

NATIONAL QUALITY FORUM

+ + + + +

BEHAVIORAL HEALTH PHASE 3  
STANDING COMMITTEE MEETING

+ + + + +

WEDNESDAY  
OCTOBER 1, 2014

+ + + + +

The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Peter Briss and Harold Pincus, Co-Chairs, presiding.

PRESENT:

PETER BRISS, MD, MPH, Medical Director, CDC,  
National Center for Chronic Disease  
Prevention and Health Promotion  
HAROLD PINCUS, MD, Director of Quality and  
Outcomes Research, New York-Presbyterian  
Hospital, The University Hospital of  
Columbia and Cornell  
ROBERT ATKINS, M.D., MPH, Senior Medical  
Director, Aetna Medicaid  
CAROLINE CARNEY DOEBBELING, M.D., Msc, Chief  
Medical Officer, MDwise, Inc. \*  
MADY CHALK, PhD, MSW, Director, Policy Center,  
Treatment Research Institute  
DAVID EINZIG, MD, Medical Director of Child  
Psychiatry, Children's Hospital And  
Clinics Of Minnesota  
JULIE GOLDSTEIN GRUMET, PhD, Director of  
Prevention and Practice, Education  
Development Center/Suicide Prevention  
Resource Center/National Action Alliance  
for Suicide Prevention

CONSTANCE HORGAN, Sc.D., Professor and  
Director, Institute for Behavioral  
Health, The Heller School for Social  
Policy and Management, Brandeis  
University

LISA JENSEN, DNP, APRN, Associate Director  
Workforce & Leadership, Office of  
Nursing Services, Veteran's  
Health Administration

DOLORES (DODI) KELLEHER, MS, DMH, Principal,  
D Kelleher Consulting

KRAIG KNUDSEN, PhD, Chief, Bureau of Research  
and Evaluation, Ohio Department of  
Mental Health and Addiction Services

MICHAEL LARDIERI, LCSW, Assistant Vice  
President Strategic Program Development,  
North Shore-LIJ Department of Psychiatry

TAMI MARK, PhD, MBA, Vice President, Truven  
Health Analytics

RAQUEL MAZON JEFFERS, MPH, MIA, Director of  
Health Integration, The Nicholson  
Foundation

BERNADETTE MELNYK, PhD, RN, CPNP/PMHNP, FAANP,  
FNAP, FAAN, Associate Vice President for  
Health Promotion, University Chief  
Wellness Officer, Dean and Professor,  
College of Nursing, Professor of  
Pediatrics & Psychiatry, College of  
Medicine, The Ohio State University

LAURENCE MILLER, MD, Senior Psychiatrist,  
Arkansas Medicaid, Arkansas Medicaid

DAVID PATING, MD, Chief, Addiction Medicine,  
Kaiser Permanente

VANITA PINDOLIA, Pharm.D., VP, Ambulatory  
Clinical Pharmacy Programs, Henry Ford  
Health System/Health Alliance Plan

RHONDA ROBINSON BEALE, Medical Physician,  
Former Chief Medical Office at Optum now  
Health Care Consultant, Health Care  
Consultant

HENA SIDDIQI, M.D., Medical Director,  
Broadlawn Manor Nursing and  
Rehabilitation

LISA SHEA, M.D., D.F.A.P.A., Deputy Medical  
Director, Quality and Regulation, Butler  
Hospital

JEFFERY SUSMAN, M.D., Dean, Northeast Ohio  
Medical University, Northeast Ohio  
Medical University

MICHAEL TRANGLE, MD, Associate Medical  
Director for Behavioral Health,  
HealthPartners

BONNIE ZIMA, MD, MPH, Professor in Residence,  
Child and Adolescent Psychiatry, UCLA  
Semel Institute for Neuroscience and  
Human Behavior

LESLIE ZUN, MD, MBA, Chair, Department of  
Emergency Medicine, Mount Sinai Hospital

NQF STAFF:

POONAM BAL, Project Analyst

HELEN BURSTIN, MD, MPH, FACP, Chief Scientific  
Officer

LAURALEI DORIAN, Project Manager

ANGELA FRANKLIN, Senior Director

ALSO PRESENT:

SAM TIERNEY, AMA PCPI

KENDRA HANLEY, AMA PCPI

SARAH HUDSON SCHOLLE, NCQA

MEREDITH JONES, AMA PCPI

TONI KAY, AMA PCPI \*

JUNQING LIU, NCQA

MICHAEL MURPHY, Massachusetts General  
Hospital \*

KAREN PIERCE, AMA PCPI \*

BOB REHM, NCQA

SARAH SAMPSEL, Azul Quality Solutions,  
Consultant to NQF

\* present by teleconference

## C O N T E N T S

Welcome	6
Peter Briss, M.D., MPH, Co-Chair	
Harold Pincus, M.D., Co-Chair	
Angela Franklin, J.D., General Counsel	
Introduction and Disclosure of Interest	6
Ann Hammersmith, J.D., General Counsel	
Project Introduction and Overview of Evaluation Process	18
Angela Franklin, J.D., General Counsel	
Lauralei Dorian, Project Manager	
Child and Adolescent Measures	
#0108: ADHD: Follow-Up Care for Children Prescribed ADHD Medication (NCQA)	104
#0722: Pediatric Symptom Checklist (PSC) and Psychosocial Functioning	35
Break	
Child and Adolescent Measures, Continued	
#1365: Child and Adolescent MDD: Suicide Risk Assessment (PCPI)	163
CONTENTS: (Continued)	
Health Screening and Assessment for People with SMI	
#2601: Body Mass Index Screening and Follow-Up For people with SMI	278
#2602: Controlling High Blood Pressure or People with SMI	302
Lunch	

# Health Screening and Assessment for People with SMI, Continued

#2603: Diabetes Care for People with SMI: Hemoglobin A1c (HbA1c) Testing (NCQA)	317
#2604: Diabetes Care for People with SMI: Medical Attention for Nephropathy (NCQA)	326
#2606: Diabetes Care for People with SMI: Blood Pressure Control ( $<140/90$ Malmstrom Hg) (NCQA)	331

## Break

#2607: Diabetes Care for People with SMI Hemoglobin A1c (HbA1c)	347
#2608: Diabetes Care for People with SMI:  Hemoglobin A1c (HbA1c)	355
#2609: Diabetes Care for People with SMI:  Eye Exam (NCQA)	358

NQF Member and Public Comment	363
-------------------------------	-----

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

(8:35 a.m.)

## Introduction and Disclosure of Interest

MS. DORIAN: Good morning, everyone.

Welcome to the Behavioral Health in-person meeting. This is Lauralei Dorian, and it's good to finally see so many of you here in person, put faces to names. Many of you we've been working with over previous years, many are new to NQF. So we welcome you all on behalf of all of us here at NQF.

Before we get started I just wanted to do a few logistic -- note a few logistic things. The restrooms are located outside of these doors to the right-hand side. People will be able to direct you if you have any questions. There should be somebody out there at the desk at all times if you had any questions about your reservations, or booking a taxi, or anything else.

A reminder that all of the lines are open to the public, and there will be time for

1 public comments at dedicated times throughout  
2 the meeting. All materials are available on  
3 SharePoint so if you have your laptops with  
4 you you'll be able to access them on  
5 SharePoint. If you have any problems please  
6 come tap one of us and we can help you out.

7 We have used a method in the past  
8 that has seemed to work to -- that we ask that  
9 you put your name tag on its side if you have  
10 comments, so that will allow the co-chairs to  
11 identify you and make sure that everybody's  
12 able to comment in time. For those of you who  
13 are on the phone, you can follow along on the  
14 public Webinar, and ask questions or comment  
15 using the chat box feature.

16 We have made dinner reservations  
17 tonight at 6:30 -- or actually I think 6:00  
18 p.m. at Mio, which is just around the corner  
19 here. It's a contemporary Latin American  
20 cuisine, so I know a lot of you indicated that  
21 you'd like to go. If anybody didn't let me  
22 know there's still openings, so come and find

1 me during lunch.

2 We will have breaks if you have --  
3 you should have the agenda in front of you.  
4 We will have breaks at 10:45, you know, give  
5 or take, 1:10 lunch and 3:15 another fifteen  
6 minute break. So we'll really try to stick  
7 pretty closely to the agenda, because we do  
8 have a fair number of measures to get through.  
9 And Howard and Peter have been with us for a  
10 long time and they're experts at keeping us  
11 all on schedule, so feel confident. So I've  
12 introduced myself and then I'll have the rest  
13 of the NQF team introduce themselves.

14 MS. FRANKLIN: Thank you so much,  
15 Lauralei.

16 I'm Angela Franklin, Senior Director  
17 for the project, and I'll let Poonam introduce  
18 herself.

19 MS. BAL: And I'm Poonam Bal, I am  
20 the project analyst on this project.

21 MEMBER SAMPSEL: And I am Sarah  
22 Sampsel, I'm a consultant to NQF on this



1 project.

2 MS. DORIAN: Great. And now we  
3 would love to hear from all of you. I'll turn  
4 it over to Harold first and then we'll go  
5 through our roster and get to hear a little  
6 bit about your backgrounds and where you're  
7 coming from.

8 CO-CHAIR PINCUS: I'm Harold Pincus,  
9 I'm a professor and Vice-Chair of psychiatry  
10 at Columbia University and also Director of  
11 Quality and Outcomes Research at New York  
12 Presbyterian Hospital. I'm also a senior  
13 scientist at the RAND Corporation.

14 And I'm delighted to welcome  
15 everybody here. We have a lot of work to do,  
16 there is a whole long list of measures. And  
17 you know, I think at some point you guys will  
18 sort of make the point that NQF has gone  
19 through a fair amount of redesign of its  
20 operations, especially of the endorsement  
21 process, and it's becoming a bit more formal  
22 in a number of ways. And I think in that way

1 more rigorous and more valid, I think, in  
2 terms of the process, and certainly more  
3 standardized.

4 And so we're going to be sort of  
5 going through this in a somewhat new way,  
6 although a lot of the same themes come  
7 through. The criteria have not changed very  
8 much and really we're going to be thinking  
9 hard about each of the criteria as we go  
10 through each of the measures. That's probably  
11 the most important, I think, distinction in  
12 terms of how things have shifted a bit, so we  
13 really do get a clear thoughtful approach at  
14 each of the measures and to think about the  
15 extent to which the measure meets or does not  
16 meet the specific criteria.

17 And then also we'll be voting on  
18 each of the criteria as we go through this.  
19 So just to kind of introduce that process, and  
20 just be aware as we go through, we'll get into  
21 more detail as we go through the first few and  
22 people get a better sense of, you know, what

1 we really mean.

2 MEMBER SUSMAN: You're off-mic a  
3 little bit.

4 CO-CHAIR PINCUS: Oh, sure. I just  
5 moved it closer. Sorry. It's -- yeah, and I  
6 got in about 1:00 o'clock last night and sort  
7 of -- after a day of being on conference calls  
8 so I have no voice. Okay. Well, thanks. And  
9 so why don't we continue to go around. Bob?

10 MS. DORIAN: And if everybody could,  
11 yeah, use your mics, because it's being  
12 recorded.

13 MEMBER ATKINS: Hello, my name is Bob  
14 Atkins. I am a psychiatrist, Senior Medical  
15 Director with Aetna Medicaid, and the behavior  
16 health lead for Aetna Medicaid nationally.

17 MEMBER TRANGLE: Hi, I'm Michael  
18 Trangle, psychiatrist and Medical Director for  
19 an integrated system in Minneapolis-St. Paul  
20 called Health Partners.

21 MEMBER HORGAN: Hello, I'm Connie  
22 Horgan, I'm a professor at the Heller School

1 of Brandeis University and Director of the  
2 Institute for Behavioral Health. I'm a health  
3 services researcher and do a lot of work in  
4 how to improve the system so that measures can  
5 be adequately implemented. Thank you.

6 MEMBER SUSMAN: I'm Jeff Susman, I'm  
7 the Dean of the College of Medicine at  
8 Northeast Ohio Medical University which is a  
9 small community-based medical school and  
10 actually at Rootstown in Cleveland, and we  
11 cover all of Northeast Ohio. My connection  
12 here is when I did do research and had some  
13 interest in other things than shuffling  
14 papers, I was interested in implementation  
15 research around depression and mood disorders.

16 MEMBER SHEA: Good morning. I'm  
17 Lisa Shea, I'm the Medical Director at Butler  
18 Hospital, a freestanding psychiatric hospital  
19 in Providence, Rhode Island, and also a  
20 clinical associate professor at the Alpert  
21 Brown Medical School.

22 MEMBER SIDDIQI: Hello, I'm Hena

1 Siddiqi, Geriatrician, Medical Director at  
2 Rudloe Manor which is also onsite with a  
3 tertiary psychiatric hospital, South Oaks  
4 Hospital. It's part of the North JRLA system.

5 MEMBER KNUDSEN: Hi, I'm Kraig  
6 Knudsen, I am the Chief of the Bureau of  
7 Research and Evaluation at the Ohio Department  
8 of Mental Health and Addiction Services.

9 MEMBER LARDIERI: I'm Mike Lardieri  
10 and I'm AVP of Strategic Program Development  
11 at the Northshore LHI Health System in New  
12 York. Previously I was with the National  
13 Council for Behavioral Health, my last time  
14 here, and I do a lot of work with HIT and  
15 integration of behavioral health and physical  
16 health.

17 MEMBER MELNYK: Good morning. I'm  
18 Bernadette Melnyk, I'm from the Ohio State  
19 University. I am the university's Chief  
20 Wellness Officer and Dean of the College of  
21 Nursing. I'm both a pediatric nurse  
22 practitioner and a psychiatric nurse

1 practitioner.

2 MEMBER ZIMA: Hi, and I'm Bonnie  
3 Zima and I'm a professor, UCLA, and I'm a  
4 child psychiatrist and health services  
5 researcher.

6 MEMBER PINDOLIA: Hi, I'm Vanita  
7 Pindolia. I am the Vice President of the  
8 Ambulatory Clinical Pharmacy programs for  
9 Henry Ford Health System and Health Alliance  
10 Plan. And I think my relationship with this  
11 committee has been, with the work I've been  
12 doing right now with the Medicaid plan to  
13 develop their dual eligible clinical programs  
14 but also on the provider side and the health  
15 plan side to improve their quality metrics for  
16 both related to behavioral health and others.

17 MEMBER KELLEHER: I'm Dodi Kelleher,  
18 I'm a behavioral health clinician and  
19 independent consultant. I work primarily with  
20 large, self-funded employer health plans,  
21 helping them integrate behavioral health into  
22 their medical and disability benefits.

1           MEMBER ROBINSON BEALE: Hi, I'm  
2 Rhonda Robinson Beale, I'm a healthcare  
3 consultant working currently with health plan  
4 in Illinois with the dual eligibles helping  
5 them to rule out and design and roll out their  
6 care management process for not only medical  
7 but also behavioral health.

8           MEMBER JENSEN: Good morning, I'm  
9 Lisa Jensen, I'm a psychiatric advance  
10 practice nurse. I work for Veterans Health  
11 Administration, Office of Nursing Services  
12 here in D.C., but I'm a virtual employee and  
13 I work from my home in Salt Lake City.

14           MEMBER EINZIG: Hi, my name is David  
15 Einzig, I'm a child psychiatrist at Children's  
16 Hospitals and Clinics of Minnesota, which is  
17 a large, freestanding children's hospital.  
18 I'll be Medical Director this coming year. My  
19 background, I did the combined training  
20 program in pediatrics and psychiatry so I have  
21 a dual role. One of my passions has to do  
22 with collaborative care models integrating

1 psychiatry and behavioral health into primary  
2 care clinics and specialty clinics, and so I'm  
3 in the pediatric clinic one day a week also.

4 MEMBER MILLER: I'm Larry Miller, I  
5 live in Little Rock, Arkansas, I'm a  
6 psychiatrist. I'm Senior Psychiatrist at a  
7 division of medical services at DHS, which is  
8 Medicaid, and I'm also clinical professor of  
9 psychiatry at the University of Arkansas for  
10 Medical Sciences.

11 MS. DORIAN: Thank you. And do we  
12 have Caroline, or any other committee members  
13 on the phone?

14 MEMBER DOEBBELING: Hi, this is  
15 Caroline.

16 MS. DORIAN: Hi, Caroline.

17 MEMBER DOEBBELING: Good morning. I  
18 am Caroline Carney and I am the Chief Medical  
19 Officer of Medwise, Inc., a health plan  
20 serving Medicaid and marketplace populations.  
21 I am an internist and psychiatrist and a  
22 researcher by training and I'm happy to be



1 here.

2 MS. DORIAN: Thank you. And anyone  
3 else on the phone from the committee? Okay.

4 Nice to see we have a few new committee  
5 members. Welcome, we're just getting started,  
6 just in time. If you wanted to -- that's  
7 Tammy. If you wanted to introduce yourself  
8 briefly by just pushing the speak button on  
9 your microphone that would be great.

10 MEMBER MARK: Hi, I'm Tami Mark from  
11 Truven Health Analytics.

12 MS. DORIAN: Great. Thank you. And  
13 Raquel? Welcome.

14 MEMBER MAZON JEFFERS: Hi, I'm  
15 Raquel Mazon Jeffers from the Nicholson  
16 Foundation.

17 Project Introduction and Overview of  
18 Evaluation Process

19 MS. DORIAN: Great. Thank you.  
20 It's good to see such a wonderful turnout. It  
21 apparently is a little bit difficult for the  
22 people over the phone to hear, so I have to

1     remind myself of this as well, but if you  
2     could just make sure to bend the microphone  
3     down and speak close to it, that would be very  
4     helpful.

5             So if we could go to the next slide,  
6     we just wanted to go over some ground rules  
7     for today's meeting. During the discussion  
8     committee members hopefully are prepared and  
9     you've reviewed all of the measures  
10    beforehand. You have measures assigned to  
11    your specific workgroup, and you were  
12    designated a lead or secondary discussant.  
13    But by this point we do expect that you have  
14    -- you will have reviewed all of the measures  
15    that were submitted to this phase of work.

16            We'll ask that you base your  
17    evaluation and recommendations on the measure  
18    evaluation criteria and guidance. You should  
19    have in your packet in front of you a brief  
20    overview of that guidance, and we'll be sure  
21    to go through it and walk you through to make  
22    sure you understand this, particularly for the

1 first measure, as we go through throughout the  
2 day.

3 We'd like you to remain engaged in  
4 the discussion, this is an open forum. Feel  
5 free to ask anything of each other and the  
6 developers. We're fortunate to have the  
7 developers here and they will be up here  
8 seated at the table or over the phone when  
9 their measure is being discussed.

10 You'll have about two to three  
11 minutes to introduce their measures so at the  
12 beginning of each measure they'll give the  
13 brief introduction and then we'll turn it over  
14 to the lead discussant to summarize what the  
15 workgroup had discussed and any questions or  
16 concerns that were raised on the workgroup  
17 call. And those summaries are found on  
18 SharePoint in those measure documents. So  
19 it's those same documents that you've been  
20 looking at, we've just updated them. They  
21 read the measure number and then ALL in  
22 capital letters.

1           So, as is the case with committee  
2 members, developers can put their cards up if  
3 they have any questions or comments to -- or  
4 if they want to respond to the committee.

5           And during -- it is important to  
6 note that during these evaluations, almost all  
7 the time the committee members make  
8 suggestions about how the measures might be  
9 improved in the future, and we do encourage  
10 that certainly. But we want to remind you  
11 that when you go to vote, you are voting on  
12 the measure as it is specified currently. So  
13 I'll turn it over to Poonam to discuss more of  
14 the role of the standing committee.

15           MS. BAL: So I have a lot of  
16 computers in front of me, so it's going to be  
17 a little difficult. But basically the role of  
18 the standing committee is to act as a proxy  
19 for NGS multi-stakeholder membership group.  
20 You all bring a different aspect to this --  
21 still not loud enough? Sorry.

22           You all bring a different knowledge

1 base and expert level to this committee, and  
2 that's why you were brought together. You  
3 will be either serving a two or three-year  
4 term and we will determine that tomorrow by  
5 random selection.

6 And basically the role is to work  
7 with NQF staff to achieve the goals of the  
8 project, which is mainly to review all the  
9 measures and evaluate them against the  
10 criteria. And, basically, determine if the  
11 criteria is met and rationale behind  
12 determining them, if they're met.

13 You'll be making the recommendations  
14 to the NQF membership and moving forward will  
15 respond to comments from both the public and  
16 membership, and also responding to any  
17 feedback from CSAC. So we'll go through -- I  
18 think we've gone through the timeline before  
19 and so there are a lot of different  
20 procedures. So throughout the process, it's  
21 just not at this point, once we get comments  
22 in, once we go through CSAC, so on, you'll be

1 asked to give feedback on those results. And  
2 then, overall, just oversee the portfolio of  
3 the behavioral health measures.

4 Okay. And so we do have a new  
5 function of the standing committee. This may  
6 not be so new for behavioral health since we  
7 are in our third phase now, but it's a new  
8 concept for NQF where the committee will  
9 continue to -- we won't seat a new committee  
10 every time we get work for the topic area, it  
11 will be standing. So if anything comes up, if  
12 we do another phase, or we need to do a  
13 temporary expert panel, the standing committee  
14 would be used for that purpose.

15 Basically, the same responsibilities  
16 that fall under what we just spoke about, but  
17 overseeing the portfolio is the main goal, we  
18 want to continue this process. So we want to  
19 make sure that all the measures are viewed  
20 together instead of just at one time. And so  
21 knowing what measures are included in the  
22 portfolio, understanding their importance, and

1 we'll briefly go over what measures are  
2 currently in the portfolio in a little bit.  
3 Understanding the issues that come with  
4 standardization, harmonization, identifying  
5 measurement gaps in the portfolio, seeing what  
6 measures we need. And then just being aware  
7 of what's going on in that topic area where  
8 you really come in, being the experts.

9 And then just also being open to  
10 external input on that portfolio, so if you  
11 get any feedback on these measures or if you  
12 learn about the use of these measures,  
13 bringing that forward is also important. Just  
14 overall, just you are now the keepers of this  
15 portfolio, so just keeping it up to date and  
16 maintaining the harmonization.

17 MS. DORIAN: Great. And now Angela  
18 will go over a brief portfolio review.

19 MS. FRANKLIN: Thanks, Lauralei.

20 And as Lauralei mentioned, this  
21 project has been underway for at least -- we  
22 are in our third phase now. And we started

1 out with Phase 2 in 2012, and during that time  
2 we endorsed ten measures, and you can see  
3 those before you in the subject areas of  
4 tobacco, alcohol, substance use, adherence to  
5 medications, health screening and assessments,  
6 post-care follow-up following hospitalization.  
7 And the key part of the behavioral health  
8 portfolio is that we're looking for measures  
9 covering all of these topics including tobacco  
10 use, alcohol use, substance use, as well as  
11 behavioral issues such as ADHD, hyperactivity  
12 disorder, as well as measures that have to do  
13 with the screening for people with serious  
14 mental illness.

15 So in our first phase you can see  
16 the measures here that we have endorsed in  
17 these areas. And I'll move on to the next  
18 slide. In our second phase we had a lot of  
19 carryover in the tobacco and alcohol portions  
20 of the portfolio, and ended up endorsing 20  
21 measures in those two areas, tobacco, alcohol  
22 and substance use.



1           Next slide. And we did move on to  
2           inpatient psychiatric services, which we call  
3           the hospital HBIPS, and looked into also the  
4           areas of depression and major depressive  
5           disorder in Phase 2 of this project. We had  
6           measures that had to do with screening on  
7           admission for hospital-based inpatient  
8           psychiatric services all the way through the  
9           process to discharge, and post-discharge  
10          continuing care, and follow-up for depression.

11          No, we're good. And in this phase  
12          we're looking again at tobacco use, alcohol  
13          use, substance use, as well as ADHD. And  
14          moving on to the next slide, depression and  
15          major depressive disorder, and health  
16          screenings and assessments for people with  
17          serious mental illness, which is the topic we  
18          touched on in Phase 1 of our project here. So  
19          we're coming full circle.

20          One of the things that we'll be  
21          asking you to do, as you review these measures  
22          is keep in mind the measures that we already

1     have in the portfolio, as well as identify  
2     gaps that you see in the portfolio, in terms  
3     of what kinds of measures we need, in terms of  
4     process measure or outcome measures, as well  
5     as measures in areas where we have definitive  
6     gaps.

7             Next slide.

8             CO-CHAIR PINCUS: Just one question,  
9     Angela?

10            MS. FRANKLIN: Yes.

11            CO-CHAIR PINCUS: What's the measure  
12     that you just went through? Does that include  
13     all of the measures that are in the portfolio  
14     of endorsed measures, or just the ones that  
15     have been in the three phases?

16            MS. FRANKLIN: These are just the  
17     ones that have been in the three phrases at  
18     this point, yes.

19            CO-CHAIR PINCUS: Yes, it would be  
20     useful at some point during the meeting if we  
21     could sort of see the list of all the measures  
22     that are in the endorsed portfolio.

1 MS. FRANKLIN: And we'll definitely  
2 tee that up, at Day 2 we're going to have a  
3 in-depth discussion of the gaps and we'll tee  
4 that up for you so that you can see the entire  
5 portfolio.

6 Questions about the portfolio or our  
7 gaps discussion that's to come on day two?  
8 Okay. So then that moves us on to our  
9 evaluation of the measures. And before we get  
10 started, I wanted to tell everyone about our  
11 new disclosure process. We gave to each of  
12 you a measure-specific disclosure of interests  
13 form, which everyone filled out, thank you for  
14 your cooperation in doing that. And we have  
15 before you on the table the results of the  
16 completion of that disclosure of interest,  
17 with regard to specific measures.

18 And please note that we have  
19 conflicts listed here. Harold Pincus and  
20 Constance Horgan have conflicts with the NCQA  
21 measures, and then Michael Trangle has a  
22 conflict with the Minnesota Community

1 Measurement measures. And Bonnie Zima has a  
2 conflict with the Mass General Measure, 0722  
3 Pediatric Symptom Checklist.

4 And just to give you a little  
5 background, NQF is in the process of reviewing  
6 and revising their comprehensive disclosure of  
7 interest policy, that is being rolled out in  
8 the coming months. Generally when we get  
9 together for these in-person meetings, we have  
10 our general counsel go around the table and  
11 ask everyone to disclose any potential  
12 interests. And that policy is being revised  
13 we won't be doing it at this particular sit-  
14 down, we'll be doing it in January, at our  
15 post-commenting call.

16 And for this particular meeting we  
17 just felt it was most important to identify  
18 the measure-specific conflicts at this time.  
19 And we've identified those, those are on the  
20 table before you, if you need to refer to  
21 those. Also if at any time you feel like you  
22 have a question about potential conflicts or

1 disclosures that need to be made, feel free to  
2 come to any NQF staff and make those at any  
3 time. Are there any questions about the  
4 disclosures of interest before us?

5 Okay. So with that I'll move on  
6 into our evaluation of measures, and just the  
7 process for today. We'll have, as Lauralei  
8 mentioned earlier, as we tee up each of the  
9 measures we'll start with a brief introduction  
10 by the developers. They're behind me at this  
11 time, but when their measure comes up they'll  
12 be coming to the table here so that we can all  
13 have a good conversation with them at the  
14 table. Assigned discussants are going to  
15 speak to the measures first, criterion by  
16 criterion, then throw it open to the workgroup  
17 members if they have additional comments, or  
18 the secondary discussant if they have  
19 additional comments. And then we'll open the  
20 floor for the full committee discussion.

21 And again, we had asked that each  
22 committee member review each of the measures,

1     so everyone should feel free to jump in and  
2     discuss the measures, unless they have a  
3     conflict. So then we will vote on the  
4     criterion and we'll proceed through each  
5     criterion in that fashion. Are there any  
6     questions about this process? Yes? Please  
7     use your mic.

8             MEMBER KELLEHER: Are we going to  
9     get a refresher on how to use the voting  
10    mechanism here?

11            MS. FRANKLIN: Yes, we will. Before  
12    our first vote we'll definitely do that. And  
13    I'd also like to tell everyone it usually  
14    takes us a little bit longer to get through  
15    the first measure so don't be nervous as we go  
16    through and we remind everyone of the  
17    criterion as we go through, and the voting  
18    process. Harold?

19            CO-CHAIR PINCUS: Just one question  
20    is, and we discussed this before, but at what  
21    point do people bring in and refer to  
22    questions and issues that came up during the

1 workgroup meetings?

2 MS. FRANKLIN: Right at the  
3 beginning, in the introduction of the measure  
4 by the lead and secondary discussants. So  
5 Harold was asking at what point do we bring in  
6 the discussion points that were made at the  
7 workgroup level, and I was saying right at the  
8 beginning, when you introduce a measure, tell  
9 a little bit about what it is and thoughts of  
10 the workgroup.

11 MS. DORIAN: And as I had mentioned  
12 before, because some of the workgroups were  
13 quite a long time ago at this point, so to  
14 access those summaries you can click on the  
15 measure number and then each section is broken  
16 down by criterion, so importance. You'll see  
17 all the survey results and then you'll see the  
18 workgroup comments. And is everyone able to  
19 access the internet and the SharePoint sites?  
20 Does anyone have any -- yes?

21 MEMBER MAZON JEFFERS: I just need  
22 the password for the WiFi.

1 MS. BAL: It's NQF, all in caps,  
2 guest. This is in all lowercase, sorry.

3 MS. DORIAN: Just going through  
4 SharePoint, if you want it to. I mean, if you  
5 recall the -- we'll also bring all of these  
6 documents up on the screen as we work through  
7 them. So if you can't access them that's  
8 perfectly fine.

9 MS. BAL: And just a reminder, if  
10 you have any questions or comments, please  
11 click the speak button so we can get it in the  
12 transcript. Thank you.

13 MEMBER SUSMAN: Are we going to have  
14 an opportunity tomorrow during the more  
15 general discussion to talk about the pros and  
16 cons of specific measures and disease states,  
17 versus broad measures?

18 MS. DORIAN: Yes, that's definitely  
19 --

20 MEMBER SUSMAN: Because it seems to  
21 plague us over and over again, and certainly  
22 --



1 MS. DORIAN: That's true. It's not  
2 unique to this committee but that's certainly  
3 something that we would want to discuss in the  
4 gaps discussion, and the idea of what sorts of  
5 measures we would like to see coming forward  
6 in the future.

7 MEMBER SUSMAN: Thank you.

8 MS. FRANKLIN: Michael?

9 MEMBER TRANGLE: This is a comment I  
10 made during one of the phone calls, too. But  
11 I don't see it on the agenda, but from the  
12 vantage point of someone in practice and kind  
13 of running a system, we have to look at how  
14 much clinicians are actually doing, you know,  
15 in the office. I think it would be wise for  
16 us to somehow, at some point, step up to  
17 10,000 feet or 50,000 feet and say what's the  
18 overall impact if we did all of these  
19 measures?

20 You know, sort of like the IRS,  
21 that's how much time it takes to do this  
22 document, you know? And begin to sort of

1 think about how we don't replicate what  
2 happens in primary care where if they did all  
3 the required measures if you were working 18  
4 hours a day, you know? And I don't know the  
5 answer to that but I think it should be in our  
6 mindset and some of our discussions.

7 MS. DORIAN: Definitely. Thank you.  
8 It's good to remember that, as sort of a  
9 framework, moving forward. Did David have a  
10 question? No? Okay.

11 MS. FRANKLIN: Did you want to give  
12 us a quick introduction to yourself?

13 MEMBER PATING: Yes. I apologize  
14 for being late, my letter had 8:30 as the  
15 start time. I'm David Pating from Northern  
16 California Kaiser Permanente. I'm  
17 Commissioner of Mental Health for the State of  
18 California, Commissioner of Health for San  
19 Francisco, and I oversee evaluation for 1.3  
20 billion in California State investment in  
21 mental health, a Mental Health Proposition 63.

22 MS. FRANKLIN: Thanks, David. And I

1 just had a note about the agenda. Before we  
2 get started, actually, what we'd like to do is  
3 start with the Pediatric Symptom Checklist  
4 Measure first. We're awaiting our second Co-  
5 Chair, who will be able to chair the first  
6 measure. So we are going to start with the  
7 Pediatric Symptom Checklist Measure first.  
8 And apologies. Could we have the developer  
9 for that speak to it, if they're in the room  
10 or on the phone?

11 CO-CHAIR PINCUS: And just to that,  
12 Tami, you're going to be the lead discussant  
13 for this one, and Michael, you're going to be  
14 secondary.

15 Child and Adolescent Measures  
16 #0722: Pediatric Symptom Checklist (PSC)  
17 and Psychosocial Functioning

18 MR. MURPHY: Hi, it's Michael  
19 Murphy. Can you hear me okay?

20 MS. DORIAN: So we can hear you,  
21 Michael.

22 MR. MURPHY: Great. So first of

1 all, I thank you for inviting me to be here on  
2 the call, and for all the work you've done  
3 looking at the PSC. We're very grateful that  
4 the PSC is a measure that NQF has endorsed,  
5 and I think today I'm just supposed to  
6 introduce it a little bit. If you won't mind,  
7 I'll just read from the first paragraph of the  
8 first document to start.

9 The PSC is a brief parent report  
10 questionnaire that's used to assess overall  
11 psychosocial functioning in children three to  
12 sixteen -- eighteen years of age. It was  
13 originally developed to be a screen that would  
14 allow individual pediatricians to identify  
15 individual patients who had problems in their  
16 caseload. And due to its widespread use in  
17 large systems, it's increasingly been used as  
18 a quality measure and as an outcome measure.

19 There's been over 150 studies of the  
20 PSC over the past three decades and in the  
21 last year or two the research has really  
22 ramped up, in terms of large-scale systems

1     like a big statewide program in Massachusetts,  
2     and a national program in Chile.

3             Just a couple more things, it's both  
4     a process measure and an outcome measure. As  
5     far as we know, it's one of just a handful of  
6     child psychiatry measures that's been endorsed  
7     by either NQF or CHIPRA. And it's also one of  
8     the few measures that bridges pediatrics and  
9     mental health, so it's about mental health in  
10    a pediatric setting.

11            So that's pretty much all I had to  
12    say. We have a one-page summary that Lauralei  
13    asked us to prepare summarizing the recent  
14    evidence which is quite strong, we think. And  
15    I don't know if, Lauralei, you were able to  
16    get that to committee members.

17            MS. DORIAN: It is posted to the  
18    SharePoint page. But actually if you could  
19    sort of summarize that in just a few  
20    sentences, that would be great.

21            MR. MURPHY: Yes. So the State of  
22    Massachusetts mandated routine psychosocial

1 screening as a part of EPSDT, people really  
2 had to do that but they had a great data  
3 system that allowed tracking of what happened.  
4 This is going back seven or eight years now.  
5 In that time approximately two million kids  
6 have been screened and Karen Hacker and her  
7 colleagues at Cambridge Health Alliance got a  
8 hold of the State Medicaid datasets and  
9 tracked what happened. And a couple of papers  
10 published in pediatrics show that the  
11 screenings did identify about 30 or 40 percent  
12 of the positive screens had not been receiving  
13 services, and about 30 percent of the kids  
14 that were newly positively screened went on to  
15 receive services. So we have confirmation in  
16 some large datasets of screening that seems to  
17 be associated with better outcomes.

18 I know time's limited so I'll stop  
19 talking.

20 CO-CHAIR PINCUS: Okay. I did.  
21 There was a delay.

22 I had a question in terms of the

1 specific definition of the measure in terms of  
2 the numerator and the denominator. And  
3 thinking of the PSC as a clinical instrument  
4 but it's used as a performance measure is  
5 different from its use as a clinical measure.  
6 And in thinking about it in terms of there  
7 being a numerator and a denominator. And so  
8 I was a little bit confused in that under the  
9 -- in the numerator statement it says, in the  
10 sections that follow delineate specifications  
11 for two different meanings of each of these  
12 uses of the PSC. And then there's a list of  
13 the four different, I guess, numerator and  
14 then four different denominator statements.

15 And I was wondering if there was --  
16 if you could say a little bit about the  
17 definition of the numerator and denominators,  
18 particularly in thinking about in the  
19 denominator statement the number of children  
20 ages three to eighteen receiving a well-child  
21 visit and then the number of children age  
22 three to eighteen seen for well-child visit in

1 a given measurement year. Is there intended  
2 to be some difference between those? I'm just  
3 thinking about the formal specifications that  
4 you're using for the numerator and denominator  
5 statement.

6 I think also this is sort of an  
7 issue that may come up in other discussions in  
8 terms of thinking about the use of a clinical  
9 instrument in -- as part of a quality measure  
10 versus the quality measure itself which uses  
11 the clinical instrument.

12 MR. MURPHY: So actually I'm not  
13 sure what the exact question is.

14 CO-CHAIR PINCUS: So can you get a  
15 little bit more specific about the numerator  
16 and the denominator of how, in terms of the  
17 actual performance measures that are reported?

18 MR. MURPHY: So start with the  
19 biggest and easiest one first. In any given  
20 year, the State of Massachusetts can figure  
21 out -- the numerator is all kids who had well-  
22 child visits, so I'm not sure which one of



1       these is which. But all well-child visits.  
2       So the process measure is whether the  
3       percentage of those kids that got screened and  
4       the number in the State of Massachusetts now  
5       is about 70 percent.

6               But other questions -- I think this  
7       is more where your question is going -- about  
8       the clinical outcome, you can also say, well,  
9       of the positive screens how many were  
10      referred, how many received services. And so  
11      you can track that, too. So one -- and  
12      finally, you can even look on a granular level  
13      or clinical level to see whether the kids that  
14      were positive last year are doing better this  
15      year.

16             I still don't know if I'm getting  
17      what the question is.

18             MEMBER SUSMAN: So from an NQF --  
19      and maybe this is a staff point of view -- in  
20      general we've had this, there's been a linkage  
21      of -- for let's say a depression measure like  
22      the PHQ of doing the measure and then perhaps

1 following it to remission or demonstrating  
2 that there has been some follow-up, did the  
3 measure get repeated again. This, as I  
4 understand it, is proposing to do all the  
5 things together within this measure which  
6 leads, I think, to some substantial confusion  
7 when we start commenting on it because we're  
8 trying to consider a sort of prevalence or  
9 incidence measure around how many people in a  
10 denominator population get screened, and then  
11 how many get followed up. And is the follow-  
12 up actually improved or worse?

13 And by confounding all three of  
14 those issues together, methodologically and  
15 then just from a pragmatic viewpoint of our  
16 doing an assessment, it gets rather  
17 complicated.

18 MR. MURPHY: You know, I think  
19 probably other committee members can speak to  
20 that better than I can. I mean, it's  
21 certainly something we wrestled with a lot  
22 when we tried to put the PSC information into

1 the NQF format. What we eventually did is to  
2 say --- we can't say is it a process measure  
3 and outcome measure. We can only report on  
4 the ways in which it's being used and that  
5 people are using it in both ways.

6 And I noticed in preparing for this  
7 meeting that the very last measure you're  
8 going to discuss on the second day has to do  
9 with the multi-dimensional mental health  
10 screening assessment, and those measure  
11 developers are advocating for routine  
12 screening of adult medical patients for a  
13 broad range of psychiatric problems. So you  
14 know, one use of this is certainly a process  
15 measure for whether mental health problems are  
16 screened for in primary care. But again, the  
17 measure is also used in other ways, too. So  
18 how that fits into the NQF approach I'm not  
19 sure.

20 CO-CHAIR PINCUS: I think in terms  
21 of evaluating the measure on the criteria we  
22 should, you know, wait for Tami and Mike to

1 present on that. But one thing, though, that  
2 would be clear and, I think, helpful for the  
3 measure developer to give us is a greater  
4 degree of precision in the specification of  
5 the denominator and the numerator as it's  
6 applied and reported.

7 But are there any other questions  
8 for the developer?

9 MEMBER ATKINS: Well, I guess it's a  
10 follow-up question. But couldn't it be  
11 divided up into multiple metrics? You're  
12 asking all the right -- from a health plan  
13 perspective you're asking all the right  
14 questions, because people do screenings and  
15 then don't do anything with it. That's  
16 common. So instead of doing it for to get --  
17 so they don't get in trouble, not because it's  
18 going to make a difference.

19 So once they do a screening, I want  
20 to know did they actually look at it and do  
21 something with it, and then did they do  
22 something useful? And all three of those are

1 critically important questions when you're  
2 looking at the actual benefits to the human  
3 being. But it may be that this is three  
4 different metrics and not one metric because  
5 you're -- and maybe that's a solution to the  
6 confusion.

7 CO-CHAIR PINCUS: And just as a  
8 maybe a recommendation to NQF, there should  
9 probably be a kind of a template that's  
10 developed for the use -- for how to describe  
11 and define quality measures that rely on  
12 clinical instruments as outcomes so that  
13 there's a standardized way of doing this. But  
14 anyway, we should probably move to Tami to  
15 talk a little bit about her evaluation,  
16 particularly of the criterion number 1,  
17 correct?

18 MS. FRANKLIN: Correct. Thank you,  
19 Harold.

20 And I just want to note that in our  
21 person and family centered care project, we  
22 are looking a lot at instruments and have

1 really done a lot of work around providing  
2 some guidance about how these measures should  
3 be constructed in that forum. So with that,  
4 Tami, if you wanted to walk us through  
5 importance?

6 MEMBER MARK: Yes. I mean, in terms  
7 of importance, there's clearly a large  
8 prevalence of undiagnosed, untreated pediatric  
9 behavior health problems that this measure  
10 tries to address. And you know, the measure  
11 -- as was mentioned by Mike, the measure is  
12 widely used in Massachusetts. Part of that  
13 stemmed from a lawsuit that, you know,  
14 identified a lack of screening and treatment  
15 and identification. So I think our -- you  
16 know, our internal committee felt that it did  
17 meet the requirements for importance and it  
18 performs -- our internal committee did feel  
19 that this measure met the criteria for  
20 measuring -- addressing a performance gap.

21 MS. DORIAN: Anybody else? Who is  
22 the second?

1 CO-CHAIR PINCUS: Mike?

2 MS. DORIAN: Mike?

3 MEMBER TRANGLE: Yes. I think what  
4 -- when we talked about in our phone call for  
5 the pre-group discussion, I don't think  
6 anybody thought it was unimportant. You know,  
7 I think the confusion about what it's  
8 measuring and utility of it wasn't even  
9 expressed as strongly as it was here.

10 In a lot of ways I think people are  
11 impressed with how it seems to have kind of  
12 started at a grassroots level. I didn't know  
13 it was because of a lawsuit. But how rapidly  
14 it --

15 MEMBER MARK: That's grassroots.

16 MEMBER TRANGLE: That's grassroots.  
17 You know, it could be on fire, those roots.  
18 But how rapidly it spread and how broadly it  
19 seems to spread. And at least from the  
20 comments we heard it looked like there was  
21 clinical utility for actual pediatricians  
22 and/or, I don't know, child psychiatrists kind

1 of in the exam rooms.

2 You know, not being a pediatrician I  
3 wondered but didn't articulate that I know the  
4 follow-ups are supposed to be at well-baby  
5 visits and those regularly scheduled visits.  
6 I have no clue whether it actually happens  
7 then. And if you're looking at evaluating it  
8 as improvement with all different kinds of  
9 time intervals in there, how that plays out as  
10 well, in terms of reliability. But we didn't  
11 really talk about that.

12 Are we going through one set at a  
13 time? We just finished importance and I  
14 rambled.

15 MS. FRANKLIN: Yes. No -- yes, and  
16 delineating the evidence, performance gap and  
17 priority, which I think you covered, both of  
18 you.

19 CO-CHAIR PINCUS: Any comments by  
20 other members of the committee?

21 (No response.)

22 CO-CHAIR PINCUS: Questions?



1           MEMBER MELNYK: I think it goes back  
2           to pediatric primary care. If we screen and  
3           we find, do we have the services that are  
4           going to be able to deal with it? Because on  
5           the United States Task Force, when depression  
6           screening came about, we changed that  
7           recommendation. We put a proviso in there,  
8           screen 12 to 18 year olds when systems are in  
9           place to accurately diagnose and treat. And  
10          I think it gets back to your earlier comment  
11          that you were making about screening and then  
12          what do we do about it, if it's positive?

13          CO-CHAIR PINCUS: And just let  
14          people put their things on the side so that we  
15          can see. So I think Rhonda was next, then  
16          David, then Larry.

17          MEMBER ROBINSON BEALE: This is  
18          really a clarification question. The  
19          pediatric screening, the PSC, when it's  
20          administered, is it something that's based on  
21          clinician judgment or is it based on patient  
22          input?

1           MEMBER MARK: Yes, I think it's a  
2 parent, it's given to the parents.

3           MEMBER ROBINSON BEALE: So my  
4 question would be what testing has been done?  
5 I just don't know the tool to look at the  
6 reliability of the tool, particularly when  
7 we're talking about measuring improvement.

8           CO-CHAIR PINCUS: Rhonda, we're  
9 going to get to that criterion later. The way  
10 this is -- you heard at the beginning where we  
11 said that we're going through criterion by  
12 criterion, not overall. So we'll get to  
13 that.

14           David?

15           MEMBER PATING: So my question goes  
16 to the issue of the relevance. I wasn't quite  
17 sure whether the need is better to find as we  
18 need to do screening or that we need to use  
19 the PSC. I think it's similar to maybe what  
20 you were measuring. I believe that there's  
21 competing measures in the field. I don't know  
22 their revelative breadth of them or the use of

1       them and so if we're driving with one measure  
2       as the goal again, or the gap is that nobody's  
3       using the PSC and that's standardized, or  
4       nobody's screening, which is to me just  
5       slightly different.

6               So I wasn't quite sure in reading  
7       this the gap. I understand there's a  
8       screening gap but is this PSC the only way to  
9       fill it and is there another way to define the  
10      measure that would address the need more  
11      broadly?

12               (Inaudible comments.)

13               CO-CHAIR PINCUS: So this is an  
14      issue of how we approached this criterion. So  
15      just to be literal about it, it's evidence to  
16      support the measure of focus. So this is the,  
17      you know, extent to which the measure is  
18      focused and sort of a concept is appropriate,  
19      not specifically whether or not it's, this  
20      particular instrument is the most valid of  
21      all.

22               And so as we go through this, you'll

1     see that when we -- there's kind of a method  
2     to the madness here, in terms of how one looks  
3     at each of the individual criteria. Because  
4     later on we'll do some work around looking at  
5     the comparability of this measure as compared  
6     to other measures, whether it's sort of best  
7     in class or not.

8             So the focus for this criterion is  
9     really focused around does this concept of  
10    measurement, is it important, okay? And we'll  
11    get to sort of the more comparative stuff and  
12    also the reliability and validity of it sort  
13    of within other criterion. So that's what  
14    we're focusing on right now. So you know,  
15    basically with regard to this measure, you  
16    know, is it important to screen? And it looks  
17    like this is actually a composite of several  
18    different measures, and something that we may  
19    want to get back to in terms of further  
20    clarification. Is it important to screen  
21    kids, number one, and is it important to  
22    follow up and see whether they improve?

1     Because it seems to me that's part of it. And  
2     so that's the concept. Whether this is the  
3     best or not, we'll get to that a little bit  
4     later. Okay?

5             Other questions? Comments? So  
6     David and then Jeffery.

7             MEMBER EINZIG: So just wanted to  
8     give the clinician perspective on doing  
9     screening if there aren't necessarily  
10    resources to refer to. So in our clinic in  
11    Minnesota, you know, that was an initial  
12    concern there, that you're going to be  
13    screening all these kids and what are you  
14    going to do with them now that you've  
15    screened? But you know, I think it's turned  
16    out that, you know, these kids do ultimately  
17    get referred if they deserve referrals.

18            And comparing it to, say you don't  
19    screen, one of the problems I have as a child  
20    psychiatrist is I get kids who are worst of  
21    the worst because they weren't referred to me  
22    sooner. And so if you're not screening and

1 the kids get worse down the road, I think the  
2 purpose -- it is important to measure with the  
3 screening tools so at least it starts the  
4 conversation and some of the information  
5 gathering for the clinician and families.

6 MEMBER SUSMAN: This may be a small  
7 quibble but a system that was doing very  
8 poorly at getting its kids into well-child  
9 exams, all those children are excluded as I  
10 read it from the denominator, and may be a  
11 very poor system compared to one that is  
12 making outreach efforts to get all the most  
13 challenging children into the population for  
14 well child checks and therefore screened.

15 If the measurement period is long  
16 enough, a year, one would assume at least in  
17 early childhood that might be a minor issue.  
18 But as you get more toward the adolescent age,  
19 I think it could be a important problem in  
20 considering one plan's performance versus the  
21 other. So perhaps it would be helpful if the  
22 measure developer has any information on

1 differential attendance where you know what  
2 the true denominator is and then look at the  
3 actual screen denominator.

4 CO-CHAIR PINCUS: Just a comment. So  
5 again, it's a little bit ambiguous. One of  
6 the problems with the criterion is that, as  
7 we're going through this now, you can see is  
8 that everything adds up to importance, you  
9 know? So you can talk about almost anything  
10 with regard to importance along the way, if  
11 it's not feasible, if it's not important ---  
12 so that's one of the issues to think about.  
13 And as we go through this we need to think  
14 about how we sort of split out some of these.

15 But Jeff, I think you're right, and  
16 so one question is, at some point we may want  
17 to come up and bring a suggestion out about  
18 the possibility of having a balancing measure  
19 for this that looks at the proportion of  
20 people, of enrolled children within these age  
21 groups who have had a well child visit. And  
22 I don't know whether such a balancing measure

1 actually exists or not but it's something to  
2 think about and talk about with the measure  
3 developer.

4 Bob?

5 MEMBER ATKINS: With regard to the  
6 issue of once you screen somebody does your  
7 delivery system or does the -- the local area  
8 have the ability to help that person? Again,  
9 I'm looking at things through the filter of a  
10 health plan. That's just as important to me  
11 because if we're not driving -- I mean, that's  
12 a huge problem almost everywhere.

13 So we need to actually know where  
14 that exists as part of -- if you will, as part  
15 of the motivation for change. Because if we  
16 don't know where there are gaps in service  
17 there's nothing we can do about it. And it  
18 also motivates delivery systems to say, well,  
19 we just don't care about that. Well, now that  
20 we're measuring it, maybe you ought to. So I  
21 think actually the lack of services increases  
22 the importance of this metric.



1 CO-CHAIR PINCUS: Rhonda?

2 MEMBER ROBINSON BEALE: I want to  
3 echo what Bob said, coming from a health plan  
4 perspective. I think given this time and the  
5 changes that are occurring in healthcare where  
6 the redistribution of funds and interests is  
7 on the radar screen, I think it's very  
8 important to be able to quantify the areas  
9 where there is a need for services and the  
10 existence of issues. And I think we all would  
11 agree that with children, we've kind of  
12 missed, well not kind of -- we have missed the  
13 boat.

14 And so having a measure that can --  
15 and I would really specify something that  
16 Jeffery was talking about, that it should be  
17 a measure that looks at the entire population  
18 of children, whatever that entity is  
19 responsible for, and that measure be used for  
20 the entire population so you can understand  
21 the prevalence of the issue. I'm not saying  
22 about what it's describing but the prevalence

1 of the issue which I think is exceptionally  
2 important right now.

3 CO-CHAIR PINCUS: Well, I think  
4 we're ready to vote on this criterion. And  
5 let me try to summarize.

6 It sounds like that there is some  
7 degree of consensus that this is the concept  
8 of measurement, screening by using a clinical  
9 measure and also follow-up and assessment of  
10 improvement which seems to be part of the  
11 composite of this measure is an important  
12 issue. That there is -- this is a highly  
13 important issue in terms of impact on kids and  
14 families, that it's -- there's a gap because  
15 there's a lot of people don't screen and don't  
16 assess and don't follow up. And that you  
17 know, that there's also a gap in terms of  
18 measures for kids. But that there's also a  
19 number of issues that have come up that we'll  
20 deal with also, that will come up along with  
21 some of the other criteria. And there may be  
22 some suggestions for balancing measures or for

1 other ways of improving the measure.

2 So we're ready to vote?

3 MS. BAL: So we're going to do a  
4 test run, hopefully everybody's ready to work.  
5 Please aim towards me, not the screens. And  
6 so just a little background. So the voting  
7 will work if we have above 60 percent, that  
8 means that's the decision you made, the  
9 consensus reached. If it's between 40 or 60  
10 that means consensus was not reached and we'll  
11 put it in the gray zone. And then if it's  
12 under 40 percent that means consensus was not  
13 -- I'm sorry, that means that the measure  
14 failed that criteria.

15 So for the first one for evidence,  
16 so for the numbers next to whatever the  
17 decision point is, so if you think the measure  
18 rates a high you put a 1, moderate 2, low 3  
19 and so on. And then that's how you vote. You  
20 only need to push it once, you'll see a green  
21 light indicating that you have voted and it  
22 was registered. And if you see a flashing

1 green light, that means the batteries may be  
2 low. Please let me know if you do see a  
3 flashing green light. And the vote,  
4 it won't work right now because I haven't  
5 started the vote. So don't fear, for right  
6 now if it's not working. Also if you get a  
7 red light that means it didn't register and  
8 definitely let us know. So we're going to do  
9 a test run real quick.

10 CO-CHAIR PINCUS: So just to  
11 clarify, we're voting on each of the sub-  
12 criterion?

13 MS. BAL: Yes.

14 CO-CHAIR PINCUS: Okay. So it's not  
15 just one gemish for the whole criterion 1,  
16 we're looking at each 1(a), 1(b), 1(c)?

17 MS. BAL: Yes. So this is only  
18 evidence -- well, right now let's just do a  
19 test run, don't -- you can put your real vote  
20 if you like but just as a test run to make  
21 sure everything works. Maybe you could  
22 actually -- everybody could just hit 1 to make

1       sure that works.

2               Give me one second. Once I hit the  
3 button then you'll be able to.

4               MS. DORIAN: So you're looking at  
5 the two side screens up there?

6               MS. BAL: Yes. But make sure you're  
7 clicking towards me. Yes.

8               And so when you see this clock  
9 you'll have one minute to vote. And if you  
10 see -- please let me know if you have a  
11 flashing green light or a red light. Just the  
12 number.

13              MS. DORIAN: And if you change your  
14 mind you can push another number. It will  
15 only register the last number that you  
16 actually --

17              MS. BAL: The last one. You can  
18 change your mind.

19              CO-CHAIR PINCUS: So the clock is  
20 ticking?

21              MS. BAL: Yes. We want a green  
22 light, no flash or red.

1           So we only have 22. Could everybody  
2           just try to aim at me again and just make sure  
3           you get that green light?

4           CO-CHAIR PINCUS: What is the  
5           denominator?

6           MS. BAL: We're trying to find 24.

7           (Laughter.)

8           MS. BAL: Are we at 23? Oh, time's  
9           up. Did everybody get a green light when you  
10          selected it? Hold on, we're just going to  
11          double check that we have 24.

12          Okay. Maybe one more test. Sorry  
13          everyone.

14          So we're going to try one more test  
15          and, just push it once and then we're good to  
16          go, hopefully. Oh, sorry, wrong button.  
17          Okay, ready now, go ahead. This is a test  
18          run, not the actual vote.

19          MS. BAL: We're at 23 -- 24. Okay,  
20          we're good to go. All right, everything's  
21          working.

22          CO-CHAIR PINCUS: Okay. So now

1 we're going to do it for real.

2 MS. BAL: Yes, now we're going to do  
3 it for real. This is the real vote.

4 CO-CHAIR PINCUS: And again, we're  
5 voting on 1(a), the first of three different  
6 criteria.

7 MS. BAL: Yes. Okay, so go ahead  
8 and vote now. We're missing one person, if we  
9 could just try one more time. Just click  
10 whatever your answer was. Oh, that makes  
11 sense. Thank you.

12 Okay. We have for evidence for 722,  
13 we have high 16, moderate 7. Zero low, zero  
14 insufficient evidence and zero insufficient  
15 evidence with exception. So we will move  
16 forward to the next vote.

17 CO-CHAIR PINCUS: Would you co-chair  
18 with me on this committee?

19 CO-CHAIR BRISS: Good morning.  
20 Thanks to everybody for being patient with my  
21 Atlanta to D.C. commute this morning. And I'm  
22 Peter Briss and Ann's not here anymore but I

1 have no conflicts.

2 MEMBER GOLDSTEIN GRUMET: Good  
3 morning, I'm Julie Goldstein Grumet with the  
4 Suicide Prevention Resource Center. I also  
5 live locally, I had to get my kids to school  
6 and then drive through rush hour so I  
7 apologize.

8 MS. DORIAN: And Mady?

9 MEMBER CHALK: I'm Mady Chalk from  
10 the Treatment Research Institute. Sorry to be  
11 late, no conflicts.

12 CO-CHAIR PINCUS: Okay. So now  
13 we're going to be voting on 1(b), the concept  
14 of a performance gap.

15 MS. BAL: Okay. Voting for gap is  
16 now open.

17 Just one more time -- sorry. We're  
18 at 22, we just need one more vote.

19 Yes -- oh, we got it. Thank you.

20 So for 722 gap, the final results  
21 are high 19, moderate 3, low 1, insufficient  
22 zero, and we will move forward with this



1       measure.

2               Are we ready to vote for this one,  
3       too?

4               Okay, sure. So we are now voting  
5       for high priority, which is -- addresses the  
6       specific national health goal priority or data  
7       demonstrated a high impact aspect of  
8       healthcare. The options are 1 high, 2  
9       moderate, 3 low and 4 insufficient. And  
10      voting is now open.

11              All right. Thank you everyone.

12              And so the result for impact for 722  
13      is high 20, moderate 3, low zero, insufficient  
14      zero, and we'll move forward to the next  
15      criterion.

16              CO-CHAIR PINCUS: So now, Tami can  
17      you introduce the discussion about scientific  
18      acceptability and going through each of the  
19      criteria?

20              MEMBER MARK: Yes. So first we're  
21      going to discuss reliability. There's a lot  
22      of information that was submitted on this. A

1 summary is provided on page 41 and there's  
2 also a large summary document of all the  
3 literature related to the pediatric symptom  
4 checklist that was included in the submission.

5 So essentially, the reliability of  
6 the PSC survey instrument has been repeatedly  
7 demonstrated, and you can see that in the  
8 references that are provided. However, the  
9 reliability of the PSC as used in  
10 administrative claims, which is essentially  
11 what this is proposing to do, to use it at a  
12 system level, has not been formally assessed  
13 as of this writing, but reading from this,  
14 indications of the reliability in the  
15 Massachusetts Medicaid claims data can be  
16 inferred from the stability of the rates of  
17 positive screening from quarter to quarter in  
18 the statewide CBHI data over six years. So  
19 I'll leave it at that.

20 CO-CHAIR PINCUS: Could you explain  
21 that again, and explain what you interpret  
22 that to mean? I'm a bit lost with that.

1           MEMBER MARK: Yes. So I think what  
2           they're saying is, as an instrument, if you  
3           just take the PSC and you do your standard  
4           Cronbach Alpha, it shows high reliability, but  
5           it's a little trickier when you think about  
6           how you do it in a -- how do you test the  
7           reliability in a office-based setting where  
8           it's based on claims data? And what they're  
9           arguing, I think, is that if you saw a lot of  
10          variation in the prevalence rates over time,  
11          that might indicate a lack of reliability.  
12          But the fact that the overall prevalence rate  
13          seemed to be pretty stable suggests that it's  
14          reliable. And I don't know if the developer  
15          is still on the phone and wants to speak to  
16          that, but that's my interpretation.

17          MS. DORIAN: Michael?

18          MR. MURPHY: Yes, I am still on the  
19          phone and I'd be happy to speak.

20          MS. FRANKLIN: Go ahead.

21          MR. MURPHY: And I thought that was  
22          a great summary. As we move up from the

1 individual case to the system level we don't  
2 have a lot of the kind of data we wish we had.  
3 And the example you gave is one way we infer  
4 it. We do give it repeatedly at Mass General  
5 Hospital every three months, it's not the same  
6 as doing it in pediatrics. We find good  
7 reliability there. And we actually have done  
8 some case reviews in clinics where we have  
9 access to the EMR and good reliability there.  
10 But certainly not much published yet.

11 CO-CHAIR PINCUS: And in validity?

12 MR. MURPHY: Yes, again --

13 CO-CHAIR PINCUS: I'm asking Tami.

14 MR. MURPHY: -- I think we've got  
15 validity on both the process measure and the  
16 outcome measure. Some of the work we've done  
17 in Chile where they use it as --

18 CO-CHAIR PINCUS: Actually I was  
19 asking Tami to continue.

20 MR. MURPHY: Oh, I'm sorry. I'm  
21 sorry.

22 MEMBER MARK: I will parse this by

1     saying I think the point that was brought up  
2     earlier about the fact that this is multiple  
3     measures rolled into one makes the validity  
4     discussion a little challenging because  
5     there's validity and then on top of that you  
6     have this validity of the instrument again,  
7     the PSC, which there is a fair amount of data  
8     to show that it's valid. You know, it  
9     measures what it purports to measure. But in  
10    the system level, you know, a little more  
11    complicated.

12           So the -- I think that perhaps the  
13    trickiest point about validity is the validity  
14    of the outcome measure. And you did -- the  
15    outcome measure again is, did someone who was  
16    screened, identified on the PSC at one visit  
17    show a reduction on the next visit and is that  
18    a valid measure of improvement of quality of  
19    care?

20           And in the submission they highlight  
21    that the American Academy of Child and  
22    Adolescent Psychiatry does, you know,

1 recommend this kind of routine screening as a  
2 way to improve outcomes but that the U.S.  
3 Preventive Services Task Force did not find  
4 sufficient evidence to recommend routine  
5 global psychosocial screening of school age  
6 children or teens at the present time. And we  
7 had a discussion as well about the evidence  
8 from the Hacker research as to whether the  
9 instrument as implemented in Massachusetts  
10 found an improvement in outcomes. And I don't  
11 know, I think the developer was going to  
12 provide some additional information on that.

13 The publications to date do show  
14 that the screen has led to improvements in  
15 case identification and into referral but  
16 there was no evidence to date that it led to  
17 improvement in outcomes.

18 CO-CHAIR PINCUS: We'll get into the  
19 developer's response in a minute. But first  
20 I want to ask Mike to just comment as well.

21 MEMBER TRANGLE: That was such a  
22 good summary I don't think I have anything to

1 add.

2 CO-CHAIR PINCUS: So let's ask the  
3 developer if he could sort of respond with the  
4 information that was provided to NQF  
5 subsequent to the workgroup call?

6 MR. MURPHY: Yes, thank you again.

7 And this came up on the workgroup  
8 call, you know, the lack of U.S. Preventive  
9 Service Task Force endorsement, it's certainly  
10 true. But there are certain things that  
11 establish their validity because of expert  
12 recommendations like AAP or the American  
13 Academy of Child and Adolescent Psychiatry, or  
14 the fact that EPSDT, the national program,  
15 recommends it. So -- and I think Tami also  
16 mentioned the multiple domains of this measure  
17 process outcome make it necessary, ultimately,  
18 to do a validity assessment of all of those  
19 things.

20 But as Tami also said, the Hacker  
21 stuff does show that routine screening on a  
22 large scale leads to increased identification

1 of kids with the problems, increased services  
2 and some of our work in Chile shows that kids  
3 who get services, do better on the PSC and  
4 kids who do better on the PSC have better  
5 grades and better attendance and large  
6 longitudinal datasets. So this is a measure  
7 that's on the bubble, it's not going to be in  
8 everybody's endorsement package, but we're  
9 hoping that NQF sees it as something important  
10 that can be recommended and endorsed at least  
11 by  
12 NQF.

13 CO-CHAIR PINCUS: So why don't we  
14 open up for discussion by the committee. And  
15 just one question for -- in terms of the NQF,  
16 I have a clarification. You say a little bit  
17 about any changes in the scientific  
18 acceptability criterion in terms of how one  
19 applies the issue of endorsement by an expert  
20 group versus, you know, what sort of empirical  
21 evidence is necessary.

22 MS. FRANKLIN: For validity? Are we



1 looking --

2 CO-CHAIR PINCUS: For validity and  
3 reliability, yes, especially validity.

4 MS. FRANKLIN: There have been --

5 CO-CHAIR PINCUS: That's -- because  
6 that -- I know there's been a lot of  
7 discussion about, you know, sort of face  
8 validity and expert opinion recommendations  
9 versus empirical evidence from studies.

10 MS. FRANKLIN: So there hasn't been  
11 a change in our criterion, per se. We do have  
12 more stringent guideline -- guidelines about  
13 how to look at face validity. And at each of  
14 your places you'll have an algorithm that kind  
15 of walks you through how you should look at  
16 the validity criterion. And you -- yes,  
17 Harold has it in his hands.

18 And this is the guidance that we're  
19 going to be using as we look at the validity  
20 aspects of each of the measures. I hope --  
21 does that help answer your question, Harold?  
22 Or is there --

1 CO-CHAIR PINCUS: So yes, maybe you  
2 just want to --

3 MS. FRANKLIN: You want to walk  
4 through?

5 CO-CHAIR PINCUS: Yes, walk us  
6 through. Be clear because this applies to all  
7 of the measures so it would be useful. And  
8 this is, I think, going to be among the most  
9 critical criteria that we discuss, so it's  
10 good to be really clear about this.

11 MS. FRANKLIN: So specifically  
12 looking at the guidance for -- and I'm looking  
13 at the guidance, algorithm number three  
14 guidance for evaluating validity. Is that  
15 your specific concern?

16 CO-CHAIR PINCUS: Mm-hmm.

17 MS. FRANKLIN: And first you're  
18 looking at whether the measure specifications  
19 are consistent with the evidence, and I think  
20 we just had that discussion about linkage back  
21 to evidence presented by the developer in  
22 Section 1(a) of the measure submission form.

1 And you want to look, and make that evaluation  
2 as a committee member, as to whether the  
3 specifications are consistent with the  
4 evidence presented.

5 And we did hear from the developer  
6 that they submitted some additional new  
7 information in the evidence realm. If you  
8 find that there isn't a clear linkage back to  
9 that evidence to support the measure you would  
10 rate this measure as low. If you did find  
11 that it was consistent, evidence consistent,  
12 you move on to whether a question of whether  
13 the potential threats to validity have been  
14 addressed by the developer, and you'd be  
15 looking at the exclusions provided in the  
16 measure. You'd also be looking to see if the  
17 measure really was able to identify  
18 differences in performance among the measured  
19 entities, and you'd also look at any ways that  
20 missing data was handled to reduce bias.

21 If you find any of these issues not  
22 addressed or of concern, you would rate the

1     measure as insufficient.  If you were  
2     satisfied with this -- had a satisfactory  
3     answer to that question, you move on to look  
4     at whether empirical validity testing was  
5     conducted in this case, or you look at whether  
6     face validity was presented to support the  
7     measure.  And in the case of face validity,  
8     you'd only be able to rate the measure as a  
9     moderate.

10           And I think that's, you know, where  
11     we -- this is a critical pieces of this  
12     particular algorithm for this measure.  Are  
13     there questions about how you would walk  
14     through the validity piece for this measure?

15           CO-CHAIR PINCUS:  No.

16           MS. FRANKLIN:  Hearing none, Harold?

17           CO-CHAIR PINCUS:  So let me sort of  
18     call this in terms of -- people who want to  
19     speak --- put their things up.  So Bob, Mike,  
20     Jeff and Larry, and Bernadette and Peter.

21           MEMBER ATKINS:  A couple points.  I  
22     guess, given the state of behavioral health

1 services, I'd be pleasantly surprised if a  
2 screen measure was tightly linked to ultimate  
3 clinical outcomes. So I don't see that as a  
4 particular challenge to the validity of a  
5 screening measure. I think that that's the  
6 ultimate goal but that's an end state. So  
7 that would be one point.

8 I do have a concern about the  
9 validity. Second point, I have a concern  
10 about validity with regard to referral to a  
11 behavioral health clinician. Increasingly --  
12 I mean, we know for a long time most of the  
13 behavioral health services in the United  
14 States are delivered in the primary care  
15 setting not by behavioral health clinicians.  
16 And I understand that there's been a  
17 longstanding concern about whether or not the  
18 quality is what we would wish, frankly in  
19 either setting, but that's a question.

20 But I do think that the other thing  
21 that, where I question validity of using  
22 referral to behavioral health clinician is

1 with the increasing sort of growth of  
2 integrated practices, whether it be a patient  
3 that's in a medical home or a behavioral  
4 health home where there are behavioral health  
5 clinicians within the practice. And that  
6 might not look like a referral, it would be  
7 contained within the primary care setting. So  
8 I'm not sure that that -- how to address that  
9 within this metric.

10 I'll stop there.

11 MEMBER TRANGLE: It's interesting,  
12 my thoughts were similar but not identical to  
13 yours.

14 I think we should think about, you  
15 know, this is a multi-functional potential  
16 measure. You know, at least in my mind, it  
17 was clearer if I tried to separate out the  
18 functions and think about how valid it is, you  
19 know? So in my mind's eye, I think about how  
20 valid it is for picking up and screening, it  
21 strikes me as reasonably valid.

22 When I thought about how valid is it

1     for referrals, you know, they're your points  
2     about is it always going to be a referral and  
3     how is that defined and how is that captured?  
4     And even if you were capturing it accurately,  
5     the other question I have is, when you're  
6     making a referral to a behavioral health  
7     person, about 50 percent never show. And if  
8     all you're measuring is the referral, you're  
9     missing a lot of the action, you know?

10           And then the part that I would  
11     probably have the most questions about is  
12     really sort of improvement, you know? Is it  
13     valid for improvement in terms of remeasuring  
14     and seeing if the numbers go down, if it was  
15     voodoo that did it or five other things? You  
16     know, who knows what the factors might have  
17     been, and it wasn't the referral.

18           So I think we should almost -- we  
19     should think about the possibility of  
20     separating this measure into different, three  
21     different parts and voting separately. I  
22     don't know if that's kosher, you know, in

1 terms of the methodology here.

2 CO-CHAIR PINCUS: Jeff?

3 MEMBER SUSMAN: I think you've  
4 articulated much of the concerns I had at the  
5 beginning of this discussion which is  
6 essentially we have, one, a measure to find  
7 prevalence or incidence, depending on how  
8 you're going to use this. Two, to find some  
9 change for process improvement.

10 The question on the process  
11 improvement side I had is do we have enough  
12 data, and this might go back either to those  
13 of you who reviewed more in-depth, or the  
14 developer, do we know what a substantial or  
15 significant clinical change in this measure  
16 is? And what data is the validity and  
17 reliability of that change based on? I was  
18 poring through the documents and I confess I  
19 didn't see strong evidence in that arena but  
20 maybe I missed it.

21 CO-CHAIR PINCUS: Bernadette?

22 MEMBER MELNYK: Because the U.S.



1 Preventive Services Task Force came up again,  
2 I just wanted to give people insight because  
3 I was on the task force. And actually brought  
4 forward this topic recommendation, because I  
5 feel it is so critical because we have one out  
6 of four children now with a mental health  
7 problem, yet less than 25 percent get any  
8 treatment. The task force voted this as a  
9 high priority for topic review, but it never  
10 made it to topic review because of other  
11 priorities. And because of people being  
12 concerned that, again, we screened and we find  
13 and we have interventions.

14 The Task Force had a lot of concern  
15 that we were taking on topics that again we  
16 don't have sufficient evidence for. And there  
17 was a lot of criticism about the task force  
18 continuing to put out insufficient evidence  
19 recommendations. So I just want to give you  
20 the background on that. There have been more  
21 recent studies that have shown screening with  
22 this particular instrument. There are

1 evidence-based interventions to improve  
2 outcomes. And those are more recent in the  
3 literature. So again, I just want to advocate  
4 for, this is a solid, valid, and reliable tool  
5 that more recent studies are coming out that  
6 say we can do something of value if we find  
7 it.

8 CO-CHAIR PINCUS: Rhonda?

9 MEMBER ROBINSON BEALE: I agree with  
10 the previous statements that I think it's  
11 difficult to really vote on this as a  
12 composite measurement. I think it would be  
13 doomed to fail in that regard because I think  
14 there is still hold.

15 I do agree that it's very important,  
16 it has significance, and I think that is, in  
17 itself, probably what drives the interest in  
18 this particular measure. I'm not clear that  
19 the PSC is anything beyond a screening tool.  
20 I don't see it as a assessment tool, and I  
21 tried to look through the studies and I  
22 certainly wasn't clear that it was a tool that

1       showed validated improvement. And so I really  
2       find it hard to go further in terms of really  
3       looking at this as a multiple measure making  
4       one vote as opposed to splitting it out in  
5       some way.

6               CO-CHAIR PINCUS: David then Larry  
7       then Peter then Mady.

8               MEMBER EINZIG: So I'm a simple guy,  
9       I just want to try and conceptualize this. So  
10      if this is a screening tool that's simply used  
11      to identify early issues with kids, I think  
12      that it's -- you know, I think it's great. I  
13      guess I need a little clarification as, is  
14      this -- if the intent of this measure is to be  
15      used as a quality measure in terms of outcome,  
16      in other words, is it good quality if the  
17      score goes down as opposed to up, you know,  
18      that's where I have a problem with it. But if  
19      it's just a simple quality measure of are we  
20      screening and are we doing something about it,  
21      that's where the greatest validity is with  
22      this tool.

1           MEMBER MILLER: In addition to  
2           simple, I'm also old and paranoid and  
3           suspicious and I have an issue about the  
4           reliability, I believe.

5           As far as I understand the  
6           administration is a 35-item parent  
7           administrative checklist, parent or youth. I  
8           don't see anywhere that the clinician also  
9           does this or validates it in some ways. And  
10          the reason I say that, we had in our system in  
11          Arkansas, we've used the Youth Outcome  
12          Questionnaire. And when we only had the  
13          parent fill it out, sometimes there's an  
14          incentive to make the child look better or  
15          worse or whatever. Some parents are concerned  
16          that if they make their child look worse or  
17          accurate that they're going to be taken away  
18          or something like this. And so when we added  
19          an element of having a clinician fill it out,  
20          the scores changed dramatically.

21          And so I'm concerned about just the  
22          basic reliability of having a parent fill out

1 the thing if a clinician hasn't also filled it  
2 out and sort of reviewed it, and especially in  
3 terms of the outcome improvement. So that's  
4 a concern that I have.

5 CO-CHAIR PINCUS: Peter.

6 CO-CHAIR BRISS: So on thing, all of  
7 my things are reacting now to people's  
8 comments. So it's -- one of them is that I  
9 would be a little careful throughout the whole  
10 two days about giving behavioral health  
11 interventions a relative pass. I think that  
12 the -- it's sort of the standard for the  
13 evidentiary standards for almost anything, as  
14 does screening and some associated through  
15 improved outcomes. And if it doesn't, it's  
16 probably -- it may not be -- and especially  
17 for a measure like this one that's likely to  
18 be used in a variety of settings, including  
19 primary care, right? Where people have lots  
20 of other pressures on their time.

21 And then I would consider this as  
22 four separate measures. I think it's

1 impossible to think about reliability and  
2 validity of this measure without thinking  
3 about it one thing at a time. It probably --  
4 in my view, it probably could be reliable and  
5 valid if it's a measure of "did screening  
6 occur," as sort of a process measure of "did  
7 screening occur?" I'm not sure that the  
8 developer has made the case here that it's  
9 actually reliable and valid for any of the  
10 other three proposed uses. And especially for  
11 the "did outcomes improve," both because at  
12 least in the submission, as I read it, you  
13 know, unless there's new data that wasn't  
14 actually submitted, I saw very thin evidence  
15 of outcome improvement. And to the extent  
16 there might be outcome improvement, this kind  
17 of a measure is very subject to regression to  
18 the mean.

19 And we talked to the developer a  
20 little about that in the workgroup call, he  
21 said it's about 50 percent. But without  
22 better data and evidence presented, I think

1       it's very hard -- beyond what's presented in  
2       this submission, I think it's very hard to  
3       evaluate its potential.

4               CO-CHAIR PINCUS:   Mady.

5               MEMBER CHALK:   I raised the question  
6       that Peter raised about to what extent,  
7       because there are other measures that we're  
8       going to be talking about that involve  
9       screening that are identified as process  
10      measures primarily.  And I was curious about  
11      why this was tagged as an outcome measure  
12      specifically when, as a process measure, in my  
13      view, it works just fine for right now, but  
14      not as an outcome measure.

15              CO-CHAIR PINCUS:   Tami.

16              MEMBER MARK:   I think part of the  
17      concern that I have, and maybe it's underlying  
18      this discussion, is that the screening in  
19      itself may not -- screening and increased  
20      identification may not lead to better  
21      outcomes.  In fact, you know, it may lead to  
22      worse outcomes as people get inappropriate --

1 children get inappropriate medications and get  
2 iatrogenic problems. And we're talking about  
3 implementing this on very large populations so  
4 the potential for, you know, having worse  
5 outcomes across many, many children is a  
6 little concerning. But at the same time, we  
7 do recognize that there is a significant need  
8 in this population. And if this were valid  
9 and did result in improved outcomes, it has  
10 the potential to be very important.

11 So given that, is there a way to  
12 vote on it, you know, giving it a contingent  
13 vote saying, you know, we would like to see  
14 this but, you know, you need to come back with  
15 this data showing this actually is going to  
16 improve population level outcomes? Or do you  
17 just -- you know, it's a "yes" or "no" and  
18 then three years they come -- they can submit  
19 it again? You know, what are our options  
20 here?

21 MS. FRANKLIN: So we -- first of  
22 all, it may not be exactly three years. But



1 we have to vote on the measure as it's  
2 constructed currently before us and we would  
3 not be able to -- we could make  
4 recommendations for the future on the measure.  
5 But we'd have to look at the measure as it is  
6 and evaluate it on its current measures --  
7 merits.

8 CO-CHAIR PINCUS: So what if it was  
9 not accepted but we made recommendations, when  
10 would they be eligible to come back?

11 MS. FRANKLIN: As -- we don't have a  
12 specific timeline right now. But it typically  
13 could be up to three years but it could be  
14 sooner, depending on if there is new evidence  
15 that they've presented to us.

16 And one other note, if you were to -  
17 - and I'm not sure if this is an option given  
18 the way the conversation's going, is if the  
19 committee decided to go forward with this  
20 measure and recommend it and evidence changed,  
21 the developer could come back within the year  
22 with an annual update with any material

1 changes to the measure for an ad hoc review.  
2 So that's also an option. But that's for the  
3 committee's determination.

4 CO-CHAIR PINCUS: So I want to make  
5 an observation as chair and then sort of a  
6 comment as a committee member. So as I see  
7 it, one of the issues that the -- our  
8 discussion suffers from is that there really  
9 isn't a clear specification of the performance  
10 measure for the use of this clinical  
11 instrument. And that for other clinical  
12 instruments that have been proposed, they  
13 actually come in a form of several different  
14 measures, each with a specific sort of  
15 assessment of the evidence and characteristics  
16 and all the other criteria for those specific  
17 uses. And I think that that's creating a  
18 problem in terms of how we discuss this. And  
19 again, I would urge NQF to consider developing  
20 a template for those kinds of situations so  
21 that we can sort of look at it that way.

22 And just a comment from my own point

1 of view, so looking at this measure as  
2 presented, I really think it's problematic in  
3 terms of the scientific acceptability. In  
4 terms of, number one, the reliability, you  
5 know, as Larry mentioned, I'd be concerned  
6 about -- you know, and particularly Tami, in  
7 terms of this widespread applicability in  
8 terms of both false positives, false negatives  
9 and, you know, especially with the different  
10 -- the heterogeneity of how it might be used  
11 in clinical settings.

12 The fact that there is really, for  
13 at least some of the purported uses, there  
14 really is no evidence of linkage to outcomes.

15 And number three is, there also does  
16 not seem to be a formula for risk adjustment.  
17 And it certainly is likely that different  
18 settings are likely to have very different  
19 groups of individuals that are coming in with  
20 different risks and not -- it's not clear how  
21 one would adjust for that if this is being  
22 used as an accountability measure. So you

1 know, I have concerns and would recommend that  
2 the developer come in with a much clearer set  
3 of performance measures using this clinical  
4 tool with increased data.

5 CO-CHAIR BRISS: I just have a  
6 couple process questions for the staff.

7 So I'm -- a lot of people around the  
8 table have expressed varying levels of concern  
9 based on which of the uses we're talking  
10 about, right? And so do we have options of  
11 splitting out uses as a committee or do we  
12 have to vote on -- do we still have to vote on  
13 the whole set together and then it's -- you  
14 know, we -- NQF's been talking about fit for  
15 purpose, right? And so someday we're going to  
16 get to the place where we can say this measure  
17 can be used for these purposes and not those,  
18 but I don't think we're there yet, is that  
19 right?

20 MS. FRANKLIN: That is correct.

21 CO-CHAIR BRISS: And so the vote  
22 that we would have to take is for all of the

1 proposed uses, is that right?

2 MS. FRANKLIN: That's correct.

3 CO-CHAIR PINCUS: Jeff, do you have  
4 a comment?

5 MEMBER SUSMAN: Yeah, just briefly.

6 I share all the concerns, but this  
7 pediatric symptom checklist probably has a  
8 larger dataset than most of the things that we  
9 consider. But because we've got these three  
10 or four different uses sort of in a fruit  
11 cocktail makes it very difficult.

12 I wonder if the staff could somehow,  
13 with the measure developer, fast-track this  
14 back and -- to separate out those uses?  
15 Because I think our job would then -- would be  
16 a lot more straightforward and we could make  
17 some discernment about what uses we would be  
18 happy with the degree of reliability, validity  
19 and other uses that we might not.

20 CO-CHAIR BRISS: I have a question  
21 about that. This is just a process question.

22 MS. FRANKLIN: Yes.

1 CO-CHAIR BRISS: So if we were to  
2 send this one back for further work, it could  
3 conceivably come back for an ad hoc review in  
4 a year, couldn't it?

5 MEMBER KELLEHER: And to add to  
6 that, if it -- could we also make  
7 recommendations about whether it should come  
8 back as separate but paired measures rather  
9 than the composite that it is right now?

10 MS. FRANKLIN: You could. And I  
11 just want to be clear, we'd have to -- for it  
12 to come back for an ad hoc it would have to  
13 have been recommended by this committee for  
14 endorsement for it to be able to come back as  
15 an ad hoc. So that would be the catch.

16 MS. DORIAN: I did just want to add  
17 a little bit of context just to make sure  
18 we're consistent across committees. I'm also  
19 working on a person and family centered care  
20 project which recently evaluated PROs, or  
21 person reported outcomes, and so this is  
22 similar in a lot of ways. And this is

1 something that NQF has struggled with in terms  
2 of these kinds of measures. Do we allow  
3 multiple measures to come in on one form or  
4 not? You know, we have to consider the burden  
5 to the developer and also the fact that, as  
6 you all have said, that they're very different  
7 uses and so they do, theoretically, seem  
8 different.

9 And we did actually allow at the end  
10 of the day the developer to submit all of the  
11 measures in one form and the committee  
12 evaluated it as one measure because the sort  
13 of argument from the developer's point of view  
14 and the user's point of view was that these  
15 are always reported together. I'm not sure if  
16 that's -- I think that's the case with this  
17 measure. But I just wanted to add that little  
18 bit of context, that that committee didn't  
19 hold it against the developer necessarily,  
20 that it was -- it all came in as one rather  
21 than separate measures.

22 CO-CHAIR PINCUS: I guess just to

1     clarify, I wasn't necessarily recommending  
2     that it has to come in as separate measures,  
3     but certainly the different uses have to have  
4     much more clear specifications for numerators  
5     and denominators as well as the risk  
6     adjustment, you know, that's appropriate for  
7     the fit. It's got to show fit to all the  
8     purposes, even if it comes in as one measure.

9             MEMBER CHALK: I think this is too  
10    important a measure, given the lack of such  
11    measures, to just toss it. No, I'm not  
12    talking about voting for it, but toss it  
13    without making a statement by this committee,  
14    we've done it in other committees, that says  
15    what we think the importance is and why --  
16    what we want the developer to do and how we  
17    want it to come back so that NQF does not  
18    forget that this measure is hanging out there.

19            MEMBER KNUDSEN: I have a question.  
20    So I'm a little confused in terms of our  
21    voting that's coming up.

22            (Laughter.)



1           MEMBER KNUDSEN: Are we voting on  
2           four measures, two process, two outcome, or  
3           are we -- this is not a composite measure  
4           because that's not what was brought forth  
5           initially. So -- or is this an overall  
6           measure that we're voting on? But then how do  
7           you vote on reliability and validity of four  
8           different things with one vote?

9           CO-CHAIR PINCUS: Well, I --

10          CO-CHAIR BRISS: Let me try that.

11          Let me try to answer.

12          So I think that we have -- I think  
13          that the vote is we would have to be voting  
14          that this is reliable and valid for any of the  
15          four uses for which it's been proposed, right?  
16          And for all of -- in principle, for all of the  
17          uses for which it's been proposed.

18          MS. DORIAN: And as Angela had  
19          mentioned before, as you are a standing  
20          committee now, you would be the ones  
21          reviewing, making recommendations now, of  
22          course, but then reviewing any changes

1 subsequent to this meeting. The measure could  
2 come back for an ad hoc review if it was  
3 significantly changed.

4 MEMBER ATKINS: So could you explain  
5 the impact of this vote on the ad hoc  
6 timeliness of the term? Because I'm a little  
7 -- it seems like it might be unintended  
8 consequences that we're going to shoot this  
9 thing and we don't want to shoot it, we want  
10 it to come back.

11 MS. FRANKLIN: So what I heard was a  
12 recommendation that just looking at the four  
13 numerator statements, as it were, the  
14 committee wasn't feeling comfortable about the  
15 reliability and validity of all of these being  
16 used. And that's what the decision's about,  
17 on the reliability and validity vote now.

18 And with -- the committee would have  
19 to recommend the measure going forward, or the  
20 other option, with certain specifications that  
21 would need to be changed by the developer.  
22 But at this time we probably would not be able

1 to have the developer make those changes in a  
2 timely way. So -- in this project.

3 You'd be also -- you'd also have the  
4 option to not vote for the -- not recommend  
5 the measure for endorsement and the developer  
6 could bring back this measure differently  
7 formulated as instructed by the committee for  
8 a full endorsement review again. And that's  
9 really kind of the two options that we have.

10 MEMBER CHALK: So I have a question.  
11 Could it be recommended that the developer  
12 view this as a trial measure?

13 MS. FRANKLIN: That is reserved  
14 actually for electronic measures.

15 MEMBER CHALK: E-measure  
16 specifications?

17 MS. FRANKLIN: Yes.

18 CO-CHAIR PINCUS: I guess let's  
19 hear from the measure developer before we  
20 vote?

21 MR. MURPHY: I'm trying to stop  
22 crying and I'll get myself together just for

1 a second.

2           Actually, I thought this was a great  
3 discussion, and I think some of the ways --  
4 I'm also quite heartened that some of the ways  
5 out of the -- I totally agree that the  
6 validity and reliability of this for some of  
7 the other uses just hasn't been demonstrated,  
8 whereas the validity and reliability as a  
9 process measure is probably pretty solid. So  
10 there may be some need to break it out and  
11 we're certainly willing to work with your  
12 committee in any way.

13           The only thing that -- a couple  
14 things concern me, and I think it just  
15 reiterates -- somebody just said we don't want  
16 to kill it, we want it to come back in a  
17 different form. I don't know if there are any  
18 pediatricians on the committee here, but I  
19 think this is one of the few pediatric, the  
20 only pediatric mental health measure. And its  
21 virtue is that it brings mental health into  
22 pediatric primary care with all the lack of

1       specificity so far. So I would hope that we  
2       find a way to keep it alive but buff it up a  
3       little bit so that it can be looked at and  
4       voted on appropriately.

5               And by the way, it is about to be e-  
6       specified, if that helps. SAMHSA just awarded  
7       a contract to have it e-specified by  
8       Mathematica, so they're expecting e-  
9       specification pretty soon.

10              CO-CHAIR PINCUS: So yes, we're now  
11       -- I think that we need to vote. I think that  
12       -- you know, I think that everybody here feels  
13       the need for some kind of way to address this  
14       issue in this population. And I think, on the  
15       other hand, you know, there -- we do need to  
16       adhere to the -- you know, to the process and  
17       apply the criteria in a -- you know, in a  
18       uniform way across all of the measures in  
19       terms of fairness and also in terms of -- you  
20       know, and I'm also sort of going back to what  
21       Tami mentioned about the potential risks in  
22       terms of application and its use in ways that

1 might actually create harm. And so that we  
2 need to think about that.

3         So you know, I think we need to vote  
4 on the measure as proposed, applying the  
5 criteria as expressed by NQF. I think we can  
6 also accompany that recommendation -- whatever  
7 recommendation comes out of the voting,  
8 accompany that with a very strong statement  
9 about the clinical need for this, its  
10 importance in terms of the needs of the  
11 population and addressing that, and some  
12 specific recommendations for how this measure,  
13 or any other similar measure, should come back  
14 to us in a way that would be more acceptable  
15 and that also could be done quickly. And  
16 that, you know, even though NQF has certain  
17 procedures, I think there's certain ways in  
18 which they can work to kind of bring it back  
19 more quickly if we make that case.

20         CO-CHAIR BRISS: The only other  
21 thing that I'd add is that the point of  
22 standing committees is to make things faster

1 in review and so we don't have to do what we  
2 would have used to have to do, which is reseal  
3 a new committee and come back in three years.

4 The other thing that I would say is  
5 that part of the point of the process is to  
6 improve measures, right? And so we'd rather  
7 have a better measure in a year than have a  
8 measure that might be misinterpreted or even  
9 harmful soon.

10 CO-CHAIR PINCUS: So let's --  
11 Poonam, can we proceed to voting?

12 MS. BAL: Okay. So we'll be voting  
13 for the reliability for 722 which includes the  
14 specifications and testing. Voting is now  
15 open.

16 Oh, I'm sorry. One high, two  
17 moderate, three low, four insufficient.

18 Okay. So the results for  
19 reliability for 722 is high one, moderate  
20 four, low three, insufficient fifteen. And we  
21 don't move forward with this measure after  
22 this vote.

1 CO-CHAIR PINCUS: Okay. And so will  
2 the recommendation be accompanied by, I think,  
3 a statement very similar to what Mady spoke of  
4 earlier?

5 MS. FRANKLIN: Yes.

6 CO-CHAIR PINCUS: Any other final  
7 comments?

8 (No response.)

9 CO-CHAIR PINCUS: Okay. Let's  
10 return to the measure -- yeah, our agenda and  
11 measure 0108. And Peter will lead us in that.

12 #0108: ADHD: Follow-Up Care for Children  
13 Prescribed ADHD Medication (NCQA)

14 CO-CHAIR BRISS: So this is 0108  
15 follow-up for children provided ADHD  
16 medication and David is the lead discussant.  
17 So if you could kick us off?

18 MEMBER EINZIG: Okay. Measure 0108,  
19 follow-up care for children prescribed ADHD  
20 medication, so kids not -- with ADHD can --

21 CO-CHAIR BRISS: I'm sorry, I  
22 misspoke. Can you let NCQA introduce the



1       measure for us?

2               MS. HUDSON SCHOLLE:   Good morning  
3       everyone.   I'm Sarah Hudson Scholle, I'm Vice  
4       President for Research and Analysis at NCQA  
5       and I'm here with Junqing Liu who is our  
6       research scientist.   And we're delighted to  
7       have a number of measures for your review  
8       today.

9               The first measure is this measure  
10      that looks at follow-up for children who are  
11      on an ADHD medication.   So this measure is  
12      based on claims data.   It's been around in our  
13      HEDIS measure set for health plans since 2005.  
14      It's currently used in a number of federal and  
15      state programs including the Children's  
16      Medicaid Core Set, PQRS, Meaningful Use.   It's  
17      proposed for later stages of reporting by the  
18      Quality Rating System for Exchange Plans.

19              It is a claims-based measure so the  
20      purpose of the measure is to say if children  
21      are on a medication for ADHD, they should be  
22      getting appropriate follow-up.   So it's

1 looking specifically at that construct. And  
2 while we have other work underway to try to  
3 look at outcomes for children with ADHD and  
4 other considerations, this is one that's  
5 currently in use because it's feasible from  
6 claims data. So we're looking to see whether  
7 children have follow-up visits to monitor  
8 their response to treatment and any potential  
9 side effects and with the goal that this  
10 medication management will support better use  
11 and outcomes.

12 Thank you.

13 CO-CHAIR BRISS: Thank you.

14 And now to David.

15 MEMBER EINZIG: Okay. So follow-up  
16 care for children prescribed ADHD medication.  
17 I think this is worth mentioning that this  
18 isn't measuring kids with ADHD on medication  
19 but it's just simply kids who are getting ADHD  
20 medication whether or not they have ADHD.

21 The numerator breaks it down into  
22 two parts. It's measuring children between

1 the ages of six and 12, newly prescribed ADHD  
2 medication with a follow-up visit by the  
3 prescribing practitioner within 30 days. And  
4 part two -- this is another study that's  
5 multi-faceted. Part two is the continuation  
6 phase where the kids have two subsequent  
7 visits in months two through nine. So number  
8 one, follow-up within 30 days; number two, two  
9 additional follow-ups months two through nine.  
10 And the denominator statement is all kids  
11 getting prescribed ADHD medication.

12 It's a process measure, and as we go  
13 through this, I'll -- I'm a clinician, I'm  
14 going to primarily give my clinical  
15 impression. I am not a statistician, a  
16 researcher and maybe a little bit of  
17 administrative work, but that's not where my  
18 primary focus is.

19 In terms of importance to measure,  
20 some of the -- review some of the comments  
21 from our group. Obviously a lot of kids are  
22 getting prescribed ADHD medications, rightly

1 or wrongly, and it is important to establish  
2 follow-up. Some of the questions  
3 pertaining to the evidence from my  
4 perspective, breaking it down into the -- how  
5 often do these follow-ups occur, I was  
6 questioning the evidence to support the one-  
7 month mark for follow-up visits and should  
8 that necessarily be used as a quality measure  
9 as opposed to six weeks, two months? And I  
10 had trouble finding the evidence to say that  
11 one -- I mean, I think we all agree that the  
12 follow-up is important and necessary. But in  
13 terms of evidence to say how frequently should  
14 that follow-up occur, I think that's lacking.

15 And one of my concerns with this  
16 measure is it takes away from services to meet  
17 the individual's needs, patient and family.

18 In terms of performance gap, I think  
19 we can all agree that there is a performance  
20 gap. I don't know if there is anything else  
21 to say about that in terms of establishing  
22 that follow-ups should be arranged and there's

1 different docs, different providers do  
2 different things. ADHD is common and it is  
3 important to treat.

4 Some of the -- in terms of  
5 importance, for follow-up, some of the  
6 comments include with regular follow-up  
7 visits, intuitively speaking, it should  
8 enhance good medication compliance, engage the  
9 patient and the families in the treatment  
10 process and adherence.

11 Should we stop there or should we  
12 continue through the whole -- okay.

13 CO-CHAIR BRISS: You can stop there.

14 Larry?

15 MEMBER MILLER: Thank you. I think  
16 the committee agreed that this was an  
17 important area to look at and I'm certainly  
18 glad that NCQA is looking at outcome measures  
19 because I think that's one of the things we  
20 struggled with that we really wanted to see  
21 this as an outcome. And the other thing, as  
22 David mentioned, this has nothing to do with

1 children who were diagnosed with ADHD, they're  
2 just given medication for this -- given  
3 medication.

4 Some of the comments that -- just to  
5 follow up. There was some concern that there  
6 was little improvement using this indicator  
7 and that less adherent children were to fall  
8 out of the indicator based on the prescribed  
9 schedule and there was some concern because  
10 those are the kids who may need the follow-up  
11 more than anybody else.

12 I think we all thought this was an  
13 important measure to look at and it certainly  
14 was a high priority given the use of  
15 stimulants and the way that this diagnosis can  
16 be thrown around. So those are my comments.

17 MS. HUDSON SCHOLLE: So this does  
18 focus on children who are using the ADHD  
19 medication. That's because our early testing  
20 work showed that the medications were  
21 prescribed when the medications were  
22 prescribed. We might not see a diagnosis of

1 ADHD on the claim but when we went back and  
2 looked at the medical record we did. And so  
3 we would be under-counting a lot of children  
4 -- if we required the diagnosis in the  
5 medication, we'd be missing more children.

6 This measure focuses on children  
7 with a new episode and this gets at your issue  
8 of, you know, how frequently should these  
9 follow-up visits be? The guidance generally  
10 doesn't give us a whole lot of -- the  
11 guidelines and testing generally don't tell us  
12 exactly what the timeframe is. They say it  
13 should be addressed based on the needs of the  
14 children. But I think what our review panels,  
15 our advisory panels said, if this is a new  
16 episode then a visit within -- a new episode  
17 of treatment, a visit within 30 days is a  
18 reasonable expectation for that beginning,  
19 right?

20 So as we had to specify this measure  
21 we had to focus on places where we were pretty  
22 confident that that was the right thing to do.

1     So new prescription, you know, without a  
2     previous history over the past four months,  
3     then you should be checking to see is the  
4     child responding or having any side effects?  
5     So that's where the one month came from.

6             The second part of the -- the second  
7     indicator looks at this longer-term follow-up  
8     approach. You know, like are you actually  
9     checking to see how kids are doing? And for  
10    that it's -- you pointed out that the decision  
11    that this measure made was to say, well, we're  
12    going to focus on children who remain on the  
13    medication. Now of course, children with ADHD  
14    may get that one prescription and not ever get  
15    it -- you know, not refill it, they drop out  
16    of our denominator. And we don't know whether  
17    that's because their symptoms magically  
18    resolved, the medicine worked, whatever, they  
19    were getting behavioral therapy and that  
20    worked. We don't know about that, we're only  
21    -- but through the claims data the only thing  
22    we can really assess is children are staying



1 on the medication, therefore someone should be  
2 monitoring them while they're on the  
3 medication.

4 And so again, you know, it's the  
5 limits of what we can measure from claims data  
6 easily. It is a limited measure and we are  
7 looking at ways to look at outcomes but we're  
8 finding that we're -- there we absolutely have  
9 no data. We actually have developed a measure  
10 for ONC through -- and CMS, and we're actually  
11 -- while we have a measure we can't find any  
12 place that can actually test it because  
13 they're not -- they don't have a standardized  
14 approach to using a patient-reported or  
15 family-reported outcome measure over time that  
16 would allow us to actually see whether kids  
17 are improving. So we're working on that in  
18 terms of it's a demonstration rather than a  
19 testing point.

20 So while we recognize that process  
21 measures based on claims data are limited,  
22 they have their limitations, they're actually

1       what we can do today.

2               You mentioned also that this -- the  
3       measure is not improving. Okay, this is --  
4       you know, over time what we've seen in a  
5       number of our measures that look at behavioral  
6       health conditions, so it's not just this  
7       measure, it's other measures that are --  
8       address behavioral health issues, we're not  
9       seeing improvement. So it's -- and that has  
10      to do with how the measures are used and who's  
11      paying attention to them.

12             And so what we've done within our  
13      own programs where we have some opportunity to  
14      influence this is that, one concern we have is  
15      that managed behavioral health organizations  
16      or the behavioral health side and the general  
17      medical side may not talk to each other  
18      enough. And one thing that we see is that --

19             MEMBER ZIMA: They might.

20             MS. HUDSON SCHOLLE: They might not.

21      But one thing that we see is that plans that  
22      are not responsible for the behavioral health

1 benefit of their members do not report this  
2 measure, right? To be responsible, the plan  
3 has to have both the responsibility for  
4 general medical and pharmacy and behavioral  
5 health, right, so that we can actually measure  
6 what's happening.

7 And so what we have done is, within  
8 our -- but we do also credit managed  
9 behavioral health organizations and we created  
10 a new expectation for those organizations that  
11 they begin to track this measure and other  
12 measures. There's a suite of measures for  
13 them to track because we're trying to get the  
14 managed behavioral health organizations to be  
15 looking at the same quality metrics that the  
16 health plans are looking at.

17 Neither of them has all the  
18 information they need, and so they have to  
19 work together, and so that's why -- that's our  
20 theory about that, is trying to encourage that  
21 collaboration. It's a message I would also  
22 give to states that are carving out behavioral

1 health and employers who carve it out, that  
2 they create a boundary unless they can force  
3 the sharing of data.

4 So those are some of the issues that  
5 we think contribute to the lack of  
6 improvement, but I think it's not that this is  
7 a sound measure, it's that there are other  
8 things in the environment that are making this  
9 and all the -- making it harder for us to  
10 improve on a number of behavioral health  
11 measures.

12 CO-CHAIR BRISS: So there are a  
13 number of cards up. Why don't we start --  
14 let's start with down at -- the mic down at  
15 the end and we'll just work around the table.

16 MEMBER ZIMA: Okay. And I was  
17 reviewing number two on workgroup one. And I  
18 think that, you know, it was really -- again,  
19 so no change in improvement but just to point  
20 out that on page 18, NCQA reports that, quote,  
21 "over the past three years this measure has  
22 shown improvement." So I -- there was a

1       little bit of a discrepancy, I think.

2               MS. HUDSON SCHOLLE: Over time it's  
3 shown -- sorry.

4               Over time we've seen improvement.  
5 Over the past couple years, though, it's been  
6 pretty steady.

7               MEMBER ZIMA: Yes, it looks quite  
8 stable.

9               The other issue is, in the indicator  
10 itself it says "med adherence," but I think  
11 you're really measuring med prescription  
12 persistence with the assumption that it's  
13 adherence. But I think to be more specific it  
14 should be "med prescription persistence."

15              And the other issue, just to echo  
16 some of the discussion, Sarah, that you're  
17 talking about, limitations of health plan data  
18 is, of course, and it's admitted in the  
19 measure, is that you can't stratify by race  
20 and ethnicity. And you know, at the same time  
21 in the measure application there is a good job  
22 as far as reviewing the literature about the

1       disparities we know about, kids and ADHD.

2               The other issue that hadn't been  
3       commented on yet is that the rationale for  
4       using the telephone visit to be counted as one  
5       of the follow-up visits, are we talking about  
6       specification yet? Or --

7               CO-CHAIR BRISS: No.

8               MEMBER ZIMA: Okay. So I'll hold  
9       down that comment.

10              CO-CHAIR BRISS: So before we work  
11       our way around the table, Caroline has a  
12       question.

13              MEMBER DOEBBELING: Thank you.

14              Hello?

15              CO-CHAIR BRISS: Hello. Yes,  
16       Caroline, please go ahead.

17              MEMBER DOEBBELING: Thank you. I  
18       wanted to make sure you all could hear me.

19              I had a concern about the measure in  
20       response to NCQA's statement about the split  
21       between behavioral health plans and medical  
22       health plans, so to speak, if the behavioral

1 health is carved out. Given the prevalence  
2 of ADHD and the treatment of ADHD by primary  
3 care providers and pediatricians, I'm not  
4 necessarily so concerned about the behavioral  
5 health carve-out with regard to explaining why  
6 this measure hasn't improved given that the  
7 bulk of prescriptions for ADHD occur in the  
8 primary care setting, and the health plans  
9 would have those data to report. So I'm not  
10 sure that that really is something that makes  
11 sense here.

12 The other question I have, and this  
13 might -- it is a question and it might be  
14 better for when we talk about the  
15 specifications. But in the numerator  
16 statement, where does ADHD have to be on the  
17 list of diagnoses that go onto a claim? Can  
18 it be anywhere in that list or does it have to  
19 be the primary diagnosis? Because often ADHD  
20 will be addressed in the context of other  
21 issues that the child is coming in to see the  
22 primary care provider for. That is a question

1 and I'm not able to tease that out from the  
2 description in the numerator.

3 MS. HUDSON SCHOLLE: It's not  
4 actually required at all. It's the medication  
5 alone that gets the child in the denominator.  
6 So we don't look for the diagnosis, we just  
7 look for the use --

8 MS. DOEBBELING: I -- okay. So then  
9 any visit for any reason by any provider in  
10 the 30 days or the nine months counts by any  
11 prescribing provider?

12 MS. HUDSON SCHOLLE: Okay. So we're  
13 not looking for the diagnosis for the -- it's  
14 the medication management is what we're  
15 looking for in the visit, not the diagnosis.

16 CO-CHAIR BRISS: So with that we'll  
17 work our way around the table. So starting  
18 with Mike.

19 MEMBER LARDIERI: Yeah, I guess my  
20 question is around the same area and I may  
21 need clarification.

22 So it's the follow-up visit with --



1 is with any prescriber? It says any  
2 practitioner. So have you found that the --  
3 especially with people churning in and out of  
4 plans, it might start with a psychiatrist and  
5 then go to a medical provider and not really  
6 have any follow-up because they didn't do any  
7 medication reconciliation and that kind of  
8 stuff. So how does that play out in the  
9 measure?

10 MS. HUDSON SCHOLLE: Actually, I  
11 think we made a mistake. It looks like it's a  
12 principal diagnosis, a principal mental health  
13 diagnosis. We're just not trying to be  
14 specific about the ADHD given that the -- that  
15 children, this can be combined.

16 We say -- let's see -- the  
17 denominator details -- I'm looking at the  
18 numerator details. Hold on.

19 (Pause.)

20 MS. HUDSON SCHOLLE: And do you have  
21 the value sets?

22 MS. FRANKLIN: We'll get back to

1       you. I want to hear --

2               CO-CHAIR BRISS: Yeah, let's  
3       continue the discussion and you can come back  
4       when you've found it.

5               And were you done, Mike?

6               MEMBER LARDIERI: Yes.

7               CO-CHAIR BRISS: Vanita.

8       MEMBER PINDOLIA: So this question comes from  
9       -- so I work with a health plan with multiple  
10      providers and then I work with our provider  
11      and an ACO for multiple health plans. And  
12      trying to improve this measure has been a  
13      great struggle.

14              And one of the comments I have is,  
15      you know, to understand really the data of  
16      having that follow-up visit within 30 days  
17      being so critical to demonstrate an  
18      improvement in medication management for these  
19      drugs. That is very difficult to get parents  
20      to come in for a second copay within 30 days.  
21      It's just -- and that's with providers'  
22      inputs, from multiple stakeholders on that

1 side with different health plans. So I think  
2 that might be why that number, if you look, is  
3 even lower than your long-term, which usually  
4 is the other way around for other measures.

5 The second part is understanding the  
6 complexity of when these patients are going  
7 through to school and if they were diagnosed  
8 in March but then in summer they take off the  
9 drug and then they resume in September, does  
10 that continuation and breakup count as the  
11 three-month has to occur in July or August  
12 when they're technically off the pill? But if  
13 you do it continuous throughout the year, in  
14 September they got their fill again. So the  
15 health plans and the physicians feel they get  
16 dinked but they didn't really need to see that  
17 patient in July. That decision was done at  
18 the end of the school year.

19 MS. HUDSON SCHOLLE: So the  
20 prescription carries over the summertime but  
21 they're not actually taking it even though  
22 they have the prescription? But would they

1     get a new prescription filled? Because we're  
2     looking at the prescription fill has to cover  
3     the 210 days.

4             MEMBER PINDOLIA: So the summer is  
5     only the three months. So within that 210  
6     days there will be a prescription at the start  
7     of that phase, and the end of the phase, so  
8     they get included into the denominator.  
9     However, we have a very difficult time getting  
10    a office copay within 30 days. But then  
11    looking at that three-month or that six-month,  
12    if that lands in that summer period there's no  
13    parent or doctor that feels it's a necessity  
14    to even have that visit. So that makes it  
15    really difficult to understand where we're  
16    missing the holes. Is it the three -- is it  
17    because of the summer months?                     So I have  
18    some concerns about the measure of them, how  
19    much it's really improving quality.

20            MS. HUDSON SCHOLLE: Okay.

21            MEMBER ROBINSON BEALE: I'm going to  
22    comment as a system administrator and from a

1 health plan perspective. While I do  
2 understand the complication and I do think the  
3 issue of the summertime medication-free issue  
4 really needs to be taken in consideration,  
5 it's complicated because in different states  
6 they have different types of rotation for  
7 children being off. So I'm not sure if that's  
8 doable or feasible, but I agree that it's a  
9 very important piece.

10 I look at this measure not as an  
11 improvement measure, I look at it as two  
12 things. One is an accountability measure and  
13 a measure of medication safety. What you're  
14 actually measuring is whether or not someone  
15 who's prescribed a stimulant for a child has  
16 actually followed them up. And when I look at  
17 it from that perspective, that's a very  
18 important issue that I think deals with  
19 patient safety but also the accountability of  
20 a provider who's actually prescribed a drug  
21 for a child.

22 So when I look at it that way, it's

1 a very important significant measure because  
2 we know of so many children who are placed on  
3 medications, don't need to be on medications  
4 and are never followed up.

5 The issue of the timeframe of the 30  
6 days, I think we're unfortunately trapped with  
7 the guidelines which is no better than  
8 offering the 30 days. And I respect that NCQA  
9 does abide by the guidelines that are put out  
10 there. It does raise a question as to whether  
11 or not the guidelines have actually looked at  
12 the incidence of side effects and when they  
13 occur and when they need to be reviewed. It  
14 might be helpful to take a look at the fallout  
15 in your second measurement in terms of office  
16 visit to determine whether or not you're  
17 getting a fallout because, one, the population  
18 may have had side effects but there's been no  
19 -- there's 30 days before they're followed up  
20 and so the parent and the child just stop and  
21 they just don't come in. So that's a  
22 complicating factor that could, in some way,

1       defeat the purpose of this being a medication  
2       safety and an accountability measure.

3               The other thing that I wanted to say  
4       is that this is also an indicator measure.  
5       It's an indicator of the strength of the  
6       system to be able to foster that kind of  
7       follow-up. I hear what you're saying about  
8       the copayments. Copayments are a big problem  
9       across the board and they're particularly a  
10      problem for behavioral health in terms of the  
11      copayments being, despite parity, still in  
12      some ways causing more problems in terms of  
13      higher dollar amounts. And particularly for  
14      something that may require -- in most states  
15      they do require that the prescription be  
16      rewritten in 30 days, and so that's a  
17      consistent schedule that one has to shell out  
18      dollars for the copayment. But to me, that's  
19      a plan issue and that's not an issue of  
20      measuring the accountability of a prescriber  
21      and the medication safety.

22              CO-CHAIR BRISS: There are lots of

1 cards up. And so I encourage us to be as  
2 efficient as possible with this time.

3 MEMBER EINZIG: So I'll try and be  
4 brief.

5 I think this is similar to the  
6 previous measure where you're putting multiple  
7 factors into one. Reasonable to have regular  
8 follow-up visits to ensure quality and safety  
9 but the question of that is that 30-day mark  
10 for me. And the lack of evidence to say that  
11 that necessarily improves outcome, I think  
12 that's missing.

13 I reviewed the AAP practice  
14 guidelines and I didn't see anything in there  
15 for one-month follow-up. In the AACAP,  
16 practice parameter, American Academy of Child  
17 and Adolescent Psychiatry. One of the last  
18 statements in the summary, I'll just repeat it  
19 word for word, "although this parameter does  
20 not seek to set a formula for the method of  
21 follow-up, significant contact with the  
22 clinician should typically occur two to four



1 times per year in cases of uncomplicated ADHD  
2 and up to weekly sessions at times of severe  
3 dysfunction or complications from treatments.  
4 Nothing in this parameter should be construed  
5 as justification for limiting clinician  
6 contact by third-party payers or for regarding  
7 more limited contact by the clinician as  
8 substandard when clinical evidence documents  
9 that the patient is functioning well."

10 So in other words, perhaps regular  
11 follow-up visits are a good indicator of  
12 quality but I think it's inappropriate to say  
13 that if a patient doesn't follow up with a  
14 prescribing provider in the first 30 days,  
15 that that necessarily assumes that is poor  
16 quality.

17 The other comment I would have is in  
18 this world that we're moving more towards  
19 collaborative care models or shared care  
20 models, if the psychologist is down the hall  
21 there's going to be frequent dialog with the  
22 prescriber and the psychologist. Or if a

1     psychiatrist does the initial prescription and  
2     then the kid with cancer has a follow-up with  
3     a hematologist/oncologist a few weeks down the  
4     road, gets their vital signs and no cardiac  
5     concerns at that visit, does that necessitate  
6     a follow-up with the psychiatrist to make sure  
7     that things are safe?

8             And one final comment, I'm trying to  
9     be brief, nobody knows the patient and  
10    families better than the clinician, it's all  
11    about the relationship. So for -- just to  
12    make it real-world, so I see families with  
13    several kids with autism, not necessarily ADHD  
14    but prescribing similar medications to help  
15    with their impulsive reactivity. They have  
16    developmental issues and they don't like  
17    change and don't like being taken out of  
18    school. And so -- and you know this family  
19    well because you see multiple kids in their  
20    family. That might be a specific example  
21    where follow-up might not be clinically  
22    indicated in the first month.

1 I can go on but I'll stop.

2 CO-CHAIR BRISS: Thank you.

3 So again, either lots of -- to the  
4 extent that there are concerns about this  
5 measure, they seem to center around the  
6 specifics of the follow-up that's being  
7 recommended, that it's a -- I'd encourage us  
8 to -- there's still a lot of cards up there.  
9 I'd encourage us to be brief, to continue to  
10 try to be brief and to try to raise issues if  
11 they're new issues.

12 MEMBER CHALK: I want to echo what  
13 Ron just said about this measure. I think as  
14 it's identified as a follow-up, a follow-up  
15 measure, I think that that's a misnomer. I  
16 think it's a medication management measure.  
17 I think it's a safety measure. And I think  
18 it's -- I think that makes every difference in  
19 the world in terms of how we think about it  
20 here. And I'll leave it at that.

21 MEMBER TRANGLE: I think my comments  
22 were actually already covered. They were

1 about behavioral health home and how do you  
2 sort of factor in efficiencies with still  
3 accountability. I would like at least to ask  
4 the developers to think about how can you  
5 incorporate internet or video, kind of working  
6 with a care manager in the clinic and not  
7 always seeing a prescriber every visit so that  
8 you can capture.

9 MEMBER SUSMAN: And from the primary  
10 care side as we're moving to medical homes  
11 that are fully integrated that are using a  
12 diversity of personnel and staffing, having a  
13 visit frankly in this condition, particularly,  
14 has pretty little purpose. I mean, you can go  
15 through a symptom checklist and ask about side  
16 effects from a nurse or someone else in the  
17 office, do it in a much, I think, more  
18 futuristic approach to these chronic  
19 conditions. So I think the underlying basis  
20 for this measure is more historical rather  
21 than forward thinking. And better systems  
22 could be penalized by integrating behavioral

1 healthcare more broadly.

2 MEMBER MARK: I had a question about  
3 the specification of the medications defined  
4 as ADHD meds on page 12. Like clonidine, is  
5 that a indicated use for ADHD or is that off-  
6 label?

7 MS. HUDSON SCHOLLE: Yes.

8 MEMBER MARK: It's -- I'm not a  
9 clinician, I just --

10 MEMBER EINZIG: May I? Generic  
11 clonidine technically is off-label. The new  
12 version of it, Kapvay, which is the extended  
13 release is FDA approved. The reason for that  
14 is historical, that clonidine is generic and  
15 nobody was going to make money off of doing  
16 studies on it. But it is commonly used as an  
17 ADHD medicine.

18 CO-CHAIR BRISS: Mike, do you still  
19 -- do you want to have a last word?

20 MEMBER LARDIERI: Ask Caroline.

21 CO-CHAIR BRISS: Oh, and Caroline.

22 I'll give Caroline the last word. I'm sorry,

1 David.

2 MEMBER DOEBBELING: Thanks.

3 I'm still not clear again about the  
4 specifications because as I read them it is  
5 for any practitioner with prescribing  
6 authority within 30 days after the earliest  
7 prescription of dispensing the new ADHD  
8 medication which means that it's not  
9 necessarily, I think, the prescriber who  
10 started the medication doing that follow-up  
11 visit. It would appear that it could be any  
12 prescriber in any of the intensive outpatient  
13 settings or other outpatient settings. So I'm  
14 not sure that it even gets to any of the  
15 comments about this is a safety measure or  
16 this is an adherence measure because it may  
17 not even be the same person doing the follow-  
18 up or the same clinic doing the follow-up.

19 MS. HUDSON SCHOLLE: And that is --  
20 we did confirm, that is true. It is the  
21 prescriber. Again, we're limited to what we  
22 can capture from the claims data and being

1     able to limit it back to the original  
2     prescriber in the claims. It turns out to be  
3     tricky, who'da thunk. But so I did want to  
4     point that out that and I appreciate the  
5     discussion about this is an outdated measure  
6     and we should be thinking about when other  
7     kinds of visits should count and other kinds  
8     of team-based approaches to care and how we  
9     should do that.

10           I'd point out that this initial --  
11     for this measure, if plans are able to track  
12     those kinds of visits, track telephone calls,  
13     again they have to be with the prescriber.  
14     But if they had those data systems that  
15     allowed that then a telephone contact with a  
16     prescriber will count for the maintenance  
17     phase of the measure. But we still have that  
18     30-day, it needs to be a face-to-face for that  
19     initiation. Again, you know, the research --  
20     that this measure was developed based on the  
21     research that weekly visits and it was just  
22     standard in the research trials that showed

1     that ADHD medications were effective, looked  
2     at follow-up every week.

3             Now since that time, the guidelines  
4     have changed a little bit and have loosened,  
5     but we're still looking at children that are  
6     getting their -- you know, a new episode and  
7     so that's why we've kept that 30-day phase and  
8     it is face-to-face.

9             CO-CHAIR BRISS:  So I want to get to  
10    the end of this discussion soon.  I know I've  
11    let this go for a while because it's -- it  
12    seems to me that the importance of the measure  
13    sort of hinges on the -- whether the details  
14    of this specifically describe follow-up is  
15    going to result in better outcomes for these  
16    kids.  But I do want to get to the end of  
17    this.  So please, if you have new things that  
18    haven't been touched on already, quickly make  
19    those points.  And otherwise, I'm going to --  
20    Bonnie?

21            MEMBER ZIMA:  Peter, you -- talking  
22    about specifications reliability now, which is



1 the evidence.

2 CO-CHAIR BRISS: No, we're talking  
3 about importance to measure.

4 MEMBER ZIMA: Okay.

5 MEMBER PINDOLIA: So for a measure  
6 that's been out already for three or six years  
7 and was developed in one way, is this a time  
8 that we can make a recommendation because of  
9 how practice has changed? And is that part of  
10 that process or no, we can't?

11 CO-CHAIR BRISS: You can. You're  
12 voting on the importance to measure of this  
13 measure as of today. It doesn't have to  
14 influence you if it's been out before.

15 Harold? My co-chair isn't helping  
16 me here.

17 CO-CHAIR PINCUS: Yeah. I just want  
18 to -- I want to just -- because I think I'm --  
19 I'm worried about our discussion of importance  
20 affecting all of the future discussions of  
21 importance. And I think just we need to  
22 separate out all the other criteria from

1 importance. And it's the importance of  
2 measuring this concept so that if -- is it  
3 worth pursuing? Is it important enough to  
4 pursue a measure on this concept, you know,  
5 beyond this specific measure? But the concept  
6 of assessing, you know, whatever this measure  
7 is intended to assess as a concept. You know,  
8 not the specifications.

9       So if all the specifications were  
10 perfect, would it still be important to look  
11 at this? I think that otherwise, when we  
12 discuss importance we're discussing  
13 everything. It's like, oh, you can't capture  
14 it, it's impractical to capture -- you know,  
15 there's no evidence about this. And otherwise  
16 it becomes a gemish. And so that this is --  
17 it sort of separate out this concept of  
18 importance for this measurement concept. And  
19 without regard to this specific measure but  
20 just so we can keep saying as we go through  
21 this.

22       CO-CHAIR BRISS: So with that, I'd

1 love to take it to a vote. And so importance  
2 to measure, please.

3 MS. BAL: So the first thing we'll  
4 be voting on is 18, evidence. And then the  
5 choices are one high, two moderate, three low,  
6 four insufficient evidence, five insufficient  
7 evidence with exception. And you can vote  
8 now.

9 (Brief pause.)

10 MEMBER SUSMAN: By the way, what  
11 does insufficient evidence with exception  
12 mean? I'm not voting that way but I'm not  
13 even sure I know what that means.

14 MS. FRANKLIN: That would -- this is  
15 Angela. That would mean that you found that  
16 the evidence presented was not support -- was  
17 not supportive of the measure but you felt  
18 like it was important enough to make an  
19 exception. And if you look at your algorithm  
20 you would have to go through an analysis  
21 starting in box ten of whether there were  
22 other measures out there that could be --

1 (Laughter.)

2 MS. FRANKLIN: I know, we're trying  
3 to be very formal about this. So you would  
4 want to look at this algorithm steps to make  
5 that exception.

6 MS. BAL: Okay. So the results are  
7 for evidence of 0108, it's high seven,  
8 moderate nine, low five, insufficient evidence  
9 one, insufficient evidence with exception  
10 zero. And we'll move forward with this  
11 measure.

12 CO-CHAIR BRISS: So with that we'll  
13 move to reliability and validity.

14 MS. BAL: Actually we'll move to  
15 gap. Yes. So we'll move to gap, and again  
16 the options are one high, two moderate, three  
17 low, four insufficient, and voting is now  
18 open.

19 (Brief pause.)

20 MS. BAL: Okay. So for performance  
21 gap for 0108 the results are high nine,  
22 moderate eleven, low one, insufficient one.

1 And we'll move forward to high priority. And  
2 again the options are one high, two moderate,  
3 three low, fourth insufficient. And we can  
4 start voting now.

5 (Brief pause.)

6 MS. BAL: And also we're looking for  
7 22 votes for this round, so everyone's aware.

8 (Brief pause.)

9 MS. BAL: All the votes are in,  
10 we're just waiting for Caroline now.

11 (Brief pause.)

12 MS. BAL: Okay. The results for  
13 high priority for 0108 is high twelve,  
14 moderate seven, low three, insufficient zero.  
15 And we'll move forward and now we can speak.

16 CO-CHAIR BRISS: And now reliability  
17 and validity. And we did tee up many of these  
18 issues in the first discussion. So David,  
19 will you tee this up first?

20 MEMBER EINZIG: Yes. So again I'm  
21 not a statistician, I'll do the best I can to  
22 talk about reliability. So this is a measure

1 from the healthcare plan level, healthcare  
2 claims looking at prescriptions being filled.  
3 As a group I think the majority of us did  
4 find, you know, it was reliable, other than  
5 the -- perhaps the dropout rate, the summer  
6 issues, kids being off medications in summers  
7 and whatnot. I'm not sure if any other folks  
8 from the committee have other things to say  
9 about reliability then we can move on to  
10 validity.

11 MEMBER ZIMA: So I was Reviewer 2 on  
12 this and as far as some -- a few issues, one  
13 is that during the CNM phase in the  
14 specifications, a telephone visit is -- can be  
15 counted as one of the follow-up visits. And  
16 when you look at sort of the fine print in  
17 this, the rationale is that within the Academy  
18 guidelines the method of contact is not stated  
19 and that's what's stated on page 25.

20 However you know, I think you had  
21 made a comment earlier, Dr. Susman, about  
22 that, you know, maybe it was okay to just have

1     somebody just get parent rating scales and not  
2     have that face-to-face. But I would argue,  
3     actually in clinical practice you actually  
4     have to lay eyes on the child and you should  
5     interview him to assess med safety and  
6     efficacy because there are times where parents  
7     actually aren't good informants. We're  
8     working with very distressed parents and  
9     sometimes you really do need to see the child.

10           The other issue is that the  
11     implication of accepting a telephone visit is  
12     that a health plan may have an acceptable pass  
13     rate but children with med side effects or  
14     ineffective medication treatment could be  
15     under-detected with that telephone visit. So  
16     I think that frankly when I looked at the  
17     Academy guidelines, they didn't specify face-  
18     to-face but I think the assumption on the  
19     folks that created the practice parameter was  
20     that it was a face-to-face contact.

21           So, and then the issue of  
22     reliability, I think -- and you see these in

1 a number of the NCQA measures, and that's  
2 because it is a claims data so they're using  
3 a beta binomial method which is basically  
4 detecting the extent of variance due to a  
5 health plan compared to measurement error. And  
6 so what you'll see is that, you know, when  
7 they did the cross check between commercial  
8 and Medicaid, the average binomial wheel went  
9 up under Medicaid. But I was wondering  
10 frankly if this is because SCS was held  
11 constant?

12 And then I think, you know,  
13 throughout the day we'll be talking about  
14 whether the approach of face validity based on  
15 an advisory panel is adequate, and then also  
16 you'll see in the construct validity where  
17 they looked at the correlation of the measure  
18 with access to primary care. And that made  
19 sense. And actually I was kind of surprised  
20 because I thought, since access was required  
21 in the measure, you would have had an even  
22 higher correlation coefficient but it was only



1 point-four. So I think those are my comments  
2 on specification reliability.

3 CO-CHAIR BRISS: Sarah, thank you.  
4 And again we've teed up several of the  
5 reliability and validity issues in the  
6 previous discussion. Are there other things  
7 that haven't been raised that the committee  
8 wants to hash out?

9 Yes?

10 MEMBER GOLDSTEIN GRUMET: So I just  
11 want to reiterate what you said because I  
12 think my concern is, by doing a review of the  
13 chart or the records, you don't actually know  
14 what they're assessing and asking. And so  
15 it's a concern that you're actually assessing  
16 the quality of that interaction and whether  
17 that actually means the child's getting better  
18 because there's inconsistencies across  
19 providers. So to me, a better measure is  
20 somehow reviewing the chart to see what  
21 exactly was asked or some kind of -- and I  
22 mean, this is a different question, but

1     ensuring some kind of a measure that actually  
2     provides the list of questions or some  
3     questionnaire. I just get concerned that this  
4     doesn't -- this shows that they're taking  
5     their medication potentially but it doesn't  
6     actually show from provider to provider what  
7     that -- what the interaction is like.

8             MEMBER SUSMAN: I'm just getting a  
9     little concerned that we're holding ourselves  
10    or the developers and measurers to a very,  
11    very high standard. While I am the first to  
12    have shot holes in some of these measures I  
13    also think that at the end of the day we  
14    should ask, are these measures valid and  
15    reliable enough to move here forward in a  
16    positive direction. And you know, in some  
17    cases I think we may not have ties directly to  
18    the ultimate outcomes or all the nuances that  
19    we might wish. On the other hand, if it  
20    starts us down a causal pathway of improvement  
21    I think there's a lot of positives to that.

22             And I've looked at depression in our

1 sort of movement in the depression world from  
2 sort of measuring did we ask about it, did we  
3 measure it? Now we're finally getting to,  
4 hopefully, outcomes and improvement. I think  
5 we're probably in the same way in a lot of  
6 behavioral health fields moving from a  
7 incidence prevalence measures to looking at  
8 improvement and ultimately looking at outcomes  
9 that are long term.

10 MEMBER MARK: For me, I think part  
11 of the calculus here again is what's the harm  
12 of, you know, maybe erring on the side of  
13 something that's not perfectly reliable in  
14 validity. In contrast to the other measure I  
15 don't feel that there's as much harm here if  
16 we have not perfect reliability and validity.  
17 And maybe people want to counter that  
18 perception.

19 MEMBER PATING: I'm really just  
20 trying to look at the evidence. And with  
21 regards to the one-month indicator and the  
22 reliability of that, I mean, it's fine to have

1 a consensus panel driving, you know, some  
2 practices. But what I'm very, very concerned  
3 is that these practice -- these measures are  
4 getting so specific and they've really  
5 substituted in many systems for clinical  
6 judgment that is not just like a quality  
7 outcome, you're driving real practice such  
8 that these measures actually supplant the --  
9 what is the prescribed care paths or even, you  
10 know, what an individual clinician wants to  
11 do. Because there's a whole systemic weight  
12 and quality measures and performance outcomes  
13 and incentive bonuses that are just -- that  
14 are tied to these measures and they're not  
15 insignificant. So it would be fine to  
16 say this is a general direction we want to go  
17 but now we're saying everybody across the  
18 nation has to have a follow-up in 30 days and  
19 there's no evidence except a consensus panel  
20 that was basing it on we don't know what.

21 So I just really want to be -- I'm  
22 actually going the opposite direction, Jeff,

1 as being hyper cautious because I'm seeing the  
2 multiplying effect of this at the grassroots  
3 level as very profound. Clinicians are just  
4 under -- this is affecting their pay if they  
5 don't do this, and they're going to do it  
6 because, you know, hook or crook, regardless  
7 of whether the patient wants to come in at 30  
8 days or it's clinically indicated, whether  
9 there's an extra cost, that's how -- that's  
10 the strength that these indicators are  
11 gathering.

12 CO-CHAIR BRISS: Necessarily  
13 quickly, I'd like to move down this row and up  
14 the other one and then let's -- so let's try  
15 and be efficient and get to -- Larry?

16 MEMBER MILLER: Yeah, I think we're  
17 having the discussion looking at this as an  
18 outcome measure and it's not, it's a process  
19 measure. It simply raises awareness that kids  
20 who are on these medications need to be  
21 followed up. And I think that's a very good  
22 beginning, I think that this is a very

1 important issue to look at and I'd just like  
2 to keep us in mind of that.

3 CO-CHAIR BRISS: David?

4 MEMBER EINZIG: So I think nobody's  
5 arguing that follow-up is important but it's  
6 the evidence behind -- we're asking to be --  
7 speak to the quality of two things. Follow-up  
8 within one month and a couple additional  
9 follow-ups in the subsequent nine months. And  
10 you know, same thing as the first measure,  
11 it's just that question of is it, you know,  
12 one vote for all measures when half of it  
13 might not be applicable.

14 And also just kind of going back, it  
15 wasn't too long ago that with anti-depressant  
16 medications the recommendation was we follow  
17 up with the prescribing provider within the  
18 first month and then every two weeks in the  
19 second month and that backfired. You know,  
20 people stopped prescribing anti-depressions  
21 and suicide rates went up. You know, there  
22 may or may not be a direct correlation.

1           So I really want to stand strong on,  
2           you know, is there evidence to say the 30-day  
3           mark, is there sufficient evidence with that?

4           MEMBER ROBINSON BEALE: Yeah, I do  
5           think all the things that have been said are  
6           very, very important. I do think it brings  
7           for NQF to have an opportunity to compile a  
8           list of questions that need to be answered by  
9           those who are developing guidelines in terms  
10          of really the evidence as it relates to the  
11          timeframe for certain things.

12          I realize NCQA uses the guidelines  
13          and tries to make the best out of the  
14          guidelines but let's go back to where the  
15          problem may be and that's the lack of  
16          specificity. And particularly with behavioral  
17          health, they are very non-specific. And so I  
18          do think there's a very strong message that  
19          needs to go back to say there are specific  
20          things that are needed in order to really  
21          drive good measurement, drive good clinical  
22          judgment. And I think without that

1       specificity we're continuously driving the  
2       system in a very non-specific and invalid way.

3               CO-CHAIR BRISS:   Bonnie?

4               MEMBER ZIMA:   Yeah, I just want to  
5       get back to the issue of do no harm.   And I  
6       think that I continue to be concerned  
7       particularly with just a telephone visit  
8       counted as one of those follow-up visits and  
9       having only two follow-up visits in nine  
10      months with a child on a Class II medication,  
11      some of the harm is that you can continue a  
12      child on a medication that's ineffective or  
13      you aren't detecting med side effects.

14              CO-CHAIR BRISS:   And the last word.

15              MEMBER MAZON JEFFERS:   The last  
16      word, huh?   I just wanted to go back to what  
17      David pointed out.   And I have no doubt that  
18      increasingly quality measures are being used  
19      at the grassroot levels to set payment and  
20      performance.   But if you think about what  
21      quality measures are really supposed to do,  
22      this measure in particular as it's looking at



1 system-wide performance, it actually sounds  
2 like it is already doing some of the things  
3 that it set out to do. So the observations  
4 that you made that the copay is a hindrance to  
5 a 30-day follow-up visit, these are really  
6 important systems that, by applying the  
7 measure, you have learned as a system.

8 And similarly the issue of the  
9 summer experience is also something that the  
10 quality measure has diagnosed, if you will,  
11 about the system of care that needs attention.  
12 So if we think about the purpose of quality  
13 improvement measures, it is driving the  
14 quality of care of the system when it's used  
15 at a system-wide and not necessarily, of  
16 course, there will be individuals for whom a  
17 30-day follow-up visit would not be clinically  
18 indicated. But my guess is they might be in  
19 the minority and outliers rather than the main  
20 -- the mean.

21 DR. PIERCE: Hi, it's Karen Pierce  
22 and I didn't know I'm in the middle but I

1       didn't know my line wasn't on. I've been  
2       listening.

3               I'm a child psychiatrist and let me  
4       tell you my concerns about -- behavioral  
5       health measures are really very hard to --

6               MS. FRANKLIN: Excuse me --

7               DR. PIERCE: Yeah?

8               MS. FRANKLIN: Who's speaking?

9               DR. PIERCE: Karen Pierce, I'm a  
10      child psychiatrist.

11              MS. FRANKLIN: Okay, thank you.

12              DR. PIERCE: I helped develop these  
13      measurements a bit ago.

14              I want to add that developing  
15      behavioral health measurements is -- we're  
16      nowhere near the level that we are in the  
17      medical level.

18              MS. FRANKLIN: Excuse me, ma'am,  
19      we're not having public comment at this time.

20              DR. PIERCE: I understand. But the  
21      issue you have is about 30 days --

22              MS. FRANKLIN: Kathy, could you

1     please say -- let us know when we have a  
2     comment?

3             Okay, I'm sorry, this is not the  
4     measure that you were a developer for. I'm  
5     sorry.

6             DR. PIERCE: Okay.

7             MS. FRANKLIN: We're looking right  
8     now at the NCQA measure.

9             DR. PIERCE: Right. Okay.

10            MS. FRANKLIN: And we're getting  
11     ready to vote as a committee. Thanks.

12            MS. BAL: All right. So we'll be  
13     voting for reliability. The options are one  
14     high, two moderate, three low, four  
15     insufficient and voting is now open.

16            (Brief pause.)

17            MS. BAL: Okay. So we have for  
18     reliability for 0108, high one, moderate  
19     fourteen, low four, insufficient three. And  
20     we can move forward with this measure to  
21     validity.

22            And we're ready to vote for this.

1       So the voting for validity is now open for  
2       0108. Again the options are one high, two  
3       moderate, three low, four insufficient.

4               (Brief pause.)

5               MS. BAL: Okay. So the results for  
6       validity for 0108 is high two, moderate  
7       fourteen, low four, insufficient three, and we  
8       can move forward with this measure to  
9       feasibility.

10              (Brief pause.)

11              MEMBER EINZIG: Okay. Feasibility,  
12       so data collection is from the healthcare  
13       plans. I don't think there were any issues --  
14       I'll keep it brief, I don't think there were  
15       any issues with the feasibility.

16              CO-CHAIR BRISS: That was mercifully  
17       brief. Thank you.

18              (Laughter.)

19              CO-CHAIR BRISS: Bonnie, anything to  
20       add?

21              MEMBER ZIMA: No comment.

22              CO-CHAIR BRISS: So any -- we have

1 had some feasibility discussion already.

2 Anybody want to make further comments that  
3 haven't already been made?

4 (No response.)

5 CO-CHAIR BRISS: Maybe it's a  
6 positive thing to be moving toward break. So  
7 let's move to voting.

8 MS. BAL: Okay. The voting for  
9 feasibility is now open. Again, the options  
10 are one high, two moderate, three low, four  
11 insufficient.

12 (Brief pause.)

13 MS. BAL: Okay. The results for  
14 feasibility 0108 is high eight, moderate  
15 fourteen, low one, insufficient zero, and  
16 we'll move forward to usability.

17 CO-CHAIR BRISS: So I think the last  
18 conversation -- we've already had a lot of  
19 conversation on usability so just to sort of  
20 highlight some of the issues and concerns.  
21 Some of David's comments about using this as  
22 a quality measure, data collection when there

1     may be lack of evidence to say that it truly  
2     does improve quality of care, lack of evidence  
3     behind the specific timelines of when follow-  
4     ups should occur. So again I think everybody  
5     agrees follow-up, regular follow-up is  
6     important and necessary, it improves quality.  
7     I think the issue has to do with standardizing  
8     care to one-size-fits-all model versus meeting  
9     the individual's needs for that particular  
10    child and family.

11           Bonnie, do you have anything to add?

12           MEMBER ZIMA: No, no additional  
13    comments.

14           MEMBER MILLER: I'm sorry, I just  
15    want to quote one of the comments, I think  
16    it's a useful comment.

17           "Although this parameter does not  
18    seek to set a formula for the method of  
19    follow-up, significant contact with a  
20    clinician should typically occur two to four  
21    times per year in cases of uncomplicated ADHD  
22    and weekly sessions at times of severe

1 dysfunction or complications. Nothing in this  
2 parameter should be misconstrued as a  
3 justification for limiting clinician contact  
4 by third-party payers or for regarding more  
5 limited contact by the clinician as  
6 substandard when clinical evidence documents  
7 that the patient is functioning well."

8 CO-CHAIR BRISS: So any further  
9 comments?

10 (No response.)

11 CO-CHAIR BRISS: Hearing none, let's  
12 move to a vote.

13 MS. BAL: Okay. The vote for  
14 usability and use is now open. The options  
15 are one high, two moderate, three low, four  
16 insufficient.

17 (Brief pause.)

18 MS. BAL: Okay. The results are,  
19 for usability and use for 0108 is high four,  
20 moderate thirteen, low six, insufficient zero,  
21 and we will move forward.

22 Do you want to go ahead straight

1       into the vote or do you want to have  
2       discussion first?

3               CO-CHAIR BRISS:   So any further  
4       discussion before we do an overall suitability  
5       vote?

6               (No response.)

7               CO-CHAIR BRISS:   Hearing none.

8               MS. BAL:   Okay.   voting is now over  
9       -- not over -- open for overall suitability.  
10      The options are one, yes; two, no.   Again, the  
11      options are one, yes; two, no.

12              (Brief pause.)

13              MS. BAL:   If everybody could just  
14      vote one more time?   We're missing one vote.  
15      The number is now 23.   Okay, perfect.   Thank  
16      you.

17              All right.   So for overall  
18      suitability for 0108, we have yes, seventeen;  
19      no, six.   So this measure is recommended.

20              CO-CHAIR BRISS:   Thank you all.

21              We're slightly behind.   We'll take a  
22      10-minute instead of a 15-minute break.   And



1 I'd like to encourage us to be back seated and  
2 be ready to go in ten.

3 (Whereupon, the above-entitled  
4 matter went off the record at 11:21 a.m. and  
5 resumed at 11:33 a.m.)

6 CO-CHAIR BRISS: So please be  
7 seated. And while people are seating  
8 themselves maybe -- we've had several new  
9 people join us and so maybe we can do some  
10 additional introductions.

11 CO-CHAIR PINCUS: Let's everybody  
12 get seated.

13 So there's a couple of people that  
14 we wanted to ask to introduce themselves.  
15 Les, if you could introduce yourself?

16 MEMBER ZUN: Good morning. Do you  
17 want me to give any background?

18 CO-CHAIR PINCUS: Please give just  
19 your background.

20 MEMBER ZUN: I'm the token emergency  
21 physician in the group, I believe, but I am  
22 kind of an oddball in that I actually am very

1       interested in behavioral emergencies. I've  
2       been doing research in behavioral emergencies,  
3       wrote a textbook on behavioral emergencies, do  
4       a conference every year on -- or I do a  
5       conference on behavioral emergencies every  
6       year. And I'm the president elect of the  
7       American Association for Emergency Psychiatry  
8       and I also sit on the Board of the American  
9       Academy of Emergency Medicine, and we're a new  
10      organization member. Thank you.

11           CO-CHAIR PINCUS: Is somebody on the  
12      phone?

13           (No response.)

14           CO-CHAIR BRISS: Helen Burstin has  
15      joined us.

16           DR. BURSTIN: Yes.

17           CO-CHAIR BRISS: Helen, would you  
18      run to the table and introduce, please?

19           DR. BURSTIN: Apologies for being  
20      late.

21           I'm Helen Burstin, I'm the Chief  
22      Scientific Officer here at NQF. Thank you

1 all, for many of you returning again to this  
2 committee and for some new faces as well.  
3 Thank you to join us in this very, very  
4 important ask. Thanks.

5 CO-CHAIR PINCUS: Committee member  
6 on the phone?

7 MEMBER DOEBBELING: Yes, I'm still  
8 on.

9 CO-CHAIR PINCUS: Everyone wonders  
10 if you got a chance to introduce yourself.

11 MEMBER DOEBBELING: I did earlier,  
12 thank you, Harold.

13 CO-CHAIR PINCUS: Okay. Good.

14 Now we're going to address measure  
15 1365 and it's a -- the measure developer is  
16 the AMAPCPI group. And so Kendra, do you want  
17 to introduce it?

18 #1365: Child and Adolescent MDD: Suicide  
19 Risk Assessment (PCPI)

20 MS. TIERNEY: Hi, everybody, and  
21 thank you for the opportunity to be here and  
22 present to you. I'm Sam Tierney, I'm with the

1 AMAPCPI in our measure development group and  
2 I'm here with my colleague Kenra Hanley who's  
3 in our measures classifications group. We  
4 have several people on the phone as well as  
5 Dr. Pierce who is a child and adolescent  
6 psychiatrist who helped us in the development  
7 of the measure.

8         So just by way of background, I  
9 wanted to explain a little bit about how the  
10 process that we used to develop the measure,  
11 just so you have a sense of the rigor that's  
12 involved in our process. The measure was  
13 developed in late 2007 as part of a set of  
14 measures for child and adolescent MDD.  
15 Together with the Child Psychiatric  
16 Association and the American Academy of Child  
17 and Adolescent Psychiatry the AMA convened  
18 physician consortium for performance  
19 improvement or PCPI, it's a mouthful. We  
20 formed a workgroup to identify and define  
21 quality measures toward improving outcomes for  
22 patients with child and adolescent major

1 depressive disorder.

2 The workgroup included a cross  
3 specialty, multi-disciplinary workgroup of key  
4 stakeholders representing a variety of  
5 disciplines; general and child and adolescent  
6 psychiatry, pediatrics, family medicine,  
7 internal medicine, emergency medicine, we had  
8 some government representatives as well and  
9 health policy folks.

10 The workgroup was charged with  
11 developing measures with the strong clinical  
12 evidence-base and based on areas that they  
13 felt there was a need for performance  
14 improvement. The measures were well vetted by  
15 a diverse group of stakeholders through a  
16 public comment process which was the community  
17 enabled comment process and we also submitted  
18 them for approval to the PCPI membership which  
19 is a broad group of medical and state  
20 specialty societies as well as other quality  
21 organizations.

22 So we feel that this measure

1 addresses a high-impact topic area. We noted  
2 some things on our form but if I could just  
3 highlight a few of them to start the review of  
4 the measure. MDD is a debilitating condition  
5 that has been increasingly recognized among  
6 youth, particularly adolescents. The  
7 prevalence of current or recent depression  
8 among children is three percent and among  
9 adolescents is six percent. The lifetime  
10 prevalence of MDD among adolescents may be as  
11 high as 20 percent.

12 Research has shown that patients  
13 with major depressive disorder are at a high  
14 risk for suicide attempts and completion.  
15 Suicide is the fourth leading cause of death  
16 among all youth and young adults between the  
17 ages of 10 and 24 years, accounting for 15  
18 percent of all mortality in that age range.  
19 We think that suicide risk, and others as  
20 well, and guidelines have felt that suicide  
21 risk is a critical consideration for this  
22 patient population and it's important that it

1 be assessed at every visit. Suicide risk  
2 assessment can help to ensure that early  
3 detection of those ideations, referral and  
4 treatment for patients at high risk of  
5 suicidal behaviors.

6 We have data in the forms that  
7 indicate that there is a significant  
8 opportunity for improvement although it might  
9 seem like this is a routine part of care. And  
10 we believe that the importance of the  
11 assessments for suicide risk is really  
12 underscored by research that indicates that  
13 many individuals who die by suicide have made  
14 contact with primary care and mental health  
15 care providers recently before their death.

16 Just a little bit about the measure.  
17 The measure has been selected for use in  
18 several national programs. It is in the  
19 Meaningful Use CHR Incentive Program and also  
20 in the Physician Quality Reporting System.

21 So with that, we look forward to  
22 your discussion. Thank you.

1 CO-CHAIR PINCUS: Bernadette, do you  
2 want to summarize the comments specifically  
3 with regard to importance? Now I -- just to  
4 clarify, I'd like, going forward, that when we  
5 talk about importance we don't talk about  
6 everything, okay? So really what we're  
7 talking about when we're talking about  
8 importance, we're talking about the idea of  
9 measuring this kind of -- within this kind of  
10 focus. Irrespective of this specific measure  
11 and its performance characteristics, is it  
12 important to measure and assess screening for  
13 suicidality among individuals who are  
14 depressed? That's the concept, the focus of  
15 this measure, and so we're looking at the  
16 importance to measuring report about this  
17 concept. We're not talking specifically about  
18 these measures' specifications, okay?

19 MS. MELNYK: So related to that  
20 concisely, our subgroup believes that this is  
21 a very important measure in terms of taking up  
22 suicidal risk. The one area of concern by our



1       workgroup members was the -- that there was a  
2       feeling that the evidence that specifically  
3       supports the premise that conducting a risk  
4       assessment reduces suicide attempts was not  
5       presented.

6               And the second point dealing with  
7       importance is the group question going down to  
8       the age of six when most children do not  
9       develop death as final and irreversible until  
10      eight to nine years of age. But otherwise  
11      than that, people believed this was an  
12      incredibly important measure.

13             CO-CHAIR PINCUS: Other comments  
14      from people around the table?

15             (No response.)

16             CO-CHAIR PINCUS: So does the  
17      measure developer have any sort of response to  
18      the two issues that Bernadette raised?

19             MS. TIERNEY: Sure. I have a  
20      colleague on the phone, Toni? I wonder if you  
21      could speak to the two issues that have been  
22      raised? And also Dr. Pierce, if you're still

1 on we'd be happy to have your comments as  
2 well.

3 DR. PIERCE: The issue, they may not  
4 have a concept of death but it's still  
5 something that can be verbalized and not  
6 understood about the finality of death. And  
7 so I think it's important that they're  
8 surveyed as much as anybody else is surveyed  
9 around death and the risk around that. So  
10 age, you're right about the understanding but  
11 you still can die if you're depressed.

12 CO-CHAIR PINCUS: I guess just --

13 MS. KAYE: This is Toni with the  
14 PCPI, are you able to hear me?

15 CO-CHAIR PINCUS: Yes.

16 MS. KAYE: I guess I'd also like to  
17 supplement what Dr. Pierce said regarding the  
18 choice of age range. We chose to go down to  
19 the age of six in part because the guidelines  
20 from the Academy of Child and Adolescent  
21 Psychologists, they did specify that the  
22 recommendations did apply to both children and

1 adolescents. And so to kind of support that  
2 we did find a 2013 cohort study by Rohde, et  
3 al, that showed in their cohort of 815  
4 participants, five percent had their first  
5 incidence of MDD between the ages of five and  
6 twelve within that younger, and they were  
7 scattered somewhat homogeneously throughout  
8 that age range, so it wasn't all twelve-year-  
9 olds. It did happen. There was incidence at  
10 younger ages as well. So we felt that  
11 justified having a suicide risk assessment as  
12 part of their MDD treatment.

13 CO-CHAIR PINCUS: What about the  
14 second issue that was raised with regard to  
15 the, sort of, the proximal relationship  
16 between screening and outcomes?

17 MS. KAYE: Hi, this is Toni again.

18 So regarding the relation to  
19 outcome, I agree it can be tough to directly  
20 link screening to suicide rates, either  
21 completion or attempts, due to -- even though  
22 it's an important area. In order to have

1       enough incidence of that to statistically  
2       significantly link the two can be tricky.  
3       However, we did find there was a study from  
4       2010 that showed they had clinics, they did  
5       intervention to increase the screening rate  
6       and then they looked at the impact on the  
7       detection of suicidal ideations and the rates  
8       of referral. And both of them, they more than  
9       doubled the referral rate, the detection rate  
10      of ideations just through increased screening.

11             And so I would propose that those  
12      are equally important outcomes that do have  
13      some more evidence and are more proximal to  
14      the screening which would be appropriate  
15      identification of risk, referral where  
16      appropriate or treatment as needed.

17             MS. TIERNEY: And this is Sam, if I  
18      could also add to what Toni said.

19             There was -- you're probably all  
20      maybe familiar with the USPSTF statement on  
21      screening for suicide risk in adolescents and  
22      adults in primary care, which was certainly a

1 different population than this measure. But  
2 in their review and when they spoke about the  
3 effectiveness of early detection in screening  
4 they really emphasized the fact that  
5 treatment, particularly psychotherapy, has  
6 been shown to have an effect, a positive  
7 effect on suicide attempts.

8           So I don't know if the data  
9 specifically around a reduction -- screening  
10 alone having a reduction of attempts is  
11 available but it seems like, based on the  
12 USPSTF review that there's clearly a link  
13 between the treatment and decreased attempts.  
14 And the screening would lead to increased  
15 treatment.

16           CO-CHAIR PINCUS: And I guess just  
17 going back to, I guess, something Tami brought  
18 up earlier, at an earlier point, is there any  
19 evidence to bear on one side or the other with  
20 regard to any kind of negative side effects of  
21 screening?

22           DR. PIERCE: I don't know of any

1 data that says it's negative. I think that's  
2 been the myth. I only see that it's been  
3 positive.

4 CO-CHAIR PINCUS: I've seen a couple  
5 of fairly rigorous reviews in this area and  
6 it's hard to find evidence for asking about  
7 suicides or a suicide.

8 DR. PIERCE: Yeah.

9 CO-CHAIR PINCUS: Any other  
10 comments, questions by the committee?

11 CO-CHAIR BRISS: I guess the other  
12 issue that is -- that this measure raises is  
13 the non-standardized assessment. So it's a  
14 bit of a checkbox measure. And so --

15 CO-CHAIR PINCUS: But that's getting  
16 into specifications.

17 CO-CHAIR BRISS: Except that it gets  
18 to the question of is this worth measuring,  
19 right? And so it's -- the question is sort of  
20 are all assessments created equal and is a  
21 checkbox measure enough?

22 DR. PIERCE: My sense is that it's

1 best to be asking and I think we need to be  
2 asking, and I think it's important to be  
3 asking about suicide. And so checkbox is what  
4 we've got right now and so I think that's  
5 where we have to start.

6 CO-CHAIR PINCUS: Any other  
7 comments, questions?

8 (No response.)

9 CO-CHAIR PINCUS: Okay. So I think  
10 we're ready to vote on importance.

11 MS. BAL: Okay. Voting is now open  
12 for evidence for 1365. And the options are  
13 one high, two moderate, three low, four  
14 insufficient, five insufficient evidence with  
15 exception.

16 (Brief pause.)

17 MS. BAL: Okay. The results for  
18 evidence for 1365 is high eighteen, moderate  
19 seven, low zero, insufficient evidence zero,  
20 insufficient evidence with exception zero.  
21 And we will move on to the next vote which is  
22 performance gap.

1           MEMBER MELNYK: The committee felt  
2           there was a great opportunity because there is  
3           a performance gap. There is a lot of  
4           variability that exists. And that variability  
5           also concerns, there's no standard criteria or  
6           a standardized tool for assessment that people  
7           use.

8           CO-CHAIR PINCUS: Okay. Ready to  
9           vote?

10          MS. BAL: Okay. Voting is now open  
11          for performance gap. The options are one  
12          high, two moderate, three low, four  
13          insufficient. And we're looking for 25 votes.

14                   (Brief pause.)

15          MS. BAL: Okay. The results for  
16          performance gap for 1365 are high eighteen,  
17          moderate six, low one, insufficient zero. And  
18          we'll move forward to priority.

19          MEMBER MELNYK: So we'll move on to  
20          the --

21          CO-CHAIR PINCUS: Yes, are there any  
22          comments about priority?



1 (No response.)

2 CO-CHAIR PINCUS: Okay. I think  
3 going forward, we'd like to take each of the  
4 categories sort of as a group and then -- you  
5 know, for discussion and then come back to the  
6 voting, you know, boom, boom, boom, okay?

7 MS. BAL: Okay. Voting is now open  
8 for high priority. And the options are one  
9 high, two moderate, three low, four  
10 insufficient.

11 (Brief pause.)

12 MS. BAL: Okay. The results for high  
13 priority for 1365 are high twenty-one,  
14 moderate four, low zero, insufficient zero,  
15 and we will move forward.

16 CO-CHAIR PINCUS: Great. So now  
17 we're going to move to scientific  
18 acceptability. And so Bernadette and Bonnie,  
19 could you sort of walk through all of the  
20 components of scientific and then --

21 MEMBER MELNYK: Sure. So face  
22 validity was assessed with an 18-member expert

1 panel who responded to one question. Eighty-  
2 nine percent of the expert panel agreed or  
3 strongly disagreed that the measure can  
4 accurately distinguish between good and poor  
5 quality. In terms of reliability the measure  
6 actually -- psychometric property for  
7 reliability is based on pilot testing of the  
8 measure. One hundred and one charts were  
9 pulled from three practice sites. There were  
10 two observers who came to the majority of  
11 agreement, 96 percent based on the denominator  
12 and 75 percent based on the numerator for the  
13 reliability.

14 That was where the concern of the  
15 workgroup came in. So the workgroup expressed  
16 concerns, we didn't know how those 101 charts  
17 were pulled. Were they randomly sampled or  
18 how were they selected?

19 Two, the workgroup had a concern  
20 about the measure requiring a minimum of two  
21 encounters within the measurement period  
22 before a patient is included in the

1 denominator. And they questioned whether one  
2 visit is more appropriate in the management of  
3 individuals with MDD.

4 The last concern was about  
5 variability in the way in which providers  
6 assessed this and that potentially use of a  
7 standardized tool would help that situation  
8 more. Bonnie, you may have other comments.

9 MEMBER ZIMA: Yes, I think just to  
10 add anything additional, on the specifications  
11 what's interesting is the way suicide risk is  
12 operationalized. And it's a little bit  
13 different than how suicide risk is  
14 operationalized in the NCQA measures.

15 And in this measure it includes  
16 identification of specific psychiatric  
17 symptoms such as psychosis, mania, substance  
18 abuse and, quote, medical conditions that may  
19 increase the likelihood of acting on suicidal  
20 ideation. And so the implications are  
21 twofold. One is that typically in a standard  
22 psychiatric evaluation, you do rule in and

1 rule out things like psychosis, depression,  
2 substance abuse and medical conditions. So  
3 the implication of having that clause is that  
4 you might overestimate suicide risk in this  
5 measure.

6 The other issue almost bordering on  
7 feasibility but I'll mention it here because  
8 it's related to specifications. And that is  
9 that, how do you operationally define, quote,  
10 medical conditions that are not -- that are  
11 going to -- may increase the likelihood of  
12 acting on suicidal ideations? So I think that  
13 in thinking about -- you know, in actually  
14 using this, how would I quantify that like in  
15 a chart, record, abstraction tool?

16 The other issue that was not  
17 mentioned yet was again with feasibility. In  
18 this -- in the materials presented, there's an  
19 assumption that all data elements are in the  
20 EHR, and that's stated under their response on  
21 3(b)1. But what's interesting is when you  
22 look at their pilot data of the 101 records,

1       there's actually 75 percent where the  
2       abstractors only agreed on the numerators. So  
3       25 percent of the time they couldn't agree on  
4       the numerator. And so I think that also kind  
5       of raises a little bit of awareness of maybe  
6       some of the difficulties in operationalizing  
7       what this suicide risk is.

8               And then the third point is, and I  
9       think it's important, is that they do disclose  
10      that there's no data on performance, despite  
11      use in federally funded programs.

12             CO-CHAIR PINCUS: Any comments from  
13      the developers?

14             MS. TIERNEY: Yes. So you've raised  
15      a number of issues so maybe if we could just  
16      deal with them individually one by one.

17             So first, I think Dr. Briss, you  
18      mentioned it earlier and you just mentioned it  
19      now about the numerator and how it's defined.  
20      So the numerator is defined loosely and I  
21      think some of the items that you are concerned  
22      about, particularly the identification of

1 specific symptoms, we actually are -- allow --  
2 we're not prescriptive with how the risk  
3 assessment needs to be completed. And we've  
4 provided some guidance based on the guidelines  
5 and what the guidelines recommend for a  
6 suicide risk assessment but that's not a  
7 requirement.

8 We also acknowledge that there is --  
9 there are standardized tools to do this and we  
10 specifically mention the Columbia Suicidal  
11 Severity Rating Scale however it's also not  
12 required. It's just one option. And so the  
13 -- some of the information you were quoting is  
14 guidance but not required by the measure.

15 And the primary reason that we  
16 followed that model is because, you know, in  
17 talking about this measure with our workgroup  
18 they felt that we didn't want to be overly  
19 prescriptive. I think someone, and I'm not  
20 sure who, when I was sitting in the peanut  
21 gallery, I overheard someone over here mention  
22 sort of a concern about, you know, quote-

1 unquote cookbook medicine or overly describing  
2 the way such assessments need to take place.  
3 And so we felt that it was appropriate to  
4 leave it up to the individual practitioner and  
5 based on the needs of the individual patient,  
6 the type of assessment that's conducted. So  
7 that I think addresses -- at least that's our  
8 perspective on the numerator statement.

9 I know you had some other questions  
10 about the feasibility and the ability to  
11 capture the data in an electronic health  
12 record which I think Kendra could probably  
13 speak to better.

14 MS. HANLEY: I think that our pilot  
15 testing experience shows that it can be  
16 captured in a variety of different ways. And  
17 what we provide, especially because this is a  
18 measure that has been implemented in national  
19 programs, is a standardized way in which to  
20 report the data. You know, we can't actually  
21 provide a specification that could be tailored  
22 to every individual EHR out there so hopefully

1       that will address the issue about the presence  
2       of the data in the EHRs. It's really up to  
3       each individual site to tailor their workflow  
4       and then use the standardized terminologies to  
5       report the data.

6               And then to the issue about the  
7       requirement of two encounters for the  
8       denominator, you know, that's something that  
9       is a standardized approach that we've taken at  
10      the PCPI when we're looking at a measure for  
11      a chronic condition. It establishes a level  
12      of accountability for that individual  
13      physician. It's not to say that you should  
14      only assess suicide if you know you're going  
15      to see the patient more than twice in the  
16      year, you should really be doing that at every  
17      visit. But for purposes of actually  
18      calculating the measure and reporting on the  
19      performance rate, we do require that minimum  
20      of two visits. So that's kind of the  
21      background and rationale around that approach.

22              CO-CHAIR PINCUS: So just to



1 clarify, so where do I find the actual  
2 specifications that are used for determining  
3 the numerator?

4 MS. HANLEY: So we attached the  
5 eMeasure zip file with the submission form.  
6 I would ask the NQF staff if they could help  
7 point the committee members.

8 CO-CHAIR PINCUS: Is this only an  
9 eMeasure or is it also --

10 MS. HANLEY: It's only an eMeasure.

11 MS. BAL: Yes, so that would be in  
12 SharePoint. Let me just --

13 CO-CHAIR PINCUS: My thinking is  
14 that would be useful for us to just see what  
15 the specifications are.

16 MEMBER ZIMA: You know, because I  
17 think when we talked about it in the  
18 workgroup, you know, we totally got it that,  
19 you know, that you were adapting something  
20 that was already used for other chronic  
21 medical conditions. But I think what came up  
22 in the discussion in the workgroup was that

1     what varied on this one compared to let's just  
2     say monitoring hypertension is the higher risk  
3     of lethality. And that's sort of what got the  
4     workgroup a little bit more concerned.

5             MS. HANLEY: You know, I think this  
6     is something that in its current state, this  
7     is how the measure is implemented. It's  
8     something that we can certainly take back and  
9     consider for future updates. It's a minor  
10    update that could be made so we certainly hear  
11    the concern about that requirement.

12            CO-CHAIR PINCUS: While we're  
13    waiting for them, somebody to bring up the  
14    specifications on this -- on the screen, why  
15    don't we go around and ask for comments. I  
16    see Mady and I see Bob. Other people who have  
17    comments?

18            Mady?

19            MEMBER CHALK: I just have a couple  
20    of questions.

21            One, is there more than one  
22    standardized tool for suicide risk assessment?

1 DR. PIERCE: There's one that's been  
2 more studied than others and that's the  
3 Columbia Scale. But there are others out  
4 there that other health plans use.

5 MEMBER CHALK: The reason I ask the  
6 question is that it's my recollection that in  
7 many of the screening measures that have come  
8 through this committee before, the big issue  
9 has become, oh, you should be using a  
10 standardized tool of some sort. I mean, we  
11 have four or five when we talk about screening  
12 for substance use disorders. They are  
13 standardized.

14 So this measure we're saying, oh, it  
15 doesn't matter and that concerns me. That's  
16 number one, apparently.

17 The other question I have is about  
18 EHR specification. Was this tested in three  
19 EHRs as is NQF's current statement about other  
20 measures?

21 MS. HANLEY: So thank you for that  
22 question.

1           It was tested in three EHRs and I  
2       would ask my colleague Meredith Jones who is  
3       on the phone to maybe provide a little more  
4       detail about the three different testing  
5       sites.

6           MS. JONES: Hi, good afternoon -- or  
7       good morning, everyone. Meredith Jones.  
8       Thanks, Kendra.

9           This measure was tested at three  
10      different EHRs, at three different sites  
11      representing different geographic locations  
12      across the country. They used three different  
13      EHRs. All of the sites were able to  
14      successfully implement the measure's  
15      specifications that were provided to them.  
16      Some sites did use the PHQ-9 as their  
17      validated tool and other sites used -- the two  
18      other ones used the Columbia Suicidal Severity  
19      Risk Rating Scale.

20           When the measures were implemented  
21      at each site, they did have a conversation  
22      after changes were made to the EHR, the

1 programmer and the physician champions had  
2 conversations with the clinicians who were  
3 going to be documenting moving forward using  
4 this measure in the EHR kind of talking about  
5 the workflow and what they would be doing.  
6 And once all the clinicians got together, they  
7 all successfully were able to report on the  
8 measure and have since been using the measure  
9 since 2012 in their EHR.

10 MS. HANLEY: Thanks, Meredith.

11 MS. JONES: Thank you.

12 MS. HANLEY: And Poonam is -- if I  
13 can just explain the EHR specification that is  
14 being displayed, this is the standard HQMF  
15 eMeasure format which is an HL-7 standard for  
16 representing a quality measure specification.  
17 This is the format that all measures included  
18 in the meaningful use program are presented in  
19 and it adheres to all the national standards  
20 that have been adopted for representing  
21 quality measures for electronic data sources.  
22 There's a top part which explains

1     some background about the measure; it's called  
2     the header. And then if you scroll down --

3             CO-CHAIR PINCUS: Where is that on  
4     here?

5             MS. BAL: It's on the SharePoint  
6     site. If you go to --

7             CO-CHAIR PINCUS: Right. But are  
8     you able to bring it up so that we can all see  
9     it?

10            MS. BAL: It's brought up. It's on  
11     -- that's the document in front of you.

12            CO-CHAIR PINCUS: I'm looking at it  
13     but I don't see anything that has  
14     specifications.

15            MS. HANLEY: So the top part is the  
16     measure header which includes who developed  
17     it, the measure description --

18            CO-CHAIR PINCUS: Right.

19            MS. HANLEY: -- the language, the  
20     exclusions, the exceptions. If you scroll  
21     down to the population criteria, this is where  
22     each of the data elements are listed.

1 CO-CHAIR PINCUS: Right. And so can  
2 we see the data elements for the numerators?

3 MS. HANLEY: Sure. So it's  
4 identified as an intervention performed  
5 suicide risk assessment. That data element  
6 maps to a SNOMED concept for suicide risk  
7 assessment which again is consistent with our  
8 more open, less prescriptive approach to what  
9 we require for reporting.

10 CO-CHAIR PINCUS: So what terms are  
11 included under that?

12 MS. HANLEY: Let me get to that.

13 All of the value sets that  
14 correspond to the data elements for the  
15 eMeasures are hosted publicly by the National  
16 Library of Medicine on what's called the Value  
17 Set Authority Center. And --

18 CO-CHAIR PINCUS: Yes. But I guess  
19 my concern is that, you know, we're sort of  
20 like buying a pig in a poke. You know, we need  
21 to be able to see what those terms are so we  
22 know what's being specified.

1 MS. HANLEY: So it is one -- it's  
2 one SNOMED concept from the procedure  
3 hierarchy, and the concept description is  
4 suicide risk assessment.

5 CO-CHAIR PINCUS: And so I'm not an  
6 informatician.

7 MS. HANLEY: Sure.

8 CO-CHAIR PINCUS: So can somebody  
9 explain to me in layman's language exactly how  
10 this data is captured and what terms  
11 constitute a suicide risk assessment?

12 MS. HANLEY: So it would really rely  
13 on the individual physician stating that  
14 that's what was done. So again, that's --

15 CO-CHAIR PINCUS: So they have to  
16 use the term suicide risk assessment?

17 MS. HANLEY: The information  
18 captured in the EHR would be mapped and then  
19 reported.

20 CO-CHAIR PINCUS: Does it have to be  
21 a separate field?

22 MS. HANLEY: It could --



1 CO-CHAIR PINCUS: Do you use natural  
2 language processing or could it be a separate  
3 --

4 MS. HANLEY: It could be a separate  
5 field. It could use natural language  
6 processing.

7 CO-CHAIR PINCUS: So what terms  
8 would count?

9 MS. HANLEY: Any of those would  
10 count.

11 CO-CHAIR PINCUS: Any -- what do you  
12 mean, any of which? So if I wrote assessment,  
13 it would count?

14 MS. HANLEY: So that's where we use  
15 the guidance in the definition. So it would  
16 be in accordance with the guidance presented  
17 in the definition --

18 CO-CHAIR PINCUS: So how --

19 MS. HANLEY: -- if you meet -- and  
20 this goes back to what Sam was speaking to  
21 earlier about it, to be at the discretion of  
22 the individual clinician and specific to the

1 needs of the patient.

2 CO-CHAIR PINCUS: I'm still -- okay,  
3 Bob?

4 MEMBER ATKINS: I have the exact  
5 same concern and I'm old and don't know  
6 everything you're talking about. So let me  
7 take it back to paper records. SI equals, and  
8 have a zero and a line through it. Does that  
9 count as a suicide assessment? Suicide risk  
10 assessment? Suicidal ideation, SI, equals  
11 zero with a line through it. Would that count  
12 as the person did a good job?

13 CO-CHAIR PINCUS: No.

14 MEMBER ATKINS: That's, I think,  
15 unfortunate.

16 (Laughter.)

17 MEMBER ATKINS: Because that's not  
18 suicide risk assessment, that's a conclusion  
19 because they have on their form that they have  
20 to address whether or not the person had SI.  
21 And if suicide risk assessment is tell me  
22 about all the things that you have in your

1 verbal description where a person actually  
2 acted like a clinician, and I don't -- I'm  
3 sorry, I'm not trying to be rude, but I just  
4 -- I've looked at a lot of paper records and  
5 I would not be comfortable with what I just --  
6 when I heard that.

7 And I'll stop talking. People are  
8 starting to laugh at me, so --

9 CO-CHAIR PINCUS: No. No. I think  
10 --

11 MS. HANLEY: That's not what the  
12 definition is.

13 MEMBER CHALK: Yes, that's what I  
14 meant when I said somebody could do anything.  
15 That there isn't a requirement of the  
16 standardized tool which --

17 MEMBER ATKINS: I'm sorry, even  
18 without a standard -- I mean, I also know a  
19 lot of people aren't going to be doing a  
20 clinical interview that will address the  
21 issues that -- I'm just like a bunch of people  
22 talked about how do you assess suicide risk.

1 Any one of them is good. But -- so sort of  
2 three ways to do a good job. There's a  
3 standardized tool, there's a good clinical  
4 assessment or there's the SI equals zero. And  
5 I think the third one shouldn't count, but the  
6 first two you're saying would count. But you  
7 also -- the third one would count and that's  
8 my concern.

9 MS. TIERNEY: I think one of the  
10 challenges is that, you know, these are  
11 performance measures so we have to be able to  
12 use data and information that can be assessed  
13 in a uniform way. And so you know,  
14 specifically for an eMeasure, you know, some  
15 of the things -- how do you define a good  
16 clinical assessment? And if -- even if you do  
17 define it, let's say we defined it as our  
18 definition does, which provides some  
19 information and guidance to an implementer,  
20 are all of those things going to be things  
21 that we could code and identify data elements  
22 from an electronic health record?

1           So I mean, I think some of this  
2       speaks to just the challenges in performance  
3       measurement in general and the ability -- the  
4       need to develop measures for which data can be  
5       collected and captured and analyzed.

6           I will say just kind of more  
7       generally to your point earlier about for  
8       other screenings, we have very clearly defined  
9       systematic tools. I would say that for -- you  
10      know, we at the PCPI have developed other  
11      measures around alcohol use screening and we  
12      do refer to specific tools because I think  
13      those have been very well studied and there's  
14      a very clear evidence of their effectiveness  
15      and their utility in identifying and screening  
16      patients who are at risk.

17           I don't think that the studies have  
18      been as well conducted or as well documented  
19      for suicide screening and the USPSTF sort of  
20      references that in their recent article. And  
21      so I think it would be very difficult for us  
22      to prescribe one particular tool that may also

1 be potentially burdensome and time-intensive.  
2 I will say for tobacco screening we do not  
3 have -- we also have developed the measure  
4 that's in the meaningful use program and in  
5 widespread use and we haven't defined a  
6 particular type of tobacco screening that has  
7 to be conducted because of, you know, wanting  
8 it to be something that could be of relatively  
9 low burden. And I think if we were going to  
10 prescribe, there probably are tools for  
11 tobacco screening assessment but we have  
12 wanted to use something that could be feasible  
13 to capture and reasonable to implement.

14 CO-CHAIR PINCUS: Let me -- what I'm  
15 trying to get at is I just want clarity. I'm  
16 not taking one side or another. And so -- and  
17 to know exactly what counts and what doesn't  
18 count. If I want to implement this in my  
19 setting, is there a methodology that allows me  
20 to do that? So you know, if this definition  
21 up there is a long list of different items  
22 that you mentioned: inquiries, specific

1 inquiry about suicidal thoughts, attempt  
2 plans, means and behaviors, identification of  
3 specific psychiatric symptoms or general  
4 medical that may increase the likelihood of  
5 acting on a suicidal idea. Assessment of past  
6 and particular recent suicidal behavior,  
7 delineation of stress and potential protective  
8 factors.

9 If I did any one of those, that  
10 would count?

11 MS. TIERNEY: Yes.

12 CO-CHAIR PINCUS: So if I asked, do  
13 you have a history -- if I asked about  
14 psychosis, do you have a history of delusions  
15 or hallucinations, that would count?

16 MS. TIERNEY: So we are not  
17 prescriptive. So some of this does rely on --

18 CO-CHAIR PINCUS: Unrelated to  
19 suicide, I just asked do you -- you know, have  
20 you ever heard things that --

21 MS. TIERNEY: There is some sort of  
22 --

1 CO-CHAIR PINCUS: I mean, no, is it  
2 yes or no, would that count?

3 MS. TIERNEY: So I guess you could  
4 say this with any measures, right? Because --  
5 (Laughter.)

6 MS. TIERNEY: -- there is -- yes,  
7 there is - I mean, I think that with  
8 performance measures in general the issue of  
9 gaming comes up. You know, oh, I could just  
10 check this box and I haven't actually done  
11 what I said I was going to do by what the  
12 measure prescribes, but I check the box and so  
13 it counts.

14 So I think most of the studies that  
15 I'm familiar with that have kind of assessed  
16 gaming in general with performance measures  
17 have --

18 CO-CHAIR PINCUS: I actually wasn't  
19 asking about gaming. I was trying to see if  
20 -- I wanted to do this, but I have to sort of  
21 program, you know, ask the people sort of in  
22 my informatics group to program it to count



1       somebody asking about hallucinations or  
2       delusions independent of any issue around  
3       suicide.

4               MS. HANLEY: I mean, the general  
5       medical conditions that are described are  
6       examples of things that may increase the  
7       likelihood. So I would say asking about  
8       hallucinations, that would not count because  
9       that's not asking about suicide and what --

10              CO-CHAIR PINCUS: But I guess you  
11       would say that, but is there any way that I --  
12       I mean, how would I --

13              MEMBER LARDIERI: Could I jump in  
14       for a minute?

15              CO-CHAIR PINCUS: Yeah.

16              MEMBER LARDIERI: Because I live in  
17       the EHR world so in order to do this, Harold,  
18       I don't think you're going to be searching the  
19       EHR for each one of these things. What you're  
20       going to do, the provider is going to do what  
21       they do, ask one or all of these things and  
22       then there's going to be a check box that is

1 going to say suicide risk assessment. They're  
2 going to check that, then that gets correlated  
3 to the SNOMED code that then says yes, he is.

4 CO-CHAIR PINCUS: So what you're  
5 saying, that there has to be a field?

6 MEMBER LARDIERI: There will be a  
7 field, the checkbox in the EHR.

8 CO-CHAIR PINCUS: Again, I'm not --  
9 I'm just trying to -- my understanding is that  
10 it doesn't have to be a field.

11 MEMBER LARDIERI: There's no way you  
12 could do without having a field unless you can  
13 do a language processing against this stuff.  
14 And you're not -- we're not there yet, unless  
15 you use a Watson.

16 CO-CHAIR BRISS: I think we may  
17 have established -- at this point, it seems to  
18 me that we've established that there's some  
19 potential looseness in the definition. I  
20 think we ought to move on, right?

21 CO-CHAIR PINCUS: Yes. And I guess  
22 the other point here is, are we really doing

1 a risk assessment or are we just asking about  
2 ideation? And I think that the state of the  
3 art of the evidence and what we have to grade  
4 risk and accurately predict, particularly  
5 given the relatively low incidence, not  
6 trivial obviously. But I mean, to really do  
7 the study and to be able to look at varied  
8 ways of assessing risk and then looking at  
9 attempted and completed suicide is a study  
10 that I don't think has been done in a broad  
11 approach to assess what are the relative ways  
12 one can assess suicidality and its predictive  
13 ability over time.

14 Let's -- people have their hands up  
15 or their cards up, so Julie, Tami, Mike and  
16 David.

17 MEMBER GOLDSTEIN GRUMET: So I think  
18 one of the things that I'm -- I was struggling  
19 with is what you said, is this about doing a  
20 screening tool or doing a risk assessment?  
21 Because there needs to be a screening tool in  
22 place which is not necessarily the same as

1       assessment. Is the person with major  
2       depressive disorder having thoughts of  
3       suicide, period, and there are many tools  
4       available that function as screeners. And  
5       that's -- that piece seems to be missing.

6               I agree that the whole argument  
7       about this, you know, list, which is an  
8       assessment, is the next step after a person is  
9       deemed at risk. And there are standardized  
10      screeners and you could provide a list of  
11      standardized screeners.

12             My other concern a little bit is  
13      that we're limiting it to major depression.  
14      And in kids, often it's anxiety and it's  
15      psychosis, substance abuse. So I wonder why  
16      we're not including them as well. I want this  
17      tool, I really -- you know, I really believe  
18      it's very important that kids are assessed for  
19      suicide risk when they're struggling with  
20      mental health issues. But I think it should  
21      be broader and I think providers need a lot  
22      more guidance because I think they're not

1 going to know how to ask these questions and  
2 we're going to struggle with a lot of  
3 providers saying you're not thinking of  
4 killing yourself, right? And we know how  
5 inappropriate that is.

6 (Inaudible comments.)

7 MEMBER GOLDSTEIN GRUMET: Well, but  
8 I think that's what we know, is that providers  
9 do and they don't know -- they're not trained  
10 well which -- you know. But I think we need  
11 to give a little bit more guidance and also  
12 clarify, is it screening or is it risk  
13 assessment? And both should happen.

14 CO-CHAIR PINCUS: Tami?

15 MEMBER MARK: Moving a little from  
16 the discussion of how prescriptive the  
17 numerator is or should be to how statistical  
18 the denominator is. Do you have  
19 specifications for MDD and are those required  
20 as part of this use of this measure? Are you  
21 able to put those up, too?

22 MS. HANLEY: So the denominator is

1 specified through diagnosis of major  
2 depressive disorder and the value sets for  
3 those are specified in ICD-9, ICD-10 and  
4 SNOMED. I don't know if Poonam has access to  
5 the VSAC. I have them on my screen but --

6 CO-CHAIR PINCUS: Okay. While  
7 they're bringing it up, Mike?

8 MEMBER TRANGLE: You know, I have  
9 some questions just about inter-rater  
10 reliability which kind of merge with  
11 feasibility. So the concerns sort of center  
12 around there are 102 patients that were part  
13 of this background thing in three different  
14 locations, you know, one being a physician-  
15 owned practice, two sites, one being a  
16 community mental health center and third one  
17 was sort of a more primary care center. And  
18 I'm quite concerned as to if you extrapolate  
19 this to the real world, and maybe this was  
20 real world versus kind of places than we're  
21 used to doing research and weren't like family  
22 practice docs, 20-minute visits putting

1 everything in, you know, I'm interested in how  
2 the uptake in the utilization and reliability  
3 vary between the three different sites. Do  
4 you see what I'm asking?

5 I have an intuition saying a busy  
6 community mental health center with  
7 practitioners that aren't used to doing  
8 research are not necessarily going to get into  
9 this, you know? Same thing with family  
10 practice. And I'm just kind of wondering  
11 about, you know, vary from sites -- are there  
12 hints in the mental health world that may play  
13 out better than in primary care or vice versa?

14 MS. TIERNEY: I'm going to ask  
15 Meredith. I don't know if you can speak to  
16 the testing project at all, and specific to  
17 the question. I don't know if that was  
18 assessed.

19 MS. JONES: Yes. So it's a part of  
20 the PCPI testing methodology to report one  
21 kappa score among the sites to demonstrate  
22 reliability. If you're interested in looking

1 at the final results from each site based on  
2 the number of charts pulled from each site we  
3 can certainly provide you that information.

4 I will reiterate what I said earlier  
5 and it kind of gets back to the conversation  
6 we've been having, is that suicide risk  
7 assessment was implemented into the EHR in a  
8 structured field. So it was, you know, like  
9 a checkbox, it wasn't something that was  
10 living in an open form or unstructured field.  
11 The sites each were able to implement the data  
12 elements in the measure that you're seeing on  
13 the specification in structured fields. But  
14 back to the point, if you would like to see  
15 the final results and the differences amongst  
16 the sites, we can provide that information to  
17 you.

18 MS. HANLEY: So it sounds like the  
19 question was more looking at how does this  
20 actually get implemented in real life, in an  
21 everyday clinical scenario. These were sites  
22 that were willing to help us test the measure,



1 to test the scientific properties of the  
2 measure. I think we'll see as broad  
3 implementation and uptake of this measure  
4 progresses, you know, at that point we'll be  
5 able to have more feedback at how it actually  
6 -- how sites have adapted to incorporating  
7 this measure.

8 MEMBER ZIMA: I just wanted to  
9 follow up on that question. I don't think  
10 they had the statistical power to test across  
11 the three sites, and only 15 records were  
12 contributed from the community mental health  
13 center.

14 And the other thing, too, which  
15 continues to be a question from the workgroup  
16 is the sampling of those three sites. Because  
17 one site was a very large extensive network of  
18 health centers; one was one private practice  
19 with two locations, a suburban location and  
20 urban, so I'm assuming the provider was one,  
21 right? And then we had CMHC. So I -- that's  
22 what I wanted to say.

1 MS. JONES: There were two practice  
2 family -- two physicians from site B, the  
3 second site.

4 MEMBER ZIMA: Okay. Fair enough.

5 MEMBER EINZIG: So giving clinical  
6 perspective here, what we do in our clinic is  
7 we ask the question, are you suicidal. And  
8 before they see us in clinic they fill out a  
9 sheet and on the sheet it asks about suicidal  
10 thoughts or any safety concerns.

11 So thinking simplistically, big  
12 picture, clinical perspective, what we're  
13 trying to do is we're trying to prevent  
14 suicide. That's what this measure is about.  
15 And raising awareness, asking the question.

16 There's plenty of screening tools  
17 for depression and then, you know, I remember  
18 reading an old study that if you ask the  
19 simple question are you depressed, they're  
20 going to answer yes or no. That just has the  
21 effect -- just as valid as any depression  
22 screening tool out there. So if you ask the

1 question, you know, I think that's reasonable  
2 to say that that's -- what we're trying to do  
3 is we're trying to make -- measure the quality  
4 of clinics in asking about suicide and  
5 preventing suicide. So if it's as  
6 straightforward as documenting that with no  
7 suicidal ideation reported or no safety  
8 concerns, I think that's reasonable and valid.

9 CO-CHAIR BRISS: Yes, that's what I  
10 -- it's going to give us more primary care  
11 perspective. I think that we could move the  
12 ball forward significantly by encouraging  
13 people to ask that question. I'm reasonably  
14 comfortable with a simple checkbox in this  
15 context, given where the field likely is, and  
16 I just wanted to validate what Bonnie said.  
17 I that this is an important enough issue that  
18 the usual chronic disease rules at PCPI  
19 shouldn't apply and I think one -- this ought  
20 to be enough.

21 CO-CHAIR PINCUS: Actually I'd like  
22 to sort of step out of the Chair role and just

1     make a concern in that we're doing this as an  
2     accountability measure. I mean, because  
3     that's -- you know. So we are placing on the  
4     same level of accountability -- and I'm  
5     thinking about this because it -- in our  
6     hospital we're actually implementing the  
7     Columbia Suicide screening tool. And we are  
8     sort of encountering some issues in  
9     implementing it because it's -- if you look on  
10    our inpatient settings there is an extensive  
11    suicide assessment that's already in place.  
12    And this is sort of on top of that.

13           And so on the one hand, you know, we  
14    have sort of that issue of people feeling sort  
15    of an additional burden, on -- but also, you  
16    know, we are really, you know, taking this  
17    very seriously and we're really running a  
18    full-scale suicide assessment either -- you  
19    know, either a very complete one as we have  
20    sort of traditionally done, or the Columbia  
21    one. Yet we are going to be compared -- which  
22    comprised a considerable amount of effort in

1 implementation. And we're going to be  
2 compared with other practices that all they  
3 have to do is have, you know, SI equals zero.

4 And it seems to me that there is an  
5 imbalance there as an accountable --  
6 accountability measure. And so that it's not  
7 just an issue of consciousness raising, but  
8 it's -- you know, if there's going to be skin  
9 in the game on these kind of things, it seems  
10 to me there should be a standardized level of  
11 expectation.

12 People raise their hands who -- just  
13 do people want to -- Jeff?

14 MEMBER SUSMAN: I just was going to  
15 say that, at least in my experience in looking  
16 at what people in primary care are actually  
17 doing in our research, actually observing  
18 encounters with depressed patients, this is a  
19 really woeful state of current practice. My  
20 belief is that in most primary care settings  
21 where this isn't a particular focus, that  
22 suicidality is not assessed in any form most

1 of the time, in fact, the vast majority of the  
2 time, which I think is a real problem.

3 There are lots of issues with this  
4 measure, I get that, and I agree, Harold, you  
5 could be unfortunately compared to the person  
6 who just checks the box. But I think the  
7 greater good here is that we're starting to  
8 measure this and to look at it and that it  
9 will be on health system screens. So I'd say  
10 let's not let the good enough, you know, stand  
11 in the way of making some progress here,  
12 recognizing that there are clearly some issues  
13 with this.

14 MEMBER MARK: Does anyone know the  
15 frequency of MDD in primary care as opposed to  
16 the question NOS? I mean, I'm concerned that  
17 maybe the sample size that we have in these  
18 facilities is so small as to not be  
19 meaningful. And I guess, you know, in terms  
20 of your point about, you know, weighing,  
21 comparing, specialty facilities to primary  
22 care facilities, you know, again if they're

1     such a little sample, you know, how useful is  
2     this measure going to be? As opposed to maybe  
3     for specialty centers, okay, you have enough  
4     to be useful. But in primary care settings  
5     where it sounds like we're really trying to  
6     make a difference, the denominator may be too  
7     small to be useful, to make this a useful  
8     measure.

9             MS. JONES: Hi, this is Meredith  
10     Jones again.

11            I just want to share a little bit  
12     more about the PCPI methodology. I'm not sure  
13     since our last conversation if you've been  
14     able to read a couple months old document  
15     which we sent to NQF staff about the  
16     testing/sampling methodology we use. We use  
17     the Donner Eliasziw kappa sample by population  
18     to determine appropriate baseline number of  
19     charts to abstract for each measure.

20            This approach we use uses the two-  
21     tailed test to determine significant sample  
22     sizes, we practice this in each measure

1 testing project. We use a value of the  
2 expected proportion of positive ratings for a  
3 measure to be tested based on available data  
4 on average performance clinicians at each site  
5 on the measure. So for example, if the  
6 average performance would be ninety percent,  
7 the proportion of positive ratings is point-  
8 nine-oh, and we use that two-tailed test at 80  
9 percent power to detect the difference between  
10 the value of a calculated kappa, which you  
11 see, and the null value of a kappa.

12 And again, I'm not sure if you got  
13 our additional guidance and the methodology  
14 that we used but the final sample of 101 is  
15 statistically significant.

16 MS. HANLEY: This is Kendra.

17 I also just wanted to comment on the  
18 point about the relevance to this in primary  
19 care if the sample is so small.

20 We're also operating in an  
21 environment of accountability where all  
22 practitioners are in need of measures to



1 report to participate in many of these public  
2 reporting programs that are affecting their  
3 reimbursements. So it's also a measure that's  
4 very important to those mental health  
5 providers who are treating patients and do  
6 have the proper sample size.

7 CO-CHAIR PINCUS: So I think we're  
8 ready to -- Bob?

9 MEMBER ATKINS: I'm sorry. I guess  
10 one final thought.

11 To me, a lot of the issues here  
12 would be reconciled if we didn't set the bar  
13 at assessment. A lot -- some of the comments  
14 seem to be around screening. The one question  
15 I think have to ask is, SI, yes or no? That  
16 in my mind is not an assessment, it's a  
17 screening question. I think by labeling it  
18 assessment you're setting a different bar.  
19 And so if you drop the bar to screening, then  
20 doing the full clinical and the Columbia and  
21 everything else is a very rich screening tool,  
22 if you will.

1           But the one question would also  
2           count as a screener and maybe that would help.  
3           I mean, it would help me at least. I had a  
4           whole different bar in my mind until this  
5           conversation.

6           MS. HANLEY: So again, I think we'll  
7           take that feedback back and we can consider  
8           that for future updates.

9           MEMBER TRANGLE: This is a general  
10          comment that I think we should think about,  
11          not just for this measure but all measures.  
12          You know, this is a new standing committee and  
13          the point of having a standing committee is to  
14          sort of vote, say yea or nay, but also to take  
15          part in process improvement of the measures  
16          over time. And I think for everything we're  
17          talking about we may need to have a standing  
18          agenda item for, you know, we vote yea or nay  
19          but then we have recommendations for measure  
20          improvement that they'll come back to us with.

21                 And then if somebody could actually  
22                 pay attention to half or a third of our

1        comments for the measurement improvement, you  
2        know, and then summarize that for us so that  
3        somehow we could vote at the end about these  
4        are the key ones you should work on and come  
5        back to us, it would make us more efficient.

6                CO-CHAIR PINCUS:    So let's move on  
7        to voting.

8                MS. BAL:    Okay.    Voting for  
9        reliability for 1365 is now open.    And the  
10       options are one low, two moderate, three low,  
11       four insufficient.    Sorry, I said one -- I  
12       meant one high.    I was looking, I was like, I  
13       feel like I said low twice.

14                (Laughter.)

15                MS. BAL:    Okay.    The results for  
16       reliability for 1365 is high three, moderate  
17       twelve, low three, insufficient six.    And yes,  
18       we're good to go forward with the next.    And  
19       then we're -- yes, above 60 percent.    So and  
20       now the voting for validity is open.    Oh,  
21       that's odd, sorry.    Okay, now it's open.    And  
22       the options are one low -- I'm sorry, one high

1       -- one high, two moderate, three low, four  
2       insufficient. One high.

3               MS. BAL: Okay. The results are  
4       high one, moderate thirteen, low four,  
5       insufficient six. And we will move forward  
6       with this measure to feasibility.

7               It's 24 votes instead of 25 this  
8       round, and we had fourteen listed as the --  
9       give us one second.

10              Forty to sixty percent is considered  
11       consensus not reached. So we will move  
12       forward but -- we continue to move forward but  
13       --

14              (Inaudible comments.)

15              DR. BURSTIN: Yes, this is the  
16       validity.

17              MS. BAL: Yes.

18              DR. BURSTIN: We'll come back to  
19       show you the percentages on validity. So,  
20       right, so that's 58 percent in our current  
21       rules, we say that if you're in the gray zone  
22       between 40 and 60, we'll continue your

1 evaluation and maybe additional information  
2 provided by the developers you can consider  
3 afterward.

4 Sixty is to move forward, right. So  
5 this is still in the gray zone and what we do  
6 now as part of our gray zone analysis continue  
7 to move these measures forward and let you  
8 finish the analysis so you don't have to then  
9 figure out how to go backwards if you get  
10 additional information.

11 MS. BAL: So the only way we'll fail  
12 a measure is if it's less than 40 percent. If  
13 we're in between 40 and 60, it's gray zone and  
14 we'll just document that consensus was not  
15 reached on that portion of the measure and  
16 we'll move on to the next option.

17 DR. BURSTIN: We can examine the  
18 public comments that come in when we release  
19 the report.

20 MEMBER SUSMAN: Is there any  
21 pragmatic importance to us, whether it's  
22 moderate or high consistency? In other words,

1     okay, so this one had 58 percent, the other  
2     one had 66 percent. It sounds like we're just  
3     doing the same thing and ultimately we're  
4     going to vote overall and it doesn't matter.  
5     Or maybe I'm missing something?

6             CO-CHAIR BRISS: What's the  
7     practical difference between consensus not  
8     reached and consensus?

9             DR. BURSTIN: Well I mean, I think  
10    the major difference is you want to identify  
11    for the public and the membership in  
12    particular that, when they see this report and  
13    it comes out, where you, in fact, couldn't  
14    reach consensus on where there were issues.  
15    So that will be clearly labeled as consensus  
16    not reached.

17            CO-CHAIR PINCUS: So it's a matter  
18    of public --

19            DR. BURSTIN: Yes.

20            CO-CHAIR BRISS: Public transparency  
21    as opposed to --

22            CO-CHAIR PINCUS: -- communication?

1 DR. BURSTIN: And some of it is, in  
2 the work we've been doing with our board on  
3 defining consensus there was a sense that  
4 you're just kind of creeping over the 50  
5 percent line probably wasn't enough. So for  
6 now we've set the threshold at 60, this is  
7 obviously a squeaker. My suspicion is this  
8 will probably be moved forward. But we just  
9 want to make very clear to the people about  
10 the discussions you had.

11 MEMBER TRANGLE: In the end it's  
12 still listed as endorsed or not endorsed at  
13 this time?

14 DR. BURSTIN: Well you know, you're  
15 still really early in this process so it will  
16 go out for comment and you'll have an  
17 opportunity to re-engage in it and see if you  
18 want to reconsider any of these issues. So at  
19 this point we just -- we'll allow the rest of  
20 the evaluation to move forward but it will  
21 clearly go out with a note that this  
22 particular element on validity was consensus

1 not reached.

2 CO-CHAIR PINCUS: Let's move on with  
3 feasibility. So Bernadette and Bonnie?

4 MEMBER MELNYK: So not to beat a  
5 dead horse, but the concern regarding this  
6 was, again, the variability and how people  
7 assess it, and the documentation.

8 And then the second comment from the  
9 workgroup was just that the developers  
10 consider expanding the measure in the future  
11 to include persistent depression in the DSM-5  
12 as well as other comorbid conditions.

13 CO-CHAIR PINCUS: Bonnie?

14 MEMBER ZIMA: No additional unique  
15 comments.

16 CO-CHAIR PINCUS: Other comments  
17 from around the table in terms of feasibility?

18 (No response.)

19 CO-CHAIR PINCUS: Okay. So I guess  
20 we're ready to vote.

21 MS. BAL: Okay. Voting for  
22 feasibility for 1365 is now open.



1 (Brief pause.)

2 MS. BAL: And the options are one  
3 high, two moderate, three low, four  
4 insufficient.

5 (Brief pause.)

6 MS. BAL: Okay. The results are  
7 high two, moderate thirteen, low five,  
8 insufficient four. And with fifteen we will  
9 move forward.

10 CO-CHAIR PINCUS: Okay. Now  
11 comments on usability and use.

12 MEMBER MELNYK: Our workgroup noted  
13 that the measure is recently in use in several  
14 reporting programs and performance data is not  
15 yet available.

16 MEMBER ZIMA: No additional unique  
17 comments.

18 (Brief pause.)

19 CO-CHAIR PINCUS: Okay. I guess  
20 we're ready to vote.

21 Oh, Bob, do you have a comment?

22 MEMBER ATKINS: No.

1 MS. BAL: Oh, sorry. I'm just going  
2 to restart it.

3 Okay, are we ready to vote? Voting  
4 is now open for usability and use, for 1365.  
5 Options are one high, two moderate, three low,  
6 four insufficient.

7 (Brief pause.)

8 MS. BAL: And we are -- is everybody  
9 voting? We should -- we still have one more  
10 in the room that we don't have.

11 (Brief pause.)

12 MS. BAL: Yeah, we're missing one in  
13 the room. We're at 23 and we should be at 24.

14 We're good in the room. Thank you.

15 Okay. The results for usability and  
16 use for 1365 are high four, moderate ten, low  
17 five, insufficient for five. So we're in the  
18 gray zone for this measure as well but we will  
19 move forward to the final vote.

20 Would you like more discussion or  
21 just to vote?

22 CO-CHAIR PINCUS: Any further

1 discussion?

2 (No response.)

3 CO-CHAIR PINCUS: Any new or unique  
4 comments?

5 (Laughter.)

6 (No response.)

7 MS. BAL: Okay. In that case,  
8 overall suitability for endorsement is now  
9 open for voting. And the options are one,  
10 yes; two, no.

11 (Brief pause.)

12 MS. BAL: Okay. The final result  
13 for 1365 is yes fifteen, no nine. And this  
14 measure is recommended for endorsement at this  
15 point in time.

16 CO-CHAIR PINCUS: So are we ready to  
17 break for lunch?

18 MEMBER MARK: Yes, we are. I just  
19 want --

20 MS. DORIAN: No, we're not. We are  
21 actually two measures behind. Perhaps we  
22 could do the next measure, at least begin it.

1 Lunch was scheduled for 1:10 and I think  
2 that's when it will be ready. So we can at  
3 least get started on the next measure.

4 MS. BAL: I don't think it's ready,  
5 though. Oh, it's back there already? Oh,  
6 they said it would take a while. We're just  
7 going to check.

8 CO-CHAIR PINCUS: Yeah. So why  
9 don't we make it so that people bring their  
10 lunch back here and let's take -- yeah, let's  
11 keep working while we eat. So let's take ten  
12 minutes to get your lunch and bring it back.

13 (Whereupon, the above-entitled  
14 matter went off the record at 12:45 p.m. and  
15 resumed at 1:12 p.m.)

16 CO-CHAIR BRISS: So I have us at  
17 about 45 minutes or so behind and with eight  
18 measures yet to go this afternoon. So I'd  
19 sort of like us to get restarted, please. So  
20 if everybody would be seated and get ready to  
21 go, I would appreciate it.

22 So Sarah, let's do the teeing up of

1 the set and then I promise I'll give you some  
2 pauses in which to eat and reduce Helen's  
3 maternal instinct, okay?

4 MS. HUDSON SCHOLLE: Thank you,  
5 Peter.

6 CO-CHAIR BRISS: So I lied, we were  
7 remiss at the end of the morning of not asking  
8 for public and member comments so we'll do  
9 that now, please.

10 Operator, can you open up the lines  
11 for public or member comment, please?

12 (Operator speaking.)

13 OPERATOR: There are no comments at  
14 this time.

15 CO-CHAIR BRISS: Thank you.

16 And with that, NCQA.

17 Health Screening and Assessment for People  
18 with SMI

19 MS. HUDSON SCHOLLE: Hello everyone,  
20 I'm still Sarah Scholle.

21 (Laughter.)

22 VOICE: We are still the committee

1       so there's a symmetry.

2                       (Laughter.)

3               MS. HUDSON SCHOLLE:   That's nice.

4               And so actually I'll be with you for  
5       the rest of the afternoon, I think, on -- and  
6       a good part of tomorrow as well, to talk about  
7       the measures that we've developed with  
8       Mathematica Policy Research. This is under  
9       contract from the Assistant Secretary for  
10      Planning and Evaluation and the Substance  
11      Abuse and Mental Health Services  
12      Administration.

13              We actually began on this journey, I  
14      was going to say three years ago but actually  
15      more like five years ago because we started  
16      with a contract from ASPE to develop measures  
17      for people with schizophrenia and we brought  
18      those measures to this committee, I think  
19      about three years ago. Those were measures  
20      that focused on care for people with  
21      schizophrenia and whatnot that looked at both  
22      continuity band of psychotics and then also

1     care for chronic health conditions and we --  
2     in looking at -- trying to look at the  
3     healthcare for this high risk population.

4             And the committee at the time said  
5     this is a really important area and we want to  
6     encourage you to continue to work in this and  
7     to broaden the work to focus on a broader set  
8     of people, not just people with schizophrenia  
9     but others with serious mental illness. And  
10    also to consider outcome measures at the time  
11    that we were limited to claims-based measures.  
12    And so that's what we did.

13            Now in addition to the input from  
14    this committee, we also had -- we started this  
15    work by conducting eight different stakeholder  
16    focus groups to get ideas about what was  
17    important, where we should focus our attention  
18    on developing behavioral health measures. And  
19    in it -- and we heard concerns about a variety  
20    of areas that we investigated but in  
21    particular concerns about early mortality of  
22    people with serious mental illness and lack of

1 access and attention to their general medical  
2 needs. So that's -- it's from both of those  
3 areas of input that we have come to you this  
4 meeting with eleven measures that look at  
5 health screening and attention to chronic  
6 disease for people with serious mental illness  
7 and people with alcohol and drug dependence.

8 Our theory about how to approach  
9 this set of measures was to focus on areas  
10 where we knew -- where we had evidence that  
11 there was a higher prevalence of the risk  
12 factor of a condition or risk, so a condition  
13 like diabetes or a risk like obesity in the  
14 population. And also evidence that there was  
15 a disparity in access to evidence-based care.  
16 And that's how we -- we actually worked  
17 through the literature, we looked at  
18 guidelines both for the general population and  
19 guidelines for the populations of people with  
20 serious mental illness. We looked at evidence  
21 about risk and disparity and of course the  
22 risk sometimes is based on the treatment and



1       -- as well as the condition.

2               And we wanted to focus on existing  
3       measures and to think about how we could use  
4       the existing measurement enterprise to shine  
5       a light on a high risk population. So that  
6       these measures are actually -- all the  
7       measures we'll talk about in this group are  
8       focused -- are measures where we started from  
9       an existing measure for the general  
10      population, we looked to see was there  
11      evidence of a high risk that people with SMI  
12      or AOD were at high risk for the condition or  
13      had a disparity in care. And then we looked  
14      to see whether the measure numerator needed to  
15      be altered. Would you expect some kind of  
16      difference in care for this high risk  
17      population?

18              We conducted testing in health  
19      plans, the -- you know, we considered who  
20      would be the right -- where would be the right  
21      level of accountability for these measures and  
22      we focused on health plans and -- thinking

1     about health plans and states are higher  
2     levels as being responsible because an  
3     individual behavioral health provider or an  
4     individual primary care provider might not  
5     have all the information they need or all the  
6     access to be able to be responsible for making  
7     sure that somebody with a serious mental  
8     illness gets BMI screening and follow-up. But  
9     health plans should be able to be responsible  
10    for that.

11           So we tested the measures in three  
12    health plans. All the measures are specified  
13    for using administrative data, claims data to  
14    identify the denominator, and a chart review  
15    either of an electronic or paper chart to  
16    determine the numerator. And our results  
17    showed in particular for the measures we're  
18    going to consider in the next series, the  
19    obesity, diabetes and hypertension measures,  
20    we saw big disparities for this population  
21    compared to the general population. And we  
22    had extensive public comment and we conducted

1 focus groups with stakeholders to get their  
2 reactions to our information and ideas about  
3 feasibility and usability.

4 Now we have submitted these measures  
5 as individual measures as they were, so we've  
6 specified them as individual measures even  
7 though we present them as a group, we present  
8 them as a group of measures for people with  
9 SMI. And part of the reason for presenting  
10 them as individual measures rather than as a  
11 composite where we'd say that people with SMI  
12 get everything or -- is that we wanted to  
13 allow for flexibility of implementation. So  
14 there's two ways that these measures could be  
15 implemented to try to improve the usability by  
16 different organizations. So a health plan  
17 that is looking at diabetes care for their  
18 general population could over-sample and  
19 report the diabetes measures for people with  
20 diabetes and serious mental illness, okay? So  
21 they could lessen the cost of doing these  
22 hybrid measures, doing these chart reviews by

1     doing that over-sampling. And then they'd  
2     really be able to compare what does it look  
3     like for the general population? What does it  
4     look like for people with SMI?

5             Another alternative would be to say,  
6     you know, what we really want to do is say  
7     look at people with serious mental illness and  
8     look at all of their risks and their needs for  
9     screenings and for attention to chronic  
10    disease. So you could say let's start with  
11    people with SMI and then out of that group  
12    we're going to expect a good proportion of  
13    them to have diabetes or hypertension, so we  
14    could do the diabetes and hypertension within  
15    that group.

16            So that's why we presented the  
17    measures as individual measures for your  
18    review. If they stand alone as an individual  
19    measure then that allows organizations that  
20    would implement these measures, whether it's  
21    -- they're measures that could be implemented  
22    for health plans or measures that could be

1       used, considered for the core sets. There's  
2       more flexibility when they're an individual  
3       measure and we thought that that was important  
4       to achieving implementation to allow that  
5       flexibility.

6               So I think that's the introduction.  
7       Thank you.

8               CO-CHAIR BRISS: Thank you.

9               And any questions or comments from  
10       the committee?

11               (Brief pause.)

12               CO-CHAIR BRISS: David, would you  
13       start?

14               MEMBER PATING: Dr. Briss, I just  
15       would like to ask, it's kind of a process  
16       question, how we should do this. Because I  
17       like the idea that we would be looking at  
18       these separately. I mean obviously we've  
19       looked at some measures and we've munched them  
20       together and we get the goulash. I heard a  
21       fruit salad, you know, it's harder to digest.

22               But at the same time these are

1 obviously, if we do consider them all, there's  
2 a cumulative impact and I just was wondering  
3 how we would handle that discussion. Would  
4 you want to look at the cumulative impact kind  
5 of at the tail end of all the discussions or  
6 should we do it like right now at the  
7 beginning and get it out of the way and then  
8 divide up the different parts?

9         You know, I imagine if you did this  
10 right, you'd have to -- you'd almost want to  
11 set up a whole -- you know, you do your  
12 psychiatric visit and then you come on back  
13 and you do a physical screening with a series  
14 of, you know, examinations to make sure that  
15 you do this checklist correctly. But I mean,  
16 that's not the question that's being asked  
17 here.

18         CO-CHAIR BRISS: Why don't we at  
19 least try to tee up those issues. Now I have  
20 a sense that there are going to be -- there  
21 are likely to be common themes that run  
22 through all of these measures, and so it

1 doesn't feel to me to be efficient if we  
2 address common themes kind of randomly and  
3 variably in measure one and three and seven,  
4 and then it's a really -- do you want to talk  
5 a little bit more about the cumulative impact  
6 issue?

7 MEMBER PATING: No. I mean, I just  
8 think that this is definitely medical and you  
9 could piecemeal it out and do it multiple  
10 visits. But probably to do it right, I mean,  
11 I would imagine you'd find the stethoscope at  
12 the back of your drawer, wherever it's been  
13 for the last 20 years, pull it out, and you  
14 know, you do a visit, you know, that  
15 systematically goes through and makes sure  
16 that you've done a physical, you've done a  
17 BMI, you've ordered the blood tests, you've  
18 set up the consultations. And you know,  
19 somehow it's framed off.

20 I was actually talking to Ms. --  
21 Vanita, and she was saying, well, is it even  
22 billable? So there's even kind of questions

1     about, you know, the pragmatics of this  
2     systemic level. But I don't have any more  
3     comments to that other than they're already  
4     obvious -- these issues of feasibility and  
5     total burden and how they impact both the set  
6     and then the individual aspects.

7             CO-CHAIR BRISS: So David, is that  
8     an argument for -- is one of the net effects  
9     of that that you'd like to eventually like to  
10    see a composite? Is that -- or --

11            MEMBER PATING: Well, that's where I  
12    think we're wanting to go. I mean, in round  
13    two of this I think we had a measure where  
14    somebody was going to get a diabetes measure  
15    and we were saying well, what we really wanted  
16    them to do was to get a health screen, but we  
17    didn't think -- I think, if I remember  
18    correctly, and I can't remember if it passed  
19    or not. But I mean, I think that these are  
20    definitely pushing towards addressing, you  
21    know, the thing that shortens -- the 25 years  
22    that shortens the chronic life of those with



1     severe mental illness, right? But again, if  
2     it's -- somebody has to do this and I think in  
3     the past we said what you really want is not  
4     a bunch of piecemeal stuff, you really want  
5     them to get linked with their primary care.

6             And so these are just these  
7     generic questions of is it -- you know, who  
8     does this, how do we do it? Is this measure  
9     pushing us as a set in that direction? And  
10    yet I also appreciate presenting them  
11    individually because each of them has aspects  
12    that we'll have to look at.

13            MEMBER ROBINSON BEALE: Yeah, I just  
14    want to make a comment. I know that this is  
15    an existing provider level measure and I think  
16    by adding the health plan level brings more  
17    teeth to the measure from the standpoint of  
18    view the health plan will have more access to  
19    data that will help identify those who have  
20    not -- if everything's billed correctly, have  
21    not had those gaps in care.

22            And I think this is important

1     because, I'm just going to say, some states  
2     are moving to these quicker than you think and  
3     are starting to make plans financially  
4     responsible for these measures. So it has a  
5     greater level of importance now than it did  
6     before.

7             CO-CHAIR BRISS: Bonnie?

8             MEMBER ZIMA: Just a general  
9     comment. In thinking about these, it's  
10    actually the timing of considering these  
11    quality measures only because I think if we  
12    had integrated care models, you know, it would  
13    fly with feasibility, right? But at this  
14    point we still also have problems with missing  
15    data with behavioral health records, not being  
16    able to connect, difficulties sometimes  
17    linking records in medical primary care and  
18    specialty mental health. I think that's going  
19    to be an issue.

20            CO-CHAIR BRISS: And Dodi, I  
21    apologize, I missed you. Sorry. Please go  
22    ahead.

1           MEMBER KELLEHER: I'm just curious,  
2           the question I have is I understand the  
3           importance of this because of the disparity  
4           issue, but only in tobacco screening did you  
5           include both seriously mentally ill and  
6           substance use and alcohol. And I was  
7           wondering what the rationale was for -- was  
8           there not enough evidence for the others?

9           MS. HUDSON SCHOLLE: Yes. We --  
10          that's the problem. There was not evidence  
11          that -- and actually we spent a huge amount of  
12          time looking for information that would help  
13          to establish whether there was a higher risk  
14          of problems. And in fact, we tested --  
15          there's just not evidence that people with  
16          alcohol or drug dependence are at higher risk  
17          of diabetes or hypertension. They're --

18          MEMBER KELLEHER: How about the  
19          disparity issue?

20          MS. HUDSON SCHOLLE: We were not  
21          able to find evidence that was on a broad  
22          base. I mean we -- and we searched a lot to

1 look through that. It was clear we found --  
2 it was easy to find that information on SMI.

3 MEMBER KELLEHER: So the disparity,  
4 did you look at disparity in terms of people  
5 with -- in treatment for, say, substance use  
6 or alcohol and/or, you know, coming from, say,  
7 the substance abuse, you know, systems,  
8 disparity in their getting, you know, what  
9 we're describing as basic health screening and  
10 treatment?

11 MS. HUDSON SCHOLLE: So our data  
12 clearly show that people with serious mental  
13 illness and alcohol and drug dependence don't  
14 have good access to general primary care. And  
15 we were encouraged to consider that as a  
16 measure, did people get access to primary  
17 care? But then you have to be able to say,  
18 well, what do you expect that visit to be?  
19 Otherwise it's not really an accountability  
20 measure, it's really an access to care measure  
21 and would not survive your evidence rules for  
22 NQF about what's the importance. And there's

1 not a guideline that says people should have  
2 a primary care visit, as sound and obvious a  
3 statement as that would be.

4 So that's why we -- you know, but  
5 that's why we went down the path of trying to  
6 say, okay, well, what should it be and where  
7 would we have enough evidence to say there is  
8 a risk, this needs to be addressed? So when  
9 we're looking for a quality measure that we  
10 can defend on all those criteria for  
11 importance, we felt like we needed to really  
12 try to adhere to -- to try to provide the  
13 evidence to support at each stage.

14 And that's why we ended up looking  
15 at the existing measures and trying to say  
16 this is -- this is actually going to be more  
17 feasible because everybody knows what those  
18 diabetes measures are and everybody knows that  
19 BMI measure -- you're already doing it.  
20 Report it for this sub-population so you can  
21 target your focus here. And what you'll find  
22 is that when you do that you'll get more

1 people into primary care.

2 MEMBER MAZON JEFFERS: So I think I  
3 have three points that I hope are overarching  
4 to your point of all these measures. The  
5 first one that came up in our workgroup was  
6 that, by proposing a set of measures  
7 specifically for the SMI population, we sort  
8 of begged the question, is there another  
9 population, sub-population or specialty  
10 population that there should be a similar set  
11 of specialized measures developed for? So  
12 that's a question that came up in our  
13 workgroup and I think it's a valid one.

14 Another point which -- it was  
15 helpful to hear your explanation of why you  
16 went for you know, the single measure to  
17 maximize flexibility to allow the measure to  
18 be used in different settings, either the  
19 specialty mental health -- specialty  
20 behavioral health setting or in a physical  
21 health setting. For me, I find not just for  
22 these measures but for a lot of the measures

1 we're talking about, I find that allowing for  
2 the flexibility actually clouds my clarity on  
3 exactly how are you using this measure and in  
4 which setting and for what purpose? You know,  
5 what are we trying to see or show or  
6 demonstrate.

7 So for example, are we talk -- you  
8 know, if you think about the SAMHSA four-  
9 quadrant model and the appropriate setting for  
10 people with SMI to be treated in, are we  
11 talking about using these particular measures  
12 in a, you know, quadrant four for someone who  
13 has mild to moderate -- I mean, I'm sorry,  
14 moderate to severe behavioral health issues  
15 and therefore we're talking primarily about a  
16 specialty care setting? Or are we talking  
17 about people who might be identified in a  
18 primary care setting?

19 So while I appreciate the  
20 flexibility, I find it also contributes to my  
21 lack of clarity because I'm not sure what  
22 setting were you trying to use the measure and

1       for which population and for what purpose  
2       ultimately. Is it to make the behavioral  
3       health provider take their stethoscope out of  
4       their drawer that's -- and blow the dust off  
5       of it? Or is it to get the primary care  
6       provider to recognize that there might be  
7       people with SMI walking through their front  
8       door? And I think it's a slightly different  
9       focus.

10               And sorry, the third thing is that  
11       particular issue of the care setting and how  
12       the measure is constructed and its relevance  
13       becomes more acute at the systems level  
14       particularly because the -- in many, many  
15       states the two systems of care are completely  
16       siloed and their data systems are completely  
17       siloed. So the feasibility of getting body  
18       mass information in a -- from a MBHO is very,  
19       very difficult at this stage.

20               So those are the three issues that I  
21       think overlap.

22               MS. HUDSON SCHOLLE: Number one, why



1 SMI? That's the subgroup that our  
2 stakeholders and focus group told us to look  
3 at, based on concerns about mortality.

4 Second --

5 MEMBER MAZON JEFFERS: Sorry, it's  
6 not "why SMI?" It's "why not something else?"

7 MS. HUDSON SCHOLLE: And we were  
8 limited in the resources that we could provide  
9 and that was the highest priority that we were  
10 directed to.

11 What settings? So these are  
12 measures specified and tested at the health  
13 plan level. So a health plan could implement  
14 them in a whole variety of ways. Health plans  
15 could tell primary care providers these are  
16 the people with SMI on your panel, go find  
17 them, okay? They need this screening. They  
18 could go -- the health plan could work to  
19 develop an integrated setting for care for  
20 people with SMI. Or a health plan could say  
21 we know you're the general provider, you are  
22 the place where people with SMI are, we're

1 going to send you a nurse there or we're going  
2 to pay you more to do this, to create this  
3 system. So that's the flexibility.

4 The reason we put it at the health  
5 plan level is because health plans are  
6 responsible for general medical and care for  
7 their populations and that's where they can  
8 work with all kinds of providers to do this.  
9 We don't intend this as a set of measures for  
10 psychiatrists alone or for family physicians  
11 alone. It's for the health plan to try to be  
12 looking at its population.

13 And then the data silos, they exist.  
14 We won't have any measures if we try to just  
15 focus on the data silos. And part of this is  
16 we're trying to get beyond the limits of the  
17 claims data where all we can do is look for  
18 tests. We can't look for a BMI, we can't look  
19 for an A1C result. We can't tell whether  
20 blood pressure is under control unless we try  
21 to confront those data silos?

22 CO-CHAIR BRISS: To kind of follow

1 specifically on the -- my question was going  
2 to be on the first part of that question. So  
3 it's the -- it strikes me that it's unarguable  
4 that these are the things that kill people  
5 with behavioral health conditions, right? And  
6 so it's unarguable that these are -- and they  
7 also kill a lot of other people, too, right?  
8 And that it's unarguable that there are  
9 treatment gaps, right, for people with  
10 behavioral health conditions.

11 But you could have elected to take  
12 kind of -- to kind of solve that problem in a  
13 variety of ways, right? And in some says  
14 this is a multiple kind of conditions problem  
15 and a measure parsimony problem, right? And  
16 so you've got perfectly good measures that  
17 address all these things in the general  
18 population, and it strikes me that you could  
19 have recommended that those measures be  
20 applied particularly to people with behavioral  
21 health conditions or recommended that the  
22 measures be stratified by people with

1 behavioral health conditions or a variety --  
2 if you're HEDIS you could actually recommend  
3 that all their measures be applied in some  
4 year to -- well, to people with behavioral  
5 health conditions. And the advantage of that  
6 kind of thing could be that you don't wind up  
7 with -- for those of us who are generalists,  
8 I get a little bit -- there are probably  
9 dozens of kind of special populations for whom  
10 a hypertension measure could be applied. And  
11 they all sound -- taken one at a time they're  
12 all really reasonable until you wind up with  
13 40 of these.

14 So can you talk a little about how  
15 you thought about that kind of stuff?

16 MS. HUDGSON SCHOLLE: Yes, and thank  
17 you.

18 You know, we talked with Helen about  
19 how we would implement these measures in a way  
20 that would make it not seem like we just  
21 created 11 new measures out of measures that  
22 already exist and trying to figure out how we

1 do it. But that's where we get back to the  
2 logic of can we demonstrate the high risk and  
3 the disparity? Because what we want is a  
4 standardized way to be able to manage and  
5 monitor the care of people with serious mental  
6 illness. If we don't have that standardized  
7 and measured in a way that people can report  
8 on it, then we're not going to get those data.

9 So that's the point of coming to NQF  
10 with these measures is to say, this is a high  
11 risk group of particular interest. It's  
12 particular interest in the duals work, it's of  
13 particular interest for Medicaid, it's of  
14 particular interest for Medicare. We're not  
15 going to get to that population unless we say,  
16 okay, we agree this is how we're going to  
17 define it and these are the measures we're  
18 going to use to monitor this high risk  
19 population.

20 So now whatever we can do to try to  
21 sort out the -- and make it sound like we're  
22 not -- that it has value for this population

1 and also to set up what would be the criteria  
2 for doing this again? So that's kind of a,  
3 how do you manage this in the measurement  
4 enterprise question? And you know, could  
5 everybody come up and say here's my favorite  
6 high risk population and I want to have a  
7 measure for them? Yes. Well then, let's set  
8 up some criteria for how you define what that  
9 is. And that's what we proposed here.

10 The other issue is, we started with  
11 25 topic areas in behavioral health where we  
12 looked at importance and evidence and  
13 stakeholder support for areas, okay? This  
14 topic area was near the top because people  
15 were so concerned about mortality. And the  
16 evidence about the impact on outcomes is the  
17 strongest. And unfortunately some of the  
18 other things that we could do to try to  
19 improve the quality of care for people with  
20 alcohol and drug dependence or with serious  
21 mental illness, we're a long way from having  
22 the evidence about what to do and exactly how

1 to measure the quality. So this rose to the  
2 top both in terms of potential for increasing  
3 the life and quality of life for this  
4 population, and in the absence of other things  
5 that we really know how to do.

6 DR. BURSTIN: We actually spent a  
7 lot of time with Sarah and her team about this  
8 issue because it is a really important issue  
9 and it has implications not just for SMI but  
10 for many different populations. I think our  
11 thought was this is still the right approach  
12 for now. I think we would love to get this  
13 committee's insights to about how we maybe  
14 could make it more of a sort of matrix  
15 approach, these are the measures for all  
16 people and then there's a subset that apply to  
17 specific populations as needed.

18 I think that's work that PCPI and  
19 NQF really need to do together, but I don't  
20 think it should stop you from looking at these  
21 measures and moving forward. That's more of  
22 an issue of trying to sense make how these

1     come together, but I think the measures on  
2     their own still need to stand on their own and  
3     that's where they, you know, specifically  
4     target the highest evidence.

5             CO-CHAIR BRISS:   And I'd like to see  
6     it, for that discussion, Helen, I'd love to  
7     see you explore this kind of thing as a  
8     stratification --

9             DR. BURSTIN:   Absolutely.

10            CO-CHAIR BRISS:   -- as opposed to  
11    creating lots and lots of new measures.

12            DR. BURSTIN:   And some of that truly  
13    is our inability to create sub-measures under  
14    measures and truly just make that available  
15    and easy to see.   We can probably link them  
16    and make it clear, you know, this measure  
17    connects to 1402 which is the general measure,  
18    things like that to just make it a little bit  
19    easier, maybe thinking about ways of pulling  
20    up the set and saying this is a population  
21    level set.   But again, those -- that's work to  
22    be done.



1 CO-CHAIR BRISS: And I will now put  
2 my Chair's hat back on and go back to Jeff.

3 MEMBER SUSMAN: I think my comments  
4 were very much along this line of trying to  
5 develop a taxonomy that's robust. And right  
6 now it seems like we're just sitting all over  
7 the map in the taxonomy. One day we're  
8 talking about Peds, next day we're talking  
9 about SMI. Then we've got people with heart  
10 failure and, oh yeah, we'd better be measuring  
11 about depression occurrence in heart failure.  
12 Do you think it's time to take a step back and  
13 start saying, okay, whole population. Then we  
14 have different divisions some of which are by  
15 age, some of which are by disease, some of  
16 which may be other factors like racial or  
17 ethnic or socioeconomic breakdowns.

18 But rather than to go down this path  
19 which I think is a lot of work, I mean, I  
20 absolutely a hundred to a thousand percent  
21 condone the focus on improving, quote, medical  
22 health in patients with SMI. But I think this

1 approach is the wrong way to go. I think it's  
2 a lot of work for this group, a lot of  
3 measures we're going to consider here today,  
4 and I think there's a much more parsimonious  
5 way to do this work, efficient way, value  
6 driven way, and that would be to again create  
7 taxonomy in the ability to develop this  
8 interlinkage, the ability to cut populations  
9 in different ways which supposedly we're going  
10 to be doing already in looking at things like  
11 risk adjustment.

12 MEMBER TRANGLE: That means me?

13 CO-CHAIR BRISS: Yes.

14 MEMBER TRANGLE: I want to -- I  
15 agree with what you were saying about the  
16 taxonomy and the need to sort of somehow be  
17 able to look at a subset of the population as  
18 a disparity group. And then have resources  
19 really help you work on it.

20 We've been attempting to do this in  
21 Minnesota and have sort of a coalition or  
22 collaborative going where we're about five

1       years into it but where we took patients, SMI  
2       patients, and looked at our disparity on --

3                       (Telephone ringing.)

4               DR. BURSTIN:  Oh, this is probably  
5       just Obama.

6                       (Laughter.)

7               MEMBER TRANGLE:  Just Obama?

8                       (Laughter.)

9               DR. BURSTIN:  It is.

10              CO-CHAIR BRISS:  Okay.  I'll try  
11       again.  Mike was talking to the mic.  I know.  
12       I know.

13              DR. BURSTIN:  It should be going by  
14       now.

15              MEMBER TRANGLE:  God, horns, too,  
16       not just --

17              DR. BURSTIN:  This happens pretty  
18       routinely when your people actually go to the  
19       White House.  You get used to sort of --

20              MEMBER TRANGLE:  Wow, that's a  
21       disparity group of one.

22                       (Laughter.)

1           MEMBER TRANGLE:   Anyway.   So we've  
2   been trying to do this and we sort of  
3   replicated some of the national data using our  
4   public payers in the data, connected it with  
5   death and saw that our disparity was 24 years.  
6   Our main causes were cardiovascular which was  
7   27 years of life lost, followed by accidents  
8   and injuries, pulmonary cancer.

9           We created sort of a bundle, we kind  
10   of likened it after the diabetes bundle and  
11   said, let's look at things separately but try  
12   and think of the idea like it was all or  
13   nothing like they do with diabetes, with the  
14   D-5, and came up with a bundle of an annual  
15   visit with a PCP measuring the BMI and -- and  
16   this is where I think I would like us to be  
17   thinking, forward thinking, because we can  
18   gnash our teeth and complain about what we  
19   can't get from claims until Obama gets  
20   replaced with four other presidents.

21           But what we did is said, BMI and  
22   what we wanted to be less than 30, you know?

1 Hypertension into the normal range. We had a  
2 lipid one but now that the standards have  
3 changed to where we're in total confusion  
4 about lipids, you know.

5 CO-CHAIR BRISS: As are the rest of  
6 us.

7 MEMBER TRANGLE: But we had  
8 hypertension and then we had either a  
9 hemoglobin A1C or a fasting blood sugar in the  
10 normal range. And then we did a high risk  
11 drinking or drug usage kind of screen to  
12 hearken to accidents and injuries which was up  
13 there, and we thought that was maybe the  
14 factor.

15 So we've been trying to work on this  
16 and we're about five years into it. And what  
17 we've found is systems with EMRs are able to  
18 sort of track this bundle and not get good  
19 data from people that aren't part of their  
20 systems. We're the land of mega-systems, you  
21 know, large integrated systems, so we can kind  
22 of do that. We've also found that we can

1     measure BMI, great, doesn't change, you know?  
2     But for things you can give a drug to, you  
3     know? So hypertension, lipids, you know,  
4     you'll measure it and actually see  
5     improvement. The drug screen doesn't get done  
6     as much.

7             We've been kind of working on this  
8     and it's all over the map. And to some  
9     extent, one of our biggest barriers to really  
10    doing a cohesive approach with any kind of  
11    real traction has to do with nobody -- the  
12    health plans and the other repositories of  
13    data do not subdivide their populations by SMI  
14    and have no way of doing that right now, you  
15    know? And aren't motivated to do that right  
16    now, you know?

17            To the extent that NQF and NCQA  
18    could think about at least piloting or testing  
19    how would it play out if somebody tried to  
20    look at this as a disparity group even though  
21    it isn't a hundred percent proven, you know,  
22    yet? It could be -- it could really start

1 getting us forward and I think this is one of  
2 those measures, like depression, and like we  
3 were talking offline about ADHD, that wouldn't  
4 it be nice someday as more and more of us are  
5 on EMRs that we actually do a symptom  
6 checklist -- whether it's a Connors' or  
7 Mackovac, whatever one you want for ADHD, and  
8 see whether people are getting better, not  
9 merely whether they're seen face-to-face  
10 within 30 days.

11 And I think this is the kind of --  
12 this is the kind of thing that the only way  
13 we're really going to make progress besides  
14 creating a disparity group is to start doing  
15 it in places where we can also get data about  
16 what is going on with BMI and these other kind  
17 of submeasures, and not stick to thinking  
18 about where we're stuck with claims.

19 MEMBER ATKINS: I think about this  
20 in terms of if I were held accountable for  
21 this and at Medicaid ---- we have plans in 16  
22 states. So the flexibility is ideal for us

1     because what I'm going to do in one market is  
2     going to be really different to achieve the  
3     same result than what I might do in another  
4     market. So I think that's actually required  
5     to have that degree of flexibility. Because  
6     a mature setting is so, so different ---- and  
7     what you're going to do about that, whether  
8     there's ACOs and so forth.

9             The issue -- and a few people have  
10    touched on this and this came up for every one  
11    of these measures so I'll put it out there now  
12    so we don't have to do it repeatedly. The  
13    business models that we have include fully  
14    integrated but we own all the data. In some  
15    settings that -- we're hoping will change over  
16    time. The plan has contracted with an MBHO  
17    where we have a delegation oversight and some  
18    degree of control over that, but it depends a  
19    lot on who you've contracted with. And then  
20    situations where the state carves it out,  
21    where we have no influence at all except  
22    through political informant stuff.



1           So ---- and I understand that in a  
2           theoretical world, the health plan really is  
3           accountable for everything that happens to its  
4           members. I would say to you that I don't live  
5           in that world and that the -- there's a very  
6           interesting sort of research question, not --  
7           would each of these metrics actually, with  
8           some variation, be explainable based on those  
9           three different ways, care -- the plans are  
10          organized?

11           So I would say to you, it would be  
12          very helpful to be able to stratify the data.  
13          And I don't know that those are the three  
14          perfect models to stratify it against but to  
15          be able to look at -- you'll have better  
16          results when it's fully integrated and they're  
17          all my members versus the other two. And I  
18          think that's a research question that's sort  
19          of kind of a different question than the one  
20          you want to ask, but an important one for the  
21          industry.

22           MEMBER CHALK: I appreciate NCQA's

1       desire to split these up but I don't buy it.

2                       (Laughter.)

3               MEMBER CHALK: I still -- as  
4       difficult as it is to make this -- to say this  
5       should be a stratified population health  
6       measure, I think it's important -- somehow or  
7       other, it's important either for this  
8       committee or some other committee or NQF to  
9       make that point. Because, once again, we're  
10      splitting out, yes, no, that ---- yes,  
11      patients with serious mental illnesses are at  
12      higher risk for diabetes. There's no question  
13      about that,       there's plenty of research.  
14      But once again we're saying, oh, we're going  
15      to create now eight -- seven diabetes measures  
16      or eight diabetes measures for one population  
17      all split out and you wouldn't do that for --  
18      you're going to do that for any other  
19      population or only SMI? And is -- are  
20      seriously mentally ill the only population  
21      that's -- subpopulation that's at higher risk?  
22      No.

1           And you know, I have my  
2       disagreements about -- there's no data about  
3       controlling high blood pressure related to  
4       people who have alcohol dependence, but that's  
5       a separate matter, I won't go into it. I  
6       really do have difficulty with saying to  
7       plans, even though I agree with your -- the  
8       problem that you're raising -- or states, you  
9       can cherry-pick these measures. You can pick  
10      which measure -- you know, pick one, implement  
11      that and so what? I don't understand what the  
12      so what is if you pick hemoglobin A1c and do  
13      nothing else. I mean, what -- so.

14           CHAIR BRISS: Caroline, you're up.

15           MEMBER DOEBBELING: Thank you.

16           I am concerned as well about this  
17      set of measures, not from -- in addition to  
18      all of the reasons that have been stated  
19      before, but one of the things that came up in  
20      the small group discussion about these  
21      measures were the performance of the measures  
22      over time. And I had raised the question

1     because these measures are and have been used  
2     in the general population for a period of  
3     time, yet none of that information was  
4     submitted. I came to learn during the course  
5     of that discussion that, because these are  
6     independent measures, they should be kept  
7     separate from that but nonetheless I still had  
8     a lot of curiosity about how each of these  
9     separate measures has performed over time  
10    since they have been used in the general  
11    population.

12           My concern about that is, if they  
13    haven't made much of an impact in the general  
14    population to get to a point where we think  
15    that they will start making a great impact in  
16    populations like the seriously mentally ill,  
17    for all of the reasons that you all have just  
18    been describing, I think is concerning and we  
19    need to think about that.

20           So I am not sure NCQA brought the  
21    data about past performance to the meeting  
22    today, but I do think we need to think about,

1 overall, how have these measures performed.

2 CHAIR PINCUS: I'm recused from  
3 talking about this measure specifically. But  
4 it just sounds to me like a lot of what we're  
5 talking about is -- almost relates to how one  
6 markets these measures or -- which I think  
7 goes to an issue more broadly -- which goes to  
8 an issue more broadly in terms of NQF's sort  
9 of way in which they catalog and -- you know,  
10 and utilize them. And how people who, you  
11 know, measure users utilize measures.

12 And is there -- I'm just wondering  
13 if there's a way to sort of separate that out?  
14 Because clearly there's work to be done by NQF  
15 to think about how measures get packaged and  
16 linked and you know, and it really -- and  
17 marketed, so to speak. Because in some ways,  
18 while you do an endorsement process, it also  
19 has elements of a marketing process.

20 DR. BURSTIN: Right, and it's  
21 marketing-based also.

22 CHAIR PINCUS: Right. And so that's

1       -- yeah, and so it might be useful -- I'm just  
2       suggesting that there might be a way to sort  
3       of separate that issue from the evaluation of  
4       each of these measures, per se.

5               DR. BURSTIN: Yeah. And in some  
6       ways I think it's -- I was just sidebar-ing  
7       with Peter, I think some of this is -- some of  
8       it's marketing but some of it's really about  
9       the implementation of how people actually use  
10      these. At least currently it's kind of beyond  
11      what we do, but we can certainly link measures  
12      on our database or something like that, just  
13      to make it clear that these measures hang  
14      together for the care of patients with SMI.  
15      It just hasn't been something -- and again I  
16      think it's a struggle for both NCQA and NQF,  
17      frankly.

18              You know, is it really a composite  
19      of the state, the individual? I mean, I think  
20      these will evolve over time and I guess we'd  
21      still want to make sure we're evaluating the  
22      measures on their merits that's before you

1       today. And a lot of these issues are really  
2       important policy issues we should continue to  
3       discuss but they shouldn't necessarily impact  
4       your evaluation of the individual measures.

5               CHAIR BRISS: And that's essentially  
6       where I was, too. So essentially what I was  
7       going to suggest is -- there seems to me to be  
8       a fair amount of feeling around the table that  
9       in addition to evaluating these measures  
10      individually, there's some additional work to  
11      be done sort of toward either composites or  
12      toward stratifying the parent measures or  
13      something. There seems to be a fair amount of  
14      sentiment around the table that we don't want  
15      to wind up having all the parent measures sort  
16      of spawn 40 sub-measures for every potentially  
17      important subpopulation. And so NQF and NCQA  
18      needs to think about that.

19             But I guess what I'd suggest now is  
20      that we go through the measures individually,  
21      unless people around the table feel so  
22      strongly about those issues that they want to

1 reject the set and have NCQA sort of go back  
2 and bring us back either a composite or a plan  
3 for stratification?

4 Michael?

5 MEMBER SUSMAN: I feel strongly but  
6 it's -- I think there is a missing player  
7 here. We're talking about NQF, NCQA, but  
8 there's a huge constituency of community  
9 mental health centers and public -- you know,  
10 where CMS and SAMHSA tend to drive what  
11 happens operationally. And so for example,  
12 one of our initiatives is every ACT team in  
13 our state has to report these measures, you  
14 know, and it's a different playground, and I  
15 would like them to be part of this discussion.  
16 I don't know how we get part of this, not now,  
17 but in the future.

18 MEMBER ROBINSON BEALE: You know, I  
19 think one of the things about these measures,  
20 and I think it was mentioned earlier but I  
21 want to re-emphasize it again, is that there's  
22 a lack of clarity across the country, across



1 health plans, across providers as to what  
2 HIPAA allows you to report and integrate and  
3 what you don't. And with that variability in  
4 that, I think it makes it really difficult to  
5 implement these measures.

6         So, for example, I sat with five  
7 different health plans who had different  
8 interpretations as to whether or not they  
9 could let their primary care physicians know  
10 that, A, their patient was an SMI patient,  
11 two, whether or not they were on a anti-  
12 psychotic, three, whether or not they needed  
13 diabetes tests. And so these are kind of  
14 fundamental, if you're going to hold a health  
15 plan accountable because they have all the  
16 data, but they can't do anything with the data  
17 because they're crossing over that magical  
18 medical/behavioral line without some clarity  
19 from HIPAA, that I think we've got a problem  
20 here.

21         And it's been an ongoing problem  
22 that I think -- and maybe those who are in the

1 room know better. I sense that they keep  
2 dancing around it but not necessarily making  
3 it exceptionally clear. I see a lot of  
4 confused faces. So if you've got a different  
5 understanding of this then I would greatly  
6 appreciate that.

7 CHAIR BRISS: Yes, sir, David.

8 MEMBER PATING: So I'm in favor of  
9 us moving through each indicator and then  
10 coming back and having a reconciliation  
11 discussion. I think what has to happen is,  
12 there's a whole -- so let's take the blood  
13 pressure measure. There's a whole general  
14 blood pressure measure, and how would this  
15 measure relate to that measure and can you --  
16 you know, it's part of the stratification and  
17 subsetting that -- and it may be part of the  
18 marketing.

19 Once my system, for example, is on  
20 the hook for an elevated blood pressure, we  
21 have to track it by the primary care standards  
22 for blood pressure measure until it's done.

1     So there's things these things will plug into,  
2     but we should look at the individual measures  
3     now and then come back at the end and -- with  
4     a second set of stratification/reconciliation  
5     issues.

6             CHAIR BRISS:  So I think that's  
7     right.  So I'd like to -- unless anybody else  
8     has something that they urgently need to say,  
9     there are a couple of cards that are still up  
10    but I think they're left over, perhaps.

11            So what -- I'll give you the last  
12    word in a second, but what I'd like us to do  
13    is move to the individual measures next,  
14    unless somebody wants to move that we reject  
15    the set, which I didn't get much of a sense of  
16    the group of.  And then just a reminder that  
17    -- just a reminder that we've got eight of  
18    these to get through in the next three hours,  
19    right?  And so I'll need us to be pretty  
20    disciplined about not -- being crisp in your  
21    comments and not repeating things that have  
22    already been said, either in the general

1 session or in -- as we go through a lot of  
2 measures that relate to each other.

3 MEMBER ATKINS: So a couple  
4 observations. One with regard to why SMI?  
5 There are a couple populations of people in  
6 our country that have systematically been  
7 ignored, SMI being one of them. People with  
8 IDD being another. Kids in foster care being  
9 a third. We have to start somewhere. And so  
10 I think that the history of public sector  
11 behavioral health really drives this focus to  
12 try to reconnect with our public -- the folks  
13 who serve in the public sector.

14 With regard to the HIPAA issue, I  
15 think there's reality and delusion there. The  
16 reality is part two, which is not HIPAA, it's  
17 about substance use disorders specifically and  
18 that is a true and real problem -- I'm  
19 actually meeting with HHS next week to  
20 encourage them to do something about that.

21 HIPAA is internal counsel explaining  
22 to people why they don't have to do their

1 jobs, as far as I'm concerned. For behavior  
2 -- for mental there are no -- HIPAA does not  
3 preclude the coordination of information with  
4 PCPs and behavioral health treatment. It's an  
5 artificial issue, it's not real.

6 MEMBER SUSMAN: It does influence  
7 the marketplace actual practice.

8 MEMBER ROBINSON BEALE: There is  
9 confusion across very large national  
10 organizations. American Academy of Surgeons  
11 sat and talked to us about how they don't mix  
12 their behavioral health data with their  
13 medical data because of HIPAA. Well, I said,  
14 what does that mean? Well, we can't do it.

15 I'm just saying there's confusion.  
16 There needs to be clarity of the statement so  
17 that people can proceed.

18 CHAIR BRISS: So with that, let's  
19 try to move through the individual measures  
20 today. The first one is Body Mass Index  
21 Screening, so 2601. So Sarah, would you like  
22 to tee up the measure for us?

1           #2601: Body Mass Index Screening and  
2           Follow-Up For people with SMI

3           MS. HUDSON SCHOLLE: I thought I was  
4           free.

5           (Laughter.)

6           MS. HUDSON SCHOLLE: BMI, obesity,  
7           huge problem related to the medications that  
8           many people with serious mental illness are  
9           on, who is the most often topic that people  
10          told us we should develop a measure that looks  
11          at this as a sign, an early sign of metabolic  
12          problems.

13          This is based on the existing  
14          measure that is specified for the Physician  
15          Quality Reporting System, so it's a provider  
16          level measure that we used. But it is -- it  
17          looks at screening and follow-up. Now in this  
18          measure what we did is we looked at what was  
19          changing the denominator to address the  
20          serious mental illness population, and then  
21          changing the numerator because our panel said  
22          that a single event is not enough for people

1 with SMI where the PQRS measure is about  
2 whether there's a follow-up plan documented in  
3 the record at the time of the visit.

4 So physician reporting measures are  
5 based on the visit and we're looking at a  
6 health plan. And so we said health plans,  
7 you're responsible, not just for a plan being  
8 documented or something being done at the  
9 visit, you're responsible further, you know,  
10 for something happening. So a follow-up visit  
11 -- follow-up plan is not enough, there needs  
12 to be two events in the record that can be in  
13 the medical record or documented in other ways  
14 by the health plan in their care management  
15 systems. But those are the two main -- that's  
16 a change to this measure.

17 MALE PARTICIPANT: Within what  
18 period of time?

19 MS. HUDSON SCHOLLE: Within three  
20 months.

21 MALE PARTICIPANT: Two events in  
22 three months?

1 MS. HUDSON SCHOLLE: Right. The  
2 period of time for the follow-up, it's two  
3 events within three months of the BMI  
4 documentation, or the documentation of the  
5 higher score.

6 And actually what I did forget to  
7 tell you, which is sometimes confusing to  
8 people, the way these screening and follow-up  
9 measures, I think we're just doing -- the  
10 screening and follow-up measures, the logic of  
11 the measures are you meet the measure if you  
12 screen negative. So a BMI less than 30, which  
13 is not obese, right? Or if you are a BMI  
14 greater than 30 and you have the two follow-up  
15 events. So it's either -- meeting the measure  
16 is if it's not a problem based on the screen  
17 or the screen -- when you screen positive  
18 there are two events.

19 And the other thing I will note  
20 about the testing results is that we saw a  
21 huge variation in testing across the three  
22 plans that we looked at. The biggest reason



1     that people did not meet the measure criterion  
2     is because they did not have a visit at all  
3     with any kind of provider. And because we  
4     looked at -- all of the health plans we tested  
5     with had responsibility for both the medical  
6     and the behavioral health benefit. And I will  
7     agree that access to those behavioral health  
8     records are hard to get, regardless of whether  
9     you're responsible for it.

10           And so -- but in this case when we  
11     did have the records, it's not like we found  
12     a lot. We didn't find a lot of BMI testing  
13     happening in the behavioral health record but  
14     it was a problem to get those and that -- it  
15     becomes more of an issue for some of the other  
16     measures but not with this one.

17           CHAIR BRISS: So they're making me  
18     do double-duty as Chair so I also get to tee  
19     this one up. So I'm going to try to model  
20     brevity.

21           So this is clearly a high priority  
22     health condition, so we're -- so obesity is

1 common in the general population, probably  
2 commoner in this population. It obviously has  
3 significant health effects ---- so clearly a  
4 high priority health condition. Screening and  
5 follow-up is uncommon in the behavioral health  
6 population, not shockingly. And then the  
7 evidence on improvements in outcomes is there  
8 in a few good studies but the effects were  
9 frankly small. So it's there as -- sort of  
10 confirming the Minnesota experience that we  
11 just heard about, right?

12 So some very intensive interventions  
13 with up to 24 follow-ups resulted in about  
14 four percent declines in body weight. So if  
15 there were -- if I were to have a quibble with  
16 the intervention it's about the balance of the  
17 intensity of the interventions that have been  
18 studied and the health outcomes that have been  
19 shown.

20 No secondary reviewer on my list.  
21 Did somebody do a second review on this one?

22 MS. HUDSON SCHOLLE: No, for these

1 measures there was only one reviewer.

2 CHAIR BRISS: Okay.

3 MS. HUDSON SCHOLLE: Since they're  
4 all so similar.

5 CHAIR BRISS: So as the second  
6 reviewer, I agree with myself.

7 (Laughter.)

8 CHAIR BRISS: And would anyone like  
9 to -- with that, the table is open. Mike?

10 MEMBER LARDIERI: Thank you. I just  
11 have a question.

12 Why on the denominators is the --  
13 for schizophrenia and bipolar, it's inpatient  
14 or two outpatient visits and for depression  
15 it's only an inpatient visit?

16 MS. HUDSON SCHOLLE: That  
17 denominator is consistent for all the  
18 measures.

19 The reason we did that is we were --  
20 we looked at the research to see how the  
21 serious mental illness population has been  
22 defined, particularly in studies that have

1 looked at this high mortality risk. We  
2 queried our expert advisory panel about how we  
3 should do this.

4 What we were concerned about is that  
5 we didn't really have a definition of  
6 disability, right? It's hard to find that in  
7 the claims data, you can't find really  
8 disabled or chronic disease. And because  
9 depression is ---- can be an episodic, mild,  
10 recurrent -- I mean, mild condition, we felt  
11 that just looking through two visits with a  
12 depression diagnosis would kind of sweep in a  
13 lot of people that might not have serious  
14 mental illness that's disabling. And so  
15 that's why we followed the model that we found  
16 in the literature of using schizophrenia and  
17 bipolar wherever it exists as an inpatient  
18 diagnosis or two outpatient events, you know,  
19 just to reconfirm it wasn't an error.

20 And then for depression we said an  
21 inpatient event because getting hospitalized  
22 would indicate that it was a level of severity

1       ---- we might not get at the chronic and  
2       disabling part, but at least a level of  
3       severity. So that's how we did it. And it  
4       did -- I mean, it narrowed down the number of  
5       people that got into the denominator when we  
6       applied that but we felt like that made more  
7       sense to us.

8               MEMBER ZIMA: I just want to add one  
9       other point, clinically, because that bias  
10      also kind of struck me -- I'm okay. And even  
11      though we might not be representing persons  
12      with major depression who are unable to access  
13      inpatient care, the other side of the coin is  
14      that, by excluding them we're less likely to  
15      have people on the atypical -- we're going to  
16      increase the risk that there's more people on  
17      atypical antipsychotics when we use this  
18      measure. And I think then that's where weight  
19      gain is more of an issue. And so in that  
20      case, I kind of felt like much more  
21      comfortable with that decision point.

22              MEMBER PATING: I just want a

1 clarification of the numerators. So you have  
2 EMI and then a follow-up care visit. I  
3 couldn't find the specs on the follow-up care  
4 visit. Does it have to be a follow-up care  
5 visit where BMI is coded or just any generic  
6 medication follow-up visit? Or maybe even not  
7 a medication visit, can it be a non-medical  
8 visit? So what constitutes follow-up  
9 specifically with regards to this measure?

10 MS. HUDSON SCHOLLE: There's a whole  
11 variety of activities that meet that follow-up  
12 criterion. And so we tried to model it on the  
13 existing measure which looked for counseling.  
14 And it could be counseling, nutrition visits.  
15 It could be pharmacotherapy. So I'm trying to  
16 find the page so I could tell you where it is,  
17 but it's a whole variety of services that are  
18 recommended by the U.S. Preventive Services  
19 Task Force and then also incorporated in the  
20 existing measure specification.

21 No, no, it has to be specific to  
22 follow-up.

1           MEMBER ATKINS: So with respect to  
2           that, this came up in our small group  
3           discussion. The first thing I noticed is the  
4           difference between this group and the general  
5           U.S., you know, task force is this SMI folks.  
6           I would think the first intervention is  
7           reevaluate the medication regime so that -- I  
8           mean, if you have an option to put them on a  
9           medicine that's less likely to cause weight  
10          gain, and ---- I mean, I've seen way too many  
11          of these come to me where they've been in  
12          treatment for years on meds and now they  
13          weight 350 pounds. So first thing I did was  
14          change them, you know? So I think that's a  
15          concern that I would have, that would be the  
16          first intervention I expect in behavioral  
17          health that's different than the general issue  
18          with obesity.

19                 And the other one is around a list  
20                 of meds and their -- and I saw something this  
21                 morning, I heard it when I was like getting  
22                 ready to come. Some medicine is on this

1 direct-to-consumer marketing about weight  
2 loss. There are several meds, other than the  
3 one that you list, that are weight-loss meds  
4 so I wouldn't want to limit it to that. I  
5 don't know how you'd do it but it's a moving  
6 target now, so I don't know how you would do  
7 it in respect. But you wouldn't want someone  
8 to lose credit if they didn't take their  
9 medicine.

10 MS. HUDSON SCHOLLE: So in terms of  
11 the medications, we did look carefully at the  
12 medications and we have a process for  
13 reviewing medications and adding medications.  
14 So there were two meds that were actually  
15 listed in the U.S. Preventative Services Task  
16 Force. One of those is not incorporated in  
17 the specs of the existing measure or our  
18 measure. And then we looked at the new  
19 measures that are coming out.

20 We actually have a process for  
21 updating measures when new medications come  
22 out, so we can respond to that. It's just we



1       can't do it like now because we have a process  
2       where we review it.

3               MEMBER ATKINS: I'm just saying --

4               MS. HUDSON SCHOLLE: Yeah. So we  
5       would do that, that would be part of our  
6       normal update, annual update of measures, to  
7       add that in.

8               MEMBER ATKINS: Okay.

9               MS. HUDSON SCHOLLE: In terms of the  
10      question about ---- we did wrestle with this  
11      question about could we look at change in  
12      medications and, you know, from the pharmacy  
13      claims, could you figure out that the meds  
14      were changed and then make a judgment that  
15      that was done to address the weight  
16      management? We felt like that was just kind  
17      of a little weird. I mean, it'd be hard to  
18      implement too. And so instead, that's why we  
19      thought, you know, the events of counseling --  
20      and I do have to say the counseling on weight,  
21      if it's with the provider who did the  
22      screening or another provider, then what that

1 would mean is at that visit you said you  
2 changed it and then you saw them again about  
3 the BMI and that would count.

4 So we felt like actually the way  
5 this is set up that you get credit for that if  
6 you saw them and their BMI was high and you  
7 said, okay, I'm going to do it again, and  
8 we're going to change meds and do it. As long  
9 as you document that you addressed that weight  
10 management issue in the record then that would  
11 count.

12 MEMBER ATKINS: You might want to  
13 elaborate on that because at least I missed  
14 that and I was looking for it.

15 MS. HUDSON SCHOLLE: Okay.

16 CHAIR BRISS: I think -- Bonnie, is  
17 your card intended to be up? All right. So  
18 I don't think I see anybody else.

19 So the question is, are these -- do  
20 these specs mirror the ones from the general  
21 population measure?

22 MS. HUDSON SCHOLLE: And we did --

1     yes. The change was that we increased the  
2     number of events from a single event to a --  
3     with two events within three months. And we  
4     did not allow ---- in the original measure,  
5     which is a provider level measure, you can  
6     say, referral to nutrition counseling. We  
7     don't -- our measure does not allow that, it's  
8     a health plan measure. If there's a referral,  
9     we want to see that nutrition counseling event  
10    for it to count.

11           CHAIR BRISS: So now I see no  
12    further cards up. And so we might be ready to  
13    vote on evidence.

14           MS. BAL: Okay. We're now ready to  
15    vote on evidence for 2601, and voting is now  
16    open.

17           We're missing one, if everybody  
18    could just try to vote again, please?

19           So the results for 2601 evidence is  
20    high, fourteen. Moderate, eight. Low, one.  
21    And we'll move forward to gap. And we're  
22    going to continue with the rest of the voting,

1 all of them together, correct? Okay.

2 Okay, voting is now open for  
3 performance gap. The options are one, high.  
4 Two, moderate. Three, low. Four, insufficient.

5 So we're only at 20 votes, if we  
6 could get everybody to vote again? Okay.  
7 Actually we've hit 23. We're good to go.  
8 Thank you.

9 Okay, so for performance gap for  
10 2601 we have high, nineteen. Moderate, four,  
11 and we'll go forward with high priority. And  
12 the voting is now open.

13 Okay. If we could just have people  
14 vote one more time, I only have 21 and we need  
15 23. Perfect. Thank you.

16 So the results for high priority for  
17 2601 is high, seventeen. Moderate, four. Low,  
18 one. Insufficient, one, and we'll move  
19 forward.

20 CHAIR BRISS: So on reliability and  
21 validity, in general the workgroup thought  
22 that the measure was precisely specified and

1 clear in the fact that it's adapted from a  
2 currently implemented general population  
3 helps. The reliability was tested with having  
4 ---- with kappa scores from two graders and  
5 the kappa scores showed almost perfect in the  
6 rater reliability.

7 The clear specification and good  
8 agreement between raters also helps support a  
9 validity argument, and expert panel and public  
10 comments generally supported the face validity  
11 of the measure. There were -- the measures  
12 were tested in plans and showed low  
13 performance generally, and there were  
14 questions that we've already talked about,  
15 about ability to implement given data-sharing  
16 problems. But in general the workgroup seemed  
17 to feel reasonably good about reliability and  
18 validity of these measures.

19 And I'll concur with myself again.  
20 With that, the table is open. The floor is  
21 open for comments.

22 MEMBER PINDOLIA: I just had one

1 question on -- I can't remember the general  
2 population HEDIS score for this. What was  
3 that and how does this one compare to that?

4 I remember the diabetes and the -- I  
5 remember all of those, I just don't remember  
6 this one. I just want to know how big of a  
7 difference it was.

8 MS. HUDSON SCHOLLE: So the current  
9 HEDIS measure only looks at screening. And so  
10 we did compare it and these results -- there  
11 was a disparity, I mean these results are much  
12 lower than the current HEDIS measure when you  
13 just looked at the screening component. But  
14 this measure is looking for screening and  
15 follow-up.

16 MEMBER PINDOLIA: Right.

17 MS. HUDSON SCHOLLE: And a different  
18 NQF panel, I guess, recommended that we try to  
19 implement that measure in HEDIS and I don't  
20 know whether --

21 MEMBER PINDOLIA: No, I understand  
22 there's a difference but I was just trying to

1 figure out the part that is related. Was it  
2 50 percent versus 30 or 80 versus 20 or --

3 MS. LIU: Ten percentage point  
4 difference between the screening rates.

5 MEMBER PINDOLIA: Thank you.

6 MEMBER MAZON JEFFERS: I have a  
7 question. So the difference between this  
8 measure and the BMI measure for the general  
9 population for HEDIS is, first, that it  
10 includes a follow-up component and, second,  
11 that the denominator includes a definition of  
12 SMI that's based on the definition that you --  
13 that is here, right? So there are really two  
14 differences to the measure?

15 MS. LIU: That difference is only  
16 comparing the screening rate. So you know,  
17 the material that didn't include the screening  
18 rate in the final measure rate.

19 MEMBER MAZON JEFFERS: So I guess I  
20 would just say that those seem like pretty big  
21 differences.

22 MEMBER CHALK: Am I right that this

1 was tested only in Medicaid plans and this is  
2 only to be -- no?

3 MS. HUDSON SCHOLLE: It was tested  
4 in a Medicaid plan that was for disabled  
5 adults.

6 MEMBER CHALK: Right.

7 MS. HUDSON SCHOLLE: A Medicaid plan  
8 for low-income adults, no disabled, and a dual  
9 SNP.

10 MEMBER CHALK: Yeah, that's what I  
11 thought.

12 MS. HUDSON SCHOLLE: So it's a  
13 special needs plan but that's a  
14 Medicare/Medicaid.

15 MEMBER CHALK: Yeah, right. So it's  
16 three public sector plans. So it's not --  
17 NCQA is not going to put this out to be used  
18 by commercial health plans, right? It's only  
19 a public sector measure?

20 MS. HUDSON SCHOLLE: Well, that's up  
21 to NCQA to determine with its --

22 (Inaudible comments.)



1           MS. HUDSON SCHOLLE: This gets to  
2           the implementation of the measure. How it's  
3           going to be used is really different.

4           CHAIR BRISS: Yeah, as a general  
5           rule, Mady, the answer is once you approve a  
6           measure it can be used by anyone for anything.  
7           That's right.

8           So any other comments before we move  
9           to voting? All right, let's vote.

10          MS. BAL: Okay. Voting is now open  
11          for reliability.

12          Oh, the options are one, high. Two,  
13          moderate. Three, low. Four, insufficient.

14          Okay. The results are high, ten.  
15          Moderate, nine. Low, four. Insufficient, zero,  
16          for reliability of 2601. And we'll move  
17          forward to validity now.

18          And voting is now open. The options  
19          again are one, high. Two, moderate. Three,  
20          low. Four, insufficient, and we're voting on  
21          validity of this measure.

22          Okay. The results for validity for

1       2601 is high, ten. Moderate, eight. Low,  
2       three. Insufficient, two. And we'll move  
3       forward to discussion on feasibility.

4               CHAIR BRISS: So the subgroup had,  
5       given that these sorts of measures are  
6       currently implemented in the general  
7       population, that these measures were likely  
8       feasible. There was some discussion about  
9       chart abstraction being a burden -- some  
10      burden, but that doesn't make it infeasible.  
11      And so the committee had few feasibility  
12      concerns. And with that I will open the floor  
13      to general discussion.

14             It appears to me that we can move  
15      straight to voting.

16             MS. BAL: So voting for feasibility  
17      for 2601 is now open. And the options are  
18      one, high. Two, moderate. Three, low. Four,  
19      insufficient.

20             MS. DORIAN: Caroline, are you on  
21      the phone? Were you planning to vote on this?

22             MEMBER DOEBBELING: I am. I forgot

1 to hit the send button.

2 MS. DORIAN: Okay. Just checking.

3 (Laughter.)

4 MS. BAL: So the results for  
5 feasibility --

6 MEMBER DOEBBELING: My typing didn't  
7 just automatically transmit. Sorry about  
8 that.

9 (Laughter.)

10 MS. DORIAN: No problem.

11 MS. BAL: The results for 2601  
12 feasibility is high, nine. Moderate, seven.  
13 Low six. Insufficient, one. And we will move  
14 forward with this measure and start discussion  
15 on usability and use.

16 CHAIR BRISS: So in general, the  
17 committee discussion about -- again this is  
18 based on a currently in-play population  
19 measure which generally supports usability.  
20 The stakeholder review was generally positive.  
21 There were issues raised that have come up  
22 around this table about -- and it seems to me

1 to have been at least partially dealt with  
2 about the kinds of interventions that might be  
3 considered.

4 But in general, I think the  
5 committee discussion had raised relatively few  
6 issues. And with that, the floor is open for  
7 any additional comment.

8 We vote.

9 MS. BAL: Okay. Voting for  
10 usability and use for 2601 is now open.  
11 Options are one, high. Two, moderate. Three,  
12 low. Four, insufficient information.

13 So the results for 2601 usability  
14 and use is high, five. Moderate, thirteen.  
15 Low, four. Insufficient information, four --  
16 I'm sorry, one. Four percent, but one. And  
17 so we will now vote on overall suitability  
18 unless there's further discussion.

19 CHAIR BRISS: Anybody want to make  
20 any closing arguments to the jury before we  
21 give the overall vote?

22 Oh, a hanging judge, who knew? All

1 right. Let's vote.

2 MS. BAL: Okay. Voting is now open.  
3 The options are one, yes; two, no.

4 We do need one more vote in the  
5 room, if we could get everybody to just hit  
6 one more time?

7 Perfect. Thank you. So final result  
8 is yes, twenty, no, three, for 2601. So this  
9 measure is being recommended.

10 CHAIR BRISS: Excellent. So we've  
11 picked up a little bit of time, we now have  
12 seven measures to do in two and a half hours.

13 (Laughter.)

14 CHAIR BRISS: And even though that  
15 was efficient, I don't recommend to the staff  
16 that they make anybody else do a one-person  
17 show of Chair primary and secondary reviewer  
18 again. So thank you.

19 If NCQA would tee up the  
20 hypertension measure for us? Oh, and just for  
21 discussion, I'm anticipating that there are  
22 going to be all kinds of issues that come up

1 with these measures that are sort of repeats  
2 of things that we've already talked about. So  
3 it's perfectly fine, I think, to say we've  
4 already talked about this issue in previous  
5 measures so that we don't have to spend a lot  
6 of time on it again, if it's just a repeat.

7 #2602: Controlling High Blood Pressure  
8 for People with SMI

9 MS. HUDSON SCHOLLE: Okay. So this  
10 measure is applying the controlling high blood  
11 pressure measure for people with serious  
12 mental illness. It uses the same denominator.  
13 We focused on blood pressure because of the  
14 high risk of cardiovascular disease in people  
15 with serious mental illness due to lifestyle  
16 factors, side effects of treatment and  
17 disparities in care.

18 And so the only thing I might point  
19 out -- it's tested in the same group and we  
20 saw disparities. Our stakeholders -- we  
21 conducted focus groups with stakeholders that  
22 did include folks from community mental health

1 centers and other -- and consumers and states  
2 and a whole variety of potential stakeholders.  
3 This one and the diabetes results, the level  
4 of disparities that we showed, I think people  
5 said -- we asked were these results  
6 surprising, did they make sense? They said,  
7 yes, not surprising but heartbreaking to see  
8 the poor level of care.

9 And the measure specification  
10 reflects the new specifications that NCQA has  
11 put out for the 2015 measure specifications  
12 for this measure, which will have an age --  
13 different blood pressure expectations  
14 depending on age. We tested it using the  
15 measure specifications that were consistent  
16 with the 2012 reporting so we could make  
17 comparisons. But the specs are aligned with  
18 that existing measure.

19 CHAIR PINCUS: So actually just to  
20 clarify, Sarah, because I didn't get to do it  
21 on each one of these, to say if they're exact  
22 -- if the specifications for the numerator are

1 exactly the same as the one for the, you know,  
2 referent measure?

3 MS. HUDSON SCHOLLE: Right. So for  
4 the controlling high blood pressure, the only  
5 change to the measure is to the denominator,  
6 of narrowing the denominator ---- or  
7 specifying it for serious mental illness. The  
8 numerator is exactly the same.

9 CHAIR BRISS: So I have Caroline as  
10 kicking off our discussion for the committee,  
11 please.

12 MEMBER DOEBBELING: Thanks, Peter.

13 This measure is a measure that,  
14 during our small group conversation about it,  
15 we found to be -- echoing Sarah's comments, an  
16 important measure because of the discrepancies  
17 between the SMI population and the general  
18 population with regard to measuring and  
19 controlling blood pressure. And also the  
20 significant morbidity and mortality as related  
21 to hypertension.

22 I don't really have any more



1        comments to make other than we did find it to  
2        be an important measure.

3                CHAIR BRISS: So ---- Raquel?

4                MEMBER MAZON JEFFERS: I just had a  
5        question. Why are pregnant women excluded  
6        from the denominator?

7                (Inaudible comments.)

8                MEMBER MAZON JEFFERS: But it's a  
9        blood pressure. It was also excluded from the  
10       body mass, so I thought maybe BMI might be  
11       related to pregnancy. But blood pressure --

12               (Laughter.)

13               CHAIR BRISS: Probably has something  
14       to do with pregnancy, right?

15               MS. LIU: I mean, it's consistent  
16       with the HEDIS general population measures  
17       exclusion because pregnancy would affect their  
18       blood pressure. So that's the reason.

19               MS. HUDSON SCHOLLE: So it's  
20       excluded from the BMI because we're looking at  
21       weight and so that's why it's excluded from  
22       that one.

1           For the hypertension measure, it has  
2       to do with, would you expect doctors work to  
3       reduce the blood pressure in pregnant women  
4       within the same timeframe that you would for  
5       the general population of people with  
6       hypertension, right? Because we're looking  
7       for a diagnosis of depression. It probably  
8       also -- you can't figure it out during that  
9       year, right, because you're -- in this measure  
10      you're identifying people who have  
11      hypertension from the claims. You're  
12      confirming the diagnosis in the medical record  
13      in the first six months of the year and you're  
14      looking to make sure that the last blood  
15      pressure of the year is under -- is meeting  
16      your threshold. And so that's why pregnancy  
17      would make it complex to implement.

18           CHAIR BRISS: Other questions or  
19      comments before we move to voting?

20           MEMBER ZUN: I noted in the measure  
21      there is a comment taken during an acute  
22      inpatient stay or ED visit. So I'm not sure

1 I understand this. So who's obligated then to  
2 ensure that the patient gets connected with  
3 their primary care doctor?

4 MS. HUDSON SCHOLLE: So what we're  
5 looking for are people that have a diagnosis  
6 of hypertension that's confirmed in an  
7 outpatient setting. Because of concerns about  
8 white coat hypertension or hypertension that  
9 might be picked up in an ED visit only, then  
10 those visits are excluded because that might  
11 not be a real diagnosis of hypertension.  
12 That's what the measure is getting at. So we  
13 are looking for people that have hypertension.  
14 And remember, with every measure what we want  
15 to do is we want to make sure that we're  
16 finding the right people. And so sometimes  
17 that means you exclude people that ought to be  
18 in the denominator but you're trying to go for  
19 specificity rather than sensitivity. So  
20 that's an explanation for that.

21 CHAIR BRISS: And isn't it also  
22 generally true in all of these measures that,

1     because you're specifying at the plan level or  
2     higher that you're asking that people get the  
3     right care, you're not micromanaging how the  
4     hand-offs get done. Isn't that right?

5             So with that, any other questions or  
6     comments before we move on to voting?

7             MS. BAL: Okay. Voting for evidence  
8     for 2602 is now opened. Options are one,  
9     high. Two, moderate. Three, low. Four,  
10    insufficient evidence. Five, insufficient  
11    evidence with exception.

12            MS. BAL: Okay. The results for  
13    evidence for 2602 is high fifteen, moderate  
14    seven, low one, insufficient zero,  
15    insufficient evidence with exception zero.  
16    And we'll move on to gap. And the voting is  
17    now open. The options are one high, two  
18    moderate, three low, four insufficient.

19            Okay. The results for performance  
20    gap for 2602 is high sixteen, moderate six,  
21    low one, insufficient zero. And we'll move to  
22    high priority. And the voting is now open.

1 Same options, one high, two moderate, three  
2 low, four insufficient.

3 Okay. The results for high priority  
4 for 2602 is high eighteen, moderate five, low  
5 zero, insufficient zero. And we can discuss  
6 reliability and validity now.

7 CO-CHAIR BRISS: So Caroline, can  
8 you tee up reliability and validity for us,  
9 please?

10 MEMBER DOEBBELING: I sure will.  
11 The comments from the workgroup on reliability  
12 and validity were very similar to those  
13 brought up in the earlier discussions. The  
14 measure is described well and the group felt  
15 that it was precisely specified and clear.  
16 And given that it had already been implemented  
17 in the general population, we understand that  
18 the measure works for the population. There  
19 were no significant concerns about the specs  
20 themselves.

21 The concerns in this area were  
22 brought up largely about whether or not the

1 health plans reliably could have some data  
2 that were going to be measured for  
3 fragmentation and care resulting in a mixed  
4 picture of what we're really seeing with the  
5 data. And all those things that were  
6 mentioned earlier about behavioral health  
7 carve-outs, questions regarding HIPAA, and  
8 that type of concern. The stakeholders  
9 generally supported the face validity of the  
10 measure.

11 There was concern that the small  
12 sample size did not provide sufficient data to  
13 conduct statistical tests, and there was still  
14 a comfort level with the fact that the data  
15 did suggest meaningful differences across  
16 plans with the general population. And I had  
17 my question about how well these measures have  
18 performed in the general population over time,  
19 and that was not addressed.

20 CO-CHAIR BRISS: Sarah, would you  
21 like to comment on the general population  
22 performance?

1 MS. HUDSON SCHOLLE: Right. So the  
2 measure has undergone some changes in  
3 specification that make it a little bit hard  
4 to look at it. But I would say that over the  
5 past five years, we've actually not seen much  
6 improvement in the measure at the health plan  
7 level for Medicaid plans. I think we see more  
8 improvement in some of the other plans, where  
9 this measure is actually being used in other  
10 kinds of pay for performance arrangements.

11 CO-CHAIR BRISS: Any other comments  
12 or questions around the reliability and  
13 validity? Hearing none, let's vote.

14 MS. BAL: Okay. Voting is now open  
15 for reliability. The options are one high,  
16 two moderate, three low, four insufficient.  
17 And this is for 2602. We only have 20 votes  
18 so if everybody could just try to do it again?  
19 Thank you.

20 And the results are, for reliability  
21 for 2602, is high nine, moderate seven, low  
22 six, insufficient four. And we'll move

1 forward to validity. And the voting is now  
2 open. Again, the options are one high, two  
3 moderate, three low, four insufficient. We  
4 need one more vote from the room. Please make  
5 sure to vote once the timer is up. If the  
6 timer's not up the vote won't be registered.  
7 Thank you.

8 So, for validity we have high nine,  
9 moderate eight, low four, insufficient two.  
10 And that will be enough to move us forward to  
11 discussion of feasibility.

12 CO-CHAIR BRISS: Caroline, you're on  
13 again.

14 MEMBER DOEBBELING: Thank you. The  
15 workgroup's comments on feasibility were  
16 around two issues. One, the requirement for  
17 medical record abstraction, which creates a  
18 burden on plans, especially for plans in which  
19 the SMI are enrolled in the health plan, but  
20 receiving their care in a very fragmented  
21 system about where and how to find that chart  
22 information. It didn't mean that these



1 measures are not feasible, but only difficult  
2 to get to.

3 And then the same concern about  
4 feasibility, with regard to the overall  
5 fragmentation of care and behavioral health  
6 carve-outs was brought up again during  
7 discussion. Some aspects of the measure can  
8 be captured from electronic sources, but not  
9 all are well maintained in an electronic  
10 sources. Overall, the feasibility discussion  
11 was much like the other measures, and no  
12 significant concerns were noted.

13 CO-CHAIR BRISS: Any comments from  
14 the floor?

15 MEMBER PINDOLIA: So on this one, I  
16 guess I do share that concern too, because in  
17 the state of Michigan there just is not any  
18 coming to the same EMR interface for  
19 behavioral health and the physical health for  
20 our dual eligibles. And I think other states  
21 may be facing that. Is there something --  
22 exceptions, is there something available for

1 health plans that cannot get information fed  
2 back of what the behavioral health component  
3 has found?

4 MS. HUDSON SCHOLLE: You're really  
5 getting into an implementation issue about how  
6 these measures would be used. So the -- these  
7 are feasible, these are imminently feasible,  
8 if people allow you access to the data. And  
9 while I don't believe that there are any laws  
10 that preclude that, it's really a matter of  
11 will and a force of will strong enough to  
12 overcome people's concerns about it and the  
13 challenges of doing it.

14 And remember, for a health plan  
15 that's -- if the health plan were responsible  
16 for this, they could make it happen. A health  
17 plan that's responsible for the medical care  
18 of this population of people with SMI, they  
19 can make this measure happen by making sure  
20 that the doctors that they're paying do this,  
21 even if -- in the general medical care, even  
22 if it's not happening in the behavioral health

1     setting. That might be a duplication of  
2     services. But they've got the ability to do  
3     that, and that's part of what we're trying to  
4     force -- we're trying to encourage them, is to  
5     pay enough attention to this.

6             But it's an implementation. So if  
7     the state of Michigan said these measures  
8     don't work, we're not going to -- we don't  
9     think it's feasible, then that would be how  
10    they might deal with it.

11            CO-CHAIR BRISS: Any other comments  
12    or questions before we move to voting?  
13    Hearing none, let's vote.

14            MS. BAL: Okay. Voting for  
15    feasibility is now open. The options are one  
16    high, two moderate, three low, four  
17    insufficient. I'm assuming Larry didn't vote,  
18    so we're just going to go ahead.

19            Okay. So for feasibility for 2602  
20    we have high seven, moderate nine, low five,  
21    insufficient one. And we'll move forward to  
22    usability and use.

1 CO-CHAIR BRISS: Caroline, one more  
2 time.

3 MEMBER DOEBBELING: Sorry. The  
4 workgroup had no significant comments about  
5 usability other than those that have already  
6 been mentioned. Nothing new to add to that  
7 discussion.

8 CO-CHAIR BRISS: I love that  
9 summary. Thank you. Any questions for -- any  
10 questions or comments from the room? Let's  
11 vote.

12 MS. BAL: Okay. Voting is now open  
13 for usability and use. We have quite a few  
14 votes still out there, if everybody could  
15 please vote. We should be looking for 22.

16 Okay. The results are -- for  
17 usability and use for 2602 are high six,  
18 moderate eleven, low six, insufficient zero.  
19 And we can go forward to the overall decision  
20 unless we have discussion.

21 CO-CHAIR BRISS: Any closing  
22 remarks? Hearing none, let's vote.

1 MS. BAL: Okay. Voting is now open,  
2 overall suitability. The options are one,  
3 yes, two, no.

4 Okay. The final result is yes,  
5 eighteen, no, five, for 2602. So this measure  
6 will be recommended.

7 CO-CHAIR BRISS: Terrific. Thank  
8 you. So, I have good news and bad news. The  
9 good news is that we're moving very fast, the  
10 bad news is that we just finished our morning,  
11 right? So with that, 2603, Sarah, you want to  
12 tee that one up for us, please?

13 #2603: Diabetes Care for People with SMI:  
14 Hemoglobin A1c (HbA1c) Testing (NCQA)

15 MS. HUDSON SCHOLLE: Okay. So NCQA  
16 calls the diabetes set of measures a measure,  
17 and they call each of the items within the set  
18 indicators. So this is one of, I think, six  
19 indicators that we're -- or measures that  
20 we're bringing to you. And all of these  
21 measures are similar to the blood pressure in  
22 that what we have done in our specifications

1 is we have defined people with SMI as the  
2 denominator. All of the numerator statements  
3 for this entire -- for the remaining, all the  
4 diabetes measures are the same. So it's the  
5 same set of numerators. So we haven't made  
6 any changes in those at all.

7 And I think the testing results were  
8 pretty consistent with what we found in the  
9 controlling high blood pressure. Again, lower  
10 performance rates. Interestingly, I would  
11 point out that the performance rates were very  
12 different for the different plans, and so the  
13 -- the plan that served low-income adults had  
14 the poorest performance rate, and that's  
15 because even among people with diabetes, very  
16 few of them had visits. And so not having a  
17 visit will contribute -- if you don't have  
18 something, then you'll automatically fail it.

19 For the -- the plan that did the  
20 best was the dual SNP. And remember that many  
21 of these measures are included in the Medicare  
22 Stars Program. And so there are special

1 incentives for Medicare plans.

2 But in addition, the dual SNP  
3 actually has -- is set up as a system to try  
4 to find people, and they have other  
5 responsibilities for managing care for this  
6 population.

7 CO-CHAIR BRISS: So with that I have  
8 Lisa Shea as the --

9 MEMBER SHEA: Yes, thank you. So in  
10 brief, our group thought that this was a very  
11 important measure, that there was demonstrated  
12 gaps. And that's all I'll say.

13 CO-CHAIR BRISS: I may have created  
14 a monster.

15 (Laughter.)

16 CO-CHAIR BRISS: Okay. Comments  
17 from the room? Let's move straight to voting.

18 MS. BAL: Okay. Voting for evidence  
19 is now open for 2603. Just confirming,  
20 everybody in the room has voted? Did someone  
21 walk out I'm not aware of?

22 If everybody could just vote one

1 more -- oh, we got it. Thank you. Okay. So  
2 for evidence for 2603 we have high nineteen,  
3 moderate four, low zero, insufficient zero,  
4 insufficient with exception zero. So we'll  
5 move forward to the gap vote. And it is now  
6 open. Still short one, so everybody please  
7 make sure to vote.

8 Okay. Perfect, thank you. So for  
9 gap we have high twenty-one, moderate two, for  
10 2603. And we can move forward to high  
11 priority. And the voting is now open.

12 Okay. The results for high priority  
13 for 2603 is high nineteen, moderate four, low  
14 zero, insufficient zero. And we can move  
15 forward to scientific acceptability.

16 MEMBER SHEA: So, again, in terms of  
17 the reliability, the workgroup generally felt  
18 that the measure was precisely specified and  
19 clearly bolstered by that it's already used in  
20 the general population. And that -- I'm  
21 looking at the reliability. And they had  
22 really high inter-rater reliability results,



1 kappa was very high.

2 Then regarding validity, they -- the  
3 measures were tested in the three plans and  
4 there was a lot of variability in the  
5 performance, as we've heard. And while there  
6 wasn't sufficient data to conduct a proper  
7 test, the group felt that there were  
8 meaningful differences that were likely to  
9 exist, and felt overall comfortable that there  
10 was validity, in terms of this measure.

11 CO-CHAIR BRISS: Comments from the  
12 room? So I think we can move to vote. Oh,  
13 I'm sorry.

14 MEMBER PATING: I'm just wondering,  
15 and I'm not an expert on diabetes, just the  
16 age or going down to 18 with HbA1c, was there  
17 other ways that that could have been framed?  
18 You know, your risk for diabetes goes up  
19 perhaps with age, with BMI, and I just don't  
20 routinely test my 18-year-olds for A1c. So I  
21 was just wondering, does --

22 MEMBER SUSMAN: This is SMI -- this

1 is SMI population.

2 MEMBER PATING: Oh, they have -- oh,  
3 I apologize.

4 CO-CHAIR BRISS: I think we can move  
5 to vote.

6 MS. BAL: Okay. Voting for  
7 reliability is now opened for 2603.

8 CO-CHAIR BRISS: We still seem to be  
9 missing --

10 MS. BAL: We're missing -- yeah.  
11 We're missing one in the room. Okay. The  
12 result for reliability for 2603 is high  
13 sixteen, moderate five, low two, insufficient  
14 zero. And we'll move forward to validity.  
15 And the voting is now open. We actually need  
16 one more from the room so everybody could  
17 please make sure that they voted.

18 Okay. Perfect. Thank you. And so  
19 for validity of 2603 we have high fourteen,  
20 moderate five, low three, insufficient one.  
21 And we can move forward to discussion of  
22 feasibility.

1           MEMBER SHEA: So like the other  
2 measures, it was deemed to be feasible. And  
3 one point I guess I would make is that the  
4 more the plans adopt these measure, then the  
5 less burden will be on them because they'll be  
6 in the same chart looking at the different  
7 measures.

8           CO-CHAIR BRISS: Excellent. So any  
9 comments from the room? Hearing none, let's  
10 vote, please.

11          MS. BAL: Okay. Voting for  
12 feasibility is now open. And just to remind  
13 you, please make sure to point at me.

14          CO-CHAIR BRISS: Not at me, at her.

15                   (Laughter.)

16          MS. BAL: Okay. The result for  
17 feasibility for 2603 -- right? Yes -- is high  
18 ten, moderate nine, low four, insufficient  
19 zero. And we can move forward to usability  
20 and use.

21          MEMBER SHEA: So usability,  
22 basically the same concerns or issues that

1       came up before. But our workgroup, in  
2       general, felt that this was a usable measure  
3       and generally favored its use.

4               CO-CHAIR BRISS: Any further  
5       comments or questions? Hearing none, let's  
6       vote.

7               MS. BAL: Okay. Voting is open for  
8       usability and use. So actually we -- I  
9       thought we were waiting on the phone. But if  
10      everybody could retry, we're missing one in  
11      the room. Just in time.

12               (Laughter.)

13              All right. So for the usability and  
14      use for 2603 we have high thirteen, moderate  
15      six, low four, insufficient zero. And we can  
16      move to overall suitability unless there's  
17      discussion.

18              CO-CHAIR BRISS: Any final  
19      discussion before we vote? Hearing none,  
20      let's vote.

21              MS. BAL: Okay. It is now open to  
22      vote. The options are one, yes, two, no.

1       Okay. The result for overall suitability for  
2       2603 is yes, twenty-one, no, two. So this  
3       will be recommended. And we can move on to  
4       the next measure.

5               CO-CHAIR BRISS: So let's go ahead  
6       and, we're about at our proposed break time,  
7       so let's do take our break, 15 minutes, and  
8       restart at 25 after, please. And we'll still  
9       have five measures to do in about 80 minutes  
10      then, so let's do -- be reseated and ready to  
11      go at 25 after, please.

12              (Whereupon, the above-entitled  
13      matter went off the record at 3:04 p.m. and  
14      resumed at 3:25 p.m.)

15              CO-CHAIR BRISS: Can we get  
16      restarted, please?

17              (Inaudible comments.)

18              CO-CHAIR BRISS: So the next one is  
19      2604, the diabetes care.

20              #2604: Diabetes Care for People with SMI:  
21      Medical Attention for Nephropathy (NCQA)

22              CO-CHAIR BRISS: I'm sorry, it's

1       nephropathy.

2               MS. HUDSON SCHOLLE:   Nephropathy,  
3       same story, same population, nephropathy --

4               CO-CHAIR BRISS:   Same song,  
5       different verse?

6                       (Laughter.)

7               MS. HUDSON SCHOLLE:   Right.   Right.  
8       Just this is about identifying the screening  
9       for one of the major complications of  
10      diabetes.   And where there's concern, and  
11      other evidence that people with serious mental  
12      illness don't get this screen.

13              CO-CHAIR BRISS:   So Bob, will you  
14      tee this up?

15              MEMBER ATKINS:   So I won't just say  
16      ditto, but I will say that we agree that both  
17      diabetes and nephropathy are bad and we should  
18      do what we can to make them less bad, yes.

19                       (Laughter.)

20              MEMBER ATKINS:   There's no -- and  
21      so the group entirely agreed that this was --  
22      that there was adequate evidence, more than

1     adequate evidence to support this as a focus,  
2     that -- sticking with the plan -- that there  
3     is clearly a performance gap, and this is very  
4     high priority, that it's high risk, high cost,  
5     problem prone and it's a terrible thing for it  
6     to happen to people. And we need to do  
7     something about it. So that's the summary.

8             CO-CHAIR BRISS: So I can hardly  
9     wait to go back and explain to my family that  
10    what I did with all these experts today is  
11    determine that bad is bad and better is  
12    better, right?

13             (Laughter.)

14             And does anybody else have comments  
15    about the evidence for this one? Let's vote,  
16    please.

17             MS. BAL: Okay. Voting for evidence  
18    is now open. Just making sure that we have  
19    enough people in the room. So yes, for  
20    evidence -- for a quorum, we have enough  
21    people to vote. And we do, no worries at all.

22             For evidence we have high fifteen,

1 moderate five, low zero, insufficient zero,  
2 insufficient with exception zero. And so we  
3 can move forward to gap. And voting for gap  
4 is now open.

5 Okay. So for gap we have high  
6 nineteen, moderate two, low zero, insufficient  
7 zero, and we can start voting on priority in  
8 one second. We can start voting now.

9 Okay. The results for priority is  
10 high sixteen, moderate six, low zero,  
11 insufficient zero. And we can discuss  
12 scientific acceptability now.

13 MEMBER ATKINS: Okay. With regard  
14 to reliability and validity, there are really  
15 minimal concerns and they replicate those that  
16 have already been spoken to. With regard to  
17 both reliability and validity -- I just want  
18 to make sure there's nothing from the group as  
19 a whole. No, we've already talked about all  
20 the issues.

21 CO-CHAIR BRISS: Anybody have  
22 comments before we vote? Hearing none.



1 MS. BAL: Voting for reliability is  
2 now open.

3 Okay. The results for reliability  
4 for 2604 is high fourteen, moderate five, low  
5 three, insufficient zero. And voting for  
6 validity is now open.

7 Okay. The results for validity for  
8 2604 is high eleven, moderate seven, low four,  
9 insufficient zero. And we'll move forward to  
10 feasibility discussion.

11 CO-CHAIR BRISS: Back to you, Bob.

12 MEMBER ATKINS: Feasibility. Again,  
13 there was really no difference from the  
14 comments made on the prior measure. We're  
15 already doing this, so there's no real  
16 increase in burden. And same issues  
17 concerning getting the data.

18 CO-CHAIR BRISS: Anybody want to  
19 comment before we vote? Hearing none.

20 MS. BAL: Voting is now open for  
21 feasibility. We're just waiting on one more  
22 vote, if people could just revote, please?

1 Thank you.

2 Okay. So the final vote for  
3 feasibility is high twelve, moderate eight,  
4 low two, insufficient zero. And we can move  
5 forward to discussion of usability and use.

6 CO-CHAIR BRISS: Bob, anything new  
7 to add on --

8 MEMBER ATKINS: There's nothing to  
9 add about usability and use. It really is  
10 identical.

11 CO-CHAIR BRISS: Would anybody else  
12 like to find something new to add? Hearing  
13 none, let's vote.

14 MS. BAL: Okay. Voting is now open  
15 for usability and use. We're missing two  
16 votes -- okay, one vote. Please just make  
17 sure to point at me.

18 Okay. The result for usability and  
19 use is high ten, moderate nine, low three, and  
20 this is for 10 -- I'm sorry, 2604. And now we  
21 can move to forward overall suitability unless  
22 there's further discussion.

1 CO-CHAIR BRISS: As always, I'll  
2 give you a chance to make a closing argument  
3 if you'd like. Hearing none.

4 MS. BAL: Okay. Voting is now open  
5 for 2604, overall suitability. Options are  
6 one, yes; two, no.

7 Okay. The final result is yes,  
8 twenty-one, no, one. So this measure will be  
9 moved forward for recommendation.

10 CO-CHAIR BRISS: So with that done,  
11 the blood pressure control and diabetes  
12 measure?

13 #2606: Diabetes Care for People with SMI:

14 Blood Pressure Control

15 (<140/90 Malmstrom Hg) (NCQA)

16 MS. HUDSON SCHOLLE: Okay. So it  
17 may be a little bit confusing that there is a  
18 blood pressure control measure that's part of  
19 the diabetes set, and then there's the blood  
20 pressure control measure that we already  
21 talked about. But let me try to explain the  
22 Venn diagram here, because there could be some

1 overlap, but not necessarily.

2 So the controlling high blood  
3 pressure measure focuses on people with  
4 hypertension, okay? And it looks to confirm  
5 the hypertension diagnosis and then -- within  
6 the year, and to see that blood pressures so  
7 controlled. The blood pressure measure that's  
8 for diabetics is for everybody who has  
9 diabetes, regardless of whether they carry the  
10 hypertension diagnosis. So some people are  
11 going to be in that -- they're going to have  
12 both hypertension and diabetes as their  
13 diagnoses and they would show up in both  
14 samples. But some people would not, and so  
15 that's why there are two separate measures.

16 MEMBER TRANGLE: That's still within  
17 SMI, right?

18 MS. HUDSON SCHOLLE: Right. This is  
19 -- right. I believe that there's some  
20 evidence that blood pressure is the thing you  
21 want to control for people with diabetes, like  
22 it's a very important indicator for people

1 with diabetes.

2 CO-CHAIR BRISS: Yes. So before we  
3 get into the details of this measure, I'd  
4 actually like to -- let's have a little bit of  
5 a harmonization discussion. So it feels to me  
6 like these are mostly overlapping on one -- I  
7 actually have some questions about whether you  
8 really need the second diabetes measure, the  
9 diabetes and hypertension measure.

10 If you've already got the  
11 hypertension measure, you could just apply it  
12 to the population with diabetes. It feels  
13 like this is mostly a historical artifact of  
14 a time when we used to treat to different  
15 targets in diabetes and hypertension. Bob, do  
16 you want to -- you can just pull up a chair.

17 MR. REHM: I do this at the office  
18 all the time. I kneel before our NCQA Gods.  
19 So I'll genuflect later.

20 (Laughter.)

21 MR. REHM: My hands aren't clasped.  
22 So the -- just for historical context, the --

1 and I'll just use the NQF as a frame.  
2 Currently there's an NQF endorsed measure for  
3 blood pressure control for people with  
4 hypertension, that's essentially the corollary  
5 of what we just talked about. We also have an  
6 NQF endorsed measure about blood pressure  
7 control for people with diabetes.

8         So in terms of lineage, these are  
9 both NQF endorsed and, as I recall, you know,  
10 strongly endorsed. There was not a lot of  
11 disharmony about that. They were aware that  
12 the blood pressure measures existed in each  
13 other's space and I think they, at least those  
14 panels, respectively, felt that these were  
15 appropriate delineations. And then Sarah's  
16 point about the Venn diagram is accurate.

17         The hypertension measure that you've  
18 just reviewed is somewhat unique because it is  
19 very, very focused on a confirmed, this  
20 confirmation of a hypertension diagnosis for  
21 all the reasons that Sarah alluded to. The  
22 diabetes measure is really, you know, do you

1     have SMI with a comorbidity of diabetes, and  
2     then do you have your blood pressure control?  
3     In some ways it's a simpler measure, it's just  
4     looking for that one value, the one value  
5     being the latest value and it's a little bit  
6     more straightforward.

7             I know it may seem like parsing but,  
8     Peter, I think that the market appreciates it.  
9     From the health plan perspective they manage  
10    patients with diabetes, and hopefully someday  
11    soon, patients with SMI as holistically, and  
12    think about them, and think about the things  
13    that they can intervene with -- distinct maybe  
14    from another population. And that's helpful  
15    to them. Sometimes they do it, sometimes they  
16    do it different ways, but at least it's a tool  
17    in their toolbox.

18            MEMBER SUSMAN: I guess I'm still a  
19    little bit unclear since we have an SMI  
20    measure with hypertension and diabetes and now  
21    the hypertension guideline is basically set at  
22    the same specification what the added value is

1       here. I still haven't heard that. Maybe I'm  
2       missing it, I'm sorry if I'm delaying our  
3       progress.

4               MR. REHM: So I'll try to be  
5       helpful. The -- what's unique about is the  
6       time element. The blood pressure measure you  
7       just, you know, recommended for endorsement,  
8       is looking at a -- trying to capture  
9       essentially a -- I wouldn't call it a new  
10      hypertension diagnosis, but a confirmed within  
11      a confined period of time. And then giving  
12      the health plan through its provides, but  
13      giving the health plan, you know, essentially  
14      -- call it six months. It can be broader than  
15      that. But enough time to engage that patient  
16      and bring their hypertension under control.

17             The diabetes measure is essentially,  
18      once I'm on that diabetes denominator, you  
19      know, and assuming the diabetes isn't resolved  
20      because they've lowered their BMI, and good  
21      things have happened in their life. But that  
22      population is just going to continue to



1     persist and show up every year, year in, year  
2     out, with a little bit of fallout. And then  
3     you're just seeing, is their blood pressure  
4     controlled along with several other  
5     indicators, like nephrology consult or any of  
6     the other indicators that are in Alc, testing  
7     and control. So it's just one of many. But  
8     it's a slightly different frame.

9             MS. HUDSON SCHOLLE: So the real  
10    unique part that the diabetes measure will  
11    get, that's people with diabetes, regardless  
12    of whether they have a diagnosis. So it will  
13    be people whose diagnosis isn't confirmed in  
14    the record. It's every person with diabetes,  
15    regardless of whether they've got a defined --  
16    whether they've ever carried that hypertension  
17    diagnosis.

18            CO-CHAIR BRISS: It's true, there  
19    are lots of people with hypertension that are,  
20    my boss would say hiding in plain sight,  
21    right? So there are lots of people who don't  
22    care, who probably have hypertension who don't

1     carry a diagnosis. The flip side of that is  
2     that there are a lot of people who, at a point  
3     in time, can be over 140, or over 90 that  
4     don't actually have hypertension.

5             MR. REHM: And the way we structured  
6     the blood pressure measure, controlling blood  
7     pressure measure is such that the clinician or  
8     a health plan who observed that high rate has  
9     time to go back and go back. It's not just  
10    one reading, it's the opportunity to, if you  
11    will, escalate. And it's essentially the last  
12    reported blood pressure of that period,  
13    wherever the measurement period lands, it's  
14    the one that's used to see whether he met the  
15    threshold. So it's a -- it's giving people  
16    both time and encouragement, and incentive to  
17    do something as opposed to not doing anything  
18    at all.

19            MEMBER TRANGLE: This is  
20    interesting. And one of the distinctions I  
21    seem to be hearing is that if one has diabetes  
22    the thought is you have a chronic disease and

1       they're going to measure this indefinitely.  
2       And if you just have hypertension it may go  
3       away. If you think about the pool that we're  
4       talking about here, which is SMI patients, I  
5       think the approach towards these patients in  
6       general is that they have a chronic disease,  
7       and we need to kind of continue to monitor  
8       them over their lifetimes to see how they deal  
9       with their BMIs and other kinds of risk  
10      factors.

11               So I get the distinctions of the  
12      timing, I'm just sort of, as I think it  
13      through, I think what we might be evolving to  
14      is, if we do start thinking about SMI as a  
15      sort of disparity group with their own things  
16      that we want to be monitoring for their  
17      lifetimes, it would be more like -- it would  
18      be diabetics, and within our cluster we just  
19      look at this. We're not there yet but I think  
20      that would be the evolution.

21               CO-CHAIR BRISS: I'm still fuzzy now  
22      about what constitutes control in the two

1 groups. I get that the diabetes measure might  
2 be more inclusive of people with elevated  
3 blood pressures, because it doesn't require  
4 people to also carry a hypertension diagnosis.  
5 But I don't get what -- I don't get what the  
6 difference is in terms of the measure of  
7 success on the measure, right?

8 MR. REHM: So one frame to think  
9 about it up here is that the diabetes measure  
10 with the threshold is -- it's saying I come in  
11 on one -- I'll just use a number, 130 over 39  
12 or -- I mean, 138 over 79, pardon me. And  
13 then I'm encouraged to say, boy, that's  
14 cutting it close, you know, I could monitor,  
15 I could do a variety of things even though I  
16 meet the standard of the measure.

17 There's a quality improvement  
18 component to this, it's not just -- I know we  
19 talked about accountability, but there is  
20 something about this, its function is much  
21 early warning and helping people stay below  
22 the line, if you will as much as it is finding

1     those that are above the line who you want to  
2     bring down below.  So it's operating at two --  
3     I guess two different levels.

4             CO-CHAIR BRISS:  But success on the  
5     measure, so separate --

6             MS. HUDSON SCHOLLE:  So among people  
7     with SMI and diabetes, we're looking for their  
8     last blood pressure of the year, regardless of  
9     whether they had a hypertension diagnosis or  
10    whether that's the first one in the year, we  
11    want it to be below the threshold.

12            For people with hypertension, we say  
13    first we have to identify you as being  
14    hypertensive and then we're going to give you  
15    six months to get to the lower rate.  So the  
16    idea there is that the -- they're just  
17    different populations.  And they're going to  
18    be overlapping, but there will be some people  
19    that are different in each group.

20            MEMBER PATING:  So could I ask,  
21    regardless of SMI status, so you have those  
22    that are SMI and we're checking for diabetes

1     and SMI we're checking for blood pressure.  
2     What about those with diabetes, are you  
3     required to check for blood pressure? Because  
4     I really want to make sure that we're staying  
5     consistent with the general population, the  
6     measures.

7             MS. HUDSON SCHOLLE: Yes. This is  
8     exactly the way it's done in the general  
9     population.

10            CO-CHAIR BRISS: So, in some ways  
11     you don't have to think of anything new,  
12     because you're a primary care clinician.  
13     Because you have the diabetes algorithm, your  
14     SMI algorithm and your blood pressure  
15     algorithm. All right, I'm sorry I derailed  
16     this a little bit but this was a little too  
17     easy for NCQA. So we needed to have a little  
18     cross-examination, right? And so --

19            MEMBER PATING: Why can't this just  
20     be a sub-measure or is it being considered a  
21     sub-measure? To me it's like it doesn't quite  
22     rise to its own status. It should be linked

1 to one of the other measures, part B, or  
2 something like that. Those are my thoughts.

3 MS. HUDSON SCHOLLE: They're all  
4 kind of sub-measures in what we're trying to  
5 do is just take the logic of saying this is  
6 what you do for diabetes and apply it to  
7 people with SMI. Same thing people with  
8 hypertension, you apply the same logic. And  
9 the original measures have that overlap, and  
10 that has been acceptable to the field. And so  
11 we're not questioning it.

12 CO-CHAIR BRISS: Acceptable to parts  
13 of the field. So Rhonda, I think you were  
14 going to be -- yeah, you were going to be the  
15 lead discussant on this before I short-  
16 circuited the discussion. Are there other  
17 things you'd like to add as we move through?

18 MEMBER ROBINSON BEALE: Essentially,  
19 I don't have anything more to add to this one,  
20 unless there's others who would like to add  
21 comments to this.

22 CO-CHAIR BRISS: So let's try

1 voting.

2 MS. BAL: Okay. So the vote for  
3 evidence is now open.

4 So the vote for evidence for 2606 is  
5 high fifteen, moderate five, low three,  
6 insufficient evidence zero, insufficient  
7 evidence with exception zero. And we'll vote  
8 on gap now. Gap is open.

9 Okay. The results for 2606 gap is  
10 high sixteen, moderate six, low one,  
11 insufficient zero. And we'll move forward to  
12 vote on high priority. And the vote is open  
13 now.

14 The vote for 2606 high priority is  
15 high thirteen, moderate five, low five,  
16 insufficient zero. And we'll move forward to  
17 discuss scientific acceptability.

18 CO-CHAIR BRISS: Rhonda, do you want  
19 to add anything on this one?

20 MEMBER ROBINSON BEALE: I'm a group  
21 of one. There were no -- I don't have any  
22 other comments to make on this.



1 CO-CHAIR BRISS: Anybody else,  
2 questions, comments or concerns?

3 MEMBER ROBINSON BEALE: I think it's  
4 all been said.

5 CO-CHAIR BRISS: All right. Hearing  
6 none, let's open the vote.

7 MS. BAL: Okay. Voting is now open  
8 for reliability for 2606. Could everyone just  
9 vote one more time? We're one person short.  
10 Thank you.

11 Okay. So for reliability we have --  
12 wait, validity. The score is high thirteen,  
13 moderate eight, low two. And that was for  
14 reliability for 2606. And now the voting for  
15 validity is open. So just need one more vote.  
16 I don't know if maybe someone stepped away, so  
17 we'll just go forward with it.

18 So for validity of 2606 we have high  
19 eight, moderate twelve, low three,  
20 insufficient zero. And we can move forward to  
21 perhaps discuss feasibility.

22 CO-CHAIR BRISS: Anybody have

1 anything new? Rhonda, have anything?

2 MEMBER ROBINSON BEALE: Nothing new  
3 on that one, unless someone else has anything.

4 CO-CHAIR BRISS: Anybody want to add  
5 anything? CO-CHAIR BRISS: Let's vote.

6 MEMBER ROBINSON BEALE: Anything new  
7 in the discussion? No? Great.

8 MS. BAL: Feasibility is now open  
9 for voting.

10 Okay. The result for feasibility  
11 for 2606 is high seven, moderate thirteen, low  
12 three, insufficient zero. And we can move  
13 forward to usability and use.

14 CO-CHAIR BRISS: Anybody have  
15 anything new? Hearing none, let's vote.

16 MS. BAL: Okay. Voting is now open  
17 for usability and use. It did take me a  
18 second, so make sure that you pushed it after  
19 the timer came on.

20 Okay. The final result for  
21 usability and use for 2606 is high seven,  
22 moderate eleven, low five, insufficient zero.

1 And we can move forward to the overall vote,  
2 unless there's some discussion.

3 CO-CHAIR BRISS: Seeing no moves  
4 toward discussion, let's vote.

5 MS. BAL: Okay. Voting is now open.  
6 One is yes, two is no for overall suitability  
7 for endorsement.

8 Okay. So for overall suitability  
9 for 2606 we have seventeen yes and six no. So  
10 this measure will move forward for  
11 endorsement. And we can move on to 2607.

12 CO-CHAIR BRISS: NCQA will kick this  
13 off. Sarah?

14 #2607: Diabetes Care for People with SMI  
15 Hemoglobin A1c (HbA1c)

16 MS. HUDSON SCHOLLE: I just want to  
17 point out that there are two measures that  
18 look at A1c control. One looks at poor  
19 control, so that's an A1c that's greater than  
20 nine. And the other looks at good control,  
21 A1c less than eight. And I think -- so  
22 basically the rationale for these measures is

1 the same. And the reason for doing this is  
2 that there's good agreement that greater than  
3 nine -- that nobody should be above nine. And  
4 but there is considerations about how far you  
5 should go in getting to good control. And so  
6 that's why we've had the greater than nine  
7 measure for a long time, but less than eight  
8 hasn't been in as long. But it's helpful to  
9 understand where your population fits. That's  
10 why there are two.

11 MEMBER SIDDIQI: So okay, did you  
12 want me to go ahead? I was going to say I  
13 will echo what Lisa had said. Evidence shows  
14 that it's -- that it's important, it's a major  
15 risk for morbidity and mortality and  
16 essentially measures the quality of care that  
17 we provide to diabetics with SMI. And  
18 there's, you know, evidence that there's  
19 disparity as to how those people are managed.

20 So do you want me to say more?

21 CO-CHAIR BRISS: Not unless you feel  
22 like there's something else new to say.

1           Would anybody else like to comment?

2           (No response)

3           CO-CHAIR BRISS: Let's vote.

4           MS. BAL: Okay. Voting for evidence  
5 for 2607 is now open.

6           (Pause)

7           MS. BAL: So we're still missing two  
8 in the room, if everybody could just vote.  
9 Let's make sure no one stepped out.

10          (Pause)

11          MS. BAL: Okay. The result for 2607  
12 evidence has a high nineteen, moderate four,  
13 low zero, insufficient zero, insufficient with  
14 exception zero. And gap is now open for  
15 voting.

16          (Pause)

17          MS. BAL: We just need two more  
18 votes, if everybody could please vote. Thank  
19 you.

20          (Pause)

21          MS. BAL: Okay. So 2607 gap is high  
22 eighteen, moderate five, low zero,

1       insufficient zero. And now we can vote for  
2       high priority.

3               (Pause)

4               MS. BAL: So we only have 17 -- or  
5       19 now. Please make sure that everybody's  
6       voting. We should have twenty-two in the room  
7       and then one on the phone.

8               (Pause)

9               MS. BAL: Okay. So we have -- for  
10      high priority we have high sixteen, moderate  
11      six for 2607, and we can start discussing  
12      scientific acceptability.

13              MEMBER SIDDIQI: Reliability, again  
14      it seems to be specified and clear. I don't  
15      know if anybody has any concerns that they're  
16      not reliable measures.

17              (No response)

18              CO-CHAIR BRISS: So let's move to  
19      voting.

20              MS. BAL: Okay. Voting is now open.

21              (Pause)

22              MS. BAL: Okay. So for reliability

1 for 2607 we have high thirteen, moderate  
2 eight, low two, insufficient zero. And now we  
3 can start voting for validity.

4 (Pause)

5 CO-CHAIR BRISS: We may have a  
6 comment on this one. Pay no attention to the  
7 scores behind the curtain.

8 Yes?

9 MEMBER MARK: I had a comment,  
10 question about the validity. So what do the  
11 guidelines say that the appropriate population  
12 based A1c levels should be? And do we have  
13 any concern about, you know, getting people  
14 too low and, you know, causing iatrogenic  
15 hypotension?

16 CO-CHAIR BRISS: Or hypoglycemia?

17 MEMBER MARK: Yeah, hypoglycemia, I  
18 guess. Yeah. So not being a clinician, but  
19 would --

20 MEMBER SIDDIQI: Long-term effects -  
21 -

22 CO-CHAIR BRISS: We're still in the

1 greater than nine, but the poor control.

2 MEMBER SIDDIQI: Yeah. The poor  
3 control.

4 MEMBER MARK: So it's not an issue  
5 at all?

6 MEMBER SIDDIQI: It's not an issue  
7 at all.

8 MS. HUDSON SCHOLLE: I don't think  
9 there's any concern that people with diabetes  
10 should have A1c's less than nine. The concern  
11 -- oh wait, I'm sorry. Or less than eight.

12 The concern has been in the lower  
13 range, and there's -- where NCQA actually does  
14 report a measure less than seven which is  
15 really marked for quality improvement. But  
16 that measure, we did not present that measure  
17 for this group. That's where the concern has  
18 been, going less than that. So I think  
19 there's very good agreement on these two  
20 thresholds.

21 CO-CHAIR BRISS: And some of this is  
22 -- some of that concern is why there are two



1 thresholds represented in these measures,  
 2 right? Most everybody agrees that nobody  
 3 essentially should be greater than nine and  
 4 probably the less than eight one might not be  
 5 sort of a hundred percent.

6 (Pause)

7 CO-CHAIR BRISS: Are there comments  
 8 on the reliability or validity?

9 (No response)

10 MS. BAL: Okay. Voting is now open.

11 (Pause)

12 MS. BAL: Okay. For validity of  
 13 2607 we have high ten, moderate ten, low  
 14 three. And we can move forward to discussion  
 15 of feasibility.

16 MEMBER SIDDIQI: Any concerns or any  
 17 questions regarding feasibility?

18 (No response)

19 CO-CHAIR BRISS: Anybody else?

20 (No response)

21 CO-CHAIR BRISS: Let's vote, please.

22 MS. BAL: Okay. Voting is now open.

1 (Pause)

2 MS. BAL: Okay. The result for  
3 feasibility for 2607 is high ten, moderate  
4 ten, low three, insufficient zero. And we can  
5 discuss usability and use now.

6 MEMBER SIDDIQI: All right.  
7 Usability, I think we all agree based on  
8 discussion that it's very useful.

9 CO-CHAIR BRISS: So if we have no  
10 further ado, let's vote, please.

11 MS. BAL: Okay. Voting is now open.

12 (Pause)

13 MS. BAL: Okay. So for usability  
14 and use the -- for 2607, the results are high  
15 eleven, moderate seven, low four, insufficient  
16 zero. And we can move to overall suitability,  
17 unless there's further discussion.

18 (No response)

19 MS. BAL: I'm going to take that as  
20 a "no" and voting is now open.

21 (Pause)

22 MS. BAL: Okay. The final result is

1     yes, twenty-one, no, one. And this measure is  
2     being moved forward for recommendation. And  
3     we can move forward to 2608.

4             #2608: Diabetes Care for People with SMI:  
5                     Hemoglobin A1c (HbA1c)

6             CO-CHAIR BRISS: And we have  
7     probably surfaced anything in the discussion  
8     of 2607 that needs to be said on 2608. Does  
9     anybody from NCQA or, you know, the -- or  
10    anybody else like to talk more about this  
11    measure before we just vote it through?

12            (No response)

13            CO-CHAIR BRISS: Why don't we try to  
14    vote it through, please.

15            MS. BAL: Okay, perfect. So voting  
16    for evidence for 2608 is now open.

17            (Pause)

18            MS. BAL: Okay. The result for  
19    evidence for 2608 is high nineteen, moderate  
20    three, low zero, insufficient zero,  
21    insufficient with exception zero. Voting for  
22    gap is now open.

1 (Pause)

2 MS. BAL: Okay. So for gap for 2608  
3 we have high eighteen, moderate five.  
4 Priority's now open.

5 (Pause)

6 MS. BAL: Okay. So we have high  
7 seventeen, moderate five, low zero,  
8 insufficient zero for gap of 2608 -- I'm  
9 sorry, that was high priority for 2608.

10 And now reliability for 2608 is now  
11 open.

12 (Pause)

13 MS. BAL: Okay. So for reliability  
14 for 2608 we have high fifteen, moderate six,  
15 low two, insufficient zero. And now voting  
16 for validity is open.

17 (Pause)

18 MS. BAL: So we have for 2608  
19 reliability, we have high ten, moderate eight,  
20 low four, insufficient zero. And that was for  
21 validity, my mistake.

22 Feasibility, the voting is open now.

1 (Pause)

2 MS. BAL: Okay. So we have  
3 feasibility for 2608 high eleven, moderate  
4 eight, low four, and we can move forward to  
5 use and usability. Voting now open.

6 (Pause)

7 MS. BAL: Okay. So we have for  
8 usability and use, we have high eleven,  
9 moderate six, low five, insufficient zero for  
10 2608. And just a reminder for overall  
11 suitability, that one is yes, two is no. And  
12 voting is now open.

13 (Pause)

14 MS. BAL: We're at 21 so if  
15 everybody could just please vote for this one?

16 (Pause)

17 MS. BAL: Okay. So for the overall  
18 suitability we have twenty yes, two no and  
19 2608 will be moved forward for recommendation.  
20 And we can move on to 2609.

21 CO-CHAIR BRISS: Sarah, would you  
22 like to tee this one up? Anything special

1 about this one?

2 #2609: Diabetes Care for People with SMI:  
3 Eye Exam (NCQA)

4 MS. HUDSON SCHOLLE: Other than this  
5 is a really big disparity. I think the --  
6 it's an even bigger disparity than the others  
7 between the test plans and for SMI population  
8 compared to the others. So even poor access  
9 to this specialty.

10 CO-CHAIR BRISS: So Caroline.

11 MS. DORIAN: Is Caroline on the  
12 phone?

13 CO-CHAIR BRISS: Caroline, are you  
14 still there?

15 MEMBER DOEBBELING: Yeah, I'm still  
16 there. I'm in the car.

17 I concur with the (telephonic  
18 interference) the gap here is tremendous. I  
19 think it's driven in large part by  
20 today's (telephonic interference) primary care  
21 referral to specialty care for this, and it's  
22 a barrier to get the SMI into our specialty

1     care exams. So the gap is (telephonic  
2     interference) and the group was in agreement  
3     about all of that. For all of the other  
4     reasons, that we will discuss: validity,  
5     reliability, usability, feasibility,  
6     everything (telephonic interference).

7             CO-CHAIR BRISS: Caroline, that was  
8     an amazingly cogent discussion while driving  
9     and picking up your kids. That's very good.

10            MEMBER DOEBBELING: I am in the  
11     parking lot behind about 50 cars right now, so  
12     it --

13            (Laughter)

14            CO-CHAIR BRISS: Okay. So with  
15     that, I think we can move to the voting,  
16     please.

17            MS. BAL: Okay. So evidence for  
18     2609 is now open.

19            (Pause)

20            MS. BAL: We are at 21. If you  
21     could just all vote again, please? I'm just  
22     trying to get as many of you here.

1 (Pause)

2 MS. BAL: Okay. For evidence of  
3 2609 we have high nineteen, moderate three,  
4 low zero, insufficient zero, insufficient with  
5 exception zero. And performance gap is now  
6 open for voting.

7 (Pause)

8 MS. BAL: So performance gap for  
9 2608 -- I'm sorry, 09, is high eighteen,  
10 moderate four, low zero, insufficient zero.  
11 And we can move forward to high priority.

12 (Pause)

13 MS. BAL: So for high priority for  
14 2609 we have high fifteen, moderate seven, low  
15 zero, insufficient zero. And now we're going  
16 to move on to reliability and voting is now  
17 open.

18 MEMBER PATING: Open? I was  
19 wondering if I could just ask a question  
20 first. Oh sorry --

21 (Laughter)

22 CO-CHAIR BRISS: Somebody has to



1 occasionally do that just to make sure that  
2 we're all awake.

3 MEMBER PATING: If I could just ask  
4 the developer the specifications for the eye  
5 exam, you know, I guess how you chart it. If  
6 your eye exam is done in the inpatient  
7 setting, as part of, you know, the routine  
8 admission or if the psychiatrist does the eye  
9 exam in the office? I mean, you've just to  
10 find ways, I think, to have the eye exam.

11 MS. HUDSON SCHOLLE: An eye exam is  
12 -- it's a specialty eye exam.

13 DR. BURSTIN: It's got to be a  
14 dilated eye exam so it can't be done just in  
15 a regular office of a non-eyecare  
16 professional.

17 (Pause)

18 MS. BAL: So are we ready to vote?

19 Okay. Voting for reliability is now  
20 open.

21 (Pause)

22 MS. BAL: We are only at 18 so

1       please be sure to vote.

2               (Pause)

3               MS. BAL: All right. So for  
4       reliability for 2609 we have high fourteen,  
5       moderate seven, low one, insufficient zero.  
6       Voting validity is now open.

7               (Pause)

8               MS. BAL: We are at 19 so just one  
9       more time, please?

10              (Pause)

11              MS. BAL: Okay. So for validity of  
12       2609 we have high twelve, moderate seven, low  
13       four, insufficient zero. And we'll move  
14       forward to feasibility unless there's  
15       discussion?

16              (No response)

17              MS. BAL: Seeing none, voting is now  
18       open.

19              (Pause)

20              MS. BAL: Okay. So feasibility for  
21       2609 is high eight, moderate eleven, low  
22       three, insufficient zero. And now we can move

1 forward to usability and use. Voting is now  
2 open.

3 (Pause)

4 MS. BAL: Okay. So for usability  
5 and use for 2609, high nine, moderate ten, low  
6 three, insufficient zero. And we're ready for  
7 overall suitability. The options are one,  
8 yes; two, no. And we are now open for voting.

9 (Pause)

10 MS. BAL: So the final result for  
11 2609 is yes, twenty, no, three, and this  
12 measure will be moved forward for endorsement.  
13 And I can no longer say this today. We're  
14 done.

15 (Laughter)

16 MS. BAL: Until tomorrow.

17 NQF Member and Public Comment

18 CO-CHAIR BRISS: So our last task  
19 for the day is to listen to public comments.  
20 So operator, if you could open the phone lines  
21 for public comment for us, please?

22 OPERATOR: At this time, if you would

1     like to make a comment, please press \* and the  
2     number one on your keypad.

3             And there are no public comments at  
4     this time.

5             CO-CHAIR BRISS: There do not appear  
6     to be public comments in the room. So I'd  
7     like to thank everybody for a hard day's work,  
8     and we had a very efficient afternoon and  
9     actually finished a little early.

10            Yeah, we wanted to loop back, and so  
11     we've now worked through that new set of  
12     measures one at a time and we were going to  
13     loop back and see if anybody had any further  
14     thoughts about how they fit together. I mean,  
15     we talked at the beginning about -- there was  
16     at least some support in the committee for  
17     moving toward either composites or for moving  
18     toward a stratification discussion that might  
19     allow us to also capture other high need or  
20     high risk populations without creating  
21     hundreds of measures. Does anybody else have  
22     wisdom to impart after the specific

1 discussions today?

2 Yes.

3 MEMBER ROBINSON BEALE: This is  
4 actually more of a question. I think we all  
5 are kind of feeling that there are a lot of  
6 measures and there's a sense of overload. One  
7 of the questions I have is whether or not, for  
8 NQF, is part of your work to -- how do you say  
9 -- prioritize measures as their feasibility or  
10 usability, as it relates to things that are  
11 being done now with some of the measures?  
12 Some of them are just measuring an outcome or  
13 a baseline or population measures. And then  
14 some of them are starting to quickly get tied  
15 to performance, payment and other kinds of  
16 things. Does NCQA take -- does National  
17 Quality Forum take on the role of prioritizing  
18 or assessing the readiness of measures for  
19 those different venues?

20 DR. BURSTIN: Funny you should ask.  
21 Yes, that's become a very hot topic these days  
22 within NQF and other circles. In fact we have

1 a meeting next week about Consensus Task Force  
2 Group I mentioned to you, and we are actually  
3 going to ask them to help us make a decision  
4 of whether we should, in fact, move forward of  
5 endorsement that either is related to intended  
6 use of a measure or potentially even a rating  
7 system for measures where you can rate it  
8 based on the quality of how well they do  
9 against those criteria, as well as whether  
10 they've already been in use. So those are the  
11 two options.

12 We'll likely then do an extra panel  
13 and try to figure out the how to make it  
14 happen. But those are really important  
15 questions. And I think this is also, you  
16 know, part of what Sarah said, some of this  
17 also gets into the implementation space of how  
18 -- you know, how NCQA might prioritize or  
19 group these in terms of HEDIS. But I think  
20 it's also clearly, you know, in their  
21 bailiwick. But I think there is an important  
22 discussion.

1           And if any of these are part of any  
2           of the federal programs, they would also  
3           likely come up as part of the Measures  
4           Applications Partnership for that.

5           MEMBER TRANGLE: You know, my  
6           thoughts are exactly along those lines. It's  
7           like the nature of these things and the nature  
8           of just how progress happens in medicine is  
9           they're all going to metastasize and spawn, it  
10          will be like rabbits, you know?

11          And we have to, I think, think about  
12          not just prioritizing but how can you, instead  
13          of like subdividing it so that they're pure  
14          and simple and discrete, how do you integrate  
15          them? And how do you actually think about  
16          simplifying and looking at the overall burden?  
17          And when is the bang worth the buck in terms  
18          of actually doing it at the clinic, you know,  
19          or hospital, whatever it is level?

20          And if you don't have a process for  
21          that, my recommendation is maybe you're  
22          starting with this little thing about how do

1 we harmonize them so they don't conflict? But  
2 I think it's got to integrate and simplify no  
3 more than it's -- no slower than it grows.

4 MEMBER SUSMAN: I think that we  
5 really should be moving to the concept of  
6 perfect care within disease entities like  
7 diabetes. Take five measures, put them  
8 together, is it really acceptable to hit sixty  
9 percent or better, or seventy percent on each  
10 one of those individually but only deliver  
11 perfect care two percent of the time? I think  
12 obviously we're further away from that with  
13 individuals with SMI but we really should be  
14 driving to consistent, reliable care for a  
15 disease entity. And that's where I think we  
16 can start developing these composites that  
17 make sense, they have a lot of shared  
18 attributes in interacting ways where  
19 controlled blood pressure, lipids, your  
20 diabetes, A1c, all that stuff, weight,  
21 whatever, fits together.

22 MEMBER CHALK: Going back to the



1 issue of the MAP, I had a question about  
2 whether at some point the measure developers  
3 or the measure implementers should be required  
4 to talk about, given what we've heard today  
5 especially, action plans. And that that  
6 should not be -- whether that should be part  
7 of their submission of a measure. We heard a  
8 lot today and we'll get more tomorrow about  
9 measures that don't move. And there are  
10 reasons measures don't move, Sarah mentioned  
11 a few, I could mention some more.

12 To just have NQF be engaged in  
13 endorsing measures that go nowhere, even if  
14 they're implemented, because there's no action  
15 plan -- and I don't -- you know, health plans  
16 have action plans. They can put performance  
17 incentives in place. But that's not the only  
18 possibility, there are all kinds of  
19 possibilities. To help plans and states and  
20 other purchasers focus on improving the  
21 quality of care.

22 And it's very discouraging to me

1       that we're going through the exercise of  
2       approving measures and saying nothing about  
3       the action that needs to follow. We're not  
4       requiring developers who submit to the NQF,  
5       especially, which is the gold standard, to  
6       have an action plan as part of their  
7       submission.

8               CO-CHAIR BRISS: So I endorse the  
9       idea of more all-or-nothing composites. As  
10      I've said already, I would much rather have  
11      recommended stratifications and -- for high  
12      priority populations like the SMI population,  
13      but not limited to the SMI population, as  
14      opposed to having different measures for every  
15      population of interest which I think reduces  
16      the signal to noise and reduces progress in  
17      the main. And I think that there's still more  
18      work to do on harmonizing measures.

19             I know I didn't get anywhere with  
20      the hypertension measures today but, you know,  
21      at HHS we -- you heard me tell the story, in  
22      2010 we worked on harmonizing measures and we

1       were working on hypertension, among other  
2       things. And there were some number like 35  
3       different hypertension related measures. And  
4       all of them taken individually had something  
5       that somebody thought was a good rationale  
6       that sort of, in a vacuum, Bob could  
7       undoubtedly explain to me. But taken  
8       together, you know, it was just an awful mess  
9       and so much more can and should be done.

10               And those are my thoughts.

11               CO-CHAIR PINCUS: I do think that --  
12       and it's just a thought in terms of some of  
13       the -- again, some of the feedback at NQF.  
14       One is, I'm in developing some more specific  
15       templates. So we talked earlier today, for  
16       example, on the patient-reported measures that  
17       clearly distinguish how to handle that as a  
18       performance measure rather than as a clinical  
19       instrument. And so that there's a different  
20       way in which one can sort of lay that out.  
21       And you know, perhaps it's not by breaking it  
22       necessarily into four different measures, but

1 to think of it as a domain of outcomes that's  
2 sort of utilized in different ways. So to  
3 think of ways of simplifying that.

4 Secondly, I think another kind of  
5 template that could be developed is just what  
6 you were talking about before is a template  
7 for thinking about high priority populations  
8 segmentation that could be a kind of  
9 complementary-type review that wouldn't  
10 require a full review like we've gone through  
11 every single measure this afternoon. But that  
12 could be a way to do that, you know, for  
13 existing measures in a much more simplified  
14 kind of process.

15 And then I think -- you know, I  
16 mean, I think what you're getting at, maybe it  
17 might fit with, in a way with what Helen had  
18 alluded to in terms of the fit for purpose  
19 efforts. But this whole issue of marketing  
20 or, you know, implementation or whatever you  
21 want to call it, about getting measures,  
22 meaningful measures out there to be used, and

1       that the strategy for which -- what kind of  
2       use this measure will have so it's not just  
3       flinging out there where it's on a list.

4               The more that that's thought through  
5       in terms of, well, who -- you know, who is  
6       this being addressed and for what type of  
7       program should be part of the assessment  
8       that's done for endorsements, because I think  
9       that that's -- so that -- and also listening  
10      to the context of, you know, how many other  
11      measures that are -- not just in -- you know,  
12      it's sort of a matrix. Measures aren't  
13      particularly a domain, but also measures for  
14      a particular use and sort of -- you know, just  
15      look at the cells in that matrix.

16             MEMBER JENSEN: I would just like to  
17      make a comment as the individual here from the  
18      Veteran's Health Administration. Certainly  
19      our recent issues could be attributed to a  
20      number of different causes. But I think it's  
21      not incorrect to say that some of the issues  
22      in Veteran's Health Administration could be

1 related to the vast number of performance  
2 measures that we were being held accountable  
3 to. And some pressure on senior leadership at  
4 facilities to demonstrate needing those  
5 performance measures and perhaps putting  
6 pressure inappropriately on providers or  
7 perhaps even not being quite honest with  
8 reporting measures.

9         So I just think it's very important  
10 to think about what measures do we really need  
11 to look at that are indicating that we're  
12 giving good care to our population, for me,  
13 the veterans, but our citizens? And not push  
14 people into being so concerned about their  
15 performance rating and their salary based on  
16 that that they're going to be dishonest and  
17 take measures that are inappropriate.

18         MEMBER PINDOLIA: So in regard to  
19 the meeting and, Helen, that you discussed  
20 that NQF is having next week, and maybe this  
21 is being done through public address and I'm  
22 missing it. But it seems like the measures

1     that are out there for three or six years and  
2     coming back, there is feedback, I know,  
3     provided directly. It's solicited by CMS for  
4     Five Star measures annually about what are  
5     some concerns that you've having about it.  
6     And then I don't think I ever get questions  
7     from NCQA, if you're having any reasons or  
8     rationale of why -- you know, if there's  
9     concerns on those measures.

10           But I think it would be very  
11     important for NQF to hear directly if a  
12     measure is staying static for three or six  
13     years, what is the feedback from the  
14     individuals that are actually doing the  
15     measuring, the health plans or other  
16     providers, of what's holding that back? And  
17     I'll give you osteo as a classic example. So  
18     we were told to do chart review. We did the  
19     chart review for 300 people and it's just 85  
20     percent false positive in how it's being  
21     coded. So do we really have a quality  
22     problem? We don't know. We're using it off

1 of a miscoding, but it continues to be a  
2 measure. That's just one example.

3 And so when we talk about tomorrow,  
4 where I was part of that group, that was why  
5 I kept bringing up every time when the measure  
6 shows no improvement for three years, it just  
7 -- I don't know if that -- if it's really  
8 improving quality by continuing it in the same  
9 way.

10 MS. HUDSON SCHOLLE: We do -- NCQA  
11 does have a policy clarification system where  
12 we get comments all the time. They're  
13 reviewed every -- when we reevaluate a  
14 measure, we do a public comment where we ask  
15 people what's going on, if we're having  
16 problems. And so we do see that. And then --  
17 and we try to address any of those concerns.  
18 And that's why you see some of the really --  
19 what look like really detailed things and you  
20 wonder, why is that in the measures? Because  
21 somebody's made a complaint or asked about it  
22 and we've gone back and said, okay, we have



1 addressed that particular consideration, yes.

2

3 And there are measures, some  
4 measures can do some things but they can't do  
5 everything. And so I do want to recognize  
6 that, that it really depends on how they're  
7 used as well. And --

8 MEMBER PINDOLIA: And I agree with  
9 that. So I -- if you don't mind, I just want  
10 to just comment back.

11 I agree that if it's staying  
12 stagnant and it's just because that metric  
13 can't do everything, but then maybe through  
14 NQF, there should be some surrogate measures  
15 that can help increase it. I know the whole  
16 onus is it's supposed to be outcome driven.  
17 We say you're supposed to achieve this, now  
18 provider, health plan, whoever, you go figure  
19 it out. But if after three to six years we  
20 can see they're not figuring it out, maybe  
21 there should be like, okay, let's take one  
22 step back. Just because our whole goal is

1 really to get the quality to improve. And I  
2 just -- and that's what I struggle with, when  
3 they're asked for 100 or 52 measures and then  
4 they're like going berserk.

5 MS. LIU: So I think, you know, when  
6 we take the national average of several  
7 hundreds of plans, it's hard to see a huge  
8 movement from year to year. But if you drill  
9 down to original levels you'll see larger  
10 improvement. And also observe large gap  
11 between -- among plans, potential low  
12 performing, high performing plans, there are,  
13 you know, 20 percent to 40 percent difference  
14 between those plans. So we try to, you know,  
15 have that as a tool for plans to monitor and  
16 how they can be better.

17 DR. BURSTIN: Just to respond to  
18 Vanita, thanks for adding that in. I think  
19 that's such an important issue broadly across  
20 the measurement enterprise. We just -- we  
21 don't have very robust feedback loops about  
22 what's happening on the front line, what's

1     working, what's not. There's lots of pockets  
2     of it that, you know, very well develop  
3     developers like NCQA and Joint Commission do.  
4     But overall, we just don't know very much  
5     about which measures move the needle and which  
6     measures don't. And I think that's -- and  
7     what are the factors that go with it? You  
8     know, people often point to the, you know, the  
9     significant reduction in the early elective  
10    deliveries, for example -- apologies to the  
11    psychiatrists -- you don't have much time to  
12    spend thinking about obstetrics.

13           But you know, there's reasons why  
14    that measure went down. You know, it's a  
15    standardized measure, there was complete  
16    agreement on the part of all the stakeholders  
17    that this was bad for moms, bad for babies.  
18    I mean, so there's a whole series of things,  
19    and I just think we need to increasingly think  
20    about -- and some of this gets back to Mady's  
21    point about how this all comes together to  
22    create sort of the plan in the grouping, or

1 back to your point about how to take the  
2 outcome and sort of nest it perhaps with the  
3 process measures. It's just about sense  
4 making, I think, and there's been very little  
5 sense making in our measurement system. So  
6 we'd love to take on a bigger role there.

7 MEMBER PATING: In that respect, I  
8 would be interested, I mean, if it's possible  
9 on some measures, coming back at like five  
10 year reviews, particularly as you go through  
11 new coding systems and just looking at -- you  
12 know, given where we are now, would we have  
13 launched some of the measures were did, you  
14 know, in cycle one or zero, and these things  
15 evolve. And so I know that it's done at the  
16 NCQA level and the shop level. But in terms  
17 of the National Quality Form, giving it sort  
18 of a cushion. We launch ships but we don't  
19 see them coming back in some way.

20 DR. BURSTIN: I mean, it's actually  
21 important to remember. I mean, at least  
22 probably about a year ago we did the analysis

1 and a 100 new measures came in and 100  
2 measures went out. So there is an effort to  
3 make sure that when there are measures that  
4 have just outlived their time, they need to  
5 go, but that's hard to do because there's a  
6 lot of people who are pretty tied to those  
7 measures for lots of programmatic reasons and  
8 other reasons.

9 So you know, I think we just want to  
10 make sure that whatever people are collecting  
11 and analyzing is actually helping to drive  
12 quality. But I think that's going to be a  
13 dream.

14 Well I mean, you do have, as part of  
15 all the maintenance measures, you know, what's  
16 in there for use and usability should improve  
17 the trends, it should improve where the  
18 measure is currently. And actually Peter and  
19 Harold are part of a standing committee focus  
20 group we did with the chairs of a whole group  
21 of our standing committees who made some  
22 pretty strong recommendations about how to

1 change our three-year maintenance process,  
2 being much more heavily oriented towards these  
3 issues of use and usability.

4 CO-CHAIR BRISS: Now we've -- the  
5 good news is that we've kind of reached a  
6 steady state, and the bad news is that the  
7 total of the claim measures is still something  
8 like 700.

9 DR. BURSTIN: No, it's 600.

10 (Laughter)

11 CO-CHAIR BRISS: I consider that to  
12 be a rounding error, Helen.

13 DR. BURSTIN: It's across many  
14 different settings and compilations.

15 CO-CHAIR BRISS: All right. So does  
16 Caroline want to get back in?

17 MS. DOEBBELING: I would if I could.  
18 Thanks, Peter.

19 In listening to the conversation, I  
20 think that there are a couple of things that  
21 we haven't brought up. I believe in the  
22 measures and what we are trying to do, but I

1     often am voting no because practically, I have  
2     seen the National Quality Forum endorsement  
3     being used against providers or health plans  
4     to say this National Quality Forum approved,  
5     therefore it's fantastic and therefore you  
6     have to use it. But the practicality of doing  
7     that is something that I think we don't talk  
8     about and we don't -- from the platform that  
9     NQF has, to help prioritize the measures or to  
10    say that for all primary care providers, these  
11    are the top ten things that will drive health  
12    in our population. It's weight, it's tobacco,  
13    it's blood pressure, it's X, Y or Z. And  
14    that's what we need to focus on.

15           From a very practical point of view,  
16    have a health plan working with providers, we  
17    have significant, significant access issues.  
18    The marketplace has only made those access  
19    issues harder because there are now more  
20    insured patients vying for smaller numbers of  
21    slots to meet many of the requirements. So  
22    the members fall into some plan's denominator,

1 but practically there is no place to put that  
2 person.

3 I don't think that the measures are  
4 going to help us change the access issues. I  
5 think that's something entirely different and  
6 a different type of conversation that we need  
7 to bring. But what happens then is providers  
8 and health plans become penalized by that  
9 because they have patients in their  
10 denominators that they practically can't be in  
11 their clinics because of those issues.

12 I also think the other practical  
13 issue at the provider level is that any  
14 provider office who has a mix of patients is  
15 going to have a mix of insurers. Whether  
16 that's Medicare, Medicaid or any of the  
17 private insurers. And so what I have seen is,  
18 to the extent that health plan with the  
19 richest incentive program or the richest pay  
20 for performance program, that's the plan that  
21 gets the most attention from the clinic. And  
22 so in Medicaid, I don't have the funds to



1 compete against some of the lucrative pay for  
2 performance programs or commercial plans,  
3 especially when the commercial plans may make  
4 up that provider's vast majority of their  
5 population. If it's a huge practice, you  
6 know, 80 percent versus 20 percent or  
7 something.

8 And so in populations where we don't  
9 see the needle being moved, I think that we  
10 have to think about what those reasons are for  
11 that. And I think the NQF would be in an  
12 ideal position to start taking a look at those  
13 broader issues.

14 CO-CHAIR BRISS: So this has  
15 continued to be a great conversation. I do  
16 just want to remind us that we're nearing the  
17 end of our time and it might be great to  
18 continue this conversation over dinner and  
19 perhaps a glass of wine or so. And within the  
20 bounds of healthy alcoholic use, right?

21 So Michael, do you want to have the  
22 last word?

1           MEMBER LARDIERI: I don't know if  
2           it's good to have the last word here.

3           But I'm listening to the  
4           conversation and I agree with what Caroline  
5           was saying. And I think some of the  
6           proliferation of the measures, like what we  
7           saw today, the measures for behavioral health  
8           are pretty much the same as they are for any  
9           other patient medically. And we might be able  
10          to lower the number of measures but require  
11          that they get reported on across race,  
12          ethnicity and then different populations.  
13          It's the same measure, and I just want to see  
14          -- I have some discomfort with behavioral  
15          health being pulled out as something separate.

16          We're trying to integrate, as  
17          opposed to keep us separate, so it should be  
18          the same measure. But then we should measure  
19          across race, ethnicity. I don't think we can  
20          not do that. And then across, okay, SMI and  
21          then maybe other populations. Instead of  
22          coming with a new measure for a specific

1 population, use the same measure and just say,  
2 okay, now we have this special population that  
3 we want you to measure on and it's all the  
4 same.

5 Because at the provider level, I  
6 agree with Caroline that, you know, if you  
7 have ten different plans you have ten  
8 different measures, it's really difficult to  
9 do that at the provider level. But if you  
10 have one measure that you just stratify and  
11 report on across race, ethnicity and sub-  
12 populations, I think that might reduce  
13 measures, get everybody on the same page, be  
14 easier to report on in the future.

15 CO-CHAIR BRISS: That seems like a  
16 great last word. Anybody else want to add?

17 Any more comments from the staff  
18 about -- anybody need reminders about dinner  
19 or where that happens or those kind of issues?

20 MEMBER DOEBBELING: And I'll look  
21 forward to my glass of wine.

22 (Laughter)

1 CO-CHAIR BRISS: All right,  
2 Caroline.

3 MEMBER SAMPSEL: So dinner  
4 reservations are at 6:00 p.m. at Mio. Mio is  
5 just north of L on Vermont, so out of the  
6 hotel, go up to L, take a right, take -- go  
7 two blocks, take a left and it's right there.  
8 It's on your left. It's eleven-something-or-  
9 other. You really can't miss it.

10 CO-CHAIR BRISS: So if anybody would  
11 like, I'll figure out an address by then and  
12 we can meet in the hotel lobby like a quarter  
13 of 6:00 and walk over. Is that okay?

14 MS. BAL: Kathy, could you just let  
15 everyone on the line know that we're  
16 adjourning for the day and we'll see them in  
17 the morning?

18 (The meeting was adjourned at 4:47  
19 p.m.)  
20  
21  
22

A				
<b>a.m</b> 1:9 6:2 161:4,5	<b>Academy</b> 69:21	<b>ACOs</b> 264:8	114:8 163:14	373:18,22
<b>A1c</b> 5:2,8,10	71:13 128:16	<b>act</b> 20:18 272:12	184:1 194:20	<b>administrative</b>
250:19 261:9	142:17 143:17	<b>acted</b> 195:2	195:20 239:2	66:10 84:7 107:17
267:12 317:14	162:9 164:16	<b>acting</b> 179:19	251:17 278:19	234:13
321:20 337:6	170:20 277:10	180:12 199:5	289:15 374:21	<b>administrator</b>
347:15,18,19,21	<b>acceptability</b> 65:18	<b>action</b> 1:21 79:9	376:17 388:11	124:22
351:12 355:5	72:18 91:3 177:18	369:5,14,16 370:3	<b>addressed</b> 75:14,22	<b>admission</b> 25:7
368:20	320:15 328:12	370:6	111:13 119:20	361:8
<b>A1c's</b> 352:10	344:17 350:12	<b>activities</b> 286:11	245:8 290:9	<b>admitted</b> 117:18
<b>AACAP</b> 128:15	<b>acceptable</b> 102:14	<b>actual</b> 40:17 45:2	310:19 373:6	<b>ado</b> 354:10
<b>AAP</b> 71:12 128:13	143:12 343:10,12	47:21 55:3 62:18	377:1	<b>adolescent</b> 3:6 4:8
<b>abide</b> 126:9	368:8	185:1 277:7	<b>addresses</b> 65:5	4:12,12 35:15
<b>ability</b> 56:8 183:10	<b>accepted</b> 89:9	<b>acute</b> 248:13	166:1 183:7	54:18 69:22 71:13
197:3 203:13	<b>accepting</b> 143:11	306:21	<b>addressing</b> 46:20	128:17 163:18
258:7,8 293:15	<b>access</b> 7:4 31:14,19	<b>ad</b> 90:1 94:3,12,15	102:11 240:20	164:5,14,17,22
315:2	32:7 68:9 144:18	98:2,5	<b>adds</b> 55:8	165:5 170:20
<b>able</b> 6:16 7:4,12	144:20 206:4	<b>adapted</b> 209:6	<b>adequate</b> 144:15	<b>adolescents</b> 166:6,9
31:18 35:5 37:15	232:1,15 234:6	293:1	326:22 327:1	166:10 171:1
49:4 57:8 61:3	241:18 244:14,16	<b>adapting</b> 185:19	<b>adequately</b> 12:5	172:21
75:17 76:8 89:3	244:20 281:7	<b>add</b> 71:1 94:5,16	<b>ADHD</b> 4:8,9 24:11	<b>adopt</b> 323:4
94:14 98:22 120:1	285:12 314:8	95:17 102:21	25:13 104:12,13	<b>adopted</b> 189:20
127:6 135:1,11	358:8 383:17,18	154:14 156:20	104:15,19,20	<b>adult</b> 43:12
170:14 188:13	384:4	158:11 172:18	105:11,21 106:3	<b>adults</b> 166:16
189:7 190:8	<b>accidents</b> 260:7	179:10 285:8	106:16,18,19,20	172:22 296:5,8
191:21 196:11	261:12	289:7 316:6 330:7	107:1,11,22 109:2	318:13
203:7 205:21	<b>accompanied</b> 104:2	330:9,12 343:17	110:1,18 111:1	<b>advance</b> 15:9
208:11 209:5	<b>accompany</b> 102:6,8	343:19,20 344:19	112:13 118:1	<b>advantage</b> 252:5
215:14 234:6,9	<b>accountability</b>	346:4 387:16	119:2,2,7,16,19	<b>advisory</b> 111:15
236:2 242:16	91:22 125:12,19	<b>added</b> 84:18	121:14 129:1	144:15 284:2
243:21 244:17	127:2,20 132:3	335:22	130:13 133:4,5,17	<b>advocate</b> 82:3
253:4 258:17	184:12 212:2,4	<b>Addiction</b> 2:7,16	134:7 136:1	<b>advocating</b> 43:11
261:17 265:12,15	213:6 216:21	13:8	158:21 263:3,7	<b>Aetna</b> 1:15 11:15
386:9	233:21 244:19	<b>adding</b> 241:16	<b>adhere</b> 101:16	11:16
<b>above-entitled</b>	340:19	288:13 378:18	245:12	<b>affect</b> 305:17
161:3 228:13	<b>accountable</b> 213:5	<b>addition</b> 84:1	<b>adherence</b> 24:4	<b>afternoon</b> 188:6
325:12	263:20 265:3	231:13 267:17	109:10 117:10,13	228:18 230:5
<b>absence</b> 255:4	273:15 374:2	271:9 319:2	134:16	364:8 372:11
<b>absolutely</b> 113:8	<b>accounting</b> 166:17	<b>additional</b> 29:17,19	<b>adherent</b> 110:7	<b>afterward</b> 221:3
256:9 257:20	<b>accurate</b> 84:17	70:12 75:6 107:9	<b>adheres</b> 189:19	<b>age</b> 36:12 39:21
<b>abstract</b> 215:19	334:16	150:8 158:12	<b>adjourned</b> 388:18	54:18 55:20 70:5
<b>abstraction</b> 180:15	<b>accurately</b> 49:9	161:10 179:10	<b>adjourning</b> 388:16	166:18 169:8,10
298:9 312:17	79:4 178:4 203:4	212:15 216:13	<b>adjust</b> 91:21	170:10,18,19
<b>abstractors</b> 181:2	<b>achieve</b> 21:7 264:2	221:1,10 224:14	<b>adjustment</b> 91:16	171:8 257:15
<b>abuse</b> 179:18 180:2	377:17	225:16 271:10	96:6 258:11	303:12,14 321:16
204:15 230:11	<b>achieving</b> 237:4	300:7	<b>administered</b> 49:20	321:19
244:7	<b>acknowledge</b> 182:8	<b>address</b> 46:10	<b>administration</b> 2:5	<b>agenda</b> 8:3,7 33:11
	<b>ACO</b> 122:11	51:10 78:8 101:13	15:11 84:6 230:12	35:1 104:10

218:18	95:2,9 113:16	260:14 289:6	285:6	165:12 231:20
<b>ages</b> 39:20 107:1	182:1 223:19	<b>annually</b> 375:4	<b>applies</b> 72:19 74:6	232:3,9 254:11,13
166:17 171:5,10	235:13 237:4	<b>answer</b> 34:5 63:10	<b>apply</b> 101:17	<b>arena</b> 80:19
<b>ago</b> 31:13 150:15	246:17 291:4,7	73:21 76:3 97:11	170:22 211:19	<b>argue</b> 143:2
154:13 230:14,15	314:8 364:19	210:20 297:5	255:16 333:11	<b>arguing</b> 67:9 150:5
230:19 380:22	<b>allowed</b> 38:3	<b>answered</b> 151:8	343:6,8	<b>argument</b> 95:13
<b>agree</b> 57:11 82:9,15	135:15	<b>anti</b> 273:11	<b>applying</b> 102:4	204:6 240:8 293:9
100:5 108:11,19	<b>allowing</b> 247:1	<b>anti-depressant</b>	153:6 302:10	331:2
125:8 171:19	<b>allows</b> 198:19	150:15	<b>appreciate</b> 135:4	<b>arguments</b> 300:20
181:3 204:6 214:4	236:19 273:2	<b>anti-depressions</b>	228:21 241:10	<b>Arkansas</b> 2:16,16
253:16 258:15	<b>alluded</b> 334:21	150:20	247:19 265:22	16:5,9 84:11
267:7 281:7 283:6	372:18	<b>anticipating</b> 301:21	274:6	<b>arranged</b> 108:22
326:16 354:7	<b>Alpert</b> 12:20	<b>antipsychotics</b>	<b>appreciates</b> 335:8	<b>arrangements</b>
377:8,11 386:4	<b>Alpha</b> 67:4	285:17	<b>approach</b> 10:13	311:10
387:6	<b>altered</b> 233:15	<b>anxiety</b> 204:14	43:18 112:8	<b>art</b> 203:3
<b>agreed</b> 109:16	<b>alternative</b> 236:5	<b>anybody</b> 7:21	113:14 132:18	<b>article</b> 197:20
178:2 181:2	<b>AMA</b> 3:15,15,16,17	46:21 47:6 110:11	144:14 184:9,21	<b>articulate</b> 48:3
326:21	3:19 164:17	157:2 170:8 275:7	191:8 203:11	<b>articulated</b> 80:4
<b>agreement</b> 178:11	<b>AMAPCPI</b> 163:16	290:18 300:19	215:20 232:8	<b>artifact</b> 333:13
293:8 348:2	164:1	301:16 327:14	255:11,15 258:1	<b>artificial</b> 277:5
352:19 359:2	<b>amazingly</b> 359:8	328:21 329:18	262:10 339:5	<b>asked</b> 22:1 29:21
379:16	<b>ambiguous</b> 55:5	330:11 345:1,22	<b>approached</b> 51:14	37:13 145:21
<b>agrees</b> 158:5 353:2	<b>Ambulatory</b> 2:17	346:4,14 349:1	<b>approaches</b> 135:8	199:12,13,19
<b>ahead</b> 62:17 63:7	14:8	350:15 353:19	<b>appropriate</b> 51:18	238:16 303:5
67:20 118:16	<b>American</b> 7:19	355:9,10 364:13	96:6 105:22	376:21 378:3
159:22 242:22	69:21 71:12	364:21 387:16,18	172:14,16 179:2	<b>asking</b> 25:21 31:5
315:18 325:5	128:16 162:7,8	388:10	183:3 215:18	44:12,13 68:13,19
348:12	164:16 277:10	<b>anymore</b> 63:22	247:9 334:15	145:14 150:6
<b>aim</b> 59:5 62:2	<b>amount</b> 9:19 69:7	<b>anyway</b> 45:14	351:11	174:6 175:1,2,3
<b>al</b> 171:3	212:22 243:11	260:1	<b>appropriately</b>	200:19 201:1,7,9
<b>alcohol</b> 24:4,10,19	271:8,13	<b>AOD</b> 233:12	101:4	203:1 207:4
24:21 25:12	<b>amounts</b> 127:13	<b>apologies</b> 35:8	<b>approval</b> 165:18	210:15 211:4
197:11 232:7	<b>analysis</b> 105:4	162:19 379:10	<b>approve</b> 297:5	229:7 308:2
243:6,16 244:6,13	139:20 221:6,8	<b>apologize</b> 34:13	<b>approved</b> 133:13	<b>asks</b> 210:9
254:20 267:4	380:22	64:7 242:21 322:3	383:4	<b>ASPE</b> 230:16
<b>alcoholic</b> 385:20	<b>analyst</b> 3:10 8:20	<b>apparently</b> 17:21	<b>approving</b> 370:2	<b>aspect</b> 20:20 65:7
<b>algorithm</b> 73:14	<b>Analytics</b> 2:10	187:16	<b>approximately</b>	<b>aspects</b> 73:20 240:6
74:13 76:12	17:11	<b>appear</b> 134:11	38:5	241:11 313:7
139:19 140:4	<b>analyzed</b> 197:5	364:5	<b>APRN</b> 2:3	<b>assess</b> 36:10 58:16
342:13,14,15	<b>analyzing</b> 381:11	<b>appears</b> 298:14	<b>area</b> 22:10 23:7	112:22 138:7
<b>aligned</b> 303:17	<b>and/or</b> 47:22 244:6	<b>applicability</b> 91:7	56:7 109:17	143:5 168:12
<b>alive</b> 101:2	<b>Angela</b> 3:12 4:3,6	<b>applicable</b> 150:13	120:20 166:1	184:14 195:22
<b>all-or-nothing</b>	8:16 23:17 26:9	<b>application</b> 101:22	168:22 171:22	203:11,12 224:7
370:9	97:18 139:15	117:21	174:5 231:5	<b>assessed</b> 66:12
<b>Alliance</b> 1:21 2:18	<b>Ann</b> 4:4	<b>Applications</b> 367:4	254:14 309:21	167:1 177:22
14:9 38:7	<b>Ann's</b> 63:22	<b>applied</b> 44:6	<b>areas</b> 24:3,17,21	179:6 196:12
<b>allow</b> 7:10 36:14	<b>annual</b> 89:22	251:20 252:3,10	25:4 26:5 57:8	200:15 204:18

207:18 213:22	290:12 326:15,20	<b>babies</b> 379:17	103:12 139:3	<b>base</b> 18:16 21:1
<b>assessing</b> 138:6	328:13 329:12	<b>back</b> 38:4 49:1,10	140:6,14,20 141:6	243:22
145:14,15 203:8	330:8	52:19 74:20 75:8	141:9,12 155:12	<b>based</b> 49:20,21
365:18	<b>Atlanta</b> 63:21	80:12 88:14 89:10	155:17 156:5	67:8 80:17 92:9
<b>assessment</b> 4:13,14	<b>attached</b> 185:4	89:21 93:14 94:2	157:8,13 159:13	105:12 110:8
5:1 42:16 43:10	<b>attempt</b> 199:1	94:3,8,12,14	159:18 160:8,13	111:13 113:21
58:9 71:18 82:20	<b>attempted</b> 203:9	96:17 98:2,10	175:11,17 176:10	135:20 144:14
90:15 163:19	<b>attempting</b> 258:20	99:6 100:16	176:15 177:7,12	165:12 173:11
167:2 169:4	<b>attempts</b> 166:14	101:20 102:13,18	185:11 190:5,10	178:7,11,12 182:4
171:11 174:13	169:4 171:21	103:3 111:1	219:8,15 220:3,17	183:5 208:1 216:3
176:6 182:3,6	173:7,10,13	121:22 122:3	221:11 224:21	232:22 249:3
183:6 186:22	<b>attendance</b> 55:1	135:1 150:14	225:2,6 226:1,8	265:8 278:13
191:5,7 192:4,11	72:5	151:14,19 152:5	226:12 227:7,12	279:5 280:16
192:16 193:12	<b>attention</b> 5:4	152:16 161:1	228:4 291:14	295:12 299:18
194:9,10,18,21	114:11 153:11	173:17 177:5	297:10 298:16	351:12 354:7
196:4,16 198:11	218:22 231:17	186:8 193:20	299:4,11 300:9	366:8 374:15
199:5 202:1 203:1	232:1,5 236:9	194:7 208:5,14	301:2 308:7,12	<b>baseline</b> 215:18
203:20 204:1,8	315:5 325:21	218:7,20 219:5	311:14 315:14	365:13
205:13 208:7	351:6 384:21	220:18 228:5,10	316:12 317:1	<b>basic</b> 84:22 244:9
212:11,18 217:13	<b>attributed</b> 373:19	228:12 238:12	319:18 322:6,10	<b>basically</b> 20:17
217:16,18 229:17	<b>attributes</b> 368:18	239:12 253:1	323:11,16 324:7	21:6,10 22:15
373:7	<b>atypical</b> 285:15,17	257:2,2,12 272:1	324:21 327:17	52:15 144:3
<b>assessments</b> 24:5	<b>August</b> 123:11	272:2 274:10	329:1,20 330:14	323:22 335:21
25:16 167:11	<b>authority</b> 134:6	275:3 314:2 327:9	331:4 344:2 345:7	347:22
174:20 183:2	191:17	329:11 338:9,9	346:8,16 347:5	<b>basing</b> 148:20
<b>assigned</b> 18:10	<b>autism</b> 130:13	364:10,13 368:22	349:4,7,11,17,21	<b>basis</b> 132:19
29:14	<b>automatically</b>	375:2,16 376:22	350:4,9,20,22	<b>batteries</b> 60:1
<b>Assistant</b> 2:8 230:9	299:7 318:18	377:10,22 379:20	353:10,12,22	<b>Beale</b> 2:19 15:1,2
<b>associate</b> 2:3,12 3:4	<b>available</b> 7:2	380:1,9,19 382:16	354:2,11,13,19,22	49:17 50:3 57:2
12:20	173:11 204:4	<b>backfired</b> 150:19	355:15,18 356:2,6	82:9 124:21 151:4
<b>associated</b> 38:17	216:3 225:15	<b>background</b> 15:19	356:13,18 357:2,7	241:13 272:18
85:14	256:14 313:22	28:5 59:6 81:20	357:14,17 359:17	277:8 343:18
<b>Association</b> 162:7	<b>average</b> 144:8	161:17,19 164:8	359:20 360:2,8,13	344:20 345:3
164:16	216:4,6 378:6	184:21 190:1	361:18,22 362:3,8	346:2,6 365:3
<b>assume</b> 54:16	<b>AVP</b> 13:10	206:13	362:11,17,20	<b>bear</b> 173:19
<b>assumes</b> 129:15	<b>awaiting</b> 35:4	<b>backgrounds</b> 9:6	363:4,10,16	<b>beat</b> 224:4
<b>assuming</b> 209:20	<b>awake</b> 361:2	<b>backwards</b> 221:9	388:14	<b>becoming</b> 9:21
315:17 336:19	<b>awarded</b> 101:6	<b>bad</b> 317:8,10	<b>balance</b> 282:16	<b>began</b> 230:13
<b>assumption</b> 117:12	<b>aware</b> 10:20 23:6	326:17,18 327:11	<b>balancing</b> 55:18,22	<b>begged</b> 246:8
143:18 180:19	141:7 319:21	327:11 379:17,17	58:22	<b>beginning</b> 19:12
<b>Atkins</b> 1:15 11:13	334:11	382:6	<b>ball</b> 211:12	31:3,8 50:10 80:5
11:14 44:9 56:5	<b>awareness</b> 149:19	<b>bailiwick</b> 366:21	<b>band</b> 230:22	111:18 149:22
76:21 98:4 194:4	181:5 210:15	<b>Bal</b> 3:10 8:19,19	<b>bang</b> 367:17	238:7 364:15
194:14,17 195:17	<b>awful</b> 371:8	20:15 32:1,9 59:3	<b>bar</b> 217:12,18,19	<b>behalf</b> 6:11
217:9 225:22	<b>Azul</b> 3:20	60:13,17 61:6,17	218:4	<b>behavior</b> 3:7 11:15
263:19 276:3		61:21 62:6,8,19	<b>barrier</b> 358:22	46:9 199:6 277:1
287:1 289:3,8		63:2,7 64:15	<b>barriers</b> 262:9	<b>behavioral</b> 1:3 2:1
	<b>B</b>			
	<b>B</b> 210:2 343:1			

3:4 6:5 12:2 13:13,15 14:16,18 14:21 15:7 16:1 22:3,6 24:7,11 76:22 77:11,13,15 77:22 78:3,4 79:6 85:10 112:19 114:5,8,15,16,22 115:4,9,14,22 116:10 118:21,22 119:4 127:10 132:1,22 147:6 151:16 154:4,15 162:1,2,3,5 231:18 234:3 242:15 246:20 247:14 248:2 251:5,10,20 252:1 252:4 254:11 276:11 277:4,12 281:6,7,13 282:5 287:16 310:6 313:5,19 314:2,22 386:7,14 <b>behaviors</b> 167:5 199:2 <b>belief</b> 213:20 <b>believe</b> 50:20 84:4 161:21 167:10 204:17 314:9 332:19 382:21 <b>believed</b> 169:11 <b>believes</b> 168:20 <b>bend</b> 18:2 <b>benefit</b> 115:1 281:6 <b>benefits</b> 14:22 45:2 <b>Bernadette</b> 2:12 13:18 76:20 80:21 168:1 169:18 177:18 224:3 <b>berserk</b> 378:4 <b>best</b> 52:6 53:3 141:21 151:13 175:1 318:20 <b>beta</b> 144:3 <b>better</b> 10:22 38:17 41:14 42:20 50:17	72:3,4,4,5 84:14 86:22 87:20 103:7 106:10 119:14 126:7 130:10 132:21 136:15 145:17,19 183:13 207:13 257:10 263:8 265:15 274:1 327:11,12 368:9 378:16 <b>beyond</b> 82:19 87:1 138:5 250:16 270:10 <b>bias</b> 75:20 285:9 <b>big</b> 37:1 127:8 187:8 210:11 234:20 294:6 295:20 358:5 <b>bigger</b> 358:6 380:6 <b>biggest</b> 40:19 262:9 280:22 <b>billable</b> 239:22 <b>billed</b> 241:20 <b>billion</b> 34:20 <b>binomial</b> 144:3,8 <b>bipolar</b> 283:13 284:17 <b>bit</b> 9:6,21 10:12 11:3 17:21 23:2 30:14 31:9 36:6 39:8,16 40:15 45:15 53:3 55:5 66:22 72:16 94:17 95:18 101:3 107:16 117:1 136:4 154:13 164:9 167:16 174:14 179:12 181:5 186:4 204:12 205:11 215:11 239:5 252:8 256:18 301:11 311:3 331:17 333:4 335:5,19 337:2 342:16 <b>blocks</b> 388:7	<b>blood</b> 4:16 5:5 239:17 250:20 261:9 267:3 274:12,14,20,22 302:7,10,13 303:13 304:4,19 305:9,11,18 306:3 306:14 317:21 318:9 331:11,14 331:18,19 332:2,6 332:7,20 334:3,6 334:12 335:2 336:6 337:3 338:6 338:6,12 340:3 341:8 342:1,3,14 368:19 383:13 <b>blow</b> 248:4 <b>BMI</b> 234:8 239:17 245:19 250:18 260:15,21 262:1 263:16 278:6 280:3,12,13 281:12 286:5 290:3,6 295:8 305:10,20 321:19 336:20 <b>BMIs</b> 339:9 <b>board</b> 127:9 162:8 223:2 <b>boat</b> 57:13 <b>Bob</b> 3:19 11:9,13 56:4 57:3 76:19 186:16 194:3 217:8 225:21 326:13 329:11 330:6 333:15 371:6 <b>body</b> 4:15 248:17 277:20 278:1 282:14 305:10 <b>bolstered</b> 320:19 <b>Bonnie</b> 3:5 14:2 28:1 136:20 152:3 156:19 158:11 177:18 179:8 211:16 224:3,13 242:7 290:16	<b>bonuses</b> 148:13 <b>booking</b> 6:19 <b>boom</b> 177:6,6,6 <b>bordering</b> 180:6 <b>boss</b> 337:20 <b>boundary</b> 116:2 <b>bounds</b> 385:20 <b>box</b> 7:15 139:21 200:10,12 201:22 214:6 <b>boy</b> 340:13 <b>Brandeis</b> 2:2 12:1 <b>breadth</b> 50:22 <b>break</b> 4:11 5:7 8:6 100:10 157:6 160:22 227:17 325:6,7 <b>breakdowns</b> 257:17 <b>breaking</b> 108:4 371:21 <b>breaks</b> 8:2,4 106:21 <b>breakup</b> 123:10 <b>brevity</b> 281:20 <b>bridges</b> 37:8 <b>brief</b> 18:19 19:13 23:18 29:9 36:9 128:4 130:9 131:9 131:10 139:9 140:19 141:5,8,11 155:16 156:4,10 156:14,17 157:12 159:17 160:12 175:16 176:14 177:11 225:1,5,18 226:7,11 227:11 237:11 319:10 <b>briefly</b> 17:8 23:1 93:5 <b>bring</b> 20:20,22 30:21 31:5 32:5 55:17 99:6 102:18 186:13 190:8 228:9,12 272:2 336:16 341:2 384:7	<b>bringing</b> 23:13 206:7 317:20 376:5 <b>brings</b> 100:21 151:6 241:16 <b>Briss</b> 1:9,11 4:2 63:19,22 85:6 92:5,21 93:20 94:1 97:10 102:20 104:14,21 106:13 109:13 116:12 118:7,10,15 120:16 122:2,7 127:22 131:2 133:18,21 136:9 137:2,11 138:22 140:12 141:16 145:3 149:12 150:3 152:3,14 156:16,19,22 157:5,17 159:8,11 160:3,7,20 161:6 162:14,17 174:11 174:17 181:17 202:16 211:9 222:6,20 228:16 229:6,15 237:8,12 237:14 238:18 240:7 242:7,20 250:22 256:5,10 257:1 258:13 259:10 261:5 267:14 271:5 274:7 275:6 277:18 281:17 283:2,5,8 290:16 291:11 292:20 297:4 298:4 299:16 300:19 301:10,14 304:9 305:3,13 306:18 307:21 309:7 310:20 311:11 312:12 313:13 315:11 316:1,8,21 317:7 319:7,13,16 321:11 322:4,8
---	---	---	--	--



323:8,14 324:4,18 325:5,15,18,22 326:4,13 327:8 328:21 329:11,18 330:6,11 331:1,10 333:2 337:18 339:21 341:4 342:10 343:12,22 344:18 345:1,5,22 346:4,5,14 347:3 347:12 348:21 349:3 350:18 351:5,16,22 352:21 353:7,19 353:21 354:9 355:6,13 357:21 358:10,13 359:7 359:14 360:22 363:18 364:5 370:8 382:4,11,15 385:14 387:15 388:1,10 <b>broad</b> 32:17 43:13 165:19 203:10 209:2 243:21 <b>broaden</b> 231:7 <b>broader</b> 204:21 231:7 336:14 385:13 <b>Broadlawn</b> 2:21 <b>broadly</b> 47:18 51:11 133:1 269:7 269:8 378:19 <b>broken</b> 31:15 <b>brought</b> 21:2 69:1 81:3 97:4 173:17 190:10 230:17 268:20 309:13,22 313:6 382:21 <b>Brown</b> 12:21 <b>bubble</b> 72:7 <b>buck</b> 367:17 <b>buff</b> 101:2 <b>bulk</b> 119:7 <b>bunch</b> 195:21 241:4 <b>bundle</b> 260:9,10,14	261:18 <b>burden</b> 95:4 198:9 212:15 240:5 298:9,10 312:18 323:5 329:16 367:16 <b>burdensome</b> 198:1 <b>Bureau</b> 2:6 13:6 <b>Burstin</b> 3:11 162:14,16,19,21 220:15,18 221:17 222:9,19 223:1,14 255:6 256:9,12 259:4,9,13,17 269:20 270:5 361:13 365:20 378:17 380:20 382:9,13 <b>business</b> 264:13 <b>busy</b> 207:5 <b>Butler</b> 3:1 12:17 <b>button</b> 17:8 32:11 61:3 62:16 299:1 <b>buy</b> 266:1 <b>buying</b> 191:20  <hr/> <b>C</b> <hr/> <b>C</b> 4:1 6:1 <b>calculated</b> 216:10 <b>calculating</b> 184:18 <b>calculus</b> 147:11 <b>California</b> 34:16 34:18,20 <b>call</b> 19:17 25:2 28:15 36:2 47:4 71:5,8 76:18 86:20 317:17 336:9,14 372:21 <b>called</b> 11:20 190:1 191:16 <b>calls</b> 11:7 33:10 135:12 317:16 <b>Cambridge</b> 38:7 <b>cancer</b> 130:2 260:8 <b>capital</b> 19:22 <b>caps</b> 32:1 <b>capture</b> 132:8 134:22 138:13,14	183:11 198:13 336:8 364:19 <b>captured</b> 79:3 183:16 192:10,18 197:5 313:8 <b>capturing</b> 79:4 <b>car</b> 358:16 <b>card</b> 290:17 <b>cardiac</b> 130:4 <b>cardiovascular</b> 260:6 302:14 <b>cards</b> 20:2 116:13 128:1 131:8 203:15 275:9 291:12 <b>care</b> 2:20,20 4:8 5:2,3,5,8,9,11 15:6,22 16:2 25:10 34:2 43:16 45:21 49:2 56:19 69:19 77:14 78:7 85:19 94:19 100:22 104:12,19 106:16 119:3,8,22 129:19,19 132:6 132:10 135:8 144:18 148:9 153:11,14 158:2,8 167:9,14,15 172:22 206:17 207:13 211:10 213:16,20 214:15 214:22 215:4 216:19 230:20 231:1 232:15 233:13,16 234:4 235:17 241:5,21 242:12,17 244:14 244:17,20 245:2 246:1 247:16,18 248:5,11,15 249:15,19 250:6 253:5 254:19 265:9 270:14 273:9 274:21 276:8 279:14 285:13 286:2,3,4	302:17 303:8 307:3 308:3 310:3 312:20 313:5 314:17,21 317:13 319:5 325:19,20 331:13 337:22 342:12 347:14 348:16 355:4 358:2,20,21 359:1 368:6,11,14 369:21 374:12 383:10 <b>careful</b> 85:9 <b>carefully</b> 288:11 <b>Carney</b> 1:16 16:18 <b>Caroline</b> 1:16 16:12,15,16,18 118:11,16 133:20 133:21,22 141:10 267:14 298:20 304:9 309:7 312:12 316:1 358:10,11,13 359:7 382:16 386:4 387:6 388:2 <b>carried</b> 337:16 <b>carries</b> 123:20 <b>carry</b> 332:9 338:1 340:4 <b>carryover</b> 24:19 <b>cars</b> 359:11 <b>carve</b> 116:1 <b>carve-out</b> 119:5 <b>carve-outs</b> 310:7 313:6 <b>carved</b> 119:1 <b>carves</b> 264:20 <b>carving</b> 115:22 <b>case</b> 20:1 68:1,8 70:15 76:5,7 86:8 95:16 102:19 227:7 281:10 285:20 <b>caseload</b> 36:16 <b>cases</b> 129:1 146:17 158:21 <b>catalog</b> 269:9	<b>catch</b> 94:15 <b>categories</b> 177:4 <b>causal</b> 146:20 <b>cause</b> 166:15 287:9 <b>causes</b> 260:6 373:20 <b>causing</b> 127:12 351:14 <b>cautious</b> 149:1 <b>CBHI</b> 66:18 <b>CDC</b> 1:11 <b>cells</b> 373:15 <b>center</b> 1:12,17 64:4 131:5 191:17 206:11,16,17 207:6 209:13 <b>Center/National</b> 1:21 <b>Center/Suicide</b> 1:20 <b>centered</b> 45:21 94:19 <b>centers</b> 209:18 215:3 272:9 303:1 <b>certain</b> 71:10 98:20 102:16,17 151:11 <b>certainly</b> 10:2 20:10 32:21 33:2 42:21 43:14 68:10 71:9 82:22 91:17 96:3 100:11 109:17 110:13 172:22 186:8,10 208:3 270:11 373:18 <b>chair</b> 3:7 35:5,5 90:5 211:22 267:14 269:2,22 271:5 274:7 275:6 277:18 281:17,18 283:2,5,8 290:16 291:11 292:20 297:4 298:4 299:16 300:19 301:10,14,17 303:19 304:9 305:3,13 306:18
--	--	---	---	--

307:21 333:16 <b>Chair's</b> 257:2 <b>chairs</b> 381:20 <b>Chalk</b> 1:17 64:9,9 87:5 96:9 99:10 99:15 131:12 186:19 187:5 195:13 265:22 266:3 295:22 296:6,10,15 368:22 <b>challenge</b> 77:4 <b>challenges</b> 196:10 197:2 314:13 <b>challenging</b> 54:13 69:4 <b>champions</b> 189:1 <b>chance</b> 163:10 331:2 <b>change</b> 56:15 61:13 61:18 73:11 80:9 80:15,17 116:19 130:17 262:1 264:15 279:16 287:14 289:11 290:8 291:1 304:5 382:1 384:4 <b>changed</b> 10:7 49:6 84:20 89:20 98:3 98:21 136:4 137:9 261:3 289:14 290:2 <b>changes</b> 57:5 72:17 90:1 97:22 99:1 188:22 311:2 318:6 <b>changing</b> 278:19 278:21 <b>characteristics</b> 90:15 168:11 <b>charged</b> 165:10 <b>chart</b> 145:13,20 180:15 234:14,15 235:22 298:9 312:21 323:6 361:5 375:18,19 <b>charts</b> 178:8,16	208:2 215:19 <b>chat</b> 7:15 <b>check</b> 62:11 144:7 200:10,12 201:22 202:2 228:7 342:3 <b>checkbox</b> 174:14 174:21 175:3 202:7 208:9 211:14 <b>checking</b> 112:3,9 299:2 341:22 342:1 <b>checklist</b> 4:9 28:3 35:3,7,16 66:4 84:7 93:7 132:15 238:15 263:6 <b>checks</b> 54:14 214:6 <b>cherry-pick</b> 267:9 <b>Chief</b> 1:16 2:6,13 2:16,19 3:11 13:6 13:19 16:18 162:21 <b>child</b> 1:18 3:6 4:8 4:12,12 14:4 15:15 35:15 37:6 40:22 47:22 53:19 54:14 55:21 69:21 71:13 84:14,16 112:4 119:21 120:5 125:15,21 126:20 128:16 143:4,9 152:10,12 154:3,10 158:10 163:18 164:5,14 164:15,16,22 165:5 170:20 <b>child's</b> 145:17 <b>childhood</b> 54:17 <b>children</b> 4:8 36:11 39:19,21 54:9,13 55:20 57:11,18 70:6 81:6 88:1,5 104:12,15,19 105:10,20 106:3,7 106:16,22 110:1,7 110:18 111:3,5,6 111:14 112:12,13	112:22 121:15 125:7 126:2 136:5 143:13 166:8 169:8 170:22 <b>children's</b> 1:18 15:15,17 105:15 <b>Chile</b> 37:2 68:17 72:2 <b>CHIPRA</b> 37:7 <b>choice</b> 170:18 <b>choices</b> 139:5 <b>chose</b> 170:18 <b>CHR</b> 167:19 <b>chronic</b> 1:12 132:18 184:11 185:20 211:18 231:1 232:5 236:9 240:22 284:8 285:1 338:22 339:6 <b>churning</b> 121:3 <b>circle</b> 25:19 <b>circles</b> 365:22 <b>circuit</b> 343:16 <b>citizens</b> 374:13 <b>City</b> 15:13 <b>claim</b> 111:1 119:17 382:7 <b>claims</b> 66:10,15 67:8 105:12 106:6 112:21 113:5,21 134:22 135:2 142:2 144:2 234:13 250:17 260:19 263:18 284:7 289:13 306:11 <b>claims-based</b> 105:19 231:11 <b>clarification</b> 49:18 52:20 72:16 83:13 120:21 286:1 376:11 <b>clarify</b> 60:11 96:1 168:4 185:1 205:12 303:20 <b>clarity</b> 198:15	247:2,21 272:22 273:18 277:16 <b>clashed</b> 333:21 <b>class</b> 52:7 152:10 <b>classic</b> 375:17 <b>classifications</b> 164:3 <b>clause</b> 180:3 <b>clear</b> 10:13 44:2 74:6,10 75:8 82:18,22 90:9 91:20 94:11 96:4 134:3 197:14 223:9 244:1 256:16 270:13 274:3 293:1,7 309:15 350:14 <b>clearer</b> 78:17 92:2 <b>clearly</b> 46:7 173:12 197:8 214:12 222:15 223:21 244:12 269:14 281:21 282:3 320:19 327:3 366:20 371:17 <b>Cleveland</b> 12:10 <b>click</b> 31:14 32:11 63:9 <b>clicking</b> 61:7 <b>clinic</b> 16:3 53:10 132:6 134:18 210:6,8 367:18 384:21 <b>clinical</b> 2:18 12:20 14:8,13 16:8 39:3 39:5 40:8,11 41:8 41:13 45:12 47:21 58:8 77:3 80:15 90:10,11 91:11 92:3 102:9 107:14 129:8 143:3 148:5 151:21 159:6 165:11 195:20 196:3,16 208:21 210:5,12 217:20 371:18 <b>clinically</b> 130:21	149:8 153:17 285:9 <b>clinician</b> 14:18 49:21 53:8 54:5 77:11,22 84:8,19 85:1 107:13 128:22 129:5,7 130:10 133:9 148:10 158:20 159:3,5 193:22 195:2 338:7 342:12 351:18 <b>clinicians</b> 33:14 77:15 78:5 149:3 189:2,6 216:4 <b>clinics</b> 1:19 15:16 16:2,2 68:8 172:4 211:4 384:11 <b>clock</b> 61:8,19 <b>clonidine</b> 133:4,11 133:14 <b>close</b> 18:3 340:14 <b>closely</b> 8:7 <b>closer</b> 11:5 <b>closing</b> 300:20 316:21 331:2 <b>clouds</b> 247:2 <b>clue</b> 48:6 <b>cluster</b> 339:18 <b>CMHC</b> 209:21 <b>CMS</b> 113:10 272:10 375:3 <b>CNM</b> 142:13 <b>co-chair</b> 4:2,2 9:8 11:4 26:8,11,19 30:19 35:11 38:20 40:14 43:20 45:7 47:1 48:19,22 49:13 50:8 51:13 55:4 57:1 58:3 60:10,14 61:19 62:4,22 63:4,17 63:17,19 64:12 65:16 66:20 68:11 68:13,18 70:18 71:2 72:13 73:2,5 74:1,5,16 76:15
---	--	--	---	--

76:17 80:2,21 82:8 83:6 85:5,6 87:4,15 89:8 90:4 92:5,21 93:3,20 94:1 95:22 97:9 97:10 99:18 101:10 102:20 103:10 104:1,6,9 104:14,21 106:13 109:13 116:12 118:7,10,15 120:16 122:2,7 127:22 131:2 133:18,21 136:9 137:2,11,15,17 138:22 140:12 141:16 145:3 149:12 150:3 152:3,14 156:16 156:19,22 157:5 157:17 159:8,11 160:3,7,20 161:6 161:11,18 162:11 162:14,17 163:5,9 163:13 168:1 169:13,16 170:12 170:15 171:13 173:16 174:4,9,11 174:15,17 175:6,9 176:8,21 177:2,16 181:12 184:22 185:8,13 186:12 190:3,7,12,18 191:1,10,18 192:5 192:8,15,20 193:1 193:7,11,18 194:2 194:13 195:9 198:14 199:12,18 200:1,18 201:10 201:15 202:4,8,16 202:21 205:14 206:6 211:9,21 217:7 219:6 222:6 222:17,20,22 224:2,13,16,19 225:10,19 226:22 227:3,16 228:8,16	229:6,15 237:8,12 238:18 240:7 242:7,20 250:22 256:5,10 257:1 258:13 259:10 261:5 309:7 310:20 311:11 312:12 313:13 315:11 316:1,8,21 317:7 319:7,13,16 321:11 322:4,8 323:8,14 324:4,18 325:5,15,18,22 326:4,13 327:8 328:21 329:11,18 330:6,11 331:1,10 333:2 337:18 339:21 341:4 342:10 343:12,22 344:18 345:1,5,22 346:4,5,14 347:3 347:12 348:21 349:3 350:18 351:5,16,22 352:21 353:7,19 353:21 354:9 355:6,13 357:21 358:10,13 359:7 359:14 360:22 363:18 364:5 370:8 371:11 382:4,11,15 385:14 387:15 388:1,10 <b>co-chairs</b> 1:10 7:10 <b>coalition</b> 258:21 <b>coat</b> 307:8 <b>cocktail</b> 93:11 <b>code</b> 196:21 202:3 <b>coded</b> 286:5 375:21 <b>coding</b> 380:11 <b>coefficient</b> 144:22 <b>cogent</b> 359:8 <b>cohesive</b> 262:10 <b>cohort</b> 171:2,3 <b>coin</b> 285:13 <b>collaboration</b>	115:21 <b>collaborative</b> 15:22 129:19 258:22 <b>colleague</b> 164:2 169:20 188:2 <b>colleagues</b> 38:7 <b>collected</b> 197:5 <b>collecting</b> 381:10 <b>collection</b> 156:12 157:22 <b>College</b> 2:14,14 12:7 13:20 <b>Columbia</b> 1:14 9:10 182:10 187:3 188:18 212:7,20 217:20 <b>combined</b> 15:19 121:15 <b>come</b> 7:6,22 10:6 23:3,8 27:7 29:2 40:7 55:17 58:19 58:20 88:14,18 89:10,21 90:13 92:2 94:3,7,12,14 95:3 96:2,17 98:2 98:10 100:16 102:13 103:3 122:3,20 126:21 149:7 177:5 187:7 218:20 219:4 220:18 221:18 232:3 238:12 254:5 256:1 275:3 287:11,22 288:21 299:21 301:22 340:10 367:3 <b>comes</b> 22:11 29:11 96:8 102:7 122:8 200:9 222:13 379:21 <b>comfort</b> 310:14 <b>comfortable</b> 98:14 195:5 211:14 285:21 321:9 <b>coming</b> 9:7 15:18 25:19 28:8 29:12 33:5 57:3 82:5	91:19 96:21 119:21 244:6 253:9 274:10 288:19 313:18 375:2 380:9,19 386:22 <b>comment</b> 5:15 7:12 7:14 33:9 49:10 55:4 70:20 90:6 90:22 93:4 118:9 124:22 129:17 130:8 142:21 154:19 155:2 156:21 158:16 165:16,17 216:17 218:10 223:16 224:8 225:21 229:11 234:22 241:14 242:9 300:7 306:21 310:21 329:19 349:1 351:6,9 363:17,21 364:1 373:17 376:14 377:10 <b>commented</b> 118:3 <b>commenting</b> 42:7 <b>comments</b> 7:1,10 20:3 21:15,21 29:17,19 31:18 32:10 47:20 48:19 51:12 53:5 85:8 104:7 107:20 109:6 110:4,16 122:14 131:21 134:15 145:1 157:2,21 158:13 158:15 159:9 168:2 169:13 170:1 174:10 175:7 176:22 179:8 181:12 186:15,17 205:6 217:13 219:1 220:14 221:18 224:15,16 225:11 225:17 227:4	229:8,13 237:9 240:3 257:3 275:21 293:10,21 296:22 297:8 304:15 305:1,7 306:19 308:6 309:11 311:11 312:15 313:13 315:11 316:4,10 319:16 321:11 323:9 324:5 325:17 327:14 328:22 329:14 343:21 344:22 345:2 353:7 363:19 364:3,6 376:12 387:17 <b>commercial</b> 144:7 296:18 385:2,3 <b>Commission</b> 379:3 <b>Commissioner</b> 34:17,18 <b>committee</b> 1:3,8 14:11 16:12 17:3 17:4 18:8 20:1,4,7 20:14,18 21:1 22:5,8,9,13 29:20 29:22 33:2 37:16 42:19 46:16,18 48:20 63:18 72:14 75:2 89:19 90:6 92:11 94:13 95:11 95:18 96:13 97:20 98:14,18 99:7 100:12,18 103:3 109:16 142:8 145:7 155:11 163:2,5 174:10 176:1 185:7 187:8 218:12,13 229:22 230:18 231:4,14 237:10 266:8,8 298:11 299:17 300:5 304:10 364:16 381:19 <b>committee's</b> 90:3 255:13
---	--	--	---	---

<b>committees</b> 94:18 96:14 102:22 381:21	<b>completion</b> 27:16 166:14 171:21	196:8 204:12 212:1 224:5	<b>condone</b> 257:21	<b>consensus</b> 58:7 59:9,10,12 148:1 148:19 220:11
<b>common</b> 44:16 109:2 238:21 239:2 282:1	<b>complex</b> 306:17	268:12 287:15	<b>conduct</b> 310:13 321:6	221:14 222:7,8,14 222:15 223:3,22 366:1
<b>commoner</b> 282:2	<b>complexity</b> 123:6	310:8,11 313:3,16	<b>conducted</b> 76:5 183:6 197:18 198:7 233:18 234:22 302:21	<b>consequences</b> 98:8
<b>commonly</b> 133:16	<b>compliance</b> 109:8	326:10 351:13	<b>conducting</b> 169:3 231:15	<b>consider</b> 42:8 85:21 90:19 93:9 95:4 186:9 218:7 221:2 224:10 231:10 234:18 238:1 244:15 258:3 382:11
<b>communication</b> 222:22	<b>complicated</b> 42:17 69:11 125:5	352:9,10,12,17,22	<b>conference</b> 1:8 11:7 162:4,5	<b>considerable</b> 212:22
<b>community</b> 27:22 165:16 206:16 207:6 209:12 272:8 302:22	<b>complicating</b> 126:22	<b>concerned</b> 81:12 84:15,21 91:5 119:4 146:3,9 148:2 152:6 181:21 186:4 206:18 214:16 254:15 267:16 277:1 284:4 374:14	<b>confess</b> 80:18	<b>consideration</b> 125:4 166:21 377:1
<b>community-based</b> 12:9	<b>complication</b> 125:2	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confident</b> 8:11 111:22	<b>considerations</b> 106:4 348:4
<b>commute</b> 63:21	<b>complications</b> 129:3 159:1 326:9	<b>concerning</b> 88:6 268:18 329:17	<b>confined</b> 336:11	<b>considered</b> 220:10 233:19 237:1 300:3 342:20
<b>comorbid</b> 224:12	<b>component</b> 294:13 295:10 314:2 340:18	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confirm</b> 134:20 332:4	<b>considering</b> 54:20 242:10
<b>comorbidity</b> 335:1	<b>composites</b> 271:11 364:17 368:16 370:9	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confirmation</b> 38:15 334:20	<b>consistency</b> 221:22
<b>comparability</b> 52:5	<b>comprehensive</b> 28:6	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confirmed</b> 307:6 334:19 336:10 337:13	<b>consistent</b> 74:19 75:3,11,11 94:18 127:17 191:7 283:17 303:15 305:15 318:8 342:5 368:14
<b>comparative</b> 52:11	<b>comprised</b> 212:22	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>conflict</b> 27:22 28:2 30:3 368:1	<b>consortium</b> 164:18
<b>compare</b> 236:2 294:3,10	<b>computers</b> 20:16	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>conflicts</b> 27:19,20 28:18,22 64:1,11	<b>Constance</b> 2:1 27:20
<b>compared</b> 52:5 54:11 144:5 186:1 212:21 213:2 214:5 234:21 358:8	<b>conceivably</b> 94:3	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confounding</b> 42:13	<b>constant</b> 144:11
<b>comparing</b> 53:18 214:21 295:16	<b>concept</b> 22:8 51:18 52:9 53:2 58:7 64:13 138:2,4,5,7 138:17,18 168:14 168:17 170:4 191:6 192:2,3 368:5	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confront</b> 250:21	<b>constituency</b> 272:8
<b>comparisons</b> 303:17	<b>conceptualize</b> 83:9	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confused</b> 39:8 96:20 274:4	<b>constitute</b> 192:11
<b>compete</b> 385:1	<b>concern</b> 53:12 74:15 75:22 77:8 77:9,17 81:14 85:4 87:17 92:8 100:14 110:5,9 114:14 118:19 145:12,15 168:22 178:14,19 179:4 182:22 186:11 191:19 194:5	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confusing</b> 280:7 331:17	<b>constitutes</b> 286:8 339:22
<b>competing</b> 50:21	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>confusion</b> 42:6 45:6 47:7 261:3 277:9,15	<b>construct</b> 106:1 144:16
<b>compilations</b> 382:14	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>Connie</b> 11:21	<b>constructed</b> 46:3 89:2 248:12
<b>compile</b> 151:7	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>Connors</b> 263:6	<b>construed</b> 129:4
<b>complain</b> 260:18	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>cons</b> 32:16	<b>consult</b> 337:5
<b>complaint</b> 376:21	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17	<b>consciousness</b> 213:7	
<b>complementary-t...</b> 372:9	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17		
<b>complete</b> 212:19 379:15	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17		
<b>completed</b> 182:3 203:9	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17		
<b>completely</b> 248:15 248:16	<b>conclude</b> 194:18 358:17	<b>concerns</b> 19:16 80:4 92:1 93:6 108:15 124:18 130:5 131:4 154:4 157:20 176:5 178:16 187:15 206:11 210:10 211:8 231:19,21 249:3 298:12 307:7 309:19,21 313:12 314:12 323:22 328:15 345:2 350:15 353:16 375:5,9 376:17		

<b>consultant</b> 2:20,20 3:20 8:22 14:19 15:3 <b>consultations</b> 239:18 <b>Consulting</b> 2:6 <b>consumers</b> 303:1 <b>contact</b> 128:21 129:6,7 135:15 142:18 143:20 158:19 159:3,5 167:14 <b>contained</b> 78:7 <b>contemporary</b> 7:19 <b>CONTENTS</b> 4:14 <b>context</b> 94:17 95:18 119:20 211:15 333:22 373:10 <b>contingent</b> 88:12 <b>continuation</b> 107:5 123:10 <b>continue</b> 11:9 22:9 22:18 68:19 109:12 122:3 131:9 152:6,11 220:12,22 221:6 231:6 271:2 291:22 336:22 339:7 385:18 <b>continued</b> 4:12,14 5:1 385:15 <b>continues</b> 209:15 376:1 <b>continuing</b> 25:10 81:18 376:8 <b>continuity</b> 230:22 <b>continuous</b> 123:13 <b>continuously</b> 152:1 <b>contract</b> 101:7 230:9,16 <b>contracted</b> 264:16 264:19 <b>contrast</b> 147:14 <b>contribute</b> 116:5 318:17 <b>contributed</b> 209:12	<b>contributes</b> 247:20 <b>control</b> 5:5 250:20 264:18 331:11,14 331:18,20 332:21 334:3,7 335:2 336:16 337:7 339:22 347:18,19 347:20 348:5 352:1,3 <b>controlled</b> 332:7 337:4 368:19 <b>controlling</b> 4:16 267:3 302:7,10 304:4,19 318:9 332:2 338:6 <b>convened</b> 164:17 <b>conversation</b> 29:13 54:4 157:18,19 188:21 208:5 215:13 218:5 304:14 382:19 384:6 385:15,18 386:4 <b>conversation's</b> 89:18 <b>conversations</b> 189:2 <b>cookbook</b> 183:1 <b>cooperation</b> 27:14 <b>coordination</b> 277:3 <b>copay</b> 122:20 124:10 153:4 <b>copayment</b> 127:18 <b>copayments</b> 127:8 127:8,11 <b>core</b> 105:16 237:1 <b>Cornell</b> 1:14 <b>corner</b> 7:18 <b>corollary</b> 334:4 <b>Corporation</b> 9:13 <b>correct</b> 45:17,18 92:20 93:2 292:1 <b>correctly</b> 238:15 240:18 241:20 <b>correlated</b> 202:2 <b>correlation</b> 144:17 144:22 150:22	<b>correspond</b> 191:14 <b>cost</b> 149:9 235:21 327:4 <b>Council</b> 13:13 <b>counsel</b> 4:3,4,6 28:10 276:21 <b>counseling</b> 286:13 286:14 289:19,20 291:6,9 <b>count</b> 123:10 135:7 135:16 193:8,10 193:13 194:9,11 196:5,6,7 198:18 199:10,15 200:2 200:22 201:8 218:2 290:3,11 291:10 <b>counted</b> 118:4 142:15 152:8 <b>counter</b> 147:17 <b>country</b> 188:12 272:22 276:6 <b>counts</b> 120:10 198:17 200:13 <b>couple</b> 37:3 38:9 76:21 92:6 100:13 117:5 150:8 161:13 174:4 186:19 215:14 275:9 276:3,5 382:20 <b>course</b> 97:22 112:13 117:18 153:16 232:21 268:4 <b>cover</b> 12:11 124:2 <b>covered</b> 48:17 131:22 <b>covering</b> 24:9 <b>CPNP/PMHNP</b> 2:12 <b>create</b> 102:1 116:2 250:2 256:13 258:6 266:15 379:22 <b>created</b> 115:9 143:19 174:20	252:21 260:9 319:13 <b>creates</b> 312:17 <b>creating</b> 90:17 256:11 263:14 364:20 <b>credit</b> 115:8 288:8 290:5 <b>creeping</b> 223:4 <b>crisp</b> 275:20 <b>criteria</b> 10:7,9,16 10:18 18:18 21:10 21:11 43:21 46:19 52:3 58:21 59:14 63:6 65:19 74:9 90:16 101:17 102:5 137:22 176:5 190:21 245:10 254:1,8 366:9 <b>criterion</b> 29:15,16 30:4,5,17 31:16 45:16 50:9,11,12 51:14 52:8,13 55:6 58:4 60:12 60:15 65:15 72:18 73:11,16 281:1 286:12 <b>critical</b> 74:9 76:11 81:5 122:17 166:21 <b>critically</b> 45:1 <b>criticism</b> 81:17 <b>Cronbach</b> 67:4 <b>crook</b> 149:6 <b>cross</b> 144:7 165:2 <b>cross-examination</b> 342:18 <b>crossing</b> 273:17 <b>crying</b> 99:22 <b>CSAC</b> 21:17,22 <b>cuisine</b> 7:20 <b>cumulative</b> 238:2,4 239:5 <b>curiosity</b> 268:8 <b>curious</b> 87:10 243:1	<b>current</b> 89:6 166:7 186:6 187:19 213:19 220:20 294:8,12 <b>currently</b> 15:3 20:12 23:2 89:2 105:14 106:5 270:10 293:2 298:6 299:18 334:2 381:18 <b>curtain</b> 351:7 <b>cushion</b> 380:18 <b>cut</b> 258:8 <b>cutting</b> 340:14 <b>cycle</b> 380:14
<b>D</b>				
<b>D</b> 2:6 6:1 <b>D-5</b> 260:14 <b>D.C</b> 1:9 15:12 63:21 <b>D.F.A.P.A</b> 3:1 <b>dancing</b> 274:2 <b>data</b> 38:2 65:6 66:15,18 67:8 68:2 69:7 75:20 80:12,16 86:13,22 88:15 92:4 105:12 106:6 112:21 113:5,9,21 116:3 117:17 119:9 122:15 134:22 135:14 144:2 156:12 157:22 167:6 173:8 174:1 180:19,22 181:10 183:11,20 184:2,5 189:21 190:22 191:2,5,14 192:10 196:12,21 197:4 208:11 216:3 225:14 234:13,13 241:19 242:15 244:11 248:16 250:13,15,17,21 253:8 260:3,4 261:19 262:13 263:15 264:14				

265:12 267:2	167:15 169:9	<b>deliver</b> 368:10	25:4,10,14 41:21	154:12 164:10
268:21 273:16,16	170:4,6,9 260:5	<b>delivered</b> 77:14	49:5 146:22 147:1	169:9 197:4
277:12,13 284:7	<b>debilitating</b> 166:4	<b>deliveries</b> 379:10	166:7 180:1	230:16 249:19
310:1,5,12,14	<b>decades</b> 36:20	<b>delivery</b> 56:7,18	204:13 210:17,21	257:5 258:7
314:8 321:6	<b>decided</b> 89:19	<b>delusion</b> 276:15	224:11 257:11	278:10 379:2
329:17	<b>decision</b> 59:8,17	<b>delusions</b> 199:14	263:2 283:14	<b>developed</b> 36:13
<b>data-sharing</b>	112:10 123:17	201:2	284:9,12,20	45:10 113:9
293:15	285:21 316:19	<b>demonstrate</b>	285:12 306:7	135:20 137:7
<b>database</b> 270:12	366:3	122:17 207:21	<b>depressive</b> 25:4,15	164:13 190:16
<b>dataset</b> 93:8	<b>decision's</b> 98:16	247:6 253:2 374:4	165:1 166:13	197:10 198:3
<b>datasets</b> 38:8,16	<b>declines</b> 282:14	<b>demonstrated</b> 65:7	204:2 206:2	230:7 246:11
72:6	<b>decreased</b> 173:13	66:7 100:7 319:11	<b>Deputy</b> 3:1	372:5
<b>date</b> 23:15 70:13,16	<b>dedicated</b> 7:1	<b>demonstrating</b>	<b>derailed</b> 342:15	<b>developer</b> 35:8
<b>David</b> 1:18 2:16	<b>deemed</b> 204:9	42:1	<b>describe</b> 45:10	44:3,8 54:22 56:3
15:14 34:9,15,22	323:2	<b>demonstration</b>	136:14	67:14 70:11 71:3
49:16 50:14 53:6	<b>defeat</b> 127:1	113:18	<b>described</b> 201:5	74:21 75:5,14
83:6 104:16	<b>defend</b> 245:10	<b>denominator</b> 39:2	309:14	80:14 86:8,19
106:14 109:22	<b>define</b> 45:11 51:9	39:7,14,19 40:4	<b>describing</b> 57:22	89:21 92:2 93:13
134:1 141:18	164:20 180:9	40:16 42:10 44:5	183:1 244:9	95:5,10,19 96:16
150:3 152:17	196:15,17 253:17	54:10 55:2,3 62:5	268:18	98:21 99:1,5,11
203:16 237:12	254:8	107:10 112:16	<b>description</b> 120:2	99:19 155:4
240:7 274:7	<b>defined</b> 79:3 133:3	120:5 121:17	190:17 192:3	163:15 169:17
<b>David's</b> 157:21	181:19,20 196:17	124:8 178:11	195:1	361:4
<b>day</b> 11:7 16:3 19:2	197:8 198:5	179:1 184:8	<b>deserve</b> 53:17	<b>developer's</b> 70:19
27:2,7 34:4 43:8	283:22 318:1	205:18,22 215:6	<b>design</b> 15:5	95:13
95:10 144:13	337:15	234:14 278:19	<b>designated</b> 18:12	<b>developers</b> 19:6,7
146:13 257:7,8	<b>defining</b> 223:3	283:17 285:5	<b>desire</b> 266:1	20:2 29:10 43:11
363:19 388:16	<b>definitely</b> 27:1	295:11 302:12	<b>desk</b> 6:18	132:4 146:10
<b>day's</b> 364:7	30:12 32:18 34:7	304:5,6 305:6	<b>despite</b> 127:11	181:13 221:2
<b>days</b> 85:10 107:3,8	60:8 239:8 240:20	307:18 318:2	181:10	224:9 369:2 370:4
111:17 120:10	<b>definition</b> 39:1,17	336:18 383:22	<b>detail</b> 10:21 188:4	379:3
122:16,20 124:3,6	193:15,17 195:12	<b>denominators</b>	<b>detailed</b> 376:19	<b>developing</b> 90:19
124:10 126:6,8,19	196:18 198:20	39:17 96:5 283:12	<b>details</b> 121:17,18	151:9 154:14
127:16 129:14	202:19 284:5	384:10	136:13 333:3	165:11 231:18
134:6 148:18	295:11,12	<b>Department</b> 2:7,9	<b>detect</b> 216:9	368:16 371:14
149:8 154:21	<b>definitive</b> 26:5	3:7 13:7	<b>detecting</b> 144:4	<b>development</b> 1:20
263:10 365:21	<b>degree</b> 44:4 58:7	<b>dependence</b> 232:7	152:13	2:8 13:10 164:1,6
<b>dead</b> 224:5	93:18 264:5,18	243:16 244:13	<b>detection</b> 167:3	<b>developmental</b>
<b>deal</b> 49:4 58:20	<b>delay</b> 38:21	254:20 267:4	172:7,9 173:3	130:16
181:16 315:10	<b>delaying</b> 336:2	<b>depending</b> 80:7	<b>determination</b> 90:3	<b>DHS</b> 16:7
339:8	<b>delegation</b> 264:17	89:14 303:14	<b>determine</b> 21:4,10	<b>diabetes</b> 5:2,3,5,8,9
<b>dealing</b> 169:6	<b>delighted</b> 9:14	<b>depends</b> 264:18	126:16 215:18,21	5:11 232:13
<b>deals</b> 125:18	105:6	377:6	234:16 296:21	234:19 235:17,19
<b>dealt</b> 300:1	<b>delineate</b> 39:10	<b>depressed</b> 168:14	327:11	235:20 236:13,14
<b>Dean</b> 2:13 3:2 12:7	<b>delineating</b> 48:16	170:11 210:19	<b>determining</b> 21:12	240:14 243:17
13:20	<b>delineation</b> 199:7	213:18	185:2	245:18 260:10,13
<b>death</b> 166:15	<b>delineations</b> 334:15	<b>depression</b> 12:15	<b>develop</b> 14:13	266:12,15,16

273:13 294:4	310:15 321:8	<b>dinked</b> 123:16	328:11 344:17	211:18 232:6
303:3 317:13,16	<b>different</b> 20:20,22	<b>dinner</b> 7:16 385:18	345:21 354:5	236:10 257:15
318:4,15 321:15	21:19 39:5,11,13	387:18 388:3	359:4	284:8 302:14
321:18 325:19,20	39:14 45:4 48:8	<b>direct</b> 6:16 150:22	<b>discussant</b> 18:12	338:22 339:6
326:10,17 331:11	51:5 52:18 63:5	<b>direct-to-consum...</b>	19:14 29:18 35:12	368:6,15
331:13,19 332:9	79:20,21 90:13	288:1	104:16 343:15	<b>disharmony</b> 334:11
332:12,21 333:1,8	91:9,17,18,20	<b>directed</b> 249:10	<b>discussants</b> 29:14	<b>dishonest</b> 374:16
333:9,12,15 334:7	93:10 95:6,8 96:3	<b>direction</b> 146:16	31:4	<b>disorder</b> 24:12
334:22 335:1,10	97:8 100:17 109:1	148:16,22 241:9	<b>discussed</b> 19:9,15	25:5,15 165:1
335:20 336:17,18	109:1,2 123:1	<b>directly</b> 146:17	30:20 374:19	166:13 204:2
336:19 337:10,11	125:5,6 145:22	171:19 375:3,11	<b>discussing</b> 138:12	206:2
337:14 338:21	173:1 179:13	<b>Director</b> 1:11,13,15	350:11	<b>disorders</b> 12:15
340:1,9 341:7,22	183:16 188:4,10	1:17,18,19 2:1,3	<b>discussion</b> 18:7	187:12 276:17
342:2,13 343:6	188:10,11,12	2:10,21 3:1,4,12	19:4 27:3,7 29:20	<b>disparities</b> 118:1
347:14 352:9	198:21 206:13	8:16 9:10 11:15	31:6 32:15 33:4	234:20 302:17,20
355:4 358:2 368:7	207:3 217:18	11:18 12:1,17	47:5 65:17 69:4	303:4
368:20	218:4 231:15	13:1 15:18	70:7 72:14 73:7	<b>disparity</b> 232:15,21
<b>diabetics</b> 332:8	235:16 238:8	<b>disability</b> 14:22	74:20 80:5 87:18	233:13 243:3,19
339:18 348:17	246:18 248:8	284:6	90:8 100:3 117:16	244:3,4,8 253:3
<b>diagnose</b> 49:9	255:10 257:14	<b>disabled</b> 284:8	122:3 135:5	258:18 259:2,21
<b>diagnosed</b> 110:1	258:9 264:2,6	296:4,8	136:10 137:19	260:5 262:20
123:7 153:10	265:9,19 272:14	<b>disabling</b> 284:14	141:18 145:6	263:14 294:11
<b>diagnoses</b> 119:17	273:7,7 274:4	285:2	149:17 157:1	339:15 348:19
332:13	287:17 294:17	<b>disagreed</b> 178:3	160:2,4 167:22	358:5,6
<b>diagnosis</b> 110:15	297:3 303:13	<b>disagreements</b>	177:5 185:22	<b>dispensing</b> 134:7
110:22 111:4	318:12,12 323:6	267:2	205:16 226:20	<b>displayed</b> 189:14
119:19 120:6,13	326:5 333:14	<b>discernment</b> 93:17	227:1 238:3 256:6	<b>distinct</b> 335:13
120:15 121:12,13	335:16 337:8	<b>discharge</b> 25:9	267:20 268:5	<b>distinction</b> 10:11
206:1 284:12,18	341:3,17,19	<b>disciplined</b> 275:20	272:15 274:11	<b>distinctions</b> 338:20
306:7,12 307:5,11	365:19 370:14	<b>disciplines</b> 165:5	287:3 298:3,8,13	339:11
332:5,10 334:20	371:3,19,22 372:2	<b>disclose</b> 28:11	299:14,17 300:5	<b>distinguish</b> 178:4
336:10 337:12,13	373:20 382:14	181:9	300:18 301:21	371:17
337:17 338:1	384:5,6 386:12	<b>disclosure</b> 4:4 6:3	304:10 312:11	<b>distressed</b> 143:8
340:4 341:9	387:7,8	27:11,12,16 28:6	313:7,10 316:7,20	<b>ditto</b> 326:16
<b>diagram</b> 331:22	<b>differential</b> 55:1	<b>disclosures</b> 29:1,4	322:21 324:17,19	<b>diverse</b> 165:15
334:16	<b>differently</b> 99:6	<b>discomfort</b> 386:14	329:10 330:5,22	<b>diversity</b> 132:12
<b>dialog</b> 129:21	<b>difficult</b> 17:21	<b>discouraging</b>	333:5 343:16	<b>divide</b> 238:8
<b>die</b> 167:13 170:11	20:17 82:11 93:11	369:22	346:7 347:2,4	<b>divided</b> 44:11
<b>difference</b> 40:2	122:19 124:9,15	<b>discrepancies</b>	353:14 354:8,17	<b>division</b> 16:7
44:18 131:18	197:21 248:19	304:16	355:7 359:8	<b>divisions</b> 257:14
215:6 216:9 222:7	266:4 273:4 313:1	<b>discrepancy</b> 117:1	362:15 364:18	<b>DMH</b> 2:5
222:10 233:16	387:8	<b>discrete</b> 367:14	366:22	<b>DNP</b> 2:3
287:4 294:7,22	<b>difficulties</b> 181:6	<b>discretion</b> 193:21	<b>discussions</b> 34:6	<b>doable</b> 125:8
295:4,7,15 329:13	242:16	<b>discuss</b> 20:13 30:2	40:7 137:20	<b>docs</b> 109:1 206:22
340:6 378:13	<b>difficulty</b> 267:6	33:3 43:8 65:21	223:10 238:5	<b>doctor</b> 124:13
<b>differences</b> 75:18	<b>digest</b> 237:21	74:9 90:18 138:12	309:13 365:1	307:3
208:15 295:14,21	<b>dilated</b> 361:14	271:3 309:5	<b>disease</b> 1:12 32:16	<b>doctors</b> 306:2

314:20	375:14 383:6	<b>drinking</b> 261:11	379:9	352:11 353:4
<b>document</b> 33:22	<b>dollar</b> 127:13	<b>drive</b> 64:6 151:21	<b>easier</b> 256:19	356:19 357:4
36:8 66:2 190:11	<b>dollars</b> 127:18	151:21 272:10	387:14	362:21
215:14 221:14	<b>DOLORES</b> 2:5	381:11 383:11	<b>easiest</b> 40:19	<b>eighteen</b> 36:12
290:9	<b>domain</b> 372:1	<b>driven</b> 258:6	<b>easily</b> 113:6	39:20,22 175:18
<b>documentation</b>	373:13	358:19 377:16	<b>easy</b> 244:2 256:15	176:16 309:4
224:7 280:4,4	<b>domains</b> 71:16	<b>drives</b> 82:17	342:17	317:5 349:22
<b>documented</b>	<b>Donner</b> 215:17	276:11	<b>eat</b> 228:11 229:2	356:3 360:9
197:18 279:2,8,13	<b>doomed</b> 82:13	<b>driving</b> 51:1 56:11	<b>echo</b> 57:3 117:15	<b>Eighty</b> 178:1
<b>documenting</b> 189:3	<b>door</b> 248:8	148:1,7 152:1	131:12 348:13	<b>Einzig</b> 1:18 15:14
211:6	<b>doors</b> 6:15	153:13 359:8	<b>echoing</b> 304:15	15:15 53:7 83:8
<b>documents</b> 19:18	<b>Dorian</b> 3:12 4:7 6:4	368:14	<b>ED</b> 306:22 307:9	104:18 106:15
19:19 32:6 80:18	6:6 9:2 11:10	<b>drop</b> 112:15 217:19	<b>Education</b> 1:20	128:3 133:10
129:8 159:6	16:11,16 17:2,12	<b>dropout</b> 142:5	<b>effect</b> 149:2 173:6,7	141:20 150:4
<b>Dodi</b> 2:5 14:17	17:19 23:17 31:11	<b>drug</b> 123:9 125:20	210:21	156:11 210:5
242:20	32:3,18 33:1 34:7	232:7 243:16	<b>effective</b> 136:1	<b>either</b> 21:3 37:7
<b>DOEBBELING</b>	35:20 37:17 46:21	244:13 254:20	<b>effectiveness</b> 173:3	77:19 80:12 131:3
1:16 16:14,17	47:2 61:4,13 64:8	261:11 262:2,5	197:14	171:20 212:18,19
118:13,17 120:8	67:17 94:16 97:18	<b>drugs</b> 122:19	<b>effects</b> 106:9 112:4	234:15 246:18
134:2 163:7,11	227:20 298:20	<b>DSM-5</b> 224:11	126:12,18 132:16	261:8 266:7
267:15 298:22	299:2,10 358:11	<b>dual</b> 14:13 15:4,21	143:13 152:13	271:11 272:2
299:6 304:12	<b>double</b> 62:11	296:8 313:20	173:20 240:8	275:22 280:15
309:10 312:14	<b>double-duty</b>	318:20 319:2	282:3,8 302:16	364:17 366:5
316:3 358:15	281:18	<b>duals</b> 253:12	351:20	<b>elaborate</b> 290:13
359:10 382:17	<b>doubled</b> 172:9	<b>due</b> 36:16 144:4	<b>efficacy</b> 143:6	<b>elect</b> 162:6
387:20	<b>doubt</b> 152:17	171:21 302:15	<b>efficiencies</b> 132:2	<b>elected</b> 251:11
<b>doing</b> 14:12 27:14	<b>dozens</b> 252:9	<b>duplication</b> 315:1	<b>efficient</b> 128:2	<b>elective</b> 379:9
28:13,14 33:14	<b>Dr</b> 142:21 153:21	<b>dust</b> 248:4	149:15 219:5	<b>electronic</b> 99:14
41:14,22 42:16	154:7,9,12,20	<b>dysfunction</b> 129:3	239:1 258:5	183:11 189:21
44:16 45:13 53:8	155:6,9 162:16,19	159:1	301:15 364:8	196:22 234:15
54:7 68:6 83:20	164:5 169:22	<hr/>	<b>effort</b> 212:22 381:2	313:8,9
112:9 133:15	170:3,17 173:22	<b>E</b>	<b>efforts</b> 54:12	<b>element</b> 84:19
134:10,17,18	174:8,22 181:17	<b>e</b> 4:1 6:1,1 101:5,8	372:19	191:5 223:22
145:12 153:2	187:1 220:15,18	<b>E-measure</b> 99:15	<b>EHR</b> 180:20	336:6
162:2 184:16	221:17 222:9,19	<b>e-specified</b> 101:7	183:22 187:18	<b>elements</b> 180:19
189:5 195:19	223:1,14 237:14	<b>earlier</b> 29:8 49:10	188:22 189:4,9,13	190:22 191:2,14
202:22 203:19,20	255:6 256:9,12	69:2 104:4 142:21	192:18 201:17,19	196:21 208:12
206:21 207:7	259:4,9,13,17	163:11 173:18,18	202:7 208:7	269:19
212:1 213:17	269:20 270:5	181:18 193:21	<b>EHRs</b> 184:2 187:19	<b>elevated</b> 274:20
217:20 222:3	361:13 365:20	197:7 208:4	188:1,10,13	340:2
223:2 235:21,22	378:17 380:20	272:20 309:13	<b>eight</b> 38:4 157:14	<b>eleven</b> 140:22
236:1 245:19	382:9,13	310:6 371:15	169:10 228:17	232:4 316:18
254:2 258:10	<b>dramatically</b> 84:20	<b>earliest</b> 134:6	231:15 266:15,16	329:8 346:22
262:10,14 263:14	<b>drawer</b> 239:12	<b>early</b> 54:17 83:11	275:17 291:20	354:15 357:3,8
280:9 314:13	248:4	110:19 167:2	298:1 312:9 330:3	362:21
329:15 338:17	<b>dream</b> 381:13	173:3 223:15	345:13,19 347:21	<b>eleven-somethin...</b>
348:1 367:18	<b>drill</b> 378:8	231:21 278:11	348:7 351:2	388:8
		340:21 364:9		



<b>Eliasziw</b> 215:17	94:14 99:5,8	80:6 271:5,6	319:20,22 320:6	360:2
<b>eligible</b> 14:13 89:10	227:8,14 269:18	334:4 336:9,13,17	322:16 324:10	<b>evidence-base</b>
<b>eligibles</b> 15:4	336:7 347:7,11	338:11 343:18	332:8 349:8,18	165:12
313:20	363:12 366:5	348:16 353:3	353:2 357:15	<b>evidence-based</b>
<b>eMeasure</b> 185:5,9	383:2	<b>establish</b> 71:11	364:7 387:13	82:1 232:15
185:10 189:15	<b>endorsements</b>	108:1 243:13	<b>everybody's</b> 7:11	<b>evidentiary</b> 85:13
196:14	373:8	<b>established</b> 202:17	59:4 72:8 350:5	<b>evolution</b> 339:20
<b>eMeasures</b> 191:15	<b>endorsing</b> 24:20	202:18	<b>everyday</b> 208:21	<b>evolve</b> 270:20
<b>emergencies</b> 162:1	369:13	<b>establishes</b> 184:11	<b>everyone's</b> 141:7	380:15
162:2,3,5	<b>engage</b> 109:8	<b>establishing</b> 108:21	<b>everything's</b> 62:20	<b>evolving</b> 339:13
<b>emergency</b> 3:8	336:15	<b>et</b> 171:2	241:20	<b>exact</b> 40:13 194:4
161:20 162:7,9	<b>engaged</b> 19:3	<b>ethnic</b> 257:17	<b>evidence</b> 37:14	303:21
165:7	369:12	<b>ethnicity</b> 117:20	48:16 51:15 59:15	<b>exactly</b> 88:22
<b>EMI</b> 286:2	<b>enhance</b> 109:8	386:12,19 387:11	60:18 63:12,14,15	111:12 145:21
<b>emphasized</b> 173:4	<b>enrolled</b> 55:20	<b>evaluate</b> 21:9 87:3	70:4,7,16 72:21	192:9 198:17
<b>empirical</b> 72:20	312:19	89:6	73:9 74:19,21	247:3 254:22
73:9 76:4	<b>ensure</b> 128:8 167:2	<b>evaluated</b> 94:20	75:4,7,9,11 80:19	304:1,8 342:8
<b>employee</b> 15:12	307:2	95:12	81:16,18 86:14,22	367:6
<b>employer</b> 14:20	<b>ensuring</b> 146:1	<b>evaluating</b> 43:21	89:14,20 90:15	<b>exam</b> 5:12 48:1
<b>employers</b> 116:1	<b>enterprise</b> 233:4	48:7 74:14 270:21	91:14 108:3,6,10	358:3 361:5,6,9
<b>EMR</b> 68:9 313:18	254:4 378:20	271:9	108:13 128:10	361:10,11,12,14
<b>EMRs</b> 261:17	<b>entire</b> 27:4 57:17	<b>evaluation</b> 2:7 4:6	129:8 137:1	<b>examinations</b>
263:5	57:20 318:3	13:7 17:18 18:17	138:15 139:4,6,7	238:14
<b>enabled</b> 165:17	<b>entirely</b> 326:21	18:18 27:9 29:6	139:11,16 140:7,8	<b>examine</b> 221:17
<b>encountering</b> 212:8	384:5	34:19 45:15 75:1	140:9 147:20	<b>example</b> 68:3
<b>encounters</b> 178:21	<b>entities</b> 75:19 368:6	179:22 221:1	148:19 150:6	130:20 216:5
184:7 213:18	<b>entity</b> 57:18 368:15	223:20 230:10	151:2,3,10 158:1	247:7 272:11
<b>encourage</b> 20:9	<b>environment</b> 116:8	270:3 271:4	158:2 159:6 169:2	273:6 274:19
115:20 128:1	216:21	<b>evaluations</b> 20:6	172:13 173:19	371:16 375:17
131:7,9 161:1	<b>episode</b> 111:7,16	<b>event</b> 278:22	174:6 175:12,14	376:2 379:10
231:6 276:20	111:16 136:6	284:21 291:2,9	175:18,19,20	<b>examples</b> 201:6
315:4	<b>episodic</b> 284:9	<b>events</b> 279:12,21	197:14 203:3	<b>exams</b> 54:9 359:1
<b>encouraged</b> 244:15	<b>EPSDT</b> 38:1 71:14	280:3,15,18	232:10,14,20	<b>Excellent</b> 301:10
340:13	<b>equal</b> 174:20	284:18 289:19	233:11 243:8,10	323:8
<b>encouragement</b>	<b>equally</b> 172:12	291:2,3	243:15,21 244:21	<b>exception</b> 63:15
338:16	<b>equals</b> 194:7,10	<b>eventually</b> 43:1	245:7,13 254:12	139:7,11,19 140:5
<b>encouraging</b>	196:4 213:3	240:9	254:16,22 256:4	140:9 175:15,20
211:12	<b>erring</b> 147:12	<b>everybody</b> 9:15	282:7 291:13,15	308:11,15 320:4
<b>ended</b> 24:20 245:14	<b>error</b> 144:5 284:19	11:10 60:22 62:1	291:19 308:7,10	328:2 344:7
<b>endorse</b> 370:8	382:12	62:9 63:20 101:12	308:11,13,15	349:14 355:21
<b>endorsed</b> 24:2,16	<b>escalate</b> 338:11	148:17 158:4	319:18 320:2	360:5
26:14,22 36:4	<b>especially</b> 9:20	160:13 161:11	326:11,22 327:1	<b>exceptionally</b> 58:1
37:6 72:10 223:12	73:3 85:2,16	163:20 226:8	327:15,17,20,22	274:3
223:12 334:2,6,9	86:10 91:9 121:3	228:20 245:17,18	332:20 344:3,4,6	<b>exceptions</b> 190:20
334:10	183:17 312:18	254:5 291:17	344:7 348:13,18	313:22
<b>endorsement</b> 9:20	369:5 370:5 385:3	292:6 301:5	349:4,12 355:16	<b>Exchange</b> 105:18
71:9 72:8,19	<b>essentially</b> 66:5,10	311:18 316:14	355:19 359:17	<b>exclude</b> 307:17

<b>excluded</b> 54:9 305:5,9,20,21 307:10 <b>excluding</b> 285:14 <b>exclusion</b> 305:17 <b>exclusions</b> 75:15 190:20 <b>Excuse</b> 154:6,18 <b>exercise</b> 370:1 <b>exist</b> 250:13 252:22 321:9 <b>existed</b> 334:12 <b>existence</b> 57:10 <b>existing</b> 233:2,4,9 241:15 245:15 278:13 286:13,20 288:17 303:18 372:13 <b>exists</b> 56:1,14 176:4 284:17 <b>expanding</b> 224:10 <b>expect</b> 18:13 233:15 236:12 244:18 287:16 306:2 <b>expectation</b> 111:18 115:10 213:11 <b>expectations</b> 303:13 <b>expected</b> 216:2 <b>expecting</b> 101:8 <b>experience</b> 153:9 183:15 213:15 282:10 <b>expert</b> 21:1 22:13 71:11 72:19 73:8 177:22 178:2 284:2 293:9 321:15 <b>experts</b> 8:10 23:8 327:10 <b>explain</b> 66:20,21 98:4 164:9 189:13 192:9 327:9 331:21 371:7 <b>explainable</b> 265:8 <b>explaining</b> 119:5	276:21 <b>explains</b> 189:22 <b>explanation</b> 246:15 307:20 <b>explore</b> 256:7 <b>expressed</b> 47:9 92:8 102:5 178:15 <b>extended</b> 133:12 <b>extensive</b> 209:17 212:10 234:22 <b>extent</b> 10:15 51:17 86:15 87:6 131:4 144:4 262:9,17 384:18 <b>external</b> 23:10 <b>extra</b> 149:9 366:12 <b>extrapolate</b> 206:18 <b>eye</b> 5:12 78:19 358:3 361:4,6,8 361:10,11,12,14 <b>eyes</b> 143:4 <hr/> <b>F</b> <hr/> <b>FAAN</b> 2:12 <b>FAANP</b> 2:12 <b>face</b> 73:7,13 76:6,7 143:17 144:14 177:21 293:10 310:9 <b>face-to-face</b> 135:18 136:8 143:2,20 263:9 <b>faces</b> 6:8 163:2 274:4 <b>facilities</b> 214:18,21 214:22 374:4 <b>facing</b> 313:21 <b>FACP</b> 3:11 <b>fact</b> 67:12 69:2 71:14 87:21 91:12 95:5 173:4 214:1 222:13 243:14 293:1 310:14 365:22 366:4 <b>factor</b> 126:22 132:2 232:12 261:14 <b>factors</b> 79:16 128:7 199:8 257:16	302:16 339:10 379:7 <b>fail</b> 82:13 221:11 318:18 <b>failed</b> 59:14 <b>failure</b> 257:10,11 <b>fair</b> 8:8 9:19 69:7 210:4 271:8,13 <b>fairly</b> 174:5 <b>fairness</b> 101:19 <b>fall</b> 22:16 110:7 383:22 <b>fallout</b> 126:14,17 337:2 <b>false</b> 91:8,8 375:20 <b>familiar</b> 172:20 200:15 <b>families</b> 54:5 58:14 109:9 130:10,12 <b>family</b> 45:21 94:19 108:17 130:18,20 158:10 165:6 206:21 207:9 210:2 250:10 327:9 <b>family-reported</b> 113:15 <b>fantastic</b> 383:5 <b>far</b> 37:5 84:5 101:1 117:22 142:12 277:1 348:4 <b>fashion</b> 30:5 <b>fast</b> 317:9 <b>fast-track</b> 93:13 <b>faster</b> 102:22 <b>fasting</b> 261:9 <b>favor</b> 274:8 <b>favorable</b> 324:3 <b>favorite</b> 254:5 <b>FDA</b> 133:13 <b>fear</b> 60:5 <b>feasibility</b> 156:9,11 156:15 157:1,9,14 180:7,17 183:10 206:11 220:6 224:3,17,22 235:3 240:4 242:13	248:17 298:3,11 298:16 299:5,12 312:11,15 313:4 313:10 315:15,19 322:22 323:12,17 329:10,12,21 330:3 345:21 346:8,10 353:15 353:17 354:3 356:22 357:3 359:5 362:14,20 365:9 <b>feasible</b> 55:11 106:5 125:8 198:12 245:17 298:8 313:1 314:7 314:7 315:9 323:2 <b>feature</b> 7:15 <b>fed</b> 314:1 <b>federal</b> 105:14 367:2 <b>federally</b> 181:11 <b>feedback</b> 21:17 22:1 23:11 209:5 218:7 371:13 375:2,13 378:21 <b>feel</b> 8:11 19:4 28:21 29:1 30:1 46:18 81:5 123:15 147:15 165:22 219:13 239:1 271:21 272:5 293:17 348:21 <b>feeling</b> 98:14 169:2 212:14 271:8 365:5 <b>feels</b> 101:12 124:13 333:5,12 <b>feet</b> 33:17,17 <b>felt</b> 28:17 46:16 139:17 165:13 166:20 171:10 176:1 182:18 183:3 245:11 284:10 285:6,20 289:16 290:4 309:14 320:17	321:7,9 324:2 334:14 <b>field</b> 50:21 192:21 193:5 202:5,7,10 202:12 208:8,10 211:15 343:10,13 <b>fields</b> 147:6 208:13 <b>fifteen</b> 8:5 103:20 225:8 227:13 308:13 327:22 344:5 356:14 360:14 <b>figure</b> 40:20 221:9 252:22 289:13 295:1 306:8 366:13 377:18 388:11 <b>figuring</b> 377:20 <b>file</b> 185:5 <b>fill</b> 51:9 84:13,19 84:22 123:14 124:2 210:8 <b>filled</b> 27:13 85:1 124:1 142:2 <b>filter</b> 56:9 <b>final</b> 64:20 104:6 130:8 169:9 208:1 208:15 216:14 217:10 226:19 227:12 295:18 301:7 317:4 324:18 330:2 331:7 346:20 354:22 363:10 <b>finality</b> 170:6 <b>finally</b> 6:7 41:12 147:3 <b>financially</b> 242:3 <b>find</b> 7:22 49:3 50:17 62:6 68:6 70:3 75:8,10,21 80:6,8 81:12 82:6 83:2 101:2 113:11 142:4 171:2 172:3 174:6 185:1 239:11 243:21 244:2 245:21
---	--	---	--	---

246:21 247:1,20 249:16 281:12 284:6,7 286:3,16 305:1 312:21 319:4 330:12 361:10 <b>finding</b> 108:10 113:8 307:16 340:22 <b>fine</b> 32:8 87:13 142:16 147:22 148:15 302:3 <b>finish</b> 221:8 <b>finished</b> 48:13 317:10 364:9 <b>fire</b> 47:17 <b>first</b> 9:4 10:21 19:1 24:15 29:15 30:12 30:15 35:4,5,7,22 36:7,8 40:19 59:15 63:5 65:20 70:19 74:17 88:21 105:9 129:14 130:22 139:3 141:18,19 146:11 150:10,18 160:2 171:4 181:17 196:6 246:5 251:2 277:20 287:3,6,13 287:16 295:9 306:13 341:10,13 360:20 <b>fit</b> 92:14 96:7,7 364:14 372:17,18 <b>fits</b> 43:18 348:9 368:21 <b>five</b> 79:15 139:6 140:8 171:4,5 175:14 187:11 225:7 226:17,17 230:15 258:22 261:16 273:6 300:14 308:10 309:4 311:5 315:20 317:5 322:13,20 325:9 328:1 329:4 344:5	344:15,15 346:22 349:22 356:3,7 357:9 368:7 375:4 380:9 <b>flash</b> 61:22 <b>flashing</b> 59:22 60:3 61:11 <b>flexibility</b> 235:13 237:2,5 246:17 247:2,20 250:3 263:22 264:5 <b>flinging</b> 373:3 <b>flip</b> 338:1 <b>floor</b> 1:8 29:20 293:20 298:12 300:6 313:14 <b>fly</b> 242:13 <b>FNAP</b> 2:12 <b>focus</b> 51:16 52:8 107:18 110:18 111:21 112:12 168:10,14 213:21 231:7,16,17 232:9 233:2 235:1 245:21 248:9 249:2 250:15 257:21 276:11 302:21 327:1 369:20 381:19 383:14 <b>focused</b> 51:18 52:9 230:20 233:8,22 302:13 334:19 <b>focuses</b> 111:6 332:3 <b>focusing</b> 52:14 <b>folks</b> 142:7 143:19 165:9 276:12 287:5 302:22 <b>follow</b> 7:13 39:10 42:11 52:22 58:16 110:5 129:13 134:17 150:16 158:3 209:9 250:22 370:3 <b>follow-up</b> 4:8,16 24:6 25:10 42:2 44:10 58:9 104:12	104:15,19 105:10 105:22 106:7,15 107:2,8 108:2,7 108:12,14 109:5,6 110:10 111:9 112:7 118:5 120:22 121:6 122:16 127:7 128:8,15,21 129:11 130:2,6,21 131:6,14,14 134:10,18 136:2 136:14 142:15 148:18 150:5,7 152:8,9 153:5,17 158:5,5,19 234:8 278:2,17 279:2,10 279:11 280:2,8,10 280:14 282:5 286:2,3,4,6,8,11 286:22 294:15 295:10 <b>follow-ups</b> 48:4 107:9 108:5,22 150:9 282:13 <b>followed</b> 42:11 125:16 126:4,19 149:21 182:16 260:7 284:15 <b>following</b> 24:6 42:1 <b>force</b> 49:5 70:3 71:9 81:1,3,8,14 81:17 116:2 286:19 287:5 288:16 314:11 315:4 366:1 <b>Ford</b> 2:18 14:9 <b>forget</b> 96:18 280:6 <b>forgot</b> 298:22 <b>form</b> 27:13 74:22 90:13 95:3,11 100:17 166:2 185:5 194:19 208:10 213:22 380:17 <b>formal</b> 9:21 40:3 140:3	<b>formally</b> 66:12 <b>format</b> 43:1 189:15 189:17 <b>formed</b> 164:20 <b>Former</b> 2:19 <b>forms</b> 167:6 <b>formula</b> 91:16 128:20 158:18 <b>formulated</b> 99:7 <b>forth</b> 97:4 264:8 <b>fortunate</b> 19:6 <b>Forty</b> 220:10 <b>forum</b> 1:1,8 19:4 46:3 365:17 383:2 383:4 <b>forward</b> 21:14 23:13 33:5 34:9 63:16 64:22 65:14 81:4 89:19 98:19 103:21 132:21 140:10 141:1,15 146:15 155:20 156:8 157:16 159:21 167:21 168:4 176:18 177:3,15 189:3 211:12 219:18 220:5,12,12 221:4 221:7 223:8,20 225:9 226:19 255:21 260:17 263:1 291:21 292:11,19 297:17 298:3 299:14 312:1,10 315:21 316:19 320:5,10 320:15 322:14,21 323:19 328:3 329:9 330:5,21 331:9 344:11,16 345:17,20 346:13 347:1,10 353:14 355:2,3 357:4,19 360:11 362:14 363:1,12 366:4 387:21 <b>foster</b> 127:6 276:8	<b>found</b> 19:17 70:10 121:2 122:4 139:15 244:1 261:17,22 281:11 284:15 304:15 314:3 318:8 <b>Foundation</b> 2:11 17:16 <b>four</b> 39:13,14 81:6 85:22 93:10 97:2 97:7,15 98:12 103:17,20 112:2 128:22 139:6 140:17 155:14,19 156:3,7 157:10 158:20 159:15,19 175:13 176:12 177:9,14 187:11 219:11 220:1,4 225:3,8 226:6,16 247:8,12 260:20 282:14 292:4,10 292:17 297:13,15 297:20 298:18 300:12,15,15,16 308:9,18 309:2 311:16,22 312:3,9 315:16 320:3,13 323:18 324:15 329:8 349:12 354:15 356:20 357:4 360:10 362:13 371:22 <b>fourteen</b> 155:19 156:7 157:15 220:8 291:20 322:19 329:4 362:4 <b>fourth</b> 141:3 166:15 <b>fragmentation</b> 310:3 313:5 <b>fragmented</b> 312:20 <b>frame</b> 334:1 337:8 340:8 <b>framed</b> 239:19 321:17
---	--	---	--	--

<b>framework</b> 34:9	<b>funded</b> 181:11	41:20 68:4 114:16	348:5 351:13	221:9 223:16,21
<b>Francisco</b> 34:19	<b>funds</b> 57:6 384:22	115:4 148:16	372:16,21	228:18,21 240:12
<b>Franklin</b> 3:12 4:3,6	<b>Funny</b> 365:20	165:5 197:3 199:3	<b>give</b> 8:4 19:12 22:1	242:21 249:16,18
8:14,16 23:19	<b>further</b> 52:19 83:2	200:8,16 201:4	28:4 34:11 44:3	257:2,18 258:1
26:10,16 27:1	94:2 157:2 159:8	218:9 232:1,18	53:8 61:2 68:4	259:18 267:5
30:11 31:2 33:8	160:3 226:22	233:9 234:21	81:2,19 107:14	271:20 272:1
34:11,22 45:18	279:9 291:12	235:18 236:3	111:10 115:22	276:1 292:7,11
48:15 67:20 72:22	300:18 324:4	242:8 244:14	133:22 161:17,18	307:18 315:18
73:4,10 74:3,11	330:22 354:10,17	249:21 250:6	205:11 211:10	316:19 325:5,11
74:17 76:16 88:21	364:13 368:12	251:17 256:17	220:9 229:1 262:2	327:9 338:9,9
89:11 92:20 93:2	<b>future</b> 20:9 33:6	268:2,10,13	275:11 300:21	339:2 345:17
93:22 94:10 98:11	89:4 137:20 186:9	274:13 275:22	331:2 341:14	348:5,12 369:13
99:13,17 104:5	218:8 224:10	282:1 287:4,17	375:17	377:18 379:7
121:22 139:14	272:17 387:14	290:20 292:21	<b>given</b> 40:1,19 50:2	380:10 381:5
140:2 154:6,8,11	<b>futuristic</b> 132:18	293:2,16 294:1	57:4 76:22 88:11	388:6,6
154:18,22 155:7	<b>fuzzy</b> 339:21	295:8 297:4 298:6	89:17 96:10 110:2	<b>goal</b> 22:17 51:2
155:10		298:13 299:16	110:2,14 119:1,6	65:6 77:6 106:9
<b>frankly</b> 77:18	<b>G</b>	300:4 304:17	121:14 203:5	377:22
132:13 143:16	<b>G</b> 6:1	305:16 306:5	211:15 293:15	<b>goals</b> 21:7
144:10 270:17	<b>gain</b> 285:19 287:10	309:17 310:16,18	298:5 309:16	<b>God</b> 259:15
282:9	<b>gallery</b> 182:21	310:21 314:21	369:4 380:12	<b>Gods</b> 333:18
<b>free</b> 19:5 29:1 30:1	<b>game</b> 213:9	320:20 324:2	<b>giving</b> 85:10 88:12	<b>goes</b> 49:1 50:15
278:4	<b>gaming</b> 200:9,16	339:6 342:5,8	210:5 336:11,13	83:17 193:20
<b>freestanding</b> 12:18	200:19	<b>generalists</b> 252:7	338:15 374:12	239:15 269:7,7
15:17	<b>gap</b> 46:20 48:16	<b>generally</b> 28:8	380:17	321:18
<b>frequency</b> 214:15	51:2,7,8 58:14,17	111:9,11 197:7	<b>glad</b> 109:18	<b>going</b> 10:4,5,8
<b>frequent</b> 129:21	64:14,15,20	293:10,13 299:19	<b>glass</b> 385:19 387:21	20:16 23:7 27:2
<b>frequently</b> 108:13	108:18,20 140:15	299:20 307:22	<b>global</b> 70:5	29:14 30:8 32:3
111:8	140:15,21 175:22	310:9 320:17	<b>gnash</b> 260:18	32:13 35:6,12,13
<b>front</b> 8:3 18:19	176:3,11,16	324:3	<b>go</b> 7:21 9:4 10:9,18	38:4 41:7 43:8
20:16 190:11	291:21 292:3,9	<b>generic</b> 133:10,14	10:20,21 11:9	44:18 48:12 49:4
248:7 378:22	308:16,20 320:5,9	241:7 286:5	18:5,6,21 19:1	50:9,11 53:12,14
<b>fruit</b> 93:10 237:21	327:3 328:3,3,5	<b>genuflect</b> 333:19	20:11 21:17,22	55:7 59:3 60:8
<b>full</b> 25:19 29:20	344:8,8,9 349:14	<b>geographic</b> 188:11	23:1,18 28:10	62:10,14 63:1,2
99:8 217:20	349:21 355:22	<b>Geriatrician</b> 13:1	30:15,17 51:22	64:13 65:18,21
372:10	356:2,8 358:18	<b>getting</b> 17:5 41:16	55:13 62:16,17,20	70:11 72:7 73:19
<b>full-scale</b> 212:18	359:1 360:5,8	54:8 105:22	63:7 67:20 79:14	74:8 79:2 80:8
<b>fully</b> 132:11 264:13	378:10	106:19 107:11,22	80:12 83:2 89:19	84:17 87:8 88:15
265:16	<b>gaps</b> 23:5 26:2,6	112:19 124:9	107:12 118:16	89:18 92:15 98:8
<b>function</b> 22:5 204:4	27:3,7 33:4 56:16	126:17 136:6	119:17 121:5	98:19 101:20
340:20	241:21 251:9	145:17 146:8	131:1 132:14	107:14 112:12
<b>functioning</b> 4:10	319:12	147:3 148:4	136:11 138:20	123:6 124:21
35:17 36:11 129:9	<b>gathering</b> 54:5	155:10 174:15	139:20 148:16	129:21 133:15
159:7	149:11	244:8 248:17	151:14,19 152:16	136:15,19 148:22
<b>functions</b> 78:18	<b>gemish</b> 60:15	263:1,8 284:21	159:22 161:2	149:5 150:14
<b>fundamental</b>	138:16	287:21 307:12	170:18 186:15	163:14 168:4
273:14	<b>general</b> 3:18 4:3,4	314:5 329:17	190:6 219:18	169:7 173:17
	4:6 28:2,10 32:15			

177:3,17 180:11	143:7 149:21	161:21 163:16	216:13	366:14
184:14 189:3	151:21,21 161:16	164:1,3 165:15,19	<b>guideline</b> 73:12	<b>happened</b> 38:3,9
195:19 196:20	163:13 178:4	169:7 177:4	245:1 335:21	336:21
198:9 200:11	188:6,7 194:12	200:22 233:7	<b>guidelines</b> 73:12	<b>happening</b> 115:6
201:18,20,20,22	196:1,2,3,15	235:7,8 236:11,15	111:11 126:7,9,11	279:10 281:13
202:1,2 205:1,2	214:7,10 219:18	249:2 253:11	128:14 136:3	314:22 378:22
207:8,14 210:20	226:14 230:6	258:2,18 259:21	142:18 143:17	<b>happens</b> 34:2 48:6
211:10 212:21	236:12 244:14	262:20 263:14	151:9,12,14	259:17 265:3
213:1,8,14 215:2	251:16 261:18	267:20 275:16	166:20 170:19	272:11 367:8
222:4 226:1 228:7	282:8 292:7 293:7	287:2,4 302:19	182:4,5 232:18,19	384:7 387:19
230:14 234:18	293:17 317:8,9	304:14 309:14	351:11	<b>happy</b> 16:22 67:19
236:12 238:20	336:20 347:20	319:10 321:7	<b>guy</b> 83:8	93:18 170:1
240:14 242:1,18	348:2,5 352:19	326:21 328:18	<b>guys</b> 9:17	<b>hard</b> 10:9 83:2 87:1
245:16 250:1,1	359:9 371:5	339:15 341:19		87:2 154:5 174:6
251:1 253:8,15,16	374:12 382:5	344:20 352:17	<b>H</b>	281:8 284:6
253:18 258:3,9,22	386:2	359:2 366:2,19	<b>Hacker</b> 38:6 70:8	289:17 311:3
259:13 263:13,16	<b>goulash</b> 237:20	376:4 381:20,20	71:20	364:7 378:7 381:5
264:1,2,7 266:14	<b>government</b> 165:8	<b>grouping</b> 379:22	<b>half</b> 150:12 218:22	<b>harder</b> 116:9
266:18 271:7	<b>grade</b> 203:3	<b>groups</b> 55:21 91:19	301:12	237:21 383:19
273:14 281:19	<b>graders</b> 293:4	231:16 235:1	<b>hall</b> 129:20	<b>harm</b> 102:1 147:11
285:15 290:7,8	<b>grades</b> 72:5	302:21 340:1	<b>hallucinations</b>	147:15 152:5,11
291:22 296:17	<b>granular</b> 41:12	<b>grows</b> 368:3	199:15 201:1,8	<b>harmful</b> 103:9
297:3 301:22	<b>grassroot</b> 152:19	<b>growth</b> 78:1	<b>Hammersmith</b> 4:4	<b>harmonization</b>
310:2 315:8,18	<b>grassroots</b> 47:12	<b>Grumet</b> 1:19 64:2	<b>hand</b> 101:15	23:4,16 333:5
321:16 332:11,11	47:15,16 149:2	64:3 145:10	146:19 212:13	<b>harmonize</b> 368:1
336:22 339:1	<b>grateful</b> 36:3	203:17 205:7	<b>hand-offs</b> 308:4	<b>harmonizing</b>
341:14,17 343:14	<b>gray</b> 59:11 220:21	<b>guess</b> 39:13 44:9	<b>handful</b> 37:5	370:18,22
343:14 348:12	221:5,6,13 226:18	76:22 83:13 95:22	<b>handle</b> 238:3	<b>Harold</b> 1:9,13 4:2
352:18 354:19	<b>great</b> 9:2 17:9,12	99:18 120:19	371:17	9:4,8 27:19 30:18
360:15 364:12	17:19 23:17 35:22	153:18 170:12,16	<b>handled</b> 75:20	31:5 45:19 73:17
366:3 367:9	37:20 38:2 67:22	173:16,17 174:11	<b>hands</b> 73:17 203:14	73:21 76:16
368:22 370:1	83:12 100:2	191:18 200:3	213:12 333:21	137:15 163:12
374:16 376:15	122:13 176:2	201:10 202:21	<b>hang</b> 270:13	201:17 214:4
378:4 381:12	177:16 262:1	214:19 217:9	<b>hanging</b> 96:18	381:19
384:4,15	268:15 346:7	224:19 225:19	300:22	<b>hash</b> 145:8
<b>gold</b> 370:5	385:15,17 387:16	270:20 271:19	<b>Hanley</b> 3:15 164:2	<b>hat</b> 257:2
<b>Goldstein</b> 1:19	<b>greater</b> 44:3 214:7	294:18 295:19	183:14 185:4,10	<b>HbA1c</b> 5:2,8,10
64:2,3 145:10	242:5 280:14	313:16 323:3	186:5 187:21	317:14 321:16
203:17 205:7	347:19 348:2,6	335:18 341:3	189:10,12 190:15	347:15 355:5
<b>good</b> 6:4,7 12:16	352:1 353:3	351:18 361:5	190:19 191:3,12	<b>HBIPS</b> 25:3
13:17 15:8 16:17	<b>greatest</b> 83:21	<b>guest</b> 32:2	192:1,7,12,17,22	<b>header</b> 190:2,16
17:20 25:11 29:13	<b>greatly</b> 274:5	<b>guidance</b> 18:18,20	193:4,9,14,19	<b>health</b> 1:3,12 2:2,5
34:8 62:15,20	<b>green</b> 59:20 60:1,3	46:2 73:18 74:12	195:11 201:4	2:7,10,11,13,18
63:19 64:2 68:6,9	61:11,21 62:3,9	74:13,14 111:9	205:22 208:18	2:20,20 3:4 4:14
70:22 74:10 83:16	<b>ground</b> 18:6	182:4,14 193:15	216:16 218:6	5:1 6:5 11:16,20
105:2 109:8	<b>group</b> 20:19 72:20	193:16 196:19	<b>happen</b> 171:9	12:2,2 13:8,11,13
117:21 129:11	107:21 142:3	204:22 205:11	205:13 274:11	13:15,16 14:4,9,9
			314:16,19 327:6	

14:14,16,18,20,21 15:3,7,10 16:1,19 17:11 22:3,6 24:5 24:7 25:15 34:17 34:18,21,21 37:9 37:9 38:7 43:9,15 44:12 46:9 56:10 57:3 65:6 76:22 77:11,13,15,22 78:4,4 79:6 81:6 85:10 100:20,21 105:13 114:6,8,15 114:16,22 115:5,9 115:14,16 116:1 116:10 117:17 118:21,22 119:1,5 119:8 121:12 122:9,11 123:1,15 125:1 127:10 132:1 143:12 144:5 147:6 151:17 154:5,15 165:9 167:14 183:11 187:4 196:22 204:20 206:16 207:6,12 209:12,18 214:9 217:4 229:17 230:11 231:1,18 232:5 233:18,22 234:1,3,9,12 235:16 236:22 240:16 241:16,18 242:15,18 244:9 246:19,20,21 247:14 248:3 249:12,13,14,18 249:20 250:4,5,11 251:5,10,21 252:1 252:5 254:11 257:22 262:12 265:2 266:5 272:9 273:1,7,14 276:11 277:4,12 279:6,6 279:14 281:4,6,7 281:13,22 282:3,4 282:5,18 287:17	291:8 296:18 302:22 310:1,6 311:6 312:19 313:5,19,19 314:1 314:2,14,15,16,22 335:9 336:12,13 338:8 369:15 373:18,22 375:15 377:18 383:3,11 383:16 384:8,18 386:7,15 <b>healthcare</b> 15:2 57:5 65:8 133:1 142:1,1 156:12 231:3 <b>HealthPartners</b> 3:5 <b>healthy</b> 385:20 <b>hear</b> 9:3,5 17:22 35:19,20 75:5 99:19 118:18 122:1 127:7 170:14 186:10 246:15 375:11 <b>heard</b> 47:20 50:10 98:11 195:6 199:20 231:19 237:20 282:11 287:21 321:5 336:1 369:4,7 370:21 <b>hearing</b> 76:16 159:11 160:7 311:13 315:13 316:22 323:9 324:5,19 328:22 329:19 330:12 331:3 338:21 345:5 346:15 <b>hearken</b> 261:12 <b>heart</b> 257:9,11 <b>heartbreaking</b> 303:7 <b>heartened</b> 100:4 <b>heavily</b> 382:2 <b>HEDIS</b> 105:13 252:2 294:2,9,12 294:19 295:9	305:16 366:19 <b>held</b> 144:10 263:20 374:2 <b>Helen</b> 3:11 162:14 162:17,21 252:18 256:6 372:17 374:19 382:12 <b>Helen's</b> 229:2 <b>Heller</b> 2:2 11:22 <b>Hello</b> 11:13,21 12:22 118:14,15 229:19 <b>help</b> 7:6 56:8 73:21 130:14 167:2 179:7 185:6 208:22 218:2,3 241:19 243:12 258:19 366:3 369:19 377:15 383:9 384:4 <b>helped</b> 154:12 164:6 <b>helpful</b> 18:4 44:2 54:21 126:14 246:15 265:12 335:14 336:5 348:8 <b>helping</b> 14:21 15:4 137:15 340:21 381:11 <b>helps</b> 101:6 293:3,8 <b>hematologist/onc...</b> 130:3 <b>hemoglobin</b> 5:2,8 5:10 261:9 267:12 317:14 347:15 355:5 <b>Hena</b> 2:21 12:22 <b>Henry</b> 2:18 14:9 <b>heterogeneity</b> 91:10 <b>Hg</b> 5:6 331:15 <b>HHS</b> 276:19 370:21 <b>Hi</b> 11:17 13:5 14:2 14:6 15:1,14 16:14,16 17:10,14	35:18 153:21 163:20 171:17 188:6 215:9 <b>hiding</b> 337:20 <b>hierarchy</b> 192:3 <b>high</b> 4:16 59:18 63:13 64:21 65:5 65:7,8,13 67:4 81:9 103:16,19 110:14 139:5 140:7,16,21 141:1 141:2,13,13 146:11 155:14,18 156:2,6 157:10,14 159:15,19 166:11 166:13 167:4 175:13,18 176:12 176:16 177:8,9,12 177:13 219:12,16 219:22 220:1,2,4 221:22 225:3,7 226:5,16 231:3 233:5,11,12,16 253:2,10,18 254:6 261:10 267:3 281:21 282:4 284:1 290:6 291:20 292:3,10 292:11,16,17 297:12,14,19 298:1,18 299:12 300:11,14 302:7 302:10,14 304:4 308:9,13,17,20,22 309:1,3,4 311:15 311:21 312:2,8 315:16,20 316:17 318:9 320:2,9,10 320:12,13,22 321:1 322:12,19 323:17 324:14 327:4,4,4,22 328:5,10 329:4,8 330:3,19 332:2 338:8 344:5,10,12 344:14,15 345:12 345:18 346:11,21	349:12,21 350:2 350:10,10 351:1 353:13 354:3,14 355:19 356:3,6,9 356:14,19 357:3,8 360:3,9,11,13,14 362:4,12,21 363:5 364:19,20 370:11 372:7 378:12 <b>high-impact</b> 166:1 <b>higher</b> 127:13 144:22 186:2 232:11 234:1 243:13,16 266:12 266:21 280:5 308:2 <b>highest</b> 249:9 256:4 <b>highlight</b> 69:20 157:20 166:3 <b>highly</b> 58:12 <b>hindrance</b> 153:4 <b>hinges</b> 136:13 <b>hints</b> 207:12 <b>HIPAA</b> 273:2,19 276:14,16,21 277:2,13 310:7 <b>historical</b> 132:20 133:14 333:13,22 <b>history</b> 112:2 199:13,14 276:10 <b>hit</b> 13:14 60:22 61:2 292:7 299:1 301:5 368:8 <b>HL-7</b> 189:15 <b>hoc</b> 90:1 94:3,12,15 98:2,5 <b>hold</b> 38:8 62:10 82:14 95:19 118:8 121:18 273:14 <b>holding</b> 146:9 375:16 <b>holes</b> 124:16 146:12 <b>holistically</b> 335:11 <b>home</b> 15:13 78:3,4 132:1 <b>homes</b> 132:10
---	---	---	--	---

<b>homogeneously</b> 171:7	286:10 288:10	<b>hypotension</b> 351:15	236:7 241:1	<b>importance</b> 22:22
<b>honest</b> 374:7	289:4,9 290:15,22		244:13 253:6	31:16 46:5,7,17
<b>hook</b> 149:6 274:20	294:8,17 296:3,7	<b>I</b>	254:21 278:8,20	48:13 55:8,10
<b>hope</b> 73:20 101:1	296:12,20 297:1	<b>iatrogenic</b> 88:2	283:21 284:14	56:22 96:15
246:3	302:9 304:3	351:14	302:12,15 304:7	102:10 107:19
<b>hopefully</b> 18:8 59:4	305:19 307:4	<b>ICD-10</b> 206:3	326:12	109:5 136:12
62:16 147:4	311:1 314:4	<b>ICD-9</b> 206:3	<b>illnesses</b> 266:11	137:3,12,19,21
183:22 335:10	317:15 326:2,7	<b>IDD</b> 276:8	<b>imagine</b> 238:9	138:1,1,12,18
<b>hoping</b> 72:9 264:15	331:16 332:18	<b>idea</b> 33:4 168:8	239:11	139:1 167:10
<b>Horgan</b> 2:1 11:21	337:9 341:6 342:7	199:5 237:17	<b>imbalance</b> 213:5	168:3,5,8,16
11:22 27:20	343:3 347:16	260:12 341:16	<b>imminently</b> 314:7	169:7 175:10
<b>horns</b> 259:15	352:8 358:4	370:9	<b>impact</b> 33:18 58:13	221:21 242:5
<b>horse</b> 224:5	361:11 376:10	<b>ideal</b> 263:22 385:12	65:7,12 98:5	243:3 244:22
<b>hospital</b> 1:14,14,18	<b>huge</b> 56:12 243:11	<b>ideas</b> 231:16 235:2	172:6 238:2,4	245:11 254:12
3:2,8,18 9:12	272:8 278:7	<b>ideation</b> 179:20	239:5 240:5	<b>important</b> 10:11
12:18,18 13:3,4	280:21 378:7	194:10 203:2	254:16 268:13,15	20:5 23:13 28:17
15:17 25:3 68:5	385:5	211:7	271:3	45:1 52:10,16,20
212:6 367:19	<b>huh</b> 152:16	<b>ideations</b> 167:3	<b>impart</b> 364:22	52:21 54:2,19
<b>hospital-based</b>	<b>human</b> 3:7 45:2	172:7,10 180:12	<b>implement</b> 188:14	55:11 56:10 57:8
25:7	<b>hundred</b> 178:8	<b>identical</b> 78:12	198:13,18 208:11	58:2,11,13 72:9
<b>hospitalization</b>	257:20 262:21	330:10	236:20 249:13	82:15 88:10 96:10
24:6	353:5	<b>identification</b>	252:19 267:10	108:1,12 109:3,17
<b>hospitalized</b> 284:21	<b>hundreds</b> 364:21	46:15 70:15 71:22	273:5 289:18	110:13 125:9,18
<b>Hospitals</b> 15:16	378:7	87:20 172:15	293:15 294:19	126:1 138:3,10
<b>hosted</b> 191:15	<b>hybrid</b> 235:22	179:16 181:22	306:17	139:18 150:1,5
<b>hot</b> 365:21	<b>hyper</b> 149:1	199:2	<b>implementation</b>	151:6 153:6 158:6
<b>hotel</b> 388:6,12	<b>hyperactivity</b>	<b>identified</b> 28:19	12:14 209:3 213:1	163:4 166:22
<b>hour</b> 64:6	24:11	46:14 69:16 87:9	235:13 237:4	168:12,21 169:12
<b>hours</b> 34:4 275:18	<b>hypertension</b> 186:2	131:14 191:4	270:9 297:2 314:5	170:7 171:22
301:12	234:19 236:13,14	247:17	315:6 366:17	172:12 175:2
<b>House</b> 259:19	243:17 252:10	<b>identify</b> 7:11 26:1	372:20	181:9 204:18
<b>Howard</b> 8:9	261:1,8 262:3	28:17 36:14 38:11	<b>implemented</b> 12:5	211:17 217:4
<b>HQMF</b> 189:14	301:20 304:21	75:17 83:11	70:9 183:18 186:7	231:5,17 237:3
<b>HUDGSON</b> 252:16	306:1,6,11 307:6	164:20 196:21	188:20 208:7,20	241:22 255:8
<b>Hudson</b> 3:16 105:2	307:8,8,11,13	222:10 234:14	235:15 236:21	265:20 266:6,7
105:3 110:17	332:4,5,10,12	241:19 341:13	293:2 298:6	271:2,17 304:16
114:20 117:2	333:9,11,15 334:4	<b>identifying</b> 23:4	309:16 369:14	305:2 319:11
120:3,12 121:10	334:17,20 335:20	197:15 306:10	<b>implementer</b>	332:22 348:14
121:20 123:19	335:21 336:10,16	326:8	196:19	366:14,21 374:9
124:20 133:7	337:16,19,22	<b>ignored</b> 276:7	<b>implementers</b>	375:11 378:19
134:19 229:4,19	338:4 339:2 340:4	<b>II</b> 152:10	369:3	380:21
230:3 243:9,20	341:9,12 343:8	<b>ill</b> 243:5 266:20	<b>implementing</b> 88:3	<b>impossible</b> 86:1
244:11 248:22	370:20 371:1,3	268:16	212:6,9	<b>impractical</b> 138:14
249:7 278:3,6	<b>hypertensive</b>	<b>Illinois</b> 15:4	<b>implication</b> 143:11	<b>impressed</b> 47:11
279:19 280:1	341:14	<b>illness</b> 24:14 25:17	180:3	<b>impression</b> 107:15
282:22 283:3,16	<b>hypoglycemia</b>	231:9,22 232:6,20	<b>implications</b>	<b>improve</b> 12:4 14:15
	351:16,17	234:8 235:20	179:20 255:9	52:22 70:2 82:1

86:11 88:16 103:6 116:10 122:12 158:2 235:15 254:19 378:1 381:16,17 <b>improved</b> 20:9 42:12 85:15 88:9 119:6 <b>improvement</b> 48:8 50:7 58:10 69:18 70:10,17 79:12,13 80:9,11 83:1 85:3 86:15,16 110:6 114:9 116:6,19,22 117:4 122:18 125:11 146:20 147:4,8 153:13 164:19 165:14 167:8 218:15,20 219:1 262:5 311:6 311:8 340:17 352:15 376:6 378:10 <b>improvements</b> 70:14 282:7 <b>improves</b> 128:11 158:6 <b>improving</b> 59:1 113:17 114:3 124:19 164:21 257:21 369:20 376:8 <b>impulsive</b> 130:15 <b>in-depth</b> 27:3 80:13 <b>in-person</b> 6:5 28:9 <b>in-play</b> 299:18 <b>inability</b> 256:13 <b>inappropriate</b> 87:22 88:1 129:12 205:5 374:17 <b>inappropriately</b> 374:6 <b>Inaudible</b> 51:12 205:6 220:14 296:22 305:7 325:17	<b>incentive</b> 84:14 148:13 167:19 338:16 384:19 <b>incentives</b> 319:1 369:17 <b>incidence</b> 42:9 80:7 126:12 147:7 171:5,9 172:1 203:5 <b>include</b> 26:12 109:6 224:11 243:5 264:13 295:17 302:22 <b>included</b> 22:21 66:4 124:8 165:2 178:22 189:17 191:11 318:21 <b>includes</b> 103:13 179:15 190:16 295:10,11 <b>including</b> 24:9 85:18 105:15 204:16 <b>inclusive</b> 340:2 <b>inconsistencies</b> 145:18 <b>incorporate</b> 132:5 <b>incorporated</b> 286:19 288:16 <b>incorporating</b> 209:6 <b>incorrect</b> 373:21 <b>increase</b> 172:5 179:19 180:11 199:4 201:6 285:16 329:16 377:15 <b>increased</b> 71:22 72:1 87:19 92:4 172:10 173:14 291:1 <b>increases</b> 56:21 <b>increasing</b> 78:1 255:2 <b>increasingly</b> 36:17 77:11 152:18 166:5 379:19	<b>incredibly</b> 169:12 <b>indefinitely</b> 339:1 <b>independent</b> 14:19 201:2 268:6 <b>Index</b> 4:15 277:20 278:1 <b>indicate</b> 67:11 167:7 284:22 <b>indicated</b> 7:20 130:22 133:5 149:8 153:18 <b>indicates</b> 167:12 <b>indicating</b> 59:21 374:11 <b>indications</b> 66:14 <b>indicator</b> 110:6,8 112:7 117:9 127:4 127:5 129:11 147:21 274:9 332:22 <b>indicators</b> 149:10 317:18,19 337:5,6 <b>individual</b> 36:14,15 52:3 68:1 148:10 183:4,5,22 184:3 184:12 192:13 193:22 234:3,4 235:5,6,10 236:17 236:18 237:2 240:6 270:19 271:4 275:2,13 277:19 373:17 <b>individual's</b> 108:17 158:9 <b>individually</b> 181:16 241:11 271:10,20 368:10 371:4 <b>individuals</b> 91:19 153:16 167:13 168:13 179:3 368:13 375:14 <b>industry</b> 265:21 <b>ineffective</b> 143:14 152:12 <b>infeasible</b> 298:10 <b>infer</b> 68:3 <b>inferred</b> 66:16	<b>influence</b> 114:14 137:14 264:21 277:6 <b>informant</b> 264:22 <b>informants</b> 143:7 <b>informatician</b> 192:6 <b>informatics</b> 200:22 <b>information</b> 42:22 54:4,22 65:22 70:12 71:4 75:7 115:18 182:13 192:17 196:12,19 208:3,16 221:1,10 234:5 235:2 243:12 244:2 248:18 268:3 277:3 300:12,15 312:22 314:1 <b>initial</b> 53:11 130:1 135:10 <b>initially</b> 97:5 <b>initiation</b> 135:19 <b>initiatives</b> 272:12 <b>injuries</b> 260:8 261:12 <b>inpatient</b> 25:2,7 212:10 283:13,15 284:17,21 285:13 306:22 361:6 <b>input</b> 23:10 49:22 231:13 232:3 <b>inputs</b> 122:22 <b>inquiries</b> 198:22 <b>inquiry</b> 199:1 <b>insight</b> 81:2 <b>insights</b> 255:13 <b>insignificant</b> 148:15 <b>instinct</b> 229:3 <b>Institute</b> 1:17 2:1 3:6 12:2 64:10 <b>instructed</b> 99:7 <b>instrument</b> 39:3 40:9,11 51:20 66:6 67:2 69:6 70:9 81:22 90:11	371:19 <b>instruments</b> 45:12 45:22 90:12 <b>insufficient</b> 63:14 63:14 64:21 65:9 65:13 76:1 81:18 103:17,20 139:6,6 139:11 140:8,9,17 140:22 141:3,14 155:15,19 156:3,7 157:11,15 159:16 159:20 175:14,14 175:19,20 176:13 176:17 177:10,14 219:11,17 220:2,5 225:4,8 226:6,17 292:4,18 297:13 297:15,20 298:2 298:19 299:13 300:12,15 308:10 308:10,14,15,18 308:21 309:2,5 311:16,22 312:3,9 315:17,21 316:18 320:3,4,14 322:13 322:20 323:18 324:15 328:1,2,6 328:11 329:5,9 330:4 344:6,6,11 344:16 345:20 346:12,22 349:13 349:13 350:1 351:2 354:4,15 355:20,21 356:8 356:15,20 357:9 360:4,4,10,15 362:5,13,22 363:6 <b>insured</b> 383:20 <b>insurers</b> 384:15,17 <b>integrate</b> 14:21 273:2 367:14 368:2 386:16 <b>integrated</b> 11:19 78:2 132:11 242:12 249:19 261:21 264:14 265:16
--	---	--	--	---



<b>integrating</b> 15:22 132:22	<b>intervene</b> 335:13	211:17 212:14	<b>Jeffers</b> 2:10 17:14 17:15 31:21	<b>keep</b> 25:22 101:2 138:20 150:2
<b>integration</b> 2:11 13:15	<b>intervention</b> 172:5 191:4 282:16	213:7 239:6	152:15 246:2	156:14 228:11
<b>intend</b> 250:9	287:6,16	242:19 243:4,19	249:5 295:6,19	274:1 386:17
<b>intended</b> 40:1 138:7 290:17	<b>interventions</b> 81:13 82:1 85:11 282:12	248:11 254:10	305:4,8	<b>keepers</b> 23:14
366:5	282:17 300:2	255:8,8,22 264:9	<b>Jeffery</b> 3:2 53:6 57:16	<b>keeping</b> 8:10 23:15
<b>intensity</b> 282:17	<b>interview</b> 143:5 195:20	269:7,8 270:3	<b>Jensen</b> 2:3 15:8,9 373:16	<b>Kelleher</b> 2:5,6 14:17,17 30:8
<b>intensive</b> 134:12 282:12	<b>introduce</b> 8:13,17 10:19 17:7 19:11	276:14 277:5	<b>job</b> 93:15 117:21 194:12 196:2	94:5 243:1,18 244:3
<b>intent</b> 83:14	31:8 36:6 65:17	281:15 285:19	<b>jobs</b> 277:1	<b>Kendra</b> 3:15 163:16 183:12
<b>inter-rater</b> 206:9 320:22	104:22 161:14,15	287:17 290:10	<b>join</b> 161:9 163:3	188:8 216:16
<b>interacting</b> 368:18	162:18 163:10,17	302:4 314:5 352:4	<b>joined</b> 162:15	<b>Kenra</b> 164:2
<b>interaction</b> 145:16 146:7	<b>introduced</b> 8:12	352:6 369:1	<b>Joint</b> 379:3	<b>kept</b> 136:7 268:6 376:5
<b>interest</b> 4:4 6:3 12:13 27:16 28:7	<b>introduction</b> 4:4,5 6:3 17:17 19:13	372:19 378:19	<b>Jones</b> 3:16 188:2,6 188:7 189:11	<b>key</b> 24:7 165:3 219:4
29:4 82:17 253:11	29:9 31:3 34:12	384:13	207:19 210:1 215:9,10	<b>keypad</b> 364:2
253:12,13,14	237:6	<b>issues</b> 23:3 24:11 30:22 42:14 55:12	<b>journey</b> 230:13	<b>kick</b> 104:17 347:12
370:15	<b>introductions</b> 161:10	57:10 58:19 75:21	<b>JRLA</b> 13:4	<b>kicking</b> 304:10
<b>interested</b> 12:14 162:1 207:1,22	<b>intuition</b> 207:5	83:11 90:7 114:8	<b>judge</b> 300:22	<b>kid</b> 130:2
380:8	<b>intuitively</b> 109:7	116:4 119:21	<b>judgment</b> 49:21 148:6 151:22	<b>kids</b> 38:5,13 40:21 41:3,13 52:21
<b>interesting</b> 78:11 179:11 180:21	<b>invalid</b> 152:2	130:16 131:10,11	289:14	53:13,16,20 54:1
265:6 338:20	<b>investigated</b> 231:20	141:18 142:6,12	<b>Julie</b> 1:19 64:3 203:15	54:8 58:13,18 64:5 72:1,2,4
<b>Interestingly</b> 318:10	<b>investment</b> 34:20	145:5 156:13,15	<b>July</b> 123:11,17	83:11 104:20
<b>interests</b> 27:12 28:12 57:6	<b>inviting</b> 36:1	157:20 169:18,21	<b>jump</b> 30:1 201:13	106:18,19 107:6
<b>interface</b> 313:18	<b>involve</b> 87:8	181:15 195:21	<b>Junqing</b> 3:17 105:5	107:10,21 110:10
<b>interference</b> 358:18,20 359:2,6	<b>involved</b> 164:12	204:20 212:8	<b>jury</b> 300:20	112:9 113:16
<b>interlinkage</b> 258:8	<b>Irrespective</b> 168:10	214:3,12 217:11	<b>justification</b> 129:5 159:3	118:1 130:13,19
<b>internal</b> 46:16,18 165:7 276:21	<b>irreversible</b> 169:9	222:14 223:18	<b>justified</b> 171:11	136:16 142:6
<b>internet</b> 31:19 132:5	<b>IRS</b> 33:20	238:19 240:4		149:19 204:14,18 276:8 359:9
<b>internist</b> 16:21	<b>Island</b> 12:19	247:14 248:20	<b>K</b>	<b>kill</b> 100:16 251:4,7
<b>interpret</b> 66:21	<b>issue</b> 40:7 50:16 51:14 54:17 56:6	271:1,2,22 275:5	<b>Kaiser</b> 2:17 34:16	<b>killing</b> 205:4
<b>interpretation</b> 67:16	57:21 58:1,12,13	299:21 300:6	<b>kappa</b> 207:21 215:17 216:10,11	<b>kind</b> 10:19 33:12 45:9 47:11,22
<b>interpretations</b> 273:8	72:19 84:3 101:14	301:22 312:16	293:4,5 321:1	52:1 57:11,12
<b>intervals</b> 48:9	111:7 117:9,15	323:22 328:20	<b>Kapvay</b> 133:12	68:2 70:1 73:14
	118:2 125:3,3,18	329:16 373:19,21	<b>Karen</b> 3:19 38:6 153:21 154:9	86:16 99:9 101:13
	126:5 127:19,19	382:3 383:17,19	<b>Kathy</b> 154:22 388:14	102:18 121:7
	143:10,21 150:1	384:4,11 385:13	<b>KAY</b> 3:17	127:6 132:5
	152:5 153:8	387:19	<b>KAYE</b> 170:13,16 171:17	144:19 145:21
	154:21 158:7	<b>it'd</b> 289:17		146:1 150:14
	170:3 171:14	<b>item</b> 218:18		161:22 168:9,9
	174:12 180:6,16	<b>items</b> 181:21 198:21 317:17		
	184:1,6 187:8	<b>J</b>		
	200:8 201:2	<b>J.D</b> 4:3,4,6		
		<b>January</b> 28:14		
		<b>Jeff</b> 12:6 55:15 76:20 80:2 93:3		
		148:22 213:13 257:2		

171:1 173:20	79:22 80:14 83:12	238:14 239:14,14	<b>Kraig</b> 2:6 13:5	200:5 219:14
181:4 184:20	83:17 86:13 87:21	239:18 240:1,21		227:5 229:21
189:4 197:6	88:4,12,13,14,17	241:7,14 242:12	<b>L</b>	230:2 259:6,8,22
200:15 206:10,20	88:19 91:5,6,9	244:6,7,8 245:4	<b>L</b> 388:5,6	266:2 278:5 283:7
207:10 208:5	92:1,14 95:4 96:6	246:16 247:4,8,12	<b>label</b> 133:6	299:3,9 301:13
213:9 223:4	100:17 101:12,15	249:21 252:18	<b>labeled</b> 222:15	305:12 319:15
233:15 237:15	101:16,17,20	254:4 255:5 256:3	<b>labeling</b> 217:17	323:15 324:12
238:4 239:2,22	102:3,16 108:20	256:16 259:11,12	<b>lack</b> 46:14 56:21	326:6,19 327:13
250:22 251:12,12	111:8 112:1,8,15	260:22 261:4,21	67:11 71:8 96:10	333:20 359:13
251:14 252:6,9,15	112:16,20 113:4	262:1,3,3,15,16	100:22 116:5	360:21 363:15
254:2 256:7 260:9	114:4 116:18	262:21 265:13	128:10 151:15	382:10 387:22
261:11,21 262:7	117:20 118:1	267:1,10 269:9,11	158:1,2 231:22	<b>launch</b> 380:18
262:10 263:11,12	122:15 126:2	269:16 270:18	247:21 272:22	<b>launched</b> 380:13
263:16 265:19	130:18 135:19	272:9,14,16,18	<b>lacking</b> 108:14	<b>Lauralei</b> 3:12 4:7
270:10 273:13	136:6,10 138:4,6	273:9 274:1,16	<b>Lake</b> 15:13	6:6 8:15 23:19,20
281:3 284:12	138:7,14 139:13	279:9 284:18	<b>land</b> 261:20	29:7 37:12,15
285:10,20 289:16	140:2 142:4,20,22	287:5,14 288:5,6	<b>lands</b> 124:12	<b>LAURENCE</b> 2:15
339:7 343:4 365:5	144:6,12 145:13	289:12,19 294:6	338:13	<b>laws</b> 314:9
372:4,8,14 373:1	146:16 147:12	294:20 295:16	<b>language</b> 190:19	<b>lawsuit</b> 46:13 47:13
382:5 387:19	148:1,10,20 149:6	304:1 321:18	192:9 193:2,5	<b>lay</b> 143:4 371:20
<b>kinds</b> 26:3 48:8	150:10,11,19,21	334:9,22 335:7	202:13	<b>layman's</b> 192:9
90:20 95:2 135:7	151:2 153:22	336:7,13,19	<b>laptops</b> 7:3	<b>LCSW</b> 2:8
135:7,12 250:8	154:1 155:1 173:8	340:14,18 345:16	<b>Lardieri</b> 2:8 13:9,9	<b>lead</b> 11:16 18:12
300:2 301:22	173:22 177:5,6	348:18 350:15	120:19 122:6	19:14 31:4 35:12
311:10 339:9	178:16 180:13	351:13,14 355:9	133:20 201:13,16	87:20,21 104:11
365:15 369:18	182:16,22 183:9	361:5,7 366:16,18	202:6,11 283:10	104:16 173:14
<b>kneel</b> 333:18	183:20 184:8,14	366:20 367:5,10	386:1	343:15
<b>knew</b> 232:10	185:16,18,19	367:18 369:15	<b>large</b> 14:20 15:17	<b>leadership</b> 2:4
300:22	186:5 191:19,20	370:19,20 371:8	36:17 38:16 46:7	374:3
<b>know</b> 7:20,22 8:4	191:22 194:5	371:21 372:12,15	66:2 71:22 72:5	<b>leading</b> 166:15
9:17 10:22 33:14	195:18 196:10,13	372:20 373:5,10	88:3 209:17	<b>leads</b> 42:6 71:22
33:20,22 34:4,4	196:14 197:10	373:11,14 375:2,8	261:21 277:9	<b>learn</b> 23:12 268:4
37:5,15 38:18	198:7,17,20	375:22 376:7	358:19 378:10	<b>learned</b> 153:7
41:16 42:18 43:14	199:19 200:9,21	377:15 378:5,13	<b>large-scale</b> 36:22	<b>leave</b> 66:19 131:20
43:22 44:20 46:10	204:7,17 205:1,4	378:14 379:2,4,8	<b>largely</b> 309:22	183:4
46:13,16 47:6,12	205:8,9,10 206:4	379:8,13,14	<b>larger</b> 93:8 378:9	<b>led</b> 70:14,16
47:17,22 48:2,3	206:8,14 207:1,9	380:12,14,15	<b>Larry</b> 16:4 49:16	<b>left</b> 275:10 388:7,8
50:5,21 51:17	207:11,15,17	381:9,15 385:6	76:20 83:6 91:5	<b>Les</b> 161:15
52:14,16 53:11,15	208:8 209:4	386:1 387:6	109:14 149:15	<b>LESLIE</b> 3:7
53:16 55:1,9,22	210:17 211:1	388:15	315:17	<b>lessen</b> 235:21
56:13,16 58:17	212:3,13,16,16,19	<b>knowing</b> 22:21	<b>late</b> 34:14 64:11	<b>let's</b> 41:21 60:18
60:2,8 61:10	213:3,8 214:10,14	<b>knowledge</b> 20:22	162:20 164:13	71:2 99:18 103:10
67:14 69:8,10,22	214:19,20,22	<b>knows</b> 79:16 130:9	<b>latest</b> 335:5	104:9 116:14
70:11 71:8 72:20	215:1 218:12,18	245:17,18	<b>Latin</b> 7:19	121:16 122:2
73:6,7 76:10	219:2 223:14	<b>Knudsen</b> 2:6 13:5,6	<b>laugh</b> 195:8	149:14,14 151:14
77:12 78:15,16,19	233:19 236:6	96:19 97:1	<b>Laughter</b> 62:7	157:7 159:11
79:1,9,12,16,22	237:21 238:9,11	<b>kosher</b> 79:22	96:22 140:1	161:11 186:1
			156:18 194:16	

196:17 203:14 214:10 219:6 224:2 228:10,10 228:11,22 236:10 254:7 260:11 274:12 277:18 297:9 301:1 311:13 315:13 316:10,22 319:17 323:9 324:5,20 325:5,7,10 327:15 330:13 333:4 343:22 345:6 346:5,15 347:4 349:3,9 350:18 353:21 354:10 377:21 <b>lethality</b> 186:3 <b>letter</b> 34:14 <b>letters</b> 19:22 <b>level</b> 21:1 31:7 41:12,13 47:12 66:12 68:1 69:10 88:16 142:1 149:3 154:16,17 184:11 212:4 213:10 233:21 240:2 241:15,16 242:5 248:13 249:13 250:5 256:21 278:16 284:22 285:2 291:5 303:3 303:8 308:1 310:14 311:7 367:19 380:16,16 384:13 387:5,9 <b>levels</b> 92:8 152:19 234:2 341:3 351:12 378:9 <b>LHI</b> 13:11 <b>Library</b> 191:16 <b>lied</b> 229:6 <b>life</b> 208:20 240:22 255:3,3 260:7 336:21 <b>lifestyle</b> 302:15 <b>lifetime</b> 166:9	<b>lifetimes</b> 339:8,17 <b>light</b> 59:21 60:1,3,7 61:11,11,22 62:3 62:9 233:5 <b>likelihood</b> 179:19 180:11 199:4 201:7 <b>likened</b> 260:10 <b>limit</b> 135:1 288:4 <b>limitations</b> 113:22 117:17 <b>limited</b> 38:18 113:6 113:21 129:7 134:21 159:5 231:11 249:8 370:13 <b>limiting</b> 129:5 159:3 204:13 <b>limits</b> 113:5 250:16 <b>line</b> 154:1 194:8,11 223:5 257:4 273:18 340:22 341:1 378:22 388:15 <b>lineage</b> 334:8 <b>lines</b> 6:21 229:10 363:20 367:6 <b>link</b> 171:20 172:2 173:12 256:15 270:11 <b>linkage</b> 41:20 74:20 75:8 91:14 <b>linked</b> 77:2 241:5 269:16 342:22 <b>linking</b> 242:17 <b>lipid</b> 261:2 <b>lipids</b> 261:4 262:3 368:19 <b>Lisa</b> 2:3 3:1 12:17 15:9 319:8 348:13 <b>list</b> 9:16 26:21 39:12 119:17,18 146:2 151:8 198:21 204:7,10 282:20 287:19 288:3 373:3 <b>listed</b> 27:19 190:22	220:8 223:12 288:15 <b>listen</b> 363:19 <b>listening</b> 154:2 373:9 382:19 386:3 <b>literal</b> 51:15 <b>literature</b> 66:3 82:3 117:22 232:17 284:16 <b>little</b> 9:5 11:3 16:5 17:21 20:17 23:2 28:4 30:14 31:9 36:6 39:8,16 40:15 45:15 53:3 55:5 59:6 67:5 69:4,10 72:16 83:13 85:9 86:20 88:6 94:17 95:17 96:20 98:6 101:3 107:16 110:6 117:1 132:14 136:4 146:9 164:9 167:16 179:12 181:5 186:4 188:3 204:12 205:11,15 215:1,11 239:5 252:8,14 256:18 289:17 301:11 311:3 331:17 333:4 335:5,19 337:2 342:16,16 342:17 364:9 367:22 380:4 <b>Liu</b> 3:17 105:5 295:3,15 305:15 378:5 <b>live</b> 16:5 64:5 201:16 265:4 <b>living</b> 208:10 <b>lobby</b> 388:12 <b>local</b> 56:7 <b>locally</b> 64:5 <b>located</b> 6:14 <b>location</b> 209:19 <b>locations</b> 188:11 206:14 209:19	<b>logic</b> 253:2 280:10 343:5,8 <b>logistic</b> 6:13,13 <b>long</b> 8:10 9:16 31:13 54:15 77:12 147:9 150:15 198:21 254:21 290:8 348:7,8 <b>long-term</b> 123:3 351:20 <b>longer</b> 30:14 363:13 <b>longer-term</b> 112:7 <b>longitudinal</b> 72:6 <b>longstanding</b> 77:17 <b>look</b> 33:13 41:12 44:20 50:5 55:2 73:13,15,19 75:1 75:19 76:3,5 78:6 82:21 84:14,16 89:5 90:21 106:3 109:17 110:13 113:7 114:5 120:6 120:7 123:2 125:10,11,16,22 126:14 138:10 139:19 140:4 142:16 147:20 150:1 167:21 180:22 203:7 212:9 214:8 231:2 232:4 236:2,4,7,8 238:4 241:12 244:1,4 249:2 250:17,18,18 258:17 260:11 262:20 265:15 275:2 288:11 289:11 311:4 339:19 347:18 373:15 374:11 376:19 385:12 387:20 <b>looked</b> 25:3 47:20 101:3 111:2 126:11 136:1 143:16 144:17	146:22 172:6 195:4 230:21 232:17,20 233:10 233:13 237:19 254:12 259:2 278:18 280:22 281:4 283:20 284:1 286:13 288:18 294:13 <b>looking</b> 19:20 24:8 25:12 36:3 45:2 45:22 48:7 52:4 56:9 60:16 61:4 73:1 74:12,12,18 75:15,16 83:3 91:1 98:12 106:1 106:6 109:18 113:7 115:15,16 120:13,15 121:17 124:2,11 136:5 141:6 142:2 147:7 147:8 149:17 152:22 155:7 168:15 176:13 184:10 190:12 203:8 207:22 208:19 213:15 219:12 231:2 235:17 237:17 243:12 245:9,14 250:12 255:20 258:10 279:5 284:11 290:14 294:14 305:20 306:6,14 307:5,13 316:15 320:21 323:6 335:4 336:8 341:7 367:16 380:11 <b>looks</b> 52:2,16 55:19 57:17 105:10 112:7 117:7 121:11 278:10,17 294:9 332:4 347:18,20 <b>loop</b> 364:10,13 <b>loops</b> 378:21
--	---	--	--	--

<b>loosely</b> 181:20 <b>loosened</b> 136:4 <b>looseness</b> 202:19 <b>lose</b> 288:8 <b>loss</b> 288:2 <b>lost</b> 66:22 260:7 <b>lot</b> 7:20 9:15 10:6 12:3 13:14 20:15 21:19 24:18 42:21 45:22 46:1 47:10 58:15 65:21 67:9 68:2 73:6 79:9 81:14,17 92:7 93:16 94:22 107:21 111:3,10 131:8 146:21 147:5 157:18 176:3 195:4,19 204:21 205:2 217:11,13 243:22 246:22 251:7 255:7 257:19 258:2,2 264:19 268:8 269:4 271:1 274:3 276:1 281:12,12 284:13 302:5 321:4 334:10 338:2 359:11 365:5 368:17 369:8 381:6 <b>lots</b> 85:19 127:22 131:3 214:3 256:11,11 337:19 337:21 379:1 381:7 <b>loud</b> 20:21 <b>love</b> 9:3 139:1 255:12 256:6 316:8 380:6 <b>low</b> 59:18 60:2 63:13 64:21 65:9 65:13 75:10 103:17,20 139:5 140:8,17,22 141:3 141:14 155:14,19 156:3,7 157:10,15	159:15,20 175:13 175:19 176:12,17 177:9,14 198:9 203:5 219:10,10 219:13,17,22 220:1,4 225:3,7 226:5,16 291:20 292:4,17 293:12 297:13,15,20 298:1,18 299:13 300:12,15 308:9 308:14,18,21 309:2,4 311:16,21 312:3,9 315:16,20 316:18 320:3,13 322:13,20 323:18 324:15 328:1,6,10 329:4,8 330:4,19 344:5,10,15 345:13,19 346:11 346:22 349:13,22 351:2,14 353:13 354:4,15 355:20 356:7,15,20 357:4 357:9 360:4,10,14 362:5,12,21 363:5 378:11 <b>low-income</b> 296:8 318:13 <b>lower</b> 123:3 294:12 318:9 341:15 352:12 386:10 <b>lowercase</b> 32:2 <b>lowered</b> 336:20 <b>lucrative</b> 385:1 <b>lunch</b> 4:18 8:1,5 227:17 228:1,10 228:12 <hr/> <div style="text-align: center;"><b>M</b></div> <hr/> <b>M.D</b> 1:15,16 2:21 3:1,2 4:2,2 <b>ma'am</b> 154:18 <b>Mackovac</b> 263:7 <b>madness</b> 52:2 <b>Mady</b> 1:17 64:8,9 83:7 87:4 104:3 186:16,18 297:5	<b>Mady's</b> 379:20 <b>magical</b> 273:17 <b>magically</b> 112:17 <b>main</b> 22:17 153:19 260:6 279:15 370:17 <b>maintained</b> 313:9 <b>maintaining</b> 23:16 <b>maintenance</b> 135:16 381:15 382:1 <b>major</b> 25:4,15 164:22 166:13 204:1,13 206:1 222:10 285:12 326:9 348:14 <b>majority</b> 142:3 178:10 214:1 385:4 <b>making</b> 21:13 49:11 54:12 79:6 83:3 96:13 97:21 116:8,9 214:11 234:6 268:15 274:2 281:17 314:19 327:18 380:4,5 <b>MALE</b> 279:17,21 <b>Malmstrom</b> 5:6 331:15 <b>manage</b> 253:4 254:3 335:9 <b>managed</b> 114:15 115:8,14 348:19 <b>management</b> 2:2 15:6 106:10 120:14 122:18 131:16 179:2 279:14 289:16 290:10 <b>manager</b> 3:12 4:7 132:6 <b>managing</b> 319:5 <b>mandated</b> 37:22 <b>mania</b> 179:17 <b>Manor</b> 2:21 13:2 <b>map</b> 257:7 262:8	369:1 <b>mapped</b> 192:18 <b>maps</b> 191:6 <b>March</b> 123:8 <b>mark</b> 2:9 17:10,10 46:6 47:15 50:1 65:20 67:1 68:22 87:16 108:7 128:9 133:2,8 147:10 151:3 205:15 214:14 227:18 351:9,17 352:4 <b>marked</b> 352:15 <b>market</b> 264:1,4 335:8 <b>marketed</b> 269:17 <b>marketing</b> 269:19 270:8 274:18 288:1 372:19 <b>marketing-based</b> 269:21 <b>marketplace</b> 16:20 277:7 383:18 <b>markets</b> 269:6 <b>mass</b> 4:15 28:2 68:4 248:18 277:20 278:1 305:10 <b>Massachusetts</b> 3:18 37:1,22 40:20 41:4 46:12 66:15 70:9 <b>material</b> 89:22 295:17 <b>materials</b> 7:2 180:18 <b>maternal</b> 229:3 <b>Mathematica</b> 101:8 230:8 <b>matrix</b> 255:14 373:12,15 <b>matter</b> 161:4 187:15 222:4,17 228:14 267:5 314:10 325:13 <b>mature</b> 264:6 <b>maximize</b> 246:17	<b>Mazon</b> 2:10 17:14 17:15 31:21 152:15 246:2 249:5 295:6,19 305:4,8 <b>MBA</b> 2:9 3:7 <b>MBHO</b> 248:18 264:16 <b>MD</b> 1:11,13,18 2:15,16 3:4,5,7,11 <b>MDD</b> 4:12 163:18 164:14 166:4,10 171:5,12 179:3 205:19 214:15 <b>MDwise</b> 1:16 <b>mean</b> 11:1 32:4 42:20 46:6 56:11 66:22 77:12 86:18 108:11 132:14 139:12,15 145:22 147:22 153:20 187:10 193:12 195:18 197:1 200:1,7 201:4,12 203:6 212:2 214:16 218:3 222:9 237:18 238:15 239:7,10 240:12,19 243:22 247:13 257:19 267:13 270:19 277:14 284:10 285:4 287:8,10 289:17 290:1 294:11 305:15 312:22 340:12 361:9 364:14 372:16 379:18 380:8,20,21 381:14 <b>meaningful</b> 105:16 167:19 189:18 198:4 214:19 310:15 321:8 372:22 <b>meanings</b> 39:11 <b>means</b> 59:8,10,12
---	---	--	--	--

59:13 60:1,7	113:5,6,9,11,15	239:3 240:13,14	371:18 372:11	115:12,12 116:11
134:8 139:13	114:3,7 115:2,5	241:8,15,17	373:2 375:12	123:4 139:22
145:17 199:2	115:11 116:7,21	244:16,20,20	376:2,5,14 379:14	144:1 146:12,14
258:12 307:17	117:19,21 118:19	245:9,19 246:16	379:15 381:18	147:7 148:3,8,12
<b>meant</b> 195:14	119:6 121:9	246:17 247:3,22	386:13,18,18,22	148:14 150:12
219:12	122:12 124:18	248:12 251:15	387:1,3,10	152:18,21 153:13
<b>measure</b> 10:15	125:10,11,12,13	252:10 254:7	<b>measure's</b> 188:14	154:5 164:3,14,21
18:17 19:1,9,12	126:1 127:2,4	255:1 256:16,17	<b>measure-specific</b>	165:11,14 168:18
19:18,21 20:12	128:6 131:5,13,15	262:1,4 266:6	27:12 28:18	179:14 187:7,20
26:4,11 28:2	131:16,17 132:20	267:10 269:3,11	<b>measured</b> 75:18	188:20 189:17,21
29:11 30:15 31:3	134:15,16 135:5	274:13,14,15,15	253:7 310:2	196:11 197:4,11
31:8,15 35:4,6,7	135:11,17,20	274:22 277:22	<b>measurement</b> 23:5	200:4,8,16 216:22
36:4,18,18 37:4,4	136:12 137:3,5,12	278:10,14,16,18	28:1 40:1 52:10	218:11,15 221:7
39:1,4,5 40:9,10	137:13 138:4,5,6	279:1,16 280:11	54:15 58:8 82:12	227:21 228:18
41:2,21,22 42:3,5	138:19 139:2,17	280:15 281:1	126:15 138:18	230:7,16,18,19
42:9 43:2,3,7,10	140:11 141:22	285:18 286:9,13	144:5 151:21	231:10,11,18
43:15,17,21 44:3	144:17,21 145:19	286:20 288:17,18	178:21 197:3	232:4,9 233:3,6,7
46:9,10,11,19	146:1 147:3,14	290:21 291:4,5,7	219:1 233:4 254:3	233:8,21 234:11
51:1,10,16,17	149:18,19 150:10	291:8 292:22	338:13 378:20	234:12,17,19
52:5,15 54:2,22	152:22 153:7,10	293:11 294:9,12	380:5	235:4,5,6,8,10,14
55:18,22 56:2	155:4,8,20 156:8	294:14,19 295:8,8	<b>measurements</b>	235:19,22 236:17
57:14,17,19 58:9	157:22 160:19	295:14,18 296:19	154:13,15	236:17,20,21,22
58:11 59:1,13,17	163:14,15 164:1,7	297:2,6,21 299:14	<b>measurers</b> 146:10	237:19 238:22
65:1 68:15,16	164:10,12 165:22	299:19 301:9,20	<b>measures</b> 4:8,12	242:4,11 245:15
69:9,14,15,18	166:4 167:16,17	302:10,11 303:9	8:8 9:16 10:10,14	245:18 246:4,6,11
71:16 72:6 74:18	168:10,12,15,21	303:11,12,15,18	12:4 18:9,10,14	246:22,22 247:11
74:22 75:9,10,16	169:12,17 173:1	304:2,5,13,13,16	19:11 20:8 21:9	249:12 250:9,14
75:17 76:1,7,8,12	174:12,14,21	305:2 306:1,9,20	22:3,19,21 23:1,6	251:16,19,22
76:14 77:2,5	178:3,5,8,20	307:12,14 309:14	23:11,12 24:2,8	252:3,19,21,21
78:16 79:20 80:6	179:15 180:5	309:18 310:10	24:12,16,21 25:6	253:10,17 255:15
80:15 82:18 83:3	182:14,17 183:18	311:2,6,9 313:7	25:21,22 26:3,4,5	255:21 256:1,11
83:14,15,19 85:17	184:10,18 186:7	314:19 317:5,16	26:13,14,21 27:9	256:14 258:3
86:2,5,6,17 87:11	187:14 188:9	319:11 320:18	27:17,21 28:1	263:2 264:11
87:12,14 89:1,4,5	189:4,8,8,16	321:10 323:4	29:6,9,15,22 30:2	266:15,16 267:9
89:20 90:1,10	190:1,16,17 198:3	324:2 325:4	32:16,17 33:5,19	267:17,21,21
91:1,22 92:16	200:12 205:20	329:14 331:8,12	34:3 35:15 37:6,8	268:1,6,9 269:1,6
93:13 95:12,17	208:12,22 209:2,3	331:18,20 332:3,7	40:17 45:11 46:2	269:11,15 270:4
96:8,10,18 97:3,6	209:7 210:14	333:3,8,9,11	50:21 52:6,18	270:11,13,22
98:1,19 99:5,6,12	211:3 212:2 213:6	334:2,6,17,22	58:18,22 69:3,9	271:4,9,12,15,20
99:19 100:9,20	214:4,8 215:2,8	335:3,20 336:6,17	73:20 74:7 85:22	272:13,19 273:5
102:4,12,13 103:7	215:19,22 216:3,5	337:10 338:6,7	87:7,10 89:6	275:2,13 276:2
103:8,21 104:10	217:3 218:11,19	339:1 340:1,6,7,9	90:14 92:3 94:8	277:19 279:4
104:11,18 105:1,9	220:6 221:12,15	340:16 341:5	95:2,3,11,21 96:2	280:9,10,11
105:9,11,13,19,20	224:10 225:13	347:10 348:7	96:11 97:2 99:14	281:16 283:1,18
107:12,19 108:8	226:18 227:14,22	352:14,16,16	101:18 103:6	288:19,21 289:6
108:16 110:13	228:3 233:9,14	355:1,11 363:12	105:7 109:18	293:11,18 298:5,7
111:6,20 112:11	236:19 237:3	366:6 369:2,3,7	113:21 114:5,7,10	301:12 302:1,5

305:16 307:22	<b>medical</b> 1:11,15,16	149:20 150:16	57:2 64:2,9 65:20	267:15 272:5,18
310:17 313:1,11	1:18 2:19,19,21	278:7 288:11,12	67:1 68:22 70:21	274:8 276:3 277:6
314:6 315:7	3:1,3,3,4 5:4	288:13,13,21	75:2 76:21 78:11	277:8 283:10
317:16,19,21	11:14,18 12:8,9	289:12	80:3,22 82:9 83:8	285:8,22 287:1
318:4,21 321:3	12:17,21 13:1	<b>medicine</b> 2:15,16	84:1 87:5,16 90:6	289:3,8 290:12
323:2,7 325:9	14:22 15:6,18	3:8 12:7 112:18	93:5 94:5 96:9,19	293:22 294:16,21
332:15 334:12	16:7,10,18 43:12	133:17 162:9	97:1 98:4 99:10	295:5,6,19,22
342:6 343:1,9	78:3 111:2 114:17	165:6,7,7 183:1	99:15 104:18	296:6,10,15
347:17,22 348:16	115:4 118:21	191:16 287:9,22	106:15 109:15	298:22 299:6
350:16 353:1	121:5 132:10	288:9 367:8	114:19 116:16	304:12 305:4,8
364:12,21 365:6,9	154:17 165:19	<b>meds</b> 133:4 287:12	117:7 118:8,13,17	306:20 309:10
365:11,13,18	179:18 180:2,10	287:20 288:2,3,14	120:19 122:6,8	312:14 313:15
366:7 367:3 368:7	185:21 199:4	289:13 290:8	124:4,21 128:3	316:3 319:9
369:9,10,13 370:2	201:5 232:1 239:8	<b>Medwise</b> 16:19	131:12,21 132:9	320:16 321:14,22
370:14,18,20,22	242:17 250:6	<b>meet</b> 10:16 46:17	133:2,8,10,20	322:2 323:1,21
371:3,16,22	257:21 277:13	108:16 193:19	134:2 136:21	326:15,20 328:13
372:13,21,22	279:13 281:5	280:11 281:1	137:4,5 139:10	329:12 330:8
373:11,12,13	306:12 312:17	286:11 340:16	141:20 142:11	332:16 335:18
374:2,5,8,10,17	314:17,21 325:21	383:21 388:12	145:10 146:8	338:19 341:20
374:22 375:4,9	<b>medical/behavio...</b>	<b>meeting</b> 1:3 6:6 7:2	147:10,19 149:16	342:19 343:18
376:20 377:3,4,14	273:18	18:7 26:20 28:16	150:4 151:4 152:4	344:20 345:3
378:3 379:5,6	<b>medically</b> 386:9	43:7 98:1 158:8	152:15 156:11,21	346:2,6 348:11
380:3,9,13 381:1	<b>Medicare</b> 253:14	232:4 268:21	158:12,14 161:16	350:13 351:9,17
381:2,3,7,15	318:21 319:1	276:19 280:15	161:20 162:10	351:20 352:2,4,6
382:7,22 383:9	384:16	306:15 366:1	163:5,7,11 176:1	353:16 354:6
384:3 386:6,7,10	<b>Medicare/Medic...</b>	374:19 388:18	176:19 177:21	358:15 359:10
387:8,13	296:14	<b>meetings</b> 28:9 31:1	179:9 185:16	360:18 361:3
<b>measuring</b> 46:20	<b>medication</b> 4:9	<b>meets</b> 10:15	186:19 187:5	363:17 365:3
47:8 50:7,20	104:13,16,20	<b>mega-systems</b>	194:4,14,17	367:5 368:4,22
56:20 79:8 106:18	105:11,21 106:10	261:20	195:13,17 201:13	373:16 374:18
106:22 117:11	106:16,18,20	<b>Melnyk</b> 2:12 13:17	201:16 202:6,11	377:8 380:7 386:1
125:14 127:20	107:2,11 109:8	13:18 49:1 80:22	203:17 205:7,15	387:20 388:3
138:2 147:2 168:9	110:2,3,19 111:5	168:19 176:1,19	206:8 209:8 210:4	<b>members</b> 16:12
168:16 174:18	112:13 113:1,3	177:21 224:4	210:5 213:14	17:5 18:8 20:2,7
257:10 260:15	120:4,14 121:7	225:12	214:14 217:9	29:17 37:16 42:19
304:18 365:12	122:18 125:13	<b>member</b> 5:15 8:21	218:9 221:20	48:20 115:1 169:1
375:15	127:1,21 131:16	11:2,13,17,21	223:11 224:4,14	185:7 265:4,17
<b>mechanism</b> 30:10	134:8,10 143:14	12:6,16,22 13:5,9	225:12,16,22	383:22
<b>med</b> 117:10,11,14	146:5 152:10,12	13:17 14:2,6,17	227:18 229:8,11	<b>membership</b> 20:19
143:5,13 152:13	286:6,7 287:7	15:1,8,14 16:4,14	237:14 239:7	21:14,16 165:18
<b>Medicaid</b> 1:15 2:16	<b>medication-free</b>	16:17 17:10,14	240:11 241:13	222:11
2:16 11:15,16	125:3	29:22 30:8 31:21	242:8 243:1,18	<b>mental</b> 2:7 13:8
14:12 16:8,20	<b>medications</b> 24:5	32:13,20 33:7,9	244:3 246:2 249:5	24:14 25:17 34:17
38:8 66:15 105:16	88:1 107:22	34:13 41:18 44:9	257:3 258:12,14	34:21,21 37:9,9
144:8,9 253:13	110:20,21 126:3,3	46:6 47:3,15,16	259:7,15,20 260:1	43:9,15 81:6
263:21 296:1,4,7	130:14 133:3	49:1,17 50:1,3,15	261:7 263:19	100:20,21 121:12
311:7 384:16,22	136:1 142:6	53:7 54:6 56:5	265:22 266:3	167:14 204:20

206:16 207:6,12 209:12 217:4 230:11 231:9,22 232:6,20 234:7 235:20 236:7 241:1 242:18 244:12 246:19 253:5 254:21 266:11 272:9 277:2 278:8,20 283:21 284:14 302:12,15,22 304:7 326:11 <b>mentally</b> 243:5 266:20 268:16 <b>mention</b> 180:7 182:10,21 369:11 <b>mentioned</b> 23:20 29:8 31:11 46:11 71:16 91:5 97:19 101:21 109:22 114:2 180:17 181:18,18 198:22 272:20 310:6 316:6 366:2 369:10 <b>mentioning</b> 106:17 <b>mercifully</b> 156:16 <b>Meredith</b> 3:16 188:2,7 189:10 207:15 215:9 <b>merely</b> 263:9 <b>merge</b> 206:10 <b>merits</b> 89:7 270:22 <b>mess</b> 371:8 <b>message</b> 115:21 151:18 <b>met</b> 1:8 21:11,12 46:19 338:14 <b>metabolic</b> 278:11 <b>metastasis</b> 367:9 <b>method</b> 7:7 52:1 128:20 142:18 144:3 158:18 <b>methodologically</b> 42:14 <b>methodology</b> 80:1	198:19 207:20 215:12,16 216:13 <b>metric</b> 45:4 56:22 78:9 377:12 <b>metrics</b> 14:15 44:11 45:4 115:15 265:7 <b>MIA</b> 2:10 <b>mic</b> 30:7 116:14 259:11 <b>Michael</b> 2:8 3:4,18 11:17 27:21 33:8 35:13,18,21 67:17 272:4 385:21 <b>Michigan</b> 313:17 315:7 <b>micromanaging</b> 308:3 <b>microphone</b> 17:9 18:2 <b>mics</b> 11:11 <b>middle</b> 153:22 <b>Mike</b> 13:9 43:22 46:11 47:1,2 70:20 76:19 120:18 122:5 133:18 203:15 206:7 259:11 283:9 <b>mild</b> 247:13 284:9 284:10 <b>Miller</b> 2:15 16:4,4 84:1 109:15 149:16 158:14 <b>million</b> 38:5 <b>mind</b> 25:22 36:6 61:14,18 78:16 150:2 217:16 218:4 377:9 <b>mind's</b> 78:19 <b>mindset</b> 34:6 <b>minimal</b> 328:15 <b>minimum</b> 178:20 184:19 <b>Minneapolis-St</b> 11:19 <b>Minnesota</b> 1:19	15:16 27:22 53:11 258:21 282:10 <b>minor</b> 54:17 186:9 <b>minority</b> 153:19 <b>minute</b> 8:6 61:9 70:19 201:14 <b>minutes</b> 19:11 228:12,17 325:7,9 <b>Mio</b> 7:18 388:4,4 <b>mirror</b> 290:20 <b>misencoding</b> 376:1 <b>misconstrued</b> 159:2 <b>misinterpreted</b> 103:8 <b>misnomer</b> 131:15 <b>missed</b> 57:12,12 80:20 242:21 290:13 <b>missing</b> 63:8 75:20 79:9 111:5 124:16 128:12 160:14 204:5 222:5 226:12 242:14 272:6 291:17 322:9,10,11 324:10 330:15 336:2 349:7 374:22 <b>misspoke</b> 104:22 <b>mistake</b> 121:11 356:21 <b>mix</b> 277:11 384:14 384:15 <b>mixed</b> 310:3 <b>Mm-hmm</b> 74:16 <b>model</b> 158:8 182:16 247:9 281:19 284:15 286:12 <b>models</b> 15:22 129:19,20 242:12 264:13 265:14 <b>moderate</b> 59:18 63:13 64:21 65:9 65:13 76:9 103:17 103:19 139:5	140:8,16,22 141:2 141:14 155:14,18 156:3,6 157:10,14 159:15,20 175:13 175:18 176:12,17 177:9,14 219:10 219:16 220:1,4 221:22 225:3,7 226:5,16 247:13 247:14 291:20 292:4,10,17 297:13,15,19 298:1,18 299:12 300:11,14 308:9 308:13,18,20 309:1,4 311:16,21 312:3,9 315:16,20 316:18 320:3,9,13 322:13,20 323:18 324:14 328:1,6,10 329:4,8 330:3,19 344:5,10,15 345:13,19 346:11 346:22 349:12,22 350:10 351:1 353:13 354:3,15 355:19 356:3,7,14 356:19 357:3,9 360:3,10,14 362:5 362:12,21 363:5 <b>moms</b> 379:17 <b>money</b> 133:15 <b>monitor</b> 106:7 253:5,18 339:7 340:14 378:15 <b>monitoring</b> 113:2 186:2 339:16 <b>monster</b> 319:14 <b>month</b> 108:7 112:5 130:22 150:8,18 150:19 <b>months</b> 28:8 68:5 107:7,9 108:9 112:2 120:10 124:5,17 150:9 152:10 215:14 279:20,22 280:3	291:3 306:13 336:14 341:15 <b>mood</b> 12:15 <b>morbidity</b> 304:20 348:15 <b>morning</b> 6:4 12:16 13:17 15:8 16:17 63:19,21 64:3 105:2 161:16 188:7 229:7 287:21 317:10 388:17 <b>mortality</b> 166:18 231:21 249:3 254:15 284:1 304:20 348:15 <b>motivated</b> 262:15 <b>motivates</b> 56:18 <b>motivation</b> 56:15 <b>Mount</b> 3:8 <b>mouthful</b> 164:19 <b>move</b> 24:17 25:1 29:5 45:14 63:15 64:22 65:14 67:22 75:12 76:3 103:21 140:10,13,14,15 141:1,15 142:9 146:15 149:13 155:20 156:8 157:7,16 159:12 159:21 175:21 176:18,19 177:15 177:17 202:20 211:11 219:6 220:5,11,12 221:4 221:7,16 223:20 224:2 225:9 226:19 275:13,14 277:19 291:21 292:18 297:8,16 298:2,14 299:13 306:19 308:6,16 308:21 311:22 312:10 315:12,21 319:17 320:5,10 320:14 321:12 322:4,14,21
--	---	---	--	--

323:19 324:16	<b>Murphy</b> 3:18 35:18	265:22	172:16 233:14	380:11 381:1
325:3 328:3 329:9	35:19,22 37:21	<b>near</b> 154:16 254:14	245:11 255:17	386:22
330:4,21 343:17	40:12,18 42:18	<b>nearing</b> 385:16	273:12 342:17	<b>newly</b> 38:14 107:1
344:11,16 345:20	67:18,21 68:12,14	<b>necessarily</b> 53:9	<b>needing</b> 374:4	<b>news</b> 317:8,9,10
346:12 347:1,10	68:20 71:6 99:21	95:19 96:1 108:8	<b>needle</b> 379:5 385:9	382:5,6
347:11 350:18	<b>myth</b> 174:2	119:4 128:11	<b>needs</b> 102:10	<b>NGS</b> 20:19
353:14 354:16		129:15 130:13	108:17 111:13	<b>nice</b> 17:4 230:3
355:3 357:4,20	<b>N</b>	134:9 149:12	125:4 135:18	263:4
359:15 360:11,16	<b>N</b> 4:1,1 6:1	153:15 203:22	151:19 153:11	<b>Nicholson</b> 2:11
362:13,22 366:4	<b>N.W</b> 1:9	207:8 271:3 274:2	158:9 182:3 183:5	17:15
369:9,10 379:5	<b>name</b> 7:9 11:13	332:1 371:22	194:1 203:21	<b>night</b> 11:6
<b>moved</b> 11:5 223:8	15:14	<b>necessary</b> 71:17	232:2 236:8 245:8	<b>nine</b> 107:7,9 120:10
331:9 355:2	<b>names</b> 6:8	72:21 108:12	271:18 277:16	140:8,21 150:9
357:19 363:12	<b>narrowed</b> 285:4	158:6	279:11 296:13	152:9 169:10
385:9	<b>narrowing</b> 304:6	<b>necessitate</b> 130:5	355:8 370:3	178:2 227:13
<b>movement</b> 147:1	<b>nation</b> 148:18	<b>necessity</b> 124:13	<b>negative</b> 173:20	297:15 299:12
378:8	<b>national</b> 1:1,8,12	<b>need</b> 22:12 23:6	174:1 280:12	311:21 312:8
<b>moves</b> 27:8 347:3	13:12 37:2 65:6	26:3 28:20 29:1	<b>negatives</b> 91:8	315:20 323:18
<b>moving</b> 21:14	71:14 167:18	31:21 50:17,18,18	<b>Neither</b> 115:17	330:19 347:20
25:14 34:9 129:18	183:18 189:19	51:10 55:13 56:13	<b>nephrology</b> 337:5	348:3,3,6 352:1
132:10 147:6	191:15 260:3	57:9 59:20 64:18	<b>nephropathy</b> 5:4	352:10 353:3
157:6 189:3	277:9 365:16	83:13 88:7,14	325:21 326:1,2,3	363:5
205:15 242:2	378:6 380:17	98:21 100:10	326:17	<b>nine-oh</b> 216:8
255:21 274:9	383:2,4	101:11,13,15	<b>nervous</b> 30:15	<b>nineteen</b> 292:10
288:5 317:9	<b>nationally</b> 11:16	102:2,3,9 110:10	<b>nest</b> 380:2	320:2,13 328:6
364:17,17 368:5	<b>natural</b> 193:1,5	115:18 120:21	<b>net</b> 240:8	349:12 355:19
<b>MPH</b> 1:11,15 2:10	<b>nature</b> 367:7,7	123:16 126:3,13	<b>network</b> 209:17	360:3
3:5,11 4:2	<b>nay</b> 218:14,18	137:21 143:9	<b>Neuroscience</b> 3:6	<b>ninety</b> 216:6
<b>Msc</b> 1:16	<b>NCQA</b> 3:16,17,19	149:20 151:8	<b>never</b> 79:7 81:9	<b>nobody's</b> 51:2,4
<b>MSW</b> 1:17	4:9 5:3,4,6,12	165:13 175:1	126:4	150:4
<b>multi-dimensional</b>	27:20 104:13,22	183:2 191:20	<b>new</b> 1:13 6:10 9:11	<b>noise</b> 370:16
43:9	105:4 109:18	197:4 204:21	10:5 13:11 17:4	<b>non-eyecare</b>
<b>multi-disciplinary</b>	116:20 126:8	205:10 216:22	22:4,6,7,9 27:11	361:15
165:3	144:1 151:12	218:17 234:5	75:6 86:13 89:14	<b>non-medical</b> 286:7
<b>multi-faceted</b>	155:8 179:14	249:17 255:19	103:3 111:7,15,16	<b>non-specific</b> 151:17
107:5	229:16 262:17	256:2 258:16	112:1 115:10	152:2
<b>multi-functional</b>	268:20 270:16	268:19,22 275:8	124:1 131:11	<b>non-standardized</b>
78:15	271:17 272:1,7	275:19 292:14	133:11 134:7	174:13
<b>multi-stakeholder</b>	296:17,21 301:19	301:4 312:4	136:6,17 161:8	<b>normal</b> 261:1,10
20:19	303:10 317:14,15	322:15 327:6	162:9 163:2	289:6
<b>multiple</b> 44:11 69:2	325:21 331:15	333:8 339:7	218:12 227:3	<b>north</b> 2:9 13:4
71:16 83:3 95:3	333:18 342:17	345:15 349:17	252:21 256:11	388:5
122:9,11,22 128:6	347:12 352:13	364:19 374:10	288:18,21 303:10	<b>Northeast</b> 3:2,3
130:19 239:9	355:9 358:3	379:19 381:4	316:6 330:6,12	12:8,11
251:14	365:16 366:18	383:14 384:6	336:9 342:11	<b>Northern</b> 34:15
<b>multiplying</b> 149:2	375:7 376:10	387:18	346:1,2,6,15	<b>Northshore</b> 13:11
<b>munched</b> 237:19	379:3 380:16	<b>needed</b> 151:20	348:22 364:11	<b>NOS</b> 214:16
	<b>NCQA's</b> 118:20			



<b>note</b> 6:13 20:6 27:18 35:1 45:20 89:16 223:21 280:19 <b>noted</b> 166:1 225:12 306:20 313:12 <b>noticed</b> 43:6 287:3 <b>NQF</b> 3:9,20 5:15 6:10,11 8:13,22 9:18 21:7,14 22:8 28:5 29:2 32:1 36:4 37:7 41:18 43:1,18 45:8 71:4 72:9,12,15 90:19 95:1 96:17 102:5 102:16 151:7 162:22 185:6 215:15 244:22 253:9 255:19 262:17 266:8 269:14 270:16 271:17 272:7 294:18 334:1,2,6 334:9 363:17 365:8,22 369:12 370:4 371:13 374:20 375:11 377:14 383:9 385:11 <b>NQF's</b> 92:14 187:19 269:8 <b>nuances</b> 146:18 <b>null</b> 216:11 <b>number</b> 8:8 9:22 19:21 31:15 39:19 39:21 41:4 45:16 52:21 58:19 61:12 61:14,15 74:13 91:4,15 105:7,14 107:7,8 114:5 116:10,13,17 123:2 144:1 160:15 181:15 187:16 208:2 215:18 248:22 285:4 291:2 340:11 364:2	371:2 373:20 374:1 386:10 <b>numbers</b> 59:16 79:14 383:20 <b>numerator</b> 39:2,7,9 39:13,17 40:4,15 40:21 44:5 98:13 106:21 119:15 120:2 121:18 178:12 181:4,19 181:20 183:8 185:3 205:17 233:14 234:16 278:21 303:22 304:8 318:2 <b>numerators</b> 96:4 181:2 191:2 286:1 318:5 <b>nurse</b> 13:21,22 15:10 132:16 250:1 <b>Nursing</b> 2:4,14,21 13:21 15:11 <b>nutrition</b> 286:14 291:6,9 <hr/> <b>O</b> <hr/> <b>O</b> 4:1 6:1 <b>o'clock</b> 11:6 <b>Oaks</b> 13:3 <b>Obama</b> 259:5,7 260:19 <b>obese</b> 280:13 <b>obesity</b> 232:13 234:19 278:6 281:22 287:18 <b>obligated</b> 307:1 <b>observation</b> 90:5 <b>observations</b> 153:3 276:4 <b>observe</b> 378:10 <b>observed</b> 338:8 <b>observers</b> 178:10 <b>observing</b> 213:17 <b>obstetrics</b> 379:12 <b>obvious</b> 240:4 245:2 <b>obviously</b> 107:21	203:6 223:7 237:18 238:1 282:2 368:12 <b>occasionally</b> 361:1 <b>occur</b> 86:6,7 108:5 108:14 119:7 123:11 126:13 128:22 158:4,20 <b>occurrence</b> 257:11 <b>occurring</b> 57:5 <b>OCTOBER</b> 1:6 <b>odd</b> 219:21 <b>oddball</b> 161:22 <b>off-label</b> 133:11 <b>off-mic</b> 11:2 <b>offering</b> 126:8 <b>office</b> 2:4,19 15:11 33:15 124:10 126:15 132:17 333:17 361:9,15 384:14 <b>office-based</b> 67:7 <b>Officer</b> 1:16 2:13 3:11 13:20 16:19 162:22 <b>offline</b> 263:3 <b>oh</b> 11:4 62:8,16 63:10 64:19 68:20 103:16 133:21 138:13 187:9,14 200:9 219:20 225:21 226:1 228:5,5 257:10 259:4 266:14 297:12 300:22 301:20 320:1 321:12 322:2,2 352:11 360:20 <b>Ohio</b> 2:7,15 3:2,3 12:8,11 13:7,18 <b>okay</b> 11:8 17:3 22:4 27:8 29:5 34:10 35:19 38:20 52:10 53:4 60:14 62:12 62:17,19,22 63:7 63:12 64:12,15 65:4 103:12,18	104:1,9,18 106:15 109:12 114:3 116:16 118:8 120:8,12 124:20 137:4 140:6,20 141:12 142:22 154:11 155:3,6,9 155:17 156:5,11 157:8,13 159:13 159:18 160:8,15 163:13 168:6,18 175:9,11,17 176:8 176:10,15 177:2,6 177:7,12 194:2 206:6 210:4 215:3 219:8,15,21 220:3 222:1 224:19,21 225:6,10,19 226:3 226:15 227:7,12 229:3 235:20 245:6 249:17 253:16 254:13 257:13 259:10 283:2 285:10 289:8 290:7,15 291:14 292:1,2,6 292:9,13 297:10 297:14,22 299:2 300:9 301:2 302:9 308:7,12,19 309:3 311:14 315:14,19 316:12,16 317:1,4 317:15 319:16,18 320:1,8,12 322:6 322:11,18 323:11 323:16 324:7,21 325:1 327:17 328:5,9,13 329:3 329:7 330:2,14,16 330:18 331:4,7,16 332:4 344:2,9 345:7,11 346:10 346:16,20 347:5,8 348:11 349:4,11 349:21 350:9,20 350:22 353:10,12 353:22 354:2,11	354:13,22 355:15 355:18 356:2,6,13 357:2,7,17 359:14 359:17 360:2 361:19 362:11,20 363:4 376:22 377:21 386:20 387:2 388:13 <b>old</b> 84:2 194:5 210:18 215:14 <b>olds</b> 49:8 171:9 <b>ONC</b> 113:10 <b>once</b> 21:21,22 44:19 56:6 59:20 61:2 62:15 189:6 266:9,14 274:19 297:5 312:5 336:18 <b>one-month</b> 128:15 147:21 <b>one-page</b> 37:12 <b>one-person</b> 301:16 <b>one-size-fits-all</b> 158:8 <b>ones</b> 26:14,17 97:20 188:18 219:4 290:20 <b>ongoing</b> 273:21 <b>onsite</b> 13:2 <b>onus</b> 377:16 <b>open</b> 6:22 19:4 23:9 29:16,19 64:16 65:10 72:14 103:15 140:18 155:15 156:1 157:9 159:14 160:9 175:11 176:10 177:7 191:8 208:10 219:9,20,21 224:22 226:4 227:9 229:10 283:9 291:16 292:2,12 293:20 293:21 297:10,18 298:12,17 300:6 300:10 301:2
--	---	---	--	---

308:17,22 311:14 312:2 315:15 316:12 317:1 319:19 320:6,11 322:15 323:12 324:7,21 327:18 328:4 329:2,6,20 330:14 331:4 344:3,8,12 345:6 345:7,15 346:8,16 347:5 349:5,14 350:20 353:10,22 354:11,20 355:16 355:22 356:4,11 356:16,22 357:5 357:12 359:18 360:6,17,18 361:20 362:6,18 363:2,8,20 <b>opened</b> 308:8 322:7 <b>openings</b> 7:22 <b>operating</b> 216:20 341:2 <b>operationalized</b> 179:12,14 <b>operationalizing</b> 181:6 <b>operationally</b> 180:9 272:11 <b>operations</b> 9:20 <b>operator</b> 229:10,12 229:13 363:20,22 <b>opinion</b> 73:8 <b>opportunity</b> 32:14 114:13 151:7 163:21 167:8 176:2 223:17 338:10 <b>opposed</b> 83:4,17 108:9 214:15 215:2 222:21 256:10 338:17 370:14 386:17 <b>opposite</b> 148:22 <b>option</b> 89:17 90:2 98:20 99:4 182:12 221:16 287:8	<b>options</b> 65:8 88:19 92:10 99:9 140:16 141:2 155:13 156:2 157:9 159:14 160:10,11 175:12 176:11 177:8 219:10,22 225:2 226:5 227:9 292:3 297:12,18 298:17 300:11 301:3 308:8,17 309:1 311:15 312:2 315:15 317:2 324:22 331:5 363:7 366:11 <b>Optum</b> 2:19 <b>order</b> 151:20 171:22 201:17 <b>ordered</b> 239:17 <b>organization</b> 162:10 <b>organizations</b> 114:15 115:9,10 115:14 165:21 235:16 236:19 277:10 <b>organized</b> 265:10 <b>oriented</b> 382:2 <b>original</b> 135:1 291:4 343:9 378:9 <b>originally</b> 36:13 <b>osteo</b> 375:17 <b>other's</b> 334:13 <b>ought</b> 56:20 202:20 211:19 307:17 <b>outcome</b> 26:4 36:18 37:4 41:8 43:3 68:16 69:14 69:15 71:17 83:15 84:11 85:3 86:15 86:16 87:11,14 97:2 109:18,21 113:15 128:11 148:7 149:18 171:19 231:10 365:12 377:16	380:2 <b>outcomes</b> 1:13 9:11 38:17 45:12 70:2 70:10,17 77:3 82:2 85:15 86:11 87:21,22 88:5,9 88:16 91:14 94:21 106:3,11 113:7 136:15 146:18 147:4,8 148:12 164:21 171:16 172:12 254:16 282:7,18 372:1 <b>outdated</b> 135:5 <b>outliers</b> 153:19 <b>outlived</b> 381:4 <b>outpatient</b> 134:12 134:13 283:14 284:18 307:7 <b>outreach</b> 54:12 <b>outside</b> 6:14 <b>over-sample</b> 235:18 <b>over-sampling</b> 236:1 <b>overall</b> 22:2 23:14 33:18 36:10 50:12 67:12 97:5 160:4 160:9,17 222:4 227:8 269:1 300:17,21 313:4 313:10 316:19 317:2 321:9 324:16 325:1 330:21 331:5 347:1,6,8 354:16 357:10,17 363:7 367:16 379:4 <b>overarching</b> 246:3 <b>overcome</b> 314:12 <b>overestimate</b> 180:4 <b>overheard</b> 182:21 <b>overlap</b> 248:21 332:1 343:9 <b>overlapping</b> 333:6 341:18 <b>overload</b> 365:6	<b>overly</b> 182:18 183:1 <b>oversee</b> 22:2 34:19 <b>overseeing</b> 22:17 <b>oversight</b> 264:17 <b>overview</b> 4:5 17:17 18:20 <b>owned</b> 206:15 <hr/> <b>P</b> <hr/> <b>P</b> 6:1 <b>p.m</b> 7:18 228:14,15 325:13,14 388:4 388:19 <b>package</b> 72:8 <b>packaged</b> 269:15 <b>packet</b> 18:19 <b>page</b> 37:18 66:1 116:20 133:4 142:19 286:16 387:13 <b>paired</b> 94:8 <b>panel</b> 22:13 144:15 148:1,19 178:1,2 249:16 278:21 284:2 293:9 294:18 366:12 <b>panels</b> 111:14,15 334:14 <b>paper</b> 194:7 195:4 234:15 <b>papers</b> 12:14 38:9 <b>paragraph</b> 36:7 <b>parameter</b> 128:16 128:19 129:4 143:19 158:17 159:2 <b>paranoid</b> 84:2 <b>pardon</b> 340:12 <b>parent</b> 36:9 50:2 84:6,7,13,22 124:13 126:20 143:1 271:12,15 <b>parents</b> 50:2 84:15 122:19 143:6,8 <b>parity</b> 127:11 <b>parking</b> 359:11 <b>parse</b> 68:22	<b>parsimonious</b> 258:4 <b>parsimony</b> 251:15 <b>parsing</b> 335:7 <b>part</b> 13:4 24:7 38:1 40:9 46:12 53:1 56:14,14 58:10 79:10 87:16 103:5 107:4,5 112:6 123:5 137:9 147:10 164:13 167:9 170:19 171:12 189:22 190:15 205:20 206:12 207:19 218:15 221:6 230:6 235:9 250:15 251:2 261:19 272:15,16 274:16,17 276:16 285:2 289:5 295:1 315:3 331:18 337:10 343:1 358:19 361:7 365:8 366:16 367:1,3 369:6 370:6 373:7 376:4 379:16 381:14,19 <b>partially</b> 300:1 <b>PARTICIPANT</b> 279:17,21 <b>participants</b> 171:4 <b>participate</b> 217:1 <b>particular</b> 28:13,16 51:20 76:12 77:4 81:22 82:18 152:22 158:9 197:22 198:6 199:6 213:21 222:12 223:22 231:21 234:17 247:11 248:11 253:11,12,13,14 373:14 377:1 <b>particularly</b> 18:22 39:18 45:16 50:6 91:6 127:9,13
--	--	--	---	--

132:13 151:16 152:7 166:6 173:5 181:22 203:4 248:14 251:20 283:22 373:13 380:10 <b>Partners</b> 11:20 <b>Partnership</b> 367:4 <b>parts</b> 79:21 106:22 238:8 343:12 <b>pass</b> 85:11 143:12 <b>passed</b> 240:18 <b>passions</b> 15:21 <b>password</b> 31:22 <b>path</b> 245:5 257:18 <b>paths</b> 148:9 <b>pathway</b> 146:20 <b>patient</b> 49:21 63:20 78:2 108:17 109:9 123:17 125:19 129:9,13 130:9 149:7 159:7 166:22 178:22 183:5 184:15 194:1 273:10,10 307:2 336:15 386:9 <b>patient-reported</b> 113:14 371:16 <b>patients</b> 36:15 43:12 123:6 164:22 166:12 167:4 197:16 206:12 213:18 217:5 257:22 259:1,2 266:11 270:14 335:10,11 339:4,5 383:20 384:9,14 <b>Pating</b> 2:16 34:13 34:15 50:15 147:19 237:14 239:7 240:11 274:8 285:22 321:14 322:2 341:20 342:19 360:18 361:3	380:7 <b>Paul</b> 11:19 <b>pause</b> 121:19 139:9 140:19 141:5,8,11 155:16 156:4,10 157:12 159:17 160:12 175:16 176:14 177:11 225:1,5,18 226:7 226:11 227:11 237:11 349:6,10 349:16,20 350:3,8 350:21 351:4 353:6,11 354:1,12 354:21 355:17 356:1,5,12,17 357:1,6,13,16 359:19 360:1,7,12 361:17,21 362:2,7 362:10,19 363:3,9 <b>pauses</b> 229:2 <b>pay</b> 149:4 218:22 250:2 311:10 315:5 351:6 384:19 385:1 <b>payers</b> 129:6 159:4 260:4 <b>paying</b> 114:11 314:20 <b>payment</b> 152:19 365:15 <b>PCP</b> 260:15 <b>PCPI</b> 3:15,15,16,17 3:19 4:13 163:19 164:19 165:18 170:14 184:10 197:10 207:20 211:18 215:12 255:18 <b>PCPs</b> 277:4 <b>peanut</b> 182:20 <b>pediatric</b> 4:9 13:21 16:3 28:3 35:3,7 35:16 37:10 46:8 49:2,19 66:3 93:7 100:19,20,22 <b>pediatrician</b> 48:2	<b>pediatricians</b> 36:14 47:21 100:18 119:3 <b>pediatrics</b> 2:14 15:20 37:8 38:10 68:6 165:6 <b>Peds</b> 257:8 <b>penalized</b> 132:22 384:8 <b>people</b> 4:14,16,17 5:1,2,3,5,8,9,11 6:15 10:22 17:22 24:13 25:16 30:21 38:1 42:9 43:5 44:14 47:10 49:14 55:20 58:15 76:18 81:2,11 85:19 87:22 92:7 121:3 147:17 150:20 161:7,9,13 164:4 169:11,14 176:6 186:16 195:7,19 195:21 200:21 203:14 211:13 212:14 213:12,13 213:16 223:9 224:6 228:9 229:17 230:17,20 231:8,8,22 232:6 232:7,19 233:11 235:8,11,19 236:4 236:7,11 243:15 244:4,12,16 245:1 246:1 247:10,17 248:7 249:16,20 249:22 251:4,7,9 251:20,22 252:4 253:5,7 254:14,19 255:16 257:9 259:18 261:19 263:8 264:9 267:4 269:10 270:9 271:21 276:5,7,22 277:17 278:2,8,9 278:22 280:8 281:1 284:13 285:5,15,16	292:13 302:8,11 302:14 303:4 306:5,10 307:5,13 307:16,17 308:2 314:8,18 317:13 318:1,15 319:4 325:20 326:11 327:6,19,21 329:22 331:13 332:3,10,14,21,22 334:3,7 337:11,13 337:19,21 338:2 338:15 340:2,4,21 341:6,12,18 343:7 343:7 347:14 348:19 351:13 352:9 355:4 358:2 374:14 375:19 376:15 379:8 381:6,10 <b>people's</b> 85:7 314:12 <b>percent</b> 38:11,13 41:5 59:7,12 79:7 81:7 86:21 166:8 166:9,11,18 171:4 178:2,11,12 181:1 181:3 216:6,9 219:19 220:10,20 221:12 222:1,2 223:5 257:20 262:21 282:14 295:2 300:16 353:5 368:9,9,11 375:20 378:13,13 385:6,6 <b>percentage</b> 41:3 295:3 <b>percentages</b> 220:19 <b>perception</b> 147:18 <b>perfect</b> 138:10 147:16 160:15 265:14 292:15 293:5 301:7 320:8 322:18 355:15 368:6,11 <b>perfectly</b> 32:8	147:13 251:16 302:3 <b>performance</b> 39:4 40:17 46:20 48:16 54:20 64:14 75:18 90:9 92:3 108:18 108:19 140:20 148:12 152:20 153:1 164:18 165:13 168:11 175:22 176:3,11 176:16 181:10 184:19 196:11 197:2 200:8,16 216:4,6 225:14 267:21 268:21 292:3,9 293:13 308:19 310:22 311:10 318:10,11 318:14 321:5 327:3 360:5,8 365:15 369:16 371:18 374:1,5,15 384:20 385:2 <b>performed</b> 191:4 268:9 269:1 310:18 <b>performing</b> 378:12 378:12 <b>performs</b> 46:18 <b>period</b> 54:15 124:12 178:21 204:3 268:2 279:18 280:2 336:11 338:12,13 <b>Permanente</b> 2:17 34:16 <b>persist</b> 337:1 <b>persistence</b> 117:12 117:14 <b>persistent</b> 224:11 <b>person</b> 6:8 45:21 56:8 63:8 79:7 94:19,21 134:17 194:12,20 195:1 204:1,8 214:5 337:14 345:9
--	--	--	--	---

384:2	167:20 184:13	93:3 95:22 97:9	14:15 15:3 16:19	383:3 384:8 385:2
<b>personnel</b> 132:12	189:1 192:13	99:18 101:10	44:12 56:10 57:3	385:3 387:7
<b>persons</b> 285:11	206:14 278:14	103:10 104:1,6,9	115:2 117:17	<b>platform</b> 383:8
<b>perspective</b> 44:13	279:4	137:17 161:11,18	122:9 125:1	<b>play</b> 121:8 207:12
53:8 57:4 108:4	<b>physicians</b> 123:15	162:11 163:5,9,13	127:19 142:1	262:19
125:1,17 183:8	210:2 250:10	168:1 169:13,16	143:12 144:5	<b>player</b> 272:6
210:6,12 211:11	273:9	170:12,15 171:13	235:16 241:16,18	<b>playground</b> 272:14
335:9	<b>pick</b> 267:9,10,12	173:16 174:4,9,15	249:13,13,18,20	<b>plays</b> 48:9
<b>pertaining</b> 108:3	<b>picked</b> 301:11	175:6,9 176:8,21	250:5,11 264:16	<b>pleasantly</b> 77:1
<b>Peter</b> 1:9,11 4:2 8:9	307:9	177:2,16 181:12	265:2 272:2	<b>please</b> 7:5 27:18
63:22 76:20 83:7	<b>picking</b> 78:20	184:22 185:8,13	273:15 279:2,6,7	30:6 32:10 59:5
85:5 87:6 104:11	359:9	186:12 190:3,7,12	279:11,14 291:8	60:2 61:10 118:16
136:21 229:5	<b>picture</b> 210:12	190:18 191:1,10	296:4,7,13 308:1	136:17 139:2
270:7 304:12	310:4	191:18 192:5,8,15	311:6 312:19	155:1 161:6,18
335:8 381:18	<b>piece</b> 76:14 125:9	192:20 193:1,7,11	314:14,15,17	162:18 228:19
382:18	204:5	193:18 194:2,13	318:13,19 327:2	229:9,11 242:21
<b>Pharm.D</b> 2:17	<b>piecemeal</b> 239:9	195:9 198:14	335:9 336:12,13	291:18 304:11
<b>pharmacotherapy</b>	241:4	199:12,18 200:1	338:8 369:15	309:9 312:4
286:15	<b>pieces</b> 76:11	200:18 201:10,15	370:6 377:18	316:15 317:12
<b>pharmacy</b> 2:18	<b>Pierce</b> 3:19 153:21	202:4,8,21 205:14	379:22 383:16	320:6 322:17
14:8 115:4 289:12	153:21 154:7,9,9	206:6 211:21	384:18,20	323:10,13 325:8
<b>phase</b> 1:3 18:15	154:12,20 155:6,9	217:7 219:6	<b>plan's</b> 54:20 383:22	325:11,16 327:16
22:7,12 23:22	164:5 169:22	222:17,22 224:2	<b>planning</b> 230:10	329:22 330:16
24:1,15,18 25:5	170:3,17 173:22	224:13,16,19	298:21	349:18 350:5
25:11,18 107:6	174:8,22 187:1	225:10,19 226:22	<b>plans</b> 14:20 105:13	353:21 354:10
124:7,7 135:17	<b>pig</b> 191:20	227:3,16 228:8	105:18 114:21	355:14 357:15
136:7 142:13	<b>pill</b> 123:12	269:2,22 303:19	115:16 118:21,22	359:16,21 362:1,9
<b>phases</b> 26:15	<b>pilot</b> 178:7 180:22	371:11	119:8 121:4	363:21 364:1
<b>PhD</b> 1:17,19 2:6,9	183:14	<b>Pindolia</b> 2:17 14:6	122:11 123:1,15	<b>plenty</b> 210:16
2:12	<b>piloting</b> 262:18	14:7 122:8 124:4	135:11 156:13	266:13
<b>phone</b> 7:13 16:13	<b>Pincus</b> 1:10,13 4:2	137:5 293:22	187:4 199:2	<b>plug</b> 275:1
17:3,22 19:8	9:8,8 11:4 26:8,11	294:16,21 295:5	233:19,22 234:1,9	<b>pockets</b> 379:1
33:10 35:10 47:4	26:19 27:19 30:19	313:15 374:18	234:12 236:22	<b>point</b> 9:17,18 18:13
67:15,19 162:12	35:11 38:20 40:14	377:8	242:3 249:14	21:21 26:18,20
163:6 164:4	43:20 45:7 47:1	<b>place</b> 49:9 92:16	250:5 262:12	30:21 31:5,13
169:20 188:3	48:19,22 49:13	113:12 183:2	263:21 265:9	33:12,16 41:19
298:21 324:9	50:8 51:13 55:4	203:22 212:11	267:7 273:1,7	55:16 59:17 69:1
350:7 358:12	57:1 58:3 60:10	249:22 369:17	279:6 280:22	69:13 77:7,9
363:20	60:14 61:19 62:4	384:1	281:4 293:12	90:22 95:13,14
<b>PHQ</b> 41:22	62:22 63:4,17	<b>placed</b> 126:2	296:1,16,18 310:1	102:21 103:5
<b>PHQ-9</b> 188:16	64:12 65:16 66:20	<b>places</b> 73:14	310:16 311:7,8	113:19 116:19
<b>phrases</b> 26:17	68:11,13,18 70:18	111:21 206:20	312:18,18 314:1	135:4,10 169:6
<b>physical</b> 13:15	71:2 72:13 73:2,5	263:15	318:12 319:1	173:18 181:8
238:13 239:16	74:1,5,16 76:15	<b>placing</b> 212:3	321:3 323:4 358:7	185:7 197:7
246:20 313:19	76:17 80:2,21	<b>plague</b> 32:21	369:5,15,16,19	202:17,22 208:14
<b>physician</b> 2:19	82:8 83:6 85:5	<b>plain</b> 337:20	375:15 378:7,11	209:4 214:20
161:21 164:18	87:4,15 89:8 90:4	<b>plan</b> 2:18 14:10,12	378:12,14,15	216:7,18 218:13

223:19 227:15 242:14 246:4,14 253:9 266:9 268:14 285:9,21 295:3 302:18 318:11 323:3,13 330:17 334:16 338:2 347:17 369:2 379:8,21 380:1 383:15 <b>point-four</b> 145:1 <b>pointed</b> 112:10 152:17 <b>points</b> 31:6 76:21 79:1 136:19 246:3 <b>poke</b> 191:20 <b>policy</b> 1:17 2:2 28:7 28:12 165:9 230:8 271:2 376:11 <b>political</b> 264:22 <b>pool</b> 339:3 <b>Poonam</b> 3:10 8:17 8:19 20:13 103:11 189:12 206:4 <b>poor</b> 54:11 129:15 178:4 303:8 347:18 352:1,2 358:8 <b>poorest</b> 318:14 <b>poorly</b> 54:8 <b>population</b> 42:10 54:13 57:17,20 88:8,16 101:14 102:11 126:17 166:22 173:1 190:21 215:17 231:3 232:14,18 233:5,10,17 234:20,21 235:18 236:3 246:7,9,10 248:1 250:12 251:18 253:15,19 253:22 254:6 255:4 256:20 257:13 258:17 266:5,16,19,20 268:2,11,14	278:20 282:1,2,6 283:21 290:21 293:2 294:2 295:9 298:7 299:18 304:17,18 305:16 306:5 309:17,18 310:16,18,21 314:18 319:6 320:20 322:1 326:3 333:12 335:14 336:22 342:5,9 348:9 351:11 358:7 365:13 370:12,13 370:15 374:12 383:12 385:5 387:1,2 <b>populations</b> 16:20 88:3 232:19 250:7 252:9 255:10,17 258:8 262:13 268:16 276:5 341:17 364:20 370:12 372:7 385:8 386:12,21 387:12 <b>poring</b> 80:18 <b>portfolio</b> 22:2,17 22:22 23:2,5,10 23:15,18 24:8,20 26:1,2,13,22 27:5 27:6 <b>portion</b> 221:15 <b>portions</b> 24:19 <b>position</b> 385:12 <b>positive</b> 38:12 41:9 41:14 49:12 66:17 146:16 157:6 173:6 174:3 216:2 216:7 280:17 299:20 375:20 <b>positively</b> 38:14 <b>positives</b> 91:8 146:21 <b>possibilities</b> 369:19 <b>possibility</b> 55:18 79:19 369:18	<b>possible</b> 128:2 380:8 <b>post-care</b> 24:6 <b>post-commenting</b> 28:15 <b>post-discharge</b> 25:9 <b>posted</b> 37:17 <b>potential</b> 28:11,22 75:13 78:15 87:3 88:4,10 101:21 106:8 199:7 202:19 255:2 303:2 378:11 <b>potentially</b> 146:5 179:6 198:1 271:16 366:6 <b>pounds</b> 287:13 <b>power</b> 209:10 216:9 <b>PQRS</b> 105:16 279:1 <b>practical</b> 222:7 383:15 384:12 <b>practicality</b> 383:6 <b>practically</b> 383:1 384:1,10 <b>practice</b> 1:20 15:10 33:12 78:5 128:13 128:16 137:9 143:3,19 148:3,7 178:9 206:15,22 207:10 209:18 210:1 213:19 215:22 277:7 385:5 <b>practices</b> 78:2 148:2 213:2 <b>practitioner</b> 13:22 14:1 107:3 121:2 134:5 183:4 <b>practitioners</b> 207:7 216:22 <b>pragmatic</b> 42:15 221:21 <b>pragmatics</b> 240:1 <b>pre-group</b> 47:5	<b>precisely</b> 292:22 309:15 320:18 <b>precision</b> 44:4 <b>preclude</b> 277:3 314:10 <b>predict</b> 203:4 <b>predictive</b> 203:12 <b>pregnancy</b> 305:11 305:14,17 306:16 <b>pregnant</b> 305:5 306:3 <b>premise</b> 169:3 <b>prepare</b> 37:13 <b>prepared</b> 18:8 <b>preparing</b> 43:6 <b>Presbyterian</b> 9:12 <b>prescribe</b> 197:22 198:10 <b>prescribed</b> 4:9 104:13,19 106:16 107:1,11,22 110:8 110:21,22 125:15 125:20 148:9 <b>prescriber</b> 121:1 127:20 129:22 132:7 134:9,12,21 135:2,13,16 <b>prescribes</b> 200:12 <b>prescribing</b> 107:3 120:11 129:14 130:14 134:5 150:17,20 <b>prescription</b> 112:1 112:14 117:11,14 123:20,22 124:1,2 124:6 127:15 130:1 134:7 <b>prescriptions</b> 119:7 142:2 <b>prescriptive</b> 182:2 182:19 191:8 199:17 205:16 <b>presence</b> 184:1 <b>present</b> 1:11 3:14 3:22 44:1 70:6 163:22 235:7,7 352:16	<b>presented</b> 74:21 75:4 76:6 86:22 87:1 89:15 91:2 139:16 169:5 180:18 189:18 193:16 236:16 <b>presenting</b> 235:9 241:10 <b>president</b> 2:8,9,12 14:7 105:4 162:6 <b>presidents</b> 260:20 <b>presiding</b> 1:10 <b>press</b> 364:1 <b>pressure</b> 4:16 5:5 250:20 267:3 274:13,14,20,22 302:7,11,13 303:13 304:4,19 305:9,11,18 306:3 306:15 317:21 318:9 331:11,14 331:18,20 332:3,7 332:20 334:3,6,12 335:2 336:6 337:3 338:6,7,12 341:8 342:1,3,14 368:19 374:3,6 383:13 <b>pressures</b> 85:20 332:6 340:3 <b>pretty</b> 8:7 37:11 67:13 100:9 101:9 111:21 117:6 132:14 259:17 275:19 295:20 318:8 381:6,22 386:8 <b>prevalence</b> 42:8 46:8 57:21,22 67:10,12 80:7 119:1 147:7 166:7 166:10 232:11 <b>prevent</b> 210:13 <b>Preventative</b> 288:15 <b>preventing</b> 211:5 <b>Prevention</b> 1:12,20 1:20,21 64:4
---	--	--	--	---

<b>Preventive</b> 70:3 71:8 81:1 286:18 <b>previous</b> 6:9 82:10 112:2 128:6 145:6 302:4 <b>Previously</b> 13:12 <b>primarily</b> 14:19 87:10 107:14 247:15 <b>primary</b> 16:1 34:2 43:16 49:2 77:14 78:7 85:19 100:22 107:18 119:2,8,19 119:22 132:9 144:18 167:14 172:22 182:15 206:17 207:13 211:10 213:16,20 214:15,21 215:4 216:18 234:4 241:5 242:17 244:14,16 245:2 246:1 247:18 248:5 249:15 273:9 274:21 301:17 307:3 342:12 358:20 383:10 <b>principal</b> 2:5 121:12,12 <b>principle</b> 97:16 <b>print</b> 142:16 <b>prior</b> 329:14 <b>priorities</b> 81:11 <b>prioritize</b> 365:9 366:18 383:9 <b>prioritizing</b> 365:17 367:12 <b>priority</b> 48:17 65:5 65:6 81:9 110:14 141:1,13 176:18 176:22 177:8,13 249:9 281:21 282:4 292:11,16 308:22 309:3 320:11,12 327:4 328:7,9 344:12,14	350:2,10 356:9 360:11,13 370:12 372:7 <b>Priority's</b> 356:4 <b>private</b> 209:18 384:17 <b>probably</b> 10:10 42:19 45:9,14 79:11 82:17 85:16 86:3,4 93:7 98:22 100:9 147:5 172:19 183:12 198:10 223:5,8 239:10 252:8 256:15 259:4 282:1 305:13 306:7 337:22 353:4 355:7 380:22 <b>problem</b> 54:19 56:12 81:7 83:18 90:18 127:8,10 151:15 214:2 243:10 251:12,14 251:15 267:8 273:19,21 276:18 278:7 280:16 281:14 299:10 327:5 375:22 <b>problematic</b> 91:2 <b>problems</b> 7:5 36:15 43:13,15 46:9 53:19 55:6 72:1 88:2 127:12 242:14 243:14 278:12 293:16 376:16 <b>procedure</b> 192:2 <b>procedures</b> 21:20 102:17 <b>proceed</b> 30:4 103:11 277:17 <b>process</b> 4:6 9:21 10:2,19 15:6 17:18 21:20 22:18 25:9 26:4 27:11 28:5 29:7 30:6,18	37:4 41:2 43:2,14 68:15 71:17 80:9 80:10 86:6 87:9 87:12 92:6 93:21 97:2 100:9 101:16 103:5 107:12 109:10 113:20 137:10 149:18 164:10,12 165:16 165:17 218:15 223:15 237:15 269:18,19 288:12 288:20 289:1 367:20 372:14 380:3 382:1 <b>processing</b> 193:2,6 202:13 <b>professional</b> 361:16 <b>professor</b> 2:1,13,14 3:5 9:9 11:22 12:20 14:3 16:8 <b>profound</b> 149:3 <b>program</b> 2:8 13:10 15:20 37:1,2 71:14 167:19 189:18 198:4 200:21,22 318:22 373:7 384:19,20 <b>programmatic</b> 381:7 <b>programmer</b> 189:1 <b>programs</b> 2:18 14:8,13 105:15 114:13 167:18 181:11 183:19 217:2 225:14 367:2 385:2 <b>progress</b> 214:11 263:13 336:3 367:8 370:16 <b>progresses</b> 209:4 <b>project</b> 3:10,12 4:5 4:7 8:17,20,20 9:1 17:17 21:8 23:21 25:5,18 45:21 94:20 99:2 207:16	216:1 <b>proliferation</b> 386:6 <b>promise</b> 229:1 <b>Promotion</b> 1:12 2:13 <b>prone</b> 327:5 <b>proper</b> 217:6 321:6 <b>properties</b> 209:1 <b>property</b> 178:6 <b>proportion</b> 55:19 216:2,7 236:12 <b>propose</b> 172:11 <b>proposed</b> 86:10 90:12 93:1 97:15 97:17 102:4 105:17 254:9 325:6 <b>proposing</b> 42:4 66:11 246:6 <b>Proposition</b> 34:21 <b>pros</b> 32:15 94:20 <b>protective</b> 199:7 <b>proven</b> 262:21 <b>provide</b> 70:12 183:17,21 188:3 204:10 208:3,16 245:12 249:8 310:12 348:17 <b>provided</b> 66:1,8 71:4 75:15 104:15 182:4 188:15 221:2 375:3 <b>Providence</b> 12:19 <b>provider</b> 14:14 119:22 120:9,11 121:5 122:10 125:20 129:14 146:6,6 150:17 201:20 209:20 234:3,4 241:15 248:3,6 249:21 278:15 281:3 289:21,22 291:5 377:18 384:13,14 387:5,9 <b>provider's</b> 385:4 <b>providers</b> 109:1	119:3 122:10,21 145:19 167:15 179:5 204:21 205:3,8 217:5 249:15 250:8 273:1 374:6 375:16 383:3,10 383:16 384:7 <b>provides</b> 146:2 196:18 336:12 <b>providing</b> 46:1 <b>proviso</b> 49:7 <b>proximal</b> 171:15 172:13 <b>proxy</b> 20:18 <b>PSC</b> 4:9 35:16 36:3 36:4,9,20 39:3,12 42:22 49:19 50:19 51:3,8 66:6,9 67:3 69:7,16 72:3,4 82:19 <b>psychiatric</b> 12:18 13:3,22 15:9 25:2 25:8 43:13 164:15 179:16,22 199:3 238:12 <b>psychiatrist</b> 2:15 11:14,18 14:4 15:15 16:6,6,21 53:20 121:4 130:1 130:6 154:3,10 164:6 361:8 <b>psychiatrists</b> 47:22 250:10 379:11 <b>psychiatry</b> 1:18 2:9 2:14 3:6 9:9 15:20 16:1,9 37:6 69:22 71:13 128:17 162:7 164:17 165:6 <b>psychologist</b> 129:20,22 <b>Psychologists</b> 170:21 <b>psychometric</b> 178:6 <b>psychosis</b> 179:17
--	---	--	---	--

180:1 199:14 204:15 <b>psychosocial</b> 4:10 35:17 36:11 37:22 70:5 <b>psychotherapy</b> 173:5 <b>psychotic</b> 273:12 <b>psychotics</b> 230:22 <b>public</b> 5:15 6:22 7:1,14 21:15 154:19 165:16 217:1 221:18 222:11,18,20 229:8,11 234:22 260:4 272:9 276:10,12,13 293:9 296:16,19 363:17,19,21 364:3,6 374:21 376:14 <b>publications</b> 70:13 <b>publicly</b> 191:15 <b>published</b> 38:10 68:10 <b>pull</b> 239:13 333:16 <b>pulled</b> 178:9,17 208:2 386:15 <b>pulling</b> 256:19 <b>pulmonary</b> 260:8 <b>purchasers</b> 369:20 <b>pure</b> 367:13 <b>purported</b> 91:13 <b>purports</b> 69:9 <b>purpose</b> 22:14 54:2 92:15 105:20 127:1 132:14 153:12 247:4 248:1 372:18 <b>purposes</b> 92:17 96:8 184:17 <b>pursue</b> 138:4 <b>pursuing</b> 138:3 <b>push</b> 59:20 61:14 62:15 374:13 <b>pushed</b> 346:18 <b>pushing</b> 17:8	240:20 241:9 <b>put</b> 6:8 7:9 20:2 42:22 49:7,14 59:11,18 60:19 76:19 81:18 126:9 205:21 250:4 257:1 264:11 287:8 296:17 303:11 368:7 369:16 384:1 <b>putting</b> 128:6 206:22 374:5 <hr/> <b>Q</b> <b>quadrant</b> 247:9,12 <b>quality</b> 1:1,8,13 3:1 3:20 9:11 14:15 36:18 40:9,10 45:11 69:18 77:18 83:15,16,19 105:18 108:8 115:15 124:19 128:8 129:12,16 145:16 148:6,12 150:7 152:18,21 153:10,12,14 157:22 158:2,6 164:21 165:20 167:20 178:5 189:16,21 211:3 242:11 245:9 254:19 255:1,3 278:15 340:17 348:16 352:15 365:17 366:8 369:21 375:21 376:8 378:1 380:17 381:12 383:2,4 <b>quantify</b> 57:8 180:14 <b>quarter</b> 66:17,17 388:12 <b>queried</b> 284:2 <b>question</b> 26:8 28:22 30:19 34:10 38:22 40:13 41:7 41:17 44:10 49:18	50:4,15 55:16 72:15 73:21 75:12 76:3 77:19,21 79:5 80:10 87:5 93:20,21 96:19 99:10 118:12 119:12,13,22 120:20 122:8 126:10 128:9 133:2 145:22 150:11 169:7 174:18,19 178:1 187:6,17,22 207:17 208:19 209:9,15 210:7,15 210:19 211:1,13 214:16 217:14,17 218:1 237:16 238:16 243:2 246:8,12 251:1,2 254:4 265:6,18,19 266:12 267:22 283:11 289:10,11 290:19 294:1 295:7 305:5 310:17 351:10 360:19 365:4 369:1 <b>questioned</b> 179:1 <b>questioning</b> 108:6 343:11 <b>questionnaire</b> 36:10 84:12 146:3 <b>questions</b> 6:17,19 7:14 19:15 20:3 27:6 29:3 30:6,22 32:10 41:6 44:7 44:14 45:1 48:22 53:5 76:13 79:11 92:6 108:2 146:2 151:8 174:10 175:7 183:9 186:20 205:1 206:9 237:9 239:22 241:7 293:14 306:18 308:5 310:7	311:12 315:12 316:9,10 324:5 333:7 345:2 353:17 365:7 366:15 375:6 <b>quibble</b> 54:7 282:15 <b>quick</b> 34:12 60:9 <b>quicker</b> 242:2 <b>quickly</b> 102:15,19 136:18 149:13 365:14 <b>quite</b> 31:13 37:14 50:16 51:6 100:4 117:7 206:18 316:13 342:21 374:7 <b>quorum</b> 327:20 <b>quote</b> 116:20 158:15 179:18 180:9 182:22 257:21 <b>quoting</b> 182:13 <hr/> <b>R</b> <b>R</b> 6:1 <b>rabbits</b> 367:10 <b>race</b> 117:19 386:11 386:19 387:11 <b>racial</b> 257:16 <b>radar</b> 57:7 <b>raise</b> 126:10 131:10 213:12 <b>raised</b> 19:16 87:5,6 145:7 169:18,22 171:14 181:14 267:22 299:21 300:5 <b>raises</b> 149:19 174:12 181:5 <b>raising</b> 210:15 213:7 267:8 <b>rambled</b> 48:14 <b>ramped</b> 36:22 <b>RAND</b> 9:13 <b>random</b> 21:5 <b>randomly</b> 178:17 239:2	<b>range</b> 43:13 166:18 170:18 171:8 261:1,10 352:13 <b>rapidly</b> 47:13,18 <b>Raquel</b> 2:10 17:13 17:15 305:3 <b>rate</b> 67:12 75:10,22 76:8 142:5 143:13 172:5,9,9 184:19 295:16,18,18 318:14 338:8 341:15 366:7 <b>rater</b> 293:6 <b>raters</b> 293:8 <b>rates</b> 59:18 66:16 67:10 150:21 171:20 172:7 295:4 318:10,11 <b>rating</b> 105:18 143:1 182:11 188:19 366:6 374:15 <b>ratings</b> 216:2,7 <b>rationale</b> 21:11 118:3 142:17 184:21 243:7 347:22 371:5 375:8 <b>re-emphasize</b> 272:21 <b>re-engage</b> 223:17 <b>reach</b> 222:14 <b>reached</b> 59:9,10 220:11 221:15 222:8,16 224:1 382:5 <b>reacting</b> 85:7 <b>reactions</b> 235:2 <b>reactivity</b> 130:15 <b>read</b> 19:21 36:7 54:10 86:12 134:4 215:14 <b>readiness</b> 365:18 <b>reading</b> 51:6 66:13 210:18 338:10 <b>ready</b> 58:4 59:2,4 62:17 65:2 155:11
---	---	---	--	--

155:22 161:2	269:16 270:8,18	98:12 102:6,7	<b>reduces</b> 169:4	<b>regular</b> 109:6
175:10 176:8	271:1 273:4	104:2 137:8	370:15,16	128:7 129:10
217:8 224:20	276:11 284:5,7	150:16 331:9	<b>reduction</b> 69:17	158:5 361:15
225:20 226:3	295:13 297:3	355:2 357:19	173:9,10 379:9	<b>regularly</b> 48:5
227:16 228:2,4,20	304:22 310:4	367:21	<b>reevaluate</b> 287:7	<b>Regulation</b> 3:1
287:22 291:12,14	314:4,10 320:22	<b>recommendations</b>	376:13	<b>Rehabilitation</b> 2:22
325:10 361:18	328:14 329:13	18:17 21:13 71:12	<b>refer</b> 28:20 30:21	<b>REHM</b> 3:19
363:6	330:9 333:8	73:8 81:19 89:4,9	53:10 197:12	333:17,21 336:4
<b>real</b> 60:9,19 63:1,3	334:22 342:4	94:7 97:21 102:12	<b>references</b> 66:8	338:5 340:8
63:3 148:7 206:19	352:15 358:5	170:22 218:19	197:20	<b>reimbursements</b>
206:20 208:20	366:14 368:5,8,13	381:22	<b>referent</b> 304:2	217:3
214:2 262:11	374:10 375:21	<b>recommended</b>	<b>referral</b> 70:15	<b>reiterate</b> 145:11
276:18 277:5	376:7,18,19 377:6	72:10 94:13 99:11	77:10,22 78:6	208:4
307:11 329:15	378:1 387:8 388:9	131:7 160:19	79:2,6,8,17 167:3	<b>reiterates</b> 100:15
337:9	<b>realm</b> 75:7	227:14 251:19,21	172:8,9,15 291:6	<b>reject</b> 272:1 275:14
<b>real-world</b> 130:12	<b>reason</b> 84:10 120:9	286:18 294:18	291:8 358:21	<b>relate</b> 274:15 276:2
<b>reality</b> 276:15,16	133:13 182:15	301:9 317:6 325:3	<b>referrals</b> 53:17	<b>related</b> 14:16 66:3
<b>realize</b> 151:12	187:5 235:9 250:4	336:7 370:11	79:1	168:19 180:8
<b>really</b> 8:6 10:8,13	280:22 283:19	<b>recommending</b>	<b>referred</b> 41:10	267:3 278:7 295:1
11:1 23:8 36:21	305:18 348:1	96:1	53:17,21	304:20 305:11
38:1 46:1 48:11	<b>reasonable</b> 111:18	<b>recommends</b> 71:15	<b>refill</b> 112:15	366:5 371:3 374:1
49:18 52:9 57:15	128:7 198:13	<b>reconciled</b> 217:12	<b>reflects</b> 303:10	<b>relates</b> 151:10
74:10 75:17 79:12	211:1,8 252:12	<b>reconciliation</b>	<b>refresher</b> 30:9	269:5 365:10
82:11 83:1,2 90:8	<b>reasonably</b> 78:21	121:7 274:10	<b>regard</b> 27:17 52:15	<b>relation</b> 171:18
91:2,12,14 99:9	211:13 293:17	<b>reconfirm</b> 284:19	55:10 56:5 77:10	<b>relationship</b> 14:10
109:20 112:22	<b>reasons</b> 267:18	<b>reconnect</b> 276:12	82:13 119:5	130:11 171:15
116:18 117:11	268:17 334:21	<b>reconsider</b> 223:18	138:19 168:3	<b>relative</b> 85:11
119:10 121:5	359:4 369:10	<b>record</b> 111:2 161:4	171:14 173:20	203:11
122:15 123:16	375:7 379:13	180:15 183:12	276:4,14 304:18	<b>relatively</b> 198:8
124:15,19 125:4	381:7,8 385:10	196:22 228:14	313:4 328:13,16	203:5 300:5
143:9 147:19	<b>recall</b> 32:5 334:9	279:3,12,13	374:18	<b>release</b> 133:13
148:4,21 151:1,10	<b>receive</b> 38:15	281:13 290:10	<b>regarding</b> 129:6	221:18
151:20 152:21	<b>received</b> 41:10	306:12 312:17	159:4 170:17	<b>relevance</b> 50:16
153:5 154:5	<b>receiving</b> 38:12	325:13 337:14	171:18 224:5	216:18 248:12
167:11 168:6	39:20 312:20	<b>recorded</b> 11:12	310:7 321:2	<b>reliability</b> 48:10
173:4 184:2,16	<b>recognize</b> 88:7	<b>records</b> 145:13	353:17	50:6 52:12 65:21
192:12 202:22	113:20 248:6	180:22 194:7	<b>regardless</b> 149:6	66:5,9,14 67:4,7
203:6 204:17,17	377:5	195:4 209:11	281:8 332:9	67:11 68:7,9 73:3
212:16,17 213:19	<b>recognized</b> 166:5	242:15,17 281:8	337:11,15 341:8	80:17 84:4,22
215:5 223:15	<b>recognizing</b> 214:12	281:11	341:21	86:1 91:4 93:18
231:5 236:2,6	<b>recollection</b> 187:6	<b>recurrent</b> 284:10	<b>regards</b> 147:21	97:7 98:15,17
239:4 240:15	<b>recommend</b> 70:1,4	<b>recused</b> 269:2	286:9	100:6,8 103:13,19
241:3,4 244:19,20	89:20 92:1 98:19	<b>red</b> 60:7 61:11,22	<b>regime</b> 287:7	136:22 140:13
245:11 252:12	99:4 182:5 252:2	<b>redesign</b> 9:19	<b>register</b> 60:7 61:15	141:16,22 142:9
255:5,8,19 258:19	301:15	<b>redistribution</b> 57:6	<b>registered</b> 59:22	143:22 145:2,5
262:9,22 263:13	<b>recommendation</b>	<b>reduce</b> 75:20 229:2	312:6	147:16,22 155:13
264:2 265:2 267:6	45:8 49:7 81:4	306:3 387:12	<b>regression</b> 86:17	155:18 178:5,7,13



206:10 207:2,22 219:9,16 292:20 293:3,6,17 297:11 297:16 309:6,8,11 311:12,15,20 320:17,21,22 322:7,12 328:14 328:17 329:1,3 345:8,11,14 350:13,22 353:8 356:10,13,19 359:5 360:16 361:19 362:4 <b>reliable</b> 67:14 82:4 86:4,9 97:14 142:4 146:15 147:13 350:16 368:14 <b>reliably</b> 310:1 <b>rely</b> 45:11 192:12 199:17 <b>remain</b> 19:3 112:12 <b>remaining</b> 318:3 <b>remarks</b> 316:22 <b>remeasuring</b> 79:13 <b>remember</b> 34:8 210:17 240:17,18 294:1,4,5,5 307:14 314:14 318:20 380:21 <b>remind</b> 18:1 20:10 30:16 323:12 385:16 <b>reminder</b> 6:21 32:9 275:16,17 357:10 <b>reminders</b> 387:18 <b>remiss</b> 229:7 <b>remission</b> 42:1 <b>repeat</b> 128:18 302:6 <b>repeated</b> 42:3 <b>repeatedly</b> 66:6 68:4 264:12 <b>repeating</b> 275:21 <b>repeats</b> 302:1 <b>replaced</b> 260:20 <b>replicate</b> 34:1	328:15 <b>replicated</b> 260:3 <b>report</b> 36:9 43:3 115:1 119:9 168:16 183:20 184:5 189:7 207:20 217:1 221:19 222:12 235:19 245:20 253:7 272:13 273:2 352:14 387:11,14 <b>reported</b> 40:17 44:6 94:21 95:15 192:19 211:7 338:12 386:11 <b>reporting</b> 105:17 167:20 184:18 191:9 217:2 225:14 278:15 279:4 303:16 374:8 <b>reports</b> 116:20 <b>repositories</b> 262:12 <b>representatives</b> 165:8 <b>represented</b> 353:1 <b>representing</b> 165:4 188:11 189:16,20 285:11 <b>require</b> 127:14,15 184:19 191:9 340:3 372:10 386:10 <b>required</b> 34:3 111:4 120:4 144:20 182:12,14 205:19 264:4 342:3 369:3 <b>requirement</b> 182:7 184:7 186:11 195:15 312:16 <b>requirements</b> 46:17 383:21 <b>requiring</b> 178:20 370:4 <b>research</b> 1:13,17	2:6 9:11 12:12,15 13:7 36:21 64:10 70:8 105:4,6 135:19,21,22 162:2 166:12 167:12 206:21 207:8 213:17 230:8 265:6,18 266:13 283:20 <b>researcher</b> 12:3 14:5 16:22 107:16 <b>reseat</b> 103:2 <b>reseated</b> 325:10 <b>reservations</b> 6:19 7:16 388:4 <b>reserved</b> 99:13 <b>Residence</b> 3:5 <b>resolved</b> 112:18 336:19 <b>Resource</b> 1:21 64:4 <b>resources</b> 53:10 249:8 258:18 <b>respect</b> 126:8 287:1 288:7 380:7 <b>respectively</b> 334:14 <b>respond</b> 20:4 21:15 71:3 288:22 378:17 <b>responded</b> 178:1 <b>responding</b> 21:16 112:4 <b>response</b> 48:21 70:19 104:8 106:8 118:20 157:4 159:10 160:6 162:13 169:15,17 175:8 177:1 180:20 224:18 227:2,6 349:2 350:17 353:9,18 353:20 354:18 355:12 362:16 <b>responsibilities</b> 22:15 319:5 <b>responsibility</b> 115:3 281:5 <b>responsible</b> 57:19	114:22 115:2 234:2,6,9 242:4 250:6 279:7,9 281:9 314:15,17 <b>rest</b> 8:12 223:19 230:5 261:5 291:22 <b>restart</b> 226:2 325:8 <b>restarted</b> 228:19 325:16 <b>restrooms</b> 6:14 <b>result</b> 65:12 88:9 136:15 227:12 250:19 264:3 301:7 317:4 322:12 323:16 325:1 330:18 331:7 346:10,20 349:11 354:2,22 355:18 363:10 <b>resulted</b> 282:13 <b>resulting</b> 310:3 <b>results</b> 22:1 27:15 31:17 64:20 103:18 140:6,21 141:12 156:5 157:13 159:18 175:17 176:15 177:12 208:1,15 219:15 220:3 225:6 226:15 234:16 265:16 280:20 291:19 292:16 294:10,11 297:14,22 299:4 299:11 300:13 303:3,5 308:12,19 309:3 311:20 316:16 318:7 320:12,22 328:9 329:3,7 344:9 354:14 <b>resume</b> 123:9 <b>resumed</b> 161:5 228:15 325:14 <b>retry</b> 324:10 <b>return</b> 104:10	<b>returning</b> 163:1 <b>revelative</b> 50:22 <b>review</b> 21:8 23:18 25:21 29:22 81:9 81:10 90:1 94:3 98:2 99:8 103:1 105:7 107:20 111:14 145:12 166:3 173:2,12 234:14 236:18 282:21 289:2 299:20 372:9,10 375:18,19 <b>reviewed</b> 18:9,14 80:13 85:2 126:13 128:13 334:18 376:13 <b>reviewer</b> 142:11 282:20 283:1,6 301:17 <b>reviewing</b> 28:5 97:21,22 116:17 117:22 145:20 288:13 <b>reviews</b> 68:8 174:5 235:22 380:10 <b>revised</b> 28:12 <b>revising</b> 28:6 <b>revote</b> 329:22 <b>rewritten</b> 127:16 <b>Rhode</b> 12:19 <b>Rhonda</b> 2:19 15:2 49:15 50:8 57:1 82:8 343:13 344:18 346:1 <b>rich</b> 217:21 <b>richest</b> 384:19,19 <b>right</b> 14:12 31:2,7 44:12,13 52:14 55:15 58:2 60:4,5 60:18 62:20 65:11 85:19 87:13 89:12 92:10,15,19 93:1 94:9 97:15 103:6 111:19,22 115:2,5 155:7,9,12 160:17 170:10 174:19
--	---	--	---	--

175:4 190:7,18 191:1 200:4 202:20 205:4 209:21 220:20 221:4 233:20,20 238:6,10 239:10 241:1 242:13 251:5,7,9,13,15 255:11 257:5 262:14,15 269:20 269:22 275:7,19 280:1,13 282:11 284:6 290:17 294:16 295:13,22 296:6,15,18 297:7 297:9 301:1 304:3 305:14 306:6,9 307:16 308:3,4 311:1 317:11 323:17 324:13 326:7,7 327:12 332:17,18,19 337:21 340:7 342:15,18 345:5 353:2 354:6 359:11 362:3 382:15 385:20 388:1,6,7 <b>right-hand</b> 6:15 <b>rightly</b> 107:22 <b>rigor</b> 164:11 <b>rigorous</b> 10:1 174:5 <b>ringing</b> 259:3 <b>rise</b> 342:22 <b>risk</b> 4:13 91:16 96:5 163:19 166:14,19,21 167:1,4,11 168:22 169:3 170:9 171:11 172:15,21 179:11,13 180:4 181:7 182:2,6 186:2,22 188:19 191:5,6 192:4,11 192:16 194:9,18 194:21 195:22	197:16 202:1 203:1,4,8,20 204:9,19 205:12 208:6 231:3 232:11,12,13,21 232:22 233:5,11 233:12,16 243:13 243:16 245:8 253:2,11,18 254:6 258:11 261:10 266:12,21 284:1 285:16 302:14 321:18 327:4 339:9 348:15 364:20 <b>risks</b> 91:20 101:21 236:8 <b>RN</b> 2:12 <b>road</b> 54:1 130:4 <b>ROBERT</b> 1:15 <b>Robinson</b> 2:19 15:1 15:2 49:17 50:3 57:2 82:9 124:21 151:4 241:13 272:18 277:8 343:18 344:20 345:3 346:2,6 365:3 <b>robust</b> 257:5 378:21 <b>Rock</b> 16:5 <b>Rohde</b> 171:2 <b>role</b> 15:21 20:14,17 21:6 211:22 365:17 380:6 <b>roll</b> 15:5 <b>rolled</b> 28:7 69:3 <b>Ron</b> 131:13 <b>room</b> 1:9 35:9 226:10,13,14 274:1 301:5 312:4 316:10 319:17,20 321:12 322:11,16 323:9 324:11 327:19 349:8 350:6 364:6 <b>rooms</b> 48:1	<b>roots</b> 47:17 <b>Rootstown</b> 12:10 <b>rose</b> 255:1 <b>roster</b> 9:5 <b>rotation</b> 125:6 <b>round</b> 141:7 220:8 240:12 <b>rounding</b> 382:12 <b>routine</b> 37:22 43:11 70:1,4 71:21 167:9 361:7 <b>routinely</b> 259:18 321:20 <b>row</b> 149:13 <b>rude</b> 195:3 <b>Rudloe</b> 13:2 <b>rule</b> 15:5 179:22 180:1 297:5 <b>rules</b> 18:6 211:18 220:21 244:21 <b>run</b> 59:4 60:9,19,20 62:18 162:18 238:21 <b>running</b> 33:13 212:17 <b>rush</b> 64:6 <hr/> <b>S</b> <hr/> <b>S</b> 4:1 6:1 <b>safe</b> 130:7 <b>safety</b> 125:13,19 127:2,21 128:8 131:17 134:15 143:5 210:10 211:7 <b>salad</b> 237:21 <b>salary</b> 374:15 <b>Salt</b> 15:13 <b>Sam</b> 3:15 163:22 172:17 193:20 <b>SAMHSA</b> 101:6 247:8 272:10 <b>sample</b> 214:17 215:1,17,21 216:14,19 217:6 310:12 <b>sampled</b> 178:17 <b>samples</b> 332:14	<b>sampling</b> 209:16 <b>Sampsel</b> 3:20 8:21 8:22 388:3 <b>San</b> 34:18 <b>Sarah</b> 3:16,20 8:21 105:3 117:16 145:3 228:22 229:20 255:7 277:21 303:20 310:20 317:11 334:21 347:13 357:21 366:16 369:10 <b>Sarah's</b> 304:15 334:15 <b>sat</b> 273:6 277:11 <b>satisfactory</b> 76:2 <b>satisfied</b> 76:2 <b>saw</b> 67:9 86:14 234:20 260:5 280:20 287:20 290:2,6 302:20 386:7 <b>saying</b> 31:7 57:21 67:2 69:1 88:13 127:7 138:20 148:17 187:14 196:6 202:5 205:3 207:5 239:21 240:15 256:20 257:13 258:15 266:14 267:6 277:15 289:3 340:10 343:5 370:2 386:5 <b>says</b> 39:9 96:14 117:10 121:1 174:1 202:3 245:1 251:13 <b>Sc.D</b> 2:1 <b>scale</b> 71:22 182:11 187:3 188:19 <b>scales</b> 143:1 <b>scattered</b> 171:7 <b>scenario</b> 208:21 <b>schedule</b> 8:11 110:9 127:17	<b>scheduled</b> 48:5 228:1 <b>schizophrenia</b> 230:17,21 231:8 283:13 284:16 <b>Scholle</b> 3:16 105:2 105:3 110:17 114:20 117:2 120:3,12 121:10 121:20 123:19 124:20 133:7 134:19 229:4,19 229:20 230:3 243:9,20 244:11 248:22 249:7 252:16 278:3,6 279:19 280:1 282:22 283:3,16 286:10 288:10 289:4,9 290:15,22 294:8,17 296:3,7 296:12,20 297:1 302:9 304:3 305:19 307:4 311:1 314:4 317:15 326:2,7 331:16 332:18 337:9 341:6 342:7 343:3 347:16 352:8 358:4 361:11 376:10 <b>school</b> 2:2 11:22 12:9,21 64:5 70:5 123:7,18 130:18 <b>Sciences</b> 16:10 <b>scientific</b> 3:11 65:17 72:17 91:3 162:22 177:17,20 209:1 320:15 328:12 344:17 350:12 <b>scientist</b> 9:13 105:6 <b>score</b> 83:17 207:21 280:5 294:2 345:12 <b>scores</b> 84:20 293:4 293:5 351:7
---	--	---	---	---

<b>screen</b> 32:6 36:13 49:2,8 52:16,20 53:19 55:3 56:6 57:7 58:15 70:14 77:2 186:14 206:5 240:16 261:11 262:5 280:12,16 280:17,17 326:12 <b>screened</b> 38:6,14 41:3 42:10 43:16 53:15 54:14 69:16 81:12 <b>screeener</b> 218:2 <b>screeners</b> 204:4,10 204:11 <b>screening</b> 4:14,15 5:1 24:5,13 25:6 38:1,16 43:10,12 44:19 46:14 49:6 49:11,19 50:18 51:4,8 53:9,13,22 54:3 58:8 66:17 70:1,5 71:21 77:5 78:20 81:21 82:19 83:10,20 85:14 86:5,7 87:9,18,19 168:12 171:16,20 172:5,10,14,21 173:3,9,14,21 187:7,11 197:11 197:15,19 198:2,6 198:11 203:20,21 205:12 210:16,22 212:7 217:14,17 217:19,21 229:17 232:5 234:8 238:13 243:4 244:9 249:17 277:21 278:1,17 280:8,10 282:4 289:22 294:9,13 294:14 295:4,16 295:17 326:8 <b>screenings</b> 25:16 38:11 44:14 197:8 236:9 <b>screens</b> 38:12 41:9	59:5 61:5 214:9 <b>scroll</b> 190:2,20 <b>SCS</b> 144:10 <b>se</b> 73:11 270:4 <b>searched</b> 243:22 <b>searching</b> 201:18 <b>seat</b> 22:9 <b>seated</b> 19:8 161:1,7 161:12 228:20 <b>seating</b> 161:7 <b>second</b> 24:18 35:4 43:8 46:22 61:2 77:9 100:1 112:6 112:6 122:20 123:5 126:15 150:19 169:6 171:14 210:3 220:9 224:8 249:4 275:4,12 282:21 283:5 295:10 328:8 333:8 346:18 <b>secondary</b> 18:12 29:18 31:4 35:14 282:20 301:17 <b>Secondly</b> 372:4 <b>Secretary</b> 230:9 <b>section</b> 31:15 74:22 <b>sections</b> 39:10 <b>sector</b> 276:10,13 296:16,19 <b>see</b> 6:7 17:4,20 24:2 24:15 26:2,21 27:4 31:16,17 33:5,11 41:13 49:15 52:1,22 55:7 59:20,22 60:2 61:8,10 66:7 75:16 77:3 80:19 82:20 84:8 88:13 90:6 106:6 109:20 110:22 112:3,9 113:16 114:18,21 119:21 121:16 123:16 128:14 130:12,19 143:9 143:22 144:6,16	145:20 174:2 184:15 185:14 186:16,16 190:8 190:13 191:2,21 200:19 207:4 208:14 209:2 210:8 216:11 222:12 223:17 233:10,14 240:10 247:5 256:5,7,15 262:4 263:8 274:3 283:20 290:18 291:9,11 303:7 311:7 332:6 338:14 339:8 364:13 376:16,18 377:20 378:7,9 380:19 385:9 386:13 388:16 <b>seeing</b> 23:5 79:14 114:9 132:7 149:1 208:12 310:4 337:3 347:3 362:17 <b>seek</b> 128:20 158:18 <b>seen</b> 39:22 114:4 117:4 174:4 263:9 287:10 311:5 383:2 384:17 <b>sees</b> 72:9 <b>segmentation</b> 372:8 <b>selected</b> 62:10 167:17 178:18 <b>selection</b> 21:5 <b>self-funded</b> 14:20 <b>Semel</b> 3:6 <b>send</b> 94:2 250:1 299:1 <b>senior</b> 1:15 2:15 3:12 8:16 9:12 11:14 16:6 374:3 <b>sense</b> 10:22 63:11 119:11 144:19 164:11 174:22 223:3 238:20 255:22 274:1	275:15 285:7 303:6 365:6 368:17 380:3,5 <b>sensitivity</b> 307:19 <b>sent</b> 215:15 <b>sentences</b> 37:20 <b>sentiment</b> 271:14 <b>separate</b> 78:17 85:22 93:14 94:8 95:21 96:2 137:22 138:17 192:21 193:2,4 267:5 268:7,9 269:13 270:3 332:15 341:5 386:15,17 <b>separately</b> 79:21 237:18 260:11 <b>separating</b> 79:20 <b>September</b> 123:9 123:14 <b>series</b> 234:18 238:13 379:18 <b>serious</b> 24:13 25:17 231:9,22 232:6,20 234:7 235:20 236:7 244:12 253:5 254:20 266:11 278:8,20 283:21 284:13 302:11,15 304:7 326:11 <b>seriously</b> 212:17 243:5 266:20 268:16 <b>serve</b> 276:13 <b>served</b> 318:13 <b>service</b> 56:16 71:9 <b>services</b> 2:4,7 12:3 13:8 14:4 15:11 16:7 25:2,8 38:13 38:15 41:10 49:3 56:21 57:9 70:3 72:1,3 77:1,13 81:1 108:16 230:11 286:17,18 288:15 315:2 <b>serving</b> 16:20 21:3	<b>session</b> 276:1 <b>sessions</b> 129:2 158:22 <b>set</b> 48:12 92:2,13 105:13,16 128:20 152:19 153:3 158:18 164:13 191:17 217:12 223:6 229:1 231:7 232:9 238:11 239:18 240:5 241:9 246:6,10 250:9 254:1,7 256:20,21 267:17 272:1 275:4,15 290:5 317:16,17 318:5 319:3 331:19 335:21 364:11 <b>sets</b> 121:21 191:13 206:2 237:1 <b>setting</b> 37:10 67:7 77:15,19 78:7 119:8 198:19 217:18 246:20,21 247:4,9,16,18,22 248:11 249:19 264:6 307:7 315:1 361:7 <b>settings</b> 85:18 91:11,18 134:13 134:13 212:10 213:20 215:4 246:18 249:11 264:15 382:14 <b>seven</b> 38:4 140:7 141:14 175:19 239:3 266:15 299:12 301:12 308:14 311:21 315:20 329:8 346:11,21 352:14 354:15 360:14 362:5,12 <b>seventeen</b> 160:18 292:17 347:9 356:7
--	--	--	--	---

<b>seventy</b> 368:9	282:19	<b>similarly</b> 153:8	357:9 375:1,12	343:7 347:14
<b>severe</b> 129:2	<b>shows</b> 67:4 72:2	<b>simple</b> 83:8,19 84:2	377:19	348:17 355:4
158:22 241:1	146:4 183:15	210:19 211:14	<b>six-month</b> 124:11	358:2,7,22 368:13
247:14	348:13 376:6	367:14	<b>sixteen</b> 36:12	370:12,13 386:20
<b>severity</b> 182:11	<b>shuffling</b> 12:13	<b>simpler</b> 335:3	308:20 322:13	<b>SNOMED</b> 191:6
188:18 284:22	<b>SI</b> 194:7,10,20	<b>simplified</b> 372:13	328:10 344:10	192:2 202:3 206:4
285:3	196:4 213:3	<b>simplify</b> 368:2	350:10	<b>SNP</b> 296:9 318:20
<b>share</b> 93:6 215:11	217:15	<b>simplifying</b> 367:16	<b>sixty</b> 220:10 221:4	319:2
313:16	<b>Siddiqi</b> 2:21 12:22	372:3	368:8	<b>Social</b> 2:2
<b>shared</b> 129:19	13:1 348:11	<b>simplistically</b>	<b>size</b> 214:17 217:6	<b>societies</b> 165:20
368:17	350:13 351:20	210:11	310:12	<b>socioeconomic</b>
<b>SharePoint</b> 7:3,5	352:2,6 353:16	<b>simply</b> 83:10	<b>sizes</b> 215:22	257:17
19:18 31:19 32:4	354:6	106:19 149:19	<b>skin</b> 213:8	<b>solicited</b> 375:3
37:18 185:12	<b>side</b> 6:15 7:9 14:14	<b>Sinai</b> 3:8	<b>slide</b> 18:5 24:18	<b>solid</b> 82:4 100:9
190:5	14:15 49:14 61:5	<b>single</b> 246:16	25:1,14 26:7	<b>solution</b> 45:5
<b>sharing</b> 116:3	80:11 106:9 112:4	278:22 291:2	<b>slightly</b> 51:5	<b>Solutions</b> 3:20
<b>Shea</b> 3:1 12:16,17	114:16,17 123:1	372:11	160:21 248:8	<b>solve</b> 251:12
319:8,9 320:16	126:12,18 132:10	<b>sir</b> 274:7	337:8	<b>somebody</b> 6:17
323:1,21	132:15 143:13	<b>sit</b> 28:13 162:8	<b>slots</b> 383:21	56:6 100:15 143:1
<b>sheet</b> 210:9,9	147:12 152:13	<b>site</b> 184:3 188:21	<b>slower</b> 368:3	162:11 186:13
<b>shell</b> 127:17	173:19,20 198:16	190:6 208:1,2	<b>small</b> 12:9 54:6	192:8 195:14
<b>shifted</b> 10:12	285:13 302:16	209:17 210:2,3	214:18 215:7	201:1 218:21
<b>shine</b> 233:4	338:1	216:4	216:19 267:20	234:7 240:14
<b>ships</b> 380:18	<b>sidebar-ing</b> 270:6	<b>sites</b> 31:19 178:9	282:9 287:2	241:2 262:19
<b>shockingly</b> 282:6	<b>sight</b> 337:20	188:5,10,13,16,17	304:14 310:11	275:14 282:21
<b>shoot</b> 98:8,9	<b>sign</b> 278:11,11	206:15 207:3,11	<b>smaller</b> 383:20	360:22 371:5
<b>shop</b> 380:16	<b>signal</b> 370:16	207:21 208:11,16	<b>SMI</b> 4:15,16,17 5:1	<b>somebody's</b> 376:21
<b>Shore-LIJ</b> 2:9	<b>significance</b> 82:16	208:21 209:6,11	5:2,3,5,8,9,11	<b>someday</b> 92:15
<b>short</b> 320:6 343:15	<b>significant</b> 80:15	209:16	229:18 233:11	263:4 335:10
345:9	88:7 126:1 128:21	<b>sitting</b> 182:20	235:9,11 236:4,11	<b>somewhat</b> 10:5
<b>shortens</b> 240:21,22	158:19 167:7	257:6	244:2 246:7	171:7 334:18
<b>shot</b> 146:12	215:21 216:15	<b>situation</b> 179:7	247:10 248:7	<b>song</b> 326:4
<b>show</b> 38:10 69:8,17	282:3 304:20	<b>situations</b> 90:20	249:1,6,16,20,22	<b>soon</b> 101:9 103:9
70:13 71:21 79:7	309:19 313:12	264:20	255:9 257:9,22	136:10 335:11
96:7 146:6 220:19	316:4 379:9	<b>six</b> 66:18 107:1	259:1 262:13	<b>sooner</b> 53:22 89:14
244:12 247:5	383:17,17	108:9 137:6	266:19 270:14	<b>sorry</b> 11:5 20:21
301:17 332:13	<b>significantly</b> 98:3	159:20 160:19	273:10 276:4,7	32:2 59:13 62:12
337:1	172:2 211:12	166:9 169:8	278:2 279:1 287:5	62:16 64:10,17
<b>showed</b> 83:1	<b>signs</b> 130:4	170:19 176:17	295:12 302:8	68:20,21 103:16
110:20 135:22	<b>siloed</b> 248:16,17	219:17 220:5	304:17 312:19	104:21 117:3
171:3 172:4	<b>silos</b> 250:13,15,21	299:13 306:13	314:18 317:13	133:22 155:3,5
234:17 293:5,12	<b>similar</b> 50:19 78:12	308:20 311:22	318:1 321:22	158:14 195:3,17
303:4	94:22 102:13	316:17,18 317:18	322:1 325:20	217:9 219:11,21
<b>showing</b> 88:15	104:3 128:5	324:15 328:10	331:13 332:17	219:22 226:1
<b>shown</b> 81:21	130:14 246:10	336:14 341:15	335:1,11,19 339:4	242:21 247:13
116:22 117:3	283:4 309:12	344:10 347:9	339:14 341:7,21	248:10 249:5
166:12 173:6	317:21	350:11 356:14	341:22 342:1,14	299:7 300:16

316:3 321:13	<b>space</b> 334:13	286:9	<b>spoke</b> 22:16 104:3	20:14,18 22:5,11
325:22 330:20	366:17	<b>specification</b> 44:4	173:2	22:13 97:19
336:2 342:15	<b>spawn</b> 271:16	90:9 101:9 118:6	<b>spoken</b> 328:16	102:22 218:12,13
352:11 356:9	367:9	133:3 145:2	<b>spread</b> 47:18,19	218:17 381:19,21
360:9,20	<b>speak</b> 17:8 18:3	183:21 187:18	<b>squeaker</b> 223:7	<b>standpoint</b> 241:17
<b>sort</b> 9:18 10:4 11:6	29:15 32:11 35:9	189:13,16 208:13	<b>stability</b> 66:16	<b>Star</b> 375:4
26:21 33:20,22	42:19 67:15,19	286:20 293:7	<b>stable</b> 67:13 117:8	<b>Stars</b> 318:22
34:8 37:19 40:6	76:19 118:22	303:9 311:3	<b>staff</b> 3:9 21:7 29:2	<b>start</b> 29:9 34:15
42:8 51:18 52:6	141:15 150:7	335:22	41:19 92:6 93:12	35:3,6 36:8 40:18
52:11,12 55:14	169:21 183:13	<b>specifications</b>	185:6 215:15	42:7 116:13,14
71:3 72:20 73:7	207:15 269:17	39:10 40:3 74:18	301:15 387:17	121:4 124:6 141:4
76:17 78:1 79:12	<b>speaking</b> 109:7	75:3 96:4 98:20	<b>staffing</b> 132:12	166:3 175:5
85:2,12 86:6 90:5	154:8 193:20	99:16 103:14	<b>stage</b> 245:13	236:10 237:13
90:14,21 93:10	229:12	119:15 134:4	248:19	257:13 262:22
95:12 101:20	<b>speaks</b> 197:2	136:22 138:8,9	<b>stages</b> 105:17	263:14 268:15
132:2 136:13	<b>special</b> 252:9	142:14 168:18	<b>stagnant</b> 377:12	276:9 299:14
138:17 142:16	296:13 318:22	174:16 179:10	<b>stakeholder</b> 231:15	328:7,8 339:14
147:1,2 157:19	357:22 387:2	180:8 185:2,15	254:13 299:20	350:11 351:3
169:17 171:15	<b>specialized</b> 246:11	186:14 188:15	<b>stakeholders</b>	368:16 385:12
174:19 177:4,19	<b>specialty</b> 16:2	190:14 205:19	122:22 165:4,15	<b>started</b> 6:12 17:5
182:22 186:3	165:3,20 214:21	303:10,11,15,22	235:1 249:2	23:22 27:10 35:2
187:10 191:19	215:3 242:18	317:22 361:4	302:20,21 303:2	47:12 60:5 134:10
196:1 197:19	246:9,19,19	<b>specificity</b> 101:1	310:8 379:16	228:3 230:15
199:21 200:20,21	247:16 358:9,21	151:16 152:1	<b>stand</b> 151:1 214:10	231:14 233:8
206:11,17 211:22	358:22 361:12	307:19	236:18 256:2	254:10
212:8,12,14,14,20	<b>specific</b> 10:16	<b>specifics</b> 131:6	<b>standard</b> 67:3	<b>starting</b> 120:17
218:14 228:19	18:11 27:17 32:16	<b>specified</b> 20:12	85:12 135:22	139:21 195:8
246:7 253:21	39:1 40:15 65:6	101:6 191:22	146:11 176:5	214:7 242:3
255:14 258:16,21	74:15 89:12 90:14	206:1,3 234:12	179:21 189:14,15	365:14 367:22
259:19 260:2,9	90:16 102:12	235:6 249:12	195:18 340:16	<b>starts</b> 54:3 146:20
261:18 265:6,18	117:13 121:14	278:14 292:22	370:5	<b>state</b> 2:15 13:18
269:8,13 270:2	130:20 138:5,19	309:15 320:18	<b>standardization</b>	34:17,20 37:21
271:11,15 272:1	148:4 151:19	350:14	23:4	38:8 40:20 41:4
282:9 302:1	158:3 168:10	<b>specify</b> 57:15	<b>standardized</b> 10:3	76:22 77:6 105:15
339:12,15 353:5	179:16 182:1	111:20 143:17	45:13 51:3 113:13	165:19 186:6
371:6,20 372:2	193:22 197:12	170:21	176:6 179:7 182:9	203:2 213:19
373:12,14 379:22	198:22 199:3	<b>specifying</b> 304:7	183:19 184:4,9	264:20 270:19
380:2,17	207:16 255:17	308:1	186:22 187:10,13	272:13 313:17
<b>sorts</b> 33:4 298:5	286:21 364:22	<b>specs</b> 286:3 288:17	195:16 196:3	315:7 382:6
<b>sound</b> 116:7 245:2	371:14 386:22	290:20 303:17	204:9,11 213:10	<b>stated</b> 142:18,19
252:11 253:21	<b>specifically</b> 51:19	309:19	253:4,6 379:15	180:20 267:18
<b>sounds</b> 58:6 153:1	74:11 87:12 106:1	<b>spend</b> 302:5 379:12	<b>standardizing</b>	<b>statement</b> 39:9,19
208:18 215:5	136:14 168:2,17	<b>spent</b> 243:11 255:6	158:7	40:5 96:13 102:8
222:2 269:4	169:2 173:9	<b>split</b> 55:14 118:20	<b>standards</b> 85:13	104:3 107:10
<b>sources</b> 189:21	182:10 196:14	266:1,17	189:19 261:2	118:20 119:16
313:8,10	246:7 251:1 256:3	<b>splitting</b> 83:4 92:11	274:21	172:20 183:8
<b>South</b> 13:3	269:3 276:17	266:10	<b>standing</b> 1:3,8	187:19 245:3

277:16	<b>straight</b> 159:22	81:21 82:5,21	230:10 243:6	208:6 210:14
<b>statements</b> 39:14	298:15 319:17	133:16 197:17	244:5,7 276:17	211:4,5 212:7,11
82:10 98:13	<b>straightforward</b>	200:14 282:8	<b>substandard</b> 129:8	212:18
128:18 318:2	93:16 211:6 335:6	283:22	159:6	<b>suicides</b> 174:7
<b>states</b> 32:16 49:5	<b>Strategic</b> 2:8 13:10	<b>study</b> 107:4 171:2	<b>substantial</b> 42:6	<b>suitability</b> 160:4,9
77:14 115:22	<b>strategy</b> 373:1	172:3 203:7,9	80:14	160:18 227:8
125:5 127:14	<b>stratification</b> 256:8	210:18	<b>substituted</b> 148:5	300:17 317:2
234:1 242:1	272:3 274:16	<b>stuff</b> 52:11 71:21	<b>suburban</b> 209:19	324:16 325:1
248:15 263:22	364:18	121:8 202:13	<b>success</b> 340:7 341:4	330:21 331:5
267:8 303:1	<b>stratification/rec...</b>	241:4 252:15	<b>successfully</b> 188:14	347:6,8 354:16
313:20 369:19	275:4	264:22 368:20	189:7	357:11,18 363:7
<b>statewide</b> 37:1	<b>stratifications</b>	<b>sub</b> 60:11 387:11	<b>suffers</b> 90:8	<b>suite</b> 115:12
66:18	370:11	<b>sub-measure</b>	<b>sufficient</b> 70:4	<b>summaries</b> 19:17
<b>static</b> 375:12	<b>stratified</b> 251:22	342:20,21	81:16 151:3	31:14
<b>stating</b> 192:13	266:5	<b>sub-measures</b>	310:12 321:6	<b>summarize</b> 19:14
<b>statistical</b> 205:17	<b>stratify</b> 117:19	256:13 271:16	<b>sugar</b> 261:9	37:19 58:5 168:2
209:10 310:13	265:12,14 387:10	343:4	<b>suggest</b> 271:7,19	219:2
<b>statistically</b> 172:1	<b>stratifying</b> 271:12	<b>sub-population</b>	310:15	<b>summarizing</b> 37:13
216:15	<b>Street</b> 1:9	245:20 246:9	<b>suggesting</b> 270:2	<b>summary</b> 37:12
<b>statistician</b> 107:15	<b>strength</b> 127:5	<b>subdivide</b> 262:13	<b>suggestion</b> 55:17	66:1,2 67:22
141:21	149:10	<b>subdividing</b> 367:13	<b>suggestions</b> 20:8	70:22 128:18
<b>status</b> 341:21	<b>stress</b> 199:7	<b>subgroup</b> 168:20	58:22	316:9 327:7
342:22	<b>strikes</b> 78:21 251:3	249:1 298:4	<b>suggests</b> 67:13	<b>summer</b> 123:8
<b>stay</b> 306:22 340:21	251:18	<b>subject</b> 24:3 86:17	<b>suicidal</b> 167:5	124:4,12,17 142:5
<b>staying</b> 112:22	<b>stringent</b> 73:12	<b>submeasures</b>	168:22 172:7	153:9
342:4 375:12	<b>strong</b> 37:14 80:19	263:17	179:19 180:12	<b>summers</b> 142:6
377:11	102:8 151:1,18	<b>submission</b> 66:4	182:10 188:18	<b>summertime</b>
<b>steady</b> 117:6 382:6	165:11 314:11	69:20 74:22 86:12	194:10 199:1,5,6	123:20 125:3
<b>stemmed</b> 46:13	381:22	87:2 185:5 369:7	210:7,9 211:7	<b>supplant</b> 148:8
<b>step</b> 33:16 204:8	<b>strongest</b> 254:17	370:7	<b>suicidality</b> 168:13	<b>supplement</b> 170:17
211:22 257:12	<b>strongly</b> 47:9 178:3	<b>submit</b> 88:18 95:10	203:12 213:22	<b>support</b> 51:16 75:9
377:22	271:22 272:5	370:4	<b>suicide</b> 1:21 4:12	76:6 106:10 108:6
<b>stepped</b> 345:16	334:10	<b>submitted</b> 18:15	64:4 150:21	139:16 171:1
349:9	<b>struck</b> 285:10	65:22 75:6 86:14	163:18 166:14,15	245:13 254:13
<b>steps</b> 140:4	<b>structured</b> 208:8	165:17 235:4	166:19,20 167:1	293:8 327:1
<b>stethoscope</b> 239:11	208:13 338:5	268:4	167:11,13 169:4	364:16
248:3	<b>struggle</b> 122:13	<b>subpopulation</b>	171:11,20 172:21	<b>supported</b> 293:10
<b>stick</b> 8:6 263:17	205:2 270:16	266:21 271:17	173:7 174:7 175:3	310:9
<b>sticking</b> 327:2	378:2	<b>subsequent</b> 71:5	179:11,13 180:4	<b>supportive</b> 139:17
<b>stimulant</b> 125:15	<b>struggled</b> 95:1	98:1 107:6 150:9	181:7 182:6	<b>supports</b> 169:3
<b>stimulants</b> 110:15	109:20	<b>subset</b> 255:16	184:14 186:22	299:19
<b>stop</b> 38:18 78:10	<b>struggling</b> 203:18	258:17	191:5,6 192:4,11	<b>supposed</b> 36:5 48:4
99:21 109:11,13	204:19	<b>subsetting</b> 274:17	192:16 194:9,9,18	152:21 377:16,17
126:20 131:1	<b>stuck</b> 263:18	<b>substance</b> 24:4,10	194:21 195:22	<b>supposedly</b> 258:9
195:7 255:20	<b>studied</b> 187:2	24:22 25:13	197:19 199:19	<b>sure</b> 7:11 11:4 18:2
<b>stopped</b> 150:20	197:13 282:18	179:17 180:2	201:3,9 202:1	18:20,22 22:19
<b>story</b> 326:3 370:21	<b>studies</b> 36:19 73:9	187:12 204:15	203:9 204:3,19	40:13,22 43:19

50:17 51:6 60:21 61:1,6 62:2 65:4 78:8 86:7 89:17 94:17 95:15 118:18 119:10 125:7 130:6 134:14 139:13 142:7 169:19 177:21 182:20 191:3 192:7 215:12 216:12 234:7 238:14 239:15 247:21 268:20 270:21 306:14,22 307:15 309:10 312:5 314:19 320:7 322:17 323:13 327:18 328:18 330:17 342:4 346:18 349:9 350:5 361:1 362:1 381:3,10 <b>surfaced</b> 355:7 <b>Surgeons</b> 277:10 <b>surprised</b> 77:1 144:19 <b>surprising</b> 303:6,7 <b>surrogate</b> 377:14 <b>survey</b> 31:17 66:6 <b>surveyed</b> 170:8,8 <b>survive</b> 244:21 <b>Susman</b> 3:2 11:2 12:6,6 32:13,20 33:7 41:18 54:6 80:3 93:5 132:9 139:10 142:21 146:8 213:14 221:20 257:3 272:5 277:6 321:22 335:18 368:4 <b>suspicion</b> 223:7 <b>suspicious</b> 84:3 <b>sweep</b> 284:12 <b>symmetry</b> 230:1 <b>symptom</b> 4:9 28:3	35:3,7,16 66:3 93:7 132:15 263:5 <b>symptoms</b> 112:17 179:17 182:1 199:3 <b>system</b> 11:19 12:4 13:4,11 14:9 33:13 38:3 54:7 54:11 56:7 66:12 68:1 69:10 84:10 105:18 124:22 127:6 152:2 153:7 153:11,14 167:20 214:9 250:3 274:19 278:15 312:21 319:3 366:7 376:11 380:5 <b>system-wide</b> 153:1 153:15 <b>System/Health</b> 2:18 <b>systematic</b> 197:9 <b>systematically</b> 239:15 276:6 <b>systemic</b> 148:11 240:2 <b>systems</b> 36:17,22 49:8 56:18 132:21 135:14 148:5 153:6 244:7 248:13,15,16 261:17,20,21 279:15 380:11  <b>T</b> <b>T</b> 4:1,1 <b>table</b> 19:8 27:15 28:10,20 29:12,14 92:8 116:15 118:11 120:17 162:18 169:14 224:17 271:8,14 271:21 283:9 293:20 299:22 <b>tag</b> 7:9 <b>tagged</b> 87:11 <b>tail</b> 238:5	<b>tailed</b> 215:21 <b>tailor</b> 184:3 <b>tailored</b> 183:21 <b>take</b> 8:5 67:3 92:22 123:8 126:14 139:1 160:21 177:3 183:2 186:8 194:7 218:7,14 228:6,10,11 248:3 251:11 257:12 274:12 288:8 325:7 343:5 346:17 354:19 365:16,17 368:7 374:17 377:21 378:6 380:1,6 388:6,6,7 <b>taken</b> 84:17 125:4 130:17 184:9 252:11 306:21 371:4,7 <b>takes</b> 30:14 33:21 108:16 <b>talk</b> 32:15 45:15 48:11 55:9 56:2 114:17 119:14 141:22 168:5,5 187:11 230:6 233:7 239:4 247:7 252:14 355:10 369:4 376:3 383:7 <b>talked</b> 47:4 86:19 185:17 195:22 252:18 277:11 293:14 302:2,4 328:19 331:21 334:5 340:19 364:15 371:15 <b>talking</b> 38:19 50:7 57:16 87:8 88:2 92:9,14 96:12 117:17 118:5 136:21 137:2 144:13 168:7,7,8 168:17 182:17 189:4 194:6 195:7 218:17 239:20	247:1,11,15,16 257:8,8 259:11 263:3 269:3,5 272:7 339:4 372:6 <b>Tami</b> 2:9 17:10 35:12 43:22 45:14 46:4 65:16 68:13 68:19 71:15,20 87:15 91:6 101:21 173:17 203:15 205:14 <b>Tammy</b> 17:7 <b>tap</b> 7:6 <b>target</b> 245:21 256:4 288:6 <b>targets</b> 333:15 <b>task</b> 49:5 70:3 71:9 81:1,3,8,14,17 286:19 287:5 288:15 363:18 366:1 <b>taxi</b> 6:20 <b>taxonomy</b> 257:5,7 258:7,16 <b>team</b> 8:13 255:7 272:12 <b>team-based</b> 135:8 <b>tease</b> 120:1 <b>technically</b> 123:12 133:11 <b>tee</b> 27:2,3 29:8 141:17,19 238:19 277:22 281:18 301:19 309:8 317:12 326:14 357:22 <b>teed</b> 145:4 <b>teeing</b> 228:22 <b>teens</b> 70:6 <b>teeth</b> 241:17 260:18 <b>teleconference</b> 3:22 <b>telephone</b> 118:4 135:12,15 142:14 143:11,15 152:7 259:3 <b>telephonic</b> 358:17	359:1,6 <b>tell</b> 27:10 30:13 31:8 111:11 154:4 194:21 249:15 250:19 280:7 286:16 370:21 <b>template</b> 45:9 90:20 372:5,6 <b>templates</b> 371:15 <b>temporary</b> 22:13 <b>ten</b> 24:2 139:21 161:2 226:16 228:11 295:3 297:14 298:1 323:18 330:19 353:13,13 354:3,4 356:19 363:5 383:11 387:7,7 <b>tend</b> 272:10 <b>term</b> 21:4 98:6 147:9 192:16 <b>terminologies</b> 184:4 <b>terms</b> 10:2,12 26:2 26:3 36:22 38:22 39:1,6 40:8,16 43:20 46:6 48:10 52:2,19 58:13,17 72:15,18 76:18 79:13 80:1 83:2 83:15 85:3 90:18 91:3,4,7,8 95:1 96:20 101:19,19 101:22 102:10 107:19 108:13,18 108:21 109:4 113:18 126:15 127:10,12 131:19 151:9 168:21 178:5 191:10,21 192:10 193:7 214:19 224:17 244:4 255:2 263:20 269:8 288:10 289:9 320:16 321:10 334:8 340:6
---	--	--	---	--

366:19 367:17 371:12 372:18 373:5 380:16 <b>terrible</b> 327:5 <b>Terrific</b> 317:7 <b>tertiary</b> 13:3 <b>test</b> 59:4 60:9,19,20 62:12,14,17 67:6 113:12 208:22 209:1,10 215:21 216:8 321:7,20 358:7 <b>tested</b> 187:18 188:1 188:9 216:3 234:11 243:14 249:12 281:4 293:3,12 296:1,3 302:19 303:14 321:3 <b>testing</b> 5:2 50:4 76:4 103:14 110:19 111:11 113:19 178:7 183:15 188:4 207:16,20 216:1 233:18 262:18 280:20,21 281:12 317:14 318:7 337:6 <b>testing/sampling</b> 215:16 <b>tests</b> 239:17 250:18 273:13 310:13 <b>textbook</b> 162:3 <b>thank</b> 8:14 12:5 16:11 17:2,12,19 27:13 32:12 33:7 34:7 36:1 45:18 63:11 64:19 65:11 71:6 106:12,13 109:15 118:13,17 131:2 145:3 154:11 156:17 160:15,20 162:10 162:22 163:3,12 163:21 167:22 187:21 189:11	226:14 229:4,15 237:7,8 252:16 267:15 283:10 292:8,15 295:5 301:7,18 311:19 312:7,14 316:9 317:7 319:9 320:1 320:8 322:18 330:1 345:10 349:18 364:7 <b>thanks</b> 11:8 23:19 34:22 63:20 134:2 155:11 163:4 188:8 189:10 304:12 378:18 382:18 <b>themselves</b> 8:13 <b>themes</b> 10:6 238:21 239:2 <b>theoretical</b> 265:2 <b>theoretically</b> 95:7 <b>theory</b> 115:20 232:8 <b>therapy</b> 112:19 <b>they'd</b> 236:1 <b>thin</b> 86:14 <b>thing</b> 44:1 77:20 85:1,6 86:3 98:9 100:13 102:21 103:4 109:21 111:22 112:21 114:18,21 127:3 139:3 150:10 157:6 206:13 207:9 209:14 222:3 240:21 248:10 252:6 256:7 263:12 280:19 287:3,13 302:18 327:5 332:20 343:7 367:22 <b>things</b> 6:14 10:12 12:13 25:20 37:3 42:5 49:14 56:9 71:10,19 76:19 79:15 85:7 93:8	97:8 100:14 102:22 109:2,19 116:8 125:12 130:7 136:17 142:8 145:6 150:7 151:5,11,20 153:2 166:2 180:1 194:22 196:15,20 196:20 199:20 201:6,19,21 203:18 213:9 251:4,17 254:18 255:4 256:18 258:10 260:11 262:2 267:19 272:19 275:1,1,21 302:2 310:5 335:12 336:21 339:15 340:15 343:17 365:10,16 367:7 371:2 376:19 377:4 379:18 380:14 382:20 383:11 <b>think</b> 7:17 9:17,22 10:1,11,14 14:10 21:18 33:15 34:1 34:5 36:5 37:14 40:6 41:6 42:6,18 43:20 44:2 46:15 47:3,5,7,10 48:17 49:1,10,15 50:1 50:19 53:15 54:1 54:19 55:12,13,15 56:2,21 57:4,7,10 58:1,3 59:17 67:1 67:5,9 68:14 69:1 69:12 70:11,22 71:15 74:8,19 76:10 77:5,20 78:14,14,18,19 79:18,19 80:3 82:10,12,13,16 83:11,12 85:11,22 86:1,22 87:2,16 90:17 91:2 92:18 93:15 95:16 96:9	96:15 97:12,12 100:3,14,19 101:11,11,12,14 102:2,3,5,17 104:2 106:17 108:11,14,18 109:15,19 110:12 111:14 116:5,6,18 117:1,10,13 121:11 123:1 125:2,18 126:6 128:5,11 129:12 131:13,15,16,17 131:17,18,19,21 132:4,17,19 134:9 137:18,21 138:11 142:3,20 143:16 143:18,22 144:12 145:1,12 146:13 146:17,21 147:4 147:10 149:16,21 149:22 150:4 151:5,6,18,22 152:6,20 153:12 156:13,14 157:17 158:4,7,15 166:19 170:7 174:1 175:1 175:2,4,9 177:2 179:9 180:12 181:4,9,17,21 182:19 183:7,12 183:14 185:17,21 186:5 194:14 195:9 196:5,9 197:1,12,17,21 198:9 200:7,14 201:18 202:16,20 203:2,10,17 204:20,21,22 205:8,10 209:2,9 211:1,8,11,19 214:2,6 217:7,15 217:17 218:6,10 218:10,16 222:9 228:1,4 230:5,18 233:3 237:6 239:8 240:12,13,17,17	240:19 241:2,15 241:22 242:2,11 242:18 246:2,13 247:8 248:8,21 255:10,12,18,20 256:1 257:3,12,19 257:22 258:1,4 260:12,16 262:18 263:1,11,19 264:4 265:18 266:6 268:14,18,19,22 268:22 269:6,15 270:6,7,16,19 271:18 272:6,19 272:20 273:4,19 273:22 274:11 275:6,10 276:10 276:15 280:9 285:18 287:6,14 290:16,18 300:4 302:3 303:4 311:7 313:20 315:9 317:18 318:7 321:12 322:4 334:13 335:8,12 335:12 339:3,5,12 339:13,19 340:8 342:11 343:13 345:3 347:21 352:8,18 354:7 358:5,19 359:15 361:10 365:4 366:15,19,21 367:11,11,15 368:2,4,11,15 370:15,17 371:11 372:1,3,4,15,16 373:8,20 374:9,10 375:6,10 378:5,18 379:6,19,19 380:4 381:9,12 382:20 383:7 384:3,5,12 385:9,10,11 386:5 386:19 387:12 <b>thinking</b> 10:8 39:3 39:6,18 40:3,8 86:2 132:21 135:6
--	--	--	---	---



180:13 185:13 205:3 210:11 212:5 233:22 242:9 256:19 260:17,17 263:17 339:14 372:7 379:12 <b>third</b> 22:7 23:22 181:8 196:5,7 206:16 218:22 248:10 276:9 <b>third-party</b> 129:6 159:4 <b>thirteen</b> 159:20 220:4 225:7 300:14 324:14 344:15 345:12 346:11 351:1 <b>thought</b> 47:6 67:21 78:22 100:2 110:12 144:20 217:10 237:3 252:15 255:11 261:13 278:3 289:19 292:21 296:11 305:10 319:10 324:9 338:22 371:5,12 373:4 <b>thoughtful</b> 10:13 <b>thoughts</b> 31:9 78:12 199:1 204:2 210:10 343:2 364:14 367:6 371:10 <b>thousand</b> 257:20 <b>threats</b> 75:13 <b>three</b> 19:10 26:15 26:17 36:11,20 39:20,22 42:13 44:22 45:3 63:5 68:5 74:13 79:20 86:10 88:18,22 89:13 91:15 93:9 103:3,17,20 116:21 124:5,16 137:6 139:5	140:16 141:3,14 155:14,19 156:3,7 157:10 159:15 166:8 175:13 176:12 177:9 178:9 187:18 188:1,4,9,10,12 196:2 206:13 207:3 209:11,16 219:10,16,17 220:1 225:3 226:5 230:14,19 234:11 239:3 246:3 248:20 265:9,13 273:12 275:18 279:19,22 280:3 280:21 291:3 292:4 296:16 297:13,19 298:2 298:18 300:11 301:8 308:9,18 309:1 311:16 312:3 315:16 321:3 322:20 329:5 330:19 344:5 345:19 346:12 353:14 354:4 355:20 360:3 362:22 363:6,11 375:1,12 376:6 377:19 <b>three-month</b> 123:11 124:11 <b>three-year</b> 21:3 382:1 <b>threshold</b> 223:6 306:16 338:15 340:10 341:11 <b>thresholds</b> 352:20 353:1 <b>throw</b> 29:16 <b>thrown</b> 110:16 <b>thunk</b> 135:3 <b>ticking</b> 61:20 <b>tied</b> 148:14 365:14 381:6 <b>Tierney</b> 3:15	163:20,22 169:19 172:17 181:14 196:9 199:11,16 199:21 200:3,6 207:14 <b>ties</b> 146:17 <b>tightly</b> 77:2 <b>time</b> 6:22 7:12 8:10 13:13 17:6 20:7 22:10,20 24:1 28:18,21 29:3,11 31:13 33:21 34:15 38:5 48:9,13 57:4 63:9 64:17 67:10 70:6 77:12 85:20 86:3 88:6 98:22 113:15 114:4 117:2,4,20 124:9 128:2 136:3 137:7 154:19 160:14 181:3 203:13 214:1,2 218:16 223:13 227:15 229:14 231:4,10 237:22 243:12 252:11 255:7 257:12 264:16 267:22 268:3,9 270:20 279:3,18 280:2 292:14 301:6,11 302:6 310:18 316:2 324:11 325:6 333:14,18 336:6 336:11,15 338:3,9 338:16 345:9 348:7 362:9 363:22 364:4,12 368:11 376:5,12 379:11 381:4 385:17 <b>time's</b> 38:18 62:8 <b>time-intensive</b> 198:1 <b>timeframe</b> 111:12 126:5 151:11 306:4	<b>timeline</b> 21:18 89:12 <b>timelines</b> 158:3 <b>timeliness</b> 98:6 <b>timely</b> 99:2 <b>timer</b> 312:5 346:19 <b>timer's</b> 312:6 <b>times</b> 6:18 7:1 129:1,2 143:6 158:21,22 <b>timing</b> 242:10 339:12 <b>to-face</b> 143:18 <b>tobacco</b> 24:4,9,19 24:21 25:12 198:2 198:6,11 243:4 383:12 <b>today</b> 29:7 36:5 105:8 114:1 137:13 258:3 268:22 271:1 277:20 327:10 363:13 365:1 369:4,8 370:20 371:15 386:7 <b>today's</b> 18:7 <b>today's(telephonic</b> 358:20 <b>token</b> 161:20 <b>told</b> 249:2 278:10 375:18 <b>tomorrow</b> 21:4 32:14 230:6 363:16 369:8 376:3 <b>Toni</b> 3:17 169:20 170:13 171:17 172:18 <b>tonight</b> 7:17 <b>tool</b> 50:5,6 82:4,19 82:20,22 83:10,22 92:4 176:6 179:7 180:15 186:22 187:10 188:17 195:16 196:3 197:22 203:20,21 204:17 210:22	212:7 217:21 335:16 378:15 <b>toolbox</b> 335:17 <b>tools</b> 54:3 182:9 197:9,12 198:10 204:3 210:16 <b>top</b> 69:5 189:22 190:15 212:12 254:14 255:2 383:11 <b>topic</b> 22:10 23:7 25:17 81:4,9,10 166:1 254:11,14 278:9 365:21 <b>topics</b> 24:9 81:15 <b>toss</b> 96:11,12 <b>total</b> 240:5 261:3 382:7 <b>totally</b> 100:5 185:18 <b>touched</b> 25:18 136:18 264:10 <b>tough</b> 171:19 <b>track</b> 41:11 115:11 115:13 135:11,12 261:18 274:21 <b>tracked</b> 38:9 <b>tracking</b> 38:3 <b>traction</b> 262:11 <b>traditionally</b> 212:20 <b>trained</b> 205:9 <b>training</b> 15:19 16:22 <b>Trangle</b> 3:4 11:17 11:18 27:21 33:9 47:3,16 70:21 78:11 131:21 206:8 218:9 223:11 258:12,14 259:7,15,20 260:1 261:7 332:16 338:19 367:5 <b>transcript</b> 32:12 <b>transmit</b> 299:7 <b>transparency</b> 222:20
--	--	--	--	--

<b>trapped</b> 126:6	291:18 294:18	107:7,8,8,9 108:9	<b>typically</b> 89:12	<b>unfortunate</b> 194:15
<b>treat</b> 49:9 109:3	311:18 319:3	116:17 125:11	128:22 158:20	<b>unfortunately</b>
333:14	331:21 336:4	128:22 139:5	179:21	126:6 214:5
<b>treated</b> 247:10	343:22 355:13	140:16 141:2	<b>typing</b> 299:6	254:17
<b>treating</b> 217:5	366:13 376:17	150:7,18 152:9		<b>uniform</b> 101:18
<b>treatment</b> 1:17	378:14	155:14 156:2,6	<b>U</b>	196:13
46:14 64:10 81:8	<b>trying</b> 42:8 62:6	157:10 158:20	<b>U.S</b> 70:2 71:8 80:22	<b>unimportant</b> 47:6
106:8 109:9	99:21 115:13,20	159:15 160:10,11	286:18 287:5	<b>unintended</b> 98:7
111:17 119:2	121:13 122:12	169:18,21 172:2	288:15	<b>unique</b> 33:2 224:14
143:14 167:4	130:8 140:2	175:13 176:12	<b>UCLA</b> 3:6 14:3	225:16 227:3
171:12 172:16	147:20 195:3	177:9 178:10,19	<b>ultimate</b> 77:2,6	334:18 336:5
173:5,13,15	198:15 200:19	178:20 184:7,20	146:18	337:10
232:22 244:5,10	202:9 210:13,13	188:17 196:6	<b>ultimately</b> 53:16	<b>United</b> 49:5 77:13
251:9 277:4	211:2,3 215:5	206:15 209:19	71:17 147:8 222:3	<b>University</b> 1:14 2:3
287:12 302:16	231:2 245:5,15	210:1,2 215:20	248:2	2:13,15 3:3,3 9:10
<b>treatments</b> 129:3	247:5,22 250:16	219:10 220:1	<b>unable</b> 285:12	12:1,8 13:19 16:9
<b>tremendous</b> 358:18	252:22 255:22	225:3,7 226:5	<b>unarguable</b> 251:3	<b>university's</b> 13:19
<b>trends</b> 381:17	257:4 260:2	227:10,21 235:14	251:6,8	<b>unquote</b> 183:1
<b>trial</b> 99:12	261:15 286:15	240:13 248:15	<b>unclear</b> 335:19	<b>Unrelated</b> 199:18
<b>trials</b> 135:22	294:22 307:18	265:17 273:11	<b>uncommon</b> 282:5	<b>unstructured</b>
<b>trickier</b> 67:5	315:3,4 336:8	276:16 279:12,15	<b>uncomplicated</b>	208:10
<b>trickiest</b> 69:13	343:4 359:22	279:21 280:2,14	129:1 158:21	<b>untreated</b> 46:8
<b>tricky</b> 135:3 172:2	382:22 386:16	280:18 283:14	<b>under-counting</b>	<b>update</b> 89:22
<b>tried</b> 42:22 78:17	<b>turn</b> 9:3 19:13	284:11,18 288:14	111:3	186:10 289:6,6
82:21 262:19	20:13	291:3 292:4 293:4	<b>under-detected</b>	<b>updated</b> 19:20
286:12	<b>turned</b> 53:15	295:13 297:12,19	143:15	<b>updates</b> 186:9
<b>tries</b> 46:10 151:13	<b>turnout</b> 17:20	298:2,18 300:11	<b>undergone</b> 311:2	218:8
<b>trivial</b> 203:6	<b>turns</b> 135:2	301:3,12 308:9,17	<b>underlying</b> 87:17	<b>updating</b> 288:21
<b>trouble</b> 44:17	<b>twelve</b> 141:13	309:1 311:16	132:19	<b>ups</b> 158:4
108:10	171:6 219:17	312:2,9,16 315:16	<b>underscored</b>	<b>uptake</b> 207:2 209:3
<b>true</b> 33:1 55:2	330:3 345:19	317:3 320:9	167:12	<b>urban</b> 209:20
71:10 134:20	362:12	322:13 324:22	<b>understand</b> 18:22	<b>urge</b> 90:19
276:18 307:22	<b>twelve-year</b> 171:8	325:2 328:6 330:4	42:4 51:7 57:20	<b>urgently</b> 275:8
337:18	<b>twenty</b> 301:8	330:15 331:6	77:16 84:5 122:15	<b>usability</b> 157:16,19
<b>truly</b> 158:1 256:12	357:18 363:11	332:15 339:22	124:15 125:2	159:14,19 225:11
256:14	<b>twenty-one</b> 177:13	341:2,3 345:13	154:20 243:2	226:4,15 235:3,15
<b>Truven</b> 2:9 17:11	320:9 325:2 331:8	347:6,17 348:10	265:1 267:11	299:15,19 300:10
<b>try</b> 8:6 58:5 62:2,14	355:1	349:7,17 351:2	294:21 307:1	300:13 315:22
63:9 83:9 97:10	<b>twenty-two</b> 350:6	352:19,22 356:15	309:17 348:9	316:5,13,17
97:11 106:2 128:3	<b>twice</b> 184:15	357:11,18 363:8	<b>understanding</b>	323:19,21 324:8
131:10,10 149:14	219:13	366:11 368:11	22:22 23:3 123:5	324:13 330:5,9,15
235:15 238:19	<b>two</b> 19:10 21:3	388:7	170:10 202:9	330:18 346:13,17
245:12,12 250:11	24:21 27:7 36:21	<b>two-tailed</b> 216:8	274:5	346:21 354:5,7,13
250:14,20 253:20	38:5 39:11 61:5	<b>twofold</b> 179:21	<b>understood</b> 170:6	357:5,8 359:5
254:18 259:10	80:8 85:10 97:2,2	<b>type</b> 183:6 198:6	<b>underway</b> 23:21	363:1,4 365:10
260:11 276:12	99:9 103:16	310:8 373:6 384:6	106:2	381:16 382:3
277:19 281:19	106:22 107:4,5,6	<b>types</b> 125:6	<b>undiagnosed</b> 46:8	<b>usable</b> 324:2
			<b>undoubtedly</b> 371:7	

<b>usage</b> 261:11	93:14,17,19 95:7	322:14,19 328:14	373:18,22	<b>voodoo</b> 79:15
<b>use</b> 11:11 23:12	96:3 97:15,17	328:17 329:6,7	<b>veterans</b> 15:10	<b>vote</b> 20:11 30:3,12
24:4,10,10,10,22	100:7 151:12	345:12,15,18	374:13	58:4 59:2,19 60:3
25:12,13,13 30:7	215:20 302:12	351:3,10 353:8,12	<b>vett</b> 165:14	60:5,19 61:9
30:9 36:16 39:5	<b>USPSTF</b> 172:20	356:16,21 359:4	<b>vice</b> 2:8,9,12 14:7	62:18 63:3,8,16
40:8 43:14 45:10	173:12 197:19	362:6,11	105:3 207:13	64:18 65:2 82:11
50:18,22 66:11	<b>usual</b> 211:18	<b>value</b> 82:6 121:21	<b>Vice-Chair</b> 9:9	83:4 88:12,13
68:17 80:8 90:10	<b>usually</b> 30:13 123:3	191:13,16 206:2	<b>video</b> 132:5	89:1 92:12,12,21
101:22 105:16	<b>utility</b> 47:8,21	216:1,10,11	<b>view</b> 41:19 86:4	97:7,8,13 98:5,17
106:5,10 110:14	197:15	253:22 258:5	87:13 91:1 95:13	99:4,20 101:11
120:7 133:5	<b>utilization</b> 207:2	335:4,4,5,22	95:14 99:12	102:3 103:22
159:14,19 167:17	<b>utilize</b> 269:10,11	<b>Vanita</b> 2:17 14:6	241:18 383:15	139:1,7 150:12
167:19 176:7	<b>utilized</b> 372:2	122:7 239:21	<b>viewed</b> 22:19	155:11,22 159:12
179:6 181:11		378:18	<b>viewpoint</b> 42:15	159:13 160:1,5,14
184:4 187:4,12	<b>V</b>	<b>vantage</b> 33:12	<b>virtual</b> 15:12	160:14 175:10,21
188:16 189:18	<b>vacuum</b> 371:6	<b>variability</b> 176:4,4	<b>virtue</b> 100:21	176:9 218:14,18
192:16 193:1,5,14	<b>valid</b> 10:1 51:20	179:5 224:6 273:3	<b>visit</b> 39:21,22 55:21	219:3 222:4
196:12 197:11	69:8,18 78:18,20	321:4	69:16,17 107:2	224:20 225:20
198:4,5,12 202:15	78:21,22 79:13	<b>variably</b> 239:3	111:16,17 118:4	226:3,19,21
205:20 215:16,16	82:4 86:5,9 88:8	<b>variance</b> 144:4	120:9,15,22	291:13,15,18
215:20 216:1,8	97:14 146:14	<b>variation</b> 67:10	122:16 124:14	292:6,14 297:9
225:11,13 226:4	210:21 211:8	265:8 280:21	126:16 130:5	298:21 300:8,17
226:16 233:3	246:13	<b>varied</b> 186:1 203:7	132:7,13 134:11	300:21 301:1,4
243:6 244:5	<b>validate</b> 211:16	<b>variety</b> 85:18 165:4	142:14 143:11,15	311:13 312:4,5,6
247:22 253:18	<b>validated</b> 83:1	183:16 231:19	152:7 153:5,17	315:13,17 316:11
270:9 276:17	188:17	249:14 251:13	167:1 179:2	316:15,22 319:22
285:17 299:15	<b>validates</b> 84:9	252:1 286:11,17	184:17 238:12	320:5,7 321:12
300:10,14 315:22	<b>validity</b> 52:12	303:2 340:15	239:14 244:18	322:5 323:10
316:13,17 323:20	68:11,15 69:3,5,6	<b>vary</b> 207:3,11	245:2 260:15	324:6,19,20,22
324:3,8,14 330:5	69:13,13 71:11,18	<b>varying</b> 92:8	279:3,5,9,10	327:15,21 328:22
330:9,15,19 334:1	72:22 73:2,3,8,13	<b>vast</b> 214:1 374:1	281:2 283:15	329:19,22 330:2
340:11 346:13,17	73:16,19 74:14	385:4	286:2,4,5,6,7,8	330:13,16 344:2,4
346:21 354:5,14	75:13 76:4,6,7,14	<b>Venn</b> 331:22	290:1 306:22	344:7,12,12,14
357:5,8 363:1,5	77:4,9,10,21	334:16	307:9 318:17	345:6,9,15 346:5
366:6,10 373:2,14	80:16 83:21 86:2	<b>venues</b> 365:19	<b>visits</b> 40:22 41:1	346:15 347:1,4
381:16 382:3	93:18 97:7 98:15	<b>verbal</b> 195:1	48:5,5 106:7	349:3,8,18 350:1
383:6 385:20	98:17 100:6,8	<b>verbalized</b> 170:5	107:7 108:7 109:7	353:21 354:10
387:1	140:13 141:17	<b>Vermont</b> 388:5	111:9 118:5 128:8	355:11,14 357:15
<b>useful</b> 26:20 44:22	142:10 144:14,16	<b>versa</b> 207:13	129:11 135:7,12	359:21 361:18
74:7 158:16	145:5 147:14,16	<b>verse</b> 326:5	135:21 142:15	362:1
185:14 215:1,4,7	155:21 156:1,6	<b>version</b> 133:12	152:8,9 184:20	<b>voted</b> 59:21 81:8
215:7 270:1 354:8	177:22 219:20	<b>versus</b> 32:17 40:10	206:22 239:10	101:4 319:20
<b>user's</b> 95:14	220:16,19 223:22	54:20 72:20 73:9	283:14 284:11	322:17
<b>users</b> 269:11	292:21 293:9,10	158:8 206:20	286:14 307:10	<b>votes</b> 141:7,9
<b>uses</b> 39:12 40:10	293:18 297:17,21	265:17 295:2,2	318:16	176:13 220:7
86:10 90:17 91:13	297:22 309:6,8,12	385:6	<b>vital</b> 130:4	292:5 311:17
92:9,11 93:1,10	310:9 311:13	<b>Veteran's</b> 2:4	<b>voice</b> 11:8 229:22	316:14 330:16
	312:1,8 321:2,10			

349:18	186:13 324:9	348:12,20 372:21	254:21 258:1,5,5	320:4 322:14
<b>voting</b> 10:17 20:11	329:21	377:5,9 381:9	258:6 262:14	325:8 329:9 344:7
30:9,17 59:6	<b>walk</b> 18:21 46:4	382:16 385:16,21	263:12 269:9,13	344:11,16 345:17
60:11 63:5 64:13	74:3,5 76:13	386:13 387:3,16	270:2 280:8	362:13 366:12
64:15 65:4,10	177:19 319:21	<b>wanted</b> 6:12 17:6,7	287:10 290:4	369:8 388:16
79:21 96:12,21	388:13	18:6 27:10 46:4	338:5 342:8	<b>we're</b> 10:4,8 17:5
97:1,6,13 102:7	<b>walking</b> 248:7	53:7 81:2 95:17	371:20 372:12,17	19:6 24:8 25:11
103:11,12,14	<b>walks</b> 73:15	109:20 118:18	376:9 380:19	25:12,19 27:2
137:12 139:4,12	<b>want</b> 20:4,10 22:18	127:3 152:16	<b>ways</b> 9:22 43:4,5,17	35:4 36:3 42:7
140:17 141:4	22:18 32:4 33:3	161:14 164:9	47:10 59:1 75:19	50:7,8,11 51:1
155:13,15 156:1	34:11 44:19 45:20	198:12 200:20	84:9 94:22 100:3	52:14 55:7 56:11
157:7,8 160:8	52:19 55:16 57:2	209:8,22 211:16	100:4 101:22	56:20 58:4 59:2,3
175:11 176:10	61:21 70:20 74:2	216:17 233:2	102:17 113:7	60:8,11,16 62:6
177:6,7 219:7,8	74:3 75:1 76:18	235:12 240:15	127:12 183:16	62:10,14,15,19,20
219:20 224:21	81:19 82:3 83:9	260:22 364:10	196:2 203:8,11	63:1,2,4,8 64:13
226:3,9 227:9	90:4 94:11,16	<b>wanting</b> 198:7	235:14 249:14	64:17 65:20 72:8
291:15,22 292:2	96:16,17 98:9,9	240:12	251:13 256:19	73:18 87:7 88:2
292:12 297:9,10	100:15,16 122:1	<b>wants</b> 67:15 145:8	258:9 265:9	92:9,15,18 94:18
297:18,20 298:15	131:12 133:19	148:10 149:7	269:17 270:6	97:6 98:8 100:11
298:16 300:9	135:3 136:9,16	275:14	279:13 321:17	101:10 105:6
301:2 306:19	137:17,18 140:4	<b>warning</b> 340:21	335:3,16 342:10	106:6 112:11,20
308:6,7,16,22	145:11 147:17	<b>Washington</b> 1:9	361:10 368:18	113:7,8,10,17
311:14 312:1	148:16,21 151:1	<b>wasn't</b> 47:8 50:16	372:2,3	114:8 115:13
315:12,14 316:12	152:4 154:14	51:6 79:17 82:22	<b>we'll</b> 8:6 9:4 10:17	120:12,14 121:13
317:1 319:17,18	157:2 158:15	86:13 96:1 98:14	10:20 18:16,20	124:1,15 126:6
320:11 322:6,15	159:22 160:1	150:15 154:1	19:13 21:17 23:1	129:18 132:10
323:11 324:7	161:17 163:16	171:8 200:18	25:20 27:1,3	134:21 136:5
327:17 328:3,7,8	168:2 182:18	208:9 223:5	28:14 29:7,9,19	137:2 138:12
329:1,5,20 330:14	198:15,18 204:16	284:19 321:6	30:4,12 32:5	140:2 141:6,10
331:4 344:1 345:7	213:13 215:11	<b>Watson</b> 202:15	50:12 52:4,10	143:7 146:9 147:3
345:14 346:9,16	222:10 223:9,18	<b>way</b> 9:22 10:5 25:8	53:3 58:19 59:10	147:5 148:17
347:5 349:4,15	227:19 231:5	45:13 50:9 51:8,9	65:14 70:18	149:16 150:6
350:6,19,20 351:3	236:6 238:4,10	55:10 68:3 70:2	103:12 116:15	152:1 154:15,19
353:10,22 354:11	239:4 241:3,4,14	83:5 88:11 89:18	120:16 121:22	155:7,10,22
354:20 355:15,21	253:3 254:6	90:21 99:2 100:12	139:3 140:10,12	160:14,21 162:9
356:15,22 357:5	258:14 263:7	101:2,5,13,18	140:14,15 141:1	163:14 168:6,7,8
357:12 359:15	265:20 270:21	102:14 110:15	141:15 144:13	168:15,17 175:10
360:6,16 361:19	271:14,22 272:21	118:11 120:17	155:12 157:16	176:13 177:17
362:6,17 363:1,8	285:8,22 288:4,7	123:4 125:22	160:21 176:18,19	182:2 184:10
383:1	290:12 291:9	126:22 137:7	209:2,4 218:6	186:12 187:14
<b>VP</b> 2:17	294:6 300:19	139:10,12 147:5	220:18,22 221:11	191:19 202:14
<b>VSAC</b> 206:5	307:14,15 317:11	152:2 164:8 179:5	221:14,16 223:19	204:13,16 205:2
<b>vying</b> 383:20	328:17 329:18	179:11 183:2,19	229:8 233:7	206:20 210:12,13
	332:21 333:16	196:13 201:11	241:12 291:21	211:2,3 212:1,6
<b>W</b>	339:16 341:1,11	202:11 214:11	292:11,18 297:16	212:17 213:1
<b>wait</b> 43:22 327:9	342:4 344:18	221:11 238:7	298:2 308:16,21	214:7 215:5
345:12 352:11	346:4 347:16	252:19 253:4,7	311:22 315:21	216:20 217:7
<b>waiting</b> 141:10				

218:16 219:18,19 221:13 222:2,3 224:20 225:20 226:12,13,14,17 227:20 228:6 234:17 236:12 240:12 244:9 245:9 247:1,15 249:22 250:1,16 253:8,14,16,17,21 254:21 257:6,7,8 258:3,9,22 261:3 261:16,20 263:13 263:18 264:15 266:9,14,14 269:4 270:21 272:7 279:5 280:9 281:22 285:14,15 290:8 291:14,17 291:21 292:5,7 297:20 305:20 306:6 307:4,15 310:4 315:3,4,8 315:18 317:9,19 317:20 322:10,11 324:10 325:6 329:14,21 330:15 339:3,19 341:7,14 341:22 342:1,4 343:4,11 345:9 349:7 351:22 357:14 360:15 361:2 363:6,13 368:12 370:1,3 374:11 375:22 376:15 385:16 386:16 388:15 <b>we've</b> 6:8 19:20 21:18 28:19 41:20 57:11 68:14,16 84:11 93:9 96:14 114:4,12 117:4 136:7 145:4 157:18 161:8 175:4 182:3 184:9 202:18 208:6 223:2,6 230:7	235:5 237:18,19 257:9 258:20 260:1 261:15,17 261:22 262:7 273:19 275:17 292:7 293:14 301:10 302:2,3 311:5 321:5 328:19 348:6 364:11 369:4 372:10 376:22 382:4,5 <b>Webinar</b> 7:14 <b>WEDNESDAY</b> 1:5 <b>week</b> 16:3 136:2 276:19 366:1 374:20 <b>weekly</b> 129:2 135:21 158:22 <b>weeks</b> 108:9 130:3 150:18 <b>weighing</b> 214:20 <b>weight</b> 148:11 282:14 285:18 287:9,13 288:1 289:15,20 290:9 305:21 368:20 383:12 <b>weight-loss</b> 288:3 <b>weird</b> 289:17 <b>welcome</b> 4:1 6:5,10 9:14 17:5,13 <b>well-baby</b> 48:4 <b>well-child</b> 39:20,22 41:1 54:8 <b>Wellness</b> 2:13 13:20 <b>went</b> 26:12 38:14 111:1 144:8 150:21 161:4 228:14 245:5 246:16 325:13 379:14 381:2 <b>weren't</b> 53:21 206:21 <b>whatnot</b> 142:7 230:21	<b>wheel</b> 144:8 <b>white</b> 259:19 307:8 <b>who'da</b> 135:3 <b>widely</b> 46:12 <b>widespread</b> 36:16 91:7 198:5 <b>WiFi</b> 31:22 <b>willing</b> 100:11 208:22 <b>wind</b> 252:6,12 271:15 <b>wine</b> 385:19 387:21 <b>wisdom</b> 364:22 <b>wise</b> 33:15 <b>wish</b> 68:2 77:18 146:19 <b>woeful</b> 213:19 <b>women</b> 305:5 306:3 <b>wonder</b> 93:12 169:20 204:15 376:20 <b>wondered</b> 48:3 <b>wonderful</b> 17:20 <b>wondering</b> 39:15 144:9 207:10 238:2 243:7 269:12 321:14,21 360:19 <b>wonders</b> 163:9 <b>word</b> 128:19,19 133:19,22 152:14 152:16 275:12 385:22 386:2 387:16 <b>words</b> 83:16 129:10 221:22 <b>work</b> 7:8 9:15 12:3 13:14 14:11,19 15:10,13 18:15 21:6 22:10 32:6 36:2 46:1 52:4 59:4,7 60:4 68:16 72:2 94:2 100:11 102:18 106:2 107:17 110:20 115:19 116:15 118:10 120:17	122:9,10 219:4 223:2 231:6,7,15 249:18 250:8 253:12 255:18 256:21 257:19 258:2,5,19 261:15 269:14 271:10 306:2 315:8 364:7 365:8 370:18 <b>worked</b> 112:18,20 232:16 364:11 370:22 <b>workflow</b> 184:3 189:5 <b>Workforce</b> 2:4 <b>workgroup</b> 18:11 19:15,16 29:16 31:1,7,10,18 71:5 71:7 86:20 116:17 164:20 165:2,3,10 169:1 178:15,15 178:19 182:17 185:18,22 186:4 209:15 224:9 225:12 246:5,13 292:21 293:16 309:11 316:4 320:17 324:1 <b>workgroup's</b> 312:15 <b>workgroups</b> 31:12 <b>working</b> 6:9 15:3 34:3 60:6 62:21 94:19 113:17 132:5 143:8 228:11 262:7 371:1 379:1 383:16 <b>works</b> 60:21 61:1 87:13 309:18 <b>world</b> 129:18 131:19 147:1 201:17 206:19,20 207:12 265:2,5 <b>worried</b> 137:19 <b>worries</b> 327:21 <b>worse</b> 42:12 54:1	84:15,16 87:22 88:4 <b>worst</b> 53:20,21 <b>worth</b> 106:17 138:3 174:18 367:17 <b>wouldn't</b> 263:3 266:17 288:4,7 336:9 372:9 <b>Wow</b> 259:20 <b>wrestle</b> 289:10 <b>wrestled</b> 42:21 <b>writing</b> 66:13 <b>wrong</b> 62:16 258:1 <b>wrongly</b> 108:1 <b>wrote</b> 162:3 193:12 <hr/> <b>X</b> <hr/> <b>X</b> 383:13 <hr/> <b>Y</b> <hr/> <b>Y</b> 383:13 <b>yea</b> 218:14,18 <b>yeah</b> 11:5,11 93:5 104:10 120:19 122:2 137:17 149:16 151:4 152:4 154:7 174:8 201:15 226:12 228:8,10 241:13 257:10 270:1,5 289:4 296:10,15 297:4 322:10 343:14 351:17,18 352:2 358:15 364:10 <b>year</b> 15:18 36:21 40:1,20 41:14,15 49:8 54:16 89:21 94:4 103:7 123:13 123:18 129:1 158:21 162:4,6 184:16 252:4 306:9,13,15 332:6 337:1,1,1 341:8 341:10 378:8,8 380:10,22 <b>years</b> 6:9 36:12 38:4 66:18 88:18
---	--	--	---	---

88:22 89:13 103:3 116:21 117:5 137:6 166:17 169:10 230:14,15 230:19 239:13 240:21 259:1 260:5,7 261:16 287:12 311:5 375:1,13 376:6 377:19 <b>York</b> 9:11 13:12 <b>York-Presbyterian</b> 1:13 <b>young</b> 166:16 <b>younger</b> 171:6,10 <b>youth</b> 84:7,11 166:6,16	116:16 117:7 118:8 136:21 137:4 142:11 152:4 156:21 158:12 179:9 185:16 209:8 210:4 224:14 225:16 242:8 285:8 <b>zip</b> 185:5 <b>zone</b> 59:11 220:21 221:5,6,13 226:18 <b>ZUN</b> 3:7 161:16,20 306:20	<b>11:21</b> 161:4 <b>11:33</b> 161:5 <b>12</b> 49:8 107:1 133:4 <b>12:45</b> 228:14 <b>130</b> 340:11 <b>1365</b> 4:12 163:15 163:18 175:12,18 176:16 177:13 219:9,16 224:22 226:4,16 227:13 <b>138</b> 340:12 <b>140</b> 338:3 <b>140/90</b> 5:6 331:15 <b>1402</b> 256:17 <b>15</b> 166:17 209:11 325:7 <b>15-minute</b> 160:22 <b>150</b> 36:19 <b>15th</b> 1:9 <b>16</b> 63:13 263:21 <b>163</b> 4:13 <b>17</b> 350:4 <b>18</b> 4:5 34:3 49:8 116:20 139:4 321:16 361:22 <b>18-member</b> 177:22 <b>18-year-olds</b> 321:20 <b>19</b> 64:21 350:5 362:8	<b>21</b> 292:14 357:14 359:20 <b>210</b> 124:3,5 <b>22</b> 62:1 64:18 141:7 316:15 <b>23</b> 62:8,19 160:15 226:13 292:7,15 <b>24</b> 62:6,11,19 166:17 220:7 226:13 260:5 282:13 <b>25</b> 81:7 142:19 176:13 181:3 220:7 240:21 254:11 325:8,11 <b>2601</b> 4:15 277:21 278:1 291:15,19 292:10,17 297:16 298:1,17 299:11 300:10,13 301:8 <b>2602</b> 4:16 302:7 308:8,13,20 309:4 311:17,21 315:19 316:17 317:5 <b>2603</b> 5:2 317:11,13 319:19 320:2,10 320:13 322:7,12 322:19 323:17 324:14 325:2 <b>2604</b> 5:3 325:19,20 329:4,8 330:20 331:5 <b>2606</b> 5:5 331:13 344:4,9,14 345:8 345:14,18 346:11 346:21 347:9 <b>2607</b> 5:8 347:11,14 349:5,11,21 350:11 351:1 353:13 354:3,14 355:8 <b>2608</b> 5:9 355:3,4,8 355:16,19 356:2,8 356:9,10,14,18 357:3,10,19 360:9 <b>2609</b> 5:11 357:20 358:2 359:18	360:3,14 362:4,12 362:21 363:5,11 <b>27</b> 260:7 <b>278</b> 4:15
<b>Z</b>	<b>0</b>		<b>3</b>	
<b>Z</b> 383:13 <b>zero</b> 63:13,13,14 64:22 65:13,14 140:10 141:14 157:15 159:20 175:19,19,20 176:17 177:14,14 194:8,11 196:4 213:3 297:15 308:14,15,21 309:5,5 316:18 320:3,3,4,14,14 322:14 323:19 324:15 328:1,1,2 328:6,7,10,11 329:5,9 330:4 344:6,7,11,16 345:20 346:12,22 349:13,13,14,22 350:1 351:2 354:4 354:16 355:20,20 355:21 356:7,8,15 356:20 357:9 360:4,4,5,10,10 360:15,15 362:5 362:13,22 363:6 380:14 <b>Zima</b> 3:5 14:2,3 28:1 114:19	<b>0108</b> 4:8 104:11,12 104:14,18 140:7 140:21 141:13 155:18 156:2,6 157:14 159:19 160:18 <b>0722</b> 4:9 28:2 35:16 <b>09</b> 360:9	<b>2</b> <b>2</b> 24:1 25:5 27:2 59:18 65:8 142:11 <b>20</b> 24:20 65:13 166:11 239:13 292:5 295:2 311:17 378:13 385:6 <b>20-minute</b> 206:22 <b>2005</b> 105:13 <b>2007</b> 164:13 <b>2010</b> 172:4 370:22 <b>2012</b> 24:1 189:9 303:16 <b>2013</b> 171:2 <b>2014</b> 1:6 <b>2015</b> 303:11	<b>3</b> <b>3</b> 1:3 59:18 64:21 65:9,13 <b>3(b)1</b> 180:21 <b>3:04</b> 325:13 <b>3:15</b> 8:5 <b>3:25</b> 325:14 <b>30</b> 38:11,13 107:3,8 111:17 120:10 122:16,20 124:10 126:5,8,19 127:16 129:14 134:6 148:18 149:7 154:21 260:22 263:10 280:12,14 295:2 <b>30-day</b> 128:9 135:18 136:7 151:2 153:5,17 <b>300</b> 375:19 <b>302</b> 4:17 <b>317</b> 5:3 <b>326</b> 5:4 <b>331</b> 5:6 <b>347</b> 5:8 <b>35</b> 4:10 371:2 <b>35-item</b> 84:6 <b>350</b> 287:13 <b>355</b> 5:10 <b>358</b> 5:12 <b>363</b> 5:15 <b>39</b> 340:11	
	<b>1</b>		<b>4</b>	
	<b>1</b> 1:6 25:18 45:16 59:18 60:15,22 64:21 65:8 <b>1(a)</b> 60:16 63:5 74:22 <b>1(b)</b> 60:16 64:13 <b>1(c)</b> 60:16 <b>1.3</b> 34:19 <b>1:00</b> 11:6 <b>1:10</b> 8:5 228:1 <b>1:12</b> 228:15 <b>10</b> 166:17 330:20 <b>10-minute</b> 160:22 <b>10,000</b> 33:17 <b>10:45</b> 8:4 <b>100</b> 378:3 381:1,1 <b>101</b> 178:16 180:22 216:14 <b>102</b> 206:12 <b>1030</b> 1:9 <b>104</b> 4:9 <b>11</b> 252:21		<b>4</b> <b>4</b> 65:9 <b>4:47</b> 388:18 <b>40</b> 38:11 59:9,12 220:22 221:12,13 252:13 271:16 378:13 <b>41</b> 66:1 <b>45</b> 228:17	

**5**

**50** 79:7 86:21 223:4  
 295:2 359:11  
**50,000** 33:17  
**52** 378:3  
**58** 220:20 222:1

**6**

**6** 4:1,4  
**6:00** 7:17 388:4,13  
**6:30** 7:17  
**60** 59:7,9 219:19  
 220:22 221:13  
 223:6  
**600** 382:9  
**63** 34:21  
**66** 222:2

**7**

**7** 63:13  
**70** 41:5  
**700** 382:8  
**722** 63:12 64:20  
 65:12 103:13,19  
**75** 178:12 181:1  
**79** 340:12

**8**

**8:30** 1:9 34:14  
**8:35** 6:2  
**80** 216:8 295:2  
 325:9 385:6  
**815** 171:3  
**85** 375:19

**9**

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Behavioral Health Phase 3  
Standing Committee Meeting

Before: NQF

Date: 10-01-14

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](http://www.nealrgross.com)