:12 381:10 CEP 1:18 certain 57:12 109:22 144:14,15 173:3 222:15 229:22 236:22 246:20 278:12 295:17,21 318:2 501:7,8 certainly 48:16 52:21 53:14 54:2 54:15 56:22 57:6 59:11 75:11,14 86:15 93:9 108:9 119:16 124:2 134:19 154:6,21 155:2 173:7 176:15,18 203:8 220:16 224:13,16 237:4 238:1 240:11 241:5 245:22 248:3,5 283:8,9 286:4 300:21 301:16 306:14 311:9 314:12 326:5 330:9 345:13 356:19 374:21 395:22 400:3 421:3 423:21
--	---	--	--	---

456:10,13,16 483:10 505:2 507:12 certified 231:10 498:8 cetera 337:7,8,8,13 337:13 338:6,6 392:15 416:4 CFMC 352:3 400:7 417:21 chair 4:2,3 16:7,9 19:13 21:21 64:8 64:16,21 65:8 chaired 12:8 Chairpersons 517:7 chairs 8:7 11:19 24:3 51:17 459:20 challenge 294:15 challenges 158:17 347:13 400:6 Chan 316:5 chance 19:19 63:13 88:21,22 89:2 118:2 189:5 191:1 192:12 277:9,9 278:22 391:17 515:21 Chancellor 11:22 chances 279:4 change 26:17 27:21 38:21 40:18 60:18 104:17 117:15 133:22 134:1 149:19 150:3 151:9,15,21 152:6 164:19,20 179:5 231:14 240:5 246:1 249:6,9 283:10,20 289:17 289:19 290:18,19 315:16 317:10,11 320:1,15 322:4,20 325:22 328:2 344:5,20 345:3 346:8 373:10,13 373:17 375:11	401:7 406:9,12 418:18 436:3 440:13 446:6 461:4,7,11 470:13 changed 181:6 290:2 328:18 352:3 373:14 429:14 431:9,11 432:4,10 459:18 changes 32:9 40:11 150:6 185:22 223:13 234:15 289:19 290:15 327:8 328:11 340:8,9 344:3 372:20 420:8 461:2 changing 151:13 182:1 187:1 282:22 372:22 chapter 328:17 characteristic 143:22 characteristics 83:5 84:21 85:6 85:21 93:1 162:13 193:3 270:8,11 303:20 373:8 479:9 characterization 129:15 characterized 482:7 charge 15:20 326:8 326:22 328:1,6,14 422:22 charges 423:1 Charlotte 419:12 chart 178:14,14 charts 132:7 Chassin 94:6 chat 112:11 check 60:11 417:17 476:10 checklist-based 323:11 checks 246:6	Chen 1:17 22:10,11 30:12,12 141:22 217:1 218:10 219:15 221:3 222:18 247:12 264:21 269:1 270:18 277:2 280:1,10 289:3 294:5 518:19 chewing 260:5 CHF 270:3 339:5,7 351:3 chi 163:12 Chicago 13:10 379:12 chicken 61:8 chief 22:11 23:7 25:9 419:1,10 children 12:16,20 Children's 1:13 14:2 chime 483:17 choose 184:16,18 416:6 434:15,16 choosing 286:13 chop 177:5 chose 370:2 chosen 25:20 Chris 119:20 chronic 253:8 270:3 516:6 chronically 198:16 Cincinnati 1:13 14:1 circumstance 168:14 circumstances 287:5 citation 270:5 cite 91:20 99:20,21 100:14 269:20 282:12 cities 366:6 city 382:15 claim 245:10 262:4 claims 83:6 84:2,6 162:7 182:21	184:8 223:20 226:5,6 234:16 235:7 237:7,8,17 239:13 241:6 244:21 245:13 246:1 252:12 261:3 262:3 266:12 267:16 283:18 363:6 366:22 477:6 claims-based 81:22 162:21 220:8 234:7 235:10 236:5 260:15 477:3 clarification 106:14,21 119:20 155:18 182:12 222:19 372:8 384:20 408:5 409:13 453:18 468:2 472:1,12 clarifications 49:22 clarified 12:6 clarify 27:19 28:2 39:15 47:13,19 152:2 162:5 167:6 181:13 183:21 189:6 279:13 287:8 358:5 380:9 479:22 503:4,18 clarifying 119:18 clarity 165:17 459:22 class 223:3 275:16 449:7,8,9 455:3 classical 94:4 classified 69:22 classify 83:14 clear 55:5 77:6 121:7 173:15 265:3,12 298:9 323:3 353:16 375:18 376:18 377:8 387:12 395:18 408:17 416:1 455:17	468:17 clearly 81:6,11 142:21 152:10 205:6 225:17 312:19 327:12 387:5 396:21 424:7 442:15,18 494:9 495:15,21 502:21 click 111:14,15,16 111:21,22 clicker 111:10 clickers 111:12 521:8,13 clinic 210:7 322:18 clinical 19:9 20:11 46:20 94:13,21 101:21 123:21 165:8 184:6,11 206:14 232:22 251:12 302:15 305:20 320:19 486:8 501:15 clinically 98:20 109:22 clinically-oriented 42:17 clinicaltrials.gov 317:7 clinicians 101:6 clinics 251:16,20 clinometric 12:4 clock 139:12 205:9 close 88:8 113:21 125:5 237:13 336:2 433:21 closed 218:5,22 242:13 255:8 268:21 closely 52:20 88:5 closer 229:2 497:11 closest 397:13 closing 163:22 cluster 128:22 222:14 clustered 85:1 150:19
--	--	---	--	---

clustering 291:2	147:21 148:16	288:8,22 291:4	437:22 438:11,17	421:15,16,17
CMGs 143:21	153:14 155:6,11	292:2,21 293:12	439:5 443:7	code-based 257:1
144:6,14	156:11,14,22	294:3,20 296:2,17	444:14,19 446:1	coded 84:2
CMI 462:13	157:8 158:2	297:4 298:10,19	446:21 449:12	codes 82:21 353:6
CMS 60:15 118:16	159:19 160:6,13	299:11 300:2	451:10 452:20	414:14
130:22 131:10	164:9 165:21	301:18 308:15	453:1,13 454:2,9	coding 247:13
137:13 161:13	166:4,5,17 167:5	317:13,17 318:18	454:22 455:13	248:4 381:8
198:6 204:17	167:16 168:1	320:21 322:7	456:7,18 457:16	434:22
205:13,15 206:13	169:8,11 170:7,18	324:16 329:4,19	458:10 460:18	coefficient 180:14
220:5 232:7 244:2	171:16 172:4,12	330:13 332:9,17	461:14 462:7,10	180:19 263:4
246:6 255:5	173:13 174:18	336:16 337:4,6	462:14 463:1,3,8	458:21
256:19 261:10,11	175:13,17 177:10	340:17 343:19	463:16 464:22	coefficients 195:3
283:16 284:1	178:3,10,18 179:9	348:12,15 349:4	466:4 467:22	197:4 296:7
306:12 310:21	181:10 182:9,19	349:16 350:8,19	468:10,20 469:17	445:12
314:12 328:20	183:20 185:1,13	351:2,7 356:1,10	470:14,20 471:19	cognitive 206:14
330:10 345:4	186:15 187:18	357:22 358:2,8,17	472:21 474:5,14	231:22 510:7
352:18 376:22	189:10 190:14	359:12 360:5	475:2,19 476:1,6	519:22
388:4 431:12	192:13 193:9,18	361:2,13 362:1,11	476:16,19 479:14	cognizant 324:20
477:5 481:8,8	193:22 194:6	363:3,15,22	479:22 480:12	cohort 117:16
co-chair 1:12,12	195:1,14 197:2	364:21 365:9,11	482:15 483:16	coincidence 183:17
6:15,18 11:20	198:1,20 199:12	365:13,15 368:18	485:10,18 487:3,7	collaborative
13:1 20:2 24:8	200:3,20 202:5,14	370:18 371:20	487:9,22 489:9	353:11
25:7,8 30:14	202:22 203:13	372:7 374:1 375:7	490:19 491:3,7,16	collapse 144:12
31:17,21 39:13	204:3,11 205:17	375:14,16 379:2	492:9,18 493:7	colleague 418:18
51:20 53:2 54:18	206:21 207:21	380:8,16,21 382:5	494:16 495:8	colleagues 106:22
55:4 59:7 61:14	209:1,8 211:8	383:6 384:19	496:10,19 497:10	172:19 351:8
63:6 67:5,7,9,10	212:11 213:7,17	386:7,12 388:20	497:17 498:5,21	399:4 476:8
68:5 77:9 78:16	213:22 215:1	390:2,6,17 392:5	500:1 501:12	520:10
79:9,13 87:16,20	216:10 217:16	392:20 394:4,10	502:11 503:16,17	collect 59:21
91:9,13,15 93:17	218:8 219:2,11	394:20 395:3,5	505:6,14 506:1,22	177:21 220:2
99:6 101:10 103:9	226:17 229:14	396:7,10 397:18	507:14,16 508:9	231:12,18
104:9,18 106:12	233:18 234:11	398:2,16 399:1,3	508:17 509:6,18	collected 232:8
106:20 108:4	236:8 240:6 241:2	400:6 402:2,16,19	509:20 510:3,13	collection 49:18
110:11 111:20	241:7 242:7,15	403:2,5,12,21	513:3,8 514:3,9	60:17 61:3,10
112:2,7,13,19	243:11,20 245:12	404:8,11,19 406:2	514:19 515:7,17	199:3 222:16
113:6,13,17 114:2	246:15 247:10	406:22 408:3	516:10,18 517:12	224:9 232:7
117:3 118:17	248:9 249:3,8,15	409:11,12 410:4	517:14,18 518:5	432:17
119:11 120:5	250:4,15 258:14	410:11 411:3,6,14	518:17 519:3,11	collective 353:11
121:16 124:4	258:21 259:2,7	411:17 412:4,17	519:21 520:2,20	collectively 78:1
125:1,18 126:14	260:3 264:17	413:5 414:20	521:7,10	274:19
126:19 127:1	267:1,20 268:7	415:2,5,13,16	co-chairs 1:10 6:13	collects 231:21
133:13 134:12	269:11 271:16	416:5,13 417:5,8	8:2	College 13:9,15
135:22 136:20	272:5,20 274:10	417:20 418:11	coalition 463:22	16:11 66:19
137:7 139:13	275:18 276:1,8,21	426:13,17,19	Coast 19:18	colleges 66:20
141:14 142:14	279:12 281:17	428:14 429:9	code 246:2 376:9	collegial 33:22
144:18 145:19	283:11 284:16	431:17 432:8	376:14 378:3	color 381:8
146:13 147:9,16	285:7 286:18	433:12 435:7,14	380:20 416:11	Colorado 3:2,18

5:2,4 351:19 374:10 416:3,21 colored 34:15 Columbia 20:9 25:10 combine 86:10 277:15 combined 160:2 combining 309:9 come 12:14 24:22 42:5 55:6,6 59:2 60:16 62:13 78:16 86:19 88:9 94:15 100:5 116:11 123:7 124:5 127:6 127:11 142:15,16 147:8 149:15,17 150:9,10 203:17 207:15 228:14 235:4 243:9 262:8 298:12 302:4 322:3 326:9 327:3 354:13 359:13 365:20 372:8 385:12 408:14 448:14 459:15 475:10 480:18 489:20 502:2 506:14 509:13 comes 109:11 116:6 136:8 168:14 185:17 187:20 237:18 303:17 311:21 312:13 371:1 446:19,20 458:6 comfort 108:14 185:22 196:7 207:22 comfortable 196:11,15 206:18 221:1 223:18 467:11 494:2 comforting 289:6 coming 11:5 55:11 77:16 137:13 154:4 185:20	223:22 225:6,12 225:15 238:3 245:11 265:20 282:15 309:9 364:13 386:16 493:17 comment 5:19 35:7 37:3,18,22 38:2 45:7 103:10,11 104:11 118:18,21 120:6 142:2 158:22 159:6,10 159:20 165:2 166:10 167:17,19 168:3 172:15 176:7 190:18 192:15 193:10 196:17 200:6 201:1 209:4 210:19 212:21,22 213:11,13 217:1 226:19 227:4 234:20,22 239:8 250:18,20 251:2,9 251:18,19 266:6 299:22 307:9 317:18 322:8 325:3 336:22 342:4 347:16 358:1,19 383:10 391:2 392:19 399:5,5,14 407:3 413:6 417:19 443:9 458:11 475:7 476:2,5,7 476:10 479:15,20 479:21 480:1 491:17 497:18 515:9 commentary 258:19 332:17 commented 344:12 comments 6:10 26:9 34:19 35:10 35:11 37:6 38:5,8 40:8 43:5 45:9 50:13,17 51:8,18	53:7,16 73:6 74:2 90:13 93:17 107:20 108:3 110:9 119:10 121:18 125:18,20 134:13 136:2 137:5 145:20 148:1,5 149:10 157:1 166:2 169:8 171:12 172:13 198:2,4,21 199:13 200:3 217:17 219:3 241:18 242:16 243:21 247:12 250:5 251:6 258:16,17 264:19 271:16 272:6 276:4 283:12 288:9 289:2 291:5 292:22 293:13 297:5,10 298:21 306:8,17 308:18 309:1 317:15 324:20,21 329:3 329:21 330:14 332:11,21 333:1 344:6,8 348:16 349:5,16,18 350:5 350:9 358:2 359:16 361:2 362:1 363:15 364:22 389:5 394:8,22 396:8 397:2 399:6 402:4 402:17 403:3,13 404:9 411:4,14,18 415:3,14,21 417:6 426:15,21 428:8 429:10 435:15 438:17 463:2,4,16 474:15 479:18 480:4,6,8 482:19 483:17 485:11 492:9 493:6 496:11,20 498:22 500:2 505:6,14	506:2 508:10,17 510:10 513:5 514:11,19 516:11 517:19,20 519:4 519:12 commercial 231:17 Commission 64:18 committee 1:3,8 4:8 9:12,19 10:2,6 10:8,12,19,21 11:11,15 12:11,21 15:16 16:21 17:11 17:13 18:6 20:22 21:10,15 22:5,8 23:3,17 25:1,19 26:12,17 27:10,20 28:10,11 32:7 33:4,11,15 34:1,5 34:7,9 35:9,10 37:4,16 38:13,14 38:15,17 39:3,18 40:7 41:2,8,12,14 41:17,20 42:1,5 43:18,21 44:11,16 45:13 49:4 50:16 51:15 54:1 55:12 56:9,17,22 57:5 57:10 59:3 63:7 63:22 64:5 67:12 67:15,17 68:6,12 68:14 69:13 72:9 74:22 75:14 76:21 77:10,11,17,19 78:18 88:15,22 90:11 91:2 93:18 100:21 107:8 108:21 134:13 148:5 156:11 159:10 236:12 240:9 259:4,10 301:1 369:13 371:2 399:17 424:7 430:21 committee's 37:21 38:2 69:21 459:3 committees 9:10 13:11 15:10 26:20	28:7 39:14 49:6 68:20 74:21 75:3 75:7 79:15 300:12 301:14 399:22 common 50:19 88:22 93:6 137:14 196:22 220:17 226:21 227:21 Commonwealth 366:10,21 401:15 424:16 communicate 296:1 communicating 327:1 communication 109:6 265:13 339:15 communities 353:5 354:3,15,16,18 355:15 360:13 366:2,2,12 367:11 367:15,22 368:14 370:2 371:12 372:18 374:7,21 375:4,6 376:16 379:8 382:14 384:13,15 387:1 387:10 405:16 416:22 community 70:14 71:1 75:18,18 77:13 139:20 168:17 173:17,19 198:11 201:9,12 205:7,15 238:11 282:16 284:6 353:5,11,15 354:5 355:12,19,20 357:4 358:7 359:10 362:8 364:14 366:13 367:10,17 368:11 371:13,18 372:5 372:15,16,19 373:8,14,15 374:11 375:20,22
--	--	--	--	---

376:4,12,18	186:19 187:16	422:13 423:22	108:10 126:22	298:14 343:17
377:22 378:9,12	218:14 266:19	424:3 454:3,6,8	137:9 169:9 200:4	conflated 217:5
379:6,16 380:12	281:6 336:22	compliments 364:3	217:17 268:9	conflict 10:15 11:1
380:13 381:22	366:5,12 378:20	component 220:8	273:5 302:3	11:3,8 15:11
382:3,13 384:9	379:9 401:15	components 444:7	318:15 324:17	23:14,16,18 28:9
386:17 388:14	459:14	composite 12:9	375:17 384:13	conflicts 10:15
391:19,20 392:1	comparing 56:14	160:3	386:10 395:20	13:21 16:22 17:14
393:17,20 396:4	143:6 145:8	comprehensive	404:1 408:3	22:6 23:8 27:21
401:2,5,7 405:17	167:18 345:11	483:6	412:17 455:2	28:3
405:18 406:15	368:15 372:15	compressed 7:3	474:16 483:19	confounding 119:7
407:4 412:16,22	373:12 374:16,17	86:4	491:5 514:1	confront 387:7
413:2 436:21	376:7 379:6 434:8	compromise 461:5	concise 34:19	confronting 45:20
437:9 462:6 490:9	445:10,11,11	computation 451:1	141:18 286:20	confused 210:14
493:15 494:6	comparison 55:19	computed 48:1	510:4,11	297:1 385:6
502:3	269:7 368:2	computer 36:7	concisely 291:14	483:14 486:12
community's	434:11 452:21	computing 163:8	conciseness 7:5	confusing 188:12
198:15 368:15	comparisons 55:22	concept 117:8	concluded 521:18	297:10 384:21
community-based	195:12 381:22	189:17,20 305:6	conclusion 102:22	385:12 503:12
357:9,13 358:12	382:1,3	454:19	123:13 133:2	confusion 413:13
359:1	compel 310:16	concepts 189:15	415:18	413:22
comorbid 191:9	315:1,5 316:20	conceptual 46:15	condense 144:9	congestive 317:19
comorbidities	321:18 323:7	46:22 54:7,11	condition 72:1,14	318:16 337:16
162:15 176:9	compelled 455:7	58:4 105:12	72:14 82:12 215:7	451:18
262:1 266:16	compelling 102:7	110:17 125:10,14	condition-specific	Congress 387:10
423:21 455:22	170:12 321:21	174:15	341:13	connect 172:6
comorbidity	356:17 357:19	conceptually 76:19	conditions 42:4,6	connected 301:15
206:11	competing 157:19	107:22 155:10	46:12 72:16,17	connecting 98:19
companies 381:17	164:3 273:22	447:18 463:20	82:22 270:3 311:1	connection 99:2
487:14	275:21 342:8,10	464:20	314:18 318:7,8	cons 399:13
company 339:20	competings 273:2	concern 105:2	320:1,11 321:17	conscious 367:9
381:9,10	competitor 117:14	119:17 138:1	323:1 328:16,19	consensus 17:12
comparability	complaint 237:15	168:4 199:16,21	328:22 335:17	26:11 37:6 38:12
197:17 367:15,16	complement 235:9	205:21,22 248:3,5	341:2,8 424:5	39:2 45:12 51:1
461:5	477:5	267:12 289:14,21	511:13 516:6	51:15 159:18
comparable 167:3	complements	307:10 338:9	conducted 99:12	212:19 265:18
240:10	478:12,17	342:6 374:4	163:6,14 170:3	397:5 398:20
compare 12:21	complete 20:4	377:15 392:7	255:5 427:17	399:12 458:4
110:8 143:17	completed 34:7	398:11 440:15	496:22	consensus-based
272:14 291:18	45:7,14 221:18	491:12 516:19	conference 1:8	50:20
368:1,13 369:15	completely 40:3	concerned 90:7	466:6 474:2,3	consequence
372:18 374:18	135:6 146:21	93:22 119:3 265:7	509:7	142:12 200:2
391:6 401:16	341:9 348:4 359:3	277:6 282:1	confess 175:5	202:11 233:21
408:20 411:1	413:8,17 414:2	335:20 338:12	confidence 131:6,7	244:7
413:20,21 423:15	completion 222:2	381:4 434:13	145:3,12 153:5	consequences
478:11 500:13	complex 6:7 198:16	concerning 102:10	163:17 297:17	153:18 154:1,8
compared 56:11	202:1 335:18	155:13	426:8	155:8,9,14 156:20
127:20 170:13	complications	concerns 78:18	confident 183:4	185:3,9 186:6

199:20 206:1 212:1 245:19 381:6 385:1 398:11 400:3 424:2 518:8 consider 52:5 55:14,20 56:20 69:9 74:5 75:14 91:2 95:12 102:3 106:10 128:16 130:19 153:21 154:1 155:15 156:13 195:10 196:19 287:10 295:20 371:4 452:14 453:21,22 considerable 124:16 171:1 216:16,20 considerably 90:2 114:6 170:12 consideration 4:11 42:4 52:3 55:9 391:16 396:6 430:1 considerations 52:18 56:2 140:18 415:20 considered 33:14 58:19 63:5 70:12 71:20 75:13 156:20 167:8 193:12 195:18 209:12,13 210:18 230:1 235:3 308:11 451:6 492:3 495:20 496:8 considering 50:7 69:10 72:12 105:15 121:10 176:9 196:17 351:10 370:15 429:20 430:8 446:2 consistency 42:20 68:16 95:17 96:11	138:7,9 146:14,16 190:2,6 497:3 501:4 consistent 102:18 166:14 197:15 280:22 292:15 439:14 consistently 103:2 190:5 221:21 393:6 constant 445:18 constitute 15:11 172:18 constitutes 105:6 137:6 274:14 construct 165:14 289:4 365:21 366:18 constructed 252:5 constructs 370:7 consulting 11:14 consumer 21:12 199:22 276:6 294:9,10 295:16 296:1,20 Consumer-Purc... 2:5 consumers 297:1 contains 84:20 contaminant 207:1 207:3,7 contemplated 258:7 contention 513:16 CONTENTS 4:1 context 115:16 141:2 181:16 182:6 193:4 284:9 325:18 346:12 494:17 contextual 182:8 continue 63:2 159:3 212:20 265:2 300:16 351:15 396:22 407:18 430:4 443:13,15	continues 250:16 continuing 32:6 continuities 338:17 continuum 22:17 contract 321:11 477:5 contracting 364:8 contractor 239:3 364:9 contractors 12:22 contrary 203:6,7 contribute 34:21 49:10 302:6 contribution 458:22 control 252:11 307:16 311:14 317:21 319:2,12 327:12 337:19 367:4 368:5 372:15 373:19 431:15 436:19 452:6 486:5 controlling 373:5 376:15,16 controls 312:19 controversial 195:16 controversy 88:10 373:21 convenes 301:4 conversation 6:11 36:19 158:20 250:16 273:18 274:7 276:2 456:6 466:13 conversations 125:16 300:15 convince 116:9 convoluted 424:20 Cook 3:3 476:13,18 476:22 477:1 481:1,6 489:16 500:4 503:5 504:13 507:21 510:16 cool 465:22	coordinate 254:14 255:19 258:5 305:4 308:8 Coordinating 21:10 108:21 coordination 81:11 229:16 255:2 308:1 313:18,21 319:9 387:18 485:2 491:14 493:1 Coots 3:4 80:6,7 160:18,19 COPD 270:3 451:19 473:18 493:20 copy 79:6,8 285:21 core 60:16 corely 44:3 corner 113:18 coronary 253:4 495:7 corporate 19:22 352:4 427:16 corporation 13:6 15:7 correct 33:4,9 67:22 109:14 119:12 147:2 149:20 155:21 174:3 240:14 262:12 380:14 409:18 449:18 489:14 corrected 453:8 correction 360:15 correctly 94:12 200:19 507:18 correlate 407:6 correlated 401:22 422:9 423:6 correlating 442:9 correlation 138:9 138:10 180:14,17 180:18 181:5,9,14 181:20 182:18 188:13 195:3	197:4 257:3 263:4 289:8 292:4,17 404:6 406:8 422:18 442:11 515:11 correlations 187:21 263:7,9 292:12 correspond 240:22 cost 3:10,13,15 136:8,8 171:12 304:16 364:10 422:19,20,21,21 422:22 428:12 430:8 473:5 483:12 484:16 493:21,22 costing 159:22 costly 401:1 costs 318:6 331:5 422:4,10 423:1 430:22 Council 21:1 Counsel 2:13 4:5 9:9 count 142:10 187:3 208:8 351:3 408:17,22 409:22 412:16 counted 174:2 202:20 215:12 244:16 287:11 288:3 counter 76:7 counter-incentive 229:19 counterintuitive 513:20 counties 436:16 counting 186:21 country 61:20 214:18 215:21 216:17 224:3 225:11 231:11 304:21 366:3 369:4 387:1 388:6 counts 82:1 202:21 410:21
--	--	---	--	---

couple 51:2 61:16 61:19 87:21 90:21 137:8 139:21 216:4 232:15 313:1 315:6 340:21 399:11 453:2 466:6 499:2	32:17 34:13 42:3 42:7,18 46:3 48:17 49:3 52:14 52:20 57:12 58:20 58:21 79:4,5,16 98:5 104:19 105:3 107:11 113:4 119:20 140:1 155:1 157:15 159:5 203:20 204:18 206:13 212:9 250:9 266:9 266:10,21 268:4 290:3 293:4 299:2 299:8 326:20 348:7 349:8,19 390:11 398:5 411:19 415:6 438:15 441:22 444:11 469:4 470:15 501:18 508:11 519:5	current 14:11 18:20 46:2 51:4 60:2 150:11 164:2 170:3 255:20 258:1 266:19 311:12 314:18 315:14 317:3 333:4 457:4 489:17	144:10 148:2,4 152:13 162:7,10 169:3 170:2,22 171:20 177:11,12 177:14,16,17 178:1,2,4,8,9,9 179:2,6,22 181:8 182:21 183:15 184:8 197:18 199:1,3,4 207:17 208:4 216:1,4 220:1,6,13,19,21 221:4,5,7 222:3,8 222:10,13,16,22 223:4,7 224:9,21 225:3,20 229:8 230:8,11 231:1,6 231:7 232:7,14 235:21 236:18,20 236:21 237:16,17 237:20 238:7,12 238:21 240:9,16 242:18 243:5 244:15 245:14 246:3 248:17 249:11 252:12 253:19 254:12,13 255:11 256:19,21 257:1 258:4 263:21 266:19 269:3,5,19 273:16 277:15 281:11,22 282:7,14,20 283:14,18 363:6,8 363:13 365:20 366:22 367:1,7,14 387:2 389:9,16 395:15 425:14,17 425:22 426:1,2,3 432:17 434:22 436:14 440:4,6 449:3 450:11,18 456:8 464:14,21 465:13 467:4,5,12 472:17 473:1,15 473:18 474:4 478:10 483:7,11	504:6,12 506:17 database 237:8 databases 16:4 date 124:15 156:9 311:3 dates 35:18 183:10 183:15 daunting 77:17 David 3:6 214:12 Davis 419:16 DaVita 251:13 311:20 day 4:19 6:19 45:7 95:3 138:15,18,21 139:4,4,6 159:15 176:16 183:16 209:22 210:4,15 265:2 268:6 286:1 290:5,12 384:7 400:16,20 423:13 423:14 434:3 449:17 452:11 456:15 477:22 510:5,21 days 4:12,15 5:12 5:16 6:7 62:8 68:3 80:15 81:5 158:7 160:15,22 162:4 166:11,16 167:15 173:21 174:10 176:10 177:2 183:22 196:13 203:11 207:15,18 209:12 211:6 212:15 215:8,11 231:13 231:19 234:1 245:6,7 254:2,3 260:22 261:2 262:10,11,14,16 262:18,19 267:3,8 267:10,19 303:7 304:11 313:1 315:6 344:17 345:15,17 364:4 400:13 407:12 408:9,17 409:4					
course 9:2 27:21 36:22 39:8 59:17 81:15 92:11 115:1 115:3 123:1 134:7 156:6 282:20 306:13 312:6 379:13 423:10 437:7 446:11	212:9 250:9 266:9 266:10,21 268:4 290:3 293:4 299:2 299:8 326:20 348:7 349:8,19 390:11 398:5 411:19 415:6 438:15 441:22 444:11 469:4 470:15 501:18 508:11 519:5	currently 15:6 37:12 44:15 45:6 48:17 52:1 55:10 57:18 60:12 64:14 70:1 71:12 120:16 164:8 195:16 215:22 232:5 304:19 344:14 383:11,22 394:7 478:17	220:1,6,13,19,21 221:4,5,7 222:3,8 222:10,13,16,22 223:4,7 224:9,21 225:3,20 229:8 230:8,11 231:1,6 231:7 232:7,14 235:21 236:18,20 236:21 237:16,17 237:20 238:7,12 238:21 240:9,16 242:18 243:5 244:15 245:14 246:3 248:17 249:11 252:12 253:19 254:12,13 255:11 256:19,21 257:1 258:4 263:21 266:19 269:3,5,19 273:16 277:15 281:11,22 282:7,14,20 283:14,18 363:6,8 363:13 365:20 366:22 367:1,7,14 387:2 389:9,16 395:15 425:14,17 425:22 426:1,2,3 432:17 434:22 436:14 440:4,6 449:3 450:11,18 456:8 464:14,21 465:13 467:4,5,12 472:17 473:1,15 473:18 474:4 478:10 483:7,11	cousin 80:11 covariate 263:1 covariates 119:1 cover 116:18 447:12 coverage 60:4 177:20 235:16 311:1 314:19 320:1,11 321:17 323:1 328:16 covered 90:20 261:8 336:19 CPHQ 2:5 crazy 450:22 create 274:19 308:9 357:12 413:22 created 323:22 creating 186:5 323:11 credentialed 321:9 321:15 credentialing 321:6 credible 91:3 107:16 114:14,16 156:17 211:19,21 Cristie 2:8 17:6 31:11 73:11 193:9 193:19 300:20 301:17 457:16 471:21 criteria 26:3,4	criterion 79:18 90:18 104:22 112:20 155:3 165:19 309:2 356:4 critical 351:16 376:17 critically 339:1 criticize 228:15 cross 14:8 134:16 139:8 cross-cutting 75:6 179:11 cross-map 256:22 crosses 132:12 crummy 279:15 CSAC 26:11 35:14 53:21 58:18 59:6 159:12 curiosity 415:19 curious 58:22 73:11 76:6 119:8 139:2 176:13 272:10 284:3,17 415:16 513:15	cut 418:1 520:7 cutoff 278:15 449:20 cuts 244:1 cutting 134:17 cycle 40:11,14,16 41:18 186:2,6 409:6 cylinders 510:8	curve 129:2 cut 418:1 520:7 cutoff 278:15 449:20 cuts 244:1 cutting 134:17 cycle 40:11,14,16 41:18 186:2,6 409:6 cylinders 510:8	D D.C 1:9 21:8 336:1 Daeman 66:19 Dallas 482:6,9 danger 129:21 darn 469:20 Dartmouth 381:6 389:9,20 393:1,3 395:15 data 2:3 49:18 54:17 60:2,11,16 61:2,10,12 63:2,3 63:17 66:7,13,16 83:6,7 84:1 86:9 88:2 102:6,9 114:15 126:2 127:5 133:8 139:8	database 237:8 databases 16:4 date 124:15 156:9 311:3 dates 35:18 183:10 183:15 daunting 77:17 David 3:6 214:12 Davis 419:16 DaVita 251:13 311:20 day 4:19 6:19 45:7 95:3 138:15,18,21 139:4,4,6 159:15 176:16 183:16 209:22 210:4,15 265:2 268:6 286:1 290:5,12 384:7 400:16,20 423:13 423:14 434:3 449:17 452:11 456:15 477:22 510:5,21 days 4:12,15 5:12 5:16 6:7 62:8 68:3 80:15 81:5 158:7 160:15,22 162:4 166:11,16 167:15 173:21 174:10 176:10 177:2 183:22 196:13 203:11 207:15,18 209:12 211:6 212:15 215:8,11 231:13 231:19 234:1 245:6,7 254:2,3 260:22 261:2 262:10,11,14,16 262:18,19 267:3,8 267:10,19 303:7 304:11 313:1 315:6 344:17 345:15,17 364:4 400:13 407:12 408:9,17 409:4

410:22 412:15 433:16 434:15,21 440:13 450:17 452:1,1,3,4,9,18 452:18,18 453:4,5 453:9,10,14 456:15 460:10 462:2,4 471:17 477:12,15,18 490:1 496:3 509:4 518:22 519:19 dead 189:11 249:13 deal 10:2 28:2 94:3 115:12 118:14 143:7,10 184:12 305:7 307:12 331:20 401:5 434:5 494:10 516:5 518:13 dealing 81:7 137:2 152:19 194:20 dealt 74:20 208:4 345:14 496:7 death 183:6,10,14 400:18 deaths 224:13 debate 139:10 286:12 Deborah 3:5 475:17,20,22 486:22 487:3 488:1 debridement 141:10 decent 366:17 515:21 decide 130:22 248:18 275:20 369:10 decided 265:22 356:14 deciding 45:10 decile 116:18 257:6 280:16,17 deciles 56:14 116:18 decimal 450:12	decision 49:9 68:16 159:12 184:20 202:12 236:20 367:9 459:20 486:10 decision-making 185:19 186:4 decisionmaking 261:16 decisions 38:2,17 77:4 93:12 184:6 184:15 185:11 266:15 486:17 487:13 502:9 518:14 declare 148:20 385:11 declared 130:1 394:6 decline 70:15 71:4 230:15 233:1,1 407:17,18 424:17 declining 290:11 default 205:9 defeat 229:18 defending 318:12 defer 332:6 491:6 define 375:22 380:4 423:10 493:11 defined 230:16 234:8 345:13 353:3,5 355:2 407:5 427:7,8 438:14 defining 315:22 316:15 375:19 377:12 379:22 428:21 definitely 25:13 62:22 63:4 234:14 280:18 343:15 429:21 432:3 470:6 definition 165:7,18 256:17 355:13 433:14 494:13,22	definitions 60:17 274:16 degree 109:10 115:10 142:12 168:6 265:4 344:18 delay 412:13 deliberation 74:6 159:10 deliberations 37:16 37:21 40:7 137:19 delighted 29:11 delineate 280:6 deliver 189:1 delivered 486:18 507:11 delivery 65:6 demand 54:22 demographic 48:5 49:15 55:15 162:12 262:2 432:1 demographics 373:16 demonstrably 139:19 demonstrate 99:9 103:16 262:20 382:18 469:21 demonstrated 96:3 124:15 126:3 163:3 170:22 171:20 211:20 330:10 345:7 469:7 demonstrating 103:17 373:4 demonstration 99:12 342:3 473:14 denominator 85:10 85:13 215:19 278:12 287:20 288:1 303:15 342:17 346:4,9 347:20 354:2,8 357:12 361:1	375:19 401:4 506:19 510:22 Denver 380:18,20 department 5:10 16:8 62:13 284:3 477:10,16,21 478:1,19 479:11 493:11 494:15 502:7 509:3 511:10,18 departure 79:15 depend 157:18 dependent 228:13 254:18 depending 45:16 86:4 183:17 274:8 284:9 459:5 503:22 depends 195:4 298:5 446:10 467:9 493:10 depiction 70:11 derivatives 66:12 derived 131:16 descent 441:21 describe 159:16 214:9 215:2 382:12 481:2,5 described 154:11 231:1 325:11,21 392:22 398:12 401:12 describes 325:20 describing 216:9 229:13 445:22 495:12 description 153:17 214:2 221:6 356:3 356:7 descriptive 444:2,3 deserts 391:10 designated 32:22 designed 261:10 264:6 368:17 420:21 421:13 desirable 198:7 desire 73:15 185:18	desires 230:12 despite 254:14 255:1 262:18 destinations 282:19 detail 216:9 347:17 detailed 441:14 details 307:7 434:19 detect 177:15 detected 176:2 deteriorating 511:15 determination 120:19 determine 104:16 185:17 233:6 291:20 determined 449:21 determines 377:21 develop 314:21 327:15 449:14,14 458:3 developed 219:22 239:10 367:2 368:11 400:21 477:7 498:11 developer 13:14,17 33:14 41:6,12 55:10,17 57:14 78:19 96:19 114:4 118:18 137:17 161:4 202:8 205:19 207:12 260:8 322:9 334:15 337:5 339:3 340:19 351:19 358:20 364:3 418:14 452:14 460:4 480:19 487:1 500:2 509:12,22 510:11,15 515:12 520:6 developer's 173:6 developers 32:12 32:18 33:1,7 34:2 34:5 53:1,7 54:22
--	---	--	--	---

55:2 56:4 69:17	310:6,15,20,22	different 10:16	153:12 263:13	disabilities 143:1
78:14 119:9	311:13,16 312:2,4	13:11 44:12 52:17	differentiating	143:12
121:17 138:5	312:7,10 313:7,22	52:18 63:14 82:11	121:13 244:12	disadvantage
168:4 180:6 203:5	314:1,8,14 315:16	84:3 85:9 92:22	differently 145:13	134:22 457:2
207:9 208:3	316:4 319:2,21	109:18,19,20	453:2	disagree 328:4
265:15 273:13	320:3,17 321:10	110:3,4,8 115:6	differs 236:5 482:2	disagreement
289:4 301:20	322:11 323:10,13	116:22 123:10,12	482:14	476:20
302:5,10 313:8	323:15 324:5	130:10,14,15,17	difficult 121:1	disappointing
316:5 343:21	326:7,9,12,15	131:19 132:19	255:2 335:5,11	191:4
351:22 405:14	327:14 328:9	133:2 143:9,15	401:2 455:10	discharge 4:12,15
406:22 416:9	333:3,9,10,15	147:2 150:15	458:15 464:21	70:22 80:15 81:6
475:6,10	334:3,4,5,8,11,19	167:1,2 169:4	482:11	96:2 98:18 109:9
developing 20:15	335:7,12,19 336:2	179:13 184:18	dimension 104:5	158:7 161:13
47:6 66:11 105:21	336:3,6,18,21	190:8 204:18	123:18 428:11,12	162:4,5 167:12
477:3	337:2 338:11	206:8,13 210:22	428:13 433:11	168:15 183:7
development 57:22	339:11,21 340:2	235:7 245:13	dimensions 109:5	198:8 203:10,11
94:21 106:3 220:4	341:22 342:11	253:16 256:5	dinner 31:18	208:11,15,15,16
261:18 402:10	344:14 345:18	265:18 267:8,9	520:19	212:16 215:12
deviation 58:21	346:12,18 347:19	271:11 272:11	direct 15:15 201:18	221:17,20,22
89:10 144:22	350:17 397:7	279:5,21 287:5,6	270:12 305:9	224:14 248:14
deviations 360:20	495:19	291:9 292:1	511:5	254:19,21,21,22
diabetes 370:17	dialyzed 347:22	294:19 297:12,13	directed 6:10	261:1 262:4 267:4
493:21	die 183:3 221:16	297:15 301:6	direction 245:21	267:11,22 282:18
diagnoses 83:8	dieticians 309:21	303:10 308:22	292:20 295:13	290:10 304:9
144:4 162:13	Dietz 3:5 475:17,20	310:10 312:11	405:18 424:9,22	305:15 306:3,5
177:1 262:1	475:21,22 486:22	314:3 319:21	directions 26:10	308:5 310:17
451:17,21	486:22 487:6,8	324:5,5 327:16	130:4 230:10	311:22 312:10
diagnosis 141:3	488:3	335:8 337:3	232:13 241:19	313:1 319:9 324:2
421:15,16 442:21	difference 114:12	338:13 339:11	289:8	339:5,22 345:17
451:17 507:1	115:18,20 217:9	340:14 341:1,9	directives 186:13	377:4 378:15
diagnostic 226:8	345:22 364:16	347:2,14 368:14	directly 24:4	380:14 400:13
diagram 76:8	382:12 387:20	369:4 376:10,14	138:20 174:19	401:8 408:18
133:16	485:6 491:18	389:15 390:7	175:11 198:13	432:12 436:18
dial 39:21	493:16 494:14	395:12 396:3	201:11 225:7,14	456:13 462:3
dial-in 40:3	499:12 504:14	398:15 411:1	252:17 268:1	477:15 485:1
dialysis 4:21 19:1	506:18 518:22	413:9,17 414:2	305:12 309:4	490:1 493:13,14
73:2 251:15,20	differences 33:22	415:17 419:1	434:8 449:2 485:7	494:8 495:16
252:11,17 253:1,3	87:1 103:21	422:19 423:2,5	director 2:15 4:3	500:20 502:8
253:9,16,21 254:5	127:18 133:4	431:8,21,22 432:6	9:3 13:7 14:13	discharged 93:3
254:6,9,11,14	134:5 188:4	433:3 451:4	18:19 20:1 66:9	138:16 142:8
255:6,8 256:2,21	197:17 225:22	455:12 473:14	309:22,22 310:15	161:21 173:16
256:22 257:12,18	273:15,16 290:8	484:2,5 490:12	319:19,20 324:10	174:21 175:20
302:12 303:3,5,8	347:12 384:13	499:11 500:5,6	324:11 325:8	186:18 201:3
303:12 304:2,7,20	405:5 461:12	507:8	327:13	202:17,18 208:9,9
305:9 307:16	500:11 503:20	differential 104:12	directors 38:16	231:20 232:17
308:2,22 309:8,12	506:8 510:1	387:13	323:5,6	282:16 303:4
309:18,19 310:2,3	512:15	differentiate 62:16	Dirksen 484:16	324:13 333:9

377:18 380:18 489:21 500:7,8 discharges 162:8 184:4 221:16 224:12 225:8 258:3 303:18,19 323:19 335:13 339:7 346:6,8 353:19 389:10 401:4 440:5 discharging 98:20 106:15 303:21 483:3 disclose 9:17,22 10:4 11:1,7,10,19 15:4 17:5,15 21:15 64:5,21 65:21 66:2 disclosure 4:4 9:6 11:2,13 23:14 64:4 67:3 disclosures 9:11 10:14,15 18:16 21:9 23:1,11 24:5 discomfort 117:21 118:5 211:10 discover 223:10,16 discovered 434:17 451:7 discrepancy 183:9 discriminate 163:20 179:20 188:9 291:21 329:16 504:4,10 discrimination 163:10 179:19 262:21 289:11 441:7 504:21 discriminatory 87:4 discuss 13:19 24:7 101:12 107:19 155:3 187:8 216:13 286:19 302:5 discussant 87:19 214:1 483:19	513:4 discussants 164:14 166:8 308:17 351:21 418:17 discussed 62:19 73:14 80:18 102:11 164:16 166:11 170:14 277:5 306:11 307:2 448:13 449:17 480:1,6 497:1 510:2 511:1 516:21 discussing 80:4 179:15 221:5 305:11 380:3 444:21 477:10 478:14 510:18 discussion 32:14,16 33:2,6,21 34:8,16 34:20 37:17,17 42:14 43:4,10,12 43:19,20 50:15 51:18 52:22 55:7 73:12 79:1,20 87:15 91:6 107:5 120:4 164:13 186:5 216:14 219:12 257:14 259:5 260:9 261:7 261:9 273:3 274:3 274:9,13 275:14 280:7 286:4 288:13 299:12 300:3,11 301:19 307:12 308:14 356:11 358:16 359:13 365:18 368:7 383:7 385:14,15 395:6 399:13 439:9 455:9 474:6 475:15 480:15 discussions 28:13 125:15 241:18 243:10 294:8 351:16 369:12	390:19 399:6 520:4,7 disease 144:12 252:21 253:4,8,20 253:22 405:7 473:15 dislike 116:17 disparities 47:21 48:6,21 52:15 61:11 235:12 405:2,8 456:22 disparity 185:5 382:19 405:9 493:4 display 378:18 displayed 384:14 disposition 198:18 disproportionate 63:9 distance 449:5,6 455:2 456:12 distaste 117:21 distinction 12:4 383:22 distinctly 93:10 distinguish 188:11 206:5 494:4 distractions 34:17 distributed 129:1 172:7 distribution 47:9 116:13 128:15 132:4 152:21 163:12 170:11 280:21 285:10 290:21 420:14 450:16 479:3,7 distributional 89:8 89:13 128:9,17 129:22 distributions 86:20 129:12 district 222:13 Ditto 6:18 divide 85:8 121:10 divided 84:16 355:8 400:14	DNA 122:20 DNP 1:16 doable 176:18 390:4 doc 490:11 doctor 320:4,12 321:19 doctor's 322:17 doctorate 66:22 doctors 336:4 512:2 document 34:15 55:16 149:10 439:12 441:16 443:16 453:3 documentation 245:16,20 247:20 453:9 documented 227:12 documents 453:13 dodgy 189:3 doing 10:22 39:8 39:11 48:8 60:15 61:11 87:10 95:2 115:22 118:1 121:3,4 136:14 144:1 149:16 150:10,12,21 180:8 187:6 224:18 246:8 281:7,8 313:11 333:19 372:17 373:6 385:10 387:9 388:2 394:2 420:9 421:8 434:4 434:18 450:9 460:9,10 463:6 465:15 489:2 518:9 dollars 478:2 domain 468:3,4,14 472:13 dominating 34:20 doohickey 131:18 door 93:2 109:4 doorstep 228:19	double 203:1,4 doubt 136:13 306:13 downward 471:6 Dr 13:22 14:12 15:5,17 16:6,15 18:10,17 19:4 20:8 21:16 22:10 23:6 24:19 28:4 29:9,17,22 30:4 30:10,12,15,17,19 30:21 31:1,3,5,7 31:15 36:2,4,10 50:5 54:4 59:8 61:15 65:16 66:1 66:5 73:9 74:7,19 75:15 77:18 80:3 80:8 92:2 93:19 97:5 98:8 99:4,7 100:1 101:11 103:10 113:7 114:22 117:6 118:20 120:11 121:21 128:19 133:17 134:15 139:6,15,21 140:7 141:22 142:19 143:18 145:9 149:12 150:2 152:1,12 153:15 154:9 155:17 156:5,15 159:22 164:15 165:4 166:18 167:10,22 168:5,22 169:21 170:15 171:9 172:9,15 173:6,14 174:3,10,12,13 175:1,5,22 176:4 176:15 177:13 178:7,13,20 179:10 181:4 182:11,20 183:6 184:2,3,7,10,13 186:16 187:3 190:13,15 191:2 196:16 198:5
--	---	---	--	--

200:5 202:15	330:4 331:2,17	492:20 493:8	dummy 262:15	educational 250:17
203:7 204:5,12	332:19 336:17	494:19 495:10	dying 185:6 187:15	effect 85:7,11 132:3
206:2 207:14	338:21 340:21	496:21 497:13		132:17 221:9
208:2,7,17,19,20	342:22 343:22	498:7 499:2 500:4	E	280:2,5,8 316:18
208:22 209:3,19	345:5,12 347:15	501:13 502:12,19	e 199:3	416:3 424:10,11
210:1,11,20 211:1	348:13 352:2,7	502:21 503:5,9	earlier 74:4 128:2	424:11 508:3
213:2 214:12	356:6,13 358:10	504:13 506:3	129:5 265:1 277:6	effective 104:17
215:3 216:15	358:14,19 360:7	507:3,15,17,21	281:14 290:4	132:14 266:18
217:1 218:10,12	361:15 363:5	510:16 513:6,10	306:17 325:4	343:8
219:15,21 221:3	364:2 365:14,16	515:9,18 517:7,16	384:6 447:13	effectively 208:11
221:12 222:18	368:10,20 371:21	518:7,19	495:2 513:15	208:12 425:7
223:4 224:8 225:1	374:20 375:8	draconian 259:9	early 149:2 313:11	443:12
225:4,10 227:5,18	377:10 379:10	draft 35:12 50:7,13	333:7,12 340:13	effects 134:9,10
228:9 230:20	380:15,17 381:1	drafting 35:5	344:10	253:7 261:21
232:15 233:4,20	384:5 386:9,13	dramatically 61:21	easier 314:9 331:19	424:8
234:4,12,19	389:7 392:19,21	228:20 328:12,21	easiest 118:7	efficiencies 68:18
236:10 237:4	395:1,7 399:9	draw 29:3 133:1	easily 33:3 150:5	efficiency 428:4,9
238:20 239:2,9,14	400:9 402:6 404:3	483:5	164:8 344:16	428:22 430:8
240:3,15 241:4	404:21 406:3	drawn 356:18	381:8 425:21	451:15 452:16
242:17 243:22	407:2 408:7,15	357:16	easy 122:9 182:22	efficient 421:12
244:20 245:22	412:6 413:6 414:6	DRG 421:19 425:8	290:22 379:11	452:2
247:12 248:10	415:1,22 416:8,10	500:19	413:19 423:8	effort 39:10 121:5
249:7,10 250:21	416:15 418:21	drill 423:4	506:19	383:3
251:10,11 258:14	426:16,18 427:13	drilldown 387:17	eat 259:5	efforts 27:17
260:11 264:21	429:4,11 430:6	drive 229:9 238:6	eaten 259:11	255:18 520:3
266:8 267:13	431:7 432:20	329:18 474:4	echo 296:19 325:3	egg 61:8
268:2 269:1,22	433:13 434:6	driven 388:15,15	echoing 236:11	eight 17:21 158:5
270:18 272:8	436:4,13 437:20	428:20	economic 455:17	256:5 330:22
273:1 277:2,12	439:17 441:6	driver 204:21	Economics 17:3	333:22 386:5
278:21 279:18	442:6 445:15	405:8	419:16 484:17	452:1 466:12
280:1,8,10,11	446:9 448:9 449:8	drives 329:9	economist 194:6	469:9 510:14
281:3,18 282:11	450:2 451:12	driving 423:20	economists 427:21	Eighteen 148:14
283:13 285:2,9,16	452:22 453:7,17	425:4 431:5 454:5	ED 271:13 284:10	either 25:20 29:6
286:22 287:7,15	454:7,13 455:14	484:13	484:15 490:8	78:3 98:22 173:19
287:17,18,22	456:8,19 459:11	drop 222:9	491:10 492:21	174:8 177:15
288:5,6 289:3	460:12,17 462:8	dropped 406:15,17	493:1 494:5	183:9 188:19
290:1 291:16	464:1,5 465:5,8	407:13 470:3	502:15,16 512:12	190:9,10 205:18
292:14 294:5,21	465:19 466:19	drops 266:21	513:17	213:6 284:4
296:3 297:9	467:1 468:1,5,6,7	drove 402:10 406:5	ED's 489:14	345:13 448:22
298:18 302:14,18	468:9,11 469:11	drum 94:2	edge 495:3	511:5
306:18 308:20	470:4 471:4	dry 27:5 41:8 57:11	editorial 305:20	El 366:3
311:19 318:20	472:16,22 476:13	63:11,18 255:5	313:9	Elect 64:16
319:14 321:1,13	476:18,22 480:17	304:19	Edmundson 1:18	elected 90:9 233:4
322:9,13,22	481:1,4,6 482:21	dual 59:13 60:4	14:12,13 30:21,21	238:4
324:16,19,22,22	483:21 485:12,22	89:14 90:4,6,9	202:15	electronic 199:2
325:6,19 327:17	487:10 489:12,16	duck 76:10	education 59:19	432:13
327:22 329:3,7	490:6,15 491:6,9	due 252:19 253:7	200:13 488:21	element 45:4 222:9

223:5 384:2 elements 27:3 199:5 231:7,7 273:16,18 Eleven 160:6 eligibility 60:4 61:21 83:6 90:4,6 90:9 142:21 162:12 205:2 223:14 eligible 89:14 138:18 501:18 eligibles 59:13 eliminate 178:7 373:21 Eliot 25:8 Ellen 97:13 else's 423:16 486:8 email 418:8 embark 475:14 embed 255:17 embodied 78:1 emeasures 65:14 emergency 5:10 19:6,10 61:18 62:13 175:19 186:1 284:3 477:10,16,21 478:1,18 479:11 493:11 494:15 502:7 509:3 511:5 511:10,18 512:2 emerging 186:11 emphasis 49:15 138:8 emphasize 420:20 460:2 490:9 empiric 54:7 238:21 empirical 46:15 47:4 54:10 58:3 155:7 443:20 empirically 63:17 empiricism 364:6 employed 67:3 employer 10:10 17:9	employment 59:19 321:11 employs 338:3 empower 311:13 enabling 469:5 enacted 254:15 enactment 255:21 encompasses 59:10 encounter 320:19 323:12 494:5 513:12 encountered 254:4 encounters 494:15 507:22 encourage 186:3,4 200:17 264:14 295:19 305:3 382:11 444:4 452:19 ended 248:16 424:19 520:5 endorse 35:15 108:9 117:8 149:22 endorsed 37:13,14 49:21 52:8 53:20 57:3 58:15 69:19 70:1 145:5 155:22 300:12 319:5 384:9 420:3 429:17 431:6 458:17 466:11 477:8 503:9,11 endorsement 26:8 57:5 70:6 98:5 120:8,10 121:12 121:14 142:17 154:5,20 155:4 156:8,8 157:14,16 157:17,18 212:8,9 250:8,9 274:5 291:18 299:12 350:6 394:21 396:13,16 417:11 417:14 430:1,5 474:18,21 508:21 509:2 519:14,18	endorsements 325:1 endorses 383:20 energy 74:14 enforcing 436:3 engaged 34:16 England 22:15 94:5 enhancements 158:15 enrollees 389:11 ensuring 34:6 entangled 494:20 enter 112:11 476:1 entertaining 364:13 entire 80:13 216:3 457:18 490:3 entirely 145:12 325:5 436:19 entities 17:21 110:19 entitled 395:22 entity 10:11 95:15 108:5 358:9,11 383:16 enveloping 55:21 environment 60:2 240:13 425:8 484:6 488:22 epidemiology 3:10 3:13,15 66:22 episode 231:20 460:10 episodes 166:14 460:7 episodic 309:17 equal 11:3 304:5 equalizer 383:1 equally 168:15 240:10 equating 174:15 equation 85:20 equivalent 136:11 ER 201:5 225:15 242:22 243:1 ERF 211:4	Eric 427:10 err 495:17 error 127:17 132:18,21 144:21 145:6 189:17 434:22 445:4 446:3,3,14,19 484:19 errors 123:8 145:11 446:7,9,11 escalate 487:14 escalated 511:22 escalation 511:21 especially 24:21 61:7 62:20 102:8 195:13 202:1 234:2 279:9 425:8 460:21 ESRD 251:16 252:4,12 257:22 258:6 essentially 42:6 62:3 180:8 332:3 467:4 establish 426:7 established 152:10 324:14 establishing 66:10 104:20 estimate 84:17 85:7 127:8 163:17 188:3 269:12 298:14 446:4 estimated 152:20 estimates 127:4 134:20 135:15 161:18 163:15 260:16 279:14 441:18 445:9 estimation 88:1 129:17 estimations 88:14 estimator 86:13 132:21 145:14 estimators 134:16 134:19 135:1,6,14 et 94:6 316:5 337:7	337:8,8,13,13 338:6,6 392:15 416:4 etcetera 39:22,22 49:11 73:3 114:16 120:9 146:15,15 147:8 ethnic 405:2 EUGENE 3:11 evaluate 26:2 33:16 55:8 79:4 163:2 327:3 443:13 444:11 459:17 evaluated 142:3 163:8 262:11 evaluating 57:11 180:22 454:20 evaluation 4:6 12:1 32:17 33:11 34:11 34:12 35:22 42:15 43:7 58:19,21 73:7 95:6 96:10 96:16,21 137:21 137:21 159:4 273:8 438:15 event 174:4 194:2,3 194:17 209:13 233:22 408:18 events 233:22 everybody 6:20 8:1 8:3 13:2 20:8 24:20 46:6 82:15 113:3 114:20 115:20 150:18 153:8 187:17 292:1 295:5 297:19 309:16 351:6 355:12 414:3 486:8 504:1 509:15 everybody's 122:19 192:7 everyone's 6:9 108:9 510:5 evidence 37:14 40:12,13,18 42:19 42:21 86:5,6 88:2
--	--	---	--	--

91:7,17,17 92:1,3 93:6,22 95:2,7,8 95:18 96:7,10,12 96:16 97:4,7,12 98:11,14,15,16,22 99:13 100:3 101:7 102:2 103:4,17 104:15 105:1,3,7 105:21 106:2,10 106:11 107:1 108:17 110:14 112:17,20 127:6 129:5,18 133:7 134:8 153:16,17 153:20 154:2,19 155:7 164:18 165:8,9,12,18 166:1,3,20 169:2 169:9,14 184:4 197:15 211:22 216:13 217:2,17 217:20 264:20 265:3,6,8 268:13 268:15 269:19,20 271:15 292:13 305:5,9 308:16,19 309:4 315:9,21 316:16,22 317:16 318:3,4,11 329:6 329:21,22 330:3 356:11,16,18 357:16,20 358:21 358:22 359:5,15 359:21 360:3 402:5,9,17,20,21 403:1 426:22 427:3 428:18 429:10,14 435:8 435:10,12 441:2 473:22 480:16 482:16,20,22 483:7,15,22 484:9 485:11,14,17 486:1,4 490:18,20 490:22 491:2 504:4 513:5 514:4 514:5,7	evidence-based 100:17,19 evolution 82:18 173:11 evolve 61:13 63:1 69:16 173:10 evolving 61:5 ex 460:11 exactly 58:7 95:1 101:3 103:6 121:8 139:15 144:11 146:20 197:2 203:7 313:9 318:14 385:6 388:4 389:22 407:6 441:4 445:9 475:9 examine 51:12 examined 53:6 173:1 examining 181:1 example 39:17 41:3 59:17 94:20 98:16 100:14 105:13 119:13 144:21 146:18 152:5 163:6 184:16,21 188:20 200:14 206:17 212:17 228:17 265:14 304:6 316:8 323:17 340:11 357:1,14 367:12 371:6 392:10 439:20 504:5 examples 61:20 exceeds 94:19 excellent 25:13 276:21 305:19 393:2 396:10 404:4 exception 289:9 473:4 excessive 437:1 453:10 exchanges 62:11 exclude 82:10	179:8 236:14 237:2 239:4 278:5 287:3 450:1 508:2 excluded 82:13 138:15,22 139:5 139:14 140:22 174:20 177:19 208:18,20 209:2 219:17 290:6 412:11 433:18 460:12,16 501:3 504:17 507:19 excludes 501:7 excluding 282:3 450:3 exclusion 82:6 139:22 142:4 263:18 266:4,5,7 266:9,10 268:4 290:3,12 460:9,15 499:3 exclusions 82:4 147:7 162:9 197:15 215:20 239:6 289:15,18 348:8 498:14 501:10 executed 432:15 exercise 74:11 exert 307:17 exist 63:2 373:4 existed 54:20 490:17 existing 148:3 355:3 490:2 exists 96:12 165:15 307:20 388:12 exogenous 422:16 expand 354:16 expatiating 183:14 expect 27:9 38:5 42:11 55:1 57:19 93:2 99:8 133:6 173:8 182:17 192:19 193:7 283:20 285:17 422:9 423:4,6	424:9 426:11 446:19 470:6 expectation 94:14 303:22 431:3 expectations 32:4,5 expected 33:16 34:2,9,11 80:21 84:16 263:8 279:13 289:8 294:12,12,13 303:16 383:20 442:10 470:17 478:7,7,8 479:3,6 479:7 481:15,17 481:19,20 482:2,4 482:7,14 491:19 497:5,6 499:13 504:2,9 513:1 expected's 512:13 expecting 83:1 194:16 expend 255:18 expenditures 478:3 experience 14:6 124:3 253:20 270:21 325:8 353:2 451:3 483:3 486:8,9 501:15 experienced 500:18 experiment 342:1 expert 2:4 10:9 13:19 45:8,18 46:7 47:19 51:11 53:17 60:10 61:4 62:19 82:17 140:13 267:5 286:3 302:7 332:6 456:3 experts 108:11 184:12 286:8 expired 183:12 explain 97:15 194:7 423:18 445:14 explained 194:11 280:19 439:10 445:2,6	explaining 439:9 explains 422:15 explanatory 192:21 442:20 explicitly 135:2 150:3 238:3 exploring 220:19 exposure 19:16 137:15 499:6,12 express 203:6 211:12 297:22 516:19 expressed 86:17 375:17 expresses 213:8 extending 484:6 extension 62:1 extensively 164:17 extent 26:3 27:1 62:9 101:22 122:6 144:13 164:4 261:12 273:10 389:14 392:12 external 69:14 extra 80:18 456:15 extreme 257:2 extremely 196:22 413:11 414:4 497:6
F				
FACC 1:22				
face 9:11 182:15 305:7 347:13 365:21 366:9,17 386:18 402:12 461:2				
FACEP 1:18				
facets 311:6				
facilitate 247:22				
facilities 4:13,21 20:3 72:22 73:2,2 84:4,11 85:1,15 87:6,7 103:15,19 106:18 107:14 118:1,6 123:4 124:10,12 130:11				

132:5 133:5 134:6	322:12 325:15	failed 374:15	185:10 187:1	225:12 351:18
134:6 136:16	326:12 327:14	failing 205:6	198:11	fee-for 224:4
143:3,6,7,9,15	329:11 337:10	failure 20:7 317:20	family's 185:19	231:15 364:16
152:15 153:1	339:14,18 346:22	318:17 337:16	FAOTA 2:5	fee-for-service 5:1
156:1 158:8 183:3	503:2,12	341:2,5 343:2,14	FAPA 2:7	5:4 224:1 237:6
184:18 192:4	facility's 85:3	354:7 375:3	far 13:20 54:20	239:13 245:1,4
198:9 200:14	117:9 163:18	382:21 443:3	129:9,19 171:14	260:18 264:7
204:19,20 209:6	facility-related	451:19 485:1	172:17 190:16	353:4 355:8 377:4
217:15 220:14	334:17	fair 55:22 57:20	214:5 225:11	396:18 400:17
222:15 244:17	fact 28:16 51:1	60:9 87:11 88:10	241:12 266:17	417:16
248:3 255:6	54:9,17 73:15	165:15 280:18	307:2 310:11	feed 376:12
257:15 260:20	80:21 83:12 90:2	292:3 305:17	349:18 397:5	feedback 69:15
263:12 269:10	96:18 100:4,6,8	319:15 338:1	434:12 492:3	233:7 255:7
271:1 278:5,6	100:16 101:7	392:7 507:14	520:3	304:22
279:10 290:19	103:20 116:21	fairly 7:3 16:19	fashion 8:6 23:19	feeders 337:19
291:9 295:8,9,22	121:5 122:14	81:6 83:15 105:6	137:22	feeds 371:14
303:3,5,8 304:2,7	123:3 136:22	124:9 132:14	fast 57:4 125:2	feel 36:16 38:20
304:20 305:9,10	165:13 176:7,11	135:15 190:19	259:6	43:5 107:2 137:16
307:16 308:3	181:15 190:18	191:3 269:3,18	faster 354:8 401:9	155:16 202:6
338:11 344:14	191:8 192:3	271:2 280:17,22	fatigue 519:22	205:19 221:1
346:12,14,18	203:10 209:16	285:18 290:21	favor 187:9 198:17	223:18 236:12
347:13,22 348:3,8	223:11 270:2	331:10 332:8	364:19 387:4,10	252:4 308:7 352:7
350:17 376:7	306:19 314:16	359:7 360:8 404:6	388:1	379:5 388:15
397:7 433:4	316:11 333:14	482:2	favorable 410:13	408:4 449:14
facility 4:19 80:5	334:16 398:6	fall 45:19 88:8	410:19	455:3 459:16
80:16 83:18 84:22	401:5 405:13	143:21 159:13	favorite 364:4	512:2
85:5,7,9,11,20	408:12 412:10	177:5 273:12	fear 506:22	feeling 376:20
91:20 95:20 108:6	422:3 428:10	405:15	feasability 463:14	feels 39:18 67:15
115:4 117:13,17	445:20 450:15	fallen 212:18	feasibility 42:10	76:10 108:6
125:13 129:1,4,15	460:2,3 471:10	falling 159:17	147:22 148:2,9	397:13 469:9
133:2,9 150:5,22	487:17 490:13	282:2 283:19	198:2 199:1,4	482:16
168:13 170:17	503:14	falls 158:18 159:2	227:3 242:16,18	fees 465:3
173:16,21 174:6	faction 512:19	339:10 350:20	243:14,19 293:13	fellow 23:17 64:13
174:16,17 181:9	factor 46:16 47:1,3	396:21 405:15	293:17,17,22	felt 100:12 222:7
184:17 187:22	47:9 48:12 191:10	428:12 450:17	349:5,9,14 386:8	407:7 450:8
188:1,4,6 189:4	factoring 202:11	489:2	389:1,1,6 390:3,8	fewer 130:11,13
198:14 199:16,21	factors 14:10 19:2	false 376:8 450:7,7	390:12,15 398:22	152:15 457:5,9
202:2,3 219:19	45:2,6 46:11,19	familiar 9:11	411:15,18,20	479:10 508:1
220:15 222:3	46:20 47:11,12,16	182:21 230:8	412:2 463:1,4,11	513:22
224:3,15 225:16	48:5,10,19,20	475:3	505:15,17,20	FFS 5:1,4
226:15 227:8	49:2,9,14,15 50:1	familiarity 68:20	517:18,19,22	field 38:21 40:18
233:3 260:7	52:9,15 193:6	families 2:6 21:7	518:3	65:2 84:10
261:20 263:13	252:16 422:16	223:8 264:13	feasible 148:6	Fields 1:18 19:4,5
264:8,12 270:7	423:20 468:3	501:20	390:9	29:22,22 61:15
271:13 277:17,20	500:21	family 12:11 80:9	federal 301:6	117:6 166:18
285:13,15 295:13	faculty 19:9 302:16	80:17 109:10	326:20	167:10 198:5
299:19 303:12	FAHA 1:22	184:5,15,19	fee 161:20 220:10	204:12 206:2

272:8 283:13	first 5:12,16 9:12	467:21 515:19	395:13 421:11	forces 425:3
364:2 365:14	14:5,16 18:15	fits 123:16 179:22	429:3 469:14	forcing 340:10
386:13 415:22	20:21 40:2 43:22	422:11	490:7	foregoing 418:3
416:8 455:14	46:13,21 60:20	fitted 440:14,17	focused 34:19 67:1	forge 266:1
483:21 491:6	61:16 67:10 74:10	464:8	108:3 120:22	forget 126:15
493:8 494:19	78:19 80:1,11	fitting 447:13	179:18 301:17	forgetting 426:11
501:13 502:19	87:22 93:20 95:8	five 89:11,20 90:1	359:3 463:18	forgive 167:11
507:15 513:10	101:14 111:21	104:12 115:16,18	focuses 264:9	form 9:20 50:7
515:18 517:7,16	112:15 137:9	172:22 176:12	focusing 357:10,11	52:4 222:14
Fifth 335:22	141:19 145:21,21	177:5 178:18	457:19	282:12 303:9
figure 76:22 453:19	164:16 168:18	222:8 232:5 240:1	folks 36:15 114:13	389:4 410:18
figures 213:12	174:4,21 216:13	240:12 241:3	122:7 131:4 137:1	formal 37:22
figuring 177:14	223:17 230:21	252:18 274:14	140:21 178:11	forming 229:7
filibuster 517:9	247:12 252:9	276:19 286:19	235:14 249:4	forms 83:18 249:4
fill 223:17	256:9 285:12,19	288:20 299:21	302:4 394:3 422:1	427:5,8
filled 6:8 221:20,22	286:5,17 288:11	329:5 332:15	461:21 471:19	formulated 456:4
240:19 427:5	301:22 305:14	363:7 373:13	485:4	forth 73:20 165:10
filling 249:4 428:1	306:2 315:11,18	386:14 394:17	follow 46:20 47:5	229:17 311:3
final 78:17 132:20	333:2 338:5	409:19,21 414:16	58:5 79:1,10 98:9	339:3 427:2
157:17 250:5	344:16 345:16	452:1 477:14	100:6 104:10	forthcoming
317:2	351:20 353:17	490:1	213:15 238:20	283:10
finalized 50:8 53:4	354:14 383:1	fix 254:10 461:3	274:11 384:5	Fortune 381:9
53:11 55:3	407:15 427:10	fixated 117:1	436:9 443:8	Forum 1:1,8 6:4
finally 43:11 89:14	429:16 434:6	fixed 132:3,17	470:20 483:22	64:11 65:13 165:5
90:4 128:9 500:22	440:6 442:17	flag 222:12	491:14	forward 50:12,22
financial 10:14	443:22 455:5	flagged 58:20 59:3	follow-up 27:4 97:6	51:14 60:20 63:3
335:14 342:5	476:16 477:9,11	376:4 437:1	175:15 185:4,21	67:18 73:7 74:21
424:2	477:18 494:8	flat 471:3	186:16 336:17	76:2 96:17 100:5
find 129:14 130:9	500:11 509:4	flatten 424:21	followed 421:12	100:10 101:1,8
158:22 178:5	519:19	flesh 221:10	following 44:8	104:4 107:4
179:4,13 188:22	Fishbane 1:19	flexibility 286:12	120:8 182:14	121:11 145:6
192:3 201:20	18:17,18 29:17,18	420:22 466:2	198:8 225:1	155:19 156:6
237:17 262:19	93:19 97:5 98:8	flexible 421:13	287:16 304:9	158:21 159:4,6,14
263:7 364:12	99:4,7 118:20	flight 351:13	305:14 306:2	211:9 212:21
393:6 417:3	159:22 165:4	flipping 386:14	308:4 345:17	222:4 226:3 231:6
436:18 497:4	308:20 319:14	Floor 1:8	follows 48:16	241:9 246:19
513:14,19	321:13 322:13,22	Florida 14:14	followup 109:8	273:19 301:16
finding 108:13	324:22 325:19	506:9	345:7	308:13 350:22
180:15 190:7	327:17 330:4	flow 178:14 199:14	Foltz 31:14	351:14 357:21
254:18	331:2,17 332:19	fluid 252:22	food 259:11,12	396:22 397:1
findings 481:2	338:21 433:13	fluid-related	391:11	399:7,10 448:21
fine 28:5,15 157:1	451:12	258:10	football 122:1	459:22 460:3
279:16 370:1,14	Fishbane's 325:6	fluids 506:10	for-profit 15:8	463:6 470:22
finish 41:21	fit 40:15 163:4	focus 42:21 75:21	for-service 351:19	471:2 490:20
finished 510:18	166:7 262:21	81:5,14 90:17	force 16:10 20:2	509:10 520:3
finishing 304:19	395:8 420:19	100:7 273:7	100:3 182:2 204:2	found 144:14 163:2
firing 510:7	441:20 442:15	275:11 354:21	343:15	257:3 263:21

270:18 366:7	320:22 456:7	funds 387:8	514:12,17	116:19 117:11
374:20,22 405:9	472:21	funny 279:10	gaps 69:12 170:6	118:2 123:13
407:6 422:18	frankly 248:1	459:14	387:18 424:6	128:14 172:4
423:17,21 424:17	free 36:16 43:5	further 79:1	431:21 491:11	188:14 190:2
436:22	137:16 408:21	153:17 165:1	gather 399:19	205:14 216:12
foundation 3:2,19	free-standing	288:12	Gawande 365:22	259:11 283:5
5:2,4 14:8 94:10	334:20	future 27:16 33:14	Gawande's 366:20	303:22 306:3
94:13 351:20	frequency 206:22	57:13 76:3 118:8	Geisinger 1:16	338:14 373:1
four 29:11 40:17	frequent 409:3	156:2 180:5,11,18	23:7	397:1 413:3
42:7 102:16	Friday 45:9 50:16	182:13 188:20	gender 234:15	443:14 456:11,11
124:19 126:5	254:6,7 255:8	198:19 319:6	384:12 389:11	489:3 493:18
146:4 147:13	333:10	452:15 494:21	Gene 418:18,22	507:13
148:10 157:5	friends 40:6		426:20 475:4	Gifford 3:6 214:12
172:22 215:22	front 8:1 13:16	G	general 2:13 4:5	214:13 215:3
237:13 252:6	27:16 32:19 37:8	gain 68:20 203:22	9:8 39:4,7 78:7	219:21 221:12
271:21 276:15	38:11,18 40:19	210:4 304:14	282:9 301:1 305:6	223:4 225:1 227:5
288:16 293:6,19	41:1,6 42:12,22	306:1	331:7 341:15	227:18 228:9
299:4 330:20	44:4 78:8 95:11	gaining 338:5	399:20 420:18	230:20 232:15
331:13 332:12	100:8 230:2,5	game 57:20 60:9	440:16 441:20	233:4 234:4,12
345:17 348:20	241:8 376:3 379:8	122:9 227:6 234:6	483:8 489:5	237:4 239:2
349:10,15,21	424:13 470:15	247:1 412:12	513:21,22 519:22	240:15 241:4
361:7 362:17	485:19 488:10	gameability 233:5	generalized 422:11	244:20 245:22
366:2,6 386:2	frustrated 67:20	gameable 246:2,13	generally 39:1	248:10 249:7,10
390:13 394:14	frustration 323:4	246:14	40:14 42:16 43:2	250:21
403:7,10,16	frustrations 319:22	gaming 121:22	43:10 57:19 82:13	give 43:22 44:6
404:14 409:22	FTE 310:1 324:11	142:12 229:12	97:18 173:9 310:1	58:9 59:9 70:10
410:1 411:9,12,21	full 34:4 79:19	gamish 217:3	325:1 348:4	71:10 77:19 78:6
414:16 415:8,11	95:17 152:20	GAO 282:21	399:22 421:6	128:13 136:12
452:3 508:1	261:2 267:15	gap 104:19,22	generate 38:6	146:18 160:16,19
four-hour 50:16	384:11 407:20	105:12,13 107:22	generated 199:1	175:11 188:18
fraction 239:1	full-throated 259:5	114:3,18 119:14	generates 377:17	192:1 245:18
423:13 481:22	fuller 437:16	121:20 124:6,8,10	377:19	258:4 272:20
512:22	fully 36:18 228:9	124:15 170:22	generation 82:21	278:1,18 286:20
frame 166:12	function 231:22	216:16 218:8,9,18	genesis 448:6	329:1 352:11
495:22 510:21	functional 12:17	255:11 265:5	geo 388:6	459:8 495:4
framed 460:21	fund 256:3 366:11	269:2,3 271:19	geocoding 60:6	given 150:11
framework 70:11	424:16	272:3 275:4 290:3	61:1	161:10 203:8
196:19 307:15,20	fundamental	290:5,12 325:2	geographic 291:12	287:4 298:14
307:21	358:15 365:19	327:9,21 330:18	355:10 400:15	303:12 368:4
framing 77:20	456:2	330:22 360:5,9	491:19 493:4	379:21 420:13
Frank 1:14 24:11	fundamentally	361:6,11 403:3,6	geography 347:9	gives 100:20
31:21 64:1 65:15	206:8 396:3	403:10 429:22	353:3	134:20 145:2
65:16 209:2 214:4	484:22	430:3 432:5	geometric 420:13	146:22 314:13
216:14 218:9,10	funded 317:6	435:15 438:3,6,9	420:17 434:18	323:16 366:9
219:14 233:15	352:18	450:14 482:17	452:21 471:16,16	382:17 391:16
243:11 244:12	funding 14:6 16:3	491:4,22 492:3,6	geriatrician 214:13	392:3 446:4
281:17 283:14	20:19 392:1	492:12,16 514:9	getting 57:16	giving 106:7

270:13	391:2 399:7,9	159:14 160:19	502:18 505:15,15	government 231:2
Glance 1:20 21:16	405:17 407:9,14	165:22 168:18	506:13 509:7,17	433:8
21:17 30:10,10	418:6 424:8	169:13 170:21	gong 192:17	Governor's 18:6
103:10 134:15	442:22 447:11	174:22 175:1,10	good 6:3 7:7 14:12	governors 382:15
179:10 182:11	452:3,11 454:19	180:9 182:22	15:15 17:16 18:10	grade 292:13
196:16 236:10	472:10 476:8	187:8 190:15	18:17 19:21 21:5	Grand 379:19
238:20 239:9	502:16,18 518:10	194:8,15,18 197:5	21:16 22:10 24:19	grant 12:15 14:7
240:3 296:3 329:7	goal 50:21 126:2	199:15 201:16,18	44:18 46:20 52:7	20:4
381:1 454:13	171:19 213:19	208:13 209:3	60:8 61:2 62:18	grants 11:13 15:9
456:19 468:1,6,9	233:13 457:9	211:15 216:12	63:4 65:16 78:20	18:20 27:22
495:10	goals 26:1 230:10	217:19 222:4	81:13 82:19 85:17	grapple 53:22
global 433:20,22	232:13,17	225:8 226:3	86:22 87:4 89:22	grate 54:21
go 7:9 8:9 9:15	goes 130:4 187:4	227:10,11 229:6	101:18,19 102:1	gray 57:22 58:9
11:16 19:5 24:2,3	201:2 209:10	230:20 233:11	115:12 116:10	158:13 159:17
24:3 32:21 35:13	232:2 243:1	235:4 242:1	124:11 129:14	212:19 233:6
35:21 36:20 37:22	300:11 380:20	244:22 246:8	130:2,19 131:5,7	396:21 397:3,14
38:9,12,16,19	388:10 408:19	249:5,6,18 261:6	138:9 140:11	397:16 399:16
45:12,16 59:5	440:19 462:5	264:3,18 271:6	163:3,4 169:1,1	417:18 447:8
63:8 70:22 74:8	503:13	272:14 273:19	176:21 178:8,9	520:1
76:2 78:20 79:12	going 9:4,5,5,13	275:13 276:11	189:1 191:13,20	great 25:11 50:5
82:5 90:18,22	16:14 29:2 31:18	278:13 279:4,5	192:5,8 193:13	68:2,8 109:1
92:13,16 107:21	32:3 35:20 36:12	281:4 288:11,11	204:3 249:3	151:2,19 168:2
132:7 138:17,20	36:21 39:5 44:2	289:20 294:9,10	262:20 276:8	195:8 241:17
138:21 141:18	50:2,8 55:6 58:2	298:12 301:15	289:10 291:22	268:8 272:5
145:5 150:17	60:18 61:5,6,12	311:5 317:4,17	313:19 321:13	301:19 305:7
154:22 155:19	62:22 63:12 68:2	320:7,15 322:4	334:10 343:7	307:12 311:8
156:5 157:13	68:6,9 73:9 74:21	331:17 332:5	344:8 358:8 359:8	326:14 328:20
158:21 168:15,16	76:1 78:6,10	334:9 335:4,12,17	362:9 363:5 364:5	334:18 342:12
168:17,19 173:4	81:12,17 82:2,3	337:20 340:17	367:4 370:21	401:5 474:5
173:21 184:21	86:7 88:13 89:12	341:15 354:16	374:12 378:14	475:16 483:8,16
187:6,9,12 193:5	92:14 93:7,14	359:16,17 361:16	385:21 386:16	495:11 520:21
197:13 199:10	98:9,13,14 101:12	372:8,18 374:18	391:11 395:3	greater 114:6
201:5,9,15 210:5	101:17 103:7	375:22 376:3,7	402:12,15 404:6	133:5 222:8
212:7 221:16	104:3 105:7,8	379:7 381:18	413:7 454:21	greatest 164:4
228:1 233:4,22	111:20 112:2,10	385:7,22 390:22	457:12 466:17	green 113:18
236:19 237:12	112:15,18 113:9	398:18 413:10,17	504:2,3 512:8	grew 353:10
241:5 242:7 244:9	114:3 115:6,9	414:4 417:19	518:17	Grigonis 1:21 15:5
244:13,18 248:20	116:14,14 124:4	418:11,16 425:1,3	goofed 91:9	15:5 31:1,1
250:17 273:8	125:22 127:2,13	426:12 427:1	Googled 210:17	149:12 152:1
292:20 295:14	127:16,18,22	433:9,10 443:1	gosh 159:22 378:16	164:15 167:22
300:2 324:4	128:10 129:17	447:9,9 448:16	393:20	168:22 169:21
342:13 350:5	130:19,20 131:3	455:11 457:13	gotten 60:7 70:5	170:15 171:9
354:2 355:18,22	134:5 136:10,11	458:3 463:22	259:11 492:8	172:9,15 175:1
356:3 370:10,14	141:17 142:1	464:1 471:12	499:22	176:4 184:13
372:9 378:2	147:11,22 148:20	480:19 482:8	governance 325:15	190:13,15 200:5
380:18 385:2,9	151:1,6,9 152:17	483:4 487:10	governing 38:14	408:7
389:6 390:21	157:3 158:11	493:18,19 499:14	310:15 327:13	ground 15:2,2 34:3

50:19	449:12 471:22	104:9,10 106:12	308:15 317:13	490:19 491:3,7
group 2:8,8 10:20	472:7,11 484:22	106:20 108:4	318:18 320:21	492:9,18 493:7
12:10 16:2 17:4,7	486:18 502:5,12	110:11 111:20	322:7 324:16	494:16 495:8
17:14 19:15 24:18	guesstimate 241:3	112:2,7,13 113:6	329:4,19 330:13	496:10,19 497:17
32:15 33:19 38:3	guest 7:17,19	118:17 119:11	332:17 336:16	498:5,21 500:1
42:1 50:10 53:6,8	guidance 27:6,11	121:16 125:18	337:4 340:17	501:12 502:11
64:10 65:13 67:14	34:13,14 48:22	126:14,19 135:22	343:19 348:12,15	503:16 505:6,14
67:19 77:2 82:9	49:21 51:4 55:11	137:7 139:13	349:4,16 350:8,19	506:1,22 507:14
90:7 108:21 117:4	56:17,21 59:9	155:11 156:14	351:7 358:1 362:5	507:16 508:9,17
117:5 120:16	67:14,16 106:7	160:13 164:9	365:11 375:16	509:6,20 510:13
137:5 153:4,7	108:15 144:20	165:21 166:5,17	379:2 382:11	513:3,8 514:3,9
175:21 189:9	145:2 189:14,21	167:5,16 168:1	391:4 397:18	514:19 515:7,17
191:11 214:5	301:8 325:7	169:8,11 170:18	398:2,16 399:1,3	516:10,18 517:12
216:11 222:19	443:16 458:1,17	171:16 172:12	400:6 402:2,16,19	518:5,17 519:3,11
236:7 253:22	459:9,13,18 460:4	173:13 174:18	403:2,5,12,21	520:2 521:7
258:16 264:18	461:4 485:19	175:13,15,17,18	404:8,11,19 406:2	hallway 7:12
265:22 268:10	guide 90:11 444:22	179:9 181:10	406:22 408:3	Hammersmith
280:4 298:17	guideline 94:21	182:9,19 183:20	409:11 410:11	2:13 4:5 9:7,8
307:13 317:6	448:15	185:1,2,13,16	411:3,6,14,17	23:2,10 24:13
364:8 374:10	guidelines 47:6	186:15 189:10	412:4,17 413:5	hand 135:13
390:22 430:7,17	49:13 488:5	190:14 192:13	414:20 415:2,5,13	167:21 195:11
434:14 449:13	Guillain-Barre	193:9,18,22 194:6	415:16 416:5,13	196:10,14 271:3
498:21 500:1	144:11	195:14 198:1,20	417:5,8,20 418:11	457:1 504:1,3
group's 70:2	guilty 109:14	199:12,14 200:3	426:13,17,19	handed 111:12
109:15 213:9	guns 444:16 476:17	200:20 201:14	428:14 429:9	handful 220:14
groups 72:15 83:13	guts 467:2	202:5,13,14,22	431:17 432:8,9	348:1
121:7 124:18	guys 41:22 120:16	203:13 204:3,11	433:12 435:7,14	handicapped 110:7
144:14 145:8	120:21 122:16	205:17 206:21	437:22 438:11,17	handle 19:12
171:3 284:20	143:3 239:4,4,17	207:21 209:1,8	439:5 443:7	271:12 331:17
432:6	298:1 342:20	211:8 213:7,17,22	444:14 446:21	handling 139:7
growing 220:11	367:19 374:14	215:1 216:10	449:12 451:10	308:4
grows 491:20	459:20	217:16 218:8	452:20 453:1,13	hands 25:13 166:6
guarantee 521:15		219:2,11 226:17	454:2,9,22 455:13	326:2 327:7
guess 25:17 64:20		229:14 230:7	456:7,18 457:16	378:16 512:1
78:13 101:11	H	232:12,21 233:18	458:10 461:14	hang 497:17
111:9 143:13	half 152:14 158:17	234:11 236:8	462:7,10,14 463:1	Hansen 102:15
166:10 182:12	182:3 213:18	240:6 241:2,7	463:8,16 464:22	happen 27:22
194:4 203:17	395:16 496:22	242:7,15 243:11	465:1,7,17 466:4	151:6,13 203:5
205:2 229:14	515:15 520:5,19	243:20 246:15	467:22 468:10,20	267:6,7 312:15
231:6 234:4,9	Hall 1:9,12,21 4:2	247:10 248:9	469:17 470:14	314:6 317:1
238:11 305:1	6:14,15 13:1,1	249:3,8,15 250:4	471:19 472:21	389:22 433:10
307:9,14 342:10	21:11,11 24:8	250:15 258:14,21	474:5,14 475:2,19	485:3
344:10 346:14	30:8,8,14 31:17	259:7 260:3	476:1,6,16,19	happened 132:2
366:22 373:18	51:20 53:2 54:18	264:17 267:1,20	479:14,22 480:12	140:16 141:9,10
416:8 424:6,12	59:7 61:14 67:5,9	268:7 274:11	482:15 483:16	496:2,4
440:18 441:3	68:5 74:3 78:16	275:15,18 296:19	485:10,18 487:3,7	happening 85:3
442:3 448:4	79:13 87:16 91:13	301:18 302:1	487:9,22 489:9	150:21 192:9
	99:6 101:10 103:9			

234:13 284:6,8 335:15 369:12 460:7 happens 28:2 52:18 81:14 128:20 285:11 313:11 357:4,6 459:5 happy 479:13 490:18 507:12 Harbor 17:20 Harborview 2:2 hard 6:22 46:3 57:4 58:6,9 107:1,3 135:18 144:5 223:11 229:11 248:19 284:20 309:11 335:10 344:15 355:12 382:8 510:5 518:9 521:5 harder 141:20 200:1 harkening 337:16 harking 466:7 harmonization 43:13 74:4,12 272:21 273:2 274:20 308:10 362:9 harmonize 261:10 harmonized 164:4 273:9,19 274:1 harms 154:14 harp 451:13 harping 302:2 Harvard 18:12,13 64:13 hat 297:16 430:10 hate 296:13 hazard 238:11 HCCs 500:17 HCRIS 422:22 HCUP 425:19 head 107:1 173:15 275:14 282:18 321:5 head-to 275:13	headline 502:20 headquarters 381:19 heads 110:18 headway 265:21 health 1:16,17,18 2:8,9 3:6,17 5:13 5:17 14:3 16:12 16:17 17:8,19 18:12,13,20 20:12 20:14,16,17 21:14 21:18,22 22:2 23:7 64:15 65:3,8 66:21 70:15 71:4 72:4,8,22 75:20 102:1 105:13 112:21 122:16 126:2 169:15,16 171:11,19,21 190:19 191:10 217:21,22 224:16 243:4 248:22 305:3 326:4,5 343:9 354:22 355:18 357:14 359:2 372:12 377:21 391:7,20 405:5 412:22 419:2,13,16 432:13 457:10 462:6 477:4,12,13 477:14,19,20 478:6,11,16,20 479:4,5,8 483:1,2 483:13 484:2 485:7 486:4,13,16 487:12,13,19 489:15,18,20,22 490:3,8,13 495:3 495:17,18 498:9 498:16,18 499:10 500:5,7,12,14,19 501:16 502:14 503:3,5,7,14 505:4 506:6,8,17 507:6,22 509:5 510:19 511:20	516:1 518:10,20 519:20 healthcare 1:14 4:18 11:22 13:4,6 13:7 14:15 15:8 15:12 17:3 20:1 22:13 65:18 67:2 97:22 98:4 112:22 113:9 126:4 214:3 214:8,15,20 251:13 419:18 Healthwise 1:21 21:12 healthy 506:14 hear 159:15 239:14 239:17 258:18 319:2 323:2 327:19 397:11 419:7 440:12 455:1 472:8 heard 55:5 80:8 121:19 181:18 213:8 234:15 261:19 311:19 324:18,22 339:19 340:20 343:21,22 447:17 484:14 488:2 514:20 516:19 hearing 99:7 205:18 225:20 299:14 337:8 388:21 390:10 392:7 499:19 heart 20:7 141:8 317:20 318:17 337:16 341:2,5 343:2,14 443:3 451:19 heavily 67:2 heavy 43:10 Hebrew 1:17 22:12 22:22 Heidenreich 1:22 16:6,7 31:5,6 74:19 101:11 113:7 153:15	154:9 184:3,10 285:9 342:22 374:3 406:3 429:11 430:6 485:12 held 46:6 219:19 228:21 244:17 Helen 1:17 2:12 22:11 24:17 30:12 40:21 50:3 51:5 51:10 58:1 74:3 76:14 77:9 99:22 120:6 136:22 141:15,21 142:15 200:20 214:4 216:13 218:9 219:14 243:12 247:11 258:21 259:3 264:18 277:1 289:2 298:16 458:13 459:9 502:11 518:18 hell 254:9 hello 475:22 help 6:10 74:17 78:3 107:15 114:9 127:15 193:11 272:17 291:13 292:11 338:7,19 356:15 387:16 394:1 427:11 434:11,18 445:13 463:20 503:18 504:11 helped 128:6 helpful 68:4 120:13 134:11 193:17 342:21 396:8 432:19 436:8 490:16 helpful/useful 392:13 helping 121:4 helps 503:14 hemodialysis 330:8 334:6 345:21	HEN 18:4 hesitated 133:10 heterogeneity 142:20 334:2,18 336:18 433:20 487:11 HHS 301:5 hi 16:15 20:8 66:5 hiccups 469:3 hide 369:14 hierarchical 86:1 97:16 296:12 398:6 high 25:2 81:8 87:1 87:2 88:6 92:12 94:19 105:6 119:6 124:11,18 125:6,9 125:11,19 126:1,3 126:4,17 127:10 146:3,11 147:12 147:19 148:9,14 157:4,11 160:2 161:16 171:3,7,18 171:20,21 172:3 179:20 180:16 181:5,8,20 190:20 191:14 193:8 194:12 197:9,12 197:19,22 199:5,9 211:5 212:2,5 218:19,22 219:2,5 219:5,9,9 222:13 233:17 242:2,5,10 242:13,22 243:15 243:18 249:19 250:2 257:7 266:5 271:9,20 272:3,6 275:3 276:12,13 276:14,19,19 281:5 288:15,20 293:5,10,18,22 299:3,8 304:12 328:14 329:16 330:19,22 331:5 331:10,11,12,15 331:15 332:2,12 332:15 335:4
---	--	---	---	--

343:11 348:19	highlighted 110:15	490:3,8,13 493:16	55:21 56:2 63:9	411:1 413:2
349:2,9,14,20	413:12 510:1	493:18 494:8,10	65:19 70:21 72:21	418:14 421:2,19
350:2 361:6,11,13	highly 78:2 198:7	495:17,18 498:9	73:20,21 77:14	423:10,12 425:16
362:16,17 363:1,1	202:1 254:20,20	498:16,17 499:10	81:13,16,16 92:13	427:16 433:16,17
363:11,12 365:7	321:16 401:22	500:5,7,7,12,13	96:1 103:13	434:1,1,4 436:20
366:4,7 369:1	422:9 423:6	500:19 501:16	105:10,11,17	437:8,10 451:16
370:2 375:3 386:1	highway 65:12	502:14 503:3,5,7	106:1,2,15 107:15	451:18,21 452:2,6
386:5 390:12,15	hip 92:21 122:7	503:14 505:4	117:12 118:14	452:16 454:6
394:13,17 401:14	hips 118:13	506:5,8,9,17,21	130:1 135:15	455:20 461:21
401:18 403:7,10	hired 323:15	507:6,22 509:4	140:9 149:17	464:9 470:12
403:15,16,18,19	historical 58:13	510:19 511:20	161:20 162:3	471:5 475:1
404:13,17 405:2	historically 228:18	512:5 516:1 518:9	166:21 167:13,14	477:11,15,18
406:9 411:9,12,20	447:19	518:20 519:20	168:7,8 173:18,20	483:4 485:4 486:3
412:2 415:7,11	history 440:2	home-monitoring	173:22 175:4,9,21	488:18 489:22
422:18 438:6,9,15	461:17	102:20	176:8 183:11,18	490:14 491:14
438:20,21 439:2,3	hit 378:5 482:17	homelessness 48:11	184:22 201:18	493:19 500:20
443:4 447:2,6	491:7	homes 210:13	202:17,21 203:1	501:1,4,6 503:13
462:17,21 463:11	hoc 40:20,21	214:17 215:21	203:11 205:8	509:3 511:6
463:14 474:8,12	hold 90:15 233:22	216:4 223:6	206:8,12 209:11	513:13
482:5 492:12,16	234:10 445:18	265:21 271:12	215:5,14 221:14	hospital's 456:10
492:18 496:12,13	holding 95:21	337:11,12 341:20	223:9 224:11	hospital-based
496:17,17 497:2	286:16 333:15	491:11	227:13 228:19	257:11
497:21 498:3	338:10,12 343:2	hometown 419:6	229:16 238:13	hospital-owned
505:9,12,17,21	358:5 369:17	homogeneous	239:5 245:11	312:4 340:2
508:12,15 509:20	home 5:12,16 72:22	194:14	248:13,15,20	hospitalist 14:3
514:13,17,22	73:21 77:6 105:13	homogenization	254:7 258:2	hospitalization
515:1,4,5 516:13	138:17,17,20	272:21	260:17 261:10,21	70:17 258:8
516:16 517:2,5,22	174:1,20 185:7,20	honest 430:20	262:3 267:4,10,22	266:13,20 287:13
518:3 519:6,9	186:19 187:16	honestly 373:2	279:8 283:6	304:12 315:4
high-intensity	210:6,7 217:15	honored 14:17	287:14 288:3	321:22 328:8
92:15	221:16 224:15,15	hook 141:7,11	303:5,7,21 304:10	344:17 346:16,21
high-volume 88:7	224:15 225:9,15	hope 35:15 343:6	308:4 309:8	347:3 355:7
higher 70:16,19	231:4 232:17	hopefully 222:16	311:16,22 312:6,9	368:15 369:2
71:5 118:8,10	236:1 243:2	520:8,18	312:14,16 314:5,7	391:21 400:22
135:10 138:2	309:16 334:21,22	horizon 55:13	321:3 323:19	477:6 478:13,19
163:21 170:16,16	341:11 353:14	267:3,10	333:17 337:21	492:22 496:2
191:5,6 193:8	354:5 376:9	hormone 316:9	338:3 339:16	499:9 511:16
200:16 217:14	395:19 477:4,12	horrible 194:15	341:6,14 342:13	513:18
225:18 257:16	477:13,14,18,20	horse 189:11	345:9 346:6	hospitalizations
263:8 326:19	478:5,11,16,20	249:14	352:20,21 357:7	5:1 262:17 304:8
342:17 345:20	479:4,5 482:22	hospice 64:9	358:5 369:6,7	315:4 316:10
371:15 426:10	483:2,13 484:2,3	184:20 186:18,22	375:10 380:18	331:7 346:7,15
446:18 455:19,21	484:3,6 485:7	187:10 198:10	383:5 389:10,12	351:18 352:13
510:20 513:17	486:4,9,11,13,16	hospital 1:13,19	389:13 393:4	356:7 384:18
highest 114:12	487:12,13,19	2:1 5:7,11 14:2,14	396:2 400:14	396:17 401:16
280:21 345:15,15	488:18,22 489:14	14:20,22 17:14	401:9 402:14	452:10 501:8,11
highlight 137:10	489:18,20,22	18:4 19:15 55:18	407:9 408:20	hospitalize 401:6

hospitalized 215:11 296:22 357:6 359:11 395:14,17 478:16,21	326:11 338:5 495:16 510:14	183:5 262:2 270:8	implication 136:18 156:19 429:5	265:13 313:18,20 358:11 359:2 374:6,7,8,22 391:19 394:2 425:6 432:16 434:12 435:15 457:10 469:6,13 491:4 506:20 514:10
hospitals 4:15 14:20 15:13,14 22:19 56:7,10,14 73:1 88:4,5,8 93:13 103:19 104:6 106:19 115:8,13 127:5,10 127:16 136:12 140:15 143:16 161:1,13 172:19 180:10 212:16 225:7 226:22 227:6 228:5,12,15 228:20 233:10 237:21 238:15 253:13 254:13 255:17 257:13 265:20 271:8 279:15 282:1 283:20 284:18 287:4,9 295:2 303:8 312:3,12 313:21 314:4 315:13 317:21 321:5 324:5 335:17 339:4,6 343:6,11 352:22 353:10 374:6 382:21 391:18 406:9 421:4 425:5 425:17 431:22 433:22 436:15 437:1 452:7 457:2 457:5,7,11 461:19 464:4	household 60:1 housekeeping 7:10 8:10 259:8 housing 355:16 378:13,14,16 379:15 HR 426:1 HRR 393:1 HSA 395:17 huge 127:16 177:4 192:12 217:8 220:10 229:2 247:19 284:13 327:8 351:3 387:10 404:5 484:21 hundred 19:17 hurt 414:17 hurting 414:21 hydrated 506:11 hypothesis 228:11 271:10 426:9 hypothesize 398:14 hypothesized 292:20	identify 48:5,6 51:12 69:11 261:3 267:16 345:8 381:9 382:18 383:15 494:14 identifying 61:11 266:16 identity 352:4 IDT 326:22 ignorance 175:6 230:18 232:22 ignored 209:1 ill 168:11 198:17 371:16 illness 455:20 imagine 238:16 420:16 422:17 425:15 433:3 442:8 immediate 139:2 330:16 503:13 immediately 162:17 267:6,7 310:17 323:12 impact 90:7 101:9 126:3 171:20 217:13 222:6 244:2,8 253:10 263:20 280:14 281:22 357:5 393:11 456:13 impacts 133:19 266:11 456:9,16 impetus 61:9 319:7 implement 416:6 implementation 18:5 20:6 49:20 56:10,16,21 60:22 155:20 298:11 359:14 implemented 20:18 41:10,11 120:9 152:5 153:19 159:1 199:3 272:16,17 implementing 18:8	implied 428:7 importance 42:7 42:18 43:3 90:22 95:5 107:11 112:16 171:14 261:7 398:6 492:22 important 8:14 25:3 33:13 45:21 46:11 47:19 96:14 97:11 100:10 101:2,9 107:10 120:12 156:1 164:1 171:10 180:4 181:3 200:11 216:7 235:12 236:6 252:2 257:10,20 263:16 275:6 284:15 296:4 311:17 313:5 320:20 331:3 334:3 339:1 356:20 364:10 368:6 371:5 372:12 375:12 379:7 380:1,6 382:22 383:3 386:19 398:7 413:11 414:5 431:14 importantly 256:14 328:10 423:22 impossible 312:12 impression 314:13 impressive 170:9 492:7 imprimatur 371:1 imprints 105:9 improve 32:6 48:7 110:19,22 187:16 222:16 256:4	improved 94:12 99:14 194:4 228:20 238:5 245:15,17,20 316:18 328:21 343:9 374:16 375:4 420:19 470:7 improvement 13:8 15:7 33:12 94:7 104:1,8 109:3 117:18 149:5,6 150:1 164:19 169:22 173:8 181:17 182:8 200:7 211:20 214:22 261:15 269:9 284:5 300:8 325:3 327:10,19 327:21 329:9,18 330:5,7 337:9 338:18 340:5 352:19 368:14 373:16 375:2 383:2 401:3 405:17 414:19 421:8 431:5 435:22 436:3,8 468:22 469:22 470:18 488:6 improvements 33:15 343:18 353:20 474:4 improves 405:19 improving 49:18 103:3 161:17 247:20 261:14 311:4 354:4
<hr/>				
I				
ICC 195:14 277:3 277:18 278:18 ICCs 277:7,21 ICD-10 82:20 ICU 83:10 162:16 262:10,11,14,18 262:19 idea 11:3 98:2 100:7 184:9 255:9 286:9 297:18 367:10 386:16 408:8 482:22 ideal 130:16 135:6 ideas 182:8 identical 511:2,2 identification 47:21 identified 104:14				

in-center 326:13	85:5,6 122:3	262:18	157:6,12 164:7	281:3 297:9
in-patient 15:13	146:2 163:9,10	indicators 63:14,15	176:21 186:17	inhibited 110:7
261:19	193:6 308:6 317:5	75:17 84:21 139:1	188:19 207:10	initial 73:5 104:11
in-person 35:3	337:15 345:2	384:7	212:3,6 224:20	154:5 165:3
274:7	374:4 458:8	indirectly 449:1	228:17 231:22	172:13 203:11
inability 236:13	inclusion 76:12	individual 10:8	250:3 262:2	374:21 402:3
inadequate 493:14	284:18	52:12 59:22	264:13 272:9	426:21
493:14 502:3	inclusive 176:19	220:16 222:3	280:4 295:3,11	initially 45:2 114:5
inappropriate	177:3,3	267:14 321:6,10	299:5,10 311:21	initiative 340:5
324:12 409:7	income 48:11 56:14	443:2 448:22	312:13,14 313:22	355:19 358:11
inappropriately	59:12,19,21,22	479:8	314:2,4 339:22	364:14 378:9
161:16 205:20	60:1 62:7,7	individually 79:17	349:22 350:4	initiatives 256:6
inaudible 66:14	424:10 449:4	274:18	376:19 381:2	300:8 356:21
incentive 308:8	455:2,18 501:19	individuals 192:6	394:14,19 415:8	357:14,15 367:13
incentives 252:3	inconsistencies	215:5 283:5	415:12 418:9	414:19
incentivize 257:20	427:6	industry 19:12	424:4 428:2	injury 122:5
inception 448:20	incorrect 450:11	inefficient 451:21	431:13 436:11	455:21
incidence 316:10	453:8	inevitably 379:7	440:21 441:21	innovation 251:12
400:19	increase 237:10	461:6	444:10 448:21	484:13
incident 141:5	increasing 68:16	inexorable 424:17	458:20 459:1	innovations 484:1
inclined 456:14	increasingly 378:3	infants 348:6	461:9 469:5,18	inpatient 4:13 5:7
include 27:1,2,3	incredible 269:18	infection 101:16	474:13 504:19	22:18 66:13 71:6
37:10 43:8 44:12	incredibly 201:12	infections 100:15	508:13,16 519:7	73:1 80:5,16 81:9
45:1 48:4,19,20	250:17 310:21	252:20 258:10,10	519:10	81:10 91:18,19
52:15 72:21 90:9	339:14 406:8	infer 54:11	infrastructure	92:9 107:14 108:5
96:10 99:21	incumbent 449:13	inference 105:17	370:13 382:18	125:13 141:4
162:12 215:16	independence	265:7	391:12	143:2 158:8 162:6
243:8 256:1,1	370:19 409:15	influence 95:15,22	infrequent 59:2	164:17 170:17
262:6 325:17	independent	99:19 100:9 101:4	Ingber 3:8 80:3,4,8	171:13 201:16
456:21 457:1,14	410:17	285:14 307:17	92:2 114:22	204:7 209:6,18
508:7	independently 79:4	309:13 408:11	121:21 128:19	215:15 218:15
included 49:9	index 254:21 409:1	influenceable	133:17 139:6,15	242:20 243:9
58:16 69:8 73:21	501:7,11	252:17	140:7 143:18	245:7 257:14
85:12 142:22	Indiana 1:15 16:17	influenced 98:18	145:9 150:2	366:5 418:13
216:18 222:22	16:19	184:4	152:12 168:5	424:3 425:18
230:10 234:8	Indianapolis 16:18	influx 407:19	173:6 174:3,12	475:1 486:10,14
239:20 253:2	indicate 26:3 33:8	information 7:16	175:5,22 176:15	489:21 492:21
263:22 278:6,7	34:21 223:6	21:14 27:14 38:12	177:13 178:7,13	493:2
286:5,8 287:12	indicated 190:3	40:4 41:7,13 49:6	178:20 181:4	input 27:10 32:7
325:13 336:20,21	indicates 99:13	54:9 58:3 59:5	183:6 184:2,7	37:20 69:1,7,14
347:7 455:8	119:5	60:7 65:9,12	187:3 191:2 203:7	75:11 302:8
504:15	indicating 128:11	82:10 83:19,21,21	204:5 207:14	399:19 427:21
includes 77:11	191:19,22	84:5,7 93:16	208:7,19,22	487:1
147:6 159:9 197:6	indication 102:7	116:22 122:22	209:19 210:1,11	insane 370:20
197:14 242:19	indicative 59:14	123:14 127:14	210:20 211:1	insert 467:4
252:21 261:22	191:7	130:21 134:3	213:2 278:21	inside 189:12 233:3
including 25:7 75:8	indicator 162:21	136:7,16 138:4	279:18 280:8	insightful 241:18

insignificant 116:9	444:9,10 447:2,7	10:16 15:11 16:22	208:5 210:18	79:22 119:11
instance 27:4 96:1	462:18,22 463:12	18:7 22:6 23:14	470:21	160:16 164:12
151:4 355:14	463:15 474:9,13	38:7 46:17 47:2,5	interruption	219:13 351:22
393:19 469:18	492:13,17 496:14	53:15 71:8 165:17	208:10	402:3 426:14
500:9 511:14	496:18 497:21	400:15 476:13	interruptions	475:5 479:15
instances 447:20	498:4 505:10,13	interested 11:12	208:7	invited 27:12 44:5
Institute 12:16	505:18,22 508:13	40:8 52:21 105:19	interval 131:7	214:1
20:11 419:16	508:16 514:13,18	284:21 416:16	145:3 297:17	involve 353:14
instituting 26:19	515:1,6 516:13,17	421:6 481:1	408:21	477:21 507:22
institution 188:11	517:2,6 518:1,4	499:19	intervals 131:6	involved 14:22
institutional 149:7	519:7,10	interesting 19:8	145:12 153:6	20:3 86:13 94:22
institutions 188:10	insurance 60:4,21	25:16 85:22	163:17 426:8	303:20 313:11
188:22 325:9	62:4,11,15,21	234:20 235:1,9	intervention 95:22	378:6
instructions 111:9	235:15 245:9	283:21 346:3	97:22 113:1	involvement 306:1
instructor 18:11	insurer 223:9	368:22 392:16	169:16 217:22	308:2
instrument 465:17	insurers 215:16	404:22 496:9	405:19 406:16	involves 42:19
instruments 109:18	integrate 65:5,10	504:21	473:20 483:9	420:6
355:18	121:6	interests 14:4	interventions 20:6	IOM 60:14
insufficient 124:20	integrated 22:12	27:22	91:5 167:1 305:14	IRF 16:2 84:6
125:7 126:5,18	intended 121:14	interface 465:20	305:15 317:8	92:14 138:14,17
146:4,12 147:14	149:19 154:19	interim 61:17	353:12,21 357:2	138:20 191:5
147:20 148:10,15	348:11 392:22	interject 97:1	359:2 490:12	280:2,13
157:5,12 171:4,8	intending 504:18	intermediate	511:7	IRFs 4:13 82:3
171:22 172:3	intense 25:1 81:9	101:21 110:15,16	intimately 14:22	83:11,13 92:17
197:10,13,20,22	161:22	427:9 454:3,5	intriguing 283:17	151:14
199:6,10 212:3,6	intensity 70:16,19	intermittent 227:1	introduce 8:20	irrespective 244:13
218:20 219:1,6,10	70:19 71:5 81:8	intern 453:18	9:16 24:16 32:13	281:8
242:3,6,11,14	92:12 247:13	internal 102:15	64:1 80:1,1 214:8	Irvine 12:1 19:10
243:16,18 249:20	248:4 507:8,10	121:5 149:7	302:11,12,13	Islands 416:12,16
250:2 271:21	intent 118:15	237:20 436:12	351:22 352:1	isolate 207:18
272:4 276:15,20	154:16,17 387:6,6	497:3	418:19,20 476:9	issue 54:2 63:11
288:16,21 293:6	416:9	internally 300:22	476:11,14	75:3,5,6 101:13
293:11,19 294:2	inter-class 138:10	International	introducing 400:8	103:7 114:5,10
299:4,9 330:20	180:14 187:21	239:16 260:13	introduction 4:6	116:11,20 120:12
331:1,13,16	188:13 195:3	interpret 181:20	33:2 36:21 64:3	122:11 128:19
332:13,16 334:1	197:4	200:19 294:10	160:17 260:10	134:14,17 137:2
348:20 349:3,10	inter-quartile 87:9	371:5	476:12 480:14	139:7 142:1,18
349:15,21 350:3	89:15 114:8	interpretation	introductions 4:4	146:14 147:1
361:7,12 362:18	inter-unit 331:22	276:6 325:6	9:6 28:22	154:8,21 155:21
363:2 365:8 386:2	interaction 34:1	502:13	introductory 9:14	156:1,13 164:22
386:6 390:13,16	326:15	interpreted 47:14	51:17	171:11 174:15
394:14,18 403:8	interclass 263:4	interpreting	intuitive 516:9	176:17 178:17
403:11,17,20	515:11	127:18 327:6	invent 92:2	186:11 215:7
404:14,18 411:10	interdisciplinary	interpretive 325:7	invest 74:14	218:17 226:3
411:13,21 412:3	314:11,20 315:2	interrupt 36:2	investigator 427:19	233:14 240:4
415:8,12 421:10	325:16	195:2 409:6	investments 387:19	263:15,17 267:17
438:7,10,22 439:4	interest 4:4 9:6	interrupted 208:4	invite 37:19 53:7	273:22 282:10,10

290:8 294:5 295:1 296:7 298:12 305:19 342:9 344:18 346:10 359:14 368:21 390:10 392:9,11 406:4 408:10 409:6 410:6 429:5 430:2 433:4 445:13,16,16 448:13 455:6 464:11 471:18 issues 13:20 15:2 27:11 45:19 67:18 67:22 69:9 72:4 74:12 88:12 90:20 100:22 147:7 149:13 155:20 170:4 189:5 223:14 225:13 247:14 252:6,7 256:8 288:10 298:11 316:1 318:8 333:18 334:2,17 335:14 337:7 338:10 342:8 365:19 367:8 377:6 382:19,19,19 385:17 386:19 387:7 390:21 391:7,21 405:20 417:2 436:22 455:9 456:20 480:18 501:20 502:2 item 8:10 188:2 220:22 274:15,15 480:1 items 7:10 IV 506:10	Jay 305:21 313:8 Jay's 313:9 JD 4:5 Jean's 459:11 jeopardy 203:2,5 Jersey 216:3,5 Jersey's 216:4 Jo 1:15 16:15 31:7 job 281:8 298:16 342:12 504:2 Joe 302:14 John 1:16 23:6 30:17 39:21 302:19 413:5 join 32:20 joined 22:22 joining 36:15 JOSEPH 3:14 journal 94:5 305:20 307:6,8 journey 6:21 Joynt 2:1 18:10,11 31:15,15 234:19 294:21 340:21 348:13 358:19 368:20 395:7 402:6 404:3,21 482:21 485:22 490:15 499:2 506:3 507:3 518:7 judge 46:2 110:13 judgment 108:13 123:16 130:5 140:20 155:13 207:8 judgments 114:22 July 35:7 45:15 50:8 53:5 498:9 jump 78:7 356:15 460:18 jumping 475:9 Junction 379:19 June 35:7 45:15 498:10 jury 108:12 343:7 justifiably 130:15 justification 59:4	140:3 447:22 455:4 justified 52:11 449:15 justify 96:12 justifying 42:21 <hr/> K K 352:19 Kalbfleisch 3:9 302:18,19 343:22 345:12 Kaplan 1:10,12 4:3 6:14,18 11:20,21 31:21 39:13 55:4 63:6 67:7,10 77:9 79:9 87:20 91:9 91:15 93:17 104:18 112:19 113:13,17 114:2 117:3 120:5 124:4 125:1 127:1 133:13 134:12 136:20 141:14 142:14 144:18 145:19 146:13 147:9,16,21 148:16 153:14 155:6 156:11,22 157:8 158:2 159:19 160:6 166:4 170:7 172:4 177:10 178:3,10 178:18 187:18 195:1 197:2 212:11 245:12 259:2 269:11 271:16 272:5,20 274:10 276:1,8,21 279:12 281:17 283:11 284:16 285:7 286:18 288:8,22 291:4 292:2,21 293:12 294:3,20 296:2,17 297:4 298:10,19 299:11 300:2	317:17 332:9 337:6 351:2 356:1 356:10 357:22 358:2,8,17 359:12 360:5 361:2,13 362:1,11 363:3,15 363:22 364:21 365:9,13,15 368:18 370:18 371:20 372:7 374:1 375:7,14 380:8,16,21 382:5 383:6 384:19 386:7,12 388:20 390:2,6,17 392:5 392:20 394:4,10 394:20 395:3,5 396:7,10 409:12 410:4 444:19 446:1 460:18 463:3 470:20 491:16 497:10 503:17 509:18 510:3 517:14,18 519:21 520:20 521:10 Karen 2:1,15 4:8 18:11 27:13 31:15 44:5,17 51:21,22 67:11 68:7 97:12 181:10 192:14 194:16 198:2 233:19 234:11 236:8 239:3 273:20 294:20 340:18 348:12 358:18 368:19 371:7 383:7 385:17 392:8 395:6 402:3 404:1 458:10 482:20 483:22 485:5,21 499:1 506:2 518:6 Karen's 296:4 KATHERINE 1:13 Kathy 13:22 30:19 59:7 142:18	175:13 186:15 318:19 336:16 412:5 453:16 468:10 487:9 KECC 302:17,17 302:22 keen 422:3 keep 6:11 7:2 34:18 45:21 50:12 69:5 94:2 107:10 120:21,21 174:18 192:18 216:9 274:17 302:2 316:2 447:9 456:14 464:18 517:10 518:19 keeping 6:10 63:19 107:7 341:13 342:12 keeps 326:21 Kelly 1:21 21:11 30:8 kept 309:9 341:5 433:7 key 45:4 47:8 48:15 49:22 109:4 213:4 222:9 310:8 Keziah 3:3 477:1 KHAN 2:14 7:7 8:19 25:17 32:3 36:8 63:21 65:15 65:21 66:3 78:9 78:21 96:22 213:15 214:10 250:19 251:8 397:4 417:17 418:6 447:8 475:17 476:4 520:12 521:12 kick 164:13 214:1,4 216:14 480:15 Kidney 3:10,12,15 kind 12:4 19:10 27:22 46:4 49:1 58:17,18,20 59:5 59:17 61:8 68:22 75:5 76:10 79:1,3
---	---	---	--	---

79:10 85:10 87:9	13:20 25:9 36:13	321:2 323:2,4,17	512:7 517:11	295:9 308:9 331:8
89:21 90:17 91:20	37:1 45:21 46:3	328:4,18 329:3	519:1 520:21,22	361:1 420:16
93:4,7 97:2	48:10 51:6 52:2	330:6,11 332:1,5	521:5	432:5 434:21
104:21 107:7,19	52:11 53:22 62:22	332:20,21 335:22	knowing 58:7	441:16 464:9
118:13 128:17	68:2 71:8 76:9,13	336:5,10 337:11	142:9 151:1	467:17,18 512:10
129:16 132:9	78:2 79:7 88:20	338:22 339:10,13	known 366:4	largely 356:18
135:16 141:12,19	90:19 92:4 94:4	340:15 341:16	knows 46:6 183:11	larger 129:22
143:8 144:1 145:5	100:8 101:3	342:18 343:16	203:17 378:1	133:9 134:6,8
145:8 150:20	102:10 106:20,22	359:4 364:12	393:20 488:19	190:9 218:17
153:4 155:10	107:3 111:3	368:9 370:1,6	Krishnan 251:10	387:6 436:1
160:2 164:19	117:22 118:17	373:3 376:2 378:4	251:11 258:15	504:22
172:8 174:5 178:2	119:17 122:15	378:13,20 379:12	306:18 311:19	largest 19:14 22:14
182:7 187:19	123:9,14 126:16	379:14,15,18,19	324:22	277:21 292:4,7
188:15 189:4	127:13,22 130:22	380:2,5 384:10	Kroch 3:11 418:21	344:4 364:10
192:1 194:18	131:1,5 135:7,10	385:6,11,17 388:8	418:22 426:16,18	481:18 512:17,19
200:12 243:22	140:3,4,13,14	388:21 389:10,14	427:13 429:4	Larry 21:17 30:10
255:12 270:19	143:14 148:3	389:16 390:20	431:7 432:20	103:9 134:14
272:13 279:1	151:16 154:20	392:14 400:11,22	434:6 436:4,13	136:8,11 179:9
283:17,21 306:22	155:11 165:16	407:5,8,14 408:20	437:20 439:17	182:9 188:8,14
308:2 318:11	166:5 170:9 173:3	410:6,7 413:1,16	441:6 442:6	196:15 236:9
332:22 337:14	178:5,9 183:17	414:1,7,18 416:21	445:15 446:9	296:2 329:6
345:3 373:14	184:11 186:6	419:8,18 420:5	448:9 449:8 450:2	380:22 382:13
379:11 381:20	187:2 188:4	422:1 425:19	452:22 453:7	454:12 456:18
382:3,9,12 390:8	189:12 190:19	430:11 433:20	454:7 460:12,17	467:22 495:9
397:14 414:11	192:11 193:13,21	437:6,7,9,19	462:8 464:1,5	Larry's 136:1
419:20 423:14	194:8,10,12 198:8	439:14 440:19	465:5,8,19 466:19	187:20
425:22 427:2	201:2 204:9	441:4,15 443:11	467:1 468:5,7	Lastly 255:12
428:19 430:10,20	205:12 206:14	443:14,18,21	469:11 470:4	late 237:18 351:7
460:20 462:5	207:16 208:9	445:8 447:14	471:4 472:16	443:14 506:11
465:21 467:10	209:16,17 210:8,9	448:3,15 449:9		520:5
484:8 504:20	217:2,10 219:19	450:13 451:13,15	L	lately 469:3
kinds 57:6 63:10	220:1 224:10,10	451:21 452:8	lab 122:19	Laughter 6:17
84:5 87:7 105:14	227:9 230:8 231:3	454:4 455:8,15	labeled 45:3 240:17	29:19 31:20 91:11
105:21 124:9	233:7 234:14	456:3,5,8 458:13	labeling 295:4	111:19 131:13
128:14,20 145:11	240:8,8 243:5	458:14,19,22	lack 164:18 247:14	135:19 148:22
169:3 178:21	244:12,16 245:5	459:5,8,9,16	308:9 333:20	159:21 213:21
188:21 195:11,12	246:13 255:9,21	460:1 462:1	lamp 92:4	287:1 351:4
300:15 465:21	259:3 267:5 274:6	463:19 464:15	landed 431:2	361:21 362:3,13
484:3,7 501:7,8	275:9 277:9 279:9	466:17 469:10,15	language 385:5	390:5 395:4
511:12	280:3 282:10,21	471:1,12 480:21	laptop 111:11	414:22
knee 92:21 122:7	284:12 285:11,12	482:13 484:17	laptops 7:16	Laura 3:16 239:15
511:17	294:13 295:13	485:16 486:4,7	large 14:20,21 16:4	260:11,12 266:8
knees 118:13	308:20 309:5	488:4 492:1,7	16:19 66:16 98:15	267:13 268:2
knew 175:2 207:6	311:9 313:17	493:16,21 500:5,6	99:11 123:8	269:22 277:12
351:6	315:8,22 316:2	500:11 503:1	132:22 161:10	280:11 282:11
knitting 272:14	317:21,22 318:22	504:4,20 506:10	234:17 254:15	285:2,16 287:7,17
know 8:2 11:5,6	319:13,15,16,20	510:5,10 511:4,17	283:4 285:18	287:22 288:6

290:1 291:16	424:18 425:2,5,10	68:18 72:4 75:18	392:10	184:14 188:12
292:14	426:8,10 429:6	75:19 84:10	limiting 440:16	189:3 203:12
LAURENT 1:20	430:15 431:16	108:14 118:5,8	line 100:15 101:16	210:13 217:3
Laurie 3:4 80:6	432:4,18 433:22	120:2 187:14	113:10 118:1	233:17 238:15
160:19	434:3 437:18	195:22 196:7	132:12 214:11	245:18 263:19
lay 327:7,7 399:12	442:9,10 446:12	207:22 211:10	425:6 471:3	272:12,17 277:4
lays 326:2	446:18 449:20	219:19 220:16	475:20 479:18	277:11 278:1
Lazar 25:8	451:5,22 453:6	226:15 232:18	linear 420:18	290:4 305:9 326:3
lead 27:13 44:6	456:2,6,16 465:12	236:1 247:7	441:20	331:19 343:1
121:4 142:6	467:6 469:19	278:19 316:9	lines 117:19 122:3	347:16 352:11,15
343:18	470:11 471:15,15	329:11,13,15	221:3 250:20	369:11 384:21
leadership 301:13	471:16,17 473:6	333:21 360:13	444:22 468:20	385:5,12,13
leading 397:14	473:20 474:22	383:16 384:9	509:8 517:14	388:22 397:10
495:3	500:22	421:2,15,17,17	lingo 71:22	411:1 428:17
leads 70:16 94:12	lengths 203:9 437:2	422:14 450:1	link 105:4 106:4,8	429:1 431:8
312:20 328:12	450:16	467:16 471:5	110:17 236:20	439:15 443:16
400:2 491:11	lengthy 9:20	479:1,2 497:2	414:9 420:18	445:7 472:1,11
lean 121:5	Leonard 419:15	503:1,10 507:18	linkage 99:14	478:14 482:16
leap 105:18	Leslie 1:21 21:11	508:4 511:21	316:17	483:14 485:8
leave 23:12 67:19	30:8 74:2 104:9	512:1	linkages 338:17	495:1 497:11
104:12 183:2	175:17 185:1,13	levels 121:13	linked 110:20	503:6,18 512:8,11
215:10 254:7	199:13 202:6	220:16 246:20	113:1 241:6	512:14 518:7,16
337:20 351:12	230:6 274:10	360:17	linking 91:3	live 377:17 381:13
428:17 479:20	296:17 351:21	lever 322:19 436:2	list 78:9 82:19	394:3 395:13
485:4 521:7,8,10	356:11,13 357:22	leverage 323:21	88:13 172:21	419:12
521:12,14,16	360:6 362:4	324:8 325:10	232:1 281:16	lived 353:8
leaves 405:9	363:16 382:10	328:3	listed 75:16 78:12	lives 22:16 194:9
leaving 174:11	391:3 392:11	levers 322:18	87:18 428:6 460:8	372:2 380:12
192:20	432:8 464:22	LI 3:12	460:15 513:3	449:1
led 145:14 450:6	Leslie's 201:1	liberty 241:19	listen 40:6	living 333:8 378:7
451:7	lesser 62:9	licensing 465:3,18	listening 318:22	LLC 477:2
left 70:13 80:22	lesson 120:1	465:21	lists 421:19	loading 488:11
113:18 122:15	let's 11:16 40:12	lie 148:17	literally 453:10	local 66:19
176:14 286:19	53:3 111:6 122:11	life 1:17 22:12,22	literature 135:11	locate 381:19
348:13	148:7 150:18	304:15 373:15	217:4,10 266:17	416:19
legitimate 464:16	167:13 178:15	light 92:6 113:18	441:15 455:15	located 22:13
Leisure 502:1	219:11 249:17	LIJ 1:19 18:20	484:10	419:11
lend 145:15	293:15 297:14	liked 369:21	little 10:16 25:18	location 93:3
length 5:6 39:19	329:21 346:1	likelihood 359:10	63:13 80:18 86:3	locations 19:17
69:20 70:21 72:10	348:16 377:10	limit 192:14 248:17	86:9 89:3 90:11	locus 319:1,12
76:6 77:2,21 83:9	418:1,6 446:22	limitation 236:15	91:22 93:21 97:2	log 420:18
162:15 226:21	465:21 467:3	495:12	97:15 101:15	logic 199:5 356:22
228:6 262:17	475:14 476:3,16	limitations 162:10	106:3,6 115:7	logical 100:2
335:21 418:13	476:17,21,21	236:13	129:18 130:2	430:17
420:13,14,15	487:4 489:11	limited 10:14 166:2	131:17 141:20	Logically 76:2
421:7 422:8,8	497:17,19 516:11	199:17 316:2	145:9 150:15	logistic 303:17
423:7,19,20	level 17:20 27:9	357:17 365:20	153:7,13 182:18	479:1

lone 430:19	200:15 218:12	103:12 107:14	71:9 73:12 80:9	146:21,22 397:11
long 6:21 13:13	221:19 223:20	114:18 116:17	83:20 84:1,4,10	low 87:1,3 88:4
64:18,22 65:2	225:20 226:12	119:21,22 125:12	86:8 89:21 90:1	96:5 115:4 124:19
72:22 80:12 93:11	241:5 277:16	133:15,15 137:3	92:6 93:14 94:8	125:6 126:5,18
122:17 149:17	279:5,10,20	139:19 140:10	94:22 100:17	127:5 135:3,8
160:22 176:7	292:19 308:13	150:8 153:9	104:12 115:22	136:7,16 146:4,11
232:1 234:10	309:3 317:4,7	166:15 174:5,6	119:1,5,7 122:13	147:13,19 148:10
238:3 255:3	328:9 334:10	179:16,18 180:3	122:17 123:20,21	148:14 157:5,11
284:12 353:9	339:2 342:19	181:16 188:9	134:18 140:10	171:4,7,22 172:3
406:18 419:21	346:22 360:16	195:5 198:17	150:12 152:18,22	179:20 190:19
423:9 425:14	379:12 381:8,12	206:19 208:14	170:16 173:2	191:3,16 193:21
439:18 450:10	388:19 391:17	220:13,20 223:2	176:22 177:7	197:9,12,20,22
460:7 463:7	393:14 397:1	236:17 246:11	179:1 182:17	199:6,9 200:15
489:13 490:7	406:14 408:15	263:21 266:3	183:2 198:14	212:3,6 218:19
510:6	409:4,5 410:22	283:2 289:18	204:16 206:10	219:1,6,10 221:6
long-serving 19:13	421:14,19 422:6	296:11 297:11	223:13 224:17,21	242:3,6,10,13
long-term 4:15	423:5 424:20	303:4,11 305:12	225:5 231:17	243:15,18 249:20
15:13,22 22:18	430:18 432:22	305:13,18,22	234:13 235:10	250:2 257:8 263:7
64:9 75:8 115:7	433:1 440:6	318:6 346:17,19	236:11 237:21	271:3,20 272:4
161:13 162:21	442:22 450:15	347:2 360:10	248:2 249:2 254:9	276:14,20 279:14
167:12 173:16,20	451:9 452:8	364:14 375:9,10	270:1,2 281:5,11	288:15,21 289:7
174:11,16 175:20	460:22 465:14,15	387:20 395:10	291:12 296:5	292:17 293:6,10
183:2 201:17	470:11 473:15,17	398:17 408:12	312:20 314:12	293:18 294:1
202:18 204:19	473:19 502:22	421:9 422:2	329:11 333:13	295:22 296:8
205:3,7 212:16	506:7 507:4 520:3	429:13 430:18	334:2,17 336:2,8	299:4,9 329:17
217:5,6 218:15	lookback 176:5	431:15,19 432:16	336:9 338:7 339:9	330:19 331:1,13
261:20	177:2 183:22	436:14,15 451:15	343:5,6 344:1,6	331:16 332:12,16
longer 28:8 61:1	207:5	454:16 459:7	347:5 348:6	334:1 348:19
296:22 429:18	looked 75:19 84:13	469:12 471:9	354:18 358:22	349:3,10,15,21
430:2 452:9,16	86:18 90:5,6	488:21 502:6	370:9 377:20	350:3 361:7,12
longer-term 386:19	110:5 114:15	looks 78:20 79:7,9	378:17 381:21	362:17 363:2
longitudinal-type	172:22 222:5	210:17 215:7	395:9 397:3 402:6	365:8 386:2,5
382:1	224:9,11 226:4	260:22 285:22	408:13 414:8	390:13,16 394:14
look 11:1 14:9	345:19 366:6	295:7 346:4	417:1 419:1,14	394:18 403:7,11
18:21 36:7 47:2	373:9 375:2,13	434:20 492:6	420:21 431:20	403:16,19 404:14
48:1,9 49:8,19	422:20 439:7	504:7	439:11,11,12	404:17 411:9,12
52:12 54:15 74:12	497:15 498:8	loops 300:17	440:21 451:14	411:21 412:2
77:18 84:2,14	504:6	lop 176:16	464:12,17,21	415:8,12 438:6,10
86:19,20 89:1,22	looking 10:3 11:9	Los 15:19	467:18,19 484:4	438:21 439:3
90:10 92:4,5	20:5 37:9 44:21	lose 89:12 179:7	488:4 493:10	442:4 447:2,6
106:8 107:21	46:1 47:10 49:20	238:4 302:7 401:8	495:13,19 499:16	455:17,17 457:3
110:8 121:12	53:19 54:8 56:13	461:9 509:7	504:8 510:16	462:17,21 463:11
123:4 127:19	65:13 72:19 73:18	loses 89:8	lots 116:15 133:21	463:14 474:8,13
130:3,9 131:7	75:21 87:12 92:7	loss 485:8	243:3 473:22	482:3 492:12,16
174:4 180:2,7,9	95:7,9,13,16,19	lost 248:7	490:12	496:13,17 497:21
180:21 181:7	96:1,6,9 97:4,11	lot 6:16 7:2 19:16	Louis 13:3	498:3 501:19
191:17 194:15,18	99:10 102:8	20:13 42:2 50:15	love 117:22 146:18	505:9,13,17,21

507:18 508:12,15 509:20 514:13,18 515:1,5 516:13,16 517:2,5,22 518:3 519:6,9 low-ish 277:4 low-performing 375:5 low-volume 88:4 127:16 lower 7:18 70:18 115:12 116:1 122:7 163:21 217:14 218:16 252:18 257:6 281:12 295:8 334:11 426:10 429:5 443:1 479:9 506:5 lowest 114:12 lows 216:18 LT 198:9 LTAC 142:4 149:16 151:7 LTACH 209:17 211:3 397:6 LTACHs 209:7 213:4 LTACs 151:6 LTCH 160:15 162:3,4,8,19,22 166:22 167:14 168:8,9,20 174:8 175:4,11 176:3,11 176:19 177:7 178:22 183:8,19 183:22 200:22 201:3,4,11,15 202:21 203:15,16 206:16 207:1,4 208:6 280:13 LTCH's 163:15 LTCHs 4:16 115:14 161:1,22 164:22 167:7 203:9 lumping 206:17	lunch 7:14 239:11 258:18 259:1 272:12 302:2 LUPAs 507:18,21 luxury 122:19 Lyzenga 2:13 4:10 9:1 68:8 74:1,18 75:1 76:4,13 78:5 90:14 <hr/> M M 302:17 M&M 495:1 M.D 333:18 MA 4:3 222:20 248:4 MAC 255:13,22 macro 43:22 Mae 1:16 19:22 30:2 magic 141:13 Mahesh 251:11 main 19:12 20:14 33:1 42:7 166:8 306:12 334:7 360:22 420:20 431:10 maintenance 37:11 37:12 40:10 69:22 70:4 154:5,20 155:5 430:1 major 17:9 59:18 178:16 236:12 256:8 266:10 270:5 282:19 402:9 492:1 majority 28:17 42:11 82:1 108:2 253:5 282:14 296:10 347:21 398:13 505:4 making 26:6 56:21 68:17 105:9 107:8 118:22 130:5 135:2 199:22 244:3 247:2 255:2 301:10 314:3	319:3 341:20 343:3,15 345:2 352:10 414:3 421:11 424:3 466:20 486:17 managed 109:7 153:1 177:18 183:5 220:11 225:13,18,21 management 13:4 284:7 289:9 387:18 451:16 485:2 manager 2:13,14 7:8 8:21 9:1 214:21 managerial 270:11 managers 255:17 managing 66:13 117:19 Manatt 64:15 65:3 mandatory 210:4 manifestations 253:8 many-to-one 312:8 340:3 map 17:13 21:9 64:8 73:11 108:20 120:14 121:8 137:1 155:20 156:6,12 298:17 300:5,6,9,19 381:8,13,15,20 390:22 mapped 414:14 416:10 marginal 142:7 Mark 427:19 marker 90:5 369:2 market 17:10 markets 416:18 Massachusetts 22:14 185:8 match 370:3 material 86:22 materials 345:7 matter 2:4 10:2,5	11:15 118:16 123:9 160:9 198:12 259:14 369:19 388:9 418:4 matters 9:22 mayors 382:16 MBA 1:12,16 4:2 MCO 216:1 222:21 MD 1:12,13,17,18 1:18,19,20,22 2:1 2:7 3:2,6,14 4:2 MDS 215:13 219:22 220:2,21 221:13,17 223:5 223:17 224:9 226:5 232:7 234:7 236:20 238:7 240:15 246:3,9 247:13,18 MDS-based 292:18 mean 11:7 28:15 58:18 77:20 86:5 89:18 92:8 93:22 98:12 112:3 114:21 115:11,11 116:9 118:12 123:4,5,11,15 124:9 128:4 130:11,14,16,16 130:22 150:19,20 153:4,10,11,20 155:7 165:15 167:6,6 168:16 176:17 178:15 181:19,22 182:1 184:8 185:19 195:9 200:17 202:22 207:2 210:20 227:6 228:16 234:5 238:1 240:4 241:4 247:17 248:19 263:14 269:16 275:1,19 286:1 291:10,13 294:8 294:19,19 315:11	319:14 328:16,20 342:18 344:1 345:14 363:12 371:12 373:20 374:7 375:21 389:13,21 392:8 393:10,22 397:19 398:4,8 413:15 417:3 420:13,17 423:9 430:9 432:20 433:14 436:13 441:12,15 442:13,15 451:2 452:12,21 462:3 463:5 465:9 466:19 467:7 471:16 472:18 483:2,7 486:7 490:11 500:4 502:22 503:3,5 507:4 513:11 meaner 302:1 meaning 41:9 86:12 192:21 meaningful 21:13 197:16 292:1 means 81:21 83:4 89:20 94:13 112:19 127:17 136:9 181:6 192:8 194:3 254:19 279:17 315:3 400:18 434:18 445:1 meant 178:9 measly-looking 132:7 measurable 269:3 measure 4:12,15,19 12:8,16,18 13:13 13:14,18,18 26:2 27:3 32:12,17 33:10 34:2,12 37:14 41:9,9 42:8 42:9,18,21 43:3 46:18 47:15 48:2 48:14 49:5 52:19
---	--	--	---	--

52:19 57:2 72:3	236:21 237:2	364:3,4 366:7,15	519:18	73:16 74:9,20
76:6,8,18 77:2,14	238:10,19 239:10	367:2,6,11,20	measure's 181:22	75:7,10,12,16,18
80:2,5 81:22 82:3	239:11,12 240:8	368:10,17 370:14	424:15 439:18	77:1,16 78:1,8,10
83:3,4,16 87:12	240:11 241:22	377:7 380:1 381:4	measured 91:4	80:9,10,15 81:4
90:19 91:8 93:20	243:7,8 244:1,2,8	382:4 383:10,13	236:1 275:11	94:1 95:10,10,11
94:11 95:5 99:3	244:9 245:14	383:18 384:3	276:4 331:22	95:12 96:8 97:4
101:2,14 102:4	246:1,4,14 247:15	385:3 388:19	344:11 352:20	97:10,10,17 98:3
103:12,15 104:4	247:21 250:9,12	389:16 392:13,17	432:7	98:7 100:5 101:13
105:21 107:11,12	251:18,21 252:5	392:21 393:13,22	measurement 2:12	105:9,14 109:16
107:13 112:16	253:20,22 256:10	394:6 396:17,20	2:14,15,16 11:22	110:6 114:4 120:7
116:12 117:9	258:1,7,17 260:7	396:22 397:2,6,7	12:5 61:6 69:11	120:15,18 136:22
118:6,21 119:3,16	260:10,14,15,21	398:7 399:10	69:12 70:18 94:7	137:13 145:7,11
122:21 123:16	261:4,7,9,11,14	400:8,9,21 401:8	144:21 166:22	149:15 154:4,6,16
125:11 130:8	261:20,21 262:22	401:20 405:3	182:16 273:5	155:5 156:5
131:20 137:3	263:11,11,16,19	406:6 408:6	275:5 329:8	157:20 159:13,13
139:17 140:9,17	263:20 264:5,12	409:20 410:14	335:14 336:12	161:2 164:3,5
141:19 142:3,5,13	265:16 266:11	413:7 415:18	370:19 371:4	165:20 166:15
145:4,5 149:18,18	272:11 273:6,11	416:2 417:14	382:8 419:14	173:10 178:21
149:22,22 151:10	273:11 277:18	418:7,12,20	432:21 446:8,10	179:16,19 180:22
152:4 154:13,14	279:1,22 280:2,5	419:19,22 420:6,7	446:11	181:2 188:2,5,16
155:2,8 157:15	280:9,12 281:16	420:20 421:22	measurements	196:21 203:1,2,4
158:6,7,18,20,21	282:12 283:3	422:18 423:8	145:7 195:15	206:19 217:13
159:4,6 160:10,14	284:9,19 286:6,19	425:21 427:15	409:15	230:2,3 232:4,6
160:17,20,21,22	287:12 288:7	428:2,4,5,9,10,20	measures 4:11 6:8	235:10 236:6,16
161:3,6,7,18	289:17 290:6,17	428:22 433:11	7:3 12:9,11 13:16	238:17 246:9
162:6,8,20 163:2	291:3 294:14,16	436:7,11 437:14	14:11 16:10,13	247:8 253:12
163:3 164:1,3,6	296:14 298:6,7	437:18 440:2	18:8 20:21 22:9	258:2 261:12
164:11,17 167:7,9	299:19,20 300:12	441:8 449:5 456:4	24:18 26:2,14	262:7 263:8,10
168:21 170:3,5,13	301:22 302:11,11	458:9,15 459:12	27:12,15 28:13,17	264:9 269:8
171:10,14 180:6	302:13 303:3,7,9	460:2,20 461:1,11	32:14,16 33:2,5	272:15 273:3,6,9
180:16 181:9	304:17,20 306:7,9	461:13 464:8	33:10,12,17 34:10	273:19,22 274:4
183:5 185:9 186:9	306:19 307:3	465:8 468:13,18	35:12,15 37:11,12	275:3,19,21 277:5
188:18,22 189:6	308:1 309:14	470:16 471:20	37:20 38:11,18,22	279:11 281:2,13
198:19 199:4	310:19 311:6	474:21 476:12	39:7 40:19,22	289:5 292:16
200:8,12,13,18	315:10,12,21	477:9 478:5,12,13	41:5 42:5,11,12	294:7,16 295:20
203:3 205:19	318:13 322:5	478:15,17,22	42:13,17,22 43:1	296:10,15 298:16
210:9 211:7 212:9	328:22 329:5	480:19 484:12	44:3,10,13,14,22	300:5 301:3,6,9
212:14,18,20	333:5,16 334:10	485:15 489:13,17	44:22 45:22 46:9	301:11 303:11
213:9 214:2,9	334:11 337:17	489:19 490:2	46:9 49:21 50:11	305:1 306:10
215:2,3,4,17,18	338:12 342:2	494:3,13 495:13	52:3,9 53:6,12,20	307:1 308:10
215:19,22 216:22	343:4,16 344:2,19	495:18,19 498:16	54:13 55:8,10,15	311:2 332:3 335:1
217:9 219:17,22	345:11,13 346:15	500:12 501:5,7,11	55:17 56:4 58:15	337:15 340:15
220:4,16 221:2	350:16,20 351:9	502:6 504:22	68:21 69:6,7,10	346:11 352:12
223:2 226:12,13	351:17 352:1,13	508:8 509:2,11	69:19 70:1,1,3,5,7	353:17 354:12
229:18 230:5	352:14 354:10,20	510:2,17,18,22	70:8,20 71:4,11	362:8 368:5
234:7,7,14 235:2	355:7,21 357:9,13	512:9,9,12 513:2	71:13,19,20 72:6	370:20 371:2
235:5,18 236:3,13	358:6,13 360:12	513:7 515:15	72:11,14 73:13,14	378:5 383:20

384:6 397:4,10 398:15 399:16 402:11 408:20 410:7 411:2 413:8 414:10 422:4,19 430:9,13,22 431:3 433:21 439:16 448:19 449:17 455:10 459:15,17 465:11 473:16 475:11 476:15 477:4,6,15 480:6 492:2 495:14,19 496:7 498:15 503:10 511:1 521:1 measuring 70:21 71:3 110:2 180:13 183:6 189:18 245:15,16 316:9 329:10,12 355:1 356:20 372:13 377:13 404:7 413:9 421:2 mechanism 255:20 median 433:14 480:21 Medicaid 59:13 60:3 61:21 62:2 62:20 161:5 231:9 Medicaid-manag... 20:17 medical 1:19,21 2:2 2:3,5 3:2,20 5:2,5 14:13 15:7,18 18:12 22:11 25:9 66:7 83:21 309:22 309:22 310:14 313:6 319:19,20 321:3 323:4,6 324:10,11 325:8 327:13 335:17 341:11,20 351:20 353:14 355:3 371:11,13 393:5,9 393:11 451:20 455:16	Medicare 5:1,4 81:22 82:1,6 83:7 139:8 142:21 161:5,11,20 162:6 179:1,6 182:21 198:6 215:15 220:9 224:1,4 225:12 226:5,6 231:9,15,16 236:18,20 237:6 239:13 244:21 245:1,3,8 252:12 260:18 331:6 336:20 351:18 353:8 355:9 360:11 361:18 363:6 364:8,17 366:22 372:21,22 377:5 386:19 387:14 389:11 396:18 400:16 417:15 493:22 498:8 500:17 Medication 313:4 488:15 medications 109:7 medicine 1:22 2:2 16:8 18:11 19:10 19:15 94:5 102:15 MEDPAC 56:11 MedPar 425:17 465:12 472:18 meds 488:17 meet 157:15 203:19 212:9 244:14,18 245:2 250:9 469:4 meeting 7:13,20 8:15,16 9:12 17:1 24:2 32:4,6,10 34:4,17 35:3,5 74:16 179:14 213:16 273:14 274:8 306:6 307:13 meetings 32:7 39:22 40:2 Mel 80:4 281:2	MELVIN 3:8 member 5:19 12:10 15:21 16:1 19:13 22:4 23:3 35:6,13 38:9 40:5,19 80:10 250:18 326:22 387:14 388:5 473:12 500:1 members 23:17 24:9 32:15 33:11 34:1,5,9 37:19 38:1,10 41:20 63:22 68:6 78:18 120:14 159:11 184:16 220:18 233:9 259:9 265:7 428:8 498:21 membership 26:7 32:8 229:1 237:15 238:10 428:19 Memphis 2:8 17:7 17:8 men 7:12 mental 20:12,14 mention 25:5 45:17 65:8 365:22 367:5 427:14 466:12 469:21 mentioned 48:4 62:21 68:11 74:4 144:4 151:5 241:1 255:11 265:15 277:2 345:18 347:10 366:10 408:5 469:2 493:3 495:2 mentions 140:1 merit 429:2 message 286:7,15 296:21 338:15 354:19 Messana 3:14 302:14,15 322:9 324:16,19 329:3 345:5 347:15 Messana's 327:22	met 1:8 26:4 112:20 113:4 meta-analysis 102:13 method 116:17 197:8 306:22 methodological 256:8 methodologically 109:14 methodologist 27:13 44:6 methodology 18:22 296:16 methods 46:21 49:16 161:8 261:17 306:20 307:7 metric 62:4 224:6 234:18 256:1 319:5 337:1 360:19 364:10,20 372:12 373:3 395:8 405:1,12 412:9 484:12 487:20 499:19 metrics 20:16 235:8,22 236:2 407:5 499:8 MHA 2:8 MI 253:4 343:13 Miami 380:19,19 mic 491:8 497:11 Michigan 3:9,12,14 4:22 14:8 302:10 302:16,21 351:8 352:9 microphone 8:13 8:15 210:19 239:8 496:20 microphones 8:11 microscope 392:18 mid-2000s 424:19 mid-range 291:1 middle 87:8 116:4 131:21 290:20 midnight 139:9	244:19 284:12 432:11 494:21 midnights 493:20 midst 44:20 68:3 mile 131:8 miles 324:6,7 336:6 million 363:8 440:5 478:2 484:16 mimic 501:10 mind 29:14 50:12 59:2 69:5 107:10 155:15 170:12 174:18 185:22 187:1 192:19 433:8 503:13 517:16,17 518:19 mindset 84:3 minimal 162:9 373:12 446:13 506:21 508:3,6 minimize 489:3,7 minimum 195:17 195:18 205:21 215:19 230:22 231:2 348:7 minor 388:11 minority 312:7 Minton 31:13 Minton-Foltz 2:2 17:16,17 31:13 76:5 106:13 203:14 209:15,21 210:3,16,21 226:18 227:16,20 246:16 284:17 371:9 412:19 461:15 462:11 minus 145:1 minuses 151:18 minute 51:22 160:16 259:3 minutes 141:15 148:18 164:11 179:12 258:22 286:19 301:21 329:5 343:20 351:10 386:15
--	--	--	---	---

418:1,2 476:10	345:19 347:9	293:18 294:1	387:14 388:5	260:6 268:12
mirroring 397:21	420:18 421:15	299:4,9 330:19,22	409:20	290:22 329:1,21
misleading 165:11	422:10,12 425:21	331:12,15 332:12	monthly 321:19	333:5 348:16
295:6	426:7 431:8 432:2	332:15 348:19	months 39:9 51:2	350:21 351:8,14
misnomer 503:6	433:10 434:7	349:2,9,14,21	137:19 156:9	361:16 396:22
misplaced 450:12	439:18 440:3,7,9	350:3 361:6,11	237:13,14 261:4	411:6 418:11,16
misreading 295:10	440:9,15,22	362:17 363:1	266:12,18 399:21	444:17 445:20
missed 25:13 168:2	441:20 442:7,11	365:8 366:16	500:18	459:22 462:14
203:18 334:14	446:15,20 448:7	386:2,5 390:12,16	Moore's 269:12	463:9 487:19
missing 126:17	450:5 454:16,17	394:13,18 403:7	270:19	490:20 491:3
177:11,12,15	454:20 455:5	403:10,16,19	morbidity 84:9	492:10 497:10
178:1,2 179:2	456:21 457:2,15	404:14,17 411:9	283:16 422:13	moved 90:5 115:16
197:18 219:7	458:22 463:19	411:12,20 412:2	morning 6:3 7:7	229:21 390:22
220:6 221:4,5,7	464:13,16 467:2,7	415:7,11 438:6,9	14:12 17:16 18:10	movement 70:18
222:8,13 224:21	467:14 468:2	438:21 439:3	18:17 19:21 21:5	73:18 119:2,5
225:3 248:17	472:12 479:1,2	447:2,6 462:17,21	21:16 22:10 24:5	200:16 470:11
338:13 373:20	498:11 499:16	463:11,14 474:8	24:19 44:18 65:16	moves 35:19 50:11
mistake 113:12	500:17 504:2	474:12 492:12,16	146:20 251:18	267:21 281:10
misunderstanding	507:10 512:11,14	496:13,17 497:21	306:18 447:17	moving 6:11,18
486:21 507:9	model's 163:12	498:3 505:9,13,17	509:14 520:17	28:6 43:21 78:5
misunderstandin...	modeling 85:22	505:21 508:12,15	mortality 101:22	105:16 121:10
33:5	88:1 122:16 123:2	514:13,17 515:1,5	188:21 283:16	213:10 269:1
misunderstood	124:3 192:19	516:13,16 517:2,5	342:9 343:12	284:13 308:21
167:17 209:9	296:12 410:5	517:22 518:3	422:13 453:12	357:20 363:3
380:10	473:4	519:6,9	473:6	381:17 446:5,7
misused 152:8	models 47:11 48:18	modes 190:8	motion 45:6	MPA 2:4
mix 103:22 109:19	123:18 128:20,21	modification 140:6	motivated 254:20	MPH 1:14 2:1,3,5
115:6 151:9,12	163:8 190:19	140:7	305:2	3:6,17 4:3
254:18 371:15	195:21 196:18,20	modifications	mouth 397:19	MSA 75:18
373:6 375:9	317:9 440:16	50:18 51:13	move 26:15 36:14	MSc 1:13
mixed 211:6	445:11	modified 140:2	43:2,6 46:4 50:22	MSHA 2:4
217:11	moderate 124:19	modify 460:20	51:13 60:20 63:3	MSN 2:2
mixing 364:5	125:6 126:4,18	461:1	73:7 79:18 93:15	MSPH 3:2
mobile 381:11	138:11 146:3,11	mom 434:4	96:20 101:1 107:4	muddy 476:21
Modality 304:1	147:13,19 148:9	moment 23:9 91:7	107:9 109:16	multi-level 86:2
model 47:7,13	148:14 157:5,11	264:19 283:7	110:10 111:6	128:21
49:10 52:10 57:20	160:2 171:3,7,22	Monday 1:5 254:6	114:1 116:3	multi-stakeholder
58:17 84:17,19	172:3 195:17	333:11	121:11 125:21	32:8 33:19
86:2 122:4 128:3	197:9,12,19,22	money 255:19	148:20,21 158:20	multi-tabbed 467:3
132:3,17 163:4,4	199:5,9 212:2,6	monitor 161:14	159:4,5 160:13	multinomial 479:1
176:14 178:4	218:19,22 219:5	263:17	166:1 172:9	multiple 111:17
179:21 191:12	219:10 242:2,6,10	monitored 142:17	192:16 196:4,9	163:15 197:17
209:14 235:17	242:13 243:15,18	monitoring 142:15	207:22 211:9,14	266:9 325:9
256:9,18 258:11	249:20 250:2	264:7 283:9 484:3	212:21 213:22	436:10 473:2
261:18,22 262:14	271:20 272:4	month 152:8	217:18 229:17	multiplied 85:14
262:20,21 267:11	276:14,19 288:15	183:16 310:13	241:14 243:13	multiply 191:8
303:17 340:9	288:21 293:5,10	315:5,6 336:5	246:19 249:17	mutability 114:10

mutable 104:21 114:17 492:5 mute 7:19 370:22 475:22	necessarily 10:22 27:15 57:1 77:6 98:15 99:10 107:12 117:1 274:22 291:18 300:13 310:2 325:18 378:19 395:11 429:8 431:3 444:22	462:13 472:2 negative 199:20 211:22 292:5 311:5 363:18 negatively 201:21 negatives 450:7 neglected 28:22 negligible 115:21 neighborhood 378:2 neighborhoods 518:11 Neo 520:19 nephrologist 18:18 302:15 310:7 312:19,22 313:10 314:7 315:1,5 316:12,21 319:8 342:4 nephrologists 305:21 306:2 310:16 321:8 nephrology 340:11 nervous 14:17 net 59:10 network 229:8 networks 229:7 never 233:13 506:13 517:16,16 new 20:10,11,13,18 22:15 25:12 26:18 36:15 53:4 64:12 65:9 66:8,20 68:13 70:5 76:20 94:5 150:8,9,10 150:19 151:8 156:17 179:1 211:19,21 216:3,4 216:5 220:21 263:20 317:6,9 336:1 406:3 407:20 411:17 440:6,8,9 445:19 481:10,13,16 482:4 Newark 366:3 news 249:3	newspaper 379:8 nice 67:11 193:8 343:17 Niewiczzyk 2:3 23:4 23:5 32:1 66:5,6 night 517:11 nine 322:14 326:10 349:14 415:12 440:5 477:20 NIS 472:18 Nobel 194:9 noise 114:19 138:8 145:3 182:17 189:16,20 190:10 nominated 9:19 10:11 nomination 37:4 nominations 37:2 non 194:2 non-hospital 70:14 257:17 non-independence 410:6 non-risk 392:2 non-trivial 502:2 nonsurgical 82:7 norm 303:13 304:4 304:6 normal 89:4,5 normally 172:7 175:10 176:22 North 1:19 18:19 419:12 Northern 19:11 note 8:7 21:9 24:8 26:16 33:13 63:21 118:19 152:4 157:16 164:10 259:8 262:7 307:19 337:5 367:22 401:19 noted 141:3 149:15 154:18 256:15 307:21 366:19 435:18 438:13 448:14 notes 78:7 79:11	420:4 notice 50:15 172:5 noticed 74:19 221:4 notified 418:17 noting 236:4 318:14 428:19 notion 187:5 196:6 229:22 376:6 nowadays 177:1 326:5 NQF 2:10 5:19 7:18 8:4 12:7,12 13:10,15 14:5,16 16:1,21 17:12,13 18:15 19:3 20:22 21:3 22:3 24:3,4,9 25:12,22 26:7,17 26:18,21 27:6 32:6 35:6,13,17 38:1,22 39:14 44:2 48:17 49:19 52:8 53:5,15,17 53:19,21 56:20,20 60:13 97:16 98:5 106:7,21 118:16 120:7 157:15 158:16 181:13 182:7 189:14,21 190:11 212:9 250:9 256:14 273:3 301:4 306:7 368:5 383:12,19 397:11 399:4 416:1 420:3 443:18 448:8,16 458:1 466:16 468:11,12 477:7 517:9 520:10 NQF's 9:8 10:15 NSF 265:10 nuanced 512:15 number 13:11 18:3 36:15 37:18 42:6 64:18 65:4 68:15 70:8 72:18 75:4,6 84:16 85:16,18
N	need 48:8 49:7 50:10 53:21 60:15 62:5 63:4 70:15 74:5 94:9 97:7,8 109:16 111:15 138:13 141:16 142:2 156:9 205:12,13 206:17 216:21 241:13,14 246:17 247:6 259:3,5 273:4 275:22 293:21 312:1 315:18 322:4 334:13 352:17 354:22 356:2 357:8 358:4 370:11,12 375:12 377:9 378:5 379:4 387:2 390:8 392:14,15 408:4 421:10 429:18 430:4 431:3 447:16 450:5 461:20 468:17 472:1,11 475:7 484:11 485:13,15 492:14 497:13 498:1 511:18 needed 57:14 177:21 322:1 needing 196:3 needs 214:11 241:11 255:13 320:4 351:12 379:16 382:14,16 392:11 449:15			

86:8 94:1 99:11 111:14 113:9 116:8 132:19,20 150:4,16,17 162:18 175:6,12 177:4 178:15 179:4 191:5,5,7 205:5 206:22 207:2,16 213:3,5 230:2 237:15 238:22 239:6 249:8 251:3 265:6 265:19 267:8 269:21 274:13 280:16 282:18 297:15 300:4 303:15,16,18 304:5 306:8 311:6 311:9 314:3 323:13 332:20 346:5,7,8 348:7 355:5,7,8 380:4,6 390:11 400:12,14 413:18,20 415:6 434:21 435:1,5,21 453:9 464:7,19 465:11 470:12 481:18 484:15 505:20 517:21 519:5 numbers 112:3,5 116:16 129:20 131:16 133:22 138:2,10 145:17 151:1 199:18 279:9 348:10 404:5 409:8 413:14,21 414:13 423:16,16 438:16 469:1,11 numerator 85:10 85:12 221:9 263:19 287:11,19 288:4 303:14 354:9 355:5 380:5 400:12 408:19 409:22 410:2	511:3 nurse 64:12 265:14 320:16 323:9,10 323:15,20 326:8 326:17,22 328:6 328:14 340:12 nurse's 328:2 nurses 309:20 313:15 334:21 nursing 4:19 66:15 72:22 174:1 209:6 210:6,6,13 214:17 215:21 216:3 217:15 218:17 223:6 231:4 233:3 236:1 253:21 260:7,20 264:8 265:21 271:11 285:13 295:12 299:19 309:16 334:21,22 337:11 337:12 338:2 339:13,17 <hr/> O o'clock 160:7 509:8 520:17 OASIS 498:15 ob 201:2 434:4,8 Obama 64:17 obesity 461:17 objections 51:7 obliged 155:15 OBRA-87 231:5 obs 281:19,19 434:2 observation 175:19 176:1,1 199:15 201:19 203:18 204:1 215:15 223:16 226:2 227:14 242:20 243:9 244:3 245:6 246:18,21 249:11 263:16,18,22 282:4,5,8,15 283:6,22 284:11	433:5 494:22 observational 305:13 316:6 observations 201:14 348:7 445:19 467:20 observe 271:7 observed 84:15 435:19 449:22 481:7 obtain 163:15 obtained 190:5 381:3 obvious 61:16 151:5 375:21 381:15 obviously 8:16 25:2 27:2 41:22 54:5 86:18 99:16,20 138:1 159:9 164:16 178:4 193:8 211:9 273:4 273:12,15 298:11 301:13 375:20 423:8 437:21 441:12 449:3 502:17 occupation 59:20 occur 28:3 141:2 174:4 345:9 346:18 452:5 occurred 262:4 occurrence 400:19 477:16 occurring 264:1 occurs 70:22 215:8 325:22 OCSQ 466:13 October 35:18 odd 76:10 194:19 OE 453:11 offend 189:12 offer 33:11 384:4 offers 487:12 Office 20:14 Officer 22:11 23:7 25:10	official 468:12 officially 83:2 offs 461:7 oftentimes 430:14 oh 116:13 178:13 178:21 208:1 234:21,21 268:2 272:7 287:7 297:7 346:1 347:9 358:18 365:13 378:16 406:14 425:12 447:11 451:11 458:12 460:17 464:5 470:4 475:21 498:22 520:12,13 okay 24:11,12,13 25:17 41:21 43:17 53:2 55:20 67:17 71:15 78:5 91:9 95:5 120:17 124:12,13 133:17 146:13 147:18,21 148:6,16 149:3 157:10 168:2 169:21 172:9 174:13 175:14 180:9 208:17 226:16 239:15 243:13 250:6,11 268:7 271:18 276:11 278:9 286:18 293:2,15 293:17 297:7 299:1 329:19 330:2 343:22 348:15 350:15 356:6 358:3,18 359:19 361:13 363:18 365:2 380:16 390:17 393:22 411:6 416:15 417:5,20 419:8,9 426:13 429:11 435:2,7 445:15 447:18 453:13 454:1,11	460:14,17 462:14 465:7 468:6,9 472:19 474:5 475:13 476:3,18 479:16 480:11,12 480:17 482:15 487:8 489:9 490:6 509:16,16 510:15 513:8 514:3 517:15 old 144:2 306:20 424:16 440:7 older 282:13,20 once 32:14 35:10 70:22 82:5 87:8 93:15 111:18 310:13 314:21 315:1 336:5 359:17 476:15 505:15 506:3 511:22 one's 182:1 455:11 one-third 251:14 ones 59:2 71:12 87:3,10 130:14 131:22 140:22 235:3 281:9 292:18 330:16 395:9 398:19 451:4 461:18 486:16 499:17 507:20 ongoing 283:9 452:15 OnPoint 4:17 onus 341:3 oops 358:3 361:14 363:22 368:18 op 244:15 open 8:16 11:4 37:2 40:3 69:14 73:4 87:14 107:5 138:13 148:8 173:7 214:11 217:20 219:4,11 250:7,18,19 260:9 264:18 268:14
--	--	--	---	---

299:16 361:7 365:4 386:14 404:12 412:5 415:9 417:12 475:20 497:8 498:20 opening 78:17 165:1 428:8 496:20 openly 24:1 operated 257:12 operating 50:10 51:3 operations 451:16 469:14 Operator 250:19 251:1 475:19 479:17,19 480:3,9 520:12 opinion 94:17 114:15 213:9 305:18 325:11 395:22 456:3 opinions 33:22 opportunities 325:2 337:9 391:22 469:12 opportunity 14:18 74:16 100:21 104:1,7,13 109:2 110:22 169:22 199:19 260:14 269:9 308:13 310:9 323:16 326:14 327:9,21 330:5,6 331:9 338:14,16 360:10 360:22 362:6 373:21 382:17 391:18 392:3 399:15,18 403:3 435:14 453:5 491:4 492:10 514:10 opposed 51:9 68:13 72:9 79:19 88:6 91:18 104:22	127:9 153:8 182:15 184:6 208:15 246:22 251:21 253:12 282:9 285:14 341:12 369:21 408:19 428:12 433:21 461:2 opposite 235:2 opt 62:12 optimal 120:1 124:17 171:2 option 246:21 orange 71:13 order 8:7,9 161:15 163:15 203:22 240:12 320:18 322:1,5 339:6 347:18 418:12,15 418:16 488:7 489:7 ordered 258:22 orders 313:13 327:2 432:15,15 ordinary 442:12 Oregon 185:6 187:9 organ 253:7 organic 312:2 339:14 organization 15:9 21:7 22:13 50:21 467:10 organizations 15:12 222:21 247:17 448:16 469:6 473:2 488:7 organized 467:2 organizing 475:16 origin 427:14 original 254:21 448:7 504:14 originally 448:8 458:16,16 ORT/L 2:4 orthopedic 226:22 228:2	Orthopedics 470:7 ought 156:20 outcome 42:13 43:1 44:21 46:8 46:16 47:1,4 91:4 95:10,12,15,22 96:14 97:4,9,10 97:17,21 98:2 99:3,19 100:9,10 101:2,8,14,21 102:4 103:15 105:5 106:9 107:13,16,18 110:15,16,17 112:21 118:6 135:8 165:20 166:21 169:15 190:22 193:2 198:8 216:21 244:9 320:14 359:6 387:20 398:10 427:7,9,20 428:5,10 448:19 485:14 494:20 outcomes 12:15 21:18 22:8 48:10 94:13 99:14 100:4 135:9 167:4 206:6 206:20 217:21 256:16 316:18 359:2 367:12 394:2 405:5 422:12 508:4 outer 86:15 outlier 451:5,7,13 452:8 outliers 224:10,20 433:18 434:13 450:3 452:17 outline 78:22 outlive 431:4 outpatient 22:17 254:5 322:18 341:4 369:8 405:19 outpatients 66:15 outreach 338:1	392:1 outside 20:19 253:3 318:21 383:5 486:2 outweigh 154:13 211:22 overall 87:13 117:9 120:1 124:16 151:2 154:12,22 155:1 157:14 163:5 212:7 215:17 216:21 220:15 221:2,21 222:7 223:2,21 225:21 226:12 234:13,17 237:11 238:16,17 239:1,7 250:5,8 263:4 266:4 269:14 274:16 275:7,8 277:3,18 294:17 299:11 311:7 330:7 343:9 345:20 346:21 350:6 356:2 371:19 394:21 396:12,15 397:21 415:13,21 417:6 417:10,13 421:7 423:5 432:3 435:20 441:11 471:5 474:15,16 474:17,20 508:18 508:19,20 509:1 511:19 512:7 519:11,13,17 overarching 275:2 overestimate 127:4 overlapped 349:18 overlay 377:20 383:19 overload 252:22 328:13 overriding 309:1 overseeing 26:13 overview 4:6 35:21 160:20	overwhelming 28:16 owned 323:14 owns 15:12 310:20 <hr/> P <hr/> P-R-O-C-E-E-D-... 6:1 p.m 259:14,15 260:2 418:4,5 521:18 Pace 2:15 4:8 27:13 44:5,18 56:6 57:16 59:1,16 62:18 68:1 97:14 98:12 99:15 147:5 154:3,17 181:12 192:17 244:11 273:21 383:9 429:21 430:12 444:8 447:21 458:12 460:5,14 packet 283:15 page 133:14 178:22 301:3 376:3 379:8 pages 79:10 86:21 123:22 paid 208:13 pain 289:9 pair 437:17,21 paired 437:13 palliative 64:10 187:10 198:10 354:5 Palo 16:9 Pam 15:17 31:3 155:16 167:22 168:1 208:1 233:18 375:7 480:14 491:5,8 497:10,17 498:5 507:16 513:3 515:8 PAMELA 2:4 panel 36:13 43:12 45:8 47:19 51:11 53:17 56:19 61:4
--	---	--	---	---

62:19 82:18 140:13 141:12 262:8 286:3 518:14 panel's 45:18 46:8 60:10 paper 270:1 305:12 366:1 424:2 papers 189:15 521:16 paradigm 306:4 322:20 325:19 395:9 paradox 204:16 parallel 168:6 509:11 511:9 paramedical 484:5 parameter 441:18 parameters 378:11 383:14 445:21 464:17 467:18 parathyroid 316:9 parsimony 69:10 part 11:3 19:6 27:7 28:6 47:22 57:2,5 62:2 75:20 77:7 80:18,19 81:18 82:5 105:10,11 106:1 108:6 117:20 143:13 169:6 177:20 200:18 205:3,13 232:10 245:8 278:8 286:9 290:13 300:6 305:2 369:4 377:21 378:8,10 400:4 405:3 407:19 412:9 431:12 448:10 458:15 459:16 501:5 512:10 516:8 participate 28:12 36:18 participation 400:16	particular 39:10 48:13 72:20 83:18 91:7 92:18 93:5 103:1 115:4 123:16 129:4 133:17 144:13 154:21 161:6,12 161:18 185:12 190:2 235:15 280:5 294:14 296:14 305:19 306:3 307:3 336:11 350:20 381:3 400:4 441:8 458:9 484:12 490:5 495:13 particularly 11:12 28:20 100:12 101:5 130:2 179:13 292:18 343:4,10 393:7 405:2,6,12 443:19 483:10 partly 298:16 partner 228:5 partners 19:15 251:13 391:19 501:15 partnership 2:6 15:21 19:14 21:6 73:13 120:15 227:22 229:3 301:4 party 106:14,16 200:22 Paso 366:3 pass 70:7 passed 25:10 471:20 password 7:18 path 370:10 patient 12:11,15 62:16 65:19 72:2 75:5 83:5 84:18 84:20 85:21 93:4 93:15 103:22 109:10 115:5	144:2 151:9,12 161:17 164:1 175:18 176:21 184:5 186:4 187:4 193:3,6 194:14 199:19 201:20 202:2,16,20 203:18 206:7,9 209:10 232:13 237:1 243:1 251:15 252:14 254:4 261:2 279:20 281:20 282:6 287:21 288:1 290:5 303:20 304:15 310:13 312:22 314:15,22 315:3,7 316:21 320:5 322:11 323:21 326:8,13,16 327:4 333:10,12 335:9 335:15,16 336:14 339:17 340:13 341:10 357:3 372:2,5 380:12 383:15 422:16 431:15 437:4 448:22 449:1 452:5 467:15 479:1,2 488:11,16 488:19,22 489:1 493:17 494:5 500:18 502:16 511:14,16 512:3,4 512:5 patient's 184:19 313:5,7 326:1 328:9,11 patient-centered 341:20 patient-hospital 422:10 patient-level 467:11 patient-specific 83:10	patients 19:1 20:6 59:14 70:22 82:2 82:7,14 83:9,14 84:9,22 86:7 87:3 92:10,19,20,20,21 93:9,12 96:14 97:11,19 101:17 101:20 106:19 115:19 117:16 118:11 122:1,4,5 129:6 140:13,14 142:7 143:11 144:14 152:16 164:7 168:12,16 169:3 173:2 175:3 176:13,19 177:8 178:8 179:1,2 186:18 187:15 188:6 198:17 201:10 204:22 205:5,16 212:1 225:8,9 230:10 242:22 243:4 247:2,5 251:16 252:13 253:19,21 254:1 257:5 260:19 261:16 264:13 267:9 281:19 282:3 284:19 285:1 303:4,19 304:7 308:4 310:4,5,16 312:10 315:1 318:1 319:8 320:7 320:9 321:18 323:18 324:2,13 326:9 330:9 331:5 333:9 334:5,8,11 335:2,3,10,18 336:7,19 337:2,12 337:20 338:4,19 339:4,21 342:12 345:22 347:7,18 347:19,21 372:3 376:9 433:15 434:8,9 455:19 457:3 477:14	478:16,20 479:8 482:14 483:3 489:15,18,20 500:7 502:1,17 505:2,5 510:20 511:4 512:16 516:6 pattern 102:19 344:20 patterns 235:13 282:22 344:3 393:5 Paul 1:22 16:6 31:5 74:18 101:10 110:15 113:6 131:2 153:14 285:7 340:18 374:2 402:3 403:22 406:2 429:10 485:11 Paula 2:2 17:17 31:13 76:4 106:12 108:4 112:8,10 203:13 209:9 226:17 246:15 247:10 284:16 371:8 412:18 461:14 Paula's 204:13 Paulette 2:3 23:4,4 32:1 64:2 66:3,6 67:6 126:14 218:3 Pauly 427:19 Pause 113:16 124:21 126:7,10 146:6,9 147:15,17 148:12 157:7,9,22 158:3 160:12 268:17,20 272:1 276:17 288:18 293:8,20 299:6,17 348:22 349:12 350:1,14 360:1 361:9 362:19,21 365:5 pay 131:12 238:2 247:7 300:18
--	--	---	---	---

340:11 388:8	137:20 139:19	153:7 158:19	performance 2:12	180:11 181:14,21
pay-for-perform...	142:6,22 143:2,22	159:3,7 160:1	2:14,14,16 12:19	200:9 212:21
384:1	150:7,13 156:4,16	176:12 177:6	16:10 20:16 22:8	254:4 255:3,4
payer 59:12 215:6	166:13,19 170:10	178:19 191:14,15	24:18 48:2,13	267:15 304:22
223:3,7,12,19	173:15 175:8	192:7 194:7,10	97:17 98:3 99:3	345:10,17 373:11
224:6 232:9	177:19,20 179:5	216:19 220:6	104:8,19,22	424:19 470:16
235:11 237:8	183:2,4 185:6	221:21 222:2,6,7	107:22 109:1	473:19 477:22
425:9 449:7,8,9	191:9,13,17	222:8 226:10,11	110:3 114:3,18	periods 37:18
455:3	195:16,19,20,20	226:13 231:10	117:10 118:3	perioperative
payers 18:7	196:7,14 200:1	233:15 239:19,22	119:14,22 120:1	12:19
paying 195:20,20	201:9 207:16	240:1,2,12,17,19	121:20 124:6,8,10	peritoneal 334:5,8
323:8,8	217:6,14 225:12	240:20,21 241:3	124:15,17 127:22	334:10 345:18
payment 109:20	227:22 228:13	248:17 252:18,20	134:21 136:4	perplexed 428:17
152:6 232:6 246:3	229:17 236:11	253:2,14,15,18	170:1,6,22 171:2	445:8
246:11 319:5	238:2 244:3,12,17	254:1,16,17,22	179:17 180:5,10	perplexing 429:1
320:18 387:13	246:19 262:9	256:3 258:3 264:3	180:12,17,18	person 36:5 201:7
391:6	284:22 289:20	264:4 266:5 269:6	181:17 182:13	224:17 227:9
payments 238:2	294:18 297:14	269:13,13,14,15	196:18 218:8,18	400:19 409:19
254:17,17 331:6	300:14 316:19	269:16 270:13,22	265:5 269:2,3	personal 235:19
pays 388:4	333:6,8 338:2	271:5 285:11,19	271:19 272:3	517:8 521:11
peak 285:22	357:5 368:5	290:19 291:8	275:4 325:2,16	personally 419:22
peculiarities 423:3	369:15,17 372:15	292:6 298:3,3	327:9,20 329:8,9	persons 501:20
pediatric 14:2,4,9	374:18 375:1	304:3,4,5,10	329:11,18 330:18	perspective 45:22
14:10 82:14	378:14 381:17	311:20 330:8,8	330:22 340:5	58:13,22 73:10
336:19,21 337:2	384:21 385:1,3,9	331:5 333:8 334:6	343:4 356:20,21	318:13 325:21
347:7 348:4,10	395:13,16 400:14	334:8 339:20,22	360:5 361:5,11	327:5 456:10
pediatrics 347:17	401:6 407:10,11	350:21 360:20	372:13 403:3,6,10	perspectives 33:20
peer 256:11 306:18	413:19 414:17,21	393:9 407:9	421:8 424:6	perusal 325:14
peer-reviewed	416:18 417:3	422:15 434:2	429:22 430:3	PharmD 1:14
258:12 307:8	425:4 430:14	439:10 441:1,9	435:15 438:3,6,9	phases 213:10,12
484:10	436:6 464:19	442:4,18 443:5,6	454:17 458:15	350:22
penalize 136:6,17	474:3 475:8	477:20 481:9,10	482:13,17 487:18	PhD 1:12,12,15,21
296:13	501:16 506:5,9,13	481:15,19 482:3,5	487:21 491:4,22	2:3,4,15 3:3,8,9
penalized 136:10	506:14,20 509:15	491:10,20,21	492:12,15 502:7	3:11,12,16 4:2,3
136:10	people's 359:10	492:4 493:1,3	514:9,12,17	phenomenal
penalizing 230:17	per-member 364:7	498:12 503:20,21	performed 94:12	454:18
penalty 152:6	per-month 364:7	510:21	163:1	phenomenon 194:8
penetration 225:18	perceive 416:17	percentage 116:7	performers 179:21	Philadelphia 419:6
Pennsylvania	perceived 488:12	238:13 239:22	performing 135:3	419:13
419:6	percent 85:16,18	252:15 264:2	375:4	phone 23:4,5 64:3
people 11:5 27:21	88:7,20,21 89:2,9	271:3 406:11	performs 326:17	66:4 108:11
28:8 32:19 50:14	89:10,11,11,20	perfect 61:7 235:5	period 12:13 26:9	214:11 475:9,12
62:10 80:22 81:7	90:1 104:12	236:4	35:17 37:3,22	475:13,18 480:7,8
92:3,6 98:19	114:11 115:12,13	perfectly 124:2	45:8 81:7 84:15	phones 7:16,20
100:14 105:20	115:14,19 127:7,9	140:11 441:21	84:19 115:22	phrase 206:3
109:21 113:22	129:13,13 150:17	perform 118:7	137:18 152:3,9	physician 12:21
115:21 136:6,9	150:18 151:16	185:12	176:5 177:21	61:19 309:8

310:12 323:7,14 324:9 325:18,20 325:20 326:1 327:1,3,5 329:2 329:12,15 336:2 336:13 337:10 physician's 421:18 physicians 184:15 307:11,17 308:3,7 315:12 324:1,3 337:12 421:20 pick 62:1 188:17 227:7 297:16 468:18 493:21 498:6 picked 84:4 picking 84:8 121:22 182:16 picture 87:14 131:19 152:18 279:6 348:10 437:16 pictures 129:10 piece 85:3 94:18 222:16 325:12 371:14 375:12 396:1 pieces 173:11 piggyback 276:4 pilots 407:4 ping 427:2 pinpointed 104:14 pitch 335:18 placard 8:6 place 32:22 85:17 110:1,6 132:10 135:18 155:3 187:5 203:21 284:20 285:18 295:17 313:3 314:5 315:19 320:3 329:2 339:16 341:22 368:11 369:17 372:1 377:14,16 377:16,18 378:7 402:14 429:18	437:3 447:14 459:14 486:2 493:9 494:8 placed 109:21 432:15 placement 456:12 places 109:22 224:4 243:3 374:15 378:19,20 417:4 437:2 453:2 plan 156:18 211:19 232:16 253:21 255:13 314:22 326:1 372:12 385:4 466:15,19 502:4 plane 336:5 planned 82:16 139:22 140:10 172:16,18 219:16 226:19 227:2 228:7 230:1 233:21 236:14 237:2 238:13,22 239:7,21 240:13 240:17 246:17 247:4 249:13 287:10 408:12,16 409:9 412:11 planned/unplann... 220:3 228:10 239:5 planning 96:2 98:18 485:1 493:13,14 plans 231:16 388:8 plausibility 486:19 plausible 106:8 128:5 485:15 486:1 play 48:13 58:8,17 122:1 229:12 469:8 470:16 played 63:16 451:3 playing 84:10 301:13 389:20 plays 433:2 436:18	448:2 plead 109:14 please 7:19 8:12 23:19 36:3,16 39:12 99:6 111:10 118:18 121:19 137:16 146:8 212:12 215:1 241:12 250:11,20 251:3 259:7 260:10 289:22 302:12 330:2 351:13 418:2 476:11 479:21 480:9 510:4 521:14 plenty 206:4 plus 84:21 164:11 187:22 201:17 505:1,2 pluses 151:18 pneumonia 20:7 271:10 343:13 451:19 point 6:6 43:14 46:17 47:8 61:16 73:5 90:14 106:13 108:20 109:15 111:10 115:3 116:18 117:6 119:12,13 125:8 128:15 131:1 158:10,12 169:2 173:7 187:20 198:18 201:10 227:17,21 243:7,7 250:12,13 272:9 276:8 279:16 291:11,22 296:4,5 298:15 313:9 317:2,3 319:17 327:22 340:7,16 345:6 346:3 364:6 371:22 373:19 388:3 412:20 425:19 426:4,5 434:10 437:5	442:18 447:18 450:2,12 451:4 453:3,17 458:1 459:3 464:16 469:13 471:14 473:8 479:15 495:11 496:9 508:5 517:7 pointed 98:6 149:1 233:14 316:4 pointing 235:6 305:22 PointRight 4:17 points 62:18 63:4 110:12 115:17 116:5,5,19,19 216:20 239:22 256:9 264:2 306:13 340:22 352:10 382:20 392:16 450:20 483:20 policies 320:8 policy 18:12 28:7 120:6 131:1 204:17 251:13 283:10 320:3 323:22 344:18,21 345:3 436:18 477:1 political 62:3 polls 186:12 pong 427:2 pool 279:20 407:12 poor 103:5 124:11 369:2 popular 144:12 population 75:20 80:21 85:15 124:18 161:11 164:2 171:3 176:19 191:8 194:14 198:7 220:9,11 237:1 251:15 252:4 257:22 273:7 275:11 279:2	282:9 287:5 304:11,13 331:8 341:21 342:16 352:19 353:2,2,3 354:11,12,21 355:2 361:18,19 372:19 383:15 385:9,11 388:13 388:16 457:10 490:3,4 500:6 populations 212:1 373:1 385:8 473:15 portfolio 4:9 26:13 27:8 44:10,15 68:11,21,22 69:2 69:8,11,16 70:8 71:12 72:7 73:5 275:8 430:20 portions 43:3 portrayal 223:8 position 124:7 196:3 320:13 458:5 positions 457:8 positive 73:17 189:2 204:6 310:22 420:16 positives 450:7 possible 52:20 60:18 99:21 145:4 176:16 202:16 203:8,12 237:5 261:13 273:10 324:4 410:9 413:21 423:12 437:17,20 457:8 possibly 134:21 351:15 post 4:12,15 64:8 65:5 80:15 81:5 158:7 161:12 175:20 212:15 post-acute 15:8,22 22:15 70:14 71:1 81:18 84:1 92:7,8 109:17 161:3
--	---	--	--	--

174:6 211:2 217:7 261:12 271:1 461:20,20 462:5 post-comment 399:18 459:21 post-discharge 160:15,22 254:2 323:12 501:17 post-LTCH 162:5 post-measure 57:21 posted 453:14 465:13 posting 35:6,11 potential 16:22 51:13 142:6,11 149:4,8 154:8,14 155:14 156:19 173:1 183:8 185:14 199:20 202:10 234:5 244:6 245:19 281:21 304:14 306:1 307:10 344:8 381:5 potentially 44:22 45:5,15 46:9 49:19 77:7 127:4 136:4 159:15 186:21 244:5 256:1 258:9 271:4 290:14,22 295:18 319:4 354:7 355:19 366:11,13 384:16 386:18 412:12 456:21 509:7 poverty 257:2 379:14 power 87:4 312:17 323:6 422:15 442:20 powerful 139:1 313:2 321:4 practical 315:15 333:18 434:10 practice 94:21	195:22 205:15 230:16 233:2,16 321:9 323:9,14 326:4,5 333:4 488:5 practices 98:18 340:11 practicing 18:14 practitioner 323:10 323:20 340:12 practitioners 320:16 323:15 preceded 100:16 preceding 162:19 precise 146:2 197:7 precisely 434:17 precision 192:2 445:9 predict 180:5 188:20 398:9 predicted 187:14 193:3 442:10 predicting 85:5 190:22 191:13 prediction 192:6 266:18 predictions 87:2,3 191:10 predictive 163:5,11 191:19 predicts 180:11 182:13 predominance 482:10 predominantly 348:3 prefer 71:18 422:6 preference 52:16 97:17 184:5 preferred 48:22 preliminary 149:14 306:6 Premier 3:11 5:8 418:14,18,22 419:2,10 421:5 422:2 425:16 473:1,1,12 474:2	475:4 premium 364:7 prepaid 364:8 prepared 34:9 109:11 213:11 prescribed 488:17 prescription 313:7 328:9 present 1:11 3:1,22 21:4 24:11 32:12 99:18 134:3,4 136:17 336:15 365:20 424:5 429:15 432:3 456:9 presentation 277:3 presented 16:14 55:9 56:4 119:14 253:13 265:8 269:4 281:14 363:6,9 474:1 presenting 455:19 presents 104:7 president 2:11,12 13:6 15:6 16:16 17:3 18:18 24:17 64:17 65:18 214:14 251:12 presiding 1:10 press 146:7 251:3 479:21 480:9 pressure 185:12 232:1 437:11 pressures 249:9 presumably 173:17 253:6 pretend 53:3 295:12 pretty 24:22 28:19 43:2 54:21 59:1 59:16 60:7 71:7 82:14,19 86:22 87:4 92:3 96:17 107:9 129:10 137:14 172:7 192:5 213:19 226:7 232:3	241:12 265:11 269:6 279:5 281:14 292:9 295:5 318:5 320:8 328:4 353:13,16 363:14 364:5 373:11 381:15 454:18 455:17 456:1 463:6 469:1 469:20 483:6 506:21 515:21 prevalence 221:7 405:7 prevalent 401:1 prevent 310:9 311:15 312:17 313:16 339:7 486:3,5 511:8,10 511:20 preventable 77:13 269:14,17 366:11 366:14 prevented 213:10 preventing 317:5 prevention 75:17 357:15 367:13 384:7 previous 16:20 22:20 79:15 170:13 171:13 243:10 262:4 306:4 313:13 400:13 455:10 473:12 513:2 previously 19:3 22:3 53:20 469:2 477:7 478:15,21 primarily 19:17 143:7,10 179:18 341:4 primary 14:4 54:2 87:21 95:9 98:19 109:8 204:21 262:1 284:7 307:22 317:22 359:1 418:17 483:18 490:11	prime 342:2 principal 427:18 442:20 principle 162:13 principles 50:9 printed 97:1 prior 12:7 22:4 41:11 83:20,22 162:14,15,17,18 176:7,11 183:21 183:22 189:14 261:9 262:3,6,16 266:12,13,17 267:4 273:14,14 287:13 290:10 292:16 311:22 356:18 406:4 458:17 500:19 priorities 33:21 275:3 491:11 priority 125:9,12 125:19 126:1,2 171:10,18,20 219:2,3,5,9 272:6 272:11 276:12,13 276:19 331:3,4,9 331:12,15 361:14 361:16,18 362:16 363:1 403:12,15 403:19 438:11,14 438:21 439:2 492:18,19 493:9 496:11,13,17 514:19,22 515:5 Priscinius 316:6 private 17:9 62:10 66:20 privilege 517:8,9 privileged 321:14 privileging 321:7 Prize 194:9 pro-rated 400:15 probabilities 122:6 probability 84:18 119:6 122:8 129:8 190:22 192:8 probable 316:17
--	--	---	--	--

probably 9:10 25:15 28:18 44:19 53:16 54:11 59:22 61:1 62:10 74:7 76:2 86:21 90:20 90:22 101:19 104:3 105:7,12 117:15 118:13 119:7 127:2 165:2 204:21 216:6 217:8,12 220:17 236:11 237:14 249:5,5 265:1 271:4 285:17 325:10 331:9 333:19 345:1 346:13 348:2 369:11 372:11 373:1 376:2 377:1 379:15 387:3,16 389:8 402:10 405:22 420:5 426:14 462:13 485:6 494:7 495:13 496:1 515:22 516:4	procedure 72:2,14 162:14 228:3 421:17 procedures 72:17 140:21 141:2 173:3 227:1 234:3 247:6 proceed 400:8 proceeding 501:1 521:18 proceedings 418:3 process 4:6 10:16 23:15 25:16 26:18 28:6 32:10 35:22 36:22 37:2 38:10 38:19 39:4,15 42:17 44:22 46:9 46:16 47:5 49:8 51:6 53:9,19 60:17 68:18 75:10 76:20,21 90:15 93:15 94:11 95:10 95:14 96:8,13 97:22 98:7 99:14 103:1 105:4 106:9 107:18 109:3,9 113:1 117:18 120:10 159:9 164:19 169:16 172:5 216:2 217:13,22 222:17 229:12 272:13,18 274:20,21 275:16 300:6,7,9 309:12 315:14,17 347:1 351:1 359:7 367:12 397:1 401:13 417:17 433:17 448:10 457:21 458:14 459:6,16 processes 91:4 100:6,8,17,19 101:3 104:13 265:12 310:11 311:14 312:18 316:18 328:2,7	421:12 434:12 produce 86:11 145:10,17 473:4 produced 207:13 profession 229:21 professional 9:21 10:19 professor 13:2,4 14:1 21:20,21 22:21 66:18 302:20 profile 25:2 profiling 428:11 profound 357:5 program 13:9 20:17 92:15 254:15 364:17,18 368:13 386:20 387:7,15,22 400:17 416:6 466:22 501:6 programmer 213:5 programs 120:19 301:7 progress 121:15 211:20 368:12 470:18 prohibited 52:6 prohibition 49:1 52:1 project 2:13,14,16 4:6 7:8,9 8:21,22 9:1 20:15 26:1 35:19 38:6 39:6 41:3 44:20 45:2,6 45:14 68:14,19 70:4 71:14 76:18 342:3 352:6 353:17 373:16 427:16 457:18 458:2,6 projects 13:11 35:17 40:15 77:5 473:14 promise 309:3 promising 402:13 promote 65:1 94:7	261:13 308:1,2 344:3 promotes 104:16 247:16 prompt 258:4 promptly 520:17 promulgated 488:6 propensity 369:5 proper 96:2 properly 116:2 properties 42:9 66:11 420:9,15 property 371:5 proportion 161:10 175:2 211:5 283:4 285:4,18 371:19 375:2 propose 406:1 478:4 proposed 137:4,18 161:14 389:4 401:19 512:6 proprietary 449:2 463:18,20 465:3 pros 399:13 prosecute 520:8 proven 83:15 provide 37:20 41:7 69:1,7,15 164:6 207:9 221:5 233:8 254:13 264:12 388:17 437:16 480:20 502:10 provided 32:18,22 34:14 96:19 189:14 192:22 222:12 264:7,11 286:17 485:7 492:21 504:7 provider 22:15 135:15 189:18 196:5 216:18 234:5 341:4 355:4 358:13 425:11 providers 47:9 97:19 101:5 124:17 135:3,9,10	163:21 164:7 171:2 189:19 222:12 261:15 264:15 291:21 296:8 305:3 317:22 321:6 329:17 336:3 353:13,14,15 367:16 382:17 393:5,10,12 413:13 457:3 483:13 provides 310:14 378:14 391:22 providing 49:20 145:6 483:5 508:6 proving 431:5 provision 467:5 proviso 367:21 proxy 449:5 psych 284:19 287:8 287:14,20 288:1,3 psychiatric 2:7 20:10 21:1 284:18 287:2,4,9 psychiatrist 20:9 psychometric 66:11 psychometrician 12:2 370:20 psychometrics 12:4 332:7 PT 489:3 public 5:19 8:17 11:6 17:9 18:13 20:17 21:22 35:6 37:18,19 38:1 39:21,21,21 40:3 40:5,20 45:7 66:21 72:4 100:5 100:16 135:5 149:5 158:22 159:6,10 165:11 200:11,19 211:18 232:5 250:18,20 251:6,9,12 258:18 357:14 384:1
---	--	---	---	--

397:2 399:5,6,14 413:14 420:2 466:10,17 468:2,4 468:14 472:4,9,10 472:13,15,17 473:9 475:7 476:2 476:4,7,10 479:15 479:18 480:1,3,5 480:8 512:6 public/member 417:19 publically 466:14 466:20 477:8 478:4,10,18 489:17 publication 381:7 publicly 278:16 472:14,17 504:18 published 102:14 307:4,5 377:1 407:3 Puerto 416:4,11,15 pull 108:15 144:6 207:18 277:22 pulling 314:2 389:21 pulmonary 72:16 pun 348:11 punishment 136:5 purchase 62:12 purchased 62:11 purchasers 17:10 purchasing 457:5 501:6 pure 129:22 132:16 134:1 176:1 purely 73:19 120:3 purpose 15:15 251:17 370:19,21 371:4 382:7 432:21 449:16 purposely 192:20 purposes 7:22 55:20 69:22 96:15 107:7 149:6 246:4 246:5 264:6 307:22 368:2	394:5 434:10 436:12 pursue 345:4 pursued 28:1 purveyor 466:17 purview 44:16 53:14 69:21 70:2 push 136:13 241:9 241:17,21 247:19 320:12 336:13 509:10 pushback 297:2 317:20 pushed 83:2 248:2 337:18 507:12 520:7 pushing 101:8 313:22 put 33:7 76:7 100:5 115:15 123:20 128:10 165:10 178:16 182:5 193:4 279:15 300:8 310:19 311:3 320:3,17 339:3 340:12 367:21 384:18 385:3 395:13 397:19 410:7 414:8 424:1 425:18 430:10,21 459:17 460:3 puts 383:13 putting 100:10 341:3 354:6 370:21 412:6,14 Q QIOs 352:18 354:17 qualification 245:3 qualify 245:1,8 qualifying 244:4 267:14 qualitative 305:18 quality 1:1,8 6:4 13:8 15:6 16:8,17	21:1 23:7 42:20 64:11,22 65:2,13 65:18 75:17 94:7 95:17 96:11 104:5 104:6,7 124:11 135:16 136:7,15 149:5,6,22 161:17 165:5 171:11 179:20 180:4 182:13,16 214:14 214:21 228:16 232:4 235:22 245:17,21 246:4,9 246:11 256:16 261:15 263:7 264:6,11,14 269:9 270:9,17 286:10 289:5 290:17 292:16 304:15 311:2,4 315:20 322:5 329:16,17 332:3 335:1,14 337:9 338:18 342:2 369:2 373:16 378:5 383:2 384:7,16 428:13 436:7 437:16 441:19 477:4 488:6 498:19 502:14 qualms 501:14 quantity 42:20 95:17 96:11 346:5 quarter 87:8 237:13 356:9 quarterly 233:9 360:14,18 367:6 401:20 402:1 414:16 quarters 306:5 quartile 117:1,2,13 366:15 quartiles 117:12 queries 67:15 query 114:4 question 44:21 52:7 53:3 57:18	58:13 77:21 91:2 91:6 93:1 97:6 108:18 125:10,14 130:6,17 138:12 142:20 143:19 144:19 155:18 175:14 176:5,20 177:11 183:1 185:16 188:17 202:15 203:14 204:4,13 207:11 208:3 209:9,10,16 213:3 219:15,17 225:2 226:16,20 230:9,13,21,22 232:11,21 245:13 251:2 262:8,10 267:3 275:2 284:4 284:15 292:3 305:12,22 307:14 321:1,14 336:10 336:18 344:22 346:1 355:17 358:8,15 366:19 367:14 368:22 376:21 379:1 380:11 389:2 399:4 416:1,14 427:4 430:4 433:19 434:14 436:1 437:13 438:1 440:19 443:22 444:18 446:17 447:22 448:5 449:13 454:3,10 458:18 462:8 468:1,21 469:16 479:20 487:4 492:4 501:2 502:11 question/comment 286:21 questions 24:6 33:4 33:9 35:1 36:13 36:16 41:4,19 51:21 52:22 68:7 73:6 74:1 78:17	87:22 90:16 111:3 111:4 112:6 117:3 117:4 125:20 126:22 137:15 139:22 148:6 170:19 171:17,17 216:8 220:18 232:16 268:9 291:7 318:14 365:19 367:3 368:3,7 377:11 408:4 428:15 432:9 433:13 435:16 438:3,18 443:11,12 444:16 470:1 514:11 quick 43:18 44:6 44:14 64:4 71:10 87:22 117:6 119:19 142:19 144:19 193:9 198:5 238:20 245:12 259:8 291:7,8 322:8 340:22 409:13 468:1 quickly 7:9 8:20 29:5 43:2,7 68:9 71:8 141:22 193:16 200:21 213:20 246:22 291:14 306:16 340:19 352:22 353:10,13 436:18 460:19 482:18 489:12 quiet 99:4 quintile 289:20 290:1,15 366:15 quintiles 290:22 401:17,17 quite 14:17 18:2 34:4 54:22 84:10 106:15,17 132:22 144:9 161:7 183:17 191:20 204:18 261:8
--	--	---	--	--

304:12 306:20 347:14 383:3 412:8 424:14 470:10 486:20 488:13 506:11	randomly 29:7 277:16 279:7 randomness 122:15,17 191:9 range 87:9 89:15 89:19 92:18,19 114:5,7,8 115:9 123:17 159:3,14 170:8 191:13,17 192:5 193:5 194:21,22 195:7 218:14 269:5 271:5 277:7,7,19 278:11 282:2 289:13 290:16,20 291:3 353:12 435:19 443:6 452:11 481:9 483:4	488:8 510:19 513:16,17 rates 86:18,18,19 116:1,6 131:20 132:9 161:14,15 163:22 164:20 170:16 187:12 188:21 218:13 256:20 257:5,6,8 257:16,17 270:7 271:2,9 283:19 295:9 328:3 343:11 352:21 358:12 366:4,7,13 366:14 369:1 406:15,17 407:17 407:18 446:12 455:21 479:3,8 499:13,13 ratifies 38:17 rating 26:5 427:16 444:8,12 ratio 4:21 85:4,13 86:3 145:14 187:21 240:16 251:20 303:10,14 303:14 304:3 350:17 423:1 453:11 rational 117:14 169:14 rationale 26:4 91:3 95:16,20 96:18 97:8,20 98:10,11 98:13,17 99:1,18 100:20 103:12 104:3 107:16 112:22 113:9 153:22 156:18 211:21 217:20 429:2 485:16 513:11 rationalize 109:21 ratios 191:19 265:14 270:10 513:21 raw 86:7 129:11	131:20 132:9 134:9,10 150:16 150:16 446:12,12 450:16 re-calibrate 440:3 re-endorsement 429:12 re-review 38:22 reach 51:1,2 121:8 195:21 338:4 reached 159:18 212:20 397:5 398:20 399:12 reaching 213:19 415:17 reacted 55:2 reacting 385:1 read 78:11 112:4,5 328:17 465:2 490:16,18 499:21 503:19 readily 156:4 reading 54:19 167:10 375:18 507:5 readjusting 328:10 readmission 4:12 4:15,19,21 5:11 14:5,9,10 15:1 16:21 17:11 18:2 18:22 19:16 20:2 22:4 26:14 71:2 73:14,16 76:11 80:10 81:4 83:16 84:15 85:14 86:17 95:11 98:16 102:12,14,17 103:13 105:11,22 106:1 110:5 115:5 116:6 122:8 141:4 142:10 158:6 160:15,21 161:2 161:14 163:16,22 164:20 166:20,22 168:7,12 176:2 196:20 200:15 201:17,21 202:20	203:19 206:22 207:4 209:12 212:15 215:8 218:13 226:20 227:2 228:22 233:1 236:2 239:12 251:20 254:2 256:20 257:4,6,8,16,17 260:8 261:11 264:9 269:5 270:7 271:2,9 283:19 284:6 285:10 288:2 289:16 290:9,11 295:9 299:20 303:2 304:3 318:16 328:3 330:7 338:8 342:13 343:11 345:21 346:11 347:1 350:16 352:21 353:1 358:12 372:1 377:13,19 379:13 380:4 397:6,7 406:6,13,14 407:18 408:18 409:1,14 410:2,8 410:15,21 412:9 412:15 413:14 416:2 430:15 440:8,10 477:11 479:12 486:3,6 493:4 494:17 495:21 501:4 509:4 511:11 513:16 readmissions 1:3 12:8 16:2,5 18:5 18:21 19:2 21:3 26:22 27:17 44:13 63:17 68:10 69:20 71:3 72:12,20 73:19 80:14,20 82:16 91:18,19 92:7 96:2,4 98:17 101:19 102:9
---	---	---	---	---

103:3,14,14,20	207:16 208:11	136:14 137:21	484:8 490:16	222:11 347:5
105:10 125:12	254:8 271:14	138:6 139:9,11	492:6 493:8,9,12	recommendation
135:12 137:10	303:6 304:10	141:8 149:19,20	494:4 495:5,11	34:12 47:15,17,22
140:10 161:11,20	335:4 372:4	151:2 152:16	496:6 499:17	56:12 156:12
186:22 187:15	380:19 409:3,17	153:10 154:3,11	502:3 506:19,19	157:17,18 301:8
203:16 213:3	410:9 495:16	156:1 164:21	507:15 510:4,5,6	437:15
216:22 219:16	readmitting 199:21	166:15 173:4	510:10 518:9	recommendations
236:14 237:3	ready 112:14	180:2 181:13	520:22 521:4	26:7 33:16 38:3
239:1,7,18,21	124:12 145:20	184:9 189:15	realm 253:3	38:15 45:11,19
240:2,13 242:19	157:2 214:7	190:1,5,20 192:2	reason 46:22 77:8	46:8,13 48:16
247:4 252:4 253:6	271:18 297:7	193:2 195:18	154:9 252:9	49:5,17 50:19
253:16 255:10,15	314:14 342:2	198:10,15 200:21	290:13 337:1	51:9,14 53:4,10
257:21 260:18	358:3 359:16	203:19 205:14	386:21,22 431:11	53:18 54:19 56:19
261:3 267:17	361:3 362:14	207:1,2,12 208:8	515:22	58:7 60:10,13,20
269:13,14,17	363:18 462:3	217:5 223:1,10	reasonable 83:5	301:5,10
270:22 271:4	Ready/set 288:13	225:10,22 227:8	103:15 108:13	recommended 56:9
277:5 303:15,16	real 19:7 57:17	229:6 235:12	157:1 163:5	182:2 274:4
310:9 312:17,21	194:13 198:5	238:20 240:4	165:14 195:10	recommending
313:16 316:14	325:22 342:14	243:5 248:21	226:7 241:2 289:7	48:2
317:5,19 318:7	360:21 381:5	257:9 275:10,13	332:8 461:8	reconcile 76:1
322:2 333:7 334:7	405:5 413:19	279:7 281:14	reasonably 176:20	reconciliation
334:12 335:2	435:1 450:14	283:2,17 284:15	181:8	313:4 488:15
337:17 341:12	460:19 504:3	284:19,20 286:7,9	reasons 68:15	reconfigure 236:21
342:20 343:3	507:19	291:8,14 295:20	206:5,11 252:1	reconsider 236:19
344:10 345:9,16	realistically 207:13	305:2 307:15	270:4 360:22	reconvene 259:1
346:2,4 352:14	realities 393:17	308:1 309:2,6	421:5 429:7	reconvening 520:4
353:19,22 354:1,1	reality 60:11	310:8,10 311:3,13	reassess 314:15	record 29:2,16
354:11 355:1	realize 46:12 353:9	311:17 313:15,19	399:15,17	133:14 160:9
357:11,19 380:1	405:7	315:9 316:7,11	reassessed 243:2	215:13 259:14
393:7,16 400:10	Realizing 349:17	321:22 324:8	reassessment	310:22 311:8
400:12 401:8,10	really 8:14,20 25:3	329:1 335:20	312:20 313:5,6	351:3 418:4,5
401:21 402:13	25:3 40:5 42:2	338:16,19 340:3	reassuring 289:6	recording 453:5
406:11 407:11	45:14 46:1 47:12	344:5,21 345:22	rebuttal 323:3	records 432:13
408:22 409:10	47:22 49:8 51:11	346:4,19 355:16	recall 9:18 484:1	recount 10:4
410:1,16 430:18	52:13 54:12 58:1	357:12 358:21	receive 254:12	recovery 247:5
437:18,21 483:1,8	59:10,21 60:15	360:21 362:9	received 9:19 12:14	rectify 455:11
498:18,19 515:21	61:2,10,17 76:21	364:12,15 376:22	14:7 16:2 82:7	recusal 28:7
readmit 371:16	90:17 95:7,13,19	377:7 386:16	255:7 262:9 306:8	recuse 28:12
408:9	97:16 101:1,9	387:19 393:4	receiver 339:12	red 61:22
readmitted 84:19	105:22 106:8	395:17,18 404:5	recognition 59:20	redirect 199:19
93:13 138:19	107:11 108:3	406:16 413:3	recognize 8:4 18:2	reduce 96:3 161:15
161:22 162:2	109:16 110:7	415:22 419:20	25:11 28:4 32:11	252:3 308:7
167:7,13 174:21	116:17 117:9,17	425:9 428:9 430:2	101:4 489:5	316:13 322:1
175:3 186:1	117:22 120:22	443:22 445:15,16	recognizes 61:4	346:7,8 353:1
202:19 203:22	125:2,10 129:9,18	450:18 454:18	recognizing 36:15	359:10 401:10
204:22 205:6,8	130:6 131:12	459:19 467:9	recollection 270:1	410:14 488:8
206:7,12,15	134:10,16 136:5	482:8 483:6 484:1	recommend 53:11	490:13

reduced 102:12 255:14 316:10 353:21,22 reduces 139:13 reducing 102:17 118:4 185:10 257:21 338:7 354:8 401:9 410:15,16 490:8 reduction 20:2 375:2 402:13 reestimated 151:11 reexamination 431:9 reexamine 438:1 reexamined 53:12 refer 441:9 references 99:20 referencing 283:2 referral 372:2 389:12 393:4 referrals 354:4 502:8 referred 21:2 501:16 516:1 referring 441:10 446:16 467:1 reflect 198:13 311:7 384:16 393:9 425:2 reflected 409:8 reflecting 47:3 398:19 reflection 77:3 375:1 502:3 reflective 115:10 reflects 186:9 393:4 502:13 refocus 108:16 regard 10:17 263:6 298:13 352:19 401:7 419:2 regarding 217:9 219:16 221:5 222:20 226:19 247:13 248:6 263:15 265:3	280:4 289:15 294:8 515:10,12 regardless 215:6,6 215:7 232:9 278:6 regards 252:8 256:7 region 224:2 225:11 355:10 389:12 393:4 400:15 469:20 480:20 481:10,11 481:13,16,17 482:6,9 491:20 regional 504:17 Regionalization 19:6 regions 19:18 431:22 436:16 481:7,8,9,21 482:1 512:21 register 111:18,21 registered 326:17 registration 224:18 regs 204:17 regular 216:1 420:7,10 regulated 321:16 regulation 315:15 317:10 320:10,18 322:4,19 325:17 333:4 340:10 regulations 315:19 325:10,14 326:18 327:6,15 regulatory 214:14 307:15,20 311:1 311:12 314:19 319:18 320:2 rehab 66:13 73:1 80:5,16 106:17 107:14 108:5 117:13,17 118:10 118:13 125:13 143:3,6,7,8,10 164:17 170:17 171:13 209:18 232:19 257:14	261:19 433:4 rehabbing 335:3 rehabilitation 2:3 4:13 15:14,20 16:3 22:18 66:7 91:19 158:8 rehabs 209:6 218:15 rehospitalization 5:15 215:4 368:16 488:8,12 489:8 491:10 510:19 511:9 519:19 rehospitalizations 4:17 5:3 250:13 311:15 328:13 356:19 357:18 359:4 401:1 417:15 501:9 rehospitalized 511:4 reimbursement 247:18 248:2 343:5 reincenting 201:21 reiterate 55:5 79:14 200:6 rejuggling 351:11 relate 333:2 339:4 related 11:14 15:1 19:2 27:11,12,17 41:8 43:12 44:2,3 44:7 47:1 48:21 49:17 50:1 52:15 69:19 78:2 93:10 97:21 116:21 122:12 157:19 158:10,13 162:10 170:4 171:11 255:12 258:10 265:9 306:18 325:14 331:6 335:13 344:6 391:13 427:4 429:5 430:16 496:4 515:22 relates 58:1 296:20	495:1 relating 164:20 303:12 relation 32:16 relations 314:18 relationship 46:15 47:4 54:7,10,12 58:5 76:9 96:13 98:4 99:9 107:17 169:15 217:21 311:17 312:2,5,8 339:15 340:1,3 355:3 408:1 relationships 311:19 324:15 relative 115:2 116:12 150:20 175:2 221:6 240:3 240:5 289:16 368:13 369:15 421:20 449:5 relatively 43:7 81:8 96:5 115:4 133:7 133:20 179:3 191:6 279:2 281:6 283:7 305:8 373:11 464:9 releases 256:19 relevant 10:1,5,21 11:10 14:7 20:19 27:11,14,15,16 48:3 68:4 79:11 155:4 356:2 420:8 430:3 441:8 444:7 reliability 43:9 138:5 145:1,22 146:1,14,16,17 163:3 181:15 182:3,4 187:19 188:3 189:7,11,13 190:12 193:14 195:15,22 197:6 219:13 220:22 241:22 242:2 262:22 263:3 276:22 279:13,14 279:19 288:9,12	288:14,20 331:18 331:19,22 332:11 332:15 363:4,10 363:13,20 364:20 365:3,7 371:6 401:11,13 403:22 404:4,13,17 420:19 439:6,9,15 439:16,21 443:19 444:15,16,17 446:22 447:1,6 496:19 497:1,9,18 497:19,19,20 498:3 515:8,16 516:11,12,16 reliable 134:21 181:22 223:1 232:3 445:3 446:14 464:13 reliably 152:15 relied 366:21 reluctant 228:5 rely 23:13 232:7 relying 105:22 remain 34:16 75:2 400:7 431:6 remained 263:1 remaining 159:5 205:2 remains 124:10 128:7 140:5 remarkably 194:12 469:1 remarks 9:14 520:11 remember 8:12 183:1 282:17 285:5 382:6 507:17 remind 9:14 10:7 23:11 258:16 309:15 319:16 333:6 335:22 443:15 reminder 10:13 42:3 remove 81:2
---	---	--	--	--

removed 49:2 81:1 85:12 113:10	representing 18:7	resident 310:20	349:6 350:10	313:13
renewable 29:10	represents 176:12 254:3	residents 417:1	359:18 361:4	resumed 259:15 306:4
renewal 428:1	Reproduce 468:19	resides 315:11	362:15 363:17,19	retain 177:8
repeat 419:9 497:14	reproduced 207:14 378:19	residual 119:7 128:6 194:10	365:1 367:18	retrospective 170:2
repeating 34:22	reproducibility 146:15 190:1,7,11	residuals 163:12 445:4	385:20 394:9	return 50:11 71:5 108:8 119:16
reply 322:9 324:17 500:2	363:10 444:20 445:13	resolve 51:7,11 53:1 127:13 457:13	396:9 402:18	126:19 512:4
report 35:5,12 42:8 42:18 43:3 50:14	reproducible 146:17 147:3	resort 416:21	403:4,14 404:10	returned 494:6
61:18 63:8 95:6	reproduction 102:19	resources 255:16 436:21 437:10	411:5,16 415:4,15	returning 26:19 260:4
112:16 189:21	request 40:20 222:18	457:6,9,11 484:21	417:7 446:6,7 510:11	returns 312:9
190:1 222:2,10	requests 39:1	493:15 502:9	responses 126:9 148:13 262:9	review 4:9 7:3 26:2 26:9 27:3,8 37:10
233:7,10 248:18	require 37:13 54:6 99:15,17 231:17	respecify 202:8	285:20 474:11 517:4	37:10,13 38:8,14
265:16 282:21	268:5 317:8,9,10	respect 33:21 67:13 67:21,21 77:10	responsibility 328:6 341:21	39:1,15 40:21,22
307:4 366:20	340:9 408:21 511:16	87:22 91:16	responsible 34:6 44:11 66:10	41:14 42:19 50:17
397:12,15 469:18	requirement 100:9 221:15 232:10	114:16 120:7	200:22 413:2	69:8 70:5 71:13
478:4 495:2	266:11 326:16	194:1 240:7	rest 93:18 449:16	94:18 95:18 96:9
504:19	requirements 431:12 468:14	279:12 289:1	restart 205:9	96:16 97:12 99:10
reported 200:12 217:4 232:6 277:8	requires 71:5 150:15 443:20	318:16 337:6,18	restate 127:2	102:14 123:21
277:19 278:14,15	465:18,20	385:8 390:18	restating 126:21	256:11 270:22
348:9 453:4	requiring 38:21 42:6	410:5	restrain 118:9	306:15,19 441:5
466:14 477:8	research 11:13 12:15 16:4 18:19	respectful 273:4	restricts 220:9	reviewed 13:14 34:10 35:14 82:17
478:11,18 489:17	21:21 66:10 67:1	respond 33:3,8 35:9 174:22	restrooms 7:11	161:8 434:14
reporting 12:13 100:6,16 135:5	94:10 357:1 419:3	182:10,10 248:10	restructure 338:16	reviewer 87:21
149:5 211:18	researched 82:9	327:18 340:19	restructuring 341:19	reviewers 356:14
238:7 264:6	researcher 14:3,16 20:12,13 21:19	343:21 407:1	result 190:2,4 200:2 249:11	reviewing 27:5,5 45:8 69:6 81:17
281:16 382:15	477:2	426:14 428:6	284:22 408:11	82:21
384:2 431:11	reside 309:7 334:20 336:12	488:1 515:12	445:20 455:18	Reviews 83:19
446:14 466:10		responded 35:10	477:17 497:2	revisit 212:22 246:17 459:21
472:4,9,14 473:10		responding 26:8,10	results 27:5 41:9 57:12 60:8 63:12	revote 126:13
512:6 518:20		response 117:15 125:1 149:13	126:17 146:11	reward 136:4 186:13
519:1		169:10 170:20	163:19 165:10	rewarded 116:15
reports 50:21 283:17 422:22		171:15 251:5	189:2 197:9	rewarding 230:17
451:8 465:18		258:20 262:12	237:12,14 263:3	rich 383:7 385:15
466:1 518:21		268:11,19 271:17	263:21 277:13	richness 119:4
repositories 66:16		276:10 291:6	280:12 292:15	Rico 416:4,11,16
represent 10:10,10 214:16 438:14		293:1,14 297:6	316:7 407:4	right 7:12 20:4,15 51:5 56:6 59:16
representative 339:19		298:22 299:13	455:19 472:5,8,10	60:19 66:1 67:21
represented 240:20 383:18		306:12 307:19	472:13,14 478:10	69:18 71:2,15
		314:11 325:13	513:12	74:9 77:20 91:1
		330:15 344:13	resume 10:4	

91:10 114:20,21 116:20 122:21 147:9 154:18 158:18 166:12 167:16 168:2 170:15 178:10 187:6 188:16,17 189:17 191:2 194:5 200:1 201:1 204:9 207:3 208:22 210:5,6 216:10 224:13 231:8 240:16 241:21 249:16 250:4,13 260:5 262:13 263:20 268:7 273:22 275:16 277:13 279:15 288:8 298:10,16 302:9 315:18 316:19 319:8,12,18 320:10 321:13,21 323:1 326:2 329:6 335:12 340:8 341:15 361:20 363:13 366:1 372:9,9 380:9 386:17 389:20 390:4 392:18 394:2 399:5 402:7 410:20 418:22 424:1,13 427:13 431:21 435:5 436:2 437:12 444:8,14 446:3,9 447:10,14,21 449:22 451:9 452:21 454:9,11 459:2,12 462:10 463:8 464:5 475:2 475:15 476:22 484:14 486:6 488:13 490:19 494:18 497:13 507:21 508:18 509:16	rigorous 106:16,17 rise 306:14 rising 284:2,4 risk 4:8 14:10 19:2 20:5 44:7 46:20 47:6,11,13 48:8 48:18 49:14 57:20 58:16 84:8 85:19 89:16,17,22 90:3 90:10 114:19 116:2 118:10 122:13 123:19 128:3 132:6,10,14 133:19 134:1,11 143:19 144:4 147:7 161:19 162:11 163:4 170:10 183:13 192:19 197:16 234:2 238:5 260:16,20 261:21 267:9,18,19 279:6 281:7,7,10 289:16 290:8,11 338:7 354:7 355:10,13 355:21 367:8 368:3,21 370:10 372:17 373:6,17 374:4 377:5 378:10 382:2 387:2,3,11 388:2 388:6,19 390:20 391:8,14 392:7 393:22 395:21 405:21 412:7 415:19 418:13 420:11,12 424:18 429:6 431:16 432:12 453:20 454:7,15 455:9 458:2 459:6 461:16 462:12 467:6 468:3 478:22 488:12 489:1 490:5 498:10,14 499:15 500:16,20 506:5	512:10,14 risk-adjust 256:10 risk-adjusted 5:6 83:3 258:12 389:18,18 405:4 474:22 risk-standardized 163:16 risks 342:8,10 RM 239:6 283:3 RN 1:15,16 2:2,15 263:9 292:4 road 244:10 Roberts 2:4 15:17 15:18 31:3,3 155:17 208:2,17 208:20 233:20 375:8 480:17 481:4 491:9 492:20 496:21 497:13 498:7 507:17 513:6 515:9 robust 231:21 232:18 300:22 483:10 497:7 Rochester 1:20 21:20 rock 135:17 role 25:19 28:14 56:20 377:15 433:3 436:19 437:8 roles 301:14 325:8 rolling 162:7 215:18 Ron 17:2 31:9 175:13 372:9 426:20 427:1 431:17 435:18 438:12 439:6 443:7,10 449:13 RONALD 2:8 room 1:9 29:4 39:16 89:21 108:10 175:19 184:12 186:2	251:8 302:4,5 476:3,5,7 480:7 511:5 512:2 521:15 root 144:22 391:12 rooted 393:16 roots 393:15 Ross 1:18 14:13 30:21 roughly 115:12 round 19:5 90:13 rounding 484:19 routinely 469:12 row 409:4 RSRR 163:16 RSRRs 163:18 RTI 3:4,8,16 4:13 4:16,20 78:14 79:22 80:4,7 160:16,19 161:3 214:5 239:9,15 260:8,9,12 301:20 rule 151:8 203:15 203:20 205:10 209:5,20 210:1,4 210:15,15 223:15 223:17 244:3,5,14 244:19,21 281:20 433:9 494:21 rules 34:3 151:15 204:17 run 9:13 27:5 41:8 57:12 63:11,18 68:9 71:7 142:18 255:6 304:19 312:4 440:6,8 455:6 468:19 running 466:1 513:21 runs 235:22 271:5 rural 324:6 336:4 347:12 354:18 393:19,21 rural-urban 392:9 rurality 370:8 Russ 202:14	S S-E-S-S-I-O-N 260:1 safe 187:17 safely 142:8 safety 16:18 65:19 75:5 161:17 521:15 sake 509:21 513:6 sample 133:9 138:6 138:8 152:11,21 163:7 190:6 195:4 263:2 277:14 283:4 285:4 329:13,14 357:17 363:9 401:13 425:18 439:20,22 498:12 samples 283:3 satisfactory 63:15 save 437:18 saved 484:21 saw 61:8 280:13 359:5 384:6 420:4 saying 53:10 58:1 97:6 113:8,11 116:13 131:6 136:5,11,14,19 138:16 156:16 180:9 185:14 192:11 193:2 195:19 221:8 225:6 239:16 248:15 317:20 339:10 374:6 397:20 398:21 410:12 442:3 479:5,6 says 48:20 123:13 132:5 167:12 281:11 302:19 320:4 324:1 420:11 453:3 470:17 472:2 503:12 scale 146:19,19,21 147:2 444:9
--	---	---	--	--

scenario 359:6	screen 12:18	137:7 140:14	397:10 400:5	24:17 64:14
SCFES 2:4	420:12	152:7 153:5 166:7	402:19 403:5	214:13,21
schedule 7:2	scroll 158:12	167:13 171:16	404:11 411:17	sense 71:10 85:11
213:18 216:7	se 143:20 247:16,21	173:1 178:15	415:5 417:8 438:4	92:19 93:7 128:13
351:10,11 418:15	search 100:18	180:11 185:14	438:19 474:16	177:15 178:11
488:10	seasonal 360:15	189:19 191:4	476:6 487:17,20	204:1 216:12
scheduled 417:22	367:4	198:3 221:20	498:22 505:7	226:7 229:20
school 1:22 13:5	seating 68:13	225:22 228:6	508:10 514:20	233:11 245:19
18:12,13 419:5,17	seats 32:19	232:19 233:9	516:22 517:20	247:2 267:8
427:17 484:17	Seattle 17:22	234:12,15 249:16	seek 50:19	279:19 282:7
science 108:1	481:11,17 482:4	250:5 267:1 270:6	seeking 97:19,19	291:11 347:6
120:22 121:8	sec 497:18	270:14 278:3	seeks 358:11	377:18 424:21
204:14,17 206:4	second 8:10 19:5	280:20 290:10,14	seen 84:12 86:21	446:4 451:14
364:5 403:22	39:20 40:2 53:3	292:17 310:4,13	101:7 123:17	467:17,19 509:12
Sciences 21:22	72:10 88:19	310:16 312:22	183:15 210:2	512:1
scientific 42:8,14	110:20 113:10	315:7,20 316:21	229:1 237:21	sensitive 190:16
43:8 90:21 108:7	127:21 160:1	318:1 319:8 320:4	281:1 282:13	398:9
111:2 119:15	196:16 199:12	323:21 324:2,13	326:11 347:11	sensitivity 93:8
120:17 124:5	230:22 232:10,21	330:12,16 333:10	376:2 406:5	192:1 226:4,10
126:20 165:8	258:17 286:1	335:11 336:6,14	407:16 414:17	sent 67:16 133:20
169:5 172:10,14	294:21 307:9	337:20 340:7,13	428:7 435:21	168:18 173:2
179:15 181:1	330:4 362:11	343:10 344:2,15	470:5 491:18	174:20 175:19
219:12 241:21	433:19 479:16	346:1 348:15	segment 169:7	243:2 280:3 283:5
251:22 271:15	487:3 499:4	369:21 376:1	237:1	sentiment 518:17
276:22 398:7	secondary 21:22	377:10 381:6	select 1:21 15:7	separate 120:21
439:5 454:14	346:14 419:4	407:22 409:7	29:6 506:5	142:3 167:8
515:7	secondly 8:14	429:13 433:1	selected 29:8,15	187:20 203:1,2
scientific-type	109:13 253:18	436:11 439:11	32:15 427:9 507:7	206:19,20 428:11
111:4	256:13 257:11	445:19 446:21	selecting 49:14	separately 112:9
scientifically 137:4	315:12 325:5	448:1 458:6,19	selection 229:8	230:1 331:18
449:20	328:1	461:11 470:4,4,17	301:5 499:6,8,11	399:7
scientist 12:5 22:1	seconds 111:16	471:2,3,17 481:3	499:18	separations 78:3
196:5 419:1,10	113:14 126:11	482:21 484:20,22	self 122:8	September 35:16
scope 71:11 197:8	329:7	488:21 489:10	semi-logged 450:5	series 353:6 470:22
230:16 233:2	section 42:15 43:7	494:2,12 506:7	send 93:2 111:15	471:1
255:22 325:15	95:6 96:20 125:9	512:21 519:3	113:17 126:15	seriously 6:19
494:10 516:3	130:9 131:17	520:18	175:8,10 187:5	168:9 466:16
score 48:1 57:21	147:8 185:3	seeing 47:12 51:10	201:20 227:8,22	serve 10:12 12:20
128:8 280:19	sections 43:19	68:7 125:20	271:13 296:21	13:5 17:12 22:6
293:3 299:1	sector 109:17 420:2	140:17 169:11	364:2 418:8 437:3	22:16 25:20
396:11 446:2,6	Security 183:10	198:21 219:3	486:9 506:9,20	251:14
score's 446:5	see 8:3 50:17 55:10	225:5,8 229:3	sending 112:8,11	served 10:18 12:9
scores 187:16	63:13 73:18 74:8	238:12 268:12	140:14 184:17	13:10,14 15:21
263:13 277:17	75:16 87:10	277:21 278:9	216:2 486:11	16:20 17:10 22:3
440:8,10	108:17 115:7,10	280:18 283:4	senior 1:17 2:12,13	39:14 205:16
scoring 89:8,13	121:16 122:11	285:4 302:1	2:15 4:3 9:1,2	388:16
128:10,17,18	132:19,22 133:3,4	337:22 349:7	22:1,12,13,22	service 12:7 25:11

64:12 65:6 98:1,4 110:9 113:1 117:19 118:1 122:3 161:21 169:17 186:19 218:1 220:10 224:5 225:13 231:16 353:14,15 355:4 364:17 393:5,9,11 495:3 501:17 507:7,10 services 14:3 19:7 20:12 65:3 118:10 161:5 283:22 286:17 354:5 369:6,7 370:8 375:10 388:17 419:3,13 484:2 485:5,6 494:22 506:21 508:6 516:1,3 serving 56:15 SES 44:8 67:13,16 67:22 456:1,20,21 457:1,3,18 458:2 SES-adjusted 258:13 session 13:17 set 65:11 78:1 83:5 85:19 161:2 181:7 223:1 230:11 231:1,21 232:14 233:13 244:15 262:15 269:5 281:22 283:5 300:13 311:13 339:6 367:1 369:20 378:11 421:1 425:15 445:19 473:18 483:12 sets 143:4 167:2 253:19 setting 70:14 71:6 72:19,20 73:20 162:1 221:17 233:16 242:20,20	243:4 248:16 249:1 254:5 383:15 486:14 489:21 settings 72:21 73:17,21 205:15 284:7 305:5 433:2 500:15 SETTLER 440:18 444:13 447:10 setup 313:15 seven 14:20 293:10 299:9 333:22 349:2 394:18 411:12 452:1 469:9 496:3 severe 511:12 sex 179:5 373:7 389:19 432:1 Shahab 2:16 8:22 51:5 52:7 53:13 111:8 112:1,4,10 112:14 113:3,14 113:19 124:14 125:4,22 126:16 146:1 147:11,18 148:8 157:3,10 158:4 169:13,19 170:21 171:6,18 172:2 197:5,11,21 198:22 199:8 211:15 212:13 217:19 218:5,18 218:21 219:4 242:1,9 243:14 249:18 250:7 268:14 271:19 276:13 288:14 293:4,16 299:2,15 329:22 330:18 331:11 332:10 348:18 349:8,19 350:12 359:20 361:5 362:16 363:20 365:3 385:22 390:11 394:12 396:12	402:21 403:6,15 404:12 411:8,19 415:6 417:10 435:9 438:5,20 447:1 462:16 463:10 474:7,17 490:21 492:11 493:5 496:12 497:20 505:8,16 508:11,20 514:5 514:12,22 516:12 517:1,21 519:5,13 shake 279:20 shape 410:18 shapes 382:8 share 63:9 206:10 shared 186:3 261:13 264:15 286:10 457:20,21 495:13 sharp 510:4 sharpen 510:9 sharpening 520:1 Shaw 3:17 214:19 214:19 Sherrie 1:9,12 4:3 6:14 11:21 13:12 25:7,8,14 87:18 111:3 126:20 273:1 294:6 308:17 317:14 332:6 337:5 339:10 409:11 444:18 470:19 503:16 509:9 Sherrie's 104:11 Sherry 190:3 196:2 Shield 14:8 shift 188:15 228:6 281:19 341:7 shifted 448:17 shifting 341:8,9,10 341:12 445:21 Shippy 2:5 21:5,6 27:19 30:6,6 58:12 200:21 276:3 397:9 398:1	398:21 399:2 427:1 428:16 435:17 436:9 437:12 438:13 455:7 466:5,21 Shore 1:19 18:19 short 138:14,21 139:3 162:2 167:7 167:13 183:21 207:6 209:11 232:12 373:11 418:2 495:22,22 507:20 520:8 short-term 162:14 166:13 174:8 175:4 176:10 shorten 39:17 shortened 473:21 shorter 39:18 255:3 425:10 452:19 shortest 423:12 shortly 111:2 214:6 show 88:2 93:6 102:21 127:6 132:8 228:18 238:21 281:15 406:14 showed 181:8 263:1 316:8 437:4 492:22 497:2 showing 94:10 164:19 189:1 266:17 270:4 305:15 439:13 450:8 483:9 shown 88:17 232:2 468:22 shows 113:18 131:20 263:11 405:4 441:17 469:19 497:7 shrink 128:1 shrinkage 86:12 88:1,3 127:4,12 132:21 133:4,19 134:2,8,16,19	135:1,5,14 136:3 235:17 280:3,8,14 280:19,20 281:4 281:10 295:1 296:7 shrinking 152:8 296:7 shrunk 86:12 sick 166:13 191:9 335:3 502:17 sickness 370:12 side 8:6 70:13 71:2 193:14,15 214:5 296:20 321:3 322:9 409:14 410:8 451:20 sides 224:11 sigma 435:5,6 sign 211:13 241:11 241:13 signal 138:7 180:4 182:13 189:16,19 190:10 signal-to-noise 182:3 significant 38:6,8 38:21 40:18 102:17 103:18 109:2 153:3 231:13 236:15 237:11 238:16 252:6 253:20 255:16 265:19 360:21 386:10 471:3 482:12 significantly 70:9 252:18 255:14 257:16 291:9 479:10 silence 23:20 silent 28:18 similar 84:12 137:11 161:7 164:4 171:13 257:13 260:21 261:18 275:12 280:12 306:10
--	--	---	---	--

374:4 402:7	72:22 209:5 210:6	291:16 292:14	448:18 449:10	77:3 79:2 85:11
416:18,19 417:4	218:17 224:15	356:13 358:14	456:12 518:14	91:6 105:19 106:5
473:5 510:17	233:3 253:21	360:7 361:15	socioeconomics	127:5 132:18
513:7	260:7,19 264:8	363:5 365:16	453:20	138:7 140:5 143:5
similarities 83:16	299:19 339:13,17	386:9 395:1	sociology 67:1	143:13 149:4
similarly 142:4	skin 493:17	sneeze 116:5	Solutions 64:15	150:15 152:19
164:21	skins 511:17	SNF 4:17 210:15	65:4	154:11 170:5
simpler 377:8	skip 72:5 261:6	215:5,9,10 217:7	solve 355:20 378:6	178:14 189:6
379:4	slide 39:12 41:22	223:20 227:8	378:12	204:13 205:8
simplest 442:8	113:11,12 158:13	228:19 238:11	somebody 89:8,11	212:18 217:2
simply 95:19 233:2	slight 237:9	239:6,12 242:22	128:10 168:2	229:4,9,11 241:1
317:3 320:2 328:5	slightly 343:12	245:7 250:13	183:11 193:15	255:21 258:11
328:18 449:21	345:20 418:12	261:4 262:5	205:12 241:11	266:3 270:2,10,13
single 188:2 364:9	slip 428:2	264:14 265:14	246:22 375:20,21	271:10 284:2
364:10,15 372:11	slow 407:17	267:4,6,15 268:1	423:16 468:18	286:12 290:7
376:4 382:20	small 115:2,17	268:5 280:9,11	495:15	292:19 301:2
388:5	123:3 130:11	282:8,17,19 283:3	someday 485:17	319:1,3 321:12
sit 10:7 21:3,9	133:20 134:7	285:1 500:8	someone's 395:19	337:7 341:14,19
28:18 108:12	144:10 153:4	SNFRM 4:20	508:5	342:6 344:18
114:20	178:15 179:4	SNFs 209:17	someplace 372:3	347:4 359:8
sites 110:3,4,8	239:1 278:5 279:2	227:22 228:4,13	somewhat 116:21	366:17 368:13
224:22 225:3	280:17 281:6,9	229:16 231:11	122:12 123:3	369:16,22 396:5
sitting 23:15,20	283:7 285:3	267:6 278:11,17	168:9 279:21	397:18 398:5
situation 81:9,10	290:18 295:8	278:20 284:21	282:13 290:16	402:9 405:8,21
98:21 143:5	348:5,10,11	286:13,16 346:13	306:10 400:7	423:2,14 425:4
150:12 173:5	371:18 464:12	433:4 500:14	451:2 513:19	433:6 436:3 444:5
379:21 386:15	482:10	social 183:9 186:10	520:6	450:22 466:3
situations 52:17	small-volume	309:21 313:14	soon 249:6 251:19	487:18,19 499:18
378:6 408:13	136:12	355:17 377:21	281:9	507:22 508:4
six 152:8 211:19	smaller 131:21	society 10:20 22:7	sorry 40:21 48:9	519:22
254:16,17 272:3	133:5 134:6	305:21	98:8 133:13 162:2	sorting 433:7
319:20 323:19	279:10 280:14	socio 48:4 49:14	166:18,19 167:16	sorts 143:11 304:22
330:3 363:7 365:7	282:2 290:16	55:14	168:1 204:9 208:1	sound 46:21 49:16
403:19 404:17	smallest 131:22	socio-demographic	208:19 210:13	137:4 274:18
435:6 466:10,11	278:10	45:1,5 46:10,19	230:7 234:21	324:22 509:8
469:9 472:4	Smith 2:7 3:16 20:8	47:16 48:12,19	246:17 272:7	sounds 90:1 113:7
500:18	20:9 30:4,4 36:2,4	49:2 50:1 52:9	297:8 298:20	313:19 398:10
Sixteen 158:5	36:10 156:15	socio-demograph...	348:13 361:14	source 83:20 84:7
size 56:2 131:21	173:14 174:10,13	56:1 59:10	364:1 365:15	118:22 183:18,19
215:19 277:20	182:20 239:14,15	socio-economic	419:9 451:11,12	230:8 242:19
278:15 281:8	260:11,12 266:8	45:3 55:12 59:18	459:8 465:1 506:3	273:16
329:13,14 335:7	267:13 268:2	63:16 90:8	sort 6:9 8:4 15:14	sources 98:19
sizes 133:9 152:21	269:22 277:12	socio-economics	19:12 26:21 50:14	199:2 225:5 392:1
280:15	280:11 282:11	59:14	52:13 53:8 67:18	South 379:12
skew 420:16	285:2,16 286:22	socioeconomic	69:5 70:6,10,12	Southern 19:11
skewed 172:8	287:7,15,17,18,22	256:15,16 257:4,7	70:17 71:10,21,22	space 21:13 28:20
skilled 4:19 66:15	288:5,6 290:1	447:15 448:6,12	72:3,10 75:9,22	86:15 369:10

span 40:16	222:5 324:9	spreads 170:10	289:16 350:16	403:8 411:21
sparse 201:22	332:18 347:1	spreadsheet 441:16	standardizing	435:11 514:6
speak 8:5 23:19	384:12 489:19	467:3 468:8	377:12	startup 68:19
76:14 88:12 93:21	specification 108:7	spurred 100:18	standards 17:12	state 18:4 20:10,14
94:9 131:2 184:13	445:17,18 485:19	square 144:22	21:14 26:11 37:7	20:18 52:14 65:9
248:5 260:14	specifications	163:13	37:7,10 38:13	65:11 82:18
277:10 289:22	33:18 57:2 107:13	squared 441:21	39:2 45:12 51:15	188:20 216:3,18
311:19 313:17	146:2 172:11	squaring 442:12	326:19	216:19 246:21
367:19 368:21	197:7,14,18	squined 192:7	standing 25:19	317:6 375:19,21
388:21 437:19	235:19 334:15	SRR 4:21 255:6	26:20 28:6 41:2	389:13 453:14
466:15 484:11	460:8 468:17	305:2 335:5	41:16 43:18,21	stated 46:14 51:22
speaking 8:13	specificity 191:22	St 13:3	44:16 68:12,19	327:14 453:1
82:13 118:4 191:6	226:5,8,11	stability 262:22	76:21 77:11	statement 53:5,9
198:17 333:1	specifics 57:17	328:8	300:11 489:13	221:8,10 269:18
364:19 388:1	278:1 493:10	stabilize 512:4	490:7	319:15 441:1
speaks 147:1 169:5	specified 55:16	stable 98:20 134:20	standpoint 135:4	482:12
389:8 513:13	149:9 174:19	263:2 469:1,20	295:16	statements 33:9
spec 119:15 375:19	185:15 383:13	staff 2:10 8:20 24:3	stands 481:22	54:1 56:18 57:6
spec'd 205:20	384:4 394:6	24:4 25:22 34:6	Stanford 1:22 16:8	58:4
special 2:11 255:13	spectrum 73:16	39:1 74:11 321:3	star 232:5 251:3	states 48:18 61:22
263:15	speculated 175:7	326:16 429:19	479:21 480:9	62:1,8 256:22
specialities 455:16	spend 6:7 21:13	441:4 443:12	start 11:19 40:1	313:12 323:5,14
specialty 109:8	42:2 179:12	453:18	47:10 49:20 64:6	326:19 340:8
421:18	322:11	staffing 263:10	68:22 78:13 90:19	347:20 360:13
specific 35:18 49:4	spends 333:13	265:14 270:10	91:14 111:8	416:4 436:16
58:7 59:4 61:19	spent 6:6 92:6	271:11 292:5,8	112:15,18 126:21	482:10
67:15 72:15,19	134:17 135:20	337:7	145:6 160:7 193:7	static 200:8
83:18 91:4 126:2	296:5 309:18	stage 227:1 455:20	219:14 246:8,10	stating 101:14
161:2 162:20	310:2 322:17	stake 14:11	267:2 338:14	statistic 88:19
165:19 171:19	414:7	stakeholders 37:3	342:1 355:11	191:3,21,21 194:1
182:6 198:1	sphere 70:13	38:20 60:14 69:14	356:15 381:17,18	194:20 289:12
242:15 243:20	318:22	stance 49:19	384:22 427:3,4,10	377:8
252:6 258:7	spirit 7:5 41:16	standard 59:21	435:17 436:14,17	statistical 48:18
308:18 309:13	43:17	60:16 61:2 89:10	447:11,12	84:11 106:11
312:16 317:15	split 19:10 75:2	94:20 123:8	started 68:14 140:8	123:6 161:9 163:1
318:7,8 325:14	138:6,8 163:7	127:17 139:7	149:2 293:16	179:17 193:13
347:11 349:4,16	182:3 190:6 263:2	144:21,22 145:6	352:21 354:14	196:18 256:9
368:11 403:2,13	277:14,15 363:9	145:10,16 232:19	355:17 375:1	261:17 279:16
404:1 433:21	400:1,2 401:13	338:13 346:16	424:21 432:20	306:20,22 307:5
458:20 463:2	439:19,22 496:22	360:20 374:9	520:16	444:1 478:8
482:19 491:5	515:15	standardization	starting 29:14 61:7	statistically 86:2
500:12 505:14	split-vote 397:10	69:9	starts 157:6 172:1	129:3 130:10,13
506:2 513:4	splitting 206:18	standardize 380:7	197:10,20 199:7	153:3 482:12
514:10 517:19,19	spoke 146:14	standardized 4:21	242:3 276:15	statistician 352:6
specifically 17:19	218:11 313:8	86:17 161:19	293:19 299:5	409:13
18:4 56:12 57:11	spread 87:6,9	231:7 251:19	348:20 349:11,22	statistics 89:4,4
83:17 154:18	117:8 118:7 132:9	260:16 269:4	350:13 402:22	163:9 216:17

262:20 270:19	450:16 451:5	352:5 373:9	235:20	94:14 98:10
302:20 307:6	453:6 456:2,6,17	409:18 410:20	strengths 235:1	102:20 269:12
385:10 414:8	465:12 467:6	steward 68:22	stress 11:2	270:19 305:13
426:6 439:12,13	469:19 470:11	stewards 58:19	strictly 321:11	316:3,7 318:5
441:19 444:3	471:15,16,17	367:1	stroke 16:5 92:20	366:11,21 401:16
446:16	473:6,20 475:1	stewardship 420:6	118:11 122:4	402:9 406:13
status 12:17 45:3	477:19 501:1,1	stick 52:20 79:2	143:8	424:14,16,18
55:12 59:13,18	506:12 507:20	272:14 302:6	strokes 118:15	427:19 492:20
60:3,4,21 62:4,15	517:13	326:20 355:12	strong 94:10,13	stuff 92:14 122:16
62:20,21 63:10,16	stay's 426:10	444:15 476:17	99:1 286:7 328:4	206:14 239:5
70:15 71:4 90:8	staying 241:20	sticking 405:16	stronger 99:17	370:9 395:16
102:1 183:7 215:6	stays 83:22 138:14	stop 50:2 174:5	105:8 513:11	434:5 518:13,15
223:7,13,19 224:7	177:16,18 204:8	211:13 216:8	strongest 104:3	521:11
224:14 226:3	208:4 244:15	241:11,13 248:7	292:10	sub-models 469:21
231:14 232:1,9	249:12 263:16,18	317:12 368:8	strongly 67:16 99:1	470:2
244:3 256:15,16	263:22 278:7,12	378:15 479:13	100:12 184:5	sub-setting 420:22
257:4,7 282:6,8	278:14,18 280:16	story 356:16	200:17 202:7	421:14
312:20 313:6	280:17 282:15	357:19 390:8	327:20 388:1	subject 2:4 10:1,5
328:11 448:12,19	283:6 433:5 434:3	straight 96:17	structure 79:2	11:15 304:21
455:17 456:12	450:10 451:22	133:11 315:9	95:14 97:22	306:21 320:20
stay 5:7 54:6 69:20	477:21 478:1	354:2 448:20	107:17 112:22	448:12
70:21 72:10 76:6	498:9 504:16	463:6 466:1	152:6 169:16	subjected 256:11
77:2,21 83:9,20	steam 100:15	470:22	217:22 309:19	submission 49:5
138:21 139:3	steering 1:3,8 22:5	straightforward	310:14 311:11,12	282:12 431:19
142:9 156:7,10	35:8 49:6 56:17	360:8 361:17	315:15,19 317:11	439:8 441:3
162:3,15,16,17	399:21	363:14	319:18 320:16	504:15
167:8,14 176:1,8	step 46:21 60:20,22	strange 151:6	322:5 333:4	submit 53:7 99:16
176:10,21 183:21	146:19 357:10	strata 62:16 441:12	339:12 483:11	129:11
201:3 203:9 205:8	383:1	441:14 442:5,15	486:13 494:3	submitted 26:9
207:6 208:5,12	steps 213:16	strategic 148:19,20	structured 107:8,9	33:17 37:11 138:5
209:11 210:18	Steri-Strip 493:18	stratification 20:5	344:14	306:11 448:11
215:9,14,15,16	Steri-Strips 495:6	47:20 48:9,22	struggle 174:14	subscribe 421:4
225:15 226:21	stethoscope 327:7	55:18,21 56:3,7	309:10 310:18	subsequent 140:16
227:14 228:6	Stettler 2:8 17:2,2	169:4 197:16	struggled 108:22	220:3
246:18 262:17	31:9,9 372:10	stratified 277:20	309:6	subsequently
267:15 280:15	373:18 431:18	280:15 421:16	struggles 501:21	407:16 459:15
284:11 314:5	439:7 442:1 448:4	434:7 442:7,21	stuck 135:16	496:5
335:21 418:14	449:7,18 463:5,17	stratify 52:16 62:6	studied 340:7	subset 393:8 466:3
420:13,14,15	464:3	222:20 223:19	studies 91:21 99:8	505:3
421:7 422:8,8	Steve 18:17 29:13	224:6	99:11,21 102:21	substance 417:2
423:7,10,13,19,21	29:17 118:19	streamlining	164:21 265:9,18	461:18
424:18 425:2,5,10	119:17 165:3,21	469:14	270:9,15 292:16	substantial 205:5
426:8 429:6	308:17,17 317:13	street 1:9 92:4,10	305:18 317:4	304:2,14 305:5
430:15 431:16	433:12 451:11	175:9 211:2,3,4	318:10 339:2	322:16 361:19
432:4,18 433:22	454:9	502:1	366:18,20 406:4	512:19
437:2 442:9,10	STEVEN 1:19	strength 86:4,5	423:18	substantially 482:2
446:13,18 449:20	Stevens 3:18 352:5	105:1 129:5	study 16:4 18:21	substantively 311:4

succeeded 213:19 429:17	supplementary 131:18	surgery 13:3,18 75:8 162:14	tag 8:1	116:8 128:1
success 343:2 351:3	supplied 442:2,3	surgical 13:8 72:16	tags 521:13	135:20 165:6
successful 23:14	supply 131:16	83:9 247:6 451:20	tail 479:10	173:9 188:8,12
suddenly 151:12	370:8	511:15	take 7:6 79:17 83:4	189:4,8,9 201:16
sufficiency 69:2	support 25:15	surprised 153:5	85:4 86:7 87:19	223:15 277:13
sufficient 98:11	204:13 263:10	159:16 440:12	92:9 95:4 106:18	279:1 296:6 303:1
306:15 426:6	327:20 409:7	473:7	110:8 122:5	306:3 333:14
441:19 446:16	Supporters 36:6	surprises 471:7	129:17 131:22	341:3 342:16
sufficiently 431:9	supporting 26:21	surrogate 316:11	139:17 141:11	359:15 384:22
suggest 104:2	supportive 311:10	surrounding 482:9	150:4 166:1 168:9	441:6 454:13,14
105:4 135:12	458:8	surveillance 484:3	187:3 229:4	458:18 471:4
163:20 165:12	supports 65:3	suspect 25:1	257:10 276:7	472:6 493:13
169:3 222:11	169:14 217:20	sustainable 388:18	285:18 310:5	495:6
235:21 338:19	269:21 357:20	swear 144:16	313:3 329:7 348:5	talks 130:9
395:15 504:9	513:15	swelling 228:1	353:9 357:10	tapped 16:1
515:20	supposed 106:22	swing 269:7	407:11 409:1	target 105:16 273:7
suggested 344:22	318:1 325:17	symptoms 495:7	427:11 457:3,11	275:7,11 284:14
suggesting 62:14	396:3 457:18	system 1:15,16,17	466:16 467:4	355:9
483:11	458:3 462:9 485:3	1:18 2:3 14:14,15	474:14 480:5	targeting 511:12
suggestion 49:18	sure 7:1 8:3,9,19	14:20 16:19 17:19	486:2 487:4	Taroon 2:11 4:3,7
165:5	29:1 36:8,17 56:8	17:21 18:20 20:1	488:19 507:19	9:2 35:21 45:20
suggestions 33:12	74:17 101:3 103:5	23:8 68:13 83:7	511:8,10	57:7 68:11 98:6
33:13 77:19	107:8 111:4 125:2	121:22 122:21	taken 110:12 123:1	119:17 121:3
172:17,20	131:8 139:18	227:7 234:6	144:16 168:21	443:8
suggests 62:5	156:7 168:20	412:12 421:5	256:17 303:21	task 16:10 20:2
103:22 263:17	173:14 181:19	473:12 486:21	takes 339:16	100:3 121:1 182:2
283:18	204:10 210:9	systematic 46:5,21	490:13	204:2 224:18
suitability 157:14	230:21 240:7	96:9 97:12 99:10	talk 25:18 32:4	TBI 92:20
212:8 250:8	247:15 277:12	102:13 178:1	57:1 88:15 89:6	team 21:3 32:20
299:12 350:6	283:14 298:8	systems 65:5 66:7	89:12 91:22	78:15 314:11,13
394:21 396:13,16	301:2,14 321:14	109:20 232:6	100:21 123:7	314:17,21 315:2
417:11,14 474:18	338:4 347:13	255:19 419:18	147:6,22 154:7	325:16 327:12
474:21 508:21	351:5,12 360:7	464:7,10	186:7 187:18	352:8 486:10
509:2 519:14,18	366:7 377:6 379:4		272:12 274:2	tear 493:17
suited 258:1	388:16 392:20		278:22 314:10	tease 191:11 192:4
summaries 254:19	406:7,7,21 414:3	T	352:15 355:6	teasing 191:18
255:1	421:11 428:16	tab 467:5	371:10 413:21	technical 27:11
summarize 67:18	438:13 443:7	table 4:1 9:15	416:22 430:15	82:17 135:17
summarizing	453:19 460:6	11:17 32:21 33:1	439:15 448:5	140:12 141:12
156:16	476:13 481:6	34:15 78:17,19	talked 260:22	176:17 286:3
summary 50:6	485:22 487:6	79:6 120:14 260:4	269:8 280:2 286:2	technically 149:1
67:11 154:11	488:16 495:6	277:22 301:13	290:4 310:11	217:12 237:5
163:9 257:19	499:17 500:4	475:11 504:7	409:21 412:8	485:13
264:5	504:13 510:16	tables 34:14 481:3	424:6 441:3 466:5	technicians 309:20
supplemental	517:10	521:9,13	491:13	313:15
285:20 295:10	Surgeons 13:9,16	tactic 226:21	talking 56:7 91:14	technology 21:14
		227:21	97:3 107:1,2	65:9,14 388:12

teleconference 3:22	61:2 64:18,22	terribly 67:20,20	264:16,17 268:8	88:19 89:7 102:1
telemedicine 338:2	65:2 73:1 93:11	86:14	269:21 283:11	107:10 125:3
telephone 251:4	115:2 135:17	territory 264:22	288:22 289:10	127:21 128:5
327:2 339:7	149:17 153:16	tertiary 14:21	291:4 292:21	143:9 149:8
Teligent 352:3	161:1 162:17	371:14 372:2	293:12 294:3	151:13 158:10
tell 9:16 11:17	165:9 176:8	test 181:15 190:17	296:17 297:4	172:6 178:20
80:12 88:22 89:3	247:14	426:9 444:1 478:8	301:18,19 317:13	180:1 186:14
112:3 131:10	terminology 168:9	497:1 515:15	318:18,20 320:21	189:20,22 192:18
132:18 133:14	terms 29:9 47:12	test/retest 263:3	329:4 343:19	195:1 197:3 216:7
187:21 193:16,22	57:4,11 60:9	277:14	351:7 352:8,10	230:18 266:2
194:2 201:4,6	64:20 68:18 69:2	tested 88:16 103:2	356:10 358:17	278:2 281:22
205:13 235:18	69:21 72:1 95:8	221:1 292:9 317:9	364:21 365:9	284:2 291:17
297:12,18,19,20	96:5,6 114:14	503:11	371:7,9,20 374:1	298:7 313:2
298:2,4 445:5	116:13 118:3	testing 19:1 33:18	375:14 380:21	341:13,17 345:5
473:11 507:3	119:20 120:20	37:15,15 146:3	382:5,10 383:6	386:14,17 404:22
telling 132:20	142:8 161:8,9	182:2 188:7 190:6	386:7 388:20	405:1,10,11 413:9
295:16 346:20	165:19 166:21	190:6,8 193:14	392:5 394:4 396:7	414:12 420:20
tells 93:7 130:8	170:9 181:1 188:1	197:7,15 263:1,6	402:2 413:5	423:7 425:12
146:20 395:18	188:7 198:6 200:9	369:20,22 383:18	417:21 426:18,19	442:13 451:13
temporary 208:16	201:1 212:21	407:21 435:3	435:22 444:13	464:6 466:3 467:8
417:1	216:22 217:3	443:20 444:1	452:20 471:19	486:1 488:20
ten 69:22 70:3	224:8,10,13,14,20	498:17 515:11	472:19,20 475:4	490:16 499:4
126:11 141:15	225:4 247:19	testretest 163:7	480:11,12,13	513:14
148:18 196:16	265:5 266:15	tests 163:1,9 226:8	482:15 483:16	things 9:15 10:5
256:4,5 434:2	275:9,9 280:9	Texas 482:9	487:7,22 489:9	11:10 12:14 23:12
496:3	281:18 285:9,13	thank 6:5,12,20	509:6 516:10	27:22 36:14 45:16
tend 60:1 129:20	286:10 289:11,17	15:16 18:8 20:7	520:2,13,21 521:3	46:5 49:22 59:11
132:10 143:21	289:18,20 290:7	22:9 23:2,10	521:4	59:12 60:3 61:16
195:7 203:9 257:6	292:14 294:11,16	24:14,15,21 25:4	thanks 8:17 9:7	62:19 75:9 80:22
292:17 334:22	304:14,15 310:19	36:1,10 40:21	18:16 25:14,16	81:1 83:11 94:9
348:4,5 452:4	318:3 327:4 328:1	51:20 53:2 59:8	28:20 36:11 41:21	97:18 98:22 99:18
453:15	328:5,15 334:18	65:15 66:3 67:5	58:12 68:8 106:19	107:7 108:20
tended 400:1	335:11 341:18,19	67:11 76:5 87:16	160:4 183:20	121:7 122:14
tendency 86:3	356:16 359:14	87:16 110:11	243:11 273:1	131:15 140:19
tends 179:3 222:14	371:2 379:22	112:13 117:4	300:20 301:17	143:8 144:15
278:14	384:3 390:2 392:6	134:12 141:14	308:12 372:7	150:10 179:6,11
Tennessee 17:8	398:18 401:10	142:14 144:18	451:10 521:6	188:21 195:5
tension 461:3	409:2,9 421:11	160:5,18 164:9,15	theme 185:4	224:16 229:22
TEP 309:6 333:13	429:12 435:5	165:21 182:11	theoretical 359:8	235:6 245:15
333:22	444:20 456:9	192:13 197:2	therapeutic 324:15	247:9 253:2
term 25:21,22 29:3	459:3 467:10	198:20 214:5	therapy 194:17	258:11 270:16
29:4,6,7,11,14,18	474:1 484:10	216:10 226:18	thereof 164:18	321:4 342:9,10
29:20,21 30:1,3,5	487:12 488:10	236:8 247:10	they'd 234:9	343:6 357:3 369:3
30:7,9,11,13,16	491:22 500:10	249:15 250:15,21	thing 7:21 28:21	379:18 381:14
30:18,20,22 31:2	501:18	251:1,10 258:13	39:20 47:18 50:6	388:21 394:2
31:4,6,8,10,12,14	terrible 378:1	258:14 259:12	61:8 62:9 65:7	404:7 417:2 419:2
31:16,22 32:1,2	379:14	260:3,11,13	67:8 85:22 86:16	425:13 429:14,15

432:10 445:20	213:13 214:5	358:16,20 359:5,7	486:1 487:11,15	389:11 396:18
456:15 459:7	216:11,17,19	360:8,9 361:17	487:16 490:15	400:10 401:21
461:13 465:22	218:3,10,12,16	363:6,14 365:16	491:13,18 492:2	501:22
473:5 484:7 486:2	226:15 227:20	366:13,15 367:18	493:8 494:19	thousands 224:12
487:19 489:2,6	228:4 229:12,20	367:19 368:22	495:1,10,11 496:1	387:1
494:1 499:2	233:14,15 234:20	369:9,11,18 370:9	496:6,8 500:4	threat 342:15
think 23:16,16,18	234:22 235:1,4,5	370:11,12,15	501:14 503:11	threats 41:4 147:6
23:20 28:19 43:13	235:8,11,20 236:3	371:19 372:13	504:13,20 506:4	332:22 336:8
46:11 47:18 48:15	236:4,10,15	373:2,12,20	506:18 512:7	three 7:13 25:21
52:11 53:13,22	238:18 240:12	374:11,12,17,17	513:11,13,20	26:22 27:20 29:20
54:1,14 55:1 56:8	241:8,10,14	375:11 376:6,8,15	515:20 516:2	29:22 30:2,17
56:12 57:9,16,22	243:22 244:6	376:17,18 377:11	518:12 519:21	31:3 39:15,19
58:4 60:8 68:3	246:18,21 247:8	379:2,3,11,17,20	thinking 53:8	40:10,13 59:18
71:19 72:7 75:12	247:14,17,21	380:2,6,10 381:21	62:14 106:4	70:2,3 124:19
75:21 77:1,7,22	248:1 261:8	382:1,22 383:2,4	235:14 275:1	125:5 126:5
78:6 81:6 93:6	264:21 265:3,18	383:11 384:2,8,19	294:13 341:1,18	133:10 146:4
94:1 99:19 101:6	265:22 266:2	385:5,16 386:9	381:18 383:12	147:13 148:10
101:12,15,17,20	270:6,14 272:15	388:3,11,15 389:1	391:5,7,9 444:6	157:5 209:12,21
102:9,10,16 103:3	275:20 280:1	391:15 395:1,8,10	472:5 511:19	210:4,14 211:6,18
103:4,5,6,7,11,12	281:21 284:13,14	396:1 397:9,20	third 89:7 286:1	237:12 254:2,3,16
103:16 104:4,18	285:2 286:11	398:5,14 400:3,5	328:15	271:20 276:14
105:1,16 107:6,18	288:9 290:13	401:17 402:10,11	thirties 348:3	288:15 293:5,17
110:22 115:17	291:16,19,21	404:3,6 405:3,6	Thomas 2:7 285:8	293:18 299:4
117:7,10,20 118:1	292:18 294:6,15	405:20 406:3,13	286:20,22 287:15	315:4 324:4,5,20
118:15 119:12	294:22 295:15,19	406:19,20 407:8	287:18 288:5	326:11 330:19
122:12 123:19	296:4,12 300:16	410:2,12 412:6,7	356:13 358:14	331:12,15 332:12
125:14 127:1	301:22 305:7	412:8,20 413:3,7	360:6,7 361:15	344:17 345:16
128:2 134:15	307:11 309:5	413:8,10,12,16	363:4,5 365:15,16	348:19 349:10,21
136:2,22 139:16	310:18 312:1	414:1,11 416:19	386:8,9 395:1	350:2 361:6,11
142:5,15 149:9,12	313:1 315:8	417:4 418:21	thought 94:8	362:17 363:1
154:7 155:12	316:11 319:15	423:7 425:11	122:12 167:17	386:2 390:13
156:4,15,22 165:9	320:14,19 322:2	427:3,11,22 428:7	204:7 227:3 248:7	394:14 397:4,15
165:16 166:11,16	323:2 324:12	428:17 429:1,2,7	258:8 284:22	403:7,16 404:14
168:7,22 169:1,2	327:4,11 329:9,10	433:6 434:13	285:13 314:12	411:9,20 415:8
169:5 170:8	330:6 331:3,19	435:18,20 436:10	342:21 384:15	452:3 466:8,9
171:12 174:14,22	332:21 334:1	437:22 440:14,16	405:11 420:4	471:17 472:3
176:5 179:11	336:9 338:22	442:8 447:10,12	430:14,17 461:17	478:9 504:7
180:3,18 181:2,4	339:9 340:14,22	447:16,18,21	465:1	three-day 203:15
183:11 184:10,14	341:14,16,17	448:7 449:18	thoughts 73:5	203:20 205:10
185:16 186:10	343:7,7,14,16	453:8 454:18	455:1 457:19,20	209:5,19 210:1
188:14 191:15	344:2,2,6,15,19	455:14 456:1,2,5	458:14 495:8	223:15,16 244:4
198:6,9 200:11	344:20,21,22	456:19,20 457:12	496:10 499:20	244:21 245:2
201:9 202:10	345:1,3 346:3,10	457:13,14,17	thousand 86:21	three-year 25:21
205:3,14 206:2,4	346:11,19 347:4,5	459:2,19,19 460:1	351:18 352:13,14	29:7,20 30:9,12
206:6,7,17 210:11	347:9,10,11	462:11 463:4,18	356:8 360:11,18	30:15,22 31:12,14
210:12,16 211:8	354:19,22 356:2,4	464:15 466:5	360:19 366:8	31:22 37:13 40:15
211:11,13 213:7	356:16 357:20	473:3,22 484:8	368:16 377:4	41:17 142:17

Threes 31:19	218:20 219:6	505:10,18 508:22	156:14 173:13	town 118:14 351:12
threshold 93:21	220:7 229:21	509:21 510:21	181:11 182:10,19	484:18
95:1 105:2 128:12	234:10,16 242:3	513:6,22 514:6,14	351:21 356:12	track 60:6 63:19
158:19 159:8	242:11 243:16	515:1 516:14	tomorrow 10:3,6	149:19 150:3,5,14
thrice 326:10	249:20 250:10	517:2 518:1,9	11:12 13:19 35:4	150:22 159:19
thrill 25:6	251:2,7 254:3	519:7,15	46:1 52:4 53:10	237:20 267:14
throw 92:10 137:8	255:3,3 263:2	timeframe 302:7	63:12,18 69:6	367:12 368:12
140:11 152:17	267:3,10,18	timeline 35:2	71:14 81:18	378:21 394:1
211:13 241:11,12	268:16 271:21	timeliness 133:12	207:10,20 213:6	401:2 464:18
276:5 396:5	276:15 279:19	timely 137:22	213:14 509:13	tracked 422:1
413:19	288:16 290:9,11	235:10 237:16	520:4,15,17	tracking 150:16
ths 203:3 521:14	293:6,19 296:5,6	254:12 351:15	tomorrow's 37:17	151:19 401:7
thumbprint 188:5	298:15 299:5	timer 112:18	ton 402:8	461:10
ticked 139:12	302:3 304:18	times 34:18 40:17	Tonight 31:17	tracks 261:1 378:4
tied 247:18 319:6	306:14 310:1	85:16,17,18 100:4	tons 318:9	traction 60:8
tight 128:16 195:13	311:21 318:2,9,15	101:8 108:16	Tony 15:5 31:1	trade 238:17 461:7
229:7	322:10,16 324:21	111:17 144:22	149:11 155:18,21	trade-off 237:9
tighten 89:18	330:1,20 331:13	306:7 326:12	156:13 164:12	tradeoff 138:3
114:20	332:13 333:14	393:12 409:4	166:6,10 167:19	335:21
tightened 90:2	342:2 345:10	427:8 501:22	167:21 172:12	tradition 8:5
tighter 124:9	348:20 349:10,22	timing 285:10	174:22 200:4	traditional 387:15
229:15	350:13 353:18	456:14	408:6	387:21
tightly 110:20	359:22 368:12	tiny 152:22 207:2	tools 66:17 473:3	traditionally 75:19
time 6:5,9 7:4 8:12	372:22 373:2,6,10	281:14	top 116:4 144:2	tragedy 388:11
14:16 18:15 19:11	373:11 375:10,11	title 77:10,15	282:18	trail 248:21
21:13 24:2,22	376:16 379:6	today 9:22 10:2,6	topic 51:19 68:21	train 248:7
34:8 42:2 60:19	385:2 386:3	10:22 11:11 27:7	69:3 75:4 121:19	training 12:3
61:13 63:1 68:14	388:10 390:13	35:4 37:8,9 39:11	121:21 166:3	trajectory 82:12
68:17 69:1,16	394:15 396:14	46:1 52:3 53:9	189:13 190:12	transcribed 8:16
71:8 80:14 90:17	402:22 403:8,17	54:8 69:6 71:9,14	217:11,17 241:20	transfer 139:9,11
92:7,21 122:17	404:2 411:10,21	71:20 72:12 73:8	370:22 382:6	142:1 228:17
124:20 126:5	412:21 414:7	74:6,7 75:22	413:1 438:11	transferred 138:19
134:18,18 135:21	417:12 422:3	78:11 93:20 95:3	468:21	173:18 174:1
136:18 137:18	429:15 432:4	105:15 120:13	topics 190:10	225:9
146:5,8 148:10	433:6 435:10	179:14 230:3,5	torn 290:7	transferring 142:7
149:19 150:3,7,8	438:22 439:13,14	236:17 253:13	total 14:21 240:1	285:15
150:14,22 151:11	439:19 440:3	265:1 269:8 277:6	274:13 326:11	transfers 138:14
151:19,22 152:3,9	445:11 447:3	296:11 305:11	363:7 484:15	139:3,3,14 174:19
157:6,20 164:12	449:22 455:6	307:2 315:22	totally 116:8 195:4	265:10
166:12 171:22	461:10 462:18	316:16 355:17	395:20 453:19	transition 93:8
173:8,10 180:10	463:7 469:1,6,22	376:3 377:2	486:15 499:3,5	286:11
181:14,21 182:8	470:17,21 471:1	457:13 496:8	touch 12:18 288:10	transitional 357:2
186:7 190:7	473:19 474:9,19	502:20	333:12 404:2	transitioned 68:12
192:14 196:4	476:14 479:21	today's 32:5 34:4	touches 358:14	92:17
197:10,20 199:6	480:4,10 490:22	37:17	tough 191:11 320:8	transitioning 81:8
200:8 210:14	492:13 495:22	told 91:14	495:4,7 520:22	92:12
212:3,10,12 218:1	496:14 497:22	Tom 20:9 30:4	tougher 387:4	transitions 81:11

136:21 261:14 265:13 352:20 497:5 transparency 165:17 211:17 383:1 384:11 transparent 11:4 300:14 466:22 transportation 391:11 trauma 17:20 226:22 247:6 traumatic 122:5 travel 336:4 traveled 449:6 456:13 traverse 265:2 traversed 265:1 traversing 264:22 Travis 2:8 17:6,6 31:11,11 193:11 193:20 194:5 299:22 300:3 457:17 471:22 472:19 treated 150:7 376:10 377:16 451:18 treating 167:3 168:11,12 310:7 310:12 314:7 treatment 326:9 376:13 470:8 505:4 treatments 150:9 treats 339:20 tremendous 182:15 381:2 455:15 tremendously 332:2 335:8 trend 397:11 424:20 471:2,6,8 trials 94:15 102:16 tribute 510:6 tricky 145:10 369:10 506:19 tried 144:17 289:4	428:2 430:13 tries 65:1 trivial 316:7 494:5 trouble 12:3 177:14 248:22 249:1 497:12 troubled 142:5 449:19 502:5 518:11 true 62:10 102:3,4 128:8 156:7,10 195:2 197:3 217:6 223:10 298:15 343:12,13,14 379:16 410:11,12 410:17 429:8 446:2 499:7 truly 62:15 374:16 trust 183:12 387:7 truth 270:5 try 29:5 40:14 51:1 51:1 52:13,19 53:1 63:3 65:10 76:1 85:2 108:16 120:20,21 121:5,9 156:7 177:8 234:6 241:5 317:4 322:19 335:18 338:3 344:1,5 351:11,15 413:20 433:10 489:2 490:13 trying 36:13 76:22 81:2 84:10 109:21 146:8 149:21 167:20 176:18 227:6 228:12 237:20 275:10 277:22 291:20 313:17 344:19 346:22 386:17 406:14 425:6 431:14 434:12 444:15 446:4 499:21 500:13 tucked 104:21 tug-of-war 31:18	tune 246:22 turn 6:12 8:1,12 9:4 35:20 44:8 51:16 239:2 334:15 423:1 426:20 turned 19:7 177:18 435:4 450:6 turns 436:21 twenties 348:2 twice 127:7 174:2 185:7 359:17 505:15 two 6:6,13 8:11 12:14 18:20 24:8 25:20,21 26:22 27:20 29:7 30:6 30:10,14 31:7,9 32:18 40:16 43:19 47:22 51:21 55:17 68:3 77:5 79:10 108:20 112:17 113:5 116:4,5 117:12,14 124:18 126:4,8,17 133:8 146:3 147:12 148:9 157:4,20 158:1 160:16 162:7 169:17 179:12,14 189:15 190:9 194:7 196:13 202:5 206:19 239:22 240:17,21 241:3 245:6,6 247:8,9 247:12 256:2,8,14 268:15 271:20 272:15 274:15 275:19,21 276:14 279:3 288:15 291:7 293:5,18,21 299:3,15 304:8 306:17 316:1 330:1,19 331:12 332:12 342:8 346:20 347:2,3 348:19 349:9,20	350:12 359:21 360:4 361:6,11 362:17,20 366:4 386:1,5 390:12 394:13 396:13 402:22 403:7,10 403:16,19 404:13 404:15 410:7 411:9,20 412:2,2 415:7 417:11 433:13 434:3 440:4 456:15,20 475:11 476:20 488:20 493:19 494:15,21 496:15 505:11 two-minute 281:20 two-stage 234:2 two-thirds 223:21 two-year 29:10 30:4,19 31:2,6,15 32:1,2 152:2,11 200:8 Twos 31:19 tying 248:1 343:4 type 15:2 41:13 55:18,22 56:16 57:13 95:21 115:4 136:3 195:15 232:19 235:15 303:19 320:15 353:12 354:20 381:7,12 389:11 389:16 477:22 483:12 types 44:12 143:15 162:13 311:18 391:6 500:6 516:3 typical 94:20 451:17,20 typically 39:5 41:17 182:1 190:20 383:5 516:7 <hr/> U <hr/> U 302:17	U.S 251:14 416:11 UCSF 22:21 UDSMR 67:4 Uh-huh 202:13 Uh-oh 286:22 ulcers 232:1 ultimate 284:14 309:10 ultimately 38:16 44:11 117:20 159:12 322:3 366:22 388:14 UM 302:21 UMICH 330:10 unaccounted 24:9 unadjusted 118:22 442:12 uncertainties 241:15 uncertainty 123:1 211:10 241:10 unclear 316:21 uncomfortable 101:5 241:16 343:1 under-prediction 191:20 underdeveloped 304:18 undergone 72:2 underlying 498:19 underneath 104:21 underscore 63:7 undersold 358:21 understand 23:3 67:17 76:8 97:2 114:9 127:15 128:6 142:1 156:2 203:4 230:14 267:20 291:14 292:11 295:12 309:11 311:17 312:1 319:11 332:1 333:18 338:10 377:15 387:5,17 423:9 445:13 463:21
--	---	---	--	--

486:15,20 490:6 499:3,5 504:11 506:16 understanding 44:1 56:8 75:1 131:15 193:12 209:4 222:21 235:12 300:10 359:9 understands 414:3 understood 141:1 230:22 241:7 460:6 465:6 470:14 underway 458:3 underwhelming 484:9 unfair 55:1 unfortunate 168:14 196:3 unfortunately 196:1 452:10 uniform 2:3 109:16 110:2 166:15 Uniformed 66:6 unintended 142:11 153:18,22 154:8 155:8,9,14 156:20 185:3,9 186:5 200:2 202:10 205:22 206:1 211:22 233:21 244:7 245:19 381:5 384:22 398:11 400:3 518:8 unintentionally 244:8 unique 253:11 306:9 338:10 unit 55:19 252:11 252:17 253:1,3,10 254:9 256:2 308:22 309:8,12 309:19,19 310:2,3 310:4,6,16,20 311:11,13,16	312:5,11 314:8,14 315:16 316:20 319:2 320:4,9 321:15 323:10,11 326:7 333:3,9,10 333:15,21 334:7 336:6,11 339:11 340:12 342:11 467:14 United 2:8 256:21 313:12 323:5,13 340:8 347:20 UnitedHealth 17:4 units 253:17 254:11,14 255:8 256:21,22 257:5 257:12,18 312:3,8 313:22 314:1 316:4 319:21 320:8,17 323:13 323:16,18 324:6,6 330:11 334:3,4,19 334:19,20,21,22 335:7,8,9,13,19 336:2,4,18,21 340:2 348:5 universe 151:22 152:2 university 1:14,15 1:19,20,22 3:9,12 3:14 4:22 12:1 13:3 16:17 17:18 19:9 20:10 21:20 64:14 65:17 66:9 302:10,16,21 352:8,9 419:5 unlock 109:4 unnecessary 393:15 unplanned 4:12,14 80:14,19 137:10 137:11 158:6 160:14,21 161:19 172:16 173:5 212:15 238:14 239:18 240:18 260:17 264:9	265:20 303:2 408:13,16 unreasonable 87:5 457:14 unrelated 391:20 unreliable 179:7 223:7 unrewarded 116:14 unstable 314:22 315:3 494:7 unusual 86:14 196:22 203:12 update 4:8 44:7 updated 37:14 327:2 414:16 441:17 updates 27:5 updating 420:6 upheld 53:18 upper 113:18 upwardly 381:11 urban 347:12 urge 374:18 urgency 354:19 urgent 354:22 Urvi 3:17 214:19 USA 376:3 377:2 502:20 usability 42:10 148:17 149:3,4,11 157:4 199:11,13 200:10 207:22 211:16 243:21 249:17,19 251:22 252:7,8 294:4 295:15,20 299:3,8 300:4,10 301:9 349:17,20 359:13 365:17 369:18 382:7 388:22 389:3 390:18 391:2 392:4,6 394:11,13,17 397:12,17,21 398:18,22 399:1,2 400:5 412:4 414:1	415:3,7,11 463:16 474:6,7,12 506:1 508:12,14 518:5 519:6 usage 478:15 use 5:10 8:14 12:19 21:13 42:10 60:1 60:3 63:1,14 66:16 82:5 83:7,8 83:9,11,12 97:1 116:12,15,22 120:7,20 121:14 128:20 129:21 130:8,20 131:9,14 132:16 133:10 134:15,19 135:14 136:21 145:18 148:2,17 149:3,4 149:8,11 155:12 157:4 162:7,22 165:9 168:10 170:3 183:9 189:5 199:11 200:10 211:16 216:5 220:7 224:5 226:9 227:1 231:2 235:17 240:15 242:22 245:10 248:14 249:19 282:8 291:11,13 292:3 294:4,17 296:13,15 298:5,6 298:8,20 299:3,8 300:4,10 301:8 346:21 349:17,20 362:7 363:9 366:5 367:11 368:5,12 369:6,18 372:13 376:19 383:4,10 383:14,17 384:3 384:20 385:4 388:11,22 390:18 391:2 392:6 394:11,13,17 397:12,16,20 414:9,10,19 415:7 415:11 416:19	417:3 420:17 422:12 424:3 426:6 428:9,18 436:11 444:4,12 449:4 458:1 463:21 465:4,10 466:9 469:5 472:14 473:13,18 474:7,12 477:10 477:16,21 478:19 488:7 490:8 493:2 498:10 499:10 500:19,22 503:22 508:12,15 509:3 511:10 515:15 519:6 useful 61:18 62:15 83:15 178:9 221:8 238:10 291:19 305:16 377:22 378:9 381:2 392:16 405:10,12 406:19 431:5 436:6 459:1 usefulness 431:4 useless 237:18 user 7:17 users 421:3 436:10 uses 80:13 84:17 149:8 232:7 usual 319:12 usually 74:8,12 184:19 194:20 312:12 322:17 339:6 371:15 419:7 434:11 451:8 452:5,7,8 469:13 utility 152:10,12 381:22 384:20 utilization 162:16 217:15 262:6 370:3 506:8,18 519:2 utilize 215:12 220:21 utilized 493:2
---	--	--	---	--

UTIs 271:9	497:15 498:6,7,17	445:2 446:3	24:17 65:18	165:2,13 166:1
UW 2:2	501:14 503:22	481:21 512:21	132:13 214:14	169:9,14 170:19
V	504:4,10 505:7,9	variation's 445:3	251:11	170:21 192:16
VA 16:9 18:14	505:12 515:8	variations 423:3,19	vice-versa 257:9	196:7,8,9,14
vacated 432:14,16	516:18,20 517:1,5	423:20 481:7	view 17:20 101:20	197:6,13 198:22
vaccination 263:9	valuable 264:12	varies 47:10 61:21	108:20 109:15	199:10 211:12,14
vacillates 185:19	521:14	224:2,3 225:10	131:1 154:12	211:15 212:7
vaguely 104:13	value 167:4 422:4	226:2 401:5	173:7 346:14	217:18 218:4
valid 140:5 232:3	436:4 457:4 501:6	variety 98:21 163:1	437:6 469:14	241:14,17,21
355:14 383:3	values 33:20	various 33:20	viewed 410:18	242:1 243:13
387:6	122:19 263:1	44:12 48:10 63:14	Vince 269:12	249:18 250:11
validation 423:17	468:4	211:11 223:14	270:19	268:13 271:18
435:3 453:22	variability 86:9	301:6 304:22	Virgin 416:12,16	272:7 276:11
validity 41:5 43:9	103:18 104:20	422:19 432:1	Virginia 1:14 65:17	288:11 293:2,15
146:16 147:1,4,5	188:1 216:20	varying 88:1,3	virtual 314:17	297:7 298:20
147:7,12 179:15	263:11 291:12	127:3,12	virtually 296:9	299:1,16 329:21
181:1 182:15	292:6 330:11	varying-shrinkage	virtue 150:6	330:2,17 332:11
188:7,9,15 189:8	360:21 439:10	88:14	visit 251:17 284:10	348:16 350:5
190:16,17 193:15	461:12 487:16,17	vascular 13:18	321:19,21 322:17	358:3 359:16
197:14 219:13	487:20 491:19	252:19 258:9	337:12 493:11	360:2 361:3
220:22 242:8,9	variable 220:2,5	vast 82:1,1 255:18	511:18	362:14 363:18
251:22 256:7	267:18 292:11	282:14 296:10	Visiting 64:12	365:6 385:19
263:6,10 288:10	503:22	Venn 76:8	visits 242:22 284:3	386:1 387:4 390:9
289:1,5 292:7,13	variables 47:3	ventilator 162:22	478:1 479:11	394:16 396:11
292:15 293:2,5,9	58:16 63:10 119:4	ventilators 202:3	484:15 488:10,11	402:20 411:22
305:7 331:18	119:4 123:20	versa 132:13	492:21 508:1	415:14 417:6
332:18,19,22	128:3 162:11	verse 328:17	513:17	435:7 439:1
333:14 336:9,14	192:21 262:16	version 81:16	visual 70:10	444:17 446:22
342:6,15 348:17	292:8 432:2 455:3	231:8 302:1	voicing 202:9	447:4 462:15,19
348:18 349:2	variance 89:18	versus 98:6,21	volume 77:16 88:5	463:9 474:6,15
355:22 358:16	445:4,6,14 446:19	106:1 107:5 120:8	88:7 127:5,10	490:20 492:10,14
363:4 365:10,17	462:2	120:9 172:16	135:3,8,9,10	495:5 496:11
365:20,21 366:9,9	variants 144:17	175:4 189:7,18	136:7,15 138:2	497:19 498:1
366:18 367:7	variation 62:7	201:15,17 206:15	228:14 229:10	508:18,18 514:3
368:4 369:20,22	103:21 104:6	217:6 238:14	279:15 295:22	516:11 519:16
371:6 382:7,8	109:1 114:17	240:18 257:2	296:8 312:20	voted 113:22 125:5
385:16 386:1,5	118:4 119:21	281:19 337:10	328:11,13 455:15	158:5,5 165:12
388:2 398:10	120:3 124:16	342:3 347:12	volunteer 10:19	219:9 243:17
399:22 401:11	128:8 171:1	369:14 377:7	vote 28:13 35:13	250:1,14,14 272:3
402:12 403:22	187:22 189:18	387:21 413:2	38:10 79:17,18	272:3 288:20
404:20 406:21	195:6,13 216:16	432:15,16 449:16	107:21,22 110:21	293:22 294:1
411:8,12 439:6	224:17,22 225:2	487:14 496:2	111:15,16 112:8	299:20,21 330:3,3
443:19 444:17	238:14,16 270:7	506:9	112:15 114:1	331:15 333:22
447:13 454:1,14	270:15 292:7	vetting 106:18	124:12,14 125:21	349:2,3,14 350:17
454:15,20 462:15	304:1 367:5	vice 2:12 11:21	126:15 145:20	350:18 360:3,4
462:17,21 496:20	422:16 431:15,20	13:6 15:6 16:7,16	147:3,12 148:6,7	439:2,3 491:2,2
	432:6 435:6,18	17:3 18:18 21:21	155:1 157:2,3,13	votes 113:20 125:5

126:12,17 146:10	362:18 365:2,4	167:20 168:5	490:9 517:9	439:20 442:6,8
147:19 157:11	392:17 394:7,10	169:6 181:5,12	wanting 458:11	444:5,20 460:20
158:4 160:3	394:12 404:12	182:5,9 185:8	wants 39:17 118:18	461:1 462:1,3
169:19 171:6	411:7,19 415:9	186:3,13 187:7,19	131:2 211:13	464:13 466:22
172:2 197:11,21	417:10 435:9	194:9 200:5,9	391:1 443:8,8	484:13 506:4,20
199:8 212:5,13	438:5,7,20 462:16	202:11 203:5	481:3	ways 41:15 100:18
218:21 219:8	463:10 490:21	204:12 220:7	warrant 431:9	108:12 116:15,22
242:5,12 243:17	492:11 496:12	229:15 233:13	Washington 1:9	123:12 150:10
250:1,12 272:2	505:8,16,20	243:7 262:7 276:5	6:20 13:3 17:19	152:18 154:15
276:18 288:19	508:11 517:21	278:3 281:2	17:22 18:3 21:8	236:5 309:9
293:9,22 299:7,18	519:13	286:20 289:2	336:1	345:11 380:4
330:21 331:14	VP 14:13	296:21 301:2	wasn't 50:14	383:11 449:10
332:14 349:1,13	vulnerable 245:14	309:1 324:17	102:18,19 154:16	484:5 510:17
350:2,15 360:3		327:4 333:6	209:9 220:1 442:1	we'll 6:7 7:13 9:15
361:10 362:20,22	W	352:11,15 364:2,6	442:2 447:19	13:19 27:7 29:5
365:7 386:4	W 1:18	369:13 370:14	448:12	32:12 35:4,6,11
394:17 396:15	wait 102:6 198:4	371:10,21 378:11	waters 476:21	35:16,18 36:8
397:17,21 398:8	228:2 239:4 259:2	379:20 381:10,13	way 46:5 51:10	37:19,21 38:7
398:12,18 403:9	259:10 433:9	398:13 407:1	54:5,6 59:21 62:6	39:5,8,9 43:6
403:18 404:15,16	458:5 498:22	412:5,19 416:22	62:14,16 76:17	44:13 45:20 52:11
411:11 412:1	502:19	418:19 420:20	79:3 93:12 104:14	52:21 72:5 74:8
415:10 417:13	waiting 113:19	427:3 430:9	107:9 110:2	74:15 76:1 79:5
435:12 438:8	124:22 126:8	443:14 446:17	117:18 118:7	95:2 108:7,16
447:5 462:20	218:4 228:1	448:1 457:10	121:13 123:11	119:16 120:18
463:13 474:20	268:18 314:14	460:2 479:14	127:10 130:17,21	125:20 126:19
491:1 492:15	505:11	480:21 483:19,21	135:4 139:7,20	140:17 145:17
496:15,16 498:2	walk 27:13 29:4	487:1 488:1,3	141:6 145:11	148:6 156:6 159:3
505:11 508:14	44:9,14 74:11	500:2 509:13	150:7,14 151:20	159:5,11 160:16
509:1 514:7,16	79:16 211:1	520:13	154:10 178:16	166:1 192:16
515:4 516:15	want 7:1 10:7 11:2	wanted 7:9 25:11	185:12,14,17	196:13 211:14
518:2 519:17	23:11,20,22 24:7	25:18 26:16 32:4	186:20 195:2	212:22 213:15
voting 38:9 79:5,20	24:20 25:3,5 29:1	43:14,18,20 45:17	197:3 206:3 223:2	214:6,7 217:18
95:1 107:4 111:7	32:11 36:17 43:16	71:10 77:22	236:22 275:1	219:13 241:21
111:11 112:6	47:13 48:6 50:3	108:19 119:17	291:19 297:22	242:7 243:13
113:20 125:5	54:13 55:18 57:7	120:3 132:16	314:1 315:21	250:17 260:9
126:1 145:21,21	61:15 63:6,21	139:18 158:10	316:15 318:12,21	268:12 301:14
147:14 148:8	76:14 78:14,21	168:20 189:6	319:6 321:20	302:9 322:8
153:16 155:16	87:19 89:5 90:19	234:19,22 262:12	333:11 342:18	330:17 343:20
158:11,14 159:11	94:2 95:4 97:13	266:3 276:3 298:8	345:13 355:1	351:21 355:6
165:7,10 169:17	97:14 99:12	324:19 351:5	356:4 370:18	399:12 426:20
171:4 172:5 189:7	100:22 101:11	368:20 370:10	383:13 390:1	452:8 453:15
196:4 207:22	102:2 106:8 118:3	378:17 383:9	393:14 398:4,18	459:21 463:8
217:19 218:5,22	118:12,19 121:18	384:4 385:18	402:15 407:7	474:14 475:10
219:4 242:12	126:21 128:16	388:3 409:12	408:1 409:5	476:7 478:13
249:17 250:7	131:4 139:10	423:18 425:20	410:17 412:11	479:16 480:5,14
268:14,21 331:11	152:7,13 153:13	437:6 460:5	413:3 419:11	482:17 490:19
359:20 361:7	164:10 165:22	465:14 473:17	421:12 429:19	492:10 502:19

508:18 514:3	279:1 284:9	website 35:12 40:4	455:13 480:14	wonderful 320:12
520:16,18	293:13 295:17,21	414:8,15 465:13	483:18 491:5	328:19
we're 6:21,22 10:3	301:21 303:1	478:11	493:7 501:12	wondering 76:11
16:19 22:14 29:2	316:15 323:8,8,11	Wednesday 254:6	507:14 513:9	143:4 224:19
36:13,21 43:20	341:15 343:20	weed 228:7	515:17 516:19	230:4 297:9
44:20,20 45:18	375:19 376:6	week 16:14 151:8	WESLEY 1:18	461:16 485:13
55:5 63:12 70:11	385:22 391:5	246:8 305:14	West 1:14 19:18	word 129:5 165:18
71:3 72:12 78:20	393:21 404:6,19	306:2 309:18	65:17	296:13
80:4 81:2,6,18,21	405:16 410:12	322:11,14 323:20	Wharton 419:5,17	words 93:16 138:16
82:20,22 84:8	418:11,15 426:21	326:11,12 483:5	427:17	397:19 468:3
86:1 87:14 93:11	433:5,9,10 441:6	weekend 254:8	what-not 187:10	472:7
95:7,9,13,16,19	444:14 447:9	weekly 326:10	whatnot 521:8	work 6:22 10:18,20
96:6,8 97:3,11	450:4 454:13,14	weeks 256:14 466:7	white 58:10 189:15	11:11 15:18 16:9
102:8 106:6,22	454:16 457:13	weight 103:6 338:5	whoa 89:1	17:8,14 20:13,20
107:2 109:20	458:17 472:5	Weighted 363:11	wide 87:6 92:18,19	28:15 32:15 34:7
111:11 112:15	475:15 476:6	welcome 4:2 6:4,13	131:8 132:8	42:1 44:1,3,7 48:7
113:19 114:2	477:9 479:5,6	6:15 13:2 24:20	261:11 297:17	53:9 55:1 60:5,15
115:6 116:8	487:17 495:6	40:8 44:17 51:18	353:12 501:4	64:10 75:4 77:15
117:10 119:14,21	497:11 500:13	54:3 75:11 78:19	widely 421:22	93:9 108:21 109:4
119:22 124:4,22	502:22 504:18	125:16	wider 378:8	109:15 121:6,15
125:22 126:8,16	509:16 511:19	well-placed 167:19	WiFi 7:16 36:5	123:18 131:11
127:13 129:17	512:8 518:19	well-spoken 258:15	wiggle 39:16	134:4 140:10,11
131:8 132:19	519:1	well-thought	wild 135:15	141:17 195:6
136:1,5,6,11,14	we've 7:2 27:12	258:15	wilder 134:9	196:12 214:20
136:17,18 137:2	32:8,18,22 34:13	well-understood	willing 24:22 27:2	222:19 272:18
138:16 141:15,17	37:1,3,5,6 50:13	387:8	136:6,17 228:14	302:16,21 305:4
141:19 145:8,21	69:22 70:4 71:9	went 82:9 100:3	295:21	314:15 315:2,17
146:8 147:3,11,21	71:16 76:20 77:8	102:2 114:7	win 194:8	321:15 328:14
148:16 149:21	84:12 86:18 87:14	123:21 134:17	wind 272:18	353:9 354:16
152:17 155:12	101:7 125:15	139:1,12 141:8	window 260:20	355:11 356:18
157:3 158:11	158:16 159:1	155:19 160:9	264:1	357:18 388:9
165:6,7,13 168:12	179:17 189:5	227:13 245:21	winds 502:6	391:18 393:1,2
169:13 170:21	234:15 235:3	248:15 259:14	wisdom 89:13 94:8	402:13 419:14
172:4,8 174:6	249:13,13 329:4	290:12 319:4	wise 329:3	443:21 448:11
180:2,9,13,15,22	335:8 390:18	353:13 354:10	wish 33:8 193:18	464:12 483:9
183:18 185:21,21	423:17 436:14	418:4,4 424:22	305:21 323:6	worked 19:3
187:8 189:4	440:14 449:17	weren't 450:3,3	Wish's 313:8	105:20 144:5
192:14 193:5	451:3 455:6 458:2	507:18	wishes 345:4	220:12 510:5
194:21 197:5	465:10 470:5	Wes 19:4 29:22	withhold 256:2	workers 309:21
208:14 211:15	471:9,20 472:16	61:14 117:5 166:8	wolf 430:19	313:14
213:18 216:12	491:13 492:3	166:17 167:5	women 2:6 7:12	workgroup 265:6
218:4 219:7	493:3 495:20	168:3 174:14	21:6	workgroups
225:19 233:7	496:8 514:20	198:4 204:11	Women's 2:1	301:10
235:4,14 236:17	516:21	205:17 283:12	wonder 93:19	working 25:22 39:9
241:11 242:1	weak 133:7 292:9	364:1 365:11	236:19 393:11	63:8 65:4,10
249:18 264:19	292:12	372:11 385:18	wondered 221:10	93:11 116:2 124:1
274:8 275:1,9	webcasted 8:17	386:12 415:21	277:10	124:1 132:15

141:13,19 300:21 307:18 352:22 354:15,18 355:15 393:7 419:21 440:15 466:17 467:15,16 486:14 488:16 511:20 works 28:15 47:12 88:11 139:17 151:20 305:6 460:22 486:7 world 35:8 81:19 144:7 150:9 151:7 151:14 177:4 191:6 248:4 308:22 502:1 worries 426:17,19 worry 151:12 315:9 518:7,15 worse 130:3 135:9 236:18 277:8 294:12 342:18 354:6 478:7 481:19,20 491:18 497:6 503:21 504:8 512:20 513:1 worst 457:8 worth 235:6 236:4 270:21 340:22 377:12 440:4 wouldn't 102:3 117:17 123:8 141:11 142:10 152:7 156:18 181:4 198:12 227:7 230:4 245:8 249:10 444:21 wound 117:13 141:10 wounds 511:15 wow 374:14 379:18 wreck 450:22 wrestled 344:12 wringing 378:15 write 433:1 written 262:9,12	298:20 306:12 311:9 323:1 424:13 wrong 139:1 146:22 147:10 167:11 186:14 190:4 205:11,14 230:18 245:21 370:5 385:2 404:7 459:2 489:14 507:5,13 <hr/> X <hr/> Y <hr/> yeah 91:16 132:19 168:5 172:6 173:12 175:22 178:13 181:12 203:3,4,8 204:5,9 206:2 244:20 279:22 379:3 393:20 426:16 428:16 429:4 430:6 436:13 437:20 439:17 442:13 462:12 466:8 488:3 year 25:22 27:20 29:21 30:1,3,7,11 30:18 31:4,8,10 39:15,19 40:10,14 56:9,11 83:2 150:4,4,4,9 152:8 152:14 158:16 162:18 182:14,18 182:18 220:4 252:14 254:20 261:5 304:9 314:21 315:2 353:17 354:17 356:9 374:13 440:4 441:17 451:6 466:8 474:2 478:2 year's 181:7 years 26:22 29:12	40:17 64:11 65:19 100:3 133:8,10 162:8 179:14 211:18,19 231:3 254:16 319:20 321:4 325:7 363:7 373:13 414:16 419:22 424:15 432:10 435:4 440:4 451:3 466:9 466:12 469:9,19 469:19 471:8 472:3,4 478:9 501:22 yelling 166:19 yes-no 121:12 YI 3:12 yield 333:20 yielded 263:3 York 20:10,11,14 20:18 25:12 64:13 65:9 66:8,20 317:6 336:1 481:10,13,16 482:4 Young 62:11 younger 142:22 143:2,11,22 373:1 yuppie 381:11 <hr/> Z <hr/> Zehra 2:16 8:22 111:7,20 199:12 zero 125:6 126:18 129:13 146:12 148:14,15 233:14 268:22 272:4,4 276:19,20 288:21 293:10,10 294:1,1 299:9 330:22 331:1,16,16 332:16 349:3,15 350:3 361:12 363:2 365:8,8 390:16,16 394:18 403:11,20 404:17 404:18 412:3	415:12 zip 257:1 353:6 376:9,14 378:3 380:20 388:6 414:14 416:11 zone 158:13 159:17 212:19 233:6 396:21 397:14,16 399:16 417:18 447:9 475:3 zoo 90:12 <hr/> 0 <hr/> 0 171:7,7 172:3,3 197:12,22,22 199:9 212:5 218:22 219:1,10 219:10 242:13 243:18 250:2 438:10 439:3 463:14,15 505:12 505:13,21 514:17 515:5,5 516:17 517:5,5 519:9 0.3 277:8 0.55 332:1 0.56 277:3 0.67 289:12 0.7 277:8 025 195:7 0327 5:6 474:22 04 195:17 05 194:3 06 194:22 196:21 065 196:21 07 194:21 195:19 08 180:19 <hr/> 1 <hr/> 1 17:20 116:18 147:20 150:4 157:12 171:3,21 197:9,12,19 199:5 199:9 212:2,9 218:1,6,7,19 219:5 242:2,9,13 243:14 249:19	250:9 270:21 435:10,13 438:6 438:21 439:3 447:2,6 462:17,21 463:11 474:8,12 474:18 479:21 480:10 490:22 492:12,16,16 496:13,18 497:21 498:4 504:16 505:9,17,21 508:12,15,21 509:20 514:5,13 514:22 516:13 517:1,22 518:3,4 519:6,14 1,000 278:20 417:15 1,400 347:19 1,500 347:19 1.1 85:16 1.3 239:22 240:1 1.7 292:5 1.88 252:13 1:04 260:2 1:05 259:1,7,7 1:40 259:15 10 116:19 171:7 199:9 212:6,14 293:22 304:3 312:11 322:20 343:20 350:3 409:4 417:16 438:9 439:3 475:1 481:8 505:21,21 518:3,3 10,000 214:16 233:8 10:45 7:14 148:19 100 129:12 144:6 253:13,15 258:3 270:22 348:2 393:9 434:15 435:4 449:19 451:1 452:17 460:10 462:2,4 1000 5:1,4 505:2
--	---	--	---	--

1030 1:9	509:5 519:9	514:12,16	2008 352:18 420:5	242:5 243:17
11 20:3 349:14	15,000 214:17	1c 126:1 171:18	429:16 448:13	250:1,12 272:2
350:3,18 415:11	231:11	219:5 276:18	471:2	276:18 284:11
438:9 447:6	150 433:16 452:11	331:11,14 362:16	2009 277:15 282:14	285:12 288:19
11.1 89:19 114:7	15th 1:9	362:22 403:15,18	2010 94:6 277:15	293:9,22 299:7,18
481:10	16 102:15 115:13	438:20 439:2	435:20 498:9	349:1,13 350:2,15
11.9 269:6	146:11 147:19	496:12,16 514:22	2011 18:1 102:15	360:3 361:10
12 12:16 65:19	237:14 299:8	515:4	239:18 252:12	362:22 365:6
150:17 172:3,3	333:7 349:2		263:21 269:5	386:4 394:16
178:22 261:4	462:21 491:2	2	283:3 412:20	396:15 404:16
266:12,18 309:18	519:20	2 150:4 171:3,21	2012 435:20	411:11 412:1
322:14,20 326:10	16.1 89:19 114:7	197:9,19 199:5	2013 498:10	415:10 417:13
394:18 396:16,16	160 4:16 324:7	212:2,10 218:1,19	2014 1:6	435:12 438:8
411:12 418:2	168 309:17	219:5 242:2,6,10	2016 151:7	447:5 462:20
439:2 492:16	17 197:22 242:13	243:15,18 244:18	204 128:3	463:13
493:3	253:18 254:1	249:19 250:10,14	205th 128:4	24-month 137:20
12-month 215:18	293:10 330:3	435:10 438:6,21	20X 115:13	24-week 102:11
12:30 7:14	332:15 403:10	447:2 462:17	21 113:22 280:17	2496 4:21 251:18
12:45 258:21	452:7 505:12	463:11,14 474:8	281:12 403:1	302:11 350:16
259:14	516:16	474:13,18 490:22	21.1 239:19 264:3	25 177:1 271:5
13 85:16,18 115:11	17-day 315:3	492:12 496:13,17	21.6 264:4	278:14 310:1
125:6 126:17	170,000 251:15	497:21 505:9,17	214 4:18	324:11 334:7
150:17 191:15	171 278:19	508:12,15,21	22 195:7 216:19	482:14
199:9 216:18	172 278:20	509:20 514:6,13	218:6 250:13	2502 4:12 78:13
242:5 292:5	18 218:14 233:15	514:18 515:1	360:3 390:15	158:6
350:17 386:5	272:3 288:20	516:13,16 517:2	463:14 498:2	2503 5:1 351:17
475:1 508:15	347:18 365:7	517:22 519:6,9,14	508:14 514:7	396:17
514:17	404:17 514:8	2-Midnight 244:2	515:4 516:15	2504 417:14
13'ish 116:7	517:5	244:14	517:4	2504:30-day 5:3
13.0 89:15 114:8	19 88:21 89:2	2,000 22:16	2200 14:21	2505 5:10 475:11
13.5 510:20	197:12 219:9	2,220 251:16	23 108:10 146:10	509:2
13.9 89:16 114:9	276:19 299:20	2.1 435:19	218:7 268:22	2510 4:19 260:7
14 157:11 171:7	361:11 504:16	20 64:11 153:7	331:14 332:14	299:19
212:14 231:19	1988 427:18	169:20 231:3	403:9,18 435:13	2512 4:14 160:11
243:17 250:2	1992 427:18	240:19,20 258:22	474:11	160:14 212:14
293:22 352:18	1a 112:16 169:14	266:4 269:12,13	2375 4:17 214:1	397:6
354:14 374:21	217:20 268:15,21	274:15 298:3,3	250:12	26 61:22 269:15
407:4 409:4	329:22 359:20	319:20 325:7	2380 5:15 475:12	260 4:20
417:16 474:12	360:3 402:21	331:15 335:9	519:18	27 69:18 129:6
496:17 498:3	403:1 435:9,12	351:9 360:20	24 125:4 126:12	252:20 253:2
515:5	490:21 491:1	363:1 407:9 412:2	137:19 146:8	481:15
142 441:12,13	514:5,7	419:22 424:15	147:19 148:13	270 360:17
442:5	1b 124:15 170:22	452:4 498:9	156:9 157:10	29.3 481:19 491:20
15 70:5 218:22	218:18 272:2	200 144:4 323:18	158:4 169:19	2a 146:1 197:6
231:3 312:11	330:18,21 361:5	335:9 505:1	171:6 172:2 192:7	242:2 288:19
325:7 330:22	361:10 403:6,9	2000 501:15	197:11,21 199:8	332:11,14 363:20
403:19 417:22	438:5,8 492:11,15	2006 420:4 448:13	212:5,13 218:21	365:3,7 404:13,16

447:1,5 497:20 498:2 516:12,15 2a2 146:2 2b 147:12 197:14 242:9 293:4,9 348:18 386:1,4 411:8,11 462:16 462:20 505:8,12 517:1,4	261:2 267:3,10,19 278:11 290:19 303:7 304:3,5,11 330:8 400:13 407:12 408:9,17 410:22 412:14 443:6 452:4,9 477:12,18,22 501:22 509:4 510:21 518:22 519:19	508:11,13 514:8 514:13 515:1 516:13 517:2,5,22 519:5,7,9 4:04 418:5 4:05 418:1,2 40 127:7 159:3 160:1 191:13 339:20 363:8 443:6 40/60 350:21 475:3 400 354:15 41.9 269:6 417 5:5 44 4:8 278:11 45 278:17,18 45-day 354:1 450,000 347:21 474 5:8 48 284:11 285:19 286:5,17 320:5 324:2 338:5 495:16	54 493:1 56 263:5 277:17 596,000 331:4 5th 35:4	8:03 6:2 80 324:6 452:18 498:11 82 88:7 127:9 220:6 84 226:10 850 421:4 425:17 464:4 87 231:6 88 482:5
3	30-day 35:16 37:22 102:8,14 183:21 207:5 228:21 239:12 260:7,16 264:1 267:15 299:19 303:2 352:20 353:22 407:10 408:21 417:15	40/60 350:21 475:3 400 354:15 41.9 269:6 417 5:5 44 4:8 278:11 45 278:17,18 45-day 354:1 450,000 347:21 474 5:8 48 284:11 285:19 286:5,17 320:5 324:2 338:5 495:16	6 6 4:2 126:17 147:19 148:14 242:13 447:6,7 454:17,21 474:12 491:2 508:15 519:20 6,000 323:5 6.5 503:21 6.8 435:19 6:00 509:8 6:01 521:18 60 111:16 113:14 151:15 159:3 329:7 422:15 439:10 441:1,9 442:3,18 443:4 450:17 452:11,18 600 231:6 63 190:21 65 142:21 360:19 670 50:13 68 4:9 6th 35:4,7 128:4	9
3 113:22 126:18 146:11 150:5 171:4,22 197:9,19 199:6 212:2 218:19 219:6 242:3,10 243:14 243:15 249:20 349:8 390:12 411:19 438:6,9,21 447:2 462:17,21 463:10,11 474:8 492:12 496:13 497:21 498:3 505:9,17,20 508:12 514:13 515:1 516:13,16 517:2,21,22 519:6 3.0 231:8 3.1 469:20 3.2 469:20 3.5 503:21 3.9 491:20 3:30 7:15 3:52 418:4 30 4:12,15,17,19 5:12,16 45:7 80:15 81:5 153:7 158:7 160:15,22 162:4 166:11,16 167:14 173:21 174:10 176:10 177:2 183:22 194:10 203:10 212:15 215:8,10 215:20 234:1 250:13 260:22	30-year 29:18 300 129:7 336:5 302 4:22 31-day 353:22 327 418:12 35 164:12 304:10 351 5:2 36 4:6 330:8 334:6 38 331:5 3A 199:1 3B 199:2 3C 199:2	4a 156:16 211:16 466:7 472:2 4b 156:17 211:19 4c 153:16 154:10 156:19 211:21	7 7 197:22 231:19 277:21 401:18 509:5 514:17 7.4 481:9 7:30 520:16 70 278:20 360:19 452:11 482:3 78 4:13 269:13,16 789 12:9 13:13 7th 35:7 128:4	
	4 4 12:16 146:11 169:20 171:4,22 197:10,12,20 199:6 212:3 218:19 219:6,10 242:3,5,10 243:15 249:20 299:2,8 349:19 415:6 438:7,21 447:2 462:17,21 463:11 474:8 492:13 496:13 497:21 498:3 505:9,13,17	5 5 1:6 89:10 114:11 212:6 242:6 250:1 250:2 264:2 496:17 5,400 256:22 5:10 475:8 5:15 475:7,9 50 88:20 116:19 158:19 159:7 254:22 311:20 339:22 416:4 450:17 452:11 500 381:9 509 5:13 519 5:17 520 5:19 53 278:19	8 8 85:17,17 125:6 157:11 243:18 363:11 401:14 492:16 515:5 8:00 1:9 520:17	

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: All Cause Admissions and
Readmissions Steering Committee

Before: NQF

Date: 05-05-14

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
true and accurate record of the proceedings.



Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com