

NATIONAL QUALITY FORUM  
+ + + +  
CARE COORDINATION STEERING COMMITTEE

+ + + +

WEDNESDAY  
OCTOBER 19, 2011

+ + + +

The Steering Committee met at the Metropolitan Center, Liaison Hotel Capitol Hill, 415 New Jersey Avenue, N.W., Washington, D.C., at 9:00 a.m., Donald Casey and Gerri Lamb, Co-Chairs, presiding.

PRESENT:

DONALD CASEY, JR., MD, MPH, MBA, Co-Chair  
GERRI LAMB, PhD, RN, FAAN, Co-Chair  
DANA ALEXANDER, RN, MSN, MBA, GE Healthcare  
KATHLEEN ALLER, MBA, McKesson Enterprise  
Intelligence  
ANNE-MARIE AUDET, MD, MSc, The Commonwealth  
Fund

JUAN EMILIO CARRILLO, MD, MPH, New York-  
Presbyterian Hospital and Weill Medical  
College of Cornell University  
JANN DORMAN, MA, PT, MBA, Kaiser Permanente  
KAREN FARRIS, RPh, PhD, University of  
Michigan College of Pharmacy  
PAMELA FOSTER, LCSW, MBA/HCM, ACM, Mayo

Clinic Health System  
WILLIAM FROHNA, MD, FACEP, MedStar  
JEFFREY GREENBERG, MD, MBA, Brigham and  
Women's Hospital  
THOMAS HOWE, MD, Aetna  
SUZANNE HEURTIN-ROBERTS, PhD, MSW, HRSA  
CHRISTINE KLOTZ, MS, Community Health

Foundation of Western and Central New York  
JAMES LEE, MD, The Everett Clinic  
RUSSELL LEFTWICH, MD, State of Tennessee

PRESENT(Cont'd):

MARC L. LEIB, MD, JD, Arizona Health Care  
Cost Containment System, Arizona's  
Medicaid Program

JULIE L. LEWIS, MBA, Amedisys, Inc.

LINDA LINDEKE, PhD, RN, CNP, University of  
Minnesota School of Nursing and Amplatz  
University of Minnesota Children's  
Hospital Clinic

DENISE LOVE, MBA, RN, National Association  
of Health Data Organizations

LORNA LYNN, MD, American Board of Internal  
Medicine

JEAN MALOUIN, MD, MPH, University of  
Michigan

MATTHEW McNABNEY, MD, Hopkins ElderPlus and  
Johns Hopkins University

EVA M. POWELL, MSW, National Partnership for  
Women & Families

BONNIE WAKEFIELD, PhD, RN, FAAN, University  
of Missouri and Iowa City VA Medical  
Center

ALONZO WHITE, MD, MBA, FCCP, CPE, Anthem  
Care Management

NQF STAFF:

TAROON AMIN

HELEN BURSTIN, MD, MPH, Senior Vice  
President of Performance Measures

SHEILA CRAWFORD

LAURALEI DORIAN, Project Manager

ANN HAMMERSMITH, JD, NQF General Counsel

SARAH LASH

NICOLE McElveen, MPH, Senior Project Manager

SUZANNE THEBERGE

WENDY VERNON, MPH, MPT, Senior Director,  
National Priorities

ALSO PRESENT:

LIPIKA SAMAL, MD, Brigham and Women's  
Hospital

ARJUN VENKATESH, MD, MBA, Brigham and  
Women's Hospital

C-O-N-T-E-N-T-S

Introductions . . . . . 4  
Disclosures of Interest . . . . . 5

Project Overview and Review of Agenda . . . . 25

Overview of Previous NQF Care Coordination  
Work  
National Priorities Partnership and Care  
Coordination. . . . . 29  
    Wendy L. Vernon, MPH, MPT

Performance Measures and Care Coordination  
. . . . . 57  
    Donald Casey, Jr., MD, MPH, MBA  
    Gerri Lamb, PhD, RN, FAAN

Information Systems to Support Care  
Coordination and Care Transitions . . . . .100  
    Lipika Samal, MD

Public & Member Comment . . . . .161

Environmental Scan: Presentations of  
Findings. . . . .166  
    Arjun Venkatesh, MD, MBA

Discussion Q&A. . . . .197  
Setting the Foundation for the Care  
Coordination Pathway. . . . .219

Framing the Call for Measures . . . . .290  
Next Steps. . . . .329  
NQF Member/Public Comment . . . . .335

Adjournment . . . . .337

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

2 9:11 a.m.

3 MS. DORIAN: Good morning,  
4 everyone. Welcome to the Care Coordination  
5 Steering Committee meeting with NQF. I'm  
6 Lauralei Dorian, project manager for this  
7 project. And I can tell you we're very  
8 excited to have you here. We're really  
9 looking forward to this project. I think  
10 we've brought together a great group of people  
11 from many different backgrounds and looking  
12 forward to the day. I think before we get  
13 started I'll have the rest of the NQF team  
14 introduce themselves. Helen?

15 DR. BURSTIN: Hi, everybody. I'm  
16 Helen Burstin. I'm the senior vice president  
17 for performance measures at NQF. Welcome.

18 MS. MCELVEEN: Good morning,  
19 everyone. Nicole McElveen, senior project  
20 manager with the National Quality Forum.

21 MS. THEBERGE: Good morning,  
22 everyone. I'm Suzanne Theberge. I'm a

1 project manager at the National Quality Forum.

2 MS. VERNON: I'm Wendy Vernon,  
3 senior director with the National Priorities  
4 Partnership at the National Quality Forum.

5 MS. HAMMERSMITH: I'm Ann  
6 Hammersmith, NQF's general counsel.

7 MS. DORIAN: And Arjun, I might  
8 have you introduce yourself as well.

9 DR. VENKATESH: Arjun Venkatesh.  
10 I'm a resident in emergency medicine at  
11 Brigham and Women's and Mass General.

12 MS. DORIAN: Thank you. And now  
13 we're going to have you go around the room.  
14 We'll do our welcomes and introductions. And  
15 at the same time we'll have Ann do your  
16 disclosures of interest. So we might start  
17 down at this end and then go around.

18 MS. HAMMERSMITH: Lauralei.

19 MS. DORIAN: Oh, of course. Oh,  
20 the chair. Sorry.

21 MS. HAMMERSMITH: Well, I give a  
22 little introduction actually.

1 MS. DORIAN: Oh.

2 MS. HAMMERSMITH: An explanation.

3 MS. DORIAN: Okay, perfect.

4 MS. HAMMERSMITH: So if you  
5 recall, all of you received a disclosure of  
6 interest policy and form from us which you  
7 filled out and which we reviewed carefully.  
8 What we'd like to do now is have you go around  
9 and disclose anything that you feel needs to  
10 be disclosed. You don't have to recount your  
11 CV because that would take way too long and  
12 you don't need to go through the form and  
13 summarize every response. What we're looking  
14 for you to do is to disclose any of your  
15 activities that may be relevant to the work  
16 that this committee will do. We're  
17 particularly interested in your disclosure of  
18 consulting work that's relevant including any  
19 speakers fees. We're also interested in any  
20 grants or research support that you have that  
21 may be relevant to the work that's before the  
22 committee.

1                   One thing that I want to talk  
2                   about very briefly is when we do these  
3                   disclosures people often say I don't have any  
4                   financial conflict. In this context  
5                   disclosures are not limited to financial  
6                   conflicts. If you've worked on something and  
7                   it's your baby a dime may not have passed  
8                   hands but you could potentially have a  
9                   conflict because you're very invested in it  
10                  and you have a very, very strong point of view  
11                  potentially. So I just want to remind you of  
12                  that.

13                  The last thing I want to remind  
14                  you of is that you serve on this committee as  
15                  an individual. We often have people say "I'm  
16                  here representing the American Association of  
17                  Healthy People," but you sit as individuals.  
18                  So, you don't represent your employer, you  
19                  don't represent any group. Even if they  
20                  nominated you to serve on the committee you  
21                  are not representing their interest. You're  
22                  here because you're experts and that's what

1 we're after, your individual expertise. So if  
2 we could start with the chairs I'm going to  
3 ask everyone to introduce themselves, tell us  
4 who you're with and then do any disclosures.

5 CO-CHAIR CASEY: Good morning,  
6 everyone. I'm Don Casey. I'm the chief  
7 medical officer for Atlantic Health, vice  
8 president of quality. And I want to welcome  
9 you all and we're very happy that you're here.  
10 I have several disclosures to make. I think  
11 all of these are non-financial but they are  
12 relevant. I have served in the capacity of  
13 members of writing groups and technical  
14 development panels for the following  
15 organizations: American College of Physicians,  
16 the American College of Cardiology, the  
17 American Heart Association, the American  
18 Hospital Association, the American Medical  
19 Association, NCQA, the American Board of  
20 Medical Specialties and also CMS and NQF.  
21 I've received funding from AHRQ for research  
22 in care coordination but not recently. And I



1 think that summarizes it.

2 CO-CHAIR LAMB: Good morning,  
3 everyone, delighted you're here. I'm Gerri  
4 Lamb. I'm co-chairing with Don. I am a  
5 faculty member at Arizona State University and  
6 continuing that vein also have activities that  
7 I think are relevant although not all  
8 financially related. I am a consultant on the  
9 INTERACT program which is transitional care  
10 for older adults between nursing homes and  
11 hospitals. I just sat on the Board of  
12 Internal Medicine's PIM related to care  
13 coordination and I am on a working group at  
14 the American Academy of Nursing on care  
15 coordination.

16 DR. WHITE: I'm Alonzo White,  
17 managing medical director for Anthem Care  
18 Management. I work for WellPoint. My  
19 responsibilities are basically case  
20 management, disease management and the health  
21 and wellness programs. I volunteer with a  
22 group called Not One More Life which is an

1 inner-city program for people without  
2 insurance who have asthma and it's designed to  
3 reduce the asthma mortality rate in the inner-  
4 city populations, strictly voluntary. And my  
5 wife is director of Meaningful Use at McKesson  
6 and is a manager in their electronic medical  
7 records and practice management software  
8 division.

9 MR. FROHNA: Good morning. My  
10 name is Bill Frohna. I'm chairman of the  
11 department of emergency medicine at Washington  
12 Hospital Center here in the District and also  
13 work for MedStar Health. Our group of  
14 emergency physicians and PAs provide services  
15 to five hospitals in the nine-hospital MedStar  
16 Health system. I oversee the operations of  
17 those five departments and so 110 physicians,  
18 about 55 PAs. The only disclosure I have to  
19 make is that I come from a family with nine  
20 siblings and many of those are involved in  
21 health care and I have made those disclosures  
22 on the form, but nothing personal.

1 MS. FOSTER: Good morning. My  
2 name is Pam Foster. I am the director of care  
3 coordination at Mayo Clinic Health System  
4 currently in Eau Claire, Wisconsin. I just  
5 transferred from the Mayo Clinic in Arizona to  
6 that position. And my disclosures I think  
7 would include that I am a board member of the  
8 American Case Management Association and I am  
9 a client of McKesson as well as Executive  
10 Health Resources. And finally, since my  
11 application I am now involved in a grant  
12 application for CMS money for care  
13 coordination through the CBO and we're just in  
14 the early stages of that.

15 DR. LEFTWICH: Good morning, I'm  
16 Russell Leftwich. I'm the chief medical  
17 informatics officer for the state of  
18 Tennessee's Office of e-Health Initiatives,  
19 the agency responsible for promoting EHR and  
20 HIT adoption in Tennessee. I've spent a great  
21 deal of time the past eight months as a  
22 volunteer with the Office of National

1 Coordinator's Transitions of Care Initiative  
2 and their standards and interoperability  
3 framework and am the co-lead of the clinical  
4 information model group and the care planning  
5 work group. And I'm a physician advisor for  
6 the American College of Physician's web-based  
7 EHR information resource. I'm glad to be here  
8 and participate, thanks.

9 MS. KLOTZ: Hello, I'm Chris Klotz  
10 and I work as program advisor to the Community  
11 Health Foundation in Western and Central New  
12 York which is based out of Buffalo, New York.  
13 My role there, I have responsibility for  
14 designing and managing large projects and  
15 initiatives, and have had responsibility since  
16 2005 with a series of projects under a care  
17 transitions initiative. And in that role I'm  
18 currently providing technical assistance for  
19 two rural applications for the community-based  
20 care transitions at CMS.

21 DR. FARRIS: I'm Karen Ferris.  
22 I'm a professor from the University of

1 Michigan College of Pharmacy and I have a few  
2 disclosures. I have worked for the past seven  
3 years on a volunteer basis doing work with the  
4 Pharmacy Quality Alliance where we develop  
5 measure concepts around medication use and  
6 pharmacist services. I'm co-PI on an NHLBI  
7 grant based back in Iowa where I was formerly  
8 and that is looking at care transitions and  
9 how pharmacists may improve that transition,  
10 I'll just leave it at that. And I'm  
11 initiating some work in the Battle Creek area  
12 with the Calhoun County group. And we are  
13 wanting to focus on who in fact manages the  
14 med list across their system. And hopefully  
15 we're going to come up with some different  
16 ways of doing that. And last year through PQA  
17 I was offered a speaking opportunity that was  
18 paid by Lilly and then most recently I've been  
19 in some discussions with Merck focused on  
20 medication adherence. And that's a very  
21 limited contract for five hours.

22 MS. DORMAN: HI, my name is Jann

1 Dorman. I work for Kaiser Permanente. I'm  
2 the senior director at our Care Management  
3 Institute and I oversee a portfolio of  
4 initiatives for care delivery improvement and  
5 innovation like palliative care, transitions,  
6 chronic disease management, et cetera. My  
7 disclosure is that takes more than all of my  
8 time and I have no other disclosures to make.

9 (Laughter)

10 MS. ALLER: Hi, I'm Kathleen Aller  
11 with McKesson Provider Technologies. I'm  
12 responsible for implementing quality measures  
13 developed by others within EHRs and for  
14 assisting providers in deploying and using  
15 those measures. But I have no involvement in  
16 creating them.

17 DR. HEURTIN-ROBERTS: Hello, I'm  
18 Suzanne Heurtin-Roberts. I'm with HRSA. My  
19 focus is quality improvement and cancer  
20 prevention and control. I'm on detail to HRSA  
21 from the National Cancer Institute. And the  
22 only thing I can think of that would be any

1 disclosure is I'm on an interagency HHS  
2 committee on quality cancer care and we're  
3 working on developing a pilot study of care  
4 coordination in cancer care. Otherwise no  
5 connections.

6 DR. LINDEKE: Good morning. I'm  
7 Linda Lindeke from Minnesota. I'm a pediatric  
8 nurse practitioner on faculty in the School of  
9 Nursing at the University of Minnesota in the  
10 Center for Children with Special Health Care  
11 Needs. It is funded by the Maternal Child  
12 Health Bureau and we have done a number of  
13 projects. I don't see any conflict. I'm not  
14 funded on any of these projects but I'm in an  
15 advisory capacity to the National Association  
16 of Pediatric Nurse Practitioners, a couple of  
17 AHRQ projects. I'm on the Medical Home  
18 Advisory Committee for the Academy of  
19 Pediatrics and also on an American Nurses  
20 Association Congress in Nursing Practice and  
21 Economics.

22 DR. AUDET: Anne-Marie Audet. I'm

1 vice president for the Program on Health  
2 Quality and Efficiency at the Commonwealth  
3 Fund. And my potential conflict is as a  
4 funder of many projects that are looking at  
5 care coordination. We have our state action  
6 to avoid rehospitalization which is looking at  
7 care transitions in over a hundred hospitals  
8 in three states. We're funding a lot of the -  
9 - we have funded measure development in the  
10 past, right now we're not doing that, but  
11 we're funding some investigators like Steve  
12 James, Jerry Anderson, Eric Coleman, so. And  
13 in that capacity sometimes I do sit on  
14 advisory committees for these projects but  
15 otherwise I have no other conflicts.

16 DR. WAKEFIELD: Bonnie Wakefield,  
17 I'm an investigator in the Health Services  
18 Research Center at the Iowa City VA where we  
19 focus on access, rural health and health  
20 information technologies. I'm also an  
21 associate research professor at the University  
22 of Missouri School of Nursing and I have no



1 disclosures.

2 MS. LEWIS: Good morning. I'm  
3 Julie Lewis. I work for Amedisys which is a  
4 national home health and hospice company. I'm  
5 their vice president of health policy so my  
6 work mostly focuses on developing and piloting  
7 alternative payment delivery models. Because  
8 I haven't been there long I should probably  
9 just add that my most recent job was with  
10 Dartmouth and Brookings working on the ACO  
11 model. So I probably would have had a lot of  
12 conflicts there but I think they're gone now.  
13 So nothing to disclose.

14 DR. CARRILLO: Good morning,  
15 Emilio Carrillo. I'm vice president for  
16 community health at New York Presbyterian  
17 Hospital where I'm very much involved with  
18 grants, contracts and programs in care  
19 coordination with CMS and the state of New  
20 York. I'm associate professor of medicine and  
21 public health at the Weill Cornell Medical  
22 School and sit on the boards of the National

1 Hispanic Medical Association and the United  
2 Way in New York where occasionally there are  
3 issues of care coordination that come my way.  
4 And I lecture and teach culture competency and  
5 cross-cultural communication. I was one of  
6 the founders of the quality interactions  
7 program.

8 MS. POWELL: I'm Eva Powell with  
9 the National Partnership for Women and  
10 Families. And just about everything I do  
11 these days is related to care coordination so  
12 I'll try to hit the high spots. I lead the  
13 health IT program at the National Partnership  
14 and through that role I provide significant  
15 support to ONC specifically on care planning.  
16 I also serve on the Quality Measures Work  
17 Group under the Health IT Policy Committee.  
18 I'm also the co-chair for the Care  
19 Coordination Council for the e-Health  
20 Initiative. I am serving with Russell on the  
21 S&I Framework Transitions of Care Group and  
22 have done a number of things with NQF

1 including the quality data model, structural  
2 measures and some other groups. I also have  
3 worked with the National Transitions of Care  
4 Collaborative specifically on elements related  
5 to health IT. And I serve on the Triple Aim  
6 faculty with IHI.

7 DR. MCNABNEY: My name is Matt  
8 McNabney and I'm a geriatrician at Johns  
9 Hopkins School of Medicine. And I'm the  
10 medical director of our PACE program which is  
11 the Program of All-Inclusive Care for the  
12 Elderly, an outstanding care coordination  
13 model which I must reveal is a bias I have.  
14 I'm also chair of the clinical practice  
15 committee with the American Geriatric Society  
16 and many of our efforts in that committee  
17 focus on care coordination and the health care  
18 home.

19 DR. LEE: Hi, I'm James Lee. I'm  
20 a practicing internist from the Everett  
21 Clinic. That's north of Seattle, Washington.  
22 My current involvement is with our local

1 hospital system, Providence Health, in coming  
2 up with a LEAN approach, taking care of  
3 patients from admission to home. And  
4 previously I was involved in the CMS physician  
5 group demonstration project with the Everett  
6 Clinic. And I don't have any conflict to  
7 disclose today.

8 MS. LOVE: I'm Denise Love. I'm  
9 executive director of the National Association  
10 of Health Data Organizations. I represent and  
11 work with states and private sector data  
12 agencies who are building large-scale claims  
13 databases to measure the cost, quality and  
14 access of care for market and policy purposes.  
15 And so my bias might be that I work with and  
16 promote claims databases for measurement for  
17 public reporting. And we are actively engaged  
18 with many states on all-payer claims databases  
19 and we are this week and going forward engaged  
20 with X12Ns who define implementation guides  
21 and core standards for payer-based reporting  
22 to state and local health departments. And I

1 have no other conflicts.

2 MS. ALEXANDER: Good morning. I'm  
3 Dana Alexander. I'm the chief nursing officer  
4 with GE Healthcare IT. I do represent GE with  
5 its membership for the National Quality Forum  
6 although I understand here I am an individual.  
7 I also chair the Nursing Informatics Working  
8 Group Public Policy Committee with AMIA. I am  
9 a member of the American Organization of Nurse  
10 Executives on their Technology Task Force and  
11 also a member of the HIMSS Nursing Committee.  
12 I do frequent speaking for each of those  
13 organizations but with no financial  
14 reimbursement. Thank you.

15 DR. MALOUIN: Good morning, I'm  
16 Jean Malouin with the University of Michigan.  
17 I'm the associate chair for clinical programs  
18 in family medicine, associate medical director  
19 for ambulatory care there. And most recently  
20 the medical director for our 450-practice  
21 statewide PCMH initiative in Michigan.

22 DR. HOWE: Good morning, Tom Howe,

1 medical director with Aetna with patient  
2 management responsibilities. But also was one  
3 of the organizers of our National Data  
4 Repository which uses existing measures for  
5 measurement of Aetna clinical management and  
6 referral of that information back to  
7 physicians. Also, piloted a PCMH project in  
8 New Jersey and an e-prescribing initiative.  
9 Other than that I don't think I have any  
10 conflicts.

11 DR. LYNN: Good morning, I'm Lorna  
12 Lynn. I work for the American Board of  
13 Internal Medicine where I have developed a  
14 number of practice improvement modules for  
15 physicians to use which put together data from  
16 charts and patient surveys to give them a  
17 picture of the quality of care they provide.  
18 Our ongoing initiative for this year is to  
19 develop a module on care coordination which  
20 Gerri serves on our committee for that. So  
21 that's an area of strong interest and we will  
22 have a viewpoint on that but are also looking

1 to learn from here. Other activities I have  
2 that might be relevant is I recently was a  
3 reviewer for the Pioneer ACO applications. I  
4 have a husband who is a consultant for some  
5 pharmaceutical companies but I honestly always  
6 have to call him and ask them which they are  
7 when I fill out a disclosure form.

8 DR. GREENBERG: Hi, I'm Jeff  
9 Greenberg. I'm associate medical director at  
10 the Brigham and Women's Physician's  
11 Organization, part of Brigham and Women's  
12 Hospital. I'm also a practicing general  
13 internist and I just started practicing at the  
14 Brigham's brand new medical home in Boston.  
15 And nothing else to disclose.

16 DR. SAMAL: I'm Lipika Samal. I'm  
17 also here from Boston, Brigham and Women's.  
18 I'm a primary care doctor and researcher, and  
19 I'm actually one of the speakers. I'm not a  
20 committee member. I have nothing to disclose.

21 MS. HAMMERSMITH: Okay, thank you,  
22 everyone. Are there any committee members on

1 the phone, Lauralei?

2 MS. DORIAN: Not yet. We're  
3 working on the phones but we'll check back in  
4 a few minutes.

5 MS. HAMMERSMITH: Oh, okay.

6 CO-CHAIR CASEY: The only one  
7 person I saw that wasn't here on my list was  
8 Mark Leib.

9 MS. HAMMERSMITH: Okay. All  
10 right.

11 MS. DORIAN: He'll be calling in.  
12 Yes.

13 MS. HAMMERSMITH: Thank you,  
14 everyone, for those disclosures. Is there  
15 anything that you, based on what you've heard  
16 that you want to discuss or any questions you  
17 have for each other or of me regarding the  
18 disclosures? Okay, thank you. Have a good  
19 meeting.

20 MS. DORIAN: Thanks, Ann. And  
21 thank you, everyone. We definitely have a  
22 very impressive group of people and we're



1 grateful to you for taking the time out of  
2 your obviously busy schedules. And thanks to  
3 Don and Gerri as well for the leadership  
4 you'll certainly be providing throughout the  
5 day.

6 So what I'm going to do now is  
7 just go through the agenda of our morning  
8 session and afternoon session. This morning  
9 you'll hear from Wendy Vernon who introduced  
10 herself earlier to talk a little bit about the  
11 NPP's relationship to care coordination  
12 endeavors in the past. And then you'll hear  
13 from Don and Gerri who we're lucky enough have  
14 been involved a lot in care coordination and  
15 performance measures in the past so they can  
16 touch upon some of the things that they've  
17 been involved in, some of the measures that  
18 came in, some of the measures that didn't come  
19 in. And then we are going to hear from Lipika  
20 who will give her presentation on her paper,  
21 her annotated outline. And then Arjun is  
22 going to talk about the findings of his

1 environmental scan.

2           And then during the afternoon  
3 session it'll be quite an interesting session  
4 I think. This is where you guys will really  
5 have the opportunity to set the pathway  
6 forward for the care coordination call for  
7 measures. We'll have a bunch of discussion  
8 questions that we can ask you and feel free to  
9 throw out questions of your own. We'll start  
10 detailing really the pathway forward and shape  
11 the specification within the call for measures  
12 and see what measures maybe are out there  
13 already that we want to encourage to come in.  
14 So it should be quite an interesting session.

15           We've already gone over the  
16 project with you on the orientation call and  
17 I think you've received a lot of documentation  
18 already, but just to remind you that this  
19 project is broken down into phases. That this  
20 first phase really gives you the opportunity  
21 to shape the future of care coordination  
22 measures and that's what's really exciting

1 about it. And so we really want to talk about  
2 where we want to be. And as you've heard in  
3 phase I the environmental scan and white  
4 paper. And then in phase II will be when we  
5 do receive measures and evaluate them through  
6 our CDP process. So does anybody have any  
7 questions so far about the schedule for the  
8 day or any questions about the project?

9 DR. BURSTIN: I just want to add a  
10 tiny bit of additional context. For some of  
11 you who have been on NQF committees for awhile  
12 this is actually quite different. We rarely  
13 have the luxury of sort of a prequel to a  
14 project. We really do see this as trying to  
15 get to that next set of care coordination  
16 measures and you will hear shortly from Don  
17 and Gerri about their efforts when they  
18 chaired the last committee. And we didn't get  
19 as robust a response to that call for measures  
20 as we had hoped so I think our thinking this  
21 time was let's take the chance. We have the  
22 time to actually work with you, think through

1 what we really need, try to sort of prime the  
2 pump of those out there to bring in the  
3 measures we think will really add value. So  
4 we'll talk more about this, but the idea would  
5 be can you help us collectively develop what  
6 we're calling a pathway towards getting those  
7 measures in which is why we're focusing for  
8 example as you'll hear shortly on the paper a  
9 lot of the emphasis is on HIT and it's not  
10 surprising many of you have experience in HIT.  
11 That obviously seems to be a key factor in  
12 bringing in measures that would actually get  
13 us that broader experience with care  
14 coordination.

15 So we'll really be, this is --  
16 you're not going to have to evaluate measures  
17 today, you're not going to do a lot of the  
18 usual work of NQF. You will get to do that  
19 next time but this is really a chance to set  
20 the direction, signal to the measure  
21 development field what's needed and then also  
22 with the help of Lipika and David Bates and

1 the folks at the Brigham then think about what  
2 the HIT infrastructure needs that will help us  
3 get there. So we may not get all those  
4 measures in this cycle, but again you'll at  
5 least be priming that pathway to bringing in  
6 the measures we think really matter. And  
7 you'll hear much more about that from Gerri  
8 and Don, but for any of you who are used to  
9 usual NQF process this is a luxury and I hope  
10 we take good advantage of it.

11 MS. VERNON: Good morning,  
12 everyone. As Helen and Lauralei mentioned I'm  
13 Wendy Vernon and I introduced myself as part  
14 of the National Priorities Partnership group  
15 at NQF. I've been there since 2007 working  
16 with the National Priorities Partners on  
17 providing input most recently to HHS on the  
18 National Quality Strategy. And what we wanted  
19 to do this morning was just give you sort of  
20 an overview of that input so that you, as you  
21 go down this pathway of developing your  
22 pathway for measures that you have some sense

1 of sort of where HHS has been in terms of the  
2 National Quality Strategy as well as what  
3 NPP's most recent input was this past month.  
4 So with that let me just get started. Can you  
5 go to the next slide?

6 So this is just more broadly NQF's  
7 mission but I thought it was important to  
8 point out that NPP is convened by the National  
9 Quality Forum and has been since its  
10 inception. And really NQF's mission, you're  
11 really here addressing the second bullet  
12 around endorsing national consensus standards  
13 sort of leading the path there. But our first  
14 bullet there is on building consensus on  
15 national priorities and goals. And so at NQF  
16 what we really want to make sure is that our  
17 work is interconnected and that we're, you  
18 know, as these priorities are developed and as  
19 our partners support them and others that we  
20 make sure that internally we're also doing our  
21 best to make sure that those priorities and  
22 goals carry through all the work of our

1 steering committees and that it informs your  
2 work moving forward.

3 The third priority area or the  
4 third mission, sorry, piece was around then  
5 promoting the attainment of national goals  
6 through education and outreach. So not only  
7 do we need to set the priorities and goals but  
8 obviously to also help to achieve them through  
9 the work that we do at NQF. So the next  
10 slide.

11 So just a quick overview of NPP.  
12 Most of you are probably familiar, some of you  
13 have participated in a lot of the work that  
14 we've done over the past several years. Some  
15 of you are actually, or your organizations are  
16 on the National Priorities Partnership but  
17 again convened by the NQF. We have about 48  
18 leaders, soon to be 51. We just had a call  
19 for nominations over the summer and we're  
20 waiting for board approval to add additional  
21 federal partners to this group as well as a  
22 couple of new partners. But really as with

1 all of NQF's work aims to be multi-stakeholder  
2 to the greatest extent possible so we include  
3 consumers, purchasers, various quality  
4 alliances. We want to make sure we have a  
5 healthy representation of health care  
6 professionals and providers, and really more  
7 recently have been looking to broaden our  
8 scope beyond the health care delivery system  
9 and really make sure that we're getting into  
10 more state-based organizations. We have the  
11 National Association of Medicaid Directors,  
12 also looking at engaging community work more  
13 fully, and then certainly health plans and  
14 industry representatives. And then you see  
15 our federal partners at the bottom there. NPP  
16 currently co-chaired by Bernie Rosof and Helen  
17 Darling. Next slide.

18           So initially when NPP was formed  
19 there wasn't any type of legislative mandate  
20 around priority-setting, it was -- really the  
21 NQF board felt that this was a void in the  
22 area, that we needed national priorities and



1 some type of common or shared goals to really  
2 help us identify what to measure, what was  
3 important, what we should all be working on.  
4 There are a lot of signals in the field of  
5 various sort of competing priorities. And so  
6 in 2008 NPP released its initial report with  
7 six priority areas but then in 2010 with the  
8 Affordable Care Act there was language in  
9 there about developing a National Quality  
10 Strategy with multi-stakeholder input. And so  
11 HHS contracted with NQF to convene the  
12 National Priorities Partnership with the goal  
13 of really having some type of national  
14 strategy that again would be able to  
15 coordinate and align public and private sector  
16 efforts to get everyone sort of rowing in the  
17 same direction so to speak. Next slide.

18 So with that late last year, so  
19 about a year ago HHS came to NQF again and  
20 said we need input on this National Quality  
21 Strategy that's to be released in early 2011.  
22 And so we provided input. We were pleased to

1 see that in March when the National Quality  
2 Strategy was released that there was pretty  
3 good -- that the priorities and the goals were  
4 fairly well informed by what NPP had  
5 recommended to HHS with a couple of exceptions  
6 which I can talk about sort of as we go  
7 through the different priority areas. But  
8 then this past year then after the release of  
9 the National Quality Strategy they came back  
10 to NPP and really wanted more information on  
11 some more specifics around goals and measures,  
12 some strategic opportunities for how we might  
13 get there and really again to help them make  
14 it more actionable. So they acknowledged that  
15 the first National Quality Strategy was a step  
16 in the right direction but that it really  
17 needed to be made a little more actionable.  
18 So that was where we focused our efforts this  
19 year. And the next slide.

20 And really before we get into the  
21 priorities and goals I just wanted to mention  
22 quickly there are three sets of strategies

1 that you might want to take a look at in your  
2 spare time. I know you've gotten a lot of  
3 reading for this meeting and you have plenty  
4 of other things to read but really wanted to  
5 make sure that we focused on sort of building  
6 these three areas out. And certainly they all  
7 hinge on the ability to measure well or  
8 support measurement. So really emphasizing  
9 that we need some type of national strategy  
10 for data collection and measurement and  
11 reporting, that we need supports for community  
12 infrastructure to be able to undertake  
13 improvement efforts, that we can't just, you  
14 know, say here are priorities and goals,  
15 everyone go forth and do this when we  
16 obviously have a lot of infrastructure needs  
17 that need to be met. And then third,  
18 recognizing that much of this will not come to  
19 fruition if we don't have payment delivery  
20 system reform that supports the achievement of  
21 these priorities and goals.

22 So as we sat down to do the work

1 over this past year of really looking at the  
2 six priority areas that were in the National  
3 Quality Strategy we had a lot of discussions  
4 about what the goals should look like. And  
5 these were sort of our guiding principles.  
6 They may help you as you think through your  
7 work as well. But one of the biggest things  
8 that we talked about was striking a balance  
9 between sort of more immediate and longer term  
10 priorities and goals. And what this really  
11 sort of boiled down to was aspirational versus  
12 achievable. Are we shooting for the moon, you  
13 know, are we asking for too much. And I  
14 think, you know, early on with NPP there  
15 really was this need to really let's aim for  
16 what we want and not be timid. This wasn't a  
17 time for timidity, that you know we do have  
18 some goals where I think the path is  
19 relatively clear of, you know, good evidence  
20 of success but it's still not widespread  
21 enough. And so we certainly want to continue  
22 to focus on some of those areas like around,

1 you know, safety and infections and things  
2 like that. But that there really is so much  
3 more that we could and should be doing. So I  
4 think you'll see as we go through the  
5 priorities and the goals that they really tend  
6 to take on, particularly I think in the care  
7 coordination and person- and family-centered  
8 care areas that they really tend to take on  
9 more of an aspirational where do we want to  
10 be. They really wanted to make sure that we  
11 focused more on health outcomes as opposed to  
12 processes, that we tend to a lot of the times  
13 and I think this came out in much of our care  
14 coordination work in 2010 when we had our Care  
15 Coordination Work Group convening meeting, you  
16 know, we tend to get in discussing a lot about  
17 adults and the elderly, and we really need to  
18 make sure that we're thinking across the  
19 entire life span and taking into account  
20 children and their needs.

21 Health equity was huge and is  
22 always a big point of discussion and we wanted

1 to make sure that we kept that front and  
2 center, that this wasn't just about improving  
3 averages, this was about also closing the gap  
4 between the best performing and those patients  
5 and populations that really need improvement  
6 desperately. Again, I think with the addition  
7 of the partners that extend beyond the walls  
8 of the health care system, wanted to make sure  
9 that we were thinking more broadly beyond  
10 health care delivery. So certainly in the  
11 priority areas that focus more on population  
12 health you'll see that a little bit more, that  
13 we tried to have goals that extended beyond  
14 health care which of course, you know, people  
15 don't live in the health care delivery system  
16 so it's important to meet them where they  
17 live. And then really emphasizing this need  
18 to have flexibility of approaches, that we  
19 can't dictate necessarily from the federal  
20 level how we will achieve these things, that  
21 states and communities really need to have the  
22 flexibility to be innovative and to meet the

1 needs of their specific populations depending  
2 on what their needs are.

3           So this is our rendition of the  
4 Triple Aim essentially, or the three aims.  
5 We're not allowed to call it the Triple Aim.  
6 But you're probably all very familiar with  
7 this, Better Care, Affordable Care, and  
8 Healthy People/Healthy Communities. And in  
9 the middle you'll see these are the priority  
10 areas of the National Quality Strategy. They  
11 are all in the middle because they are all --  
12 they all have some impact on each of the three  
13 areas, they're all interrelated. We don't see  
14 plucking one priority out necessarily and just  
15 talking about the goals within that priority  
16 area. And you'll see sort of as -- I think  
17 this is the one area where I could dive into  
18 each and every one of these areas and figure  
19 out how it, you know, care coordination is so  
20 critically important in all of them. So what  
21 I'm going to focus on today a little more in  
22 detail is the person- and family-centered care

1 and the effective communication and care  
2 coordination priority areas, but you'll see  
3 how obviously all of these are impacted by  
4 care coordination. So the next slide.

5 So this is the first priority area  
6 and I'm going to go through these pretty  
7 quickly but you have them and certainly if you  
8 have any other questions about the specifics  
9 I'm happy to answer them. But essentially for  
10 the first two priority areas, for health and  
11 well-being and then for the preventing and  
12 treatment of the leading causes of mortality  
13 which will be on the next slide, the  
14 subcommittee that was focused on this really  
15 wanted to make sure that we got at three  
16 different levels of improvement, that we  
17 focused on things that could be done at the  
18 community level, community-level supports,  
19 policies, those types of things, things that  
20 could be achieved by individuals that were  
21 really focused on healthy lifestyle behaviors,  
22 and then things that could be impacted by the



1 delivery of clinical preventive services. And  
2 so obviously when you look at the measure  
3 concepts and some of the things that NPP was  
4 encouraging HHS to look to when selecting  
5 measures you can see things that very clearly  
6 need improved care coordination, mental  
7 health, oral health. So any type of  
8 prevention activity certainly you need to have  
9 effective care coordination.

10 So the next slide is really  
11 getting at the prevention and treatment of  
12 cardiovascular disease. HHS indicated and now  
13 they have a Million Hearts initiative that's  
14 geared at really improving cardiovascular  
15 disease. And so again you'll see that three-  
16 part goal strategy around community  
17 interventions, healthy lifestyle behaviors and  
18 clinical preventive services. And really  
19 emphasizing there addressing tobacco use,  
20 making sure that there's better control for  
21 patients who have high blood pressure and high  
22 cholesterol, that we address some of the

1 dietary problems that people have access to  
2 healthy foods, et cetera.

3           The next one is patient safety and  
4 I sort of wish that I'd flipped the slides  
5 again. I thought about that this morning when  
6 I woke up. But because the original NPP work  
7 included admissions or preventable  
8 readmissions in the care coordination priority  
9 area but as the National Quality Strategy came  
10 out HHS really framed this more under safety  
11 and so we included it there as well. And so  
12 this really mirrors the work of the  
13 Partnership for Patients that's currently  
14 underway through HHS and CMMI. And so NPP  
15 decided we really just need to reinforce the  
16 work that's going on there. But in addition  
17 to emphasizing hospital readmissions which is  
18 what the Partnership for Patients is focusing  
19 on, NPP really felt it was important to focus  
20 also on hospital admissions. So looking at  
21 admissions for ambulatory-sensitive  
22 conditions, obviously also a strong need for

1 care coordination there.

2 And then the other thing that we  
3 wanted to do was, in addition to the areas of  
4 safety, the healthcare-associated conditions  
5 that HHS had identified with the Partnership  
6 for Patients which are in very fine print at  
7 the bottom, but they're things like  
8 healthcare-associated infections and UTI and  
9 bloodstream infections and falls and pressure  
10 ulcers. Really wanted to make sure that we  
11 also tackled some of these areas of  
12 inappropriate care that can also be harmful to  
13 patients. So that's where you see the  
14 inappropriate medication use in polypharmacy,  
15 some of the inappropriate maternity care which  
16 was the work of NPP's earlier overuse work  
17 group.

18 And then before we launch into the  
19 two priority areas which I felt like were  
20 really important to this work in terms of  
21 affordable care this is a priority area on its  
22 own. HHS had not really got a lot of detail

1 in the National Quality Strategy around  
2 affordable care and so this group really spent  
3 a lot of time talking about what was going to  
4 be important to patients and to employers and  
5 to the federal government. And so we looked  
6 a lot at things that got at consumer  
7 affordability and insurance coverage and  
8 whether patients were able to obtain needed  
9 care in addition to sort of those bigger  
10 numbers around, you know, our continually  
11 escalating health care expenditures nationally  
12 and at the state level.

13 So as we looked to patient- and  
14 family-centered care this is really I think  
15 one of the areas where care coordination is  
16 obviously critically important. The care  
17 needs to be focused on the patient to ensure  
18 that they have a positive experience of care  
19 and that they're getting high-quality and safe  
20 care, that their care is accessible, all of  
21 those things very important for this group to  
22 consider I think. Using a shared decision-

1 making process and developing care plans,  
2 really enabling patients and their families to  
3 navigate and coordinate their care. And these  
4 actually mirror the original goals of NPP.  
5 It's things that NPP partners have really been  
6 espousing for several years and I think these  
7 really resonate with the field as things that  
8 are important. As we got into measure  
9 concepts, you know, we certainly had some  
10 areas around experience that we can look to.  
11 Really wanted to start to get into whether  
12 patients felt like they had the confidence to  
13 manage chronic conditions and I think before  
14 I even go to the next slide, these two really  
15 I think emphasize how interrelated these two  
16 priority areas are because it was really hard  
17 for the subcommittee that worked on this to  
18 sort of tease them apart. So it's kind of  
19 like where can we -- HHS asked us for three  
20 goals for priority area, two measures per  
21 goal, and it was sort of like where can we get  
22 in these various concepts that we feel are so

1 important while sticking to this, you know,  
2 wanting to have a parsimonious set and not  
3 really I think, you know, they really could  
4 have gone much broader and included a lot more  
5 goals, but really trying to keep it to a  
6 limited number -- used I think these two  
7 priority areas to really try to get in a lot  
8 of important concepts. And I think as you go  
9 through talking about what your pathway  
10 forward is I hope that this will be sort of  
11 helpful in seeing where NPP feels like the  
12 important areas are and how we might be able  
13 to get there. So the next slide.

14 This focuses on, and it's played  
15 out a lot more in detail in the report but  
16 certainly looking at some of the measure gap  
17 areas and where NPP felt like more nationally  
18 there were gaps. And this is probably an  
19 important place to stop and talk about the  
20 types of measures that NPP was really looking  
21 at. So HHS wanted measures to monitor  
22 national progress. So when we looked at what

1 types of measures to recommend back to them we  
2 really looked at things that were already  
3 reported in like AHRQ's health care and  
4 disparities report and some of the  
5 Commonwealth Fund reports that come out,  
6 things that are already out there that have  
7 been in use for awhile to look at some of  
8 these things. So, you know, as you go through  
9 your work obviously the -- and I have a slide  
10 that will play this out in a moment in a  
11 little more detail but you know, what types of  
12 things at the provider or the health care  
13 professional level when you're thinking about  
14 accountability could help to support those.  
15 So in terms of these measure gaps what NPP was  
16 really wanting to see was that we would have  
17 sort of this national composite of really how  
18 patients and families are experiencing their  
19 care, that we would have some national  
20 indicator of the breadth of use of experience  
21 surveys, and that we would have a national  
22 type of measure to really assess whether

1 patients have these longitudinal care plans  
2 across time that aren't just, you know,  
3 discharge plans as they're coming out of the  
4 hospital and that they integrate shared  
5 decision-making. So really in this area the  
6 NPP felt like there was a lot of room for  
7 measure development in terms of what we would  
8 want to measure progress by at a much bigger  
9 sort of population level which I think is  
10 different from what you will probably be  
11 looking at in your work, but I hope that this  
12 can help to sort of guide that a little bit.

13           So, for effective communication  
14 and care coordination got into a lot of  
15 discussion about the importance of the quality  
16 of care transitions and communications across  
17 settings. Wanted to ensure that we, and this  
18 is where the earlier work of NPP had a  
19 priority area focused on palliative and end of  
20 life care which did not make it into the  
21 National Quality Strategy. So NPP felt it was  
22 important to, you know, provide input to HHS



1 on the priority areas as they come out in the  
2 National Quality Strategy, but to continue to  
3 emphasize the importance of palliative care,  
4 end of life care, really looking at the care  
5 that patients with chronic illness and  
6 disability need. And so this was if you will  
7 sort of that got snuck in I guess you could  
8 say. So wanting to make sure that the care  
9 coordination, I think this came out in the NPP  
10 work that we did, was really in the eyes of  
11 the recipient, that it's not something -- care  
12 transitions or good care coordination is not  
13 what we say it is, it's what the patients  
14 experience and what they feel they have been  
15 prepared to do and to manage. And so you know  
16 a lot of that gets back to quality of life and  
17 experience.

18 And then the third goal area is  
19 really a challenging one and it was really  
20 trying to push this notion of how do we get at  
21 this shared accountability. And obviously  
22 there's a lot of work going on in this area

1 right now but really how do we determine  
2 whether there is better communication. How do  
3 we determine whether there's good coordination  
4 between the health care delivery system and  
5 the community resources and supports? How do  
6 monitor that and watch for improvement there?  
7 And so I think that again is an area of  
8 difficulty for measurement, I think, but  
9 hopefully we're starting to blaze new trails  
10 there.

11 So you can see some of the measure  
12 concepts again. We wanted to incorporate some  
13 of the earlier palliative work. NQF does have  
14 a palliative steering committee doing work  
15 there. So, but you can sort of see  
16 emphasizing again care transitions and control  
17 of chronic diseases, and really looking again  
18 at those outcomes.

19 In terms of measure gaps, again,  
20 you know, we have measures of experience of  
21 care transitions, Eric Coleman's measure, but  
22 it's not something that we're really able to

1 look at yet at a broader population level and  
2 so that's really what NPP was desirous to see,  
3 if there are measures out there that can sort  
4 of look more broadly at how as a nation we're  
5 doing. How as a nation are we doing with  
6 having complete transition records? Are we  
7 doing better with chronic disease control?  
8 How are we doing in providing care that's  
9 concordant with patient's wishes, whether end  
10 of life or other? And so a lot of work to be  
11 done here and a lot of blank spaces where, in  
12 some of the other areas, for the health and  
13 well-being areas for example we had a lot that  
14 we could pull from because there are a lot of  
15 measures that are being reported at the  
16 national level through Healthy People 2020 for  
17 example that we could sort of say these are  
18 things that we would like to emphasize as part  
19 of the National Quality Strategy. But in this  
20 area really still rather limited in what we  
21 could pull from. So, the next slide.

22 So, this is my very rudimentary

1 slide. And some of you may hear us talk about  
2 a measurement cascade, or rolling up and  
3 rolling down of measures. And it's very small  
4 print, but essentially what we're trying to  
5 demonstrate here is that we have these  
6 national goals. So if the national goal is  
7 around, you know, improving patient experience  
8 across the board, that nationally wouldn't it  
9 be great if a hundred percent of our patient  
10 population experienced positive care  
11 transitions. Then what does that mean needs  
12 to happen at a state level, at a health plan  
13 level? What would we need to measure at a  
14 provider level, at a clinician level or even  
15 at a patient consumer level? Which is, you  
16 know, the patient-consumer is sort of  
17 throughout this. But on the far right side  
18 all of those boxes going down really stem from  
19 that top one, that you know, states could  
20 measure how their patient populations are  
21 doing on care transitions. Health plans could  
22 look at their populations and how they're

1 doing. Providers, clinicians, all of those  
2 could look at that as sort of a guiding star  
3 of what's important. But then you might also  
4 think about are there standard things that are  
5 being included in care plans, and are health  
6 plans ensuring that their network providers  
7 are including those. I can't even read my own  
8 things there now, that's really sad. But  
9 essentially what we're trying to show here is  
10 that it may not be that what's measured at a  
11 national level is what we need to measure at  
12 a provider. I think there are opportunities  
13 where it could be. But what at a  
14 provider/clinician level would feed into that?  
15 So what are the most essential things that we  
16 would want to measure to ensure that we had  
17 positive care transitions for all of our  
18 patients? So again, very rudimentary and not  
19 in any way evidence-based, it was just my  
20 thought process. So if you go back to it keep  
21 that in mind.

22 This slide really just sort of

1 encompasses the sort of vision for the  
2 National Quality Strategy is that really we  
3 get on the same page. We're all working  
4 towards the same things, we're all rowing the  
5 same directions. And so I won't belabor this  
6 but just wanted to include it to demonstrate  
7 that we're really hoping that we start to see  
8 unified signals. We've seen some good  
9 evidence so far. I think, Helen, you were the  
10 one who discovered SAMHSA's framework that  
11 they had developed for their patient  
12 population which mirrored the National Quality  
13 Strategy to a tee. They basically took the  
14 goals of the National Quality Strategy and the  
15 work that we were doing at the time with our  
16 Healthy People/Healthy Communities  
17 subcommittee and looked at it for their  
18 population. So for care coordination or for  
19 the safety area, for example, for readmissions  
20 they wanted to see the patient populations  
21 that are most important to SAMHSA, how are  
22 they doing with readmissions and preventable

1 readmissions. How are they doing on some of  
2 these other areas. So it was really, really  
3 promising to see that and hope that we  
4 continue to see more examples of how, you  
5 know, federal but also the private sector is  
6 embracing this and starting to align behind  
7 it.

8 I think there's one more slide.  
9 This just essentially wanted to communicate  
10 sort of that at NQF and as part of the  
11 measurement enterprise sort of how we see the  
12 priorities kind of being the starting point  
13 of, you know, what are the goal areas that we  
14 want to make sure we emphasize. We also have  
15 a list of high-impact conditions. And then as  
16 we go through, how does that inform the  
17 endorsement process which is why we feel it's  
18 important to make sure that we sort of set up  
19 the work of these steering committees with  
20 just a brief overview of the NPP and the  
21 National Quality Strategy. And then how does  
22 that trickle down and how -- what's needed at

1 various levels with the electronic data  
2 platform and aligning environmental drivers.  
3 And you can see some of the other work that  
4 NQF is undertaking to try to get all of this  
5 sort of moving in this same direction, and  
6 that all of our various work is aligned around  
7 these. So I think with that I will stop.  
8 I've used all my time.

9 MS. DORIAN: Thank you. Does  
10 anybody have any questions for Wendy? And by  
11 the way, we have asked for the heat to be  
12 turned up in case of you are feeling chilly.

13 DR. CARRILLO: Very comprehensive  
14 and really aligns very nicely. I do have a  
15 comment. And you know, kind of like the horse  
16 is out of the barn so it's just probably a  
17 comment. It's that in, you know, almost 10  
18 years ago the Institute of Medicine's Unequal  
19 Care showed that we have a huge problem in  
20 this country with inequities in care. And as  
21 the IOM pointed out a lot of that, a  
22 significant portion of that is driven by



1 communication. And so when we talk about  
2 effective communication and care coordination  
3 I really see very little if anything about  
4 cross-cultural communication, cultural  
5 competency, health literacy, language  
6 interpretation, translation which are huge,  
7 huge issues. So, again, there is mention of  
8 cultural sensitivity, there are the patient-  
9 centered goals, but I think that more  
10 attention to that would have been positive.

11 CO-CHAIR CASEY: I think that's a  
12 great point, Juan, and something that, you  
13 know, when we talked about it before in the  
14 previous steering committee it did come up in  
15 spades but I don't think it made it with the  
16 clarity that you're asking for, and I think  
17 that's something we've got to keep in mind  
18 throughout this deliberation, so thank you.

19 DR. BURSTIN: I'll also just add  
20 that Nicole is actually leading our parallel  
21 disparities committee which is doing a call  
22 for crosscutting measures. Actually, Emilio

1 was the chair of our Cultural Competency and  
2 Disparities Committee this last round so we  
3 actually specifically wanted him on this  
4 committee to make sure we made those  
5 connections as well to the disparities and  
6 cultural competency side. But again, you  
7 know, if you know of particular areas and  
8 measures that would be appropriate we could  
9 easily figure out which project to bring them  
10 to.

11 MS. DORIAN: Okay, I think with  
12 that thank you very much, Wendy. I'll hand it  
13 over to Don and Gerri now to go through some  
14 past work.

15 CO-CHAIR LAMB: Okay, we're  
16 entering now the background and context-  
17 setting which Wendy just started for us with  
18 the National Priorities Partnership. And  
19 again, I think as we look around the room we  
20 have tremendous expertise and diversity. And  
21 I think Don and I would like to emphasize what  
22 Helen started us out with. It is an

1 extraordinary opportunity here somewhat  
2 unusual. In NQF's usual processes is for us  
3 to be able to step back and look at the work  
4 that's gone on in care coordination and to  
5 rethink, reframe, revise if we need to, add to  
6 it in terms of setting a direction for a  
7 measurement of care coordination. Again, if  
8 we take a look at the stages of the work ahead  
9 of us today is really that process of what do  
10 we want in terms of setting that pathway  
11 towards the call for measures, the evaluation  
12 of measures and to invite all of us to think  
13 about what is meaningful measurement of care  
14 coordination. So where have we been, where do  
15 we want to go and to set the pathway.

16 So this morning what Don and I are  
17 going to start off with is a little bit of the  
18 background on the initial work on the steering  
19 committee. We have individuals in our group  
20 who sat on that steering committee and so we  
21 will also draw from that experience. But what  
22 we also want to do is lay out for you the

1 assumptions that we made and some of the  
2 general premises not so that we can put them  
3 in stone and say this is the way we need to  
4 proceed, but to open them up and say do they  
5 still make sense. In this stage of moving  
6 forward do we still support those premises,  
7 should they be guiding principles, do we want  
8 to add to them, and so forth. So we're going  
9 to do some context work here and invite all of  
10 you to join in. And then we will have the  
11 invited papers which will then lead into the  
12 afternoon and the afternoon will be our  
13 discussion of setting that pathway forward.  
14 So before I go through these slides, Don,  
15 would you like to?

16 CO-CHAIR CASEY: Well, I echo  
17 Gerri's sentiments about having you. This is  
18 a great group. And you know, I sort of view  
19 the work as in two parts, just to summarize.  
20 And I think if we could put Wendy's slide 28  
21 back up that might help because I think that's  
22 an excellent sort of framework for us to think

1 about -- is that? I'm sorry, the next one.

2 Yes.

3 So, there are really two parts to  
4 the work we're doing, and one is that there's  
5 going to be a very specific focus on that  
6 second set of boxes there around performance  
7 measurement and the NQF endorsement process.  
8 So that will be a major part of the work we  
9 will do. And as you know, one of the goals is  
10 to frame the request for measure submission.  
11 But then I think throughout the work now when  
12 we do the performance measure evaluation and  
13 afterward you're going to really sort of help  
14 us look at that entire slide vis-a-vis all the  
15 different moving parts that are up there, not  
16 to so much reconstruct everything, but to  
17 build on it, to enhance it, to add things like  
18 Emilio mentioned so the we continue to move  
19 forward with this for the future. I'm glad  
20 the room next door agrees with me.

21 (Laughter)

22 CO-CHAIR CASEY: I planned that

1 perfectly. That what you're really trying to  
2 do is to inform current and future measure  
3 developers in this field to bring forward new  
4 strategies, innovations, the implementation of  
5 information systems to help us achieve those  
6 goals that Wendy talked about. And I think  
7 those are really the two important priorities  
8 to keep in your mind throughout this. That  
9 first part will be very technical, that  
10 performance measure evaluation and we have  
11 certain rules and criteria that we use to  
12 evaluate that. So you'll, if you're not  
13 familiar with this, need to become very  
14 familiar with it. So I just think, Gerri,  
15 having that two-part mindset always in tow  
16 will be important throughout this process.

17 CO-CHAIR LAMB: We would encourage  
18 you as we go through these discussions this  
19 morning, jot down notes for yourselves so that  
20 when we get to the roadmap we can really kind  
21 of pull in all of those pieces as well. Can  
22 you move forward on the slides, please? Okay.

1           The earlier work that you have in  
2           your packets -- go back one, please. There we  
3           go. Okay. The previous consensus report, the  
4           2010 report which you have was very much  
5           framed by the work that happened in 2006, the  
6           NQF definition and framework for measuring and  
7           reporting care coordination. And we'll hit  
8           the highlights of that in just a bit. The  
9           importance of that is it really did frame the  
10          call for measures and the evaluation of the  
11          measures. And Karen and Christine, as members  
12          of that committee if you want to jump in  
13          anywhere you just feel free. And so having  
14          that definition and the domains of care  
15          coordination was really foundational to the  
16          work in the 2010 report.

17                 And then as we get into the 2010  
18          report we're going to draw your attention not  
19          only to the measures that were submitted and  
20          the ones that were sent forward for  
21          recommendation but where some of the strengths  
22          and the gaps were as well, plus the premises.

1 And we in the first committee spent a lot of  
2 time talking about those premises, what would  
3 be the guiding principles that would assist us  
4 in the evaluation. So we wanted to highlight  
5 some of those for you as well. Next slide.

6 Okay, just a reminder, this is the  
7 NQF-endorsed definition and it goes with the  
8 framework. It is that in that document that  
9 guided the call for measures as well as the  
10 review of the measures care coordination is a  
11 function that helps ensure that the patient's  
12 needs and preferences for health services and  
13 information-sharing across people, functions  
14 and sites are met over time. And as I'm sure  
15 all of you know there's been a lot of writing  
16 and discussion on definitions of care  
17 coordination and we'll be hearing more about  
18 that later in the invited papers in terms of  
19 what are -- what are being looked at in terms  
20 of the components of care coordination, the  
21 domains, so that we can also look at do we  
22 want to add anything, think anything is



1 missing from the way that it has been defined  
2 in the past. As Don was saying, the intent  
3 here is not to start from scratch, it is  
4 really to build and refine on what has gone  
5 before. Next one.

6 CO-CHAIR CASEY: Gerri, could I  
7 just?

8 CO-CHAIR LAMB: Of course.

9 CO-CHAIR CASEY: Before you do  
10 that maybe as the, I guess, historian, go  
11 back. In 2006, if you could go back to the  
12 last slide. Thank you. We were actually what  
13 is referred to as a technical expert panel,  
14 not a steering committee, and we were  
15 subservient to a steering committee that was  
16 looking at a whole host of global measures.  
17 And as I think I mentioned on the call, when  
18 we put the call out for measures I think we  
19 got two or three and we adopted I think one or  
20 two. I think the CTM3 measure put forward by  
21 Eric Coleman was one of those. But it was  
22 very clear to us as, and I was the chair, not

1 the expert. There were a lot of experts as we  
2 went around the room thinking about this.  
3 Even the experts couldn't define very clearly  
4 amongst themselves what care coordination was  
5 and couldn't articulate where they thought  
6 real opportunities for measurement were that  
7 were explicitly available in the environment.  
8 So you know, I do think that this carried us  
9 forward into the steering committee that was  
10 the last one. But I think that's important to  
11 mention, that this has been a total work in  
12 progress, and the amount of work that we've  
13 accomplished in the past five years has been  
14 enormous but really still very much a starting  
15 point. So just recall that this is, again,  
16 thoughtfully put together with a lot of input  
17 from the membership, voted upon and agreed  
18 upon by NQF.

19 CO-CHAIR LAMB: To add to that  
20 too, those of you who are familiar with the  
21 AHRQ Atlas on care coordination measures  
22 probably remember that in the opening pages

1 they talked about reviewing more than 40  
2 definitions of care coordination and creating  
3 an amalgam that we'll see later. So again, to  
4 echo this is emergent. It's also, as we all  
5 know, moving very quickly. Next slide.

6           Going back to the endorsed  
7 definition and framework. These are the five  
8 key domains that were identified in the 2006  
9 work and these again were the domains that  
10 guided the call for measures as well as  
11 practices. We have health care home, plan of  
12 care, communication, information systems and  
13 transitions. Might note here in terms of the  
14 previous work there has been a lot of  
15 discussion of transitions and that focus has  
16 received a lot of attention. But as you can  
17 see the framework has five domains and we'll  
18 go into a little bit more about the measures  
19 that were received. Also, if you go back to  
20 the definition in framework there is a  
21 definition of each of these domains and a  
22 description of them. Those are also I

1 believe, and Nicole can correct me, are also  
2 in the consensus report. Next slide.

3 So the intent here as Don has said  
4 was to -- of the first committee that resulted  
5 in the 2010 report was to set the stage. It  
6 was also to accelerate future work so that it  
7 was meant as a base. And we have the benefit  
8 of having that work but not to be limited by  
9 it. Some of the areas that we wanted just to  
10 go through so that we could revisit them  
11 later, and if you have comments please, you  
12 know, make them, is that if you look on pages  
13 39, 40 and 41 of the consensus report and we  
14 would encourage you to take a look at that,  
15 there were some foundational premises that the  
16 first committee established related to care  
17 coordination that also framed the review of  
18 the performance measures. And we'll hit just  
19 a couple of them here but they are outlined  
20 and described on 39, 40 and 41.

21 The first premise was that care  
22 coordination was relevant to all patients. So

1 that what drove the thinking was that all  
2 patients needed some aspect, some degree of  
3 care coordination, okay, and that it, number  
4 two, varied in intensity. So that there was  
5 considerable discussion as we'll get into  
6 later this afternoon about care coordination,  
7 case management, how do we titrate for risk  
8 levels and to be able to at least for this  
9 first kind of pass at this work we set the  
10 premise that care coordination existed on a  
11 continuum of intensity and that we were not  
12 going to segment out case management practice,  
13 okay? So that it allowed us to look at care  
14 coordination as a whole rather than beginning  
15 to say what's care coordination that everybody  
16 needs, what's case management, how are we  
17 going to risk adjust so that we could stay  
18 focused and look at care coordination,  
19 understanding that we really did not address  
20 case management and risk level in great  
21 detail. So far so good? Okay.

22 And that care coordination could

1 be a function that existed, could be delivered  
2 at the individual team and the organizational  
3 level. And so with all those implications for  
4 measurement. And consistent I think with what  
5 you heard Wendy say is that the first steering  
6 committee felt that the patient and family  
7 experience and perspective on care  
8 coordination had to be front and center, that  
9 that was absolutely critical to this work.

10 We also did have another  
11 assumption related to outcomes, the focus on  
12 outcomes and to guide the measurement work was  
13 to focus on those aspects of care coordination  
14 that had evidence linking them to important  
15 value-laden outcomes. We also had an area  
16 importantly that we affectionately labeled the  
17 gray zone in terms of what we wanted to start  
18 with in terms of care coordination measures.  
19 And as you'll see, after the call for measures  
20 77 measures were submitted. And some of them  
21 were condition-specific, some of them were  
22 specifically about appointment-keeping or

1 making, some of them were following treatment  
2 guidelines. And to get our arms around what  
3 is this thing called care coordination because  
4 we agreed that it could be linked to so many  
5 things that, you know, making appointments,  
6 yes, it is part of it. However, where do we  
7 want to focus meaningful measurement? So for  
8 this starting work we established that the  
9 measures needed to cross providers and  
10 settings so that in some way it approached  
11 that whole aspect of care coordination that  
12 happens at the intersection between providers  
13 and settings. It's not merely following  
14 treatment guidelines. Important, but that was  
15 not the centrality of care coordination. And  
16 so you can see our effort and the struggle we  
17 had in terms of centering on what is important  
18 about care coordination. And so for the  
19 purposes of this first go-around we said the  
20 measures that were sent in, if they were only  
21 did we follow treatment guidelines, that  
22 didn't capture where we were going. If it was

1 making an appointment for somebody after they  
2 left the hospital, important, but it wasn't  
3 where we wanted to center, okay? And again,  
4 we're throwing out these assumptions and gray  
5 areas for your deliberation and our  
6 deliberation together about where do we want  
7 to be. Don or Karen or Chris?

8 CO-CHAIR CASEY: Well, I -- Gerri,  
9 thank you for putting this backdrop together  
10 because I think it helps. I would totally  
11 agree with this framework and I will say that  
12 to take your points ahead a little bit further  
13 this challenge of having very shall I say  
14 strong-willed experts around the table who are  
15 very good at what they do in their own context  
16 was something that we struggled with because  
17 everyone had their own perspective. And I  
18 think what we ended up trying to challenge the  
19 group with is to get out of that for the  
20 moment and try to put in the center what the  
21 team would look like and understand that for  
22 example, I'll make it up because I practiced



1 primary care for 20 years, that a primary care  
2 physician ought to be really, really good at  
3 some of the things that he or she thinks  
4 aren't necessarily part of their job to do to  
5 coordinate care. So I'm just giving you that  
6 example as something that we tried to think  
7 about in terms of making this crosscutting  
8 across the traditional boundaries of how we  
9 coordinate care now. And so it's not to say  
10 that one is not important than the other but  
11 to bring that sort of equality to the  
12 forefront so that at any moment in time  
13 whoever is dealing with the patient directly  
14 is in part taking the lead for helping the  
15 patient make decisions about how to coordinate  
16 care better.

17 DR. BURSTIN: I just one  
18 additional thing to add. I think many of the  
19 measures we saw last time that were condition-  
20 specific were actually more about referral to  
21 specialists. So if you've been seeing an ED  
22 and you've had a headache you should have seen

1 a neurologist. If you've had X you should see  
2 so-and-so. And I think our feeling with that  
3 did not feel care coordination-like at all and  
4 very far off scope for the people who are also  
5 around the table and the expertise they  
6 brought to the table. So we tabled, for the  
7 most part said those didn't fit. But I want  
8 to be a little careful about things like  
9 appointment-making or keeping because there  
10 actually may be really important aspects in  
11 there that would be really important. If you  
12 think about, you know, Bill's role from the  
13 ED, ensuring that follow-up got done, or  
14 ensuring that somebody leaves the hospital and  
15 has that appointment, or has some kind of  
16 follow-up may be generalizable enough and  
17 important enough that I think we'd want to  
18 even potentially consider those.

19 I know Anne-Marie supported some  
20 work that NCQA and Hopkins had done about  
21 closing the referral loop, very broad-based  
22 kinds of concepts. I don't want them to think

1 those are off the table, but you know, I think  
2 we're trying to stay out of the box of every  
3 condition, every specialty having a slightly  
4 different way to approach this and try to keep  
5 this sort of very important national quality  
6 strategy as very crosscutting.

7 CO-CHAIR CASEY: You know, Helen,  
8 that's a great example of one of the  
9 challenges we had. Because our discussion was  
10 okay, so you've made an appointment for this  
11 person and this person has the appointment.  
12 Now what? And so, you know, that was kind of  
13 like the measure didn't capture the now what,  
14 and so that's why I think what Helen is trying  
15 to say is appointments are really important to  
16 care coordination but we've got to know what  
17 else is going on to be sure things are carried  
18 forward. So we were trying to be  
19 intentionally I think thoughtful about being  
20 sure that we didn't make just the transactions  
21 in and of themselves the measure of care  
22 coordination alone, that it had to fit with

1 something else.

2 I also believe that the other part  
3 that I continually remind myself about was  
4 piqued by Emilio's challenge about disparities  
5 because I was scratching my head going damn,  
6 I thought we worked on that. And so let me  
7 refer to page 38 of the document. And Helen,  
8 this is something that I think we probably  
9 need to do a little bit more work with on the  
10 committee with Lauralei is that we started by  
11 also calling out existing NQF-endorsed  
12 measures and frameworks. And so you'll see,  
13 Emilio, that we looked very closely at the  
14 cultural competency measures that were in  
15 here, the preferred practices I should say,  
16 and included them in this document. So I just  
17 think we need to call out the continuous  
18 update of the NQF treasure trove now.

19 And you can see other examples of  
20 it. For example, on page 17 there are  
21 opportunities for measurement based upon  
22 existing measures that might not have been

1 initially endorsed specifically for care  
2 coordination but may actually fit the paradigm  
3 going forward of being supportive of that. So  
4 you know, we've got -- I think my final  
5 message here is we've got a lot of opportunity  
6 to look at what we've got and just try to  
7 coordinate that better. So.

8 MS. KLOTZ: Yes, I just wanted to,  
9 having participated in that steering committee  
10 just kind of reiterate what you're saying.  
11 There was some frustration, I think, amongst  
12 all of us as we looked at the number of  
13 measures that came in and realized how few  
14 really looked at the issue of care  
15 coordination. And I'm hopeful that in the  
16 couple of years that have gone by since those  
17 that maybe some people who were looking at  
18 those in a more narrow way have now really  
19 understood that they have to look at it for  
20 the full connection of that coordination loop  
21 and that maybe this time we'll get something  
22 good.

1 CO-CHAIR CASEY: You know, Chris,  
2 Chris was really great. I think we were in  
3 one of the subgroups together and I think that  
4 you know the other opportunity we had in that  
5 context was we didn't just sweep the measures  
6 away. What we did was we provided very  
7 thoughtful and constructive feedback to the  
8 measure developers who brought measures  
9 forward to say can you just go back and start  
10 re-framing this part of what you're looking  
11 at. And I think, Helen, that is another  
12 opportunity for us is to give constructive  
13 feedback to measure developers who bring  
14 things forward, who don't quite get across the  
15 threshold of us bringing them for endorsement,  
16 but could give them actual guidance by saying  
17 look at this or add this. So I think that's  
18 another rule to keep in mind here that's a  
19 little nuanced but is something that I think  
20 we should.

21 DR. BURSTIN: Well, and actually  
22 one very concrete example. Last year Brandeis

1 did some work for CMS as part of a measure  
2 they had put forward to us on readmissions,  
3 follow-up care and preventable ED use. And  
4 the committee at the time just looked at it  
5 and said, you know, we get the readmission  
6 part, we understand why you may want a  
7 composite that looks at ED use in follow-up  
8 but as stand-alones there are lots of issues  
9 with both those measures. So we agreed they  
10 were reasonable as sort of a control of the  
11 overall measure, but as an example of the  
12 measure that was follow-up I think it was  
13 within I think 10 days after the  
14 hospitalization. One of the main concerns  
15 actually raised by a lot of the leading people  
16 in care coordination said but you don't need  
17 a doctor visit. I mean, this could be in your  
18 home, this could be a home care visit.  
19 There's no way, that that measure just didn't  
20 reach the bar because they were so exclusively  
21 focused on was there a CPT code for an in-  
22 office visit. So those are opportunities for

1 us to go back to developers like that as well  
2 and say, you know, this actually could be a  
3 very useful measure if you thought more  
4 broadly and conceptually of what care  
5 coordination could really bring to the table.

6 DR. GREENBERG: Yes, I wonder if -  
7 - is there any thought to doing this in phases  
8 similar to the way meaningful use was done in  
9 phases with sort of low bars in phase I that  
10 get progressively more intensive over time?  
11 Some of the measures that you seem to be  
12 tossing off I think would do a lot of good in  
13 the short term. Making sure that sick  
14 patients do have a follow-up in a short period  
15 of time with the right provider would I think  
16 benefit a lot of patients and would force  
17 providers to improve their access which is a  
18 huge problem at least for I think many people.  
19 So sure, we'd rather know that they're doing  
20 medication reconciliation and filling out a  
21 care plan and doing all sorts of things, but  
22 you know, if by next year or a couple of years



1 we just knew that patients were getting  
2 appropriate follow-up I think we'd be in a  
3 much better place than we are right now. And  
4 maybe think about these other things down the  
5 road once IT systems are set up that we can  
6 use to ensure those things and hold people  
7 accountable.

8 CO-CHAIR LAMB: I think, you know,  
9 that's an excellent point. And if we think  
10 about this work in terms of opportunity and  
11 incremental build I would also suggest that if  
12 we begin to take a look at the patient-  
13 centeredness piece is what are those critical  
14 junctures that are important to the patient.  
15 Is, you know, perhaps from the flow of care  
16 getting an appointment is meaningful but from  
17 a patient's point of view is it the most  
18 meaningful piece. And I think that's some of  
19 the deliberation that we need to have is what  
20 would it mean to raise the bar and push this  
21 work forward to the next stage, understanding  
22 that this is going to evolve. Even the

1 thinking about care coordination has advanced  
2 dramatically since we started the work on the  
3 2010. I think that there's so much national  
4 emphasis on it right now that people are  
5 really focused on what is this experience.  
6 And I think all of us have had the experience  
7 of family members coming to us and saying this  
8 did not feel coordinated, this was not a  
9 coherent experience, what is this all about.  
10 So, point well taken but let's also think  
11 about what that bar is from the patient.

12 CO-CHAIR CASEY: Yes, I think your  
13 point is something we actually struggle with  
14 all the time at NQF. And let me say that the  
15 big challenge now in the criteria for  
16 evaluation is to be sure as best we can that  
17 there is evidentiary linkage to a patient-  
18 centered outcome. And so that is going to be  
19 the challenge. I think what you're talking  
20 about is a more fundamental paradigm and it's,  
21 this is oversimplified, but we talk about  
22 measures for what we call accountability which

1 includes public reporting and a whole host of  
2 other strategies that relate to trying to  
3 determine the focus of actually moving things  
4 forward. That is different from the measures  
5 for quality improvement where we're measuring  
6 it because it helps us identify opportunities  
7 in our practice to do X, Y and Z. And I think  
8 that, you know, ultimately the consensus  
9 development process is going to be much more  
10 focused on the accountability side of it. And  
11 that means the closer there are real proven  
12 linkages to patient-centered outcomes the  
13 better. So that's always the push and pull,  
14 and I don't think NQF ever says no to anything  
15 you're saying. I think it's just a challenge  
16 because of the scope of the work to be sure we  
17 have that counterbalancing understanding of  
18 what the work is.

19 DR. BURSTIN: Just to build on  
20 that, I'd also make the point that all of our  
21 measures are up for reevaluation every three  
22 years as part of our maintenance process. So

1 it clearly could be that a measure may work  
2 now and in three years it'll be like, whoa,  
3 that's certainly outlived its usefulness and  
4 the committee, especially as we -- and we  
5 talked about this a little on the orientation  
6 call, but we'll talk about this more as we get  
7 into actual measures. We've also been raising  
8 the bar of our criteria. It is harder to get  
9 a measure endorsed now certainly than it was  
10 three years ago. That old measure of  
11 discharge instructions for CHF which  
12 essentially became a checkbox measure was  
13 removed from endorsement several years ago by  
14 NQF saying it's not a valid indicator of -- or  
15 I guess it's being reviewed. It's being  
16 reviewed right now. We removed the smoking  
17 measure several years ago and it was not,  
18 obviously, not a valid indicator of did you  
19 actually do smoking cessation counseling.

20 Our surgery committee, for  
21 example, just looked at all the SCIP measures.  
22 There's a SCIP measure that says did you order

1 VTE prophylaxis and there's a measure that  
2 said did you administer VTE prophylaxis. Well  
3 they said ordering is gone. You know, we  
4 don't care anymore. We really only care if  
5 it's administered.

6 So it is a different model. I  
7 think we are moving towards measures that are  
8 really as much as we can proximal to the  
9 outcome, less distal, lots of narrow process  
10 steps. And there may be opportunities. If a  
11 measure meets the bar now, that's fine. It  
12 may not need to live forever. It's fine if a  
13 measure has a life and then a better measure  
14 or more advanced measure comes forward.

15 CO-CHAIR CASEY: Yes, and this is  
16 an example of where taking that discipline  
17 back to the measure developer by saying keep  
18 working on this is useful feedback still. So,  
19 yes.

20 DR. LEE: And on that subject of  
21 taking small steps, for us folks who are  
22 taking care of patients day to day with care

1 management program, currently the system is  
2 built around medical condition. You know, a  
3 complex patient with heart failure, for  
4 example. And there's been a lot of experience  
5 learned doing so and people are in the process  
6 of replicating across different conditions.  
7 You know, but of course more research needed  
8 to show that structure works. And so tiny  
9 steps sounds perfectly reasonable and perhaps  
10 even consider condition-based approach as our  
11 first step.

12 DR. MCNABNEY: I have another  
13 comment, sort of building on the type of  
14 outcomes that would be pursued with regard to  
15 patient preferences and patient  
16 accountability. So how might we measure how  
17 coordinatable a patient is? So we can  
18 establish -- we can establish outcomes that  
19 may be not achievable because the patients  
20 themselves either prefer or just are not  
21 manageable or are not capable of adhering to  
22 well-coordinated care. And I think we need to

1 not, certainly not let providers or systems  
2 off the hook by any stretch, but have a  
3 measure or strive for a measure that  
4 demonstrates that that was evaluated, you  
5 know, measured in some way and documented  
6 because, you know, like James, working with a  
7 lot of people that the best efforts, their  
8 care is not able to be coordinated and then  
9 the outcomes are therefore bad.

10 CO-CHAIR CASEY: Yes, I think it's  
11 a great question and really, really important.  
12 And something we struggled with before. And  
13 to the extent that you can define some sort of  
14 standardized elements that might relate to  
15 patient-level characteristics I think that may  
16 be important, especially if we get into this  
17 notion of risk adjustment. But for the, you  
18 know, experiential part of this we've all had  
19 patients who, you know, despite our best  
20 intention are upset with a lot of other things  
21 besides us and don't want to be bothered with  
22 anything that we ask them to do so it seems.

1 So I think you're talking to the choir here  
2 about this and I do think in the area of  
3 accountability it's a sensitivity to, from my  
4 perspective, being fair to the people that  
5 actually have to do the work, that at least in  
6 their own minds some of it is beyond their  
7 control, quote unquote. So I think having  
8 that sensitivity is important and will come  
9 into our discussions.

10 DR. WHITE: Can I ask a quick  
11 question also? We talked a little bit about  
12 special populations with cultural competency  
13 but what about behavioral health? Because in  
14 my experience that's a huge barrier that if  
15 you can't address that you can't address the  
16 rest of it.

17 DR. BURSTIN: There seems to be a  
18 lot of projects we're launching these days.  
19 We're also about to launch a behavioral  
20 health/mental health project. So, again,  
21 we've tried to keep this somewhat separate but  
22 I think this is very fair game particularly in



1 this committee about sort of the interstices.  
2 So people who sort of fall between mental  
3 health/primary care kinds of issues, those  
4 coordination approaches I think would be fine  
5 here as well. And we can you know have that  
6 other committee take a look at those as well.  
7 Those are obviously critically important and  
8 were a hallmark of that SAMHSA framework that  
9 they put forward as well.

10 CO-CHAIR LAMB: Just a request. I  
11 think Eva, is it Eva? Eva's idea of putting  
12 your card up so that we can kind of track  
13 people. The other thing is remember that  
14 after you finish speaking please turn off your  
15 mic because it blocks other people. I think  
16 Eva, you were next.

17 MS. POWELL: Thanks. I'll put out  
18 a suggestion and it's just something I've been  
19 thinking about lately. And it is relative to  
20 all of the other comments as well. Of course,  
21 the problem that we're trying to solve is how  
22 do we standardize something that will rarely

1 if ever be an actual standardized process  
2 because care coordination depends on all of  
3 the various and sundry individual needs of an  
4 individual patient. And I've thought for some  
5 time that one way to approach this that's a  
6 little bit different, it's still though I  
7 think a process measure would be to measure  
8 according to a care plan. In other words, I  
9 haven't been able to think of a scenario where  
10 a care plan would not be appropriate for a  
11 patient. And so even the healthiest patient  
12 still needs to go to the dentist twice a year,  
13 get a mammogram, get a pap smear. So, if that  
14 can be a point of standardization and then  
15 measure against the care plan then that might  
16 be a way to approach this.

17 Now, of course part of the problem  
18 with that is that there is no such thing as a  
19 longitudinal shared care plan yet. We tried  
20 to work that into the meaningful use stage II  
21 and I've never heard such weeping and gnashing  
22 of teeth in my life, so. So there's a lot of

1 work to be done there. But it seems like that  
2 would be a way to get at these issues of  
3 accountability because that would be something  
4 that would need to be built into a care plan  
5 as being very specific about this is the step,  
6 this is when it needs to be done by and this  
7 is the person who's responsible, and then  
8 using technology to assess at a certain point  
9 of time did this stuff happen and that can get  
10 it out of the manual mode of actual people  
11 having to go through and measure. But I don't  
12 know how to do that. But it seems like that's  
13 a little bit different approach while it's  
14 still kind of a process measure.

15 CO-CHAIR CASEY: So let me see if  
16 this helps because I think, again, that that's  
17 an excellent point and something we struggled  
18 with. I would say that it is difficult given  
19 the diversity as I'll call it of the way care  
20 coordination gets done now to expect that  
21 we're going to have a one-size-fits-all  
22 because communities are different in terms of

1 the resources they have as an example. I  
2 mean, Chris was very helpful in her mind in  
3 terms of helping us clarify that. But the  
4 outcomes, the expected outcomes should be the  
5 prize, do you see what I mean? So if there  
6 are five different ways to get to the expected  
7 outcomes that's really what we're looking for.

8 As far as the process goes, again  
9 I'm going to challenge you to think about  
10 whether the process that's in place could  
11 achieve the expected outcome. Do you know  
12 what I mean? In other words we have a lot of  
13 process that we think theoretically is a great  
14 idea and it sometimes makes people feel good,  
15 but is it necessarily tangibly proven to be a  
16 benefit. And we're not expecting perfection  
17 here, but to the extent that we can have that  
18 linkage then that can be a positive support of  
19 what we're trying to do.

20 DR. AUDET: So actually that was  
21 my point which was made before so I'm glad you  
22 brought it up right now. I distinguish

1 enablers and actual functions, and I think  
2 what I'm hearing is we're really not  
3 interested in enablers per se. Making an  
4 appointment is an enabler. If you don't make  
5 an appointment you cannot have care  
6 coordination. These are just the basic  
7 enabling capacity. But we really want to go  
8 to the next stages as I think what you were  
9 saying here, also have -- the relationship  
10 between having an enabler is essential but not  
11 sufficient. We need to see what else is  
12 there.

13 DR. CARRILLO: Yes, I wanted to  
14 build on some of the points that Matthew made  
15 about the issue of fairness and complexity and  
16 doing leveling. And you know, it's the old  
17 20/80 rule. I mean, 20 percent of the  
18 patients bring about 80 percent of the cost.  
19 And we have to be mindful of health reform, we  
20 have to be mindful of the pickle that Medicare  
21 and CMS are in. So I think that for us to  
22 inform the nation we need to be mindful of

1 that and the most severely impaired and  
2 disadvantaged patients are something that we  
3 should be looking at. And it can be looked  
4 at. In New York state working with CMS  
5 there's a program that is called Health Home  
6 where there's a leveling in terms of care  
7 coordination for patients that are severely  
8 persistently mentally ill, patients that have  
9 three chronic conditions, two chronic  
10 conditions, all of the above, and different  
11 reimbursements for care management. I mean,  
12 there's actually a reimbursement for care  
13 management functions. So I think that we need  
14 to keep our eyes on the prize and think about  
15 the very high-need patients that need linking  
16 with housing resources, linking with rehab, et  
17 cetera, et cetera. So I wanted just to amend  
18 that to what Matthew said.

19 CO-CHAIR LAMB: Perhaps as we get  
20 into the afternoon we can come back to that  
21 because I think your point speaks to the issue  
22 that we were dealing with before which is how

1 does the high-risk individual fit into this  
2 measurement pattern. If we deal with an  
3 assumption that all patients require some  
4 aspect of care coordination but there are some  
5 groups that need very in-depth complex care  
6 coordination and how do we deal with that.  
7 And whether we would still adhere to that  
8 assumption of keeping it as a continuum versus  
9 separating it out. Can I get the next slide?  
10 We just have just a few more.

11 Okay, just so that you have a  
12 sense of where things ended with the first  
13 stage is that after the call for measures 77  
14 measures were submitted, and ultimately 10  
15 were recommended for endorsement and endorsed.  
16 And take a look there in terms of the five  
17 domains that came out of the framework. Only  
18 two domains were addressed in the new endorsed  
19 measures, plan of care which I think Eva was  
20 talking to before and transitions. There were  
21 no measures that were recommended for  
22 endorsement in the health care home, in

1 communication, and information systems. So  
2 that again this is fertile ground for  
3 discussion this afternoon in terms of where do  
4 we want to be going, what are the issues. And  
5 as you go back through the consensus report  
6 you'll see a lot of dialogue about what the  
7 issues were and what measures were submitted  
8 that were not recommended for endorsement.  
9 Last slide.

10 I think it's the last one, yes, is  
11 overall this work, the 2010 consensus report,  
12 really was establishing a foundation,  
13 beginning to build on the definition and  
14 framework and define an infrastructure for  
15 care coordination as in the health care home,  
16 the plan of care. And it did identify as we  
17 just talked about the need for high-risk care  
18 coordination measures although at that time we  
19 made a decision to keep them linked in.  
20 Process-wise it was seen as a start. There  
21 were a few measures that moved forward but it  
22 began to establish that context of what's



1 important, what isn't important, and now  
2 several years later the recommendations we may  
3 make may build on that, they may be different.  
4 And as you saw from the measures that went  
5 forward, transitional care measures have been  
6 better developed, better thought of, you know,  
7 in terms of the work that's been done in the  
8 past linking them to outcomes. And then  
9 again, outcomes is a start and if you looked  
10 at the paper that came out of the workshop on  
11 care coordination there are issues with some  
12 of the outcome measures like preventable  
13 hospitalization. That has been one that has  
14 been the focus of a lot of dialogue whether  
15 there is consistency in the way that that's  
16 being measured.

17           So overall a good start. I think  
18 we deliberated on lots of critical issues,  
19 tried to get our thinking down for future  
20 work. So hopefully it will be helpful as we  
21 go to this next stage in looking at how do we  
22 want to advance the field.

1 CO-CHAIR CASEY: Gerri, just let  
2 me make one more point and that relates to the  
3 preferred practices. I think that when we  
4 started working on this with Nicole we were  
5 getting lots of sort of quasi-anecdotal or  
6 published examples of strategies that didn't  
7 fit measurements. So I would encourage you  
8 all to really get seriously familiar with the  
9 preferred practices as well. I think  
10 obviously our focus here is on measures but  
11 part of the challenge was that we got lots of  
12 great ideas at least in terms of the things  
13 that you're doing as an example including some  
14 of the things Emilio was talking about like  
15 behavioral health, children with special  
16 needs, et cetera, et cetera. So embedded in  
17 the preferred practices is a lot of rich data  
18 on sort of the things that we pulled out of  
19 all this wisdom that actually was also quite  
20 extensive. So pay attention to that as well.  
21 I think we're at the break, Lauralei?

22 MS. DORIAN: Yes. Right in time

1 for morning tea.

2 CO-CHAIR CASEY: So what time do  
3 we want to be back? About 10 minutes?

4 MS. DORIAN: Yes, I'd say about 10  
5 minutes.

6 CO-CHAIR CASEY: Okay, great.  
7 Thanks.

8 MS. DORIAN: Thank you.

9 (Whereupon, the foregoing matter  
10 went off the record at 10:51 a.m. and resumed  
11 at 11:12 a.m.)

12 MS. DORIAN: Okay. Lipika? Can  
13 you just test the mic for me quickly?

14 DR. SAMAL: Testing. Okay.

15 MS. DORIAN: Okay, so over to you.

16 DR. SAMAL: I didn't think I  
17 needed this but maybe I do, this is a big  
18 room.

19 MS. DORIAN: I'd like to remind  
20 everybody as well that you should have the  
21 annotated outline for the commission paper in  
22 your folders that you've received. Yes, in

1 your folders. So you might want to take that  
2 out and follow along. And feel free to start.

3 DR. SAMAL: Okay. So my name is  
4 Lipika Samal. I am a primary care doctor and  
5 researcher at Brigham and Women's Hospital.  
6 I'm working with David Bates who's the chief  
7 of my division and he's very involved with  
8 this project. He's unable to make it today.  
9 And the other three members of our team, one  
10 is going to present right after me, that's  
11 Arjun Venkatesh and there's also Omar Hasan  
12 who's a hospitalist in general medicine and  
13 Lynn Volk who is an expert in quality  
14 measurement.

15 So just to orient you to the  
16 process here, this is really meant to garner  
17 feedback from you. This report is going to be  
18 partially completed in a month. So basically  
19 the first draft is due in a month and the idea  
20 is for the paper to be available to you when  
21 you're evaluating measures in the next phase.

22 So what I'd like you to do is to

1 take out the outline which is in your folder,  
2 and I think you've located that, and I have 20  
3 minutes. So I did not include all of the  
4 information in the outline in the slides but  
5 I'm going to ask you to write comments on this  
6 outline. I'm going to collect it from you  
7 afterward. You can also email me later but I  
8 just think this is a better way to make use of  
9 our 20 minutes that we have and then we'll  
10 have 30 minutes for questions but it will be  
11 combined between me and Arjun Venkatesh. So  
12 just to make sure that I get all of your  
13 comments so that we can make this as useful as  
14 possible.

15 So basically the goals here as I  
16 just said are to provide guidance to the  
17 steering committee and we want to identify  
18 areas where using clinical information systems  
19 or health information technology may improve  
20 upon existing measures. And so just this  
21 bullet point here, I just wanted to say  
22 basically you know we've up until now mostly

1 depended on insurance claims, patient-reported  
2 measures such as surveys and chart review  
3 which are, patient-reported and chart review  
4 are very costly, time-consuming. Insurance  
5 claims in lieu of a shared payer database you  
6 know are prone to measurement error from dual  
7 coverage or changes in coverage. So there are  
8 reasons why electronic measures could  
9 potentially be an improvement over our current  
10 measures. And then the last bullet point  
11 here, condition-specific. So many of our  
12 measures are condition-specific. And you  
13 know, we're talking about care coordination  
14 which can include the idea of a condition  
15 coordinated over time for an individual but  
16 also should include cross-condition  
17 coordination and cross-setting. But cross-  
18 setting as everyone has been saying has been  
19 emphasized.

20 So I really don't have time to do  
21 a background section unfortunately. Page 3 of  
22 your packet is kind of the, I mean it is the

1 outline of what I would envision as the  
2 background section. So if you could just, you  
3 know, take a look at that. If you have any  
4 ideas of other things that would help to set  
5 the stage or orient the reader let me know.  
6 I purposefully kept it really limited because  
7 I just felt like that was, it was too broad an  
8 area to really, to spend a lot of time on in  
9 the paper. So basically I'm just going to go  
10 through one slide on meaningful use and then  
11 I'll jump into the other areas. So I'll spend  
12 about five minutes talking about data needs  
13 and five minutes talking about current  
14 capabilities and then five minutes talking  
15 about each of these two sections.

16 So, many of the people in the room  
17 are very intimately aware of meaningful use  
18 and basically the things I wanted to just  
19 emphasize in this slide were that in the core  
20 set there's one explicit measure of care  
21 coordination and that is a measure of transfer  
22 of information across care transitions. And

1 you know, as we were just talking about,  
2 that's not all that there is to care  
3 coordination. And so there are a number of  
4 other measures that are related and they're  
5 categorized and they're under different  
6 headings. And I think that's really important  
7 to remember as people are talking about  
8 meaningful use and talking about care  
9 coordination in the same sentence. The stage  
10 1 menu set includes medication reconciliation  
11 and a summary of care record which are two  
12 other I would say tasks/data needs. And as  
13 far as I know and if someone here was on the  
14 committee they could correct me. I believe  
15 these were initially part of the core set for  
16 stage 1. Who was it that was saying they were  
17 on the meaningful use committee? I couldn't  
18 see you. Okay. Do you know were these  
19 initially part of the core set? These two,  
20 medication reconciliation, summary of care  
21 record?

22 MS. POWELL: I believe that they



1 were. I think med rec was optional --

2 DR. SAMAL: Okay, yes. Because my  
3 understanding was there were a number of  
4 things that had started out as being not  
5 optional and had been moved to optional  
6 because organizations just did not feel they  
7 would be able to meet those. This is what we  
8 were talking about with the -- exactly. Okay,  
9 yes. Exactly. Exactly. So organizations did  
10 not feel that it was reasonable to include  
11 everything in the not optional and that's kind  
12 of what Jeff Greenberg was talking about  
13 before with an incremental approach.

14 And then what's exciting is the  
15 stage 2 proposed set does include measures for  
16 a number of other care coordination concepts.  
17 But once again, this is all going to be  
18 interplay between organizational priorities  
19 and you know of course all the things that  
20 guide that, and federal regulation. So that's  
21 all I'm going to say about that. Obviously  
22 it's a very truncated background section. And

1 if anyone wants to make any further comments  
2 about that or anyone? Okay. Let's go on  
3 then.

4 So the first section begins on  
5 page 4 of your outline. You know, as of right  
6 now it's titled Data Needs. So this is the  
7 area where we could shoot for the moon as  
8 Wendy Vernon was saying before. This is the  
9 area where we want to identify all of the  
10 different data elements and also what I  
11 consider to be aspects of data which are  
12 really important for care coordination  
13 measurement. So what I call core clinical  
14 data elements, I don't know if there's a  
15 better word for this. The problem was  
16 allergies and medication lists. It's sort of  
17 like very small set of information that you'd  
18 really want to have when transitioning care.  
19 It's obviously not enough information when  
20 you're talking about caring for the whole  
21 patient and across the life spectrum in care  
22 transitions. So comprehensive care planning,

1 I just put that bullet there to remind me to  
2 talk about the idea that we're talking across  
3 conditions, we're talking about a person's  
4 entire lifetime. And communication across  
5 settings is sort of one of the sticking points  
6 in health information systems.

7 So I just, on both of these slides  
8 cited these two papers which were two of the  
9 only ones that I felt they were, you know,  
10 this one is a primary research investigation  
11 and this one's a systematic review. I would  
12 be open to suggestions from others of other  
13 places in the literature where I could find  
14 primary data about these concepts. There's a  
15 lot of papers that are thought pieces. There  
16 are not a lot of papers that have really gone  
17 out to practices as they did in the Ann  
18 O'Malley paper, or looked at a number of  
19 different types of computer discharge  
20 summaries as they did in this paper. And so  
21 really that's what I'm looking for here is  
22 trying to find scientific data behind the data

1 needs and current capabilities.

2           So first of all, the top bullet  
3 and sub-bullets are related to this Motamedi  
4 paper where I thought it was interesting.  
5 When they looked across the literature and  
6 they did a systematic review of the literature  
7 they found these, what I consider aspects of  
8 high-quality discharge summaries which are  
9 somewhat subjective. Providers talked about  
10 discharge summaries being comprehensive,  
11 brief, brief is very important, and legible  
12 which is a problem that is solved by health  
13 information systems. Another thing that was  
14 discussed there and in other venues is the  
15 fact that there's often not a record of  
16 patient education in discharge summary and so  
17 that's a really important part of discharging  
18 a patient but there isn't really a place to  
19 record that in our records often. And that's  
20 I think an artifact of our paper charting  
21 methods.

22           The second bullet here is, you

1 know, just basically like a laundry list of  
2 functionality to support different tasks. So  
3 thinking about what we want to do with  
4 medication reconciliation. We want to really  
5 raise the bar there and go beyond what we've  
6 done in the past. We want to track laboratory  
7 tests from the time that they are even  
8 conceptualized to the time the order is  
9 written on paper or put into a computer system  
10 through the result coming back to the provider  
11 and the result being communicated to the  
12 patient. This is what people call loop  
13 closure. And we don't really have  
14 functionality to support all these tasks yet  
15 but that's something we're thinking ahead that  
16 we really like. And tracking referrals, I  
17 think we talked a lot about tracking referrals  
18 but once again, this is about loop closure.  
19 So making sure that all of the players,  
20 including the family and patient, understand  
21 what the specialist said, what the generalist  
22 is going to handle, what the specialist is

1 going to handle and all those concepts.

2           And then population-oriented tools  
3 which I think sometimes people don't include  
4 under care coordination but I think definitely  
5 should be because when you are talking about  
6 like a disease registry for example you know  
7 the action that you take once you have that  
8 information in front of you is actually care  
9 coordination on the individual level. So  
10 that's a tool to manage a population. But  
11 every time you look at that list and say this  
12 patient hasn't had such and such, that's the  
13 care coordination. So we need that data and  
14 then we also need tools to support those  
15 tasks. So, all right.

16           So just to stop before going into  
17 the current capabilities. Did anyone want to  
18 just right now let me know if I've missed any  
19 data needs that you think are important to  
20 cover? Or if there's other places in the  
21 literature, organizational experience. Are  
22 you raising your hand?

1 MS. LOVE: I think an emerging  
2 data source and under 1(b) I made a note that  
3 consideration or mention of the statewide all-  
4 payer claims databases.

5 DR. SAMAL: Yes.

6 MS. LOVE: Even though they may  
7 not be fruitful today I am hopeful that they  
8 should be encouraged in this document  
9 somewhere, but that the vision would include  
10 them for future measures. Because they do  
11 bring across payers and providers, all the  
12 data and all the utilization data.

13 DR. SAMAL: Yes, I understand what  
14 you're saying. Are there any sources either  
15 in academic literature or organizational  
16 experience that I could use to write about  
17 that?

18 MS. LOVE: I would refer you first  
19 to the APCDCouncil.org site where we have a  
20 lot of Commonwealth papers out there that  
21 states have been using to build that business  
22 case.

1 DR. SAMAL: Okay.

2 MS. LOVE: And then I can probably  
3 find some other papers and send you some  
4 links.

5 DR. SAMAL: Great.

6 MS. LOVE: But we're trying to put  
7 a compendium on the APCDcouncil.org site.

8 DR. SAMAL: Great. Great. Yes, I  
9 think that's very important, especially as we  
10 get into the barriers and we talk about lack  
11 of interoperability I think that's really  
12 important. Yes.

13 DR. AUDET: Two small items. One  
14 on your clinical information characteristics  
15 of desirable information, comprehensive,  
16 brief, legible.

17 DR. SAMAL: Yes.

18 DR. AUDET: I think it would be  
19 great to get a bit more specific about brief,  
20 such as really what's really important is what  
21 are the items that need followed up and by  
22 when.



1 DR. SAMAL: Okay.

2 DR. AUDET: And another source of  
3 -- it's not going to be scientific data  
4 because I think some of this is still in pilot  
5 but there's, there are two groups that I think  
6 you might want to touch base on that are doing  
7 a lot of testing of these measures. And one  
8 is the Premier. They're doing a lot of  
9 piloting of measures. And they're trying to  
10 get at some of these care coordination  
11 measures and patient-reported outcomes. And  
12 the other one is the Dartmouth collaborative  
13 on accountable care organizations. So these  
14 are two kind of test pools or test beds. So  
15 you may not, it's not published literature  
16 yet.

17 DR. SAMAL: Well, I mean, that's  
18 part of the problem I'm running into is  
19 there's not a lot of published literature. So  
20 whatever is out there, you know, it would be  
21 good to bring as much of that together as we  
22 can. All right. Great. I'm so glad people

1 are participating. Oh, yes.

2 CO-CHAIR LAMB: Just a point of  
3 clarification. In the section on data needs.

4 DR. SAMAL: Yes.

5 CO-CHAIR LAMB: It's framed as  
6 functionality to support care coordination  
7 tasks. And so if these are the supports I'm  
8 interpreting them as structural antecedents,  
9 that you have to have them in place to  
10 actually track whatever is measured related to  
11 care coordination. So is there also a section  
12 here in terms of what the data needs are going  
13 to be for the care coordination measures?

14 DR. SAMAL: Okay, I see what  
15 you're saying. So in other words, well, I'm  
16 not totally sure what you're saying. Are you  
17 saying if I talk about these as structure,  
18 like the Donabedian structure-process-outcome,  
19 then I also need to talk about the process  
20 that you go through and then from that would  
21 come all of the data elements that you would  
22 measure. Is that right?

1 CO-CHAIR LAMB: Not necessarily  
2 the process, but if these are the pieces that  
3 you need in place to be able to track what's  
4 important, what about the discussion about  
5 what is actually tracked related to the  
6 quality of care coordination and the outcome.

7 DR. SAMAL: Okay, I see what  
8 you're saying. So come out with all of the  
9 actual data elements from each of these.  
10 Okay. That makes sense.

11 DR. CARRILLO: Yes, in terms of  
12 data needs, thinking about the customer. Who  
13 is using the data and who needs to input the  
14 data. Particularly in dealing with the high-  
15 risk, high-cost patients the community-based  
16 resources are very important. Community-based  
17 organizations --

18 DR. SAMAL: Right.

19 DR. CARRILLO: -- behavioral  
20 services, social services. And it's a real  
21 challenge. I mean, clinicians have been,  
22 nurses and doctors and hospitals have been

1 working on this for a long, long time.

2 DR. SAMAL: Right.

3 DR. CARRILLO: But for us to be  
4 successful we need to be able to have  
5 interoperability with this whole sea of  
6 resources --

7 DR. SAMAL: Yes.

8 DR. CARRILLO: -- that are for the  
9 most part not very much technically oriented.  
10 So that's an important need that I don't know  
11 to what extent it's been looked at, but  
12 certainly in New York state people are  
13 wrestling with it at all levels of care.

14 DR. SAMAL: Yes, that's right.  
15 And so you're saying that even if it's not, if  
16 they don't have electronic records in those  
17 organizations we need to somehow be able to  
18 capture the information.

19 DR. CARRILLO: You know, a CDR,  
20 you know, how are we going to project the  
21 information. And also what information we  
22 need from them.

1 DR. SAMAL: Right, right.

2 DR. CARRILLO: I mean, could it  
3 just be faxing something that is secure? I  
4 mean, how are we going to get that information  
5 that may not be an EMR but that it's  
6 desperately important?

7 DR. SAMAL: Yes, definitely. And  
8 I know that some organizations are using  
9 electronic records. Like there's something  
10 called Efforts to Outcomes someone I know uses  
11 in their orientation, so.

12 DR. CARRILLO: So, I mean if fax  
13 technology is what's available to some of  
14 these critical services that we need to  
15 coordinate care with is there a way of  
16 integrating that kind of lower tech data into  
17 our data exchange?

18 DR. SAMAL: That makes sense, yes.  
19 Okay.

20 MS. KLOTZ: And one other thing  
21 here. You mentioned the importance of patient  
22 education, and that brings to my thought

1 patient understanding. I mean it's one thing  
2 to have done education but does the patient  
3 understand. I don't know if there are any  
4 measures of that. The only one that comes to  
5 mind might be the patient activation measure  
6 that would at least give you a sense of the  
7 individual's readiness to understand and take  
8 responsibility.

9 DR. SAMAL: Yes. I mean, there  
10 are actually a lot of validated measures about  
11 the patient-provider relationship, trust,  
12 communication, knowledge, efficacy and things  
13 like that. So I mean that's a really good  
14 point, that could be incorporated as well.

15 DR. LEFTWICH: In terms of what's  
16 coming or likely coming, the clinical  
17 information model work group in the S&I  
18 Framework that I co-chaired concluded that the  
19 medication list, the problem list, the allergy  
20 and intolerance list and patient demographics  
21 should be core data elements that are in every  
22 document that's part of a transition of care,

1 close loop referral, hospital discharge  
2 summary and the patient instructions from the  
3 hospital discharge. That was presented to the  
4 HIT Standards Committee two months ago and  
5 they indicated two weeks ago that that would  
6 be their recommendation for states to have  
7 meaningful use, that that functionality be  
8 part of the requirement for an EHR to be  
9 certified for that. So.

10 DR. SAMAL: Okay.

11 DR. LEFTWICH: And those are  
12 defined down to data elements that will make  
13 it interoperable between systems.

14 DR. SAMAL: Great.

15 DR. LEFTWICH: And include some  
16 additional data elements from what's been  
17 there previously like the date of  
18 reconciliation on the medication list, the  
19 problem list and who reconciled them. The  
20 identity of the primary care physician and the  
21 demographics.

22 DR. SAMAL: So now it's just been

1 approved. So where would I find that like  
2 online or what would I look under to find  
3 that?

4 DR. LEFTWICH: The Standards and  
5 Interoperability Framework has a wiki that's  
6 siframework.org with all of their work. The  
7 HIT Standards Committee and Policy Committees  
8 have recordings of all of their meetings.

9 DR. SAMAL: Right, I saw that on  
10 the website. Okay, great. So that was just  
11 approved because I'd seen some stuff from July  
12 and August. Okay, great, thank you. That's  
13 very useful.

14 DR. LYNN: Just one last thing  
15 over here. Hello. It may be implicit in what  
16 you're talking about but in terms of patient  
17 perspective I think you also, with care  
18 coordination you have to include family  
19 perspective.

20 DR. SAMAL: Yes, yes. Of course,  
21 yes.

22 MS. ALEXANDER: I'm sorry. I



1 wanted to make a point too to keep in mind  
2 regarding discharge summaries. And that  
3 thinking about the discharge summary from the  
4 perspective of the care team and based upon a  
5 plan of care, and not solely upon the  
6 perspective of the physician discharge  
7 summary.

8 DR. SAMAL: Right.

9 MS. ALEXANDER: Particularly in  
10 your previous slide when you were talking  
11 about the patient education is often not  
12 included in the discharge summary because it's  
13 not documented. Well often patient education  
14 is documented but it is not included in the  
15 physician discharge summary.

16 DR. SAMAL: Exactly, so it's in  
17 the nursing clinical documentation.

18 MS. ALEXANDER: Yes or it could be  
19 other clinicians too such as PT, speech, that  
20 type of thing.

21 DR. SAMAL: Right, right. Okay,  
22 that's a really good point. Okay. Yes.

1 MS. POWELL: Another comment just  
2 to go along with that is it may be helpful  
3 just to kind of take a step -- well, it  
4 depends. If you're looking at what is  
5 existing out there now this may not be the  
6 case, but to the degree you're trying to set  
7 a path forward part of the problem with this  
8 has been a lot of the same information is in  
9 a lot of various and sundry different  
10 documents and this is something we ran into in  
11 the context of meaningful use. The comment  
12 was made that there's really not a lot of  
13 value to a discharge summary without a plan.  
14 So the idea is let's have one document that's  
15 a discharge summary and plan, and that then  
16 brings value in and you've eliminated one  
17 document. So I guess the larger framing for  
18 my comment is I think part of what we need to  
19 do is not figure out how to put what we're  
20 doing now into electronic format but take a  
21 step back and say how is what we're doing now  
22 not helpful, and how is it a lot of rework.

1 And let's look at how can -- what information  
2 is necessary at what points in time to whom,  
3 and let's design as few documents or as few  
4 presentations of information as possible that  
5 can give that valuable information when and  
6 where it's needed. So that's my first point.

7 Then the second point would be on  
8 the comprehensive care plan, and this is  
9 another place where, again, my mind just  
10 naturally gravitates toward this as like the  
11 primo document from which pieces can be taken  
12 for specific purposes. But then I think part  
13 of the care plan really has to be and it  
14 really needs to start with a goal. And that  
15 needs probably to be an element of information  
16 that goes across whatever documents or  
17 whatever care settings there are. The high-  
18 level goals, not just clinical but also  
19 patient goals because those are two very  
20 different things. And then that can become a  
21 frame of reference for actual specific actions  
22 related to care coordination.

1 DR. SAMAL: And so when you say  
2 "goals" do you mean goals along the lines of  
3 like a clinical goal for the patient, or a  
4 goal like a very broad goal, like I want to be  
5 able to live on my own again?

6 MS. POWELL: Both. And I think  
7 that's part of what makes this hard. I think  
8 of this in a similar way to what Wendy talked  
9 about in terms of the cascading of measures.  
10 What is the ultimate clinical goal for this  
11 patient who has terminal cancer? It's not  
12 cure, it's palliative care. And so then what  
13 does that mean, and what does that mean for  
14 each member of the care team, who's  
15 responsible for what, what are the roles of  
16 the patient and family, and then what are the  
17 goals for the family in that circumstance.  
18 And then again kind of the cascading so that  
19 people understand this is the overall care  
20 plan but underneath that umbrella of the  
21 longitudinal shared care plan then each  
22 individual discipline or person or area of

1 focus however that might be for the patient  
2 will have its own kind of sub-plan.

3 DR. SAMAL: That makes sense. I  
4 think that's a really good example because I  
5 think a lot of times palliative care teams in  
6 the hospital are doing that. You know,  
7 they're cascading the patient's overall goals  
8 of care into various, you know, areas like ICU  
9 or whatever.

10 MS. POWELL: Right and that's just  
11 an example because it's an easy one because it  
12 kind of already exists. But that should be  
13 the approach I think for any particular  
14 person, whether or not they're palliative care  
15 or not.

16 DR. SAMAL: Okay, that makes  
17 sense.

18 CO-CHAIR CASEY: So I know Linda's  
19 got her card up but let me jump in here  
20 because Gerri and I were having deja vu all  
21 over again. And just emphasize for you and  
22 also the committee that for example if you

1 look on page 18 of Preferred Practices you can  
2 see a lot of what you're talking about. So I  
3 would again harken back to what's there. And  
4 some of the things you're talking about  
5 because I didn't process them all may actually  
6 not be all there so how do we enhance that.  
7 But I think both the committee and yourself  
8 should really use this as a structure to help  
9 inform what you're talking about.

10 DR. SAMAL: Yes, okay, definitely.

11 CO-CHAIR CASEY: So Linda had her  
12 hand up.

13 DR. LINDEKE: I wanted to raise  
14 one point. It's not, I haven't read about it  
15 here but in my clinician role working with  
16 premature infants at discharge I'm very  
17 fortunate compared to Gerri, we really do  
18 start at the beginning of this story with  
19 pregnancy and all that. But we talk a great  
20 deal and it does come into these summaries  
21 about risk because we're sending discharge  
22 summaries about unique physiology, a

1 combination of all sorts of rare events in  
2 some cases, multi-diagnoses that will take  
3 huge amounts of family and community  
4 resources. And we've realized we need to say  
5 eye condition, at risk for blindness,  
6 pulmonary condition, interventricular  
7 hemorrhage, at risk for, in order to get the  
8 clinicians whoever they might be, even  
9 sometimes the family attention, that this  
10 isn't just an eye screening you can do down  
11 the block. So I don't know if you see this in  
12 the literature. It's extremely important with  
13 multi-diagnosis special needs children and  
14 others I'm sure to, "at risk for."

15 DR. SAMAL: Okay. How am I doing  
16 on time? We're out of time. No, we have a  
17 little bit more time for questions. I guess  
18 we'll just move ahead to the next section  
19 which begins on page 5. Okay. So, this is,  
20 you know, now these are things that I  
21 identified from just these few papers as  
22 current capabilities and I think a major

1        overarching question that you guys, that you  
2        can help me on is should I be looking for the  
3        frontrunners in each area or am I trying to  
4        understand what the general, what's going on  
5        generally? So I mean for example, I've used  
6        a lot of, I've used the NEMESIS data set a lot  
7        and that does not have anything about care  
8        coordination that I know of in it. Maybe in  
9        a broad sense it does. But we don't have a  
10       lot of nationally representative data on care  
11       coordination so, you know, I would really just  
12       be going to things like there's a survey I  
13       quoted on the next slide and, you know, give  
14       me some idea of whether you want me to talk  
15       about like what's the best, what's the state  
16       of the art or you know what do we have  
17       generally. I think some of the points that I  
18       brought up here, so for example the first  
19       point is from the same paper in Journal of  
20       General Internal Medicine which was that they  
21       went to a number of practices that are fully  
22       electronic and they found out that continuity



1 with the PCP is not built into that system.  
2 They have a separate scheduling system and  
3 someone has to think, okay, who is their  
4 doctor, let me figure that out before  
5 scheduling them. Also for referrals I think  
6 this is like something everybody knows but,  
7 you know, fully electronic practices, they're  
8 communicating with non-electronic practices so  
9 often they're sending out their requests and  
10 receiving reports by fax and then they're  
11 scanning them in as a PDF which makes it, you  
12 know, at this point fairly useless for quality  
13 measurement and also for clinical care I would  
14 say. And then in multispecialty practices and  
15 this is something I can say from my  
16 experience, you know, we don't even really  
17 send a true referral request anymore because  
18 we're just expected to read each other's  
19 notes. And so you know, that really does not  
20 fit into the framework of making sure that the  
21 specialist understands what the question is  
22 and whether you want co-management or just

1 recommendations and then tracking the referral  
2 to completion. That really isn't, even fully  
3 electronic practices with very advanced  
4 electronic systems there's not necessarily a  
5 function for that. And so then just maybe,  
6 let's just go to the next slide and then we'll  
7 stop there.

8           So this is a survey of regional  
9 health information organizations or RIOs and  
10 they were able to survey I think the number  
11 for response for different questions was  
12 different, but for the first question can  
13 people in the inpatient setting access  
14 information from the ambulatory setting. Out  
15 of the 59 surveyed 44 said they could. And  
16 then vice versa, if a primary care provider is  
17 doing a follow-up visit and the discharge  
18 summary is not available at time of visit.  
19 Now remember, if you're having people follow  
20 up within a week that's really, that happens  
21 a lot. Only 32 out of the 43 surveyed had  
22 that. I say only because I mean, those are

1 not -- these are what I would think are some  
2 of the key things that you need for care  
3 transitions. So that's why I said only. But  
4 if you have other sources of information about  
5 either of these issues so the ambulatory  
6 settings, care transitions or ambulatory  
7 inpatient. Yes.

8 CO-CHAIR LAMB: If we kind of go  
9 back to the NQF framework and we take a look  
10 at those domains and then we also look at  
11 other definitions of care coordination it's --  
12 care coordination happens at -- between, it's  
13 between the providers, between the patients.  
14 And you know, and I know that it becomes  
15 really complex but care coordination I think  
16 as Wendy said before is owned by the patient.  
17 Providers support it but virtually every  
18 provider in a health care setting is doing it.  
19 I think it's important to move beyond looking  
20 at the medical component and the PCP to  
21 specialist in the hospital or in the  
22 ambulatory care setting, to broaden out that

1 this is something that goes across every  
2 professional that is there because it doesn't  
3 work otherwise. And so it would be good to  
4 kind of broaden out that perspective and take  
5 a look at what is it going to take to share  
6 information that's being generated by  
7 virtually everyone in the health care system.  
8 And it makes it really complex and I know we  
9 need to start it, but if we stay so focused on  
10 just communication in one venue we're never  
11 really going to get to what the issues are and  
12 how to solve them.

13 DR. SAMAL: Okay, yes, that's very  
14 useful to know because there's a -- I didn't  
15 really, let's see here. What did I include  
16 about this. Under page 6 there's 1(e) is  
17 about personal health records. And I guess  
18 (f) also is related to this. Because you  
19 know, I think we were just, before this  
20 meeting we were talking about consumer health  
21 informatics and the question was whether or  
22 not that fits in here. You know, it's a huge

1 field and now people are generating all kinds  
2 of quantitative data at home which we need to  
3 figure out how to process in the health care  
4 system. So yes, I definitely think that's  
5 important. It's very helpful to know that we  
6 want to try to at least touch on that as well.

7 CO-CHAIR CASEY: So that's the  
8 nurse speaking. And as the doctor I defer to  
9 the nurse.

10 (Laughter)

11 DR. SAMAL: That's always a good  
12 idea because usually we're wrong. Okay.

13 CO-CHAIR LAMB: Not just the  
14 nurse, every health care professional, and we  
15 have many of them represented around the room  
16 as well.

17 DR. SAMAL: You know, definitely.  
18 And just to give an example from something I  
19 had worked on, I worked on a systematic review  
20 about consumer health informatics. And we had  
21 decided to really take that completely out of  
22 the health care setting. So we actually said

1 if a doctor, nurse or someone in the health  
2 care system had to be involved with the use of  
3 the technology then it wouldn't be included in  
4 our study. So that ruled out all patient  
5 portals, and it was very interesting to look  
6 at the literature. And this actually was  
7 funded by AHRQ and is on their website. But  
8 yes, there definitely are studies out there  
9 and there's information out there. So we can,  
10 if we're trying to do that, we're trying to  
11 cast a wide net, that's good to know. We can  
12 pull in examples from all of the different  
13 areas. So. Yes.

14 DR. MALOUIN: So I had a comment.  
15 I'm not sure exactly where this fits in but I  
16 think it just, it speaks to the biggest  
17 challenge that I've found in measuring care  
18 coordination. So what we're doing in the  
19 state of Michigan is we have a large, we're  
20 part of the CMS multi-payer advanced primary  
21 care demonstration project and we have about  
22 450 practices that are across a wide

1 geographic region with a lot of different  
2 EMRs, a lot of different capabilities. And so  
3 we, one of our primary goals is care  
4 management, care coordination. That's one of  
5 the initiatives that we're implementing. And  
6 so we, the first thing we did was come up with  
7 a list of metrics of what we want to measure  
8 to sort of, you know, for quality, for patient  
9 satisfaction and what do we want to measure  
10 for care coordination. And it's hard enough  
11 to agree on the measures but it's impossible  
12 to try and measure them when you're going  
13 across multiple EHRs. And so I think what we  
14 have to think about is that everybody's doing  
15 a lot of great work in their own systems, but  
16 in order to do meta-analyses of this work and  
17 look at, sort of draw really broad conclusions  
18 you have to be measuring common things. And  
19 that's I think where the challenge is. So  
20 even if we come up with, you know, a great set  
21 of core measures, if we can't develop  
22 reproducible ways of capturing those I think

1 we're never going to be able to really add to  
2 the knowledge and the literature on this, in  
3 this area.

4 DR. SAMAL: Yes, definitely.

5 DR. MALOUIN: So that's my  
6 challenge. I'm sure it's all of our  
7 challenges.

8 DR. SAMAL: And that's why it's  
9 tough for me to decide whether we should look  
10 at sort of the front-runner systems which are  
11 very, which are isolated. You know, our  
12 system is very advanced but we're isolated.  
13 We are slowly trying to scoop in practices  
14 into our system but we can't really talk to  
15 other systems either.

16 DR. MALOUIN: Exactly.

17 DR. SAMAL: I don't know if we  
18 should focus there or if we should focus as  
19 you're saying more on like what is actually  
20 happening in real life and how hard is it for  
21 us to actually go across these.

22 DR. MALOUIN: Well, and how do we



1 get from where we are to where we want to be.  
2 Because I think that's the biggest challenge.  
3 And what we ended up doing is sort of taking  
4 these sort of indirect markers like, you know,  
5 reduced ED visits because that's all we've got  
6 and we're saying well, if you're coordinating  
7 care well then you're going to end up with X,  
8 Y or Z, but that's really not getting at the  
9 processes of care that got you to that  
10 outcome.

11 DR. SAMAL: And those measures  
12 then drive different systems such as ones  
13 where the ED tries to set up a care  
14 coordination program, or you know, and then  
15 that's not exactly what we're talking about  
16 here either. So okay, let's just keep going.

17 CO-CHAIR CASEY: I'm sorry, Emilio  
18 has his.

19 DR. SAMAL: Oh, I'm sorry. Yes.

20 DR. CARRILLO: Just to build on  
21 what Gerri said before. I think that rather  
22 than just an afterthought or a section 7 that

1 the whole idea of the communication at the  
2 patient-centered level, the patient and also  
3 communicating with the homeless shelter and  
4 the rehab center and the CBO and the visiting  
5 nurse. That, we may not have it but that has  
6 to be a destination. I mean, so maybe the  
7 organization of the paper needs to be in a way  
8 that reflects the gaps that we have rather  
9 than just like a summary, then we also need to  
10 work on the following. Because that just gets  
11 lost. I think that, you know, out in the  
12 field this is where the action is.

13 DR. SAMAL: Right.

14 DR. CARRILLO: That's where it's  
15 happening and we need to point towards that  
16 direction the way that Gerri said.

17 DR. SAMAL: Right, that makes  
18 sense. Okay, so let's see. So what's the  
19 next? Okay, so now we're moving to page --  
20 well, it's really page 7. So you know, at  
21 this point I'm just basically listing some of  
22 the various -- and these actually, a lot have

1       come up now in our conversation which is  
2       great. And if you want to mention others  
3       that's great. I organized it under technical  
4       and organizational though some of them could  
5       fit under both, and we could go back and forth  
6       and discuss those, even those categorizations.  
7       So first of all, lack of data standards. So  
8       this is something that's being addressed and  
9       right now is slowly in the process of becoming  
10      a reality of having data standards that will  
11      allow the technical interoperability. Legacy  
12      homegrown systems. So like for example we  
13      have a system that's very advanced that we  
14      built that we want to keep using. And there's  
15      also older versions of commercial electronic  
16      health record systems that are not able to be  
17      - you know, you may hear that Epic, I  
18      shouldn't say Epic, but I'm just saying you  
19      may hear that a commercial system is  
20      interoperable with your system but the person  
21      you're communicating with may have an old  
22      version of that system. So that can be an

1 issue.

2                   And then kind of going to a  
3 different area which is, you know, one that's  
4 sort of you know what I'm really interested  
5 from a research perspective, that's part of  
6 the reason I think about it a lot, clinical  
7 decision support tools which are tools for  
8 physicians, once again going back to physician  
9 focus, at the point of care. They don't  
10 support audit and feedback in a lot of cases  
11 and so you're doing double work, you're doing  
12 data entry but you're not getting a report  
13 back, and then if you do get the report back  
14 it's not necessarily in a time or place where  
15 you can react to that and provide care  
16 coordination for a patient.

17                   And then the last part of that  
18 bullet is about risk stratification which I  
19 think is what you're talking about, right?  
20 Okay. I was thinking about it more from the  
21 perspective of, you know, providers often say  
22 don't give me these cookie-cutter

1 recommendations from clinical practice  
2 guidelines because they don't apply to this  
3 patient. So you know, being able to be more  
4 intelligent than that and providing  
5 recommendations for people is I think the next  
6 step.

7 Another issue is just encounter-  
8 based documentation. So in very short, acute  
9 hospitalizations having all the information  
10 kind of in one encounter and just kind of  
11 putting that on a shelf and starting the next  
12 one as a separate chart the next time the  
13 patient comes to the hospital makes sense but  
14 when you're talking about longitudinal care  
15 over someone's lifetime or collaboration then  
16 that type of system of organizing information  
17 does not make any sense. And then I think  
18 someone also talked about, well this is  
19 basically what you're talking about,  
20 measurement bias because information about  
21 care transitions is stored in different  
22 systems. So whether it be paper charts or

1 electronic that is a measurement issue. Any  
2 other thoughts or comments there? Okay. Yes,  
3 okay.

4 MS. ALLER: I would just comment  
5 that --

6 CO-CHAIR CASEY: Use your  
7 microphone.

8 MS. ALLER: The whole issue of  
9 data standards is just astronomical.

10 DR. SAMAL: Yes.

11 MS. ALLER: And when we talk about  
12 things like a care plan it's wonderful. But  
13 unless we not only have a very clear structure  
14 with implementation guidelines and it's had  
15 time to mature so that it's well-adopted and  
16 the bugs are worked out of it we're not going  
17 to have high-quality data for measurement.

18 DR. SAMAL: Yes.

19 MS. ALLER: So it's not good  
20 enough just to have a standard that somebody's  
21 put together if it hasn't had time to be out  
22 in the industry, be tested, be used and worked

1 through so that we mean the same thing when we  
2 use it.

3 DR. SAMAL: That makes sense.

4 Then someone else had a comment? Yes.

5 MS. POWELL: This is a piece  
6 technical but it's actually I think a bigger  
7 organizational issue I guess. But the issue  
8 of just because you -- yes, data standards are  
9 a huge problem. But we do have a lot of  
10 standards and data still doesn't flow. So  
11 it's not just a problem of standards, it's  
12 also a problem of incentives both on the  
13 vendor end. Just from a market perspective if  
14 you are the Brigham and Women's you don't have  
15 a vendor issue. You'll get the attention of  
16 your vendor because of the volume that you  
17 produce for them, but if you're a very tiny  
18 one-doc shop out in rural Montana getting the  
19 attention of a vendor is going to take awhile  
20 if you get that.

21 DR. SAMAL: Yes.

22 MS. POWELL: Just, again, it's a

1 simple market kind of concept. So there's  
2 that issue. I don't want to take us away from  
3 this if we're not ready to leave it but I  
4 think part of the reason for that issue is the  
5 fact that there's also not always an incentive  
6 and often a disincentive on the organizational  
7 standpoint to share data. And that gets at  
8 what Gerri was talking about is that what  
9 we're really trying to get at is shared  
10 accountability. But if there's all kinds of  
11 disincentives for sharing information so that  
12 we can actually perform the functions that we  
13 need to perform to coordinate care for  
14 patients then we've really got a huge  
15 roadblock.

16 DR. SAMAL: Yes.

17 MS. POWELL: And that then in turn  
18 kind of I think affects vendors and market  
19 products because there's not a demand.

20 DR. SAMAL: Exactly. Exactly.

21 And so, and I think that's part of the reason  
22 why I said that data needs really is driving



1 this is that what I want to try to do is  
2 encapsulate that concept coming from the other  
3 side and saying here's what we need so we want  
4 to drive development around that. And then  
5 you know, the whole piece of reimbursement and  
6 creating the incentives is kind of out of our  
7 control but maybe by driving the data needs  
8 and saying what we really need then we're able  
9 to push that forward. Yes.

10 DR. AUDET: About clinical  
11 decision support, I would also probably  
12 suggest adding that. Right now clinical  
13 decision support is really focused on a  
14 fragmented delivery system and what we really  
15 need is clinical decision support that  
16 supports the care team and the care plan. So  
17 an evidence-based care plan that everyone has  
18 available. So it's not only one person  
19 ordering a medication but it's really talking  
20 about care coordination underneath it.

21 DR. SAMAL: That makes sense, yes.  
22 Okay. So yes, we could just go to the next.

1 So I called this organizational and if, you  
2 know, if people would rather it be called  
3 policy or maybe taken out completely because  
4 it's not you know technical information let me  
5 know. But this is, a lot of these are kind of  
6 corollaries to the other bullet points because  
7 as I was thinking about it I was thinking we  
8 can't really leave that out. So resistance to  
9 changing legacy systems. I mean, that's  
10 because people like me are used to using a  
11 system and it's also because the organization  
12 doesn't really have an incentive to do that.  
13 Or I mean they do, but you know, the incentive  
14 has got to be weighed against a lot of other  
15 priorities as well. And it's tough to even  
16 know when you go into that process how much  
17 it's going to cost, how long it's going to  
18 take, what you're going to get from it. So  
19 that's an issue that is going to come up a lot  
20 I think in the future.

21 Then the next is, you know, this  
22 is once again kind of physician-centric I

1 think because it's about the resistance to  
2 mediating care plans between specialties. And  
3 we don't often do a good job with that. And  
4 finding ways to do that at an organizational  
5 level is really important before you can get  
6 buy-in into any technical solution to the  
7 problem. Yes.

8 DR. WHITE: Let me just add one  
9 other problem that you may not have considered  
10 because a lot of the carriers have a lot of  
11 claims information. It's very useful. They  
12 may also have members who are in case  
13 management and other health and wellness  
14 programs, disease management, et cetera. But  
15 when a member changes plans that information  
16 doesn't follow the member.

17 DR. SAMAL: Yes.

18 DR. WHITE: And is there a way  
19 that we could make sure that that information  
20 gets, you know, transmitted from one carrier  
21 to the next, or from one provider to the next  
22 so that they have that information?

1 DR. SAMAL: That makes a lot of  
2 sense. I mean, I think in lieu of having an  
3 interoperable solution that makes a lot of  
4 sense, yes. Yes. Okay. So, yes.

5 DR. LINDEKE: Can I make -- were  
6 you on the next slide? A very quick comment.  
7 Trying to educate the next generation of  
8 health care providers when the environment is  
9 click and drop-down menus really worries me.  
10 My colleagues and I talked about this  
11 yesterday, of engaging the thought process  
12 when the day is spent clicking rather than the  
13 clinical decision-making unique to this  
14 patient. I don't know where it is in the  
15 literature but it's a huge unintended  
16 consequence danger for care quality.

17 DR. SAMAL: And I guess the other  
18 things that relate to that are the patient-  
19 provider relationship is affected by the  
20 clicking and also just the human-computer  
21 interface affects your cognitive process as  
22 well. So I don't know if that's too broad to

1 get into at this report but we'll have to  
2 think about that further. Okay.

3 MS. KLOTZ: I'd also like to  
4 suggest thinking about the fact that as we  
5 know most care coordination is done by the  
6 patient and the family, and that we need to be  
7 careful that this isn't a process of taking  
8 that responsibility away from the patient and  
9 family.

10 DR. SAMAL: That's a good point.  
11 And I think that's where I also have to decide  
12 how much to talk about personally controlled  
13 health records or that type of technology  
14 which is actually trying to put the power back  
15 with the patient and family more.

16 DR. HEURTIN-ROBERTS: Can I follow  
17 up?

18 DR. SAMAL: Yes.

19 DR. HEURTIN-ROBERTS: On just what  
20 Linda said. I guess part of what's concerning  
21 me about this, or just a concern I have is  
22 that there's a real danger that we collect

1 information that is easily collectible through  
2 electronic health records and not necessarily  
3 what we really want to know. You know, it's  
4 like looking under the lamppost for keys you  
5 dropped somewhere else. And I think we need  
6 to be really mindful of this.

7 DR. SAMAL: That makes sense, that  
8 makes sense. And I think that's also what we  
9 were talking about before.

10 MS. POWELL: Can I just add  
11 something to what Christine said? I think it  
12 is important to consider the patient and  
13 family because they do certainly have a role  
14 in this and yet they're -- part of the reason  
15 why care coordination doesn't happen as well  
16 as it could or should is because the health  
17 system itself is not doing some of the things  
18 that it needs to do to help the patient and  
19 family be successful in that. And so I just  
20 want to be careful about not -- in places  
21 where this is really hard just kind of turfing  
22 it to the patient and family. Because things

1 such as making appointments and navigating the  
2 health care system, that's difficult for those  
3 of us who actually work in this all day every  
4 day and to think that a patient is going to be  
5 successful at that is, I just want to make  
6 sure that we're assigning responsibilities  
7 well.

8 DR. SAMAL: Right, right. I mean  
9 people have likened it to the banking industry  
10 or airline industry where now you as the  
11 consumer do all the work basically. We don't  
12 want to get to that point.

13 MS. POWELL: Yes. But there are  
14 certainly places where patients and families  
15 can be more involved or have, given the right  
16 tools.

17 DR. SAMAL: Right. That makes  
18 sense. Okay, so just --

19 MS. KLOTZ: To clarify what I was  
20 trying to say too is that the system should  
21 support the patient and the family, not push  
22 it off to them.

1 DR. SAMAL: Right. And yes.  
2 Right. I did put a bullet in and it's  
3 actually here on page, right next to the --  
4 I'm sorry, let me see here. It's about  
5 personal health records. Where did I write  
6 that. It's page 8, the second bullet point.  
7 I wrote that because if we are going to talk  
8 about consumer health informatics there's a  
9 huge literature around that as a concern. And  
10 even, not just consumer health informatics.  
11 I mean, patients are concerned about  
12 electronic exchange of information in general.  
13 So I think that's definitely a huge issue that  
14 we should at least address. Okay.

15 So the last two bullet points here  
16 are actually kind of the same thing. The  
17 first one is from the paper in the Journal of  
18 General Internal Medicine which was that, you  
19 know, when they talked to clinicians providers  
20 were describing work-arounds for tasks where  
21 when they interviewed the vendors, the vendors  
22 said no, we actually have a function to do



1       that.  So I think that's something we don't  
2       want to forget is that clinicians don't  
3       necessarily get the training and the support  
4       that they need to really use what's even  
5       available in the products.  So that's an  
6       organizational problem.  And then --

7                 DR. WHITE:  Excuse me.  I wanted  
8       to make a comment about that.

9                 DR. SAMAL:  Yes.

10                DR. WHITE:  That is true but some  
11       physicians are also -- clinicians are also  
12       resistant.  And there's still a lot of  
13       resistance out there.  I think we all sort of  
14       assume that everybody's on the same page and  
15       they aren't.

16                DR. SAMAL:  Yes.

17                DR. WHITE:  And there are a lot of  
18       providers out there who still don't want to  
19       use electronic medical records.

20                DR. SAMAL:  That's right.  That's  
21       definitely true.  And people are talking about  
22       sort of the graying out, is that really going

1 to be a phenomenon where people gray out and  
2 the ones that aren't using are going to retire  
3 or not. Are there also people that are coming  
4 in that will be resistant.

5 DR. WHITE: The other thing is we  
6 need to remember that these systems are  
7 phenomenally expensive, especially if you're  
8 in a one- or two-provider practice setting.

9 DR. SAMAL: That's right. And I  
10 know that some of the efforts around the  
11 regional extension centers were meant to try  
12 to create community-wide resources, regional  
13 resources for clinicians, but I don't really  
14 know that that's really penetrated the market  
15 or if people really are even aware of that  
16 yet. So. Okay.

17 And then work flow redesign change  
18 management. So you know basically we now have  
19 moved to thinking that the health IT should  
20 fit the work flow but when we're talking about  
21 raising the bar and encouraging people to do  
22 things they haven't with care coordination we

1 have to remember that we're asking them to  
2 redesign their work flow to use the health IT  
3 that's supposed to encourage the care  
4 coordination. So concepts of change  
5 management are important I think.

6 DR. LEE: You know in some of the  
7 more successful stories we hear around using  
8 EHR I think the training is not just  
9 conditions but staff as well because then that  
10 defines a proper workload you know per member.  
11 So bullet number three, consider adding staff.

12 DR. SAMAL: Yes.

13 CO-CHAIR CASEY: So I just want to  
14 point out that it's noontime now.

15 DR. SAMAL: Okay.

16 CO-CHAIR CASEY: And I know that  
17 you've got some slides to cover and people  
18 still want to make comments, but I want to be  
19 mindful of our schedule because we're behind  
20 now, so.

21 DR. SAMAL: Yes, and we have more  
22 time for questions.

1 CO-CHAIR CASEY: And we'll  
2 probably bring Arjun after lunch.

3 DR. SAMAL: Oh, I see. Okay.  
4 That's fine. So let's just go to the next  
5 slide. So I'm not going to read through  
6 everything here but basically bullet 1 talks  
7 about problems with the way that documentation  
8 is -- well, we talked about some of that  
9 already, how documentation is optimized more  
10 for capturing information, for billing and  
11 capturing your decision-making process in a  
12 way that may not actually be helpful in this  
13 situation. We talked about bullet number 2 I  
14 think already and we talked about bullet  
15 number 3. Great. Okay. Could we go to the  
16 next one? Okay.

17 So, you know, really this is now  
18 sort of bullet points that respond to the  
19 other bullet points. So we don't have to go  
20 through each one. We talked about the first,  
21 the second, the third. I brought this up  
22 earlier saying there's not really electronic

1 tools for tracking the task. Even if you have  
2 a disease registry it may not help with that.  
3 We talked a little bit about insurance  
4 information flowing to other insurers, but we  
5 didn't talk much about that coming to the  
6 point of care coming into the care settings.  
7 So for example, you know, knowing if a patient  
8 has filled a prescription, that is something  
9 that really I think makes a huge difference in  
10 your decision-making process and your  
11 conversation with the patient. Talked about  
12 personal health records. What we didn't talk  
13 about is the fact that we haven't really  
14 gotten to a point where everyone has agreed  
15 upon bidirectional communication for many  
16 reasons, time, work flow, cost, liability. So  
17 that's a whole area that we could focus on in  
18 the future. And I think in the paper this  
19 really is going to be almost like a laundry  
20 list unless people feel like there is some  
21 data behind any of these that we could cite.  
22 Otherwise it'll sort of just be a discussion

1 section. Next slide, please.

2 And you know, these are just kind  
3 of responses to the issues with documentation,  
4 clinical decision support. And just another  
5 idea about being able to display information,  
6 quantitative data, longitudinal data to  
7 patients and providers in a way that is  
8 helpful to the patient to understand their  
9 self-management and to, rather than counter-  
10 based documentation that we have now which  
11 makes it very difficult I think to bring  
12 things together for patients. So that is  
13 really my last slide and if anyone has any  
14 other comments right now that's fine. I know  
15 that people probably don't because they'd like  
16 to eat lunch.

17 So, I'm going to collect your  
18 outlines and then if you want to email me  
19 that's fine. My email is just my first  
20 initial "L" and my last name S-A-M-A-L at  
21 partners.org. Or if you just write your name  
22 and email on your outline I will contact you.

1 Thank you.

2 CO-CHAIR CASEY: And Lipika,  
3 you'll be here through the rest of the  
4 meeting.

5 DR. SAMAL: Yes and I'll be here  
6 all day.

7 CO-CHAIR CASEY: So thank you very  
8 much.

9 DR. SAMAL: Thank you.

10 (Applause)

11 DR. BURSTIN: Just one comment.  
12 So, Lipika is just as you could tell at a  
13 fairly early stage of developing this paper.  
14 So this input has been great. You'll see a  
15 draft of this paper come back to you for  
16 review. We're hoping the paper serves two  
17 roles one of which is obviously to help inform  
18 the committee about what are the likely  
19 directions, but also I think it's -- we're  
20 also hoping this is part of that critical  
21 pathway of putting something like this out  
22 there that allows developers and others to

1 start thinking about where they potentially  
2 could go for the next generation of measures.  
3 So thank you, Lipika.

4 DR. SAMAL: Thank you.

5 CO-CHAIR CASEY: So Lauralei, is  
6 it lunchtime?

7 MS. DORIAN: It is lunchtime now.  
8 We'll have Arjun's presentation after lunch.  
9 I think what we might do is just maybe break  
10 for 10 minutes for lunch and then we can take  
11 lunch back to the table if that's okay with  
12 everyone?

13 CO-CHAIR CASEY: Have a working  
14 lunch then.

15 MS. DORIAN: A working lunch, does  
16 that sound good? Okay, thank you.

17 CO-CHAIR CASEY: Is everyone okay  
18 with that?

19 MS. DORIAN: Operator, are you  
20 there?

21 OPERATOR: Yes, I'm here.

22 MS. DORIAN: Can you see if there



1 are any public members on the phone for public  
2 comment, please?

3 OPERATOR: No one is on the phone  
4 yet.

5 MS. DORIAN: Okay, thank you very  
6 much.

7 OPERATOR: You're welcome.

8 (Whereupon, the foregoing matter  
9 went off the record at 12:05 p.m. and resumed  
10 at 12:25 p.m.)

11 CO-CHAIR CASEY: So let's kind of  
12 review while you're eating what we've done.  
13 We started off with sort of getting to know  
14 folks. We've reviewed some of the detail  
15 about the journey we're on vis-a-vis what this  
16 committee's going to try to accomplish in the  
17 next few months. We've had I think a very  
18 elegant presentation from Lipika on the work  
19 she's doing and I think she appreciates the  
20 feedback you've given. We're really going to  
21 look forward to having this paper in our hands  
22 during our deliberations.

1                   We thought we'd change the agenda  
2                   a little bit because we want to be sure to  
3                   capture everyone's point of view in the room.  
4                   We've noticed that some people are a little  
5                   less shy than others so for those of you who  
6                   are shy, get over it. You're going to be  
7                   asked to talk. Because we really do want to  
8                   be sure that everyone in the room is  
9                   participating on this in this afternoon.

10                   We are going to -- I'm going to  
11                   say a few words, then Arjun is going to do his  
12                   presentation. Arjun, about 20-25 minutes.  
13                   And what we're going to do is ask him to go  
14                   through his slides and then what we will do  
15                   then is have a round table with your reaction  
16                   to what he's talking about. And also, you  
17                   know, what you've heard so far. We're going  
18                   to ask you to be, try to be brief and if  
19                   you've heard other ideas not to repeat them.  
20                   And then Lauralei is actually going to be  
21                   capturing a lot of the content of what your  
22                   comments are in this process of going around

1 the room. Helen suggested too that in this  
2 process if you can think about sources of  
3 measures that are either in development or are  
4 in play. And if you can help us identify  
5 where those measures lie. We're thinking that  
6 a pull strategy of trying to reach out to  
7 these particular areas would be also useful in  
8 terms of our request. So I think that was a  
9 really good enhancement.

10 Then what we will do is I think  
11 we're going to then break into the questions  
12 that are in your agenda because we do want to  
13 really at a high level talk about these  
14 questions. The major goal is to help frame  
15 the call for measures which is a written  
16 document and will go out to the NQF membership  
17 and the public, the rest of the country, in  
18 terms of saying now is the time to submit.  
19 And it's in that document that we will really  
20 try to be guiding in terms of what it is we  
21 want. So we want your input about what we're  
22 going to be asking of those measure

1 developers. So, and then keep in mind again  
2 that we're in two levels. One is you're going  
3 to be doing the review of measures but also  
4 trying to reframe and redefine the current and  
5 future state around care coordination based  
6 upon all this stuff that's here. So again,  
7 please read the preferred practices several  
8 times and you know, you don't have to do it  
9 today, but after you get home, to be sure that  
10 you take advantage of the great work that's  
11 been done before. So did I do that okay? So,  
12 any questions about our agenda or any  
13 comments? Does that seem reasonable?

14 We're still on a goal to be done  
15 by 4:00. We know some people may actually  
16 have to leave a little bit early. So if  
17 that's the case and you feel like you're going  
18 to be missing something we could either make  
19 the phone available to you if you want to stay  
20 called in or we could be sure that if you  
21 missed something that we would give you a  
22 chance. How many people have to leave before

1 4:00? Just a show of hands. So only a  
2 couple. So, we'll be sure, 3:00, 3:00 or  
3 4:00.

4 MS. DORIAN: Don?

5 CO-CHAIR CASEY: Yes.

6 MS. DORIAN: May I also call your  
7 attention to the fact that in your folders you  
8 have a sort of brief summary that includes all  
9 of the preferred practices from last year. So  
10 that might, it's just a two-pager. So that  
11 might be useful.

12 CO-CHAIR CASEY: That's a great  
13 point to just keep that over to the side so  
14 you can look at it when you're wondering if,  
15 you know, because it's a lot of stuff. So  
16 with that I want to introduce Arjun and thank  
17 him for his patience. And Arjun, we really  
18 look forward to this. I think what you've  
19 provided us already is very interesting and I  
20 think it will serve really as the foundation  
21 for our discussion about how to reframe the  
22 basis for what we're talking about. So it's

1 all yours, Arjun.

2 DR. VENKATESH: Just as a little  
3 background I'm a fourth-year resident right  
4 now in emergency medicine and I don't have  
5 much prior experience at all with care  
6 coordination. But I did have the opportunity  
7 to start a mini-fellowship with Helen at NQF  
8 this year and this seemed like a good project  
9 to start with. So, this kind of reflects a  
10 view maybe from the outside of care  
11 coordination. There's a lot more, many more  
12 experts in the room so it'll be interesting to  
13 get your perspectives when you see what I show  
14 you about where it seems like there's been a  
15 lot of measurement development and where some  
16 of the gaps are moving forward.

17 So as my disclosures I have some  
18 unrelated grant support from a variety of  
19 foundations. And then I do also have some  
20 consulting money related to 30-day  
21 readmissions from AHRQ but that's outside the  
22 scope of this project fortunately. Okay.

1                   So my main goal is going to be to  
2                   quickly outline the approach that I used and  
3                   what the purpose of the environmental scan was  
4                   as well as then to kind of describe the  
5                   methods by which I conducted a bit of a  
6                   systematic review, and then describe some of  
7                   what the measure characteristics that are out  
8                   there as well as what some of the subsequent  
9                   measurement gaps are by doing some mapping of  
10                  those measures. And then we can leave that  
11                  then with the discussion that'll kind of flow  
12                  into what we're going to do next which is to  
13                  think about future measurement gaps and what  
14                  may already be in development in those areas.

15                  So my primary objective was to  
16                  identify all current measures that are related  
17                  to the NQF-endorsed definition which you  
18                  already kind of reviewed earlier and I put it  
19                  up there again. What's challenging about it  
20                  is because the definition is so comprehensive  
21                  and includes so many things, in order for this  
22                  project to get done, in order to be efficient

1 it really became important to start drawing  
2 some more lines for what would be included  
3 within the environmental scan.

4           What I knew that we had was kind  
5 of what was low-hanging fruit, things that  
6 were easy to identify. The 2010 NQF report  
7 had 10 measures and 25 preferred practices.  
8 In 2011 the AHRQ Atlas was done which many  
9 people in this room were part of in various  
10 advisory group or executive committee forms,  
11 and that had -- that identified 61 measures  
12 relevant to care coordination. And then as we  
13 kind of came into this project some of the  
14 initial work that had already been done by NQF  
15 had really identified some major themes. And  
16 that was the incorporation of health care  
17 information technology, broad-based measures  
18 and moving towards outcomes away from  
19 processes. And what that left me with at the  
20 end was the question was where are the current  
21 measurement gaps.

22           So my approach was a "system"-atic



1 review. The quotation marks are important  
2 because for the methodological purists in the  
3 room I'd be raked over the coals. But the  
4 primary sources for the information were the  
5 primary literature, the Grey Literature, and  
6 then to some degree expert opinion interviews.  
7 I've made those all different sizes to show  
8 you the relative importance that they played  
9 in terms of how I identified what measures  
10 were already out there and what they were  
11 actually measuring. The anticipated outcomes  
12 was an inventory of existing measures as well  
13 as then a mapping analysis of this to the NQF  
14 and AHRQ frameworks. And that is more of a  
15 thought exercise to think about measurement  
16 gaps as opposed to say that one of those  
17 frameworks is better or more appropriate for  
18 thinking about measurement frameworks. And  
19 then finally to draw some qualitative  
20 conclusions about trends in measurement.

21 The search itself from the primary  
22 literature was largely out of PubMed, Cochrane

1 Review, using things like review articles that  
2 were there and things like the AHRQ Atlas.  
3 Databases being primarily the federally  
4 available ones, and then the Grey Literature,  
5 things that had been identified at CMS,  
6 previous AHRQ projects from PCPI and a variety  
7 of other sources, including Google but not  
8 including Wikipedia.

9           So in order to draw some of those  
10 lines that I said before to figure out what we  
11 could and could not include I thought it was  
12 fairly important. Because care coordination  
13 is so comprehensive and includes so many  
14 things and touches on so many things across  
15 the care spectrum. So we made an early  
16 decision to include both broad-based measures  
17 and condition-specific measures. And the  
18 reason is that ultimately it's very likely  
19 that there is some balance between these two  
20 that allows better measurement of care  
21 coordination. To simply measure things at the  
22 broad level and avoid the clinical conditions

1 ignores a lot of what's happening underneath,  
2 but then to do just the clinical condition and  
3 miss the broad measures, we've talked about  
4 already a lot this morning as to why that can  
5 be problematic. And then included measures  
6 regardless of their data source. So had I  
7 limited this search to electronic measures I  
8 could have finished this project in a day but  
9 we included paper surveys, electronics  
10 measures as well as claims-based measures.

11 What I started excluding were  
12 things that I felt either were a little  
13 outside of the definition, were going to be  
14 outside the scope of the project that this  
15 steering committee would work with and that  
16 would also help make sure the project could  
17 get efficiently completed. Measures that were  
18 specific measures of team communication within  
19 one setting I excluded. Measures that had not  
20 either had any field testing at all or even  
21 any structured assessment of their face  
22 validity, also out. Measures of screening

1 practices, you know, percentage of patients  
2 that got colon cancer screening completed in  
3 the last year, I excluded those. Measures  
4 that looked at single intervention and  
5 response. So blood pressure response after  
6 initiation of anti-hypertensive therapy, I  
7 kept those out. And then measures that were  
8 designed for other health care systems  
9 specific to like a Swedish trust or something  
10 like that seemed like they wouldn't be really  
11 helpful to consider within this group. And  
12 then 30-day readmission and emergency  
13 department throughput I also kept out since  
14 those are within other projects. Lauralei.

15 So, abstracted key measures in all  
16 of these. Whether or not they've been NQF-  
17 endorsed, was there any basis to say that they  
18 could be electronically measured right now,  
19 when were they endorsed, and then map them to  
20 two frameworks. The NQF mapping was assigned  
21 by me and that was looking at the original six  
22 domains that we've mentioned, or five domains,

1       sorry, that we've mentioned before. And then  
2       when mapping it to the AHRQ framework when the  
3       project was done a lot of mapping was already  
4       done for those 61 measures they included.  
5       This analysis done includes 125 measures. So  
6       for that 61 where they were already mapped by  
7       AHRQ I left it as-is and then after that it's  
8       subject to my interpretation.

9               So in total I was able to identify  
10       124 measures. What's important here is that  
11       only 86 of those actually have published  
12       specifications, meaning that they can be found  
13       in the primary literature or within a  
14       clearinghouse or that they are somewhere where  
15       if somebody wanted to identify measures for  
16       their use that they could go and find them.  
17       And that becomes more important when we start  
18       looking at what types of measures were the 30  
19       percent will really start helping us  
20       understand some of the gaps.

21               About a quarter of these can be  
22       electronically measured or have some testing

1 around being electronically measured, and the  
2 vast majority of that falls in the unpublished  
3 category. There was only one outcome measure  
4 if we want to define "outcome" by a health-  
5 related outcome as opposed to something like  
6 preventable hospitalization or ED visitation  
7 or something like that. And about two-thirds  
8 of the measures would be considered kind of  
9 broad or crosscutting versus about a third  
10 being condition-specific. And then a quarter  
11 of these had NQF endorsement. And the reason  
12 this 30 number is very different than the 10  
13 number we were talking about before is that  
14 there are measures that have NQF endorsement  
15 that have come through other projects. For  
16 example, follow-up after TIA would have come  
17 through a different project so it wouldn't  
18 have been part of the 2010 project but  
19 certainly falls within the purview of care  
20 coordination.

21 So data sources. My pie charts.  
22 Go ahead. Every presentation needs this but

1 I don't have any Venn diagrams. So like I  
2 said before, if you take a first glance at  
3 what data sources measures come from it's  
4 about a quarter being electronic and three-  
5 quarters being manual of some sort. Another  
6 way to cut this though -- go ahead and click -  
7 - is to start looking at what types of data it  
8 is that goes within it. So, measures that are  
9 coming from electronic medical records are  
10 about a fifth. Survey-based, and by that that  
11 means largely paper or telephone questionnaire  
12 is about a third. Chart review, two-fifths,  
13 and then a small amount are claims-based  
14 measures. And that could include both  
15 administrative billing claims as well as like  
16 pharmacy benefit type claims both within that.

17 Now, this is slightly different  
18 because what this starts to say is well, what  
19 about the measures that are published, that  
20 are available and that people could find and  
21 do something about. And what you start seeing  
22 here now is that the vast majority of measures

1 are surveys of patient experience and the next  
2 large vast majority is chart review, and  
3 there's very little in the scope of electronic  
4 measures that are available for people to find  
5 and be able to use.

6 And then there's an analysis  
7 looking at all the measures in terms of their  
8 level of measurement. And this was the level  
9 that was specified by the measure developer.  
10 And since, for those who have been through the  
11 NQF consensus development project before,  
12 measure developers can specify either one or  
13 multiple levels of measurement for a measure.  
14 So what I did first was in the aggregate which  
15 is the dark blue I took every measure and I  
16 classified it by whatever its highest level of  
17 measurement was. So if it could be measured  
18 at the provider level or the system level I  
19 assigned it to the system. And then the  
20 disaggregate which is the light blue shows  
21 measures that are, when -- that concern what  
22 the closest to the patient, the most distal



1 level is. And so obviously as you can see as  
2 you go from dark blue to light blue more  
3 measures are considered to be at the health  
4 care provider level. What I think is probably  
5 the bigger takeaway from this is that there  
6 are very few measures that are kind of at the  
7 hospital level which I thought was a little  
8 bit surprising. And the reason that there are  
9 so many practice-level and health care  
10 provider level measures is because when you  
11 remember that last slide, right, half that pie  
12 was patient experience surveys. That's all  
13 over there. And that's why it looks like  
14 there's so many measures but really what those  
15 are is that they're all various iterations on  
16 the same small sliver of measurement.

17 So frameworks for mapping. I  
18 think a handout came out before and that was  
19 something I just kind of prepared for my own  
20 as a mental exercise for myself to think about  
21 when I find all these measures how do I make  
22 that useful for you all to be able to

1 interpret. And I thought well the best thing  
2 to do is then to put it to some framework for  
3 the measurement of care coordination so that  
4 you can start to think about where the gaps  
5 are. There was the NQF framework that was  
6 essentially made up of five domains and then  
7 four principles and that's 2006. And then  
8 there was a framework that the AHRQ Atlas  
9 uses. And the way they originally organized  
10 it was as mechanisms and what they call those  
11 are coordination activities and then broad  
12 approaches which are fundamentals across all  
13 activities as well as effects. And they  
14 thought about effects from the perspective of  
15 the patient, the health care professional or  
16 the system. And, next slide. The way they  
17 also described it in the AHRQ Atlas was to  
18 think of broad approaches as the structures  
19 and the coordination activities as processes  
20 and the effects as outcomes if you want to put  
21 it in a Donabedian sense.

22 The way I kind of framed it for

1 the purpose of this activity is the next slide  
2 which is this. And looks really messy and  
3 really scary but it is kind of colorful. And  
4 what it largely is is that the blue up here is  
5 the AHRQ coordination activities. So those  
6 are all the processes. And then the red is  
7 the NQF care coordination domains. And to me  
8 those seem to be the most relevant. Most of  
9 these kind of green, broad approaches that  
10 were defined by AHRQ as crosscutting things  
11 that make sense is that all kind of map up  
12 almost to one domain each. So in general what  
13 I thought was the most valuable thing would be  
14 to look at what measures look like if you use  
15 one framework and then what if I re-map the  
16 measures using a different framework. How  
17 would that be different in terms of what kind  
18 of gaps you see. And that was the goal of  
19 doing this. Next slide.

20 So, first broad stroke is if we  
21 look at NQF domains and the number of measures  
22 per each domain there's clearly gaps with

1 information systems and health care home.  
2 Now, those are slightly newer concepts to some  
3 degree and there just hasn't been much that's  
4 been, there's really very little almost  
5 measurement-wise that can fall within either  
6 of those categories. Transitions and  
7 communications seem to have a little bit more,  
8 and then plan of care has the most, and the  
9 reason plan of care has the most again is that  
10 many of the patient experience surveys that  
11 have been developed since the late '80s, early  
12 '90s focus on various aspects of what's  
13 included in plan of care and the way the NQF  
14 domain is defined for plan of care is very  
15 comprehensive and very wide. It includes, you  
16 know, everything from patient assessment and  
17 self-assessment to needs assessment by the  
18 provider to follow-up and all that kind of  
19 collapsed within one group.

20 If we map it to the AHRQ  
21 definition you start to see that there's a  
22 little bit more granularity. So an example of

1 one would be looking at the transitions  
2 between settings and transitions of needs.  
3 And the difference there is that a transition  
4 between setting and the AHRQ definition is  
5 what you would think of traditionally,  
6 hospital to home, home between ambulatory  
7 provider and specialty provider, something  
8 like that. But transition needs is the  
9 development of measures that really think  
10 about patients as they move from one set of  
11 needs to another. Adolescent into an adult  
12 care setting, right? Early elderly into more  
13 of a geriatric population, whatever it may be.  
14 So there's much less measurement that's  
15 happening right there. Similarly when it  
16 comes to measures that try to attempt to  
17 measure whether or not resources are aligned  
18 or whether or not there's any linkage to the  
19 community, again, very few measures and that  
20 probably links to a lot of the things we were  
21 talking about before which is some of the data  
22 considerations and things like that where it

1 becomes difficult to really develop measures  
2 that are really capturing some of that. Next  
3 slide.

4           So, where are the gaps when we say  
5 electronic measurement? And the thing to  
6 think about here when I present this data is  
7 when you see electronic measures those are  
8 things that we've identified primarily through  
9 the Gray Literature or from other NQF projects  
10 and things like that. These aren't measures  
11 that are publicly easily found or for anybody  
12 to pick up and use but what it's start showing  
13 is that where we do see electronic measurement  
14 may be the potential for some of this pull  
15 strategy of people that would be willing to  
16 submit measures, but it also starts to show  
17 where there's not even in much electronic  
18 that's been proposed so far. So, these are  
19 hundred percent bars.

20           So this is according to the NQF  
21 definition. And what you find here is that  
22 where there are most electronic measures fits

1 within information systems and that would be  
2 what you would think which is essentially  
3 measures of structure, right? Do you have a  
4 medical record that does these four things?  
5 Do you have patient -- does the patient feel  
6 like they have a medical record that has  
7 covered these eight elements? Things like  
8 that would fall under the information systems  
9 and that's why there's a lot of electronic  
10 measures there because most measures are  
11 structure measures that fall within that.  
12 Otherwise, for virtually, for transitions,  
13 communication plan of care, health care home  
14 there's very few, right? The percentage of  
15 measures that are electronic become very small  
16 basically across all domains. If we do this  
17 by the AHRQ definition, again the same thing.  
18 Very few measures would be considered  
19 electronic in many domains and there's almost  
20 none in certain domains such as interpersonal  
21 communication or establishing accountability,  
22 aligning resources in the community. So, what

1 I think this starts to paint the picture of  
2 recognizing is that when -- this environmental  
3 scan will show that there's a variety of  
4 measures around care coordination, very, very  
5 few are electronic and the areas that we have  
6 measurement gaps in already when we think  
7 about electronic measurement gaps in those  
8 areas it's even a bigger problem.

9 And so this addresses the second  
10 question I had and I've alluded to before was  
11 does the availability of the measure help  
12 frame how we think about these gaps. And by  
13 availability I mean has it been published and  
14 is it available to somebody looking for a  
15 measure to use. So if we do this by the NQF  
16 domain you can see how big of a difference it  
17 is, right? The number of published measures  
18 is tremendous and plan of care again, very  
19 high, as I said before, because that includes  
20 all the patient experience work. But when you  
21 look at published electronic measures they're  
22 very small slivers, they're almost none for



1 most categories. And then the same thing  
2 holds true for the AHRQ framework on the next  
3 slide here. Which is, again, many, many  
4 measures will be published and may be  
5 available, but if you only take the published  
6 ones that are electronic, again, it's a very,  
7 very small number that are able to be -- that  
8 are available to anybody who's looking to do  
9 any measurement. Next slide.

10 So, how does the use of the  
11 framework alter the analysis? And this starts  
12 pointing to whether or not thinking about  
13 whether or not what framework is used to think  
14 about these measures in this current project  
15 affects whether or not you address measurement  
16 gaps that exist currently across the spectrum.  
17 So the first one I'll take as an example is  
18 that proactive plan of care, right, that big  
19 catch-all category that existed for the NQF  
20 framework was actually relevant and mapped out  
21 - and this was, AHRQ maps this out actually  
22 even in their document to these five

1 coordination activities as well as this one  
2 broad approach. So then if you start looking  
3 at measure mapping within each of these  
4 categories you start seeing why grouping it in  
5 that one large category starts to miss a lot,  
6 and that's the next slide.

7 If you look just at the proactive  
8 plan of care you'd see that there was 80-some  
9 measures that addressed it, that you know  
10 there's over NQF-endorsed measures for plan of  
11 care. And there's even, I think there was  
12 eight electronic measures that are -- fit  
13 within the plan of care. But then when you  
14 start doing it across all those subcategories,  
15 when you mapped it across the AHRQ, most of  
16 those measures are in monitoring, following up  
17 and assessing needs. And assessing needs  
18 tends to be patient experience of assessment  
19 of needs and monitoring follow-up tends to be  
20 kind of a general transition to a lot of  
21 claims-based measures of follow-up. You know,  
22 two week after TIA, cardiac rehab after AMI,

1 things like that that start falling in that  
2 group versus linkage to community, care  
3 management, much, much less measurement and  
4 almost no measurement when it comes to NQF  
5 endorsement or things that are published and  
6 electronic. I also did this then for the  
7 communication group. It was a very important  
8 ones, everybody's always mentioning it in a  
9 variety of ways and it mapped out to two,  
10 really three of AHRQ coordination activities  
11 because they separate what is interpersonal  
12 communication, face-to-face, interactions  
13 between individuals and informational  
14 communication which is the actual transfer of  
15 certain data elements, and then a care  
16 management broad approach. And again if you  
17 look here what happens in the next slide is  
18 that communication has 40 measures in the  
19 broad domain, very few NQF-endorsed and then  
20 I think only one is published in electronic.  
21 But then when you start comparing it to the  
22 subcategories we see that interpersonal

1 communication and information communication  
2 both, I guess, information communication,  
3 sorry, has the most number of measures and  
4 this really comes down to, again, things such  
5 as -- I'm trying to think of the best classic  
6 example of that measure that would fall into  
7 that. Data elements included at discharge  
8 from hospital. Some of the transitions  
9 measures that were included last time would  
10 fall into a lot of that. Very much less about  
11 care management and on establish  
12 accountability I think this is interesting and  
13 probably worth some discussion later. There's  
14 a lot of measures that map to establish  
15 accountability but that doesn't mean I think  
16 that it meets the way everybody in this room  
17 probably is thinking of establishing  
18 accountability. So for example, if you ask a  
19 patient if they can identify their clinician,  
20 right, then that type of a measure is  
21 considered an established accountability  
22 measure. But that really doesn't get at a lot

1 of ideas and themes that you guys have  
2 discussed with respect to care coordination.  
3 So I think when we see a lot of measures in  
4 establish accountability as you see these  
5 slides and if you look at these again in the  
6 future I would take it with a grain of salt  
7 because a lot of that is not necessarily  
8 getting to what really is an idea of shared  
9 accountability or negotiated responsibility  
10 and things like that. Next slide.

11 So I think this is the last  
12 question I asked which was do the gaps defer  
13 based on the focus of measurement. And that  
14 meant, by focus I mean whether or not it's  
15 condition-specific or broad. And so what you  
16 see here is that not entirely surprising, plan  
17 of care measures is the place where there's a  
18 lot more condition-specific measures than  
19 broad measures. And that I think is largely  
20 driven by a lot of the claims-based measures  
21 that look for follow-up. And that's just the  
22 easiest way to do that. And also not

1 surprising, any measure of the health care  
2 home is not really condition-specific in  
3 general. Actually, the one that's condition-  
4 specific here, it was specific to children  
5 with special health care needs and one other  
6 condition that I can't remember what it was  
7 offhand. But in general across these what we  
8 see is that most of the condition-specific  
9 measures are in a specific plan of care and I  
10 think that that'll probably hold true as  
11 future measures are proposed as well. If you  
12 do this by the AHRQ framework, again, most of  
13 the condition-specific measures are on  
14 monitored follow-up and monitored follow-up  
15 again is usually transitions between settings  
16 and there's very little when it comes down to  
17 alignment of resources, the linkage to the  
18 community. In general, most of the measures  
19 when you map it across this, I think it  
20 diffuses some of that plan of care and follow-  
21 up. So the reason there were so many in  
22 planned care by the NQF analysis now gets

1 diffused across four or five categories here.

2 So that's why it starts to look like the  
3 number of condition-specific measures are  
4 about the same across the domains. Next  
5 slide.

6 So what are some of the key  
7 findings? So, from the descriptive analysis  
8 I would say that most electronic measures are  
9 not formally specified or published. So while  
10 I was able to map them, those electronic  
11 measures, that doesn't mean that there's a  
12 clear numerator, denominator statement, or a  
13 lot of things that we would think about in  
14 terms of traditional measure specification to  
15 make them usable for anybody. So the question  
16 becomes is there an electronic set of measures  
17 out there that we just don't know about.  
18 Almost all the measures are process measures  
19 and I think this then gets to both a semantic  
20 game as well as meaningful kind of thought  
21 game around what is an outcome measure for  
22 care coordination. The one that I include as

1 an example is drug-related morbidity  
2 associated with drugs that need a high amount  
3 of prescription drug monitoring. And so  
4 actually, the outcome that they used within  
5 the measure that's reported is the actual  
6 drug-related morbidity. But are some of these  
7 other processes, rehospitalization, emergency  
8 department visitation, are some of these other  
9 things also outcomes measures? And I think  
10 that that's worth thinking about because it  
11 really -- what kind of guidance a measure  
12 developer gets around that will have a big  
13 impact on what they feel they can submit or  
14 not submit into the consensus development  
15 process.

16 And then most measures right now  
17 are patient experience surveys. That's the  
18 vast, vast majority of it. And then, so given  
19 that, how can you comprehensively measure  
20 activities across the spectrum when the  
21 majority of available measures take only that  
22 small sliver of the whole process and there's



1 a lot of measures right there, there's a lot  
2 of overlapping work for that little bit of  
3 area. Next slide.

4 This is my kind of what I think  
5 has been the timeline of care coordination  
6 measurement is that the '80s and the '90s were  
7 a lot of patient experience surveys because  
8 that's what was kind of doable by data. Then  
9 that has started to move towards a lot of  
10 condition-specific claims and measurements.  
11 So I think that that actually will be where --  
12 go ahead and click -- where we are right now  
13 is in that area. And that where this could  
14 move to is more of these medical record-based  
15 or activity and process thinking about  
16 different measures. But I'm not sure we're  
17 like, there's not really much to say that  
18 there is something to use out there right now.  
19 And what will be interesting to see is what  
20 happens if somebody proposes a patient  
21 experience survey in this consensus  
22 development project. You know, do you want to

1 continue to include those types of things in  
2 a discussion and review them, or should the  
3 process really move towards the other end of  
4 that spectrum? Next slide.

5 One thing I found challenging was  
6 where to put information systems in this. We  
7 have it in the 2006 framework as a separate  
8 domain but in reality I think the discussion  
9 is and a lot has happened since 2006 is that  
10 it's more of a crosscutting foundation. It's  
11 a type of infrastructure that is necessary for  
12 all these different kinds of measures. So to  
13 simply bucket measures in there I don't think  
14 is a very useful thing, or useful way to think  
15 about it. There's definitely the need to  
16 consider sub-activities. I think looking at  
17 that plan of care mapping shows you that,  
18 where you can miss things if we use too broad  
19 of a group. And then the other thing to think  
20 about is is there a model out there that is  
21 better suited for measure mapping. Is there  
22 something that is more sequential or more

1 comprehensive where you can actually take  
2 measures and put them into mutually exclusive  
3 buckets to understand how well you've covered  
4 care coordination as a whole? Next slide.

5           So, in conclusion, the main gaps  
6 would be a lack of electronic measures and in  
7 certain measure areas it would be those with  
8 respect to the health care home, transitions  
9 within the ambulatory setting. There's a lot  
10 between the hospital and the ambulatory  
11 setting. There's very little that goes at the  
12 referral loop that happens within the  
13 ambulatory setting and as more and more things  
14 happen outside of the hospital setting the  
15 importance of those measures becomes  
16 increasingly important. There's really  
17 nothing that starts to get at community  
18 linkage and understanding how community  
19 resources play into care coordination as well  
20 as transition needs.

21           And then I think the last kind of  
22 thing about gaps is how do you get beyond the

1 patient experience survey. And a lot of  
2 people have kind of mentioned this today which  
3 is instead of it just being did you do patient  
4 education or did the patient get an experience  
5 survey is did they actually understand it. So  
6 is that patient assessment, is that other  
7 forms or ways of measuring whether or not  
8 you're getting true person- and family-  
9 centered care. And I think that those are  
10 probably the areas that have the most room for  
11 improvement but it would be interesting to  
12 hear from everybody if they're aware of any  
13 measures there and particularly ones that are  
14 in the close term and being near the point of  
15 development where they'd be in the next  
16 project. I think that's it.

17 CO-CHAIR CASEY: So Arjun, thank  
18 you very much. This is a lot of hard work and  
19 we want to be able to be sure we get some  
20 questions here and comments. I think that we  
21 will do our round table after this but right  
22 now I want to focus on this presentation and

1 get your reaction and comments. And let's  
2 just spend a few minutes doing that. So, go  
3 ahead.

4 MS. ALEXANDER: So the eMeasures,  
5 the lower number of the eMeasures I don't fund  
6 surprising at all. Whether that's NQF-  
7 endorsed measures or other. And if we think  
8 about particularly right now in the industry  
9 as related to NQF-endorsed measures that we're  
10 in, you know, a process of retooling current  
11 NQF-endorsed measures into eMeasures. I mean  
12 this is a very huge undertaking. So were you  
13 I guess aware of that and was any  
14 consideration given to that in terms of the  
15 results here and what you're reporting in  
16 terms of gaps?

17 DR. VENKATESH: I think that that  
18 exactly is what makes sense, is that what --  
19 I think that the industry right now. I mean,  
20 it's all very new. And so as these measures  
21 do get retooled I would anticipate that a lot  
22 of those measures that are currently

1 classified as not electronic would hopefully  
2 be then, could be classified as electronic and  
3 would change that. My guess is then is that  
4 then if you think about kind of globally where  
5 some of those measures are that those will be  
6 still some of the gaps. So we don't really  
7 have many measures, for example, to measure  
8 community linkage. So, as we retool current  
9 measures to go electronic we're still going to  
10 have a gap with community linkage afterwards.  
11 But I'm sure if I redid this in like 12 months  
12 it would be completely different.

13 MS. ALEXANDER: I would agree.  
14 And I think the other aspect that's going on  
15 in the industry too that will help support  
16 this initiative of retooling the eMeasures and  
17 creating standardization for some of the data  
18 and information-sharing that we were talking  
19 about earlier is the quality data model which  
20 I think there's actually a webinar on today  
21 from NQF, and then the measure authoring tool  
22 for stewards as well too. So I see all of

1 those activities supporting measure  
2 development and then particularly for  
3 eMeasures as well in the future. Thank you.

4 CO-CHAIR CASEY: Yes, Karen.

5 DR. FARRIS: I would just comment  
6 that the segmentation of the proactive plan of  
7 care is probably the most profound to me  
8 personally because I did serve with a few  
9 people in here on the first committee and that  
10 just became a big bucket. And maybe sometimes  
11 we weren't exactly sure, you know, we'd put it  
12 there. So I think that that's very insightful  
13 and I think helpful to this group.

14 CO-CHAIR LAMB: I'd like to echo  
15 that. First off, for somebody who isn't  
16 familiar with care coordination literature I  
17 think you did an astounding job. The other  
18 question is when we're going to get this so  
19 that we can see, you know, the groupings. But  
20 what struck me was the granularity, you know,  
21 and I think you pointed that out. And just  
22 based on your experience in working with the

1 hundred and some odd measures whether you  
2 think that the granularity in the AHRQ mapping  
3 will help us not just look at gaps but be  
4 clearer on where there's value in filling  
5 those gaps.

6 DR. VENKATESH: Yes, I think you  
7 know, from the developer of measures  
8 perspective I'm wondering if what you're  
9 alluding to now when it's more directed, it's  
10 more granular. If your measure fits within  
11 that it may almost to some degree drive more  
12 measurement development because people feel  
13 like it fits that bucket versus something like  
14 proactive plan of care can seem so broad and  
15 so much more difficult to capture within a  
16 measure. So I could see maybe using some of  
17 this language or even incorporating some of it  
18 into the call for measures to help guide  
19 measure developers so that it makes it easier  
20 for them. Having been on the measure  
21 development side I can totally see how it  
22 would be a lot easier to follow something that



1 helps categorize it for me as opposed to  
2 having to come to the table and try to  
3 categorize it when I know that there's 40  
4 definitions, 55 frameworks in the whole world  
5 out there.

6 CO-CHAIR CASEY: So, I want to  
7 point out a nuance here that I think is  
8 important. And I think it may be obvious to  
9 some but I'm not sure it is to everyone. And  
10 that is distinguishing between what you call  
11 HIT and data standards. Because I think that  
12 somehow or another data standards sometimes  
13 get rolled into HIT and I think they're  
14 related but different. But that is probably  
15 symptomatic proof of your findings, that we  
16 don't have these data standards. So I wonder  
17 if you could comment on that distinction in  
18 your presentation and maybe call that out a  
19 little bit more clearly.

20 DR. VENKATESH: Yes, there's like  
21 a pool of measures sometimes that were  
22 probably classified as administrative claims

1 measures or got classified as chart review  
2 measures and the reason being is that to  
3 capture the information necessary to know if  
4 somebody had appropriate follow-up and  
5 something was done at that follow-up for  
6 example requires multiple data sources. And  
7 part of that is based on the data standards  
8 that I think go into each of those data  
9 sources. So you can always know that somebody  
10 saw a doctor of some sort after they were in  
11 one setting, or you can know that somebody  
12 went from a primary care doctor to a  
13 specialist and saw a primary care doctor  
14 again, but if you wanted to know was there a  
15 consult report mailed back you'd have to do a  
16 chart abstraction. And so I think that that  
17 is a place where to some degree there's,  
18 you're almost there with, you have part of the  
19 data standards or you have part of the data  
20 elements in something that is electronically  
21 abstractable but then a little bit more is  
22 not. And I guess what would be interesting is

1 if when you put it back to measure developers,  
2 you know, what's the standard going to be? To  
3 be considered a measure that's electronic,  
4 right, everything has to be found and how  
5 electronic I guess.

6 CO-CHAIR CASEY: Other questions?  
7 Anne-Marie.

8 DR. AUDET: It may just be me but  
9 I'm a bit confused about two things. One is  
10 the distinction between a measure where the  
11 source is electronic versus the information  
12 system that is the domain of a preferred  
13 practice. I'm having a hard time kind of  
14 putting this together but it may just be me.

15 CO-CHAIR CASEY: No, it's not  
16 about you.

17 DR. VENKATESH: I think it's  
18 challenging. If you go back and you look at  
19 the paragraph that's written after information  
20 systems from the 2006 document and then you  
21 look at even the discussion in this AHRQ  
22 document about health IT there's a lot of

1 evolution in there and that happened between  
2 '06 and '10. And I'm sure if you looked at it  
3 now, and I'm not by any means a meaningful use  
4 expert and knowledgeable about everything  
5 that's happened in that gap, that language has  
6 evolved even more.

7 I think the way I thought about it  
8 to some degree was there are measures of these  
9 kind of do you have an information system that  
10 is able, and these are just structural  
11 measures of, you know, can it help with care  
12 coordination. You could have this information  
13 system and these structural measures and be  
14 horrible at care coordination theoretically.  
15 And then there are measures that are measuring  
16 some coordination activity, follow-up,  
17 medication management, something like that  
18 that are abstractable electronically. And  
19 they're definitely two different things. My  
20 guess is the former group though -- it's very  
21 hard to have the latter without the former so  
22 maybe that's a way of having them both. But

1 I think that those, when you think about it in  
2 terms of like the NQF domain for information  
3 systems when I mapped it both those fall in  
4 the same bucket.

5 DR. AUDET: The reason I'm asking  
6 this is because if we're thinking of the path  
7 and trailing the path at some point are we  
8 looking for measures that would be only  
9 available if you had this domain of health  
10 information technology and not available, like  
11 having information about a patient from all  
12 team members at the point of care. That's  
13 going to be impossible with paper. So I'm  
14 just thinking about the path. Are we, you  
15 know, getting more -- calling for more  
16 advanced measures that are even, or there  
17 could be some that are only available if you  
18 have the information technology, or those that  
19 could be both.

20 CO-CHAIR CASEY: My guess would be  
21 -- Helen, help me out -- that if you had  
22 measures like that they would be highly

1 preferential in the endorsement process, not  
2 to the exclusion of the other measures.

3 DR. BURSTIN: Yes, it's a really  
4 interesting observation. I think that we want  
5 to make sure there are measures out there that  
6 people can use but we also want to recognize  
7 there are measures out there for systems that  
8 are capable of using them, that we don't want  
9 to push out measures that feel, I don't need  
10 this, I'm way beyond this. So I suspect we're  
11 going to wind up with sort of a binary set,  
12 one that's probably more suited to those who  
13 aren't quite -- finished that HIT journey. I  
14 don't know if you ever finish it. And ones  
15 that actually really are more for the advanced  
16 systems.

17 And just a follow-up comment as  
18 well about the retooling aspect of it because  
19 I think it's a really interesting comment.  
20 One of our concerns though is that when we  
21 retool measures developed for another data  
22 system is you are kind of doing that junk in

1 the -- looking for your keys under the  
2 lamplight. You're still sort of operating  
3 under the idea that this is what I have  
4 available and I'm just taking the measure as  
5 I had it and I'm using the data standards in  
6 an EHR to create it. And I think we kind of  
7 want to also get to measures where de novo you  
8 say like some of the advanced health systems  
9 who've created measures with their HIT  
10 systems, these are the ones you can only do,  
11 and I can develop this because I know what I  
12 have in front of me. We thought about what  
13 was most important and then we looked to see  
14 if our data model could support it as opposed  
15 to the other way around.

16 CO-CHAIR CASEY: Does that help?

17 Okay, Jeff, were you going to?

18 DR. GREENBERG: I think Helen hit  
19 a lot of what I was thinking. I mean, it  
20 seems like having a domain of HIT would  
21 hopefully be obsolete soon, that we could just  
22 measure things electronically and you can't,

1 you know, it's hard to step up to the plate if  
2 you can't do that. And therefore it sort of  
3 assumes that you have electronic systems in  
4 place if that's how we're going to measure  
5 you. But I do see that you can't do that  
6 right away.

7 CO-CHAIR CASEY: So you could see  
8 like the patient having like the NFL  
9 quarterback, the care coordination on his arm  
10 there? That's still usable. You know, the  
11 quarterback's got all the plays, right? I'm  
12 kidding.

13 MS. POWELL: Thanks. Along the  
14 lines of what Helen was saying about -- and  
15 really using this as an opportunity to look at  
16 what do we really need to be measuring that's  
17 going to be helpful. I think Arjun in his  
18 presentation asked the question what do we  
19 mean by care coordination outcomes and that's  
20 been a question rolling around in my brain all  
21 morning. What are we really after? And I'm  
22 not sure we've answered the question. And it



1 seems to me like we really need to answer that  
2 question before we go much further if we're  
3 going to focus to any degree on outcomes. And  
4 it struck me as I was looking at some of the  
5 materials put together since a lot of great  
6 work has been put together to identify the  
7 domains. Perhaps there's a way to take the  
8 domains and look at them and say okay, what is  
9 one outcome for each of these domains that  
10 would really give a clear picture that the  
11 domain has been addressed as an outcome? And  
12 I don't know what those would be, but to me  
13 that would be a way to really start moving  
14 toward outcomes, some of which may be able to  
15 be measured using electronic means, others of  
16 which maybe not, and some of which may require  
17 multiple electronic data sources that we have  
18 no way to link at this point. But that to me  
19 seems a little bit more progressive and moves  
20 us away from looking at like some of the  
21 measures that were endorsed because that's  
22 what we had at the time. The cardiac rehab

1 and all of these things that are very, very  
2 specific to a very, very specific patient. I  
3 don't know, that just seems to me to be moving  
4 us a little bit closer to having these  
5 measures apply to all patients as opposed to  
6 just a very small subset.

7 CO-CHAIR CASEY: So it's a very  
8 good point, Eva. I mean I have this practice  
9 with my team of when people have great ideas  
10 putting them in charge of helping us to define  
11 what it is they are. But as I'm thinking of  
12 it I would guess things like improved health  
13 status, functional capacity, quality of life,  
14 obviously some clinical endpoints as well  
15 would just off the top of my head be things we  
16 would want to start thinking about. Knowing  
17 that probably none of these measures may  
18 actually have these as endpoints yet. But is  
19 that sort of what you're thinking?

20 MS. POWELL: I think so. And  
21 again, not having taken that specific a look  
22 at this yet, but like I say, perhaps looking

1 at those things, and if we needed to get more  
2 specific look at, say, health care home. What  
3 really is the outcome that we're after in  
4 having a health care home and make it very  
5 specific to that. And some of them may be  
6 some of the things you just mentioned. But  
7 there may be others. I think where I have  
8 trouble is defining what is really a care  
9 coordination outcome versus what is just an  
10 outcome measure that we should be measuring  
11 anyway. I don't know.

12 CO-CHAIR LAMB: Eva, that's a  
13 really critical point I think that we really  
14 need to deliberate on in the discussion. When  
15 we go around you'll have an opportunity to  
16 talk about that. But that moves us towards a  
17 premise that care coordination is really  
18 central to all outcomes and it runs the risk  
19 of if it achieves all outcomes what doesn't it  
20 achieve and how do we know it which just makes  
21 it really complex. It is such a central  
22 function but we've got to tease out some of

1 this. So we'll have that opportunity to go  
2 around and talk about it. Does anybody have  
3 any more questions about or comments? Jeff?

4 DR. GREENBERG: Yes, I totally  
5 agree with Eva and I'm glad she brought that  
6 up. I think we need not just outcomes but  
7 useful outcomes for this process. You know,  
8 something like quality of life is clearly an  
9 outcome but I'm not sure that's necessarily  
10 going to be useful in terms of how we evaluate  
11 measures. You know, that's, as you said,  
12 that's sort of an outcome of most of what we  
13 try to do in health care. So we need outcomes  
14 potentially, it's, you know, use of the  
15 emergency room, use of admissions, et cetera,  
16 that directly, you know more closely relate to  
17 these exact things we're talking about.  
18 Because some of the high-level outcomes that  
19 really do matter to patients may not  
20 necessarily guide us that well in terms of the  
21 processes we want to try to make standard.

22 CO-CHAIR CASEY: Tom.

1 DR. HOWE: Yes, before we start to  
2 assign outcomes to some of these domains I  
3 think it might be worth thinking about  
4 reordering some of these domains into the old  
5 paradigm of structure, process and outcome.  
6 And some of these domains I think as Jeff was  
7 alluding to are really just structural. You  
8 can't do care coordination that's essentially  
9 measurable or up to I think community  
10 standards without HIT. And some of these I  
11 think are enabling the process, that care  
12 coordination is a process and we need to  
13 define the subsets that allow us to measure  
14 that as I think we started to do. But once we  
15 define those then we can link outcomes to  
16 them.

17 CO-CHAIR CASEY: Yes, you know,  
18 Tom, very well put. The harkening back to  
19 this and Chris and Karen, maybe you can help  
20 us recall this. I think what we were, when we  
21 were sort of with a complete blank piece of  
22 paper on this we started defining it in terms

1 of what we thought critical elements of  
2 success might be from our own experience. And  
3 you know, obviously there was a lot there but  
4 things like community-based social services  
5 and the like were things that came to mind.  
6 But as you point out those are not outcomes.  
7 So, I think that balancing the structure  
8 process and outcome is going to be critical  
9 because you can never get to outcomes without  
10 knowing what it is you're trying to focus on  
11 with what you've got. So I think it's an  
12 elegant thing to keep in the back of our mind.  
13 Because it's very easy to jump to outcomes and  
14 just talk about that and not backfill with all  
15 the necessary ingredients needed to achieve  
16 improved whatever. So. Yes, one more  
17 question and then we're going to --

18 DR. AUDET: Well, I think in this,  
19 I really like also the process -- the  
20 structure, process, outcome. In reviewing the  
21 documents you sent there was a whole review of  
22 the literature on the impact of care

1 coordination. And I was struck by the fact  
2 that there's not a lot of evidence except  
3 maybe for transitional care. And so that is  
4 another challenge that this discussion you  
5 know poses is the evidence available to us.  
6 And there's another really great review of the  
7 literature on the cost of care coordination by  
8 Alfred Weit where he also shows, he's done a  
9 really comprehensive review of the literature,  
10 that we know about the cost of not providing  
11 good care coordination but we don't really  
12 know what the impact of good care  
13 coordination. So I think in this discussion  
14 maybe this structure/process/outcome will be  
15 a good way for us to anchor because if we base  
16 it on the evidence we're going to have some  
17 trouble.

18 DR. BURSTIN: And just one follow-  
19 up comment to that. That's actually really  
20 important. I think the other issue is that  
21 when you're going to get to look at measures,  
22 when that happens sometime this winter you're

1 going to need to look to see if you think  
2 there's evidence for the measure focus. So in  
3 some ways even if you may not necessarily be  
4 bringing in the outcomes of each of these  
5 domains and as I scan through it it was a very  
6 useful exercise. You're right, most of these  
7 do lend themselves to process, Tom. I think  
8 the issue still is going to be, it would be  
9 interesting, even if you think they're the  
10 right processes that are highly linked to  
11 outcomes we at least need to think through  
12 what those outcomes are to see if the evidence  
13 exists that that process is outcome-based. So  
14 it's going to come up anyway. I'm not sure  
15 they're going to be the ones that you're going  
16 to bring in in this project per se but I think  
17 you're going to want to be able to start  
18 thinking about how to judge those processes.

19 CO-CHAIR CASEY: So let me before  
20 I turn it over to Gerri say one last thing  
21 about evidence. Those of you who know Gordon  
22 Guyatt may have heard him teach this.



1 Gordon's a big master. He's one of the  
2 godfathers of the grade system, obviously,  
3 involved with Cochrane and the like. And what  
4 he taught me was that we have to be careful  
5 about saying there's no evidence. What we  
6 really mean is that the quality of evidence is  
7 very poor or low to support our hypothesis.  
8 And so there's a lot of good evidence -- I'm  
9 sorry, there's a lot of evidence that there's  
10 stuff going on. The quality of whether it  
11 actually achieves its intended effect is low  
12 or poor at best. So I just want to -- that's  
13 my pet peeve I realize but I get nervous when  
14 people say there's no evidence. I think we  
15 should just be mindful of that in our  
16 deliberations. So that's all I'll say.

17 CO-CHAIR LAMB: Okay. Here's your  
18 opportunity now to answer the question that  
19 we've been asking all morning which is what is  
20 really important to measure. So, if you would  
21 take just a few minutes and jot down you know  
22 what you believe is important on a go-forward

1 basis, keeping the theme here in terms of  
2 we're not retooling the same old, same old.  
3 We're trying to advance the thinking in this  
4 area. Is if you would jot down what do you  
5 think is important here, what should we move  
6 forward as we go from. This is stage 1  
7 remember, where we're looking at what is  
8 important to measure to frame the call for  
9 measures. So take a few minutes, maybe just  
10 a couple and jot down. And then we're going  
11 to go around, everybody will have an  
12 opportunity, and Lauralei will be keeping  
13 track of these. So we're going to ask you if  
14 you can and we know this is difficult, keep  
15 your comments as brief as you can, but if  
16 somebody has already said what you think is  
17 important just kind of say "And I agree with"  
18 so that we can keep moving around. Because  
19 this hopefully will give us kind of the  
20 foundation for the discussion of framing the  
21 call for measures which will move us from this  
22 stage ultimately into stage 2.

1                   The other thing is as you frame  
2                   your comments about what's important, if you  
3                   have any thoughts about this discussion about  
4                   outcomes or available measures please bring  
5                   that up then so that we can kind of use this  
6                   as our chance to tap into your expertise. So  
7                   just take a few minutes and write down what do  
8                   you think is important. What should be on the  
9                   table here.

10                   CO-CHAIR CASEY: And Gerri, why  
11                   don't we let our colleagues who have to leave  
12                   early maybe go first.

13                   CO-CHAIR LAMB: Everybody had a  
14                   chance to jot down their ideas? We're good?  
15                   Anybody need any more time? All right. Let's  
16                   start down.

17                   MS. LEWIS: So there's been so  
18                   many great things said today and I'm going to  
19                   try, because so much has already been said, to  
20                   just try to add a little bit from my  
21                   perspective on this. So the two things that  
22                   come to mind for me, one is some sort of

1 metric of taking the whole person into  
2 account. And what I mean by that is that I  
3 think often that 10 minutes in the physician's  
4 office has very little to do with what is  
5 going on with that patient. And so as I said  
6 earlier, we work with patients in the home,  
7 from the home perspective. And what you learn  
8 in 10 minutes in a patient's home is very,  
9 very different than what you learn in the  
10 patient's office, or in the physician's  
11 office. You know, whether it's that, you  
12 know, the roof's falling in or there's no  
13 caregiver or, you know, there's shots being  
14 fired out in the street. You know, there has  
15 to be some mechanism in care coordination to  
16 understand that whole person perspective.

17           And that kind of leads into my  
18 second comment which is I think sometimes when  
19 we write performance measures we inadvertently  
20 keep ourselves inside the box of the current  
21 system. We don't mean to but it's how we all  
22 think and so that's what we end up doing. And

1 to that point I want to make sure, and I  
2 actually haven't heard this much today so I'm  
3 just, but this is just from my own -- so that  
4 I say it. I think it's really hard to look at  
5 the physician as the person who's going to do  
6 all this coordination. It's expensive, they  
7 don't have the time, they're in short supply.  
8 You know, they certainly, it's hard to get  
9 economies of scale in physician's offices.  
10 And so I guess I just want to make sure that  
11 as we think about who's going to do this care  
12 coordination that we're open to all the  
13 different, whether it's community, you know,  
14 home care, whatever it is that we leave that  
15 open and we don't kind of inadvertently put  
16 ourselves in that box.

17 DR. CARRILLO: I think that  
18 something that came up earlier this morning is  
19 that we're kind of limiting our vision to that  
20 narrow slice of the clinical interplay between  
21 hospital, home, you know, primary care  
22 physician. And I think that in terms of care

1 coordination we have to begin to define  
2 measures that go outside of the comfort zone  
3 that we all have because you know, we've all  
4 been around those institutions and have been  
5 patients. I think we need to figure out how  
6 we're going to capture the family involvement  
7 and how are we going to begin to capture the  
8 involvement of the homeless shelter, the CBO,  
9 the church activity, you know, whatever these  
10 other points of contact that are most  
11 important for the person. So I would widen  
12 that scope.

13 CO-CHAIR LAMB: And please  
14 remember, too, if you have thoughts about  
15 outcomes or measures to add that as well. Do  
16 either of you want to add anything to that?  
17 Eva, hang on just a sec because I think we're  
18 going to go over here just so that we can  
19 capture your input before you leave. Anything  
20 else from both of you that you wanted to just  
21 add?

22 DR. CARRILLO: Not right now.

1 CO-CHAIR LAMB: Okay.

2 DR. WAKEFIELD: So I just wanted  
3 to comment on the previous speaker's comment  
4 about HIT as a foundation rather than a  
5 measure. Because the chart has become a  
6 billing and legal document and not so good at  
7 telling the patient's story. And furthermore  
8 we've taken the paper record, a bad paper  
9 record, and translated it to a bad electronic  
10 record. And so you know, you really can't get  
11 the patient's story out of their record  
12 anymore. And I think it has the potential to  
13 both do that and allow for efficient data  
14 abstraction for measures. So, I think what's  
15 important to measure is this patient's story.  
16 So I would support this shared plan of care  
17 which is updated on an ongoing basis and I  
18 think by recommending measures like that it  
19 will force HIT to redesign, to be able to do  
20 that. Because as-is, you know, it's just done  
21 the way it is, the old paper record. So I  
22 think we need to look at how, what, sort of

1 shoot for the sky, decide what we want and  
2 then have the infrastructure respond to make  
3 it fit.

4 CO-CHAIR LAMB: Eva?

5 MS. POWELL: Thanks. I actually  
6 agree very much with Bonnie's comment. I hope  
7 that this group will really think outside the  
8 box because so much of what you said about  
9 EHRs is what we struggle with meaningful use,  
10 is what do we want to have happen versus what  
11 is possible today, and there's a huge chasm.  
12 And I also want to agree with Julie's point  
13 about, and I think this has been addressed a  
14 little bit today, but I think we do need to  
15 bear in mind that the vast majority of care  
16 coordination is really not a physician  
17 function, that it's certainly a multi-  
18 disciplinary function and at least in my  
19 experience working in a hospital very few of  
20 those functions actually get taken care of by  
21 physicians. And that's not to minimize their  
22 importance in creating, say, a care plan but



1 just, we will have totally missed the boat if  
2 we really zero in on physician activity here.

3 But in terms of what I think is  
4 really important to measure I tend to be a  
5 very concrete thinker sometimes and so I did  
6 kind of outline some measures that are out of  
7 the box. And I have no idea how we'd actually  
8 go about measuring these, but since we are  
9 where we are I'll throw them out there. One  
10 would be consistency in making necessary  
11 linkages to clinical and non-clinical  
12 supports. Another would be effectiveness of  
13 a continuous feedback loop between patient and  
14 caregiver and their care team members. And  
15 then the third that I came up with, and these  
16 certainly are not comprehensive, would be  
17 patient and caregiver experience of care  
18 coordination. And that's probably the one  
19 that's closest to being an actual measure,  
20 having actual capability of measuring. And  
21 forgive me for my lack of knowledge of details  
22 of what is out there, but I guess the

1 difference I see here is I think it's  
2 important to measure both patient and  
3 caregiver experience and to at least stratify  
4 the results by those two different categories,  
5 and then have that be overall care  
6 coordination, not just care transitions,  
7 although certainly care transitions I think  
8 would be an important point to stratify as  
9 well.

10 DR. MCNABNEY: So I'm going to  
11 build on a couple of these comments. So kind  
12 of along the non-clinical theme I think, when  
13 you think of care coordination over 99 percent  
14 of what patients do is by themselves and so to  
15 the extent that care coordination has an  
16 impact on that non-clinically supervised  
17 setting. So the carryover of clinical  
18 expertise and how we measure that I think is  
19 important. So I think the patient's  
20 understanding of what care coordination is and  
21 its value. One, conveying it, and then  
22 measuring that impact and its registering with

1 the patient.

2 And then going back to the  
3 statement of goals of care, something that we  
4 as clinicians and everybody in health care  
5 throw out which is very, in a real sense is  
6 quite a vague term. So I think of the ability  
7 to articulate in a structured way, or at least  
8 have documentation of goals of care and how  
9 that plays into the -- using care coordination  
10 techniques is important. So as far as  
11 outcomes I was thinking one process outcome  
12 would be tracking of adherence to goals of  
13 care with regard to self-management and  
14 patient preferences. And an outcome measure  
15 would be adherence to those. What they're  
16 collected and documented or noted in a care  
17 coordination model would be adherence to those  
18 as stated.

19 CO-CHAIR LAMB: Before you move  
20 on, for those outcomes are you aware of any  
21 measures out there that we can look at related  
22 to adherence to goals of care and self-

1 management?

2 DR. MCNABNEY: So, I think it's a  
3 real reflection of how -- I mean if you read,  
4 as all of us do, recommendations for patients  
5 they talk about, even in the documents we've  
6 looked at today, goals of care. And I think  
7 that that in itself is so vague. So I think  
8 if, I mean it could be as simple as a practice  
9 having a mechanism to establishing, you know,  
10 it could be an internal process and then a  
11 documentation of -- so to answer your  
12 question, I don't know of data that's shown  
13 that, but I think you could think of a  
14 practice- or a health plan-specific way of  
15 doing that and how well they adhere to it  
16 which I think would be more realistic than  
17 sort of a national plan.

18 DR. LEE: You know, looking at  
19 this issue I first asked myself the question,  
20 well, what do these domains mean. And it's  
21 kind of interesting. Health care home on page  
22 -- on one of the pages here it says "Patient

1 has an opportunity to select." Well, that  
2 means there's a selection process for this.  
3 This is not an outcome measure we're talking  
4 about just to have a home. And tomorrow it  
5 could be something else. So I think to me --  
6 and I'm a very concrete person, I apologize --  
7 having a plan for every patient, work on  
8 transitions to avoid quality and safety issues  
9 that happens along the way, and really ask the  
10 hard question how does IT help us to get  
11 there. Those are two pieces that have some  
12 concrete progress over time and it's likely  
13 we'll have more refined literature around how  
14 to look at these two issues. And then the IT  
15 issue really is about how to help with that.  
16 So that's my opinion, just to look at what  
17 we've got today and make improvements.

18 MS. LOVE: I think I'm coming at  
19 this from a different, way different  
20 perspective. So I'm just going to put it out  
21 there. My perspective is measurement precedes  
22 the science so many times. I mean, it's ahead

1 of, it's really a political statement and  
2 that's the arena I live in. And yet those  
3 political statements, the science should catch  
4 up and it will catch up but that's how we  
5 transform the system.

6 So when I think of all the  
7 discussion today I did some thoughts. If I  
8 were talking to legislators tomorrow in a  
9 state which I probably will do next week it's  
10 why should you invest in care coordination?  
11 Because they're cutting social services right  
12 and left. And so we're fighting a fight out  
13 there. So I need the measures to say this  
14 absolutely reduces the cost or the resource  
15 use, either upstream or downstream. So, you  
16 know, I'm fishing for that magic sweet spot  
17 where you can say, you know, by investing X  
18 dollars you can save. So, it really is that  
19 return on investment, but also reduction of  
20 complications and readmissions. So that begs  
21 some sort of person-centric linkage.

22 So then that begs sort of a

1 community capacity that I'm looking for.  
2 What's the community capacity assessment? If  
3 I have a patient in Kaiser that has nowhere to  
4 go out in the community, you know, am I  
5 talking to public health? Are those hubs and  
6 connections made so you can do tradeoffs in a  
7 more, maybe a non-traditional way outside of  
8 an ACO or health care setting. So some sort  
9 of capacity for what the linkages are within  
10 the community, maybe a score of this is a  
11 sharing community, or a collaborative  
12 community versus, you know, a siloed  
13 community, I don't know. I'm brainstorming  
14 again.

15 And then, you know, there's  
16 patient factors that I look at. And this gets  
17 back to if I see a failure of care or a bad  
18 outcome and medication not filled, or non-  
19 compliance, what is the patient's insurance  
20 like. You know, what's the socioeconomic.  
21 And so that begs sort of a patient risk score  
22 and we talked about that earlier today, or

1       just buckets of types of patients that might  
2       have extra care coordination considerations.  
3       And just like we worked for a decade to get  
4       present on admission on hospital coding and  
5       some of you can throw things at me, I foresee  
6       a day where maybe in these transitions we have  
7       a code for present with records on admission  
8       to a hospital. You know, so I really think  
9       that is possible in this new world. And so I  
10      keep thinking of Steve Jobs and saying there  
11      is an app for that, we just have to be  
12      creative and think a little outside the box.  
13      And so I'm not coming at it with absolute  
14      measures. Hopefully I'll come up to speed.

15                 But I'm thinking more of the  
16      infrastructure needed both in the community,  
17      in the health care system and also if I were  
18      working with a provider system, just as an  
19      unpaid consultant, you know, is there an  
20      assessment of a provider capacity, you know,  
21      or a payer capacity system that, a checklist  
22      that they could do a self-assessment and say,



1       yes, we have the capacity to do these things  
2       or we don't and that's another measurable sort  
3       of thing that could get us along that way. So  
4       these are just some brainstorming ideas I came  
5       up with.

6                   MS. ALEXANDER: So to build upon  
7       what has already been said is that, you know,  
8       why, first starting off, why we need care  
9       coordination. Because I really believe it is  
10      the function that is what is needed to manage  
11      and achieve not only individual health but  
12      population health. And care coordination is  
13      dynamic. The plan of care as I see a part of  
14      care coordination is dynamic and it's really  
15      based upon the patient needs and it is not  
16      owned by any one discipline but as what's been  
17      previously stated, that it really needs to be  
18      touched upon and driven by all of those care  
19      team delivery members that are actually  
20      touching and engaged with this patient across  
21      all care settings. And we need to think  
22      beyond the traditional settings into the

1 church and other community settings as well  
2 too. So again, at this point I don't have any  
3 specifics on specific measures, but I'm sure  
4 that will come soon here in my thinking as we  
5 continue discussion. Thank you.

6 DR. MALOUIN: Hi. So I think, you  
7 know, all of us in this room have spent a good  
8 deal of time looking at the evidence, sort of  
9 trying to come up with conclusions that are  
10 consistent and most us have probably found  
11 that there is a lot of inconsistency in the  
12 evidence. There's a lot of people doing a lot  
13 of things out there, but there's not always a  
14 common set of elements that is, you know, yes  
15 indeed this is what's shown to be successful.  
16 And now we're starting to get those. We're  
17 starting to get like with complex care  
18 coordination, you know, close to the doctor,  
19 medication reconciliation, attention to  
20 transitions. So anything that's moving  
21 forward needs to really emphasize the common  
22 elements of the literature that we've found.

1 And I have to tell you, you know, middle  
2 America, all of America, the people who are  
3 actually doing this stuff, they don't know the  
4 evidence. They don't read about this stuff.  
5 They just know what they've been doing for  
6 years. And so I think it'll be most helpful  
7 if we come up with measures that will  
8 actually, that aren't sufficiently vague that  
9 they're subject to a lot of different types of  
10 interpretation. For example, care plan. I  
11 think that's something that always comes up  
12 and it's been pointed out here that that can  
13 mean a number of different things. So what is  
14 it about a care plan that's important? It  
15 should be X, Y and Z. Obviously those things  
16 are hard to measure sometimes and that's I  
17 think what the barrier is. But I think the  
18 more we can use these measures to actually  
19 help drive the way people care for patients I  
20 think that will be in our best interest.  
21 Because we, because people really don't know  
22 what's -- they don't know what works, they

1 don't know what doesn't work. And I've been  
2 living this for the past year so I know this.

3 Measures such as transition care,  
4 you know, we all know now that transition care  
5 is thought to be helpful but what does that  
6 mean? It means a million different things to  
7 a million different people. And so you know,  
8 we look to things that are measurable. Like  
9 for instance, PCP visit after hospital  
10 discharge. And those of us who know there  
11 might be better ways to do that, but that's  
12 all we have because we have claims data. Can  
13 we come up with better ways to measure things  
14 that will be meaningful and that will also  
15 drive the behavior that we know does work?

16 I think, you know, one of the  
17 problems is that we've all talked -- I'm not  
18 going to elaborate on the EHR, the HIT  
19 problems that we have, but there's so much  
20 variability in what vendors are offering now  
21 that it's often impossible to try and come up  
22 with a common set of elements. And hopefully

1 I think the intention of meaningful use was to  
2 do that. And it sort of got caught up in the  
3 politics. And hopefully the next generation  
4 of meaningful use recommendations that come  
5 out will be more meaningful. But I think we  
6 really need to get EHR vendors onboard and  
7 perhaps that's a way to do that.

8 And lastly, as far as specific  
9 measures I'm probably going to kind of go  
10 against what I just said about being as  
11 specific as possible because I think that we  
12 also shouldn't ignore both the patient  
13 experience of care as well as the PCP  
14 experience of care. Because as a family  
15 physician I know when my patient's care has  
16 not been coordinated. I mean, I just know and  
17 the family knows too. They don't know exactly  
18 what went wrong but you can tell. When a  
19 patient leaves the hospital, you know, they  
20 know, or actually when they get back to their  
21 PCP they know whether or not their care was  
22 coordinated. They don't know what should have

1       been or what shouldn't have been done, they  
2       just know that they felt like they were thrown  
3       out into a big black hole. So I think that  
4       even though maybe we're trying to get away  
5       from those surveys I think we don't want to  
6       lose that patient experience.

7                   CO-CHAIR CASEY: Let me just jump  
8       in and tell you a little anecdote that Wendy  
9       mentioned before. I have this fantasy of  
10      having a patient experience measure which  
11      relates to the patient satisfaction that they  
12      just had to be readmitted to the hospital. I  
13      wondered what the performance on that one  
14      would be. So I hear you.

15                   DR. HOWE: I think we're at the  
16      point where we need to focus on measures that  
17      will enforce the process piece here. The  
18      coordination of care is really about the plan  
19      of care, or should be. And one of the highest  
20      priorities I think is to develop some standard  
21      elements that are part of that plan of care so  
22      you know one when you see one. And that would

1 be, the professional societies and other  
2 groups including community resources to decide  
3 what are the standard elements in a plan of  
4 care. Because you need that plan of care as  
5 the hub of the wheel of all these other spokes  
6 that we're talking about. Is there a  
7 transition plan from hospital to home? Is  
8 there a closed loop from that referral to the  
9 specialist back to the PCP? Is the family  
10 preference and the patient preference recorded  
11 and operated on in that plan of care? Are the  
12 conditions that are associated and certainly  
13 with the complex patients captured in that  
14 plan of care so that you have the total  
15 picture. And with that, once you've gotten  
16 and you need an accountable team leader. It  
17 doesn't have to be the physician, but somebody  
18 needs to be accountable for maintaining that  
19 plan of care and having that relationship with  
20 the patient and the family. From there you  
21 can then get to some outcomes I think.

22 You can certainly then focus on

1        what does the patient think happened to their  
2        plan of care and you should be able to  
3        structure that such that it's not a huge  
4        effort to capture. And you could also ask the  
5        providers did they think they met the plan of  
6        care. But there are metrics out there now  
7        that would essentially roll up to some sort of  
8        adherence score, medication adherence,  
9        referral completion, visits after some  
10       transition of care, lifestyle changes,  
11       preventive health adherence. I mean, there  
12       are a whole slew of measures that can be  
13       rolled into a bundle that indicate that  
14       somebody's care is being coordinated.

15                    And we need to keep track of care  
16       coordination ability. There are going to be  
17       subsets, there are populations that don't  
18       trust their caregivers, they don't speak  
19       English, they don't have a relationship and  
20       working in the form of a team, they have, you  
21       know, outreach fatigue. They don't want to  
22       hear from anybody. Leave me alone. We need



1       some way to capture, you know, that there's a  
2       spectrum of impactability that's going to --  
3       that might adversely affect a provider's  
4       measurement in their being able to achieve  
5       whatever this outcome goal is. So we need to  
6       capture that as well in some sort of risk  
7       adjustment. I have no clue how to do that.

8                       CO-CHAIR CASEY: And Tom, you  
9       don't know of any particular sources that we  
10      could tap into that have anything near what  
11      you're talking about?

12                     DR. HOWE: I do not.

13                     DR. LYNN: So I can think of a  
14      couple of sources that might get at some of  
15      what Tom was just talking about. The Council  
16      of Medical Subspecialties of the American  
17      College of Physicians has had a group working  
18      on what they're calling the medical home  
19      neighbor where they have been defining what  
20      some of the elements should be in the  
21      correspondence between a primary care  
22      physician, a consultant and back again to make

1       sure that information is passed in a clear  
2       way.  And they've been doing some on-the-  
3       ground testing of those.  There's also a group  
4       out at UCSF in their safety net hospital at  
5       San Francisco General working on an e-referral  
6       system where they've done some publishing I  
7       think in JGIM.  There's been some really nice  
8       stuff out there.

9                A couple of thought that I had  
10       build on what Eva and Matthew were saying.  I  
11       think continuing to go to patients and to  
12       family caregivers to ask them if they have the  
13       knowledge and the resources that they need to  
14       provide care is something that's going to be  
15       important.  And I really applaud NQF for  
16       moving to a more crosscutting measurement  
17       scheme so that it's not did your PCP give you  
18       a comprehensive nutrition plan for your  
19       diabetes which is really pretty focused, but  
20       do you have what you need to take care of your  
21       multiple chronic conditions is something that  
22       I think is important for all providers to

1 understand whether we're achieving that or  
2 not.

3 I've also been wondering if there  
4 are some adverse events that we could be  
5 measuring that would be sort of akin to  
6 hospital-acquired infections that would be  
7 markers of the failure of care coordination.  
8 So would failure to get needed follow-up be a  
9 marker of that that could be measured at a  
10 practice level, a group practice level  
11 perhaps, to see if that's something that we  
12 could see go down over time as we implemented  
13 more processes of care.

14 And the final thing I'd like to  
15 say is that a lot of what we're talking about  
16 talks about the medical home. And I think so  
17 much of what's defined in the patient-centered  
18 medical home is terrific. And the  
19 availability of that kind of care for many  
20 patients is just not there.

21 DR. GREENBERG: So I agree with a  
22 lot of that has already been said. A couple

1 things I would add is, one, I think care  
2 coordination does apply to all patients but I  
3 think there has to be an effort to identify  
4 high-risk patients. All these things cannot  
5 be done and should not be done for all  
6 patients. So I think we need to be able to  
7 promote sorting out through whatever means  
8 necessary, whether it's just a smart nurse  
9 looking at patients or you know a risk  
10 stratification software tool, who are the  
11 high-risk patients and then are appropriate  
12 pieces of infrastructure being put into place  
13 to help manage them better than a traditional,  
14 you know, solo doc can do.

15 The other thing I would add is on  
16 the subject of a medical home or health care  
17 home, you know, there's a lot of attention  
18 being put on the primary care practice in  
19 terms of being the center of coordinating care  
20 and it may be. But having one practice  
21 coordinating care is a bit like, you know, one  
22 hand clapping. There has to be the

1 involvement of other docs and specialists and  
2 community groups, but I think we've got to get  
3 the specialists involved. You know, if I'm a  
4 primary care doc and send my patient to a  
5 thoracic surgeon, you know, I shouldn't have  
6 to figure out what he's thinking so I can  
7 coordinate that care. He's got to be  
8 contributing to that plan of care too. So it  
9 puts a premium on integration, on the  
10 structure of a system and involving all of the  
11 parties in taking part in care coordination.  
12 And I think I'll stop there.

13 CO-CHAIR CASEY: So, not to  
14 disrupt the flow, but Jeff hit on an important  
15 point that reminded me of a discussion we had  
16 in the last steering committee vis-a-vis not  
17 just thinking of this from the standpoint of  
18 a disease. In other words, there should be a  
19 wellness plan of care like the preventive  
20 services and following the wellness guidelines  
21 that are, you know, put forth by the Heart  
22 Association that don't have to involve 25

1 people. And I think we were trying to build  
2 on that, but I think your point is as the  
3 condition of the patient, the individual gets  
4 more complex that's going to be a much  
5 different space than what I'm talking about.  
6 So I think I want to balance that to be sure  
7 that, you know, I capture clearly what you  
8 said in my mind but also remind people that  
9 we're talking about -- that's how "for  
10 everyone" got in there is to think about it  
11 that way.

12 DR. GREENBERG: And I fully agree  
13 that everyone needs, you know, this does apply  
14 to everyone. But certainly some patients need  
15 more intensive care. The folks that we're  
16 trying to keep out of the hospital and trying  
17 to keep out of the emergency room will need,  
18 you know, more intensive resources than  
19 others. But I agree that everyone needs  
20 something.

21 CO-CHAIR LAMB: Going back to what  
22 Lorna was saying, adding it to Jeff's is

1 perhaps if we look at the medical home  
2 neighbor and the tools that are coming out of  
3 that, maybe that'll give us some ideas in  
4 terms of not just the connectivity between  
5 physicians and specialists but between all  
6 providers, that we can kind of extrapolate to  
7 what would this look like if this worked  
8 across the system.

9 DR. WHITE: Okay. I was thinking  
10 about quality of life. But not only, you  
11 know, which is measurable and there are  
12 instruments which you can do that, but not  
13 only of the member or the patient but also for  
14 the caregiver. And I'm thinking in terms of  
15 some sort of patient satisfaction for the  
16 caregiver, quality of life, depression  
17 screening, that sort of thing because those  
18 are the things that lead to caregiver fatigue.  
19 And I think that leads to a lot of the  
20 coordination problems that we have.

21 The second thing that I thought  
22 about was, well, you know everybody's talking

1 about all these measures and all these  
2 wonderful things but I think only one other  
3 person mentioned the cost and I think that was  
4 Denise. And in my mind you've got to pay for  
5 these things. And so the reimbursement  
6 strategies have to support the work and they  
7 have to be aligned. And you have to be able  
8 to sell these to employers because I don't  
9 care what's happening with health care reform,  
10 most health care insurance is purchased by  
11 employers, not individuals. And even after  
12 the exchanges that's still going to be the  
13 case. And so you have to be able to sell this  
14 to that. So you have to be able to show cost  
15 avoidance, savings, reduction in utilization,  
16 return on investment, all of those things are  
17 important.

18 And then finally, people have  
19 talked about the plan of care. And I totally  
20 agree with that and there need to be standard  
21 elements, but you also need to have goals  
22 because goals lead to outcomes that are



1 measurable. So I think that's going to be  
2 critical to the success.

3 CO-CHAIR CASEY: Alonzo, from  
4 where you sit would it be tenable to reframe  
5 that context in terms of appropriate use of  
6 resources?

7 DR. WHITE: Absolutely.

8 CO-CHAIR CASEY: Okay. Rather  
9 than just it's lower cost.

10 DR. WHITE: No, no, no, but you're  
11 exactly right. I spent 22 years in Kaiser so  
12 I'm very familiar with those concepts. And in  
13 general if you give people better care it's  
14 lower cost. And so you want to do the right  
15 thing. And I think by framing it that way you  
16 can achieve that goal.

17 MR. FROHNA: I also agree with  
18 what Al was saying there about the cost, about  
19 the financial aspect, but also access I think  
20 is another key component that we haven't  
21 really mentioned a whole lot about. And  
22 specifically I'm going to expand I think what

1 Jeff was saying, the medical home neighbor.  
2 You think about it now it should be the  
3 medical home neighborhood. I mean, it really  
4 is more than just the medical home and a  
5 physician, it should be actually a whole  
6 group, a whole neighborhood providing the care  
7 and coordinating that.

8 Also that care coordination is not  
9 owned by any one discipline but I'll tell you,  
10 I think today the emergency department or  
11 emergency medicine has been mentioned about a  
12 half dozen times. As an emergency physician,  
13 just to kind of educate folks on this and  
14 maybe point out why patients seek us out may  
15 get to the point of access. And that is that  
16 over 130 million visits last year to the EDs,  
17 emergency physicians basically comprise about  
18 4 percent of all physicians and really the  
19 health care costs associated with ED visits is  
20 about 2 percent of all health care costs. So  
21 actually relatively speaking, good deal. But  
22 when you look at what happens after hours, our

1 specialty provides greater than 60 percent,  
2 it's actually upwards of 66 percent of all  
3 after hours care. And maybe we're just not,  
4 you know, we hear so much about the patients  
5 and their access. Well, are we really getting  
6 to the root of what they're looking for and  
7 what they need and what they want? And so  
8 that's what I wanted to just point out there.

9           And then as far as some kind of a  
10 measure, taken along with Jeff's comment as  
11 well, the high-risk, the high-service utilizer  
12 of care and how can we measure that. And  
13 maybe it is -- you know, when I go in and I  
14 work I know if a patient -- how many prior  
15 visits they've been there, when the last visit  
16 that they've been to the ED. So I know, I can  
17 quickly filter on the high users. And in the  
18 district with the highest per capita dialysis  
19 patient population. I mean, there is a  
20 patient population that, boy, if we could get  
21 that under control and maybe we can reduce  
22 costs, reduce visits, et cetera there you may

1 have a real measurable goal. But that's just  
2 one small element.

3 MS. FOSTER: Okay. I was sort of  
4 coming at this as well from an outcome  
5 perspective and really thinking about how do  
6 we measure good care coordination. And in my  
7 mind that really does link to resource  
8 utilization. And if you have a patient that  
9 is utilizing a lot of resources can we say  
10 that we are really providing coordinated care.  
11 But there are, given the fact that there are  
12 dialysis patients, there are transplant  
13 patients, et cetera, I think that utilization  
14 resource has to be risk adjusted.

15 Another I guess idea that I had  
16 related to a lot of these evidentiary pieces  
17 of providing care coordination is outcomes.  
18 And I'm wondering if we've looked at the PQRI  
19 data and linked to that at all? And I don't  
20 know if you looked at that in your study. But  
21 I think the PQRI data is very good, it's very  
22 rich and I had the experience of abstracting

1 for that last year. And you know, for  
2 patients for heart failure, CAD, DM and  
3 hypertension there are very specific measures  
4 in there. So they look at the patient's A1C.  
5 So if the A1C is high are we doing a good job  
6 of coordinating diabetic care? So I think  
7 that might be something in terms of outcomes  
8 that we would want to look at.

9 And then just finally, a couple of  
10 other ideas that I had in terms of measuring  
11 the health information. In the report there  
12 was no measure recommendation for that and I  
13 had just jotted down on the way here, you  
14 know, patient's access to their own records.  
15 And you know, we give them education but is  
16 the education really adjusted for their health  
17 literacy. If they don't, if English isn't  
18 their primary language how well are we  
19 translating, what are we providing in their  
20 language of origin and how are we doing that.  
21 Because not every patient responds to written  
22 documentation. So I think somehow that has to

1 be assessed in all of this.

2 And then finally, the last thing I  
3 just wanted to say was in terms of talking  
4 about medical appointments this morning, you  
5 know, we were talking about having that as a  
6 standard because it's there and that's what we  
7 know. And you know, it really isn't -- Mayo  
8 Clinic did a study, I think it was published  
9 last year, that said that actually  
10 appointments have no, there's no evidence that  
11 they reduce readmissions. But what reduces  
12 readmissions is not the appointment but it's  
13 the handoff to the appointment. So if you --  
14 because most of the time the PCP doesn't treat  
15 the patient in the hospital so the patient  
16 goes back to their PCP, a discharge summary  
17 gets faxed. That really doesn't, that tells  
18 just partial, you know, very little of the  
19 story. So it's the phone call. And at Mayo  
20 Clinic that's something that we are measuring.  
21 We are making sure that the patients have a  
22 phone call back to their, the treating

1 physician calls the accepting physician and  
2 the expectations for what has to happen in the  
3 ambulatory setting then occur that way. So  
4 you know, I think that that -- and I think  
5 that is measurable actually.

6 CO-CHAIR CASEY: So Pamela, just -  
7 - so it would be instinctive to believe that  
8 if you had a measure of success let's say for  
9 care coordination and you had one patient with  
10 one chronic illness as opposed to one with  
11 three, instinctively you would expect higher  
12 failure rates for perfection on the one with  
13 the three than the one in terms of successful  
14 care coordination. Or, if --

15 MS. FOSTER: Right.

16 CO-CHAIR CASEY: I'll make it up,  
17 a heart -- two heart failure patients. One  
18 had very poor muscle mass and was unable to  
19 exercise on a regular basis as opposed to that  
20 other one who could do that and was much more  
21 independent would probably require some  
22 adjustment to the measure.

1 MS. FOSTER: Exactly. Right.

2 Some -- yes.

3 CO-CHAIR CASEY: I was using the  
4 disease model.

5 DR. LEFTWICH: You may have  
6 already caught on that I think HIT is  
7 foundational to all of it. So what I have is  
8 some more granular measures that are process  
9 and structure, and to -- under the category of  
10 patient involvement and engagement. And to  
11 reiterate some what Pam said I think there  
12 should be a measure of patients receiving  
13 enduring copies of instruction and education  
14 in their preferred language and format, and  
15 that patients should have access to their  
16 information including their master care plan  
17 in its current state. And that patients  
18 should have the ability, the mechanism to  
19 upload their observations and their data, home  
20 monitoring data for example, to their care  
21 plan and their record.

22 And under the topic of



1 communication and information transfer I think  
2 there should be measures of the right and  
3 appropriate information being transferred.  
4 Too much information is just as bad as no  
5 information at all. It needs to be the  
6 appropriate selected information. A measure  
7 of the completeness of those core data  
8 elements that we talked about, the medication  
9 lists, problem lists, allergies and  
10 intolerances, and the timeliness of the  
11 delivery of those transition of care  
12 documents. Do they get there before the  
13 patient does or at least with the patient.  
14 Otherwise their value is certainly degraded.

15           And along the lines of the one  
16 element that should be there in the care plan  
17 and aligned with that patient-centered medical  
18 home neighbor is the care team shouldn't be  
19 conceptual. There should be a roster, it  
20 should include contact information and it  
21 should include what their role is on the care  
22 team and that they have accepted that role,

1 including what level of involvement they are -  
2 - as a specialist. Whether they're assuming  
3 care of the patient or just doing a consult.

4 And I would ask your indulgence  
5 for about three minutes to talk about HIT  
6 innovation that's out of the blocks and that  
7 I found a couple of people are not aware of,  
8 something that's out of the blocks and into  
9 the pilot phase to demonstrate that it does  
10 work and I think it will likely revolutionize  
11 the HIT environment over the next few years.  
12 One aspect of it is the Direct Project which  
13 was begun about a year and a half ago which to  
14 be brief is secure email that can be exchanged  
15 between systems and even between individuals  
16 who don't have systems, who just have a secure  
17 Outlook email account and can include  
18 obviously a PDF file but could also include  
19 these standard documents, transition of care  
20 documents. And that is expected to be a  
21 requirement that certified EHR systems for  
22 stage 2 of meaningful use will be able to

1 create and receive those direct email messages  
2 between them.

3 Then aligned with that is the S&I  
4 Framework efforts that I already mentioned,  
5 the transition of care documents. But along  
6 with that there's an initiative to create  
7 provider directories in each state that would  
8 include not just physicians but the entire  
9 care team and the facilities and an in-point  
10 electronic address for those individuals as  
11 well as the traditional contact information,  
12 and an indication of what type of electronic  
13 documents they're able to receive, whether  
14 they have a system or not. There's another  
15 initiative that was launched less than two  
16 months ago that I spent much of yesterday on  
17 called Query Health that envisions creating a  
18 process and standards by which a query can be  
19 sent to any EHR system asking for a de-  
20 identified list of patients with condition X  
21 on medication Y and with lab result Z or  
22 whatever combination of data elements,

1 including quality measure, would be returned  
2 to the requester that originated that query.  
3 And those could obviously be aggregated into  
4 population health data including quality  
5 measures. And it's referred to as sending a  
6 question to the data instead of sending the  
7 data to a repository. And I would hope that  
8 we envision leveraging these innovations and  
9 expect that the measure developers leverage  
10 them as well anticipating that in the  
11 foreseeable future that will be a mechanism to  
12 gather information to communicate both between  
13 systems and with patients. If you sign up for  
14 a Microsoft HealthVault PHR today you get a  
15 direct address when you sign up so that  
16 anybody could send you a direct secure message  
17 be it patient instructions or your discharge  
18 summary.

19 DR. BURSTIN: Could I ask you a  
20 follow-up question? Specifically about your  
21 role in HIEs because I think the health  
22 information exchange aspect of this we haven't

1 really talked about. But it does seem like  
2 there would be a set of measures that would  
3 potentially emerge if you actually had an HIE  
4 where you could for example look at  
5 unnecessary repeated lab tests or unnecessary  
6 repeated imaging. Have you seen anything like  
7 that emerging?

8 DR. LEFTWICH: Yes, there is that  
9 potential but most of the HIEs I'm aware of,  
10 that sort of quality measurement if you will  
11 is not in their acceptable use policies. So  
12 they would have to be modified and that would  
13 be a challenge I think. Whereas the direct  
14 messaging type thing might -- would be much  
15 easier because it's up to the recipient of  
16 that query whether or not they respond. The  
17 other advantage to the direct at least in the  
18 use of patient care is that it's HIPAA-  
19 compliant in that it's a push transition and  
20 doesn't require patient consent as an HIE  
21 does.

22 MS. KLOTZ: Okay. Several of the

1 things I had jotted down have been well  
2 covered, things around the patient  
3 understanding and the connections to the non-  
4 medical and the inclusion of family. Thinking  
5 about patient goal versus the physician's goal  
6 I think has to be thought about. So I was  
7 trying to think about some of the potential  
8 measurement things and I was thinking about  
9 the CTM-3. And I don't know how many of you  
10 know that. I assume most everyone does and of  
11 course right now I can't think of the question  
12 specifically. But if you think about  
13 understanding your medications as you're  
14 moving from the hospital to home isn't that  
15 almost the same question we'd want to ask  
16 anytime somebody's looking at their  
17 medications. And wondering how that could be  
18 stimulated to do some slight modifications of  
19 the CTM-3 that really would not think just  
20 about transitions but about care coordination.

21 Another thought in terms of  
22 measurement, I'm wondering if the Stanford

1 Chronic Disease Management Program has come up  
2 with any kinds of measures that look at  
3 understanding of medical conditions and  
4 treatments, and you know, ability to kind of  
5 be involved with those themselves. Another  
6 thing, there's this discussion today about  
7 medical home neighborhood. I heard Ed Wagner  
8 speaking last week about, actually he was  
9 calling it medical neighborhood I believe.  
10 And you know, Ed Wagner is the developer in  
11 his group of the chronic disease model. Their  
12 group is now working on a model that relates  
13 to medical neighborhood and it's the same  
14 kinds of ideas we've just been talking about.  
15 And I wonder if his group is also thinking in  
16 terms of measurement in terms of that  
17 neighborhood idea that could potentially be  
18 addressed.

19 And then the last point I was  
20 thinking about is we're involved with some  
21 things that relate to fall prevention and the  
22 idea that you can't -- it's a pretty long time

1 span between measuring certain activities that  
2 reduce risk behaviors and then whether it  
3 results in a fall later. So thinking in terms  
4 of the idea of intermediate measures, that if  
5 people have, you know, using falls as the  
6 example, if people have reduced some of their  
7 risks in their home that are risk for falls,  
8 if they are working on strength and balance,  
9 if they're having their vision checked, those  
10 are kind of intermediate measures. That if  
11 those things are being done then there's very  
12 high probability you'll have fewer falls  
13 later. So if we could think of the same,  
14 maybe there's some evidence, you know, very  
15 tight research that can be done that say these  
16 particular processes around care coordination  
17 are indicators that it's a good job. So then  
18 we can look at those processes. And I guess  
19 I would just say think about process measures  
20 as intermediate measures, not throw them out  
21 because they're not really telling us the  
22 outcome.



1 DR. FARRIS: This will be quick.  
2 What Bonnie and Dana said about the plan of  
3 care. What Tom said about process measures  
4 and now just what Christine said about process  
5 measures. We can't just throw them out the  
6 window and maybe that's really where we are  
7 with this concept. And so while we all want  
8 outcome measures, maybe we're not quite there.  
9 What Bill and Jeff said about integration of  
10 all providers, and particularly what Jeff said  
11 about focusing on the most vulnerable.  
12 Everybody does need care coordination but we  
13 all know there are a set of people who need it  
14 more than others. And so figuring out  
15 measures specifically for those individuals I  
16 think is more important in the short term than  
17 -- in the short term.

18 And then finally, what Russell  
19 said about accountability in that there's a  
20 plan of care, but who's in charge of that plan  
21 of care? Are there providers and/or the  
22 patient who have different parts of it that

1 they're trying to achieve in terms of specific  
2 goals? And having the patient's input to say  
3 I want my physician to help me do this, my  
4 social worker's got to help me do this, my  
5 pharmacist has got to help me do this, or  
6 something like that.

7           And then my final comment is that  
8 a med list is only as good as the last patient  
9 interview, and/or follow-up with the community  
10 pharmacist, and/or follow-up with the primary  
11 care doc, and/or follow-up with the  
12 specialist. So I'll stop there.

13           CO-CHAIR LAMB: Clearly we know  
14 who's going to do our summary later.

15           MS. DORMAN: So I'm actually going  
16 to reference Eva. I was really heartened to  
17 hear that I wasn't the only one confused about  
18 what is care coordination and what could the  
19 outcomes possibly be. So it's been a great  
20 morning to think about that. And the way I  
21 typically start that thought is to go, well if  
22 there were patients in the room here what

1 would they be thinking about this  
2 conversation? And that led me to the thought  
3 in terms of outcomes. I mean, if I'm a  
4 patient my ultimate outcome is did I reach my  
5 goal? No matter what that goal is. And so  
6 that's my suggestion for an outcome, that care  
7 coordination we know is a meta process over  
8 the clinical process and that it has a meta  
9 goal, a meta outcome of achieving the  
10 patient's goal. The only measurement, the  
11 only place I know of, and I am sadly free of  
12 great expertise in care coordination  
13 literature, but the only thing I'm aware of is  
14 the gold standards framework in the UK that  
15 they use for palliative care. And it's more  
16 of a social patient engagement process where  
17 every patient is asked what their preferred  
18 setting of death is. They're asked what their  
19 first choice is and what their fallback. You  
20 know, if we can't get to that what would be  
21 the next choice. And they, the whole health  
22 care system works to make that happen

1 including the patient and family. So that  
2 care coordination is something that happens  
3 with the patient and family, not to them. And  
4 it's an interesting paradigm and I'll just  
5 offer that. I think it's, I don't think it  
6 approaches the level that it could be called  
7 measurement but it might be an interesting  
8 place to look.

9           Then my second set of thoughts was  
10 around coordination itself and really  
11 wondering if we're being ambitious enough. I  
12 hear us talking about coordination as a  
13 salvage process because of the bad health care  
14 system, but are we thinking enough about  
15 coordination as a way to deal with the  
16 inevitable complexities and tradeoffs in the  
17 best possibly provided health care. And what  
18 is that meta process and how would we measure  
19 that? As in addition to just the salvage  
20 kinds of activities that we know have to  
21 happen. So those are my thoughts. Thanks.

22           CO-CHAIR CASEY: Jann, can I ask a

1 little bit more about palliative care. You  
2 know, I personally think we did not do a very  
3 good job of calling that out in the last  
4 documents. And in specific what's called  
5 advanced care planning which is very easily  
6 mis-translated in my opinion to end of life  
7 care and DNR and all this other stuff. And  
8 those who have followed the work of Diane  
9 Meier and others understand this, especially  
10 in the early phase of chronic illness that  
11 advanced care planning is not about how you  
12 die but how you live.

13 MS. DORMAN: Right. We say it's  
14 about living well.

15 CO-CHAIR CASEY: And do you think  
16 that there could be more space in this  
17 context, knowing that we've got a palliative  
18 care group working on this to call that out in  
19 the structure of the?

20 MS. DORMAN: Well, I personally  
21 agree that it's useful to make a distinction  
22 between the medical-legal aspects of, you

1 know, quote, "advanced care planning for end  
2 of life" and the very real capabilities to get  
3 to, you know, to incorporate a patient's  
4 values and choices into the goals that are  
5 set. And that's relevant anytime, whether  
6 it's a 2-year-old with a cold or very complex  
7 illness. But I think it does provide a good  
8 place to look because those people, man, those  
9 people are skilled. They've been on the front  
10 lines for decades and they know a lot about  
11 how to do it and what really matters when you  
12 do it.

13 MS. ALLER: So there have been a  
14 lot of comments about how care coordination  
15 requires the whole team. And we as a nation  
16 are incenting health IT in the physician  
17 office and in the hospital, but we haven't  
18 done a good job of incenting it more broadly  
19 in long-term care, in home care and in the  
20 various community linkages. I've heard a lot  
21 of comments today about evidence and the lack  
22 thereof, or the quality of the evidence we

1 have. I heard a lot about needing to roll up  
2 measures. And so part of what I was noodling  
3 on is we have incented certain care transition  
4 type behaviors, med reconciliation for  
5 example, in the EHR incentive program. I  
6 would like to get a better measure of how is  
7 that changing patient experience, how is that  
8 changing outcome. I'd like to stratify  
9 against those who have had that reconciliation  
10 happen and those who haven't, get the evidence  
11 on which of those things we've incented are in  
12 fact changing outcomes and experience and then  
13 incent those technologies more across the rest  
14 of the care team. So what's the return on  
15 investment not just from a cost and a resource  
16 standpoint but from a patient outcome and  
17 experience standpoint. And then, okay, let's  
18 build on the things that really are moving the  
19 bar for the patients.

20 I think there's a real challenge  
21 as well between what we can measure and what  
22 we aspire to measure, and we have to maintain

1 that balance and take those baby steps that  
2 Jeff talked about earlier. And say okay,  
3 we're not going to have the perfect measure,  
4 let's at least get the few things, correlate  
5 that with what we can and take the next steps  
6 and keep moving that bar.

7 DR. HEURTIN-ROBERTS: I've been  
8 thinking about outcomes. And mostly I've been  
9 puzzling about outcomes because the question  
10 of measuring an outcome is determined, is  
11 based on what we call an outcome. And  
12 outcomes are rather ephemeral. We're talking  
13 about an outcome of what, an outcome when.  
14 We're thinking of, and maybe I'm thinking,  
15 maybe we should be thinking models and not  
16 measures. I don't want to throw that in. But  
17 we're thinking of care and care coordination  
18 as though it were just linear, you know,  
19 structure, process, outcome. In reality it's  
20 an ongoing process that occurs over time and  
21 at any point in time you could slice off a  
22 chunk of that continuum and say this is an



1 outcome. As far as I can tell the only  
2 universal outcome would be death. I mean that  
3 happens to everybody, nobody gets out alive.  
4 But if we're going to frame the question of  
5 measuring outcomes, we need to frame outcomes  
6 of what. What's an episode? Which chunk of  
7 care are we looking at? And that'll be an  
8 artificial demarcation no doubt, but I think  
9 we have to if we're going to be able to  
10 measure outcome effectively. Okay.

11 That being said I want to remind  
12 us all that care is not linear even though we  
13 think of it that way. It's pretty complex.  
14 It involves not only individuals, not only  
15 individual disciplines but involves a lot of  
16 different systems that come together. And we  
17 can frame it and think of it in terms of  
18 particular medical home or even a medical  
19 neighborhood, but what comes to bear in care  
20 coordination is, you know, different  
21 disciplines providing care, family systems,  
22 you know, financial systems, funding systems,

1 economic systems, social systems, geographic  
2 and all of that. And so when we're doing this  
3 I know we have to think of this in a more  
4 simplistic fashion in order to measure it, but  
5 I think we have to acknowledge the complexity  
6 that's involved. Otherwise we're trying to  
7 measure a process that we've artificially  
8 simplified and aren't really becoming  
9 cognizant of that. We need to realize that  
10 we're talking about something very complex.  
11 I have no doubt that statisticians will be  
12 able to deal with this complexity more and  
13 more. Not me, but statisticians. I mean,  
14 there's network analysis and so on. I think  
15 there are ways to study this. But I think we  
16 need to realize that it's there and deal with  
17 it.

18 DR. LINDEKE: I think we will have  
19 a very big debt in five years if we have not  
20 responded to the nation's hope for care  
21 coordination to deliver cost savings and  
22 quality. The fact that I think everyone here

1 is on multiple projects with the word "care  
2 coordination" somewhere in the title, it's  
3 astounding because five years ago it was just  
4 in the small print buried somewhere. We were  
5 talking about access at that point. So we  
6 spent a lot of time talking about access but  
7 we know that churning, which means you change  
8 your health plan multiple times, or ER where  
9 you might get, you know, 10 minutes of a  
10 hectic schedule with a person you'll never see  
11 again is not quality care. So the  
12 coordination piece has got to be measured.  
13 And to me we have to look at team, we have to  
14 see what is a high-functioning team and  
15 measure it, and the family is part of that  
16 team. It can't be done by the person whose  
17 name is on the bill and that primarily is the  
18 physician. That's not realistic in this  
19 country. We've also got a workforce of over  
20 3 million nurses whose first course in nursing  
21 school is going to really be about care  
22 coordination. If we can get beyond turf, if

1 we can get a harness, really the bean-counting  
2 of HIT over meaningful data. And my concern  
3 is rehospitalization is probably not going to  
4 do it. A Canadian study this summer showed  
5 15-20 percent of rehospitalization was  
6 preventable. The other 80 percent with, you  
7 know, universal access, had to be  
8 rehospitalized. That's not going to deliver  
9 what the nation is looking for.

10 So I have high hopes for this  
11 work. I will feel real bad in five years if  
12 we don't deliver. And it's got to be  
13 connected to -- to me some of the biggest  
14 heroes in our country are the Medicaid  
15 providers and those systems, the safety net  
16 providers. It's got to be connected to them  
17 or we're just doing more fancy stuff that the  
18 rest of the world that produces really darn  
19 good outcomes with less money looks at us,  
20 they just shrug and say, "Those Americans."

21 DR. AUDET: On the last, ditto. I  
22 was thinking of, you know, what is important

1 to measure to frame this call and I was  
2 thinking more on the principles. And those  
3 principles have been already clearly announced  
4 here. But the first one would be that why are  
5 we measuring. It has to be significant. It  
6 has to be a measure that shows that if you are  
7 a high performer on that measure you have had  
8 impact on the three-part aim. You've had  
9 impact on some aspect of outcomes, of quality  
10 of care, some impact on patient health and  
11 some impact on cost.

12 And the patient voice in this I  
13 think is really clear. An anecdote about the  
14 discussion we were having about discharge  
15 summaries being, you know, now being retired.  
16 It could be, and the discussion about calling  
17 people. In our current initiative on avoiding  
18 rehospitalization, calling after discharge is  
19 one of the best practice. So we would think  
20 it's a best practice but when we start to ask  
21 patients, they're getting calls by six  
22 different people. That is not care

1 coordination. So we have to be careful about,  
2 again, processes that are not linked to  
3 something else because we think it's a good  
4 thing.

5 The second principle, and here I  
6 was a bit challenged between a measure -- our  
7 discussion about whether a measure should  
8 apply to all patients versus condition-  
9 specific or even I think perhaps even more  
10 important, risk-specific as opposed to  
11 condition-specific. Whether we're talking  
12 about that being in one measure or are we  
13 talking about the NQF portfolio of measures.  
14 So that in the end we may need specific, you  
15 know, measures that are specific to a certain  
16 risk, you know, a population. And I'm  
17 thinking here of Joanne Lynn's Bridges to  
18 Health and her segmentation of the population.  
19 So in our portfolio it may be good if we could  
20 have a representation of these various  
21 segments of the population, not in one  
22 measure, in addition to measures that apply to

1 all people.

2           And just a comment on CTM-3. And  
3 we are currently, the visiting nurse of New  
4 York is actually piloting this measure in a  
5 home health setting. So they're adapting the  
6 measure and looking at whether they can use  
7 that measure in the transition between the  
8 hospital to the home health. So that's  
9 actually, that's happening right now and would  
10 be available to us to review some of the  
11 results.

12           CO-CHAIR LAMB: I think Don and I  
13 would like to add our thoughts to this too.  
14 So take off my co-chair hat for a second. I  
15 would like to just share with you what I've  
16 been thinking about in terms of the patient-  
17 centered measures as well as outcomes. In  
18 terms of -- and let me acknowledge a lot of  
19 this comes from months of coordinating care  
20 for my mother -- is the issue of perception of  
21 plan of care and whether there's one plan of  
22 care. And I think Russell said before is the

1 accountability for that plan of care, or does  
2 anybody, you know, do you believe that anyone,  
3 that everyone is working from that same plan  
4 of care and who would you go to if you felt  
5 the plan of care was off track. So, that  
6 whole idea of does anybody out there know me  
7 and is there one plan of care because my  
8 experience was I believed that if I had gone  
9 to any of the myriad of providers everyone  
10 would have said yes, there's one plan of care.  
11 Family member? No, there wasn't. And I was  
12 sleeping in the hospital trying to make sure  
13 it stayed on plan of care.

14 Another one is, and Russell I  
15 think touched on this, is the issue of how do  
16 we capture sequencing and timing of care. If  
17 you look at the AHRQ definition there's the  
18 whole element, the domain of organizing care,  
19 and it reminds me of, do you remember the  
20 mantra of managed care from the '90s? Right  
21 care, right time, right place, right cost. Is  
22 that care coordination is not time, at any



1 time we feel as providers it needs to happen,  
2 it's what's the right sequencing and timing.  
3 Do things happen when they need to happen to  
4 get you towards your goals? Whether it be  
5 tests, procedures, services, resources or  
6 whatever. So how do we capture that whole  
7 idea of sequencing of care?

8 The other one I would throw in,  
9 and again I think Russell, you spoke to it, I  
10 would name it a little bit differently, is a  
11 family burden care coordination measure. How  
12 much energy are family members putting into  
13 coordinating care for their family members and  
14 is it more or less? I mean, that's going to  
15 take us down the road than is reasonable.  
16 Another personal experience. I was spending  
17 probably 95 percent of my time trying to keep  
18 things on track and at some point not only got  
19 exhausted but got resentful that I was  
20 spending all my time coordinating care and not  
21 spending quality of time with my parent.

22 Outcomes. I think you've

1 mentioned things that speak to symptom  
2 management, self-care, functionality and was  
3 just at a conference at the American Academy  
4 of Nursing where people were suggesting that  
5 self-care and symptom management really should  
6 be some of the core outcome measures across  
7 the care continuum, and that I think the  
8 challenge is going to be, is getting good  
9 performance measures that really capture that  
10 in a meaningful way.

11 CO-CHAIR CASEY: Well, I've found  
12 this round table very enlightening and helpful  
13 and totally additive to what we've done. I  
14 want to harken back to my good friend Tom Howe  
15 though who I think points out that we've got  
16 to get real clear on what the elements are in  
17 the plan of care, knowing that it'll be  
18 flexible. It'll have to be. I'm in the midst  
19 of writing with a whole team of people a new  
20 ACCHA guideline on heart failure which we just  
21 had our first draft out on Monday. It's not  
22 public yet. And I was responsible for the

1 discharge planning. And I said I'm not going  
2 to write a section on discharge planning, I  
3 refuse. This is about care coordination and  
4 having a plan of care for heart failure  
5 patients. And while I can't share the  
6 specifics because this is embargoed, I have in  
7 here as a starting point for the physicians  
8 and nurses guideline-directed medical and  
9 device therapy being the first group. The  
10 second is management of comorbidities which  
11 includes preventive care, secondary and  
12 primary. Patient and family education which  
13 includes quality of life assessment, advanced  
14 care planning, CPR training for family  
15 members, social networks in addition to diet.  
16 Then physical activity and rehab, psychosocial  
17 factors such as depression, alcohol use,  
18 gender-specific issues, sexual activity.  
19 Clinician follow-up and care coordination  
20 which includes which doctor do I see next, is  
21 the advanced practice nurse better in this  
22 situation than the cardiologist and are there

1 other people like pharmacists who can help me  
2 with my medication. And how does that all fit  
3 together in my personal health record.

4 Then the last part is this  
5 business of health literacy, whether I have  
6 access to care, whether I have access to  
7 payment for care, whether I'm disabled, what  
8 other community resources there are. So it  
9 helped me to sort of share with you that  
10 vision of what we're trying to put in the  
11 guideline because I think that's what we're  
12 trying to get to. And it may not be perfect,  
13 but believe me, sitting with a group of  
14 cardiologists it's big progress. So. No  
15 offense to my colleagues the cardiologists.

16 CO-CHAIR LAMB: You know, that  
17 speaks to the issue of timing as well because  
18 -- and it's just, it's a conundrum of how to  
19 capture this. If you think about heart  
20 failure as your prototype, what gets people  
21 into problems that end up in the hospital is,  
22 you know, you think about it, late pickup of

1 warning signs. It is if they're getting into  
2 trouble they need to recognize them and they  
3 need to act on them. And how do we capture  
4 did -- were the systems in place that people  
5 not only were educated, because that's pretty  
6 straightforward about somebody taking their  
7 weight and recognizing they're gaining it, but  
8 did they take the right action and were the  
9 support systems there. Anybody in home care  
10 who tries to get somebody quickly into a PCP,  
11 whatever role that PCP is, often ends up  
12 sending that person into the ER because they  
13 can't get a response fast enough. So the  
14 timing of that whole kind of cascade of events  
15 becomes really critical to capture and how do  
16 we do that.

17 CO-CHAIR CASEY: Yes, Emilio.

18 DR. CARRILLO: Just one comment.

19 One measure that wasn't mentioned, I think it  
20 should be put on the table, is a measure that  
21 helped, it's already an NQF-sponsored measure,  
22 that helps to capture issues of health

1 literacy, language and culture, which is  
2 teach-back. Something that's in the nursing  
3 world and in many different dimensions coming  
4 into increased use. And yes, is there a care  
5 plan and has there been a teach-back. I think  
6 that I would recommend that.

7 CO-CHAIR CASEY: So, why don't we  
8 take a well-earned break. And Gerri, what  
9 time do we want to come back?

10 CO-CHAIR LAMB: Let's just, when  
11 we come back what we're going to do is see if  
12 anybody has any reflections on this discussion  
13 quickly, and then move into the questions that  
14 Lauralei put together for us so that we can  
15 kind of frame it. Because we need to pull  
16 this into looking at what the framework is  
17 going to be for the call for measures. We've  
18 generated tons of critical issues and this is  
19 going to be kind of the grist for putting  
20 together a document for you to respond to. So  
21 how about, what is it, it's 2:30-ish? How  
22 about if we take 15 because we know we're not

1 going to come back before then anyway, and  
2 then we'll move into any comments, and then  
3 we'll go into kind of the final stages.

4 Fifteen.

5 (Whereupon, the foregoing matter  
6 went off the record at 2:37 p.m. and resumed  
7 at 2:56 p.m.)

8 CO-CHAIR CASEY: We still have  
9 some work to do and we have to push through  
10 the rest of this agenda. So, yes. So what  
11 I'd like to do is before we get into the final  
12 phase of our discussion let's let Lauralei and  
13 Nicole sort of provide you with a teach-back  
14 as to what we think we heard so that we're  
15 capturing the elements. And we've all made  
16 copious notes so hopefully this will work.  
17 But I will turn it over to Lauralei.

18 MS. DORIAN: Well, I think we each  
19 took hundreds of pages of notes, and we'll  
20 have the transcripts afterwards so we'll go  
21 through them and come up with a document that  
22 we'll send to everybody for your feedback

1 that's much more thorough. But Nicole and  
2 Suzanne put this together. Do you want to say  
3 anything about it?

4 MS. MCELVEEN: So these are  
5 quickly some of the themes that we felt sort  
6 of rose to the top or that you had mentioned  
7 more often throughout the group as a whole.  
8 Of course, this isn't the whole comprehensive  
9 list. So, viewing the whole perspective of  
10 the entire patient there was a lot of  
11 discussion around support and education for  
12 the patient and the caregiver. Cost and  
13 resource use as a justification for care  
14 coordination. In addition, all other aspects  
15 related to cost. There was also a lot of talk  
16 about the possibilities and limitations around  
17 HIT infrastructure and health information  
18 exchanges, the involvement of the family, and  
19 coordination with organizations outside the  
20 traditional health care system. So there's a  
21 lot of discussion around resources within  
22 churches, community-based health organizations



1 and community centers. So again, these were  
2 just the few that we felt the group talked  
3 about most common, but certainly not the  
4 entire comprehensive list.

5 MS. DORIAN: And maybe one thing  
6 that I just remembered that would be important  
7 to add is asking the question for whom is care  
8 coordination most important. And so what are  
9 those high-risk populations? Are they  
10 necessarily the high-cost populations and  
11 should there be certain aspects of measurement  
12 that address those populations in particular?  
13 Are there any other major themes that you  
14 think we left off this list? We'll resend  
15 this through.

16 CO-CHAIR CASEY: Well, I think the  
17 notion of, and I think Julie spoke of this  
18 right off the bat, focusing on the whole  
19 person, i.e., not just the medical part of the  
20 person. The multidisciplinary nature of care  
21 coordination. I think Bonnie mentioned this  
22 with the need for the feedback about the plan

1 of care and its effectiveness being a  
2 continuous process. Matthew kind of  
3 reiterated the patient-centeredness. Dr. Lee  
4 spoke a lot about patient safety and HIT which  
5 I think you captured. And so, Denise I think  
6 also was in that space. Dana was reminding us  
7 about population health, measuring it not just  
8 at the individual patient level but also at  
9 the population level as well. The -- Tom  
10 talking about the standard elements of a plan  
11 of care and also, you know, the notion of a  
12 care coordination index which I think others  
13 mentioned. The -- some comments about the  
14 interactions with the specialties. Lorna and  
15 Jeff sort of spoke about the medical  
16 neighborhood and how people relate to each  
17 other. Al spoke about the quality of life and  
18 caregiver and incentives. Bill talked about  
19 access and availability being sort of key  
20 parts to this. And you don't need to write  
21 all this down, but I'm just. Pam brought up  
22 the resource utilization, talked about PQR

1 data risk adjustment. Russ talked about the  
2 master care plan, timely access. I wasn't  
3 here for your entire presentation, Russ, but  
4 I know you talked about several things.  
5 Accountability and the Direct Project, the S-9  
6 framework. Chris was talking about some other  
7 models like Stanford and Ed Wagner and  
8 thinking about whether CTM could be modified  
9 in some ways to get at even more of what we're  
10 trying to accomplish. Karen summarized  
11 everything. She's an old pro. But I think  
12 Karen was really trying to pull all these  
13 things together for us and that was elegantly  
14 done. Jann among other things talked about  
15 palliative care. Kathleen talked about  
16 incentives. And the return on investment not  
17 just financially on patient outcomes and  
18 experience. I kind of got tired at that  
19 point, no offense to the rest of you.

20 Suzanne talked about non-linearity  
21 of care coordination. This isn't like a model  
22 where you try to fit a line through care

1 coordination. It's got many different  
2 dimensions and it will take certain types of  
3 sort of, I don't even know what the word is.  
4 You use the term statistical. I'm not even  
5 sure that's it. I think you used network.  
6 Model. Network models and things like that,  
7 where we look at the connections. Linda and  
8 Anne-Marie were also in there with a lot of  
9 this stuff. So I think we got everything in  
10 here. I think it's good.

11           So at this point I think what we  
12 want to do is let's go back to our agenda and  
13 let's look at the potential questions. These  
14 were meant as discussion questions related to  
15 both the foundation for the pathway which I  
16 think we've incorporated but this has to do  
17 now with informing the staff about how to put  
18 the call for measures together. So I want you  
19 to be real specific. Try not to repeat what  
20 we've done, but really look at these  
21 questions. And maybe we ought to step through  
22 them or you can pick one out and say, you

1 know, this was one I want to talk to. It  
2 might be better to do that.

3 I think in answer to the first  
4 question do the current domains adequately  
5 reflect care coordination I'll answer that for  
6 the staff and say they adequately partially  
7 reflect it. And that what we tried to do is  
8 now enhance that. We've got the AHRQ document  
9 and we've also got great input from Arjun and  
10 Lipika in terms of their enhancements to this.  
11 And we'll be working with you on this. But  
12 certainly they helped inform the framework and  
13 the way that we're going to ask the question  
14 of the environment about the presence of  
15 useful measures that could be considered by  
16 this group for consensus development.

17 So, you know, look at those  
18 questions. You may have already thought about  
19 it. There may be other questions as well. I  
20 think, would it be safe to say that we in  
21 general if we're talking about broad-based  
22 measures would generally agree that to the

1 last question of risk adjustment or  
2 stratification, that that would be a desirable  
3 trait? Do most people agree with that? I  
4 don't want to get into the details of how the  
5 risk adjustment is done, but given that I  
6 think we've identified that there are layers  
7 of complexity is it reasonable to agree with  
8 that statement? So.

9 DR. GREENBERG: Don, are you  
10 talking about risk-adjusting outcomes or  
11 actually using the process of risk-stratifying  
12 a population of patients as sort of part of  
13 the expected activities of the measure?

14 CO-CHAIR CASEY: I think it's  
15 both. It's got to be both, Jeff. I mean,  
16 what I mean is that, you know, you've got to  
17 have a way to risk-stratify and then you have  
18 to have a way to fairly measure the  
19 differences across these.

20 DR. GREENBERG: I think both are -  
21 - I'm clearly thinking of outcomes you need to  
22 be able to risk-stratify to be fair.

1 CO-CHAIR CASEY: Right.

2 DR. GREENBERG: But I think also  
3 we want to, I think we should be promoting  
4 risk-stratifying one's patients as a practice  
5 that we need to do.

6 CO-CHAIR CASEY: So that's a good  
7 point, that that's going to land in this other  
8 area of what do we want the future state to  
9 look like and we'll have to think about that.  
10 But surely -- yes, Anne-Marie.

11 DR. AUDET: Just a question. They  
12 would have to do both, not just risk  
13 adjustment without risk stratification.

14 CO-CHAIR CASEY: What's your  
15 opinion?

16 DR. AUDET: I would say yes, they  
17 would have to do both.

18 DR. WHITE: I think they're  
19 actually part and parcel of each other.  
20 They're sort of a -- you need one to do the  
21 other.

22 CO-CHAIR LAMB: I would suggest

1 too that we go back to the discussions we've  
2 had about what's the reason for this. Many of  
3 us have said there are populations within all  
4 of the people that are seen in the health care  
5 system that need, number one, more intense  
6 care coordination, and two is is risk -- we've  
7 got to keep in mind risk for what. And in  
8 this case it's risk for adverse outcomes of  
9 poor care coordination. It's not risk for  
10 everything in the health care system. So as  
11 we think about risk stratification and  
12 adjustment, I think part of the discussion on  
13 the go-forward basis is for what, and does it  
14 look like the same kind of risk adjustment and  
15 stratification for other outcomes like  
16 mortality, hospitalization and so forth  
17 because the parameters of risk may be  
18 different in this context.

19 CO-CHAIR CASEY: Well, that raises  
20 -- Helen's going to kick me so if I jump.  
21 Raises the question about the NQF-endorsed  
22 outcome measures that have risk adjustment,



1       whether we think that -- and I know the  
2       answer, I'm answering my own question --  
3       whether we think that the -- would those  
4       adequately reflect whether differences can be  
5       measured for improvements in care coordination  
6       based upon the way they're risk-adjusted now.  
7       In other words, I think they're very much  
8       driven by claims data that relate to clinical  
9       variables and not so much by some of these  
10      other -- I haven't jumped yet, so. So I  
11      think, Gerri, that's another perhaps  
12      futuristic question about how do we make some  
13      of the work that's done now related to  
14      outcomes like mortality and readmissions if  
15      that is an outcome more sensitive to the  
16      impact of care coordination. And that might  
17      take us in a different direction than the way  
18      the measures are currently calculated. My  
19      sense is I don't know but I'm guessing  
20      probably they don't do a very good job of  
21      that.

22                   DR. BURSTIN: There's an article

1 in JAMA today for those of you who haven't  
2 seen it that specifically goes through the  
3 different risk models for readmissions showing  
4 they're actually not nearly as precise as we  
5 would certainly like. But I think in general,  
6 though, you know, risk adjustment for an  
7 outcome could be very well justified. We  
8 don't usually risk-adjust processes and much  
9 of what we're talking about here are  
10 processes. And I think there is also an  
11 opportunity to do the risk stratification. I  
12 think Alonzo's point and I think Jeff's  
13 earlier as well, thinking about stratifying  
14 for targeting, to think of, you know, who's  
15 high-risk. So I think there are sort of three  
16 very different models of how to use risk.

17 CO-CHAIR CASEY: Denise.

18 MS. LOVE: Risk adjustment is an  
19 interesting discussion. I'm for risk  
20 adjustment but sometimes risk adjustment that  
21 washes away all variation, especially for  
22 consumer information. And then thinking of

1 care coordination. Maybe the risk adjustment  
2 is to differentiate those populations and  
3 accentuate them. So it may be a different  
4 purpose. And so we don't want to just, you  
5 know, throw in the hierarchical modeling that  
6 I'm so fond of.

7 CO-CHAIR CASEY: Yes, certainly  
8 some of the work that I've been doing with the  
9 CMS-sponsored group out of the Colorado QIO  
10 that has developed these community-based  
11 readmission measures is doing risk adjustment  
12 for that precise reason which is to better  
13 understand the nature of the community. There  
14 are 14 of them. So that they can better try  
15 to define what the interventions might be that  
16 are different from, you know, the other  
17 communities.

18 MS. LOVE: If you're doing a  
19 hospital report card sometimes you wash away  
20 the differences because you want to be fair.  
21 So, again, it depends on the purpose.

22 CO-CHAIR CASEY: Well, again, and

1 so we always get into this sharp edge of CMS  
2 would like risk-adjusted measures for public  
3 reporting to help Medicare beneficiaries  
4 discriminate and perhaps become related to  
5 payment policy. And so, you know, you can, I  
6 know we don't have a CMS representative here.  
7 I'm not trying to be mean to them, I'm just  
8 trying to say that that is one of the goals of  
9 NQF is to support those efforts. So we have  
10 to expect that that type of thinking is going  
11 to persist. But your point is well taken.  
12 And when we endorse measures accountability is  
13 going to be something we're going to talk more  
14 about. So that's it.

15 My other, I'm just doing this  
16 because I'm a little tired of being in  
17 Washington so much but number 3, I think I  
18 heard should these measures be condition-  
19 specific or broadly applicable. And I think  
20 what I heard some people say is you shouldn't  
21 do one without the other. In other words, we  
22 should have broad measures and we should have,

1 for lack of a better phrase, condition-  
2 specific measures because practitioners can  
3 translate more easily. Did I get that, Dr.  
4 Lee? I think you were the one that brought  
5 that up.

6 DR. LEE: Yes, I like to think of  
7 it as how do we get its flywheel going. You  
8 know, get things started, more science, more  
9 integration. How do we get it going?

10 CO-CHAIR CASEY: So again the  
11 answer is kind of sort of both, right?

12 DR. LEE: Correct.

13 CO-CHAIR CASEY: Anne-Marie?

14 DR. AUDET: Just this JAMA paper  
15 that came out. Condition-specific is great  
16 and I will also stress, I'm not a lumper as  
17 you can tell. Population and risk-specific.  
18 Because if you look at this JAMA article  
19 actually the predictors of readmissions are  
20 not, you know, severity of illness, they're  
21 actually socioeconomic and all that other  
22 stuff. So that's more population and risk of

1 poor coordination than a condition. So I  
2 would stress both condition and population.

3 CO-CHAIR CASEY: Yes. So, but I  
4 think that the third nuance here is that we  
5 want patient-level measures that are more  
6 global too, right, Anne-Marie? So it's  
7 condition-specific, it's population and it's -  
8 - does that? Hey, that's pretty good. Other  
9 thoughts.

10 DR. LYNN: I'm wondering how this  
11 fits in with the NQF work on multiple chronic  
12 conditions.

13 DR. BURSTIN: So for those of you  
14 who don't know NQF has been doing some work  
15 trying to take the patient, the framework that  
16 was done a couple of years ago, this measure  
17 on framework to begin thinking about care  
18 longitudinally which was very oriented to  
19 longitudinal care of a single condition, and  
20 think about it differently in terms of care  
21 for patients with -- they're actually now  
22 calling it complex multiple chronic conditions

1 because sometimes one bad complex condition is  
2 enough. You don't need four of them if one of  
3 them is really bad. Alzheimer's, I mean  
4 there's some logic here. And what they've  
5 been trying to do, and I can't remember if the  
6 report is out for comment or completed  
7 comment, but we could share it with this group  
8 is they've at least tried to come up with some  
9 framework to think about what kind of measures  
10 you might bring in that might be crosscutting  
11 for all those kinds of patients. When  
12 condition-specific measures are appropriate  
13 and if so, is there better -- are there better  
14 ways to stratify by patient risk in terms of  
15 things like functional status and you know,  
16 end stage issues.

17 CO-CHAIR CASEY: So I'll just tell  
18 you a little anecdote because it's, you know,  
19 it's after 3:00. But my dad, he's going to be  
20 87 in two weeks. He claims he's still in law  
21 practice. He's probably at his office now.  
22 And he goes to the doctor and he always calls

1 me up and says, well, I've got to tell you  
2 about this, this and this. And I'm like Dad,  
3 please, please make a list of these things so  
4 you won't forget when you go to the doctor,  
5 you know. Because he's got, I mean he's not  
6 seriously ill but he's got all these things  
7 going on. So he comes back from the doctor  
8 and I can't wait to call him and talk to him  
9 about how it went. And I said well? Did you  
10 talk about the list? He goes no, I forgot  
11 where I put the list.

12 (Laughter)

13 CO-CHAIR CASEY: So that's like, I  
14 give up. How do you adjust for that, you know  
15 what I mean? So I think we got some good  
16 traction on some of these. Let's see. Yes.

17 DR. LEE: Don, before we leave  
18 that question 3, something that fell out of  
19 the question set that's in the other documents  
20 is the level of measurement, how far down do  
21 we want to go. I really think we want to make  
22 sure we can measure populations but I'd really



1 emphasize at least from my point of view that  
2 we need measures that are specific at the  
3 physician or the office or the care team or  
4 the medical home or whatever that locus of  
5 care coordination is, that we be able to get  
6 at least some measures down to that level of  
7 specificity.

8 CO-CHAIR CASEY: Yes, I think for  
9 both accountability and quality improvement  
10 that's going to be critical. Because  
11 practitioners at that level need to know  
12 what's wrong in order to see if they can fix  
13 it in some way. And you know, one of the ways  
14 to do it is to say well we're going to, I'll  
15 put you on this website too and let people  
16 think about it. So, but I do think that that  
17 is really one of the levels of the goals here  
18 to inform the people on the ground doing the  
19 work. So. Eva?

20 MS. POWELL: Thanks. If it's okay  
21 I just want to back up really quickly to  
22 number 2, the assumptions. And I agree with

1       them on the one hand because I recognize that  
2       a call for measures is a call for measures  
3       that need to be specific and evidence-based,  
4       but I really, really worry that if we stick  
5       only to this notion of evidence-based in the  
6       same way that we've thought about it for the  
7       measures that we have now, that we're not  
8       going to end up with anything more than what  
9       we got before. Because as we've heard  
10      numerous times the evidence is not clear or  
11      it's lacking or however you want to put that.  
12      And so what made me think of this was, I think  
13      it was Jean that made the point about we need  
14      to somehow come up with measures that allow  
15      for latitude in terms of process. And then I  
16      can't remember what Christine said but she  
17      also made me think about this notion that as  
18      we make information electronic the line  
19      between quality improvement and research  
20      becomes very blurred. And so I'm wondering if  
21      since part of our task also is to develop a  
22      pathway toward implementation of emerging

1 measures, in addition to obviously the need to  
2 have a call for measures that are very  
3 specific and evidence-based could there be a  
4 part of this pathway that becomes part of the  
5 learning health care system where we design  
6 measures that are not necessarily evidence-  
7 based but are maybe based on pseudo-evidence,  
8 I don't know what you would call it, but  
9 something that makes someone think that it  
10 might be a good idea and then become part of  
11 a testing loop. Because I just really worry,  
12 I don't know how we're going to generate this  
13 evidence if we're stuck in our same way of  
14 thinking about evidence that we've been in  
15 relative to the measures that we have now.  
16 And this would seem to be a really good  
17 opportunity, particularly because so much is  
18 related to process in the world of care  
19 coordination, to put some latitude out there  
20 and have certain parameters, and I don't know  
21 what they would be, but have certain  
22 parameters that then provide more latitude

1 than what we've had before as a way of  
2 generating the evidence that we so need and  
3 want. I don't know, is there a possibility  
4 for that? Does that make any sense?

5 CO-CHAIR CASEY: No, it actually  
6 is, well, Helen and I have had this sort of  
7 ongoing discussion that I think has resulted  
8 in some positive change for how NQF evaluates  
9 evidence. And you know, let's be clear.  
10 There are sort of levels of measures now that  
11 exist that are well informed by lots of  
12 observational and clinical trial data like PCI  
13 within 90 minutes. I mean, we know that time  
14 is myocardium and we know that the faster you  
15 get an open vessel for a patient with an ST  
16 elevation MI the better likelihood there is  
17 for survival and improved quality of life and  
18 et cetera, et cetera. In this arena where  
19 it's so messy one could neither expect nor  
20 anticipate randomized controlled trials of  
21 that nature to describe, to attempt to  
22 describe the evidence. And I think that

1 that's where we're going to have to be very  
2 clear and careful about how we're going to  
3 think about as a group evaluating evidence as  
4 it comes in.

5           And I think it will boil down to  
6 making judgments like, you know, it's hard for  
7 us to be sure that care coordination has  
8 occurred if in fact the patient sees a  
9 physician in the office and there's a claim  
10 for it. So, on the other hand, if we know  
11 that in some of these measures that what the  
12 physician did was to actually provide an  
13 intervention that assured that a patient got  
14 the care that was needed for that particular  
15 problem, that that would be a higher level.

16           So I just want to harken back to  
17 Guyatt's mantra about not feeling as though  
18 it's a bad thing that there's limited evidence  
19 and that it has poor quality. I mean, I think  
20 we're going to be faced with that dilemma. So  
21 I want to be sensitive to it. But I don't,  
22 and I think your other point about informing

1 the future state will again be derived on what  
2 Suzanne talked about, developing these newer  
3 models to actually develop better ways to  
4 describe the outcomes. Because it isn't going  
5 to fit into a nice, neat, you know,  
6 generalized linear model usually I would  
7 guess.

8 So I hope that gets to the  
9 dilemma. It probably doesn't answer your  
10 question. We're going to get a lot of  
11 measures that we're going to look at right  
12 away that aren't going to really pass the  
13 sniff test that still may be worth it for us  
14 to bring forward to consensus development with  
15 the clear understanding that this is the first  
16 phase of what we're trying to accomplish. So,  
17 I don't want to throw the baby out with the  
18 bath water. And Helen, I hope you agree with  
19 that general philosophy here because I know  
20 when we started this Helen was like we don't  
21 have any measures and we've got to get some in  
22 here. You know, so she was just worried that

1       there would be nothing left after all this  
2       work and I don't think we anticipate having  
3       that occur this time. So I hope that makes  
4       you feel a little better. But it's going to  
5       be hard.

6                   My philosophy is as long as we're  
7       transparent with saying here's the quality of  
8       the evidence and that people are clear about  
9       understanding that it may not be perfect but  
10      it's still worth a try that it's still okay.  
11      I don't know how we fit that into the  
12      consensus development process but I think this  
13      is one of these vague areas where it's going  
14      to take a different mindset I think.

15                   DR. BURSTIN: Just one thing to  
16      add. People haven't seen that NQF in the last  
17      year did an evidence task force report which  
18      we could share with folks which really went  
19      through our perspectives of how evidence  
20      should be assessed. It is interesting in some  
21      of these emerging areas that are more  
22      crosscutting, not the clinical ones so much,

1 but some of these emerging areas where the  
2 evidentiary base may not be the classic sort  
3 of medical model. What's quality, quantity  
4 and consistency evidence is one we're really  
5 going to have to work through and that's what  
6 our new evidence task force requires. But  
7 there is still an element of allowing a  
8 steering committee to make a recommendation  
9 for a measure to go forward based on the  
10 expert opinion of the group where they feel  
11 like the benefits significantly outweigh the  
12 risks. And we actually just went through this  
13 in our palliative care committee. Again, the  
14 evidence on some things, these things are just  
15 not as clear, but they are so obvious to  
16 anybody that the benefits significantly exceed  
17 the risks. Some issues around sort of  
18 chaplaincy, for example, and palliative care.  
19 So I think we'll have the opportunity to work  
20 that through but that's why we're going to  
21 need to have that very structured process to  
22 go through the evidence.



1 CO-CHAIR CASEY: So, let me -- not  
2 to keep bringing up Guyatt, but Guyatt will  
3 say that if there is professional consensus  
4 that intervention X is useful that's evidence.  
5 It may not be of the quality. Do you see what  
6 I'm saying? So, I just want to be sure we  
7 don't get stuck on these terms evidence-based  
8 like we know what we're talking about. Sorry,  
9 Christine.

10 MS. KLOTZ: Is there any room for  
11 having something that's, I don't remember  
12 this, actually. Whether it could be  
13 provisional or labeled as promising? No.  
14 It's either endorsed or not.

15 DR. BURSTIN: At this point it's  
16 endorsed or not. I mean, I think a lot of  
17 those promising practices is what you guys did  
18 last round in terms of the practices. I think  
19 at this point if we're going to bring a  
20 measure forward it needs to be standardized  
21 sufficiently with a sufficient evidence base  
22 that it can be used for the various

1 accountability applications, including public  
2 reporting and pay-for-performance. So, no.  
3 But at the same time you can also make that  
4 assessment, that some of these things are kind  
5 of really obvious and you still think it  
6 should go forward because it's -- the benefits  
7 are really important.

8 CO-CHAIR CASEY: There is, though,  
9 Helen, this notion that there must be some  
10 field testing of the measure, right? Which in  
11 some ways is kind of sort of a level of  
12 evidence. And I think, Chris, we did find  
13 that there were some measures that really  
14 hadn't been adequately field tested and we  
15 actually gave the feedback back to the measure  
16 developer to do X, Y and Z. Do you remember  
17 this, Karen? So, I mean I think that it's  
18 never, like, you know, your measures didn't  
19 make the cut, they're bad. It's more like  
20 here's -- it's a continuum to get them in the  
21 shape where they can then succeed at the next  
22 round of endorsement.

1 DR. HEURTIN-ROBERTS: We're about  
2 trying to improve quality and care delivery.  
3 At the same time, if we want that to happen we  
4 want to have a better science of quality  
5 improvement. So I think that we can't only  
6 think about improving quality of delivery. I  
7 think that we need to at least see ourselves,  
8 or see this endeavor in the context of a  
9 research effort and be research-friendly  
10 knowing that this is going to generate huge  
11 amounts of data that you know we'd really like  
12 to be user-friendly for researchers. So you  
13 know we can't, we're not going to improve  
14 quality unless we also have a science of  
15 quality improvement that's functional and can  
16 use this data. I just think we need to keep  
17 that in mind.

18 CO-CHAIR CASEY: I've never been  
19 on a consensus development project that didn't  
20 have embedded in the deliverable a set of  
21 recommendations some of which would be very  
22 concrete for current and future researchers to

1 enhance. So that'll be part of our work for  
2 sure. But I think it's really important to  
3 emphasize it. So, yes, Anne-Marie?

4 DR. AUDET: Just a quick question  
5 for information. Last time you did this you  
6 sent signal to the field that this was, you  
7 know, something important. And you actually  
8 had a framework. So I'm just curious whether  
9 you at NQF, I know you have calls for  
10 measures, but do you hear from people who say  
11 oh, I'm now ready?

12 DR. BURSTIN: It's a great  
13 question and I think what we've seen is there  
14 are some measure developers who have made  
15 significant progress. Like NCQA of doing the  
16 work you funded. And one of the big issues  
17 here has been the continuing lack of sort of  
18 base support for measure development with some  
19 notable exceptions, thank you. They've  
20 developed a very nice model of what closing  
21 the referral loop will look like. When I  
22 talked to them a couple of weeks ago and said

1 so I'm really excited, you know, care  
2 coordination is starting up. When are we  
3 going to get that measure? And they went  
4 well, we're not actually sure we can spec it  
5 out because the EHRs don't exist yet that can  
6 do the measure. So it may be that there's  
7 work in place and I think there are some  
8 elements of that measure that we hope can come  
9 forward because they're really important. But  
10 sometimes I think the research work and the  
11 development work are not quite in synch.

12 I think there's more out there  
13 than we realize. Some of the work we did last  
14 summer supporting ONC on their potential  
15 measures for meaningful use 2013, I mean,  
16 there were some impressive measures out there  
17 that some of the leading health systems like  
18 Kaiser and Park Nicollet and others were using  
19 that were more sometimes transactional but did  
20 get at elements like did patients have access  
21 to their lab results within seven days. I  
22 mean, there may be some sort of baby step

1 measures out there that some of the leading IT  
2 systems could bring us, but we have tried to  
3 signal. I've talked about this everywhere.  
4 It's just, I think this is a really tough area  
5 to do without the data platform.

6 DR. GREENBERG: I think we need  
7 also to balance the need for standards with  
8 the need for innovation and the acknowledgment  
9 that we don't really know how to do this that  
10 well. And we want people to keep trying new  
11 things. And we run the risk, if we say  
12 everyone has to do X or Y that people are not  
13 going to try to do it differently. So, you  
14 know, I don't know if that's something that  
15 you come across in other areas where you've  
16 done this, but I wouldn't want to box people  
17 in too much because you know my hospital has  
18 done, you know, really well using nurse care  
19 coordinators for high-risk Medicare patients.  
20 But there are other ways of doing that. And  
21 I wouldn't want a measure that says you have  
22 to do that because you may be able to do it

1 many other ways. And I want to -- we should  
2 be able to give people credit for doing those  
3 things but yet of course we do need some  
4 standards also. So I just think it sounds  
5 like a tough balance to meet.

6 CO-CHAIR LAMB: One of the things  
7 that we might consider, it struck me as we  
8 were going through this day. If we look at  
9 number 5 which is, and those are probably two  
10 separate very important questions that we've  
11 been deliberating on is what are the  
12 priorities and if we can begin to flesh out  
13 all the stuff we were talking about as we went  
14 around the table and give some, you know, some  
15 bench posts to people about here's what we  
16 think is important to look at. What are you  
17 doing in this area? Because I agree with  
18 Helen, I think there is a ton of stuff going  
19 on out here but people are not necessarily  
20 framing it or seeing it as care coordination  
21 work. So that if we can begin to say for  
22 instance, I'm just going to make this up,

1 we're interested in looking at how patients  
2 are engaged in the care coordination process  
3 and it might look like A, B, C, D, E, if  
4 you're doing anything in this area and you're  
5 measuring it and you have some outcomes we  
6 want to hear from you. Because I think right  
7 now a lot of this work is invisible. So that  
8 if we can begin to put some, you know, some  
9 structure around this in terms of what is  
10 important. So I think somebody, it may have  
11 been Dana or Jean said before is the goal here  
12 is to help people understand what's important  
13 about care coordination to improve it. And  
14 the more we can begin to help that field I  
15 think it's going to be really useful and I  
16 think we may be surprised. But I think we're  
17 going to have to structure better than the  
18 last call for measures.

19 CO-CHAIR CASEY: So that's a good  
20 lead-in. What outcomes are relevant to care  
21 coordination? I mean, I think we talked about  
22 it but can you just punch a button and tell us



1 in a word or two? Tom.

2 DR. HOWE: Yes. I think we've  
3 kind of thrown up our hands that there is no  
4 easily obtainable outcome. I'm not sure  
5 that's correct. I think if the care  
6 coordination is focused on a patient-family  
7 set of goals were they met or not? And if  
8 somebody with some foundation money or if it's  
9 already been done can come up with a fairly  
10 concise standardized measurement tool that a  
11 patient and/or family could fill out, one, it  
12 would get you the level, at the practice level  
13 you'd get the level of engagement with folks  
14 that are actually paying attention to a care  
15 coordination plan. That's a significant  
16 metric right there.

17 CO-CHAIR CASEY: So, I know we're  
18 getting a little bit into syntax here but  
19 would a reasonable outcome be to measure  
20 successful achievement of a plan of care?

21 DR. HOWE: Right.

22 CO-CHAIR CASEY: Is that what

1       you're saying?

2                   DR. HOWE:   With specific goals on  
3       it.

4                   CO-CHAIR CASEY:   With specific  
5       goals, of course, right.

6                   DR. HOWE:   And did they get  
7       measured.

8                   CO-CHAIR CASEY:   Of the goals,  
9       achievement of the goals of the plan of care.

10                  DR. HOWE:   Right.

11                  CO-CHAIR CASEY:   Right.

12                  DR. HOWE:   And I don't know that  
13       there is a standardized tool out there.

14                  CO-CHAIR CASEY:   But I think if  
15       one would accept the word "outcome" in that  
16       statement that would be perhaps a way to  
17       phrase that.   Is there anyone pushing back on  
18       that?

19                  DR. BURSTIN:   Well, it doesn't  
20       need to be only outcomes, though.   I don't  
21       want us to think that this call for measures  
22       can't include really important processes,

1 evidence-based, linked to outcomes. I think  
2 we need to know what those outcomes are so we  
3 can judge the evidence of whether those  
4 processes in fact make sense but some of those  
5 outcomes are actually some of the ones we  
6 already have. I mean, you could argue  
7 readmission measures are one example. We've  
8 got all-cause readmission begins October 31st  
9 at NQF, the project. We're also in the midst  
10 of our resource use project. I mean, those  
11 may be the kind of outcomes you would use to  
12 judge the quality of care coordination. So I  
13 guess I don't want us to feel like we have to  
14 be only in the outcomes box.

15 MS. ALEXANDER: So I would agree  
16 that if we're, you know, asking the question  
17 what are measures of success for care  
18 coordination that it would include outcomes.  
19 Maybe not just only outcomes. And I do agree  
20 that that would include then the plan of care  
21 that which also would include then, you know,  
22 what are the outcomes that we're driving

1       towards, what are the goals that we're setting  
2       forth in order to drive towards those  
3       outcomes. Then how we achieve those. And  
4       measuring those achievement of those goals and  
5       outcomes not only from the care provider's  
6       perspective but also the patient's perspective  
7       as well too. And then earlier I think it was  
8       Pam that had mentioned I think another measure  
9       of success could be utilization if it was  
10      risk-adjusted as well.

11                   CO-CHAIR CASEY: Yes, Matthew.

12                   DR. MCNABNEY: Here's an example.  
13      This is a geriatrics example so it's somewhat  
14      limited but regarding care plans and goals of  
15      care, care plans. Joanne Lynn and Richard  
16      Schamp both in different articles on the same  
17      concept constructed these three pathways  
18      described as longevity, functional and  
19      palliative. And it had criteria, described  
20      criteria which a patient would declare which  
21      pathway they would want. It's complicated,  
22      more complicated than it sounds to help

1 somebody assign themselves into one of those  
2 pathways but you -- and they were used and we  
3 used them to prescribe care that fits into  
4 those pathways. But you could imagine that  
5 outcomes that would be appropriate for those  
6 pathways, you know. It could be different  
7 pathways for different populations but that  
8 you could then say, well, given that patient  
9 assigned themselves with help to a certain  
10 approach to care they met that care pathway,  
11 whether it's longevity, functional or  
12 palliative.

13 CO-CHAIR CASEY: Yes, I mean I  
14 think you really have hit some gold here in  
15 something that I hadn't thought of which is  
16 back to how does a patient decide what the  
17 correct plan of care is for him or her, right?  
18 So if I've got a risk of prostate cancer which  
19 I do and there are five different directions  
20 to go in to make my plan of care how does that  
21 get informed and is that -- that I think  
22 involves a certain level of, I don't know

1 whether it's exactly care coordination but  
2 it's a precedent too. Saying if I choose this  
3 pathway then what I'm going to try to do is  
4 coordinate my care in this direction. I mean,  
5 I think that's what you're saying, right? So,  
6 Helen and Gerri, that seems like a pretty good  
7 hierarchy of needs in terms of, I'll make it  
8 up, instruments that help shared decision-  
9 making to determine the pathway. Is that kind  
10 of what you're saying? So what do you think  
11 about that? That seems like it would be in  
12 play here.

13 CO-CHAIR LAMB: I would just  
14 suggest that when we start reviewing all the  
15 things that everybody has thrown out is to  
16 keep these questions in mind in terms of what  
17 is it we're trying to accomplish here which is  
18 really looking at, again, what's important in  
19 this process and how does it link to outcomes.  
20 Because I think to pull, you know, nascent  
21 measures and measures that we can actually  
22 look at that go beyond what we saw before,

1 we're going to have to define this for folks  
2 really clearly in terms of what we're looking  
3 for. So whether it be these outcomes and  
4 we've generated a list of several different  
5 outcomes. I'm thinking just in the interest  
6 of time here we're going to need to move into  
7 next steps soon.

8 DR. BURSTIN: Just one quick  
9 response to that as well and it's an important  
10 distinction between a tool and a measure. So  
11 NQF doesn't endorse the tool, we endorse the  
12 accountability measure that may be how you use  
13 the tool, what the results of the tool were.  
14 So in this area for example the Foundation for  
15 Informed Medical Decision-making has been  
16 doing some very elegant work on sort of  
17 measures of decision quality. Now those may  
18 be appropriate but we would be careful about  
19 avoiding, that we would not at least in the  
20 current environment be bringing in the tool  
21 that supports the SDM.

22 CO-CHAIR CASEY: Why don't we take

1 two final comments and then --

2 DR. HEURTIN-ROBERTS: Just the  
3 idea, outcomes are only meaningful relative to  
4 some antecedent. That's the only way you can  
5 evaluate it. So I think when we're thinking  
6 of defining an outcome and measuring it it has  
7 to be related to something that's come before,  
8 that's all.

9 CO-CHAIR CASEY: Which would  
10 include a process. Tom, did you have your?

11 DR. HOWE: Yes. I don't know if  
12 this is getting you into territory you don't  
13 want to get to but if we think patient  
14 engagement and feedback is critical to  
15 assessing at least a key outcome here in terms  
16 of how do they think they did with their goals  
17 with their care home there may need to be some  
18 thought to supplying an incentive. I mean, we  
19 have payers now paying for wellness  
20 incentives. This may be worth putting out  
21 there as a patient incentive.

22 CO-CHAIR CASEY: Lauralei?



1 MS. DORIAN: We did have some time  
2 set aside to specifically structure the call  
3 for measures but actually I think the round  
4 table did exactly that. So, and illuminated  
5 and elicited from you what you'd like to see  
6 in the call for measures. So in terms of next  
7 steps I do have some dates here. What we'll  
8 work on doing in the immediate next few weeks  
9 will be distilling all the information you've  
10 heard as I said and circulating it to you for  
11 comment. We did have, I'm trying to think  
12 here. Oh, we have the first draft of the  
13 white paper is due on November 22nd and then  
14 we have a tentative conference call scheduled  
15 with you between December 7th and 9th. So  
16 we're going to either poll you today or via  
17 email to see which of those days would work  
18 best for you. But perhaps during that meeting  
19 that would also be another good time to review  
20 the call for measures specifically and the  
21 paper that we've put together as a result of  
22 today's meeting.

1                   And the other thing that I wanted  
2                   to talk about, I don't know if you received  
3                   the email with your information to access  
4                   SharePoint but this is the first project  
5                   that's using SharePoint at NQF and I think  
6                   it'll be a really good way because care  
7                   coordination is so big and you guys are a  
8                   great group. And I feel like there's a lot of  
9                   really good discussion that can take place on  
10                  that site and so many documents. So rather  
11                  than sending you emails with copious amounts  
12                  of material all the time we can post it on  
13                  there. So does that sound good to everybody?

14                 DR. MCNABNEY: Does it alert you  
15                 when there's a new post?

16                 MS. DORIAN: You can set it to  
17                 alert you for that. And I'll send through  
18                 sort of instructions on how to use it. It's  
19                 pretty straightforward but it can be a little  
20                 bit confusing at first. But there's a  
21                 discussion board, there's a calendar. We can  
22                 post draft -- I can post a draft of the call

1 for measures for you to comment on. There's  
2 a forum. You can use it in a lot of different  
3 ways. So I think it'll be good to test how  
4 useful it is going forward.

5 MS. LOVE: I assume if there is  
6 something you'd post out there that you really  
7 want to call our attention to that you'll --

8 MS. DORIAN: I'll always alert  
9 you. Yes, I'll send you an email as well.

10 CO-CHAIR LAMB: Lauralei, could  
11 you go back to the previous slide in terms of  
12 next steps? Okay. So that, okay, here we are  
13 on October 19th. Are we going to get anything  
14 then in terms of responding to before the  
15 first draft of the white paper or is that the  
16 first request for a response?

17 MS. DORIAN: That will be the  
18 first date where you receive the white paper  
19 itself. But we'll send something to you about  
20 this meeting and the call for measures before  
21 that. Soon, yes, in the next couple of weeks.  
22 And then in terms of that conference call on

1 December 7th, 8th or 9th there's also a  
2 polling tool on that SharePoint site. So I  
3 might send that link to you tomorrow actually  
4 and you can poll to see which of those days  
5 works best for you.

6 CO-CHAIR LAMB: Okay. And the  
7 white paper is going to be in the form of a  
8 potential call for measures? Is that how it's  
9 going to look or no?

10 MS. DORIAN: The white paper is  
11 the commission paper that Lipika presented on.

12 CO-CHAIR LAMB: Oh, okay.

13 MS. DORIAN: Sorry, yes.

14 CO-CHAIR LAMB: So where's the  
15 call for measures in here? The development of  
16 the call for measures.

17 MS. DORIAN: The call for  
18 measures, well that closes, let's see. That  
19 closes on January 9th. There's an open call  
20 for measures right now but as soon as we have  
21 finalized our call for measures we can post  
22 that as soon as that's ready. So I was

1 thinking in the next few weeks if we can. Do  
2 you think that's doable?

3 DR. BURSTIN: We moved away from a  
4 30-day call for measures and we let just  
5 developers know way in advance. They've known  
6 for months that this is coming and this is due  
7 in January. So and we can also modify that if  
8 we need to. But we'll go back, pull down the  
9 call that's up there now that's just very  
10 general and add the specificity and the  
11 prioritization you've put in today. And we'll  
12 repost that and send it out so people know  
13 what you really want to get in. We just  
14 wanted to at least let them know this is --  
15 our submission form is now open at all times  
16 so people can start working on the forms early  
17 on. They are a lot of work to submit and pull  
18 together so we really want to give people at  
19 least three months to prepare.

20 CO-CHAIR CASEY: Would it be  
21 helpful to share with the committee maybe one  
22 such submission just so you can see it?

1       Because when you see it you're not going to be  
2       happy, it's a lot of work but we're going to  
3       be expecting all of you to really spend a lot  
4       of time and effort on this. So I think it  
5       might be, just to get your juices flowing.  
6       Karen?

7                   DR. FARRIS: Are we expected to  
8       comment on the call for measures or you guys  
9       are just putting it together and it's going?

10                   MS. DORIAN: No, we'll definitely  
11       expect you to comment on that. Within I guess  
12       let's see if -- I mean, we can give you a week  
13       to comment on it and then we'll send it out  
14       within the next week or two. But we'll send  
15       through all of these revised dates tomorrow as  
16       well so you know exactly what's expected of  
17       you. Are there any other questions on the  
18       project in general?

19                   MS. ALEXANDER: Just to make  
20       mention while you're just conversing here that  
21       if we have -- however this week timeline comes  
22       for us to respond to build in Thanksgiving in

1       there too.

2                   MS. DORIAN:   Yes, definitely.

3       That's a good point.

4                   CO-CHAIR CASEY:   And then Lauralei  
5       there will be, we will then, once the measures  
6       are in we will be doing some prep work for an  
7       actual another second face to face meeting.

8                   MS. DORIAN:   Yes, so that'll be  
9       part of when phase II officially kicks off.  
10      We'll have another conference call, orient you  
11      to phase II, to the details of the CDP process  
12      and then I think the in-person meeting is  
13      scheduled for the end of February.

14                  DR. AUDET:   So there are two  
15      public comments.   Well, there are two public  
16      things.   Public comment for the white paper  
17      and then there's going to be a submission, the  
18      submission of the measures.   That's in phase  
19      II.

20                  MS. DORIAN:   Correct.   The  
21      evaluation of the measures is in phase II.   So  
22      the public comment period is on the commission

1 paper that was part of phase I.

2 DR. BURSTIN: We'll also have  
3 public comment on the measures in phase II,  
4 yes.

5 MS. DORIAN: Yes. That's a much  
6 longer process.

7 CO-CHAIR CASEY: That's when it  
8 really gets fun.

9 MS. DORIAN: Yes, exactly. Yes.  
10 Operator, are you there?

11 OPERATOR: Yes, I am here and  
12 there is no one on the phone.

13 MS. DORIAN: Okay. Thank you for  
14 checking. Well, before Don and Gerri say  
15 anything I would just like to say thank you  
16 all so much for today. I found it incredibly  
17 enlightening and I think it really will impact  
18 the future of this work, particularly the work  
19 you do in phase II. And thank you to our co-  
20 chairs. And look forward to working with you  
21 in the future.

22 CO-CHAIR LAMB: It's been a



1 pleasure having this conversation today. I  
2 just have so much more I'm going home thinking  
3 about now. So looking forward to working with  
4 you all on the reports and the feedback and  
5 seeing you again in February. So thank you so  
6 much for a great meeting. And notice we ended  
7 on time.

8 (Whereupon, the foregoing matter  
9 went off the record at 3:47 p.m.)

10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

<b>A</b>				
<b>ability</b> 35:7 227:6 240:16 256:18 263:4	290:19 291:2 317:20 330:3	<b>act</b> 33:8 285:3	152:14 185:15 259:10 260:15 289:12	139:13 205:16 206:15 207:8 269:5,11 270:1 283:13,21
<b>able</b> 33:14 35:12 44:8 46:12 50:22 59:3 69:8 87:8 90:9 105:7 115:3 116:4,17 124:5 130:10 136:1 139:16 141:3 145:8 158:5 173:9 176:5 177:22 185:7 191:10 196:19 204:10 209:14 216:17 223:19 240:2 241:4 244:6 248:7 248:13,14 258:22 259:13 273:9 274:12 294:22 305:5 318:22 319:2	<b>accessible</b> 44:20 <b>ACCHA</b> 282:20 <b>accomplish</b> 161:16 291:10 310:16 326:17 <b>accomplished</b> 66:13 <b>account</b> 37:19 220:2 258:17 <b>accountability</b> 47:14 49:21 82:22 83:10 86:16 88:3 91:3 144:10 183:21 188:12,15 188:18,21 189:4,9 265:19 280:1 291:5 300:12 305:9 314:1 327:12 <b>accountable</b> 81:7 113:13 239:16,18 <b>achievable</b> 36:12 86:19 <b>achieve</b> 31:8 38:20 62:5 92:11 211:20 214:15 233:11 241:4 249:16 266:1 324:3 <b>achieved</b> 40:20 <b>achievement</b> 35:20 321:20 322:9 324:4 <b>achieves</b> 211:19 217:11 <b>achieving</b> 243:1 267:9 <b>acknowledge</b> 274:5 279:18 <b>acknowledged</b> 34:14 <b>acknowledgment</b> 318:8 <b>ACM</b> 1:19 <b>ACO</b> 17:10 23:3 231:8	<b>action</b> 16:5 110:7 138:12 285:8 <b>actionable</b> 34:14 34:17 <b>actions</b> 123:21 <b>activation</b> 118:5 <b>actively</b> 20:17 <b>activities</b> 6:15 9:6 23:1 178:11,13,19 179:5 186:1 187:10 192:20 199:1 264:1 268:20 294:13 <b>activity</b> 41:8 179:1 193:15 204:16 222:9 225:2 283:16,18 <b>actual</b> 78:16 84:7 90:1 91:10 93:1 115:9 123:21 187:14 192:5 225:19,20 335:7 <b>acute</b> 141:8 <b>adapting</b> 279:5 <b>add</b> 17:9 27:9 28:3 31:20 57:19 59:5 60:8 61:17 64:22 66:19 73:18 78:17 136:1 147:8 150:10 219:20 222:15,16,21 244:1,15 279:13 289:7 311:16 333:10 <b>adding</b> 145:12 155:11 246:22 <b>addition</b> 38:6 42:16 43:3 44:9 268:19 278:22 283:15 288:14 307:1 <b>additional</b> 27:10 31:20 73:18 119:16 <b>additive</b> 282:13 <b>address</b> 41:22 69:19 88:15,15	58:14 185:15 259:10 260:15 289:12 <b>addressed</b> 95:18 139:8 186:9 209:11 224:13 263:18 <b>addresses</b> 184:9 <b>addressing</b> 30:11 41:19 <b>adequately</b> 293:4,6 297:4 314:14 <b>adhere</b> 95:7 228:15 <b>adherence</b> 13:20 227:12,15,17,22 240:8,8,11 <b>adhering</b> 86:21 <b>Adjournment</b> 3:24 <b>adjust</b> 69:17 304:14 <b>adjusted</b> 252:14 253:16 <b>adjustment</b> 87:17 241:7 255:22 291:1 294:1,5 295:13 296:12,14 296:22 298:6,18 298:20,20 299:1 299:11 <b>administer</b> 85:2 <b>administered</b> 85:5 <b>administrative</b> 175:15 201:22 <b>admission</b> 20:3 232:4,7 <b>admissions</b> 42:7,20 42:21 212:15 <b>Adolescent</b> 181:11 <b>adopted</b> 65:19 <b>adoption</b> 11:20 <b>adult</b> 181:11 <b>adults</b> 9:10 37:17 <b>advance</b> 97:22 218:3 333:5 <b>advanced</b> 82:1 85:14 130:3 134:20 136:12	139:13 205:16 206:15 207:8 269:5,11 270:1 283:13,21 <b>advantage</b> 29:10 164:10 261:17 <b>adverse</b> 243:4 296:8 <b>adversely</b> 241:3 <b>advisor</b> 12:5,10 <b>advisory</b> 15:15,18 16:14 168:10 <b>Aetna</b> 1:22 22:1,5 <b>affect</b> 241:3 <b>affectionately</b> 70:16 <b>affordability</b> 44:7 <b>affordable</b> 33:8 39:7 43:21 44:2 <b>afternoon</b> 25:8 26:2 60:12,12 69:6 94:20 96:3 162:9 <b>afterthought</b> 137:22 <b>afterward</b> 61:13 101:7 <b>agencies</b> 20:12 <b>agency</b> 11:19 <b>agenda</b> 3:4 25:7 162:1 163:12 164:12 287:10 292:12 <b>aggregate</b> 176:14 <b>aggregated</b> 260:3 <b>ago</b> 33:19 56:18 84:10,13,17 119:4 119:5 258:13 259:16 275:3 302:16 316:22 <b>agree</b> 72:11 135:11 198:13 212:5 218:17 224:6,12 243:21 246:12,19 248:20 249:17 269:21 293:22 294:3,7 305:22

310:18 319:17 323:15,19 <b>agreed</b> 66:17 71:4 79:9 157:14 <b>agrees</b> 61:20 <b>ahead</b> 59:8 72:12 109:15 127:18 174:22 175:6 193:12 197:3 229:22 <b>AHRQ</b> 8:21 15:17 66:21 134:7 166:21 168:8 169:14 170:2,6 173:2,7 178:8,17 179:5,10 180:20 181:4 183:17 185:2,21 186:15 187:10 190:12 200:2 203:21 280:17 293:8 <b>AHRQ's</b> 47:3 <b>aim</b> 19:5 36:15 39:4,5 277:8 <b>aims</b> 32:1 39:4 <b>airline</b> 151:10 <b>akin</b> 243:5 <b>Al</b> 249:18 290:17 <b>alcohol</b> 283:17 <b>alert</b> 330:14,17 331:8 <b>Alexander</b> 1:13 21:2,3 120:22 121:9,18 197:4 198:13 233:6 323:15 334:19 <b>Alfred</b> 215:8 <b>align</b> 33:15 55:6 <b>aligned</b> 56:6 181:17 248:7 257:17 259:3 <b>aligning</b> 56:2 183:22 <b>alignment</b> 190:17 <b>aligns</b> 56:14 <b>alive</b> 273:3 <b>Aller</b> 1:14 14:10,10	142:4,8,11,19 270:13 <b>allergies</b> 106:16 257:9 <b>allergy</b> 118:19 <b>Alliance</b> 13:4 <b>alliances</b> 32:4 <b>allow</b> 139:11 213:13 223:13 306:14 <b>allowed</b> 39:5 69:13 <b>allowing</b> 312:7 <b>allows</b> 159:22 170:20 <b>alluded</b> 184:10 <b>alluding</b> 200:9 213:7 <b>all-cause</b> 323:8 <b>All-Inclusive</b> 19:11 <b>all-payer</b> 20:18 <b>Alonzo</b> 2:13 9:16 249:3 <b>Alonzo's</b> 298:12 <b>alter</b> 185:11 <b>alternative</b> 17:7 <b>Alzheimer's</b> 303:3 <b>amalgam</b> 67:3 <b>ambitious</b> 268:11 <b>ambulatory</b> 21:19 130:14 131:5,6,22 181:6 195:9,10,13 255:3 <b>ambulatory-sens...</b> 42:21 <b>Amedisys</b> 2:3 17:3 <b>amend</b> 94:17 <b>America</b> 235:2,2 <b>American</b> 2:7 7:16 8:15,16,17,17,18 8:19 9:14 11:8 12:6 15:19 19:15 21:9 22:12 241:16 282:3 <b>Americans</b> 276:20 <b>AMI</b> 186:22 <b>AMIA</b> 21:8 <b>AMIN</b> 2:15	<b>amount</b> 66:12 175:13 192:2 <b>amounts</b> 127:3 315:11 330:11 <b>Amplatz</b> 2:4 <b>analysis</b> 169:13 173:5 176:6 185:11 190:22 191:7 274:14 <b>anchor</b> 215:15 <b>Anderson</b> 16:12 <b>and/or</b> 265:21 266:9,10,11 321:11 <b>anecdote</b> 238:8 277:13 303:18 <b>Ann</b> 2:18 5:5,15 24:20 107:17 <b>Anne-Marie</b> 1:15 15:22 74:19 203:7 292:8 295:10 301:13 302:6 316:3 <b>annotated</b> 25:21 99:21 <b>announced</b> 277:3 <b>answer</b> 40:9 209:1 217:18 228:11 293:3,5 297:2 301:11 310:9 <b>answered</b> 208:22 <b>answering</b> 297:2 <b>antecedent</b> 328:4 <b>antecedents</b> 114:8 <b>Anthem</b> 2:13 9:17 <b>anticipate</b> 197:21 308:20 311:2 <b>anticipated</b> 169:11 <b>anticipating</b> 260:10 <b>anti-hypertensive</b> 172:6 <b>anybody</b> 27:6 56:10 182:11 185:8 191:15 212:2 219:15 240:22 260:16 280:2,6 285:9	286:12 312:16 <b>anymore</b> 85:4 129:17 223:12 <b>anytime</b> 262:16 270:5 <b>anyway</b> 211:11 216:14 287:1 <b>apart</b> 45:18 <b>APCDcouncil.org</b> 111:19 112:7 <b>apiece</b> 143:5 <b>apologize</b> 229:6 <b>app</b> 232:11 <b>applaud</b> 242:15 <b>Applause</b> 159:10 <b>applicable</b> 300:19 <b>application</b> 11:11 11:12 <b>applications</b> 12:19 23:3 314:1 <b>apply</b> 141:2 210:5 244:2 246:13 278:8,22 <b>appointment</b> 72:1 74:15 75:10,11 81:16 93:4,5 254:12,13 <b>appointments</b> 71:5 75:15 151:1 254:4 254:10 <b>appointment-kee...</b> 70:22 <b>appointment-ma...</b> 74:9 <b>appreciates</b> 161:19 <b>approach</b> 20:2 75:4 86:10 90:5,16 91:13 105:13 125:13 167:2 168:22 186:2 187:16 325:10 <b>approached</b> 71:10 <b>approaches</b> 38:18 89:4 178:12,18 179:9 268:6 <b>appropriate</b> 58:8 81:2 90:10 169:17	202:4 244:11 249:5 257:3,6 303:12 325:5 327:18 <b>approval</b> 31:20 <b>approved</b> 120:1,11 <b>area</b> 13:11 22:21 31:3 32:22 39:16 39:17 40:5 42:9 43:21 45:20 48:5 48:19 49:18,22 50:7 51:20 54:19 70:15 88:2 103:8 106:7,9 124:22 128:3 136:3 140:3 157:17 193:3,13 218:4 295:8 318:4 319:17 320:4 327:14 <b>areas</b> 33:7 34:7 35:6 36:2,22 37:8 38:11 39:10,13,18 40:2,10 43:3,11 43:19 44:15 45:10 45:16 46:7,12,17 49:1 51:12,13 55:2,13 58:7 68:9 72:5 101:18 103:11 125:8 134:13 163:7 167:14 184:5,8 195:7 196:10 311:13,21 312:1 318:15 <b>arena</b> 230:2 308:18 <b>argue</b> 323:6 <b>Arizona</b> 2:1 9:5 11:5 <b>Arizona's</b> 2:2 <b>Arjun</b> 2:24 3:17 5:7,9 25:21 100:11 101:11 156:2 162:11,12 165:16,17 166:1 196:17 208:17 293:9 <b>Arjun's</b> 160:8
---	--	--	--	--

<b>arm</b> 208:9	<b>assigning</b> 151:6	301:14 316:4	122:21 126:3	24:15 76:21 121:4
<b>arms</b> 71:2	<b>assist</b> 64:3	335:14	131:9 139:5 140:8	141:8 158:10
<b>art</b> 128:16	<b>assistance</b> 12:18	<b>audit</b> 140:10	140:13,13 149:14	164:5 189:13
<b>article</b> 297:22	<b>assisting</b> 14:14	<b>August</b> 120:12	159:15 160:11	199:22 202:7
301:18	<b>associate</b> 16:21	<b>authoring</b> 198:21	202:15 203:1,18	233:15 272:11
<b>articles</b> 170:1	17:20 21:17,18	<b>availability</b> 184:11	213:18 214:12	297:6 307:7,7
324:16	23:9	184:13 243:19	227:2 231:17	312:9
<b>articulate</b> 66:5	<b>associated</b> 192:2	290:19	237:20 239:9	<b>basic</b> 93:6
227:7	239:12 250:19	<b>available</b> 66:7	241:22 246:21	<b>basically</b> 9:19
<b>artifact</b> 108:20	<b>Association</b> 2:6	100:20 117:13	254:16,22 282:14	54:13 100:18
<b>artificial</b> 273:8	7:16 8:17,18,19	130:18 145:18	286:9,11 287:1	101:15,22 103:9
<b>artificially</b> 274:7	11:8 15:15,20	153:5 164:19	292:12 296:1	103:18 109:1
<b>aside</b> 329:2	18:1 20:9 32:11	170:4 175:20	304:7 305:21	138:21 141:19
<b>asked</b> 45:19 56:11	245:22	176:4 184:14	309:16 314:15	151:11 154:18
162:7 189:12	<b>assume</b> 153:14	185:5,8 192:21	322:17 325:16	156:6 183:16
208:18 228:19	262:10 331:5	205:9,10,17 207:4	331:11 333:8	250:17
267:17,18	<b>assumes</b> 208:3	215:5 219:4	<b>backdrop</b> 72:9	<b>basis</b> 13:3 165:22
<b>asking</b> 36:13 57:16	<b>assuming</b> 258:2	279:10	<b>backfill</b> 214:14	172:17 218:1
155:1 163:22	<b>assumption</b> 70:11	<b>Avenue</b> 1:9	<b>background</b> 58:16	223:17 255:19
205:5 217:19	95:3,8	<b>averages</b> 38:3	59:18 102:21	296:13
259:19 289:7	<b>assumptions</b> 60:1	<b>avoid</b> 16:6 170:22	103:2 105:22	<b>bat</b> 289:18
323:16	72:4 305:22	229:8	166:3	<b>Bates</b> 28:22 100:6
<b>aspect</b> 69:2 71:11	<b>assured</b> 309:13	<b>avoidance</b> 248:15	<b>backgrounds</b> 4:11	<b>bath</b> 310:18
95:4 198:14	<b>asthma</b> 10:2,3	<b>avoiding</b> 277:17	<b>bad</b> 87:9 223:8,9	<b>Battle</b> 13:11
206:18 249:19	<b>astounding</b> 199:17	327:19	231:17 257:4	<b>bean-counting</b>
258:12 260:22	275:3	<b>aware</b> 103:17	268:13 276:11	276:1
277:9	<b>astronomical</b> 142:9	154:15 196:12	303:1,3 309:18	<b>bear</b> 224:15 273:19
<b>aspects</b> 70:13 74:10	<b>as-is</b> 173:7 223:20	197:13 227:20	314:19	<b>becoming</b> 139:9
106:11 108:7	<b>atic</b> 168:22	258:7 261:9	<b>balance</b> 36:8	274:8
180:12 269:22	<b>Atlantic</b> 8:7	267:13	170:19 246:6	<b>beds</b> 113:14
288:14 289:11	<b>Atlas</b> 66:21 168:8	<b>awhile</b> 27:11 47:7	264:8 272:1 318:7	<b>began</b> 96:22
<b>aspirational</b> 36:11	170:2 178:8,17	143:19	319:5	<b>beginning</b> 69:14
37:9	<b>attainment</b> 31:5	<b>a.m</b> 1:10 4:2 99:10	<b>balancing</b> 214:7	96:13 126:18
<b>aspire</b> 271:22	<b>attempt</b> 181:16	99:11	<b>banking</b> 151:9	<b>begins</b> 106:4
<b>assess</b> 47:22 91:8	308:21	<b>A1C</b> 253:4,5	<b>bar</b> 79:20 81:20	127:19 323:8
<b>assessed</b> 254:1	<b>attention</b> 57:10		82:11 84:8 85:11	<b>begs</b> 230:20,22
311:20	63:18 67:16 98:20	<hr/> <b>B</b> <hr/>	109:5 154:21	231:21
<b>assessing</b> 186:17,17	127:9 143:15,19	<b>B</b> 320:3	271:19 272:6	<b>begun</b> 258:13
328:15	165:7 234:19	<b>baby</b> 7:7 272:1	<b>barn</b> 56:16	<b>behavior</b> 236:15
<b>assessment</b> 171:21	244:17 321:14	310:17 317:22	<b>barrier</b> 88:14	<b>behavioral</b> 88:13
180:16,17 186:18	331:7	<b>back</b> 13:7 22:6 24:3	235:17	88:19 98:15
196:6 231:2	<b>Audet</b> 1:15 15:22	34:9 47:1 49:16	<b>barriers</b> 112:10	115:19
232:20 283:13	15:22 92:20	53:20 59:3 60:21	<b>bars</b> 80:9 182:19	<b>behaviors</b> 40:21
314:4	112:13,18 113:2	63:2 65:11,11	<b>base</b> 68:7 113:6	41:17 264:2 271:4
<b>assign</b> 213:2 325:1	145:10 203:8	67:6,19 78:9 80:1	215:15 312:2	<b>belabor</b> 54:5
<b>assigned</b> 172:20	205:5 214:18	85:17 94:20 96:5	313:21 316:18	<b>believe</b> 68:1 76:2
176:19 325:9	276:21 295:11,16	99:3 109:10	<b>based</b> 12:12 13:7	104:14,22 217:22

233:9 255:7 263:9 280:2 284:13 <b>believed</b> 280:8 <b>bench</b> 319:15 <b>beneficiaries</b> 300:3 <b>benefit</b> 68:7 80:16 92:16 175:16 <b>benefits</b> 312:11,16 314:6 <b>Bernie</b> 32:16 <b>best</b> 30:21 38:4 82:16 87:7,19 128:15 178:1 188:5 217:12 235:20 268:17 277:19,20 329:18 332:5 <b>better</b> 39:7 41:20 50:2 51:7 73:16 77:7 81:3 83:13 85:13 97:6,6 101:8 106:15 169:17 170:20 194:21 236:11,13 244:13 249:13 271:6 283:21 293:2 299:12,14 301:1 303:13,13 308:16 310:3 311:4 315:4 320:17 <b>beyond</b> 32:8 38:7,9 38:13 88:6 109:5 131:19 195:22 206:10 233:22 275:22 326:22 <b>bias</b> 19:13 20:15 141:20 <b>bidirectional</b> 157:15 <b>big</b> 37:22 82:15 99:17 184:16 185:18 192:12 199:10 217:1 238:3 274:19 284:14 316:16 330:7	<b>bigger</b> 44:9 48:8 143:6 177:5 184:8 <b>biggest</b> 36:7 134:16 137:2 276:13 <b>bill</b> 10:10 265:9 275:17 290:18 <b>billing</b> 156:10 175:15 223:6 <b>Bill's</b> 74:12 <b>binary</b> 206:11 <b>bit</b> 25:10 27:10 38:12 48:12 59:17 63:8 67:18 72:12 76:9 88:11 90:6 91:13 112:19 127:17 157:3 162:2 164:16 167:5 177:8 180:7 180:22 193:2 201:19 202:21 203:9 209:19 210:4 219:20 224:14 244:21 269:1 278:6 281:10 321:18 330:20 <b>black</b> 238:3 <b>blank</b> 51:11 213:21 <b>blaze</b> 50:9 <b>blindness</b> 127:5 <b>block</b> 127:11 <b>blocks</b> 89:15 258:6 258:8 <b>blood</b> 41:21 172:5 <b>bloodstream</b> 43:9 <b>blue</b> 176:15,20 177:2,2 179:4 <b>blurred</b> 306:20 <b>board</b> 2:7 8:19 9:11 11:7 22:12 31:20 32:21 52:8 330:21 <b>boards</b> 17:22 <b>boat</b> 225:1 <b>boil</b> 309:5 <b>boiled</b> 36:11 <b>Bonnie</b> 2:12 16:16 265:2 289:21	<b>Bonnie's</b> 224:6 <b>Boston</b> 23:14,17 <b>bothered</b> 87:21 <b>bottom</b> 32:15 43:7 <b>boundaries</b> 73:8 <b>box</b> 75:2 220:20 221:16 224:8 225:7 232:12 318:16 323:14 <b>boxes</b> 52:18 61:6 <b>boy</b> 251:20 <b>brain</b> 208:20 <b>brainstorming</b> 231:13 233:4 <b>brand</b> 23:14 <b>Brandeis</b> 78:22 <b>breadth</b> 47:20 <b>break</b> 98:21 160:9 163:11 286:8 <b>Bridges</b> 278:17 <b>brief</b> 55:20 108:11 108:11 112:16,19 162:18 165:8 218:15 258:14 <b>briefly</b> 7:2 <b>Brigham</b> 1:21 2:22 2:24 5:11 23:10 23:11,17 29:1 100:5 143:14 <b>Brigham's</b> 23:14 <b>bring</b> 28:2 58:9 62:3 73:11 78:13 80:5 93:18 111:11 113:21 156:2 158:11 216:16 219:4 303:10 310:14 313:19 318:2 <b>bringing</b> 28:12 29:5 78:15 216:4 313:2 327:20 <b>brings</b> 117:22 122:16 <b>broad</b> 103:7 124:4 128:9 135:17 148:22 170:22 171:3 174:9	178:11,18 179:9 179:20 186:2 187:16,19 189:15 189:19 194:18 200:14 300:22 <b>broaden</b> 32:7 131:22 132:4 <b>broader</b> 28:13 46:4 51:1 <b>broadly</b> 30:6 38:9 51:4 80:4 270:18 300:19 <b>broad-based</b> 74:21 168:17 170:16 293:21 <b>broken</b> 26:19 <b>Brookings</b> 17:10 <b>brought</b> 4:10 74:6 78:8 92:22 128:18 156:21 212:5 290:21 301:4 <b>bucket</b> 194:13 199:10 200:13 205:4 <b>buckets</b> 195:3 232:1 <b>Buffalo</b> 12:12 <b>bugs</b> 142:16 <b>build</b> 61:17 65:4 81:11 83:19 93:14 96:13 97:3 111:21 137:20 226:11 233:6 242:10 246:1 271:18 334:22 <b>building</b> 20:12 30:14 35:5 86:13 <b>built</b> 86:2 91:4 129:1 139:14 <b>bullet</b> 30:11,14 101:21 102:10 107:1 108:2,22 140:18 146:6 152:2,6,15 155:11 156:6,13,14,18,19 <b>bunch</b> 26:7 <b>bundle</b> 240:13	<b>burden</b> 281:11 <b>Bureau</b> 15:12 <b>buried</b> 275:4 <b>Burstin</b> 2:16 4:15 4:16 27:9 57:19 73:17 78:21 83:19 88:17 159:11 206:3 215:18 260:19 297:22 302:13 311:15 313:15 316:12 322:19 327:8 333:3 336:2 <b>business</b> 111:21 284:5 <b>busy</b> 25:2 <b>button</b> 320:22 <b>buy-in</b> 147:6 <hr/> <b>C</b> <hr/> <b>C</b> 320:3 <b>CAD</b> 253:2 <b>calculated</b> 297:18 <b>calendar</b> 330:21 <b>Calhoun</b> 13:12 <b>call</b> 3:21 23:6 26:6 26:11,16 27:19 31:18 39:5 57:21 59:11 63:10 64:9 65:17,18 67:10 70:19 76:17 82:22 84:6 91:19 95:13 106:13 109:12 163:15 165:6 178:10 200:18 201:10,18 218:8 218:21 254:19,22 269:18 272:11 277:1 286:17 292:18 304:8 306:2,2 307:2,8 320:18 322:21 329:2,6,14,20 330:22 331:7,20 331:22 332:8,15 332:16,17,19,21 333:4,9 334:8
---	---	---	--	---

335:10	209:22	85:4,4,22,22	194:17 195:4,8,19	273:19,21 274:20
<b>called</b> 9:22 71:3	<b>cardiologist</b> 283:22	86:22 87:8 89:3	196:9 199:7,16	275:1,11,21
94:5 117:10 146:1	<b>cardiologists</b>	90:2,8,10,15,19	200:14 202:12,13	277:10,22 279:19
146:2 164:20	284:14,15	91:4,19 93:5 94:6	204:11,14 205:12	279:21,22 280:1,4
259:17 268:6	<b>Cardiology</b> 8:16	94:11,12 95:4,5	208:9,19 211:2,4	280:5,7,10,13,16
269:4	<b>cardiovascular</b>	95:19,22 96:15,15	211:8,17 212:13	280:18,20,21,22
<b>calling</b> 24:11 28:6	41:12,14	96:16,17 97:5,11	213:8,11 214:22	281:7,11,13,20
76:11 205:15	<b>care</b> 1:3 2:1,14 3:5	100:4 102:13	215:3,7,11,12	282:7,17 283:3,4
241:18 263:9	3:7,9,12,13,19 4:4	103:20,22 104:2,8	220:15 221:11,14	283:11,14,19
269:3 277:16,18	8:22 9:9,12,14,17	104:11,20 105:16	221:21,22 223:16	284:6,7 285:9
302:22	10:21 11:2,12	106:12,18,21,22	224:15,20,22	286:4 288:13,20
<b>calls</b> 255:1 277:21	12:1,4,16,20 13:8	110:4,8,13 113:10	225:14,17 226:5,6	289:7,20 290:1,11
303:22 316:9	14:2,4,5 15:2,3,4	113:13 114:6,11	226:7,13,15,20	290:12 291:2,15
<b>Canadian</b> 276:4	15:10 16:5,7	114:13 115:6	227:3,4,8,9,13,16	291:21,22 293:5
<b>cancer</b> 14:19,21	17:18 18:3,11,15	116:13 117:15	227:22 228:6,21	296:4,6,9,10
15:2,4 124:11	18:18,21 19:3,11	118:22 119:20	230:10 231:8,17	297:5,16 299:1
172:2 325:18	19:12,17,17 20:2	120:17 121:4,5	232:2,17 233:8,12	302:17,19,20
<b>capabilities</b> 103:14	20:14 21:19 22:17	123:8,13,17,22	233:13,14,18,21	305:3,5 307:5,18
108:1 110:17	22:19 23:18 25:11	124:12,14,19,21	234:17 235:10,14	309:7,14 312:13
127:22 135:2	25:14 26:6,21	125:5,8,14 128:7	235:19 236:3,4	312:18 315:2
270:2	27:15 28:13 32:5	128:10 129:13	237:13,14,15,21	317:1 318:18
<b>capability</b> 225:20	32:8 33:8 37:6,8	130:16 131:2,6,11	238:18,19,21	319:20 320:2,13
<b>capable</b> 86:21	37:13,14 38:8,10	131:12,15,18,22	239:4,4,11,14,19	320:20 321:5,14
206:8	38:14,15 39:7,7	132:7 133:3,14,22	240:2,6,10,14,15	321:20 322:9
<b>capacity</b> 8:12 15:15	39:19,22 40:1,4	134:2,17,21 135:3	241:21 242:14,20	323:12,17,20
16:13 93:7 210:13	41:6,9 42:8 43:1	135:4,10 137:7,9	243:7,13,19 244:1	324:5,14,15,15
231:1,2,9 232:20	43:12,15,21 44:2	137:13 140:9,15	244:16,18,19,21	325:3,10,10,17,20
232:21 233:1	44:9,11,14,15,16	141:14,21 142:12	245:4,7,8,11,19	326:1,4 328:17
<b>capita</b> 251:18	44:18,20,20 45:1	144:13 145:16,16	246:15 248:9,9,10	330:6
<b>Capitol</b> 1:9	45:3 47:3,12,19	145:17,20 147:2	248:19 249:13	<b>careful</b> 74:8 149:7
<b>capture</b> 71:22	48:1,14,16,20	148:8,16 149:5	250:6,8,19,20	150:20 217:4
75:13 116:18	49:3,4,4,8,11,12	150:15 151:2	251:3,12 252:6,10	278:1 309:2
162:3 200:15	50:4,16,21 51:8	154:22 155:3	252:17 253:6	327:18
202:3 222:6,7,19	52:10,21 53:5,17	157:6,6 164:5	255:9,14 256:16	<b>carefully</b> 6:7
240:4 241:1,6	54:18 56:19,20	166:5,10 168:12	256:20 257:11,16	<b>caregiver</b> 220:13
246:7 280:16	57:2 59:4,7,13	168:16 170:12,15	257:18,21 258:3	225:14,17 226:3
281:6 282:9	63:7,14 64:10,16	170:20 172:8	258:19 259:5,9	247:14,16,18
284:19 285:3,15	64:20 66:4,21	174:19 177:4,9	261:18 262:20	288:12 290:18
285:22	67:2,11,12 68:16	178:3,15 179:7	264:16 265:3,12	<b>caregivers</b> 240:18
<b>captured</b> 239:13	68:21 69:3,6,10	180:1,8,9,13,14	265:20,21 266:11	242:12
290:5	69:13,15,18,22	181:12 183:13,13	266:18 267:6,12	<b>caring</b> 106:20
<b>capturing</b> 135:22	70:7,13,18 71:3	184:4,18 185:18	267:15,22 268:2	<b>carried</b> 66:8 75:17
156:10,11 162:21	71:11,15,18 73:1	186:8,11,13 187:2	268:13,17 269:1,5	<b>carrier</b> 147:20
182:2 287:15	73:1,5,9,16 74:3	187:15 188:11	269:7,11,18 270:1	<b>carriers</b> 147:10
<b>card</b> 89:12 125:19	75:16,21 77:1,14	189:2,17 190:1,5	270:14,19,19	<b>Carrillo</b> 1:16 17:14
299:19	79:3,16,18 80:4	190:9,20,22	271:3,14 272:17	17:15 56:13 93:13
<b>cardiac</b> 186:22	80:21 81:15 82:1	191:22 193:5	272:17 273:7,12	115:11,19 116:3,8

116:19 117:2,12 137:20 138:14 221:17 222:22 285:18 <b>carry</b> 30:22 <b>carryover</b> 226:17 <b>cascade</b> 52:2 285:14 <b>cascading</b> 124:9,18 125:7 <b>case</b> 9:19 11:8 56:12 69:7,12,16 69:20 111:22 122:6 147:12 164:17 248:13 296:8 <b>cases</b> 127:2 140:10 <b>Casey</b> 1:10,12 3:10 8:5,6 24:6 57:11 60:16 61:22 65:6 65:9 72:8 75:7 78:1 82:12 85:15 87:10 91:15 98:1 99:2,6 125:18 126:11 133:7 137:17 142:6 155:13,16 156:1 159:2,7 160:5,13 160:17 161:11 165:5,12 196:17 199:4 201:6 203:6 203:15 205:20 207:16 208:7 210:7 212:22 213:17 216:19 219:10 238:7 241:8 245:13 249:3,8 255:6,16 256:3 268:22 269:15 282:11 285:17 286:7 287:8 289:16 294:14 295:1,6,14 296:19 298:17 299:7,22 301:10 301:13 302:3 303:17 304:13	305:8 308:5 313:1 314:8 315:18 320:19 321:17,22 322:4,8,11,14 324:11 325:13 327:22 328:9,22 333:20 335:4 336:7 <b>cast</b> 134:11 <b>catch</b> 230:3,4 <b>catch-all</b> 185:19 <b>categories</b> 180:6 185:1 186:4 191:1 226:4 <b>categorizations</b> 139:6 <b>categorize</b> 201:1,3 <b>categorized</b> 104:5 <b>category</b> 174:3 185:19 186:5 256:9 <b>caught</b> 237:2 256:6 <b>causes</b> 40:12 <b>CBO</b> 11:13 138:4 222:8 <b>CDP</b> 27:6 335:11 <b>CDR</b> 116:19 <b>center</b> 1:9 2:13 10:12 15:10 16:18 38:2 70:8 72:3,20 138:4 244:19 <b>centered</b> 57:9 82:18 196:9 279:17 <b>centeredness</b> 81:13 <b>centering</b> 71:17 <b>centers</b> 154:11 289:1 <b>central</b> 1:24 12:11 211:18,21 <b>centrality</b> 71:15 <b>certain</b> 62:11 91:8 183:20 187:15 195:7 264:1 271:3 278:15 289:11 292:2 307:20,21 325:9,22	<b>certainly</b> 25:4 32:13 35:6 36:21 38:10 40:7 41:8 45:9 46:16 84:3,9 87:1 116:12 150:13 151:14 174:19 221:8 224:17 225:16 226:7 239:12,22 246:14 257:14 289:3 293:12 298:5 299:7 <b>certified</b> 119:9 258:21 <b>cessation</b> 84:19 <b>cetera</b> 14:6 42:2 94:17,17 98:16,16 147:14 212:15 251:22 252:13 308:18,18 <b>chair</b> 5:20 19:14 21:7,17 58:1 65:22 <b>chaired</b> 27:18 <b>chairman</b> 10:10 <b>chairs</b> 8:2 336:20 <b>challenge</b> 72:13,18 76:4 82:15,19 83:15 92:9 98:11 115:21 134:17 135:19 136:6 137:2 215:4 261:13 271:20 282:8 <b>challenged</b> 278:6 <b>challenges</b> 75:9 136:7 <b>challenging</b> 49:19 167:19 194:5 203:18 <b>chance</b> 27:21 28:19 164:22 219:6,14 <b>change</b> 154:17 155:4 162:1 198:3 275:7 308:8 <b>changes</b> 102:7 147:15 240:10	<b>changing</b> 146:9 271:7,8,12 <b>chaplaincy</b> 312:18 <b>characteristics</b> 87:15 112:14 167:7 <b>charge</b> 210:10 265:20 <b>chart</b> 102:2,3 141:12 175:12 176:2 202:1,16 223:5 <b>charting</b> 108:20 <b>charts</b> 22:16 141:22 174:21 <b>chasm</b> 224:11 <b>check</b> 24:3 <b>checkbox</b> 84:12 <b>checked</b> 264:9 <b>checking</b> 336:14 <b>checklist</b> 232:21 <b>CHF</b> 84:11 <b>chief</b> 8:6 11:16 21:3 100:6 <b>Child</b> 15:11 <b>children</b> 15:10 37:20 98:15 127:13 190:4 <b>Children's</b> 2:5 <b>chilly</b> 56:12 <b>choice</b> 267:19,21 <b>choices</b> 270:4 <b>choir</b> 88:1 <b>cholesterol</b> 41:22 <b>choose</b> 326:2 <b>Chris</b> 12:9 72:7 78:1,2 92:2 213:19 291:6 314:12 <b>Christine</b> 1:23 63:11 150:11 265:4 306:16 313:9 <b>chronic</b> 14:6 45:13 49:5 50:17 51:7 94:9,9 242:21 255:10 263:1,11	269:10 302:11,22 <b>chunk</b> 272:22 273:6 <b>church</b> 222:9 234:1 <b>churches</b> 288:22 <b>churning</b> 275:7 <b>circulating</b> 329:10 <b>circumstance</b> 124:17 <b>cite</b> 157:21 <b>cited</b> 107:8 <b>city</b> 2:12 10:4 16:18 <b>claim</b> 309:9 <b>claims</b> 20:12,16,18 102:1,5 111:4 147:11 175:15,16 193:10 201:22 236:12 297:8 303:20 <b>claims-based</b> 171:10 175:13 186:21 189:20 <b>Claire</b> 11:4 <b>clapping</b> 244:22 <b>clarification</b> 114:3 <b>clarify</b> 92:3 151:19 <b>clarity</b> 57:16 <b>classic</b> 188:5 312:2 <b>classified</b> 176:16 198:1,2 201:22 202:1 <b>clear</b> 36:19 65:22 142:13 191:12 209:10 242:1 277:13 282:16 306:10 308:9 309:2 310:15 311:8 312:15 <b>clearer</b> 200:4 <b>clearinghouse</b> 173:14 <b>clearly</b> 41:5 66:3 84:1 179:22 201:19 212:8 246:7 266:13 277:3 294:21 327:2
--	---	--	--	--

<b>click</b> 148:9 175:6 193:12	134:20 170:5 300:1,6	175:3 201:2 216:14 219:22	219:2 226:11 270:14,21 287:2	67:12 96:1 107:4 118:12 132:10
<b>clicking</b> 148:12,20	<b>CMS-sponsored</b>	232:14 234:4,9	290:13 328:1	138:1 157:15
<b>client</b> 11:9	299:9	235:7 236:13,21	335:15	171:18 183:13,21
<b>Clinic</b> 1:20,25 2:5	<b>CNP</b> 2:4	237:4 263:1	<b>commercial</b> 139:15	187:7,12,14,18
11:3,5 19:21 20:6	<b>coals</b> 169:3	273:16 286:9,11	139:19	188:1,1,2 257:1
254:8,20	<b>Cochrane</b> 169:22	287:1,21 303:8	<b>commission</b> 99:21	<b>communications</b>
<b>clinical</b> 12:3 19:14	217:3	306:14 317:8	332:11 335:22	48:16 180:7
21:17 22:5 41:1	<b>code</b> 79:21 232:7	318:15 321:9	<b>committee</b> 1:3,8	<b>communities</b> 38:21
41:18 101:18	<b>coding</b> 232:4	328:7	4:5 6:16,22 7:14	39:8 54:16 91:22
106:13 112:14	<b>cognitive</b> 148:21	<b>comes</b> 85:14 118:4	7:20 15:2,18	299:17
118:16 121:17	<b>cognizant</b> 274:9	141:13 181:16	18:17 19:15,16	<b>community</b> 1:23
123:18 124:3,10	<b>coherent</b> 82:9	187:4 188:4	21:8,11 22:20	12:10 17:16 32:12
129:13 140:6	<b>cold</b> 270:6	190:16 235:11	23:20,22 27:18	35:11 40:18 41:16
141:1 145:10,12	<b>Coleman</b> 16:12	273:19 279:19	50:14 57:14,21	50:5 127:3 181:19
145:15 148:13	65:21	304:7 309:4	58:2,4 59:19,20	183:22 187:2
158:4 170:22	<b>Coleman's</b> 50:21	334:21	63:12 64:1 65:14	190:18 195:17,18
171:2 210:14	<b>collaboration</b>	<b>comfort</b> 222:2	65:15 66:9 68:4	198:8,10 213:9
221:20 225:11	141:15	<b>coming</b> 20:1 48:3	68:16 70:6 76:10	221:13 231:1,2,4
226:17 267:8	<b>collaborative</b> 19:4	82:7 109:10	77:9 79:4 84:4,20	231:10,11,12,13
297:8 308:12	113:12 231:11	118:16,16 145:2	89:1,6 101:17	232:16 234:1
311:22	<b>collapsed</b> 180:19	154:3 157:5,6	104:14,17 119:4	239:2 245:2 266:9
<b>clinician</b> 52:14	<b>colleagues</b> 148:10	175:9 229:18	120:7 125:22	270:20 284:8
126:15 188:19	219:11 284:15	232:13 247:2	126:7 159:18	289:1 299:13
283:19	<b>collect</b> 101:6	252:4 286:3 333:6	168:10 171:15	<b>community-based</b>
<b>clinicians</b> 53:1	149:22 158:17	<b>comment</b> 3:14,23	199:9 245:16	12:19 115:15,16
115:21 121:19	<b>collected</b> 227:16	56:15,17 86:13	312:8,13 333:21	214:4 288:22
127:8 152:19	<b>collectible</b> 150:1	122:1,11,18	<b>committees</b> 16:14	299:10
153:2,11 154:13	<b>collection</b> 35:10	134:14 142:4	27:11 31:1 55:19	<b>community-level</b>
227:4	<b>collectively</b> 28:5	143:4 148:6 153:8	120:7	40:18
<b>close</b> 119:1 196:14	<b>College</b> 1:17,19	159:11 161:2	<b>committee's</b> 161:16	<b>community-wide</b>
234:18	8:15,16 12:6 13:1	199:5 201:17	<b>common</b> 33:1	154:12
<b>closed</b> 239:8	241:17	206:17,19 215:19	135:18 234:14,21	<b>comorbidities</b>
<b>closely</b> 76:13	<b>colon</b> 172:2	220:18 223:3,3	236:22 289:3	283:10
212:16	<b>Colorado</b> 299:9	224:6 251:10	<b>Commonwealth</b>	<b>companies</b> 23:5
<b>closer</b> 83:11 210:4	<b>colorful</b> 179:3	266:7 279:2	1:15 16:2 47:5	<b>company</b> 17:4
<b>closes</b> 332:18,19	<b>combination</b> 127:1	285:18 303:6,7	111:20	<b>compared</b> 126:17
<b>closest</b> 176:22	259:22	329:11 331:1	<b>communicate</b> 55:9	<b>comparing</b> 187:21
225:19	<b>combined</b> 101:11	334:8,11,13	260:12	<b>compendium</b> 112:7
<b>closing</b> 38:3 74:21	<b>come</b> 10:19 13:15	335:16,22 336:3	<b>communicated</b>	<b>competency</b> 18:4
316:20	18:3 25:18 26:13	<b>comments</b> 68:11	109:11	57:5 58:1,6 76:14
<b>closure</b> 109:13,18	35:18 47:5 49:1	89:20 101:5,13	<b>communicating</b>	88:12
<b>clue</b> 241:7	57:14 88:8 94:20	106:1 142:2	129:8 138:3	<b>competing</b> 33:5
<b>CMMI</b> 42:14	114:21 115:8	155:18 158:14	139:21	<b>complete</b> 51:6
<b>CMS</b> 8:20 11:12	126:20 135:6,20	162:22 164:13	<b>communication</b>	213:21
12:20 17:19 20:4	139:1 146:19	196:20 197:1	18:5 40:1 48:13	<b>completed</b> 100:18
79:1 93:21 94:4	159:15 174:15,16	212:3 218:15	50:2 57:1,2,4	171:17 172:2



303:6	105:16 107:14	<b>conducted</b> 167:5	<b>consistent</b> 70:4	308:20
<b>completely</b> 133:21	110:1 155:4 180:2	<b>conference</b> 282:3	234:10	<b>conundrum</b> 284:18
146:3 198:12	249:12	329:14 331:22	<b>constructed</b> 324:17	<b>convene</b> 33:11
<b>completeness</b> 257:7	<b>conceptual</b> 257:19	335:10	<b>constructive</b> 78:7	<b>convened</b> 30:8
<b>completion</b> 130:2	<b>conceptualized</b>	<b>confidence</b> 45:12	78:12	31:17
240:9	109:8	<b>conflict</b> 7:4,9 15:13	<b>consult</b> 202:15	<b>convening</b> 37:15
<b>complex</b> 86:3 95:5	<b>conceptually</b> 80:4	16:3 20:6	258:3	<b>conversation</b> 139:1
131:15 132:8	<b>concern</b> 149:21	<b>conflicts</b> 7:6 16:15	<b>consultant</b> 9:8 23:4	157:11 267:2
211:21 234:17	152:9 176:21	17:12 21:1 22:10	232:19 241:22	337:1
239:13 246:4	276:2	<b>confused</b> 203:9	<b>consulting</b> 6:18	<b>conversing</b> 334:20
270:6 273:13	<b>concerned</b> 152:11	266:17	166:20	<b>conveying</b> 226:21
274:10 302:22	<b>concerning</b> 149:20	<b>confusing</b> 330:20	<b>consumer</b> 44:6	<b>cookie-cutter</b>
303:1	<b>concerns</b> 79:14	<b>Congress</b> 15:20	52:15 132:20	140:22
<b>complexities</b>	206:20	<b>connected</b> 276:13	133:20 151:11	<b>coordinatable</b>
268:16	<b>concise</b> 321:10	276:16	152:8,10 298:22	86:17
<b>complexity</b> 93:15	<b>concluded</b> 118:18	<b>connection</b> 77:20	<b>consumers</b> 32:3	<b>coordinate</b> 33:15
274:5,12 294:7	<b>conclusion</b> 195:5	<b>connections</b> 15:5	<b>contact</b> 158:22	45:3 73:5,9,15
<b>compliance</b> 231:19	<b>conclusions</b> 135:17	58:5 231:6 262:3	222:10 257:20	77:7 117:15
<b>compliant</b> 261:19	169:20 234:9	292:7	259:11	144:13 245:7
<b>complicated</b>	<b>concordant</b> 51:9	<b>connectivity</b> 247:4	<b>Containment</b> 2:2	326:4
324:21,22	<b>concrete</b> 78:22	<b>consensus</b> 30:12,14	<b>content</b> 162:21	<b>coordinated</b> 82:8
<b>complications</b>	225:5 229:6,12	63:3 68:2,13 83:8	<b>context</b> 7:4 27:10	87:8 102:15
230:20	315:22	96:5,11 176:11	58:16 60:9 72:15	237:16,22 240:14
<b>component</b> 131:20	<b>condition</b> 73:19	192:14 193:21	78:5 96:22 122:11	252:10
249:20	75:3 86:2 102:14	293:16 310:14	249:5 269:17	<b>coordinating</b> 137:6
<b>components</b> 64:20	127:5,6 171:2	311:12 313:3	296:18 315:8	244:19,21 250:7
<b>composite</b> 47:17	190:3,6 246:3	315:19	<b>continually</b> 44:10	253:6 279:19
79:7	259:20 278:8	<b>consent</b> 261:20	76:3	281:13,20
<b>comprehensive</b>	300:18 301:1	<b>consequence</b>	<b>continue</b> 36:21	<b>coordination</b> 1:3
56:13 106:22	302:1,2,19 303:1	148:16	49:2 55:4 61:18	3:5,8,9,13,19 4:4
108:10 112:15	<b>conditions</b> 42:22	<b>consider</b> 44:22	194:1 234:5	8:22 9:13,15 11:3
123:8 167:20	43:4 45:13 55:15	74:18 86:10	<b>continuing</b> 9:6	11:13 15:4 16:5
170:13 180:15	86:6 94:9,10	106:11 108:7	242:11 316:17	17:19 18:3,11,19
195:1 215:9	107:3 155:9	150:12 155:11	<b>continuity</b> 128:22	19:12,17 22:19
225:16 242:18	170:22 239:12	172:11 194:16	<b>continuous</b> 76:17	25:11,14 26:6,21
288:8 289:4	242:21 263:3	319:7	225:13 290:2	27:15 28:14 37:7
<b>comprehensively</b>	302:12,22	<b>considerable</b> 69:5	<b>continuum</b> 69:11	37:14,15 39:19
192:19	<b>condition-based</b>	<b>consideration</b>	95:8 272:22 282:7	40:2,4 41:6,9 42:8
<b>comprise</b> 250:17	86:10	111:3 197:14	314:20	43:1 44:15 48:14
<b>computer</b> 107:19	<b>condition-specific</b>	<b>considerations</b>	<b>contract</b> 13:21	49:9,12 50:3
109:9	70:21 102:11,12	181:22 232:2	<b>contracted</b> 33:11	54:18 57:2 59:4,7
<b>concept</b> 144:1	170:17 174:10	<b>considered</b> 147:9	<b>contracts</b> 17:18	59:14 63:7,15
145:2 265:7	189:15,18 190:2,8	174:8 177:3	<b>contributing</b> 245:8	64:10,17,20 66:4
324:17	190:13 191:3	183:18 188:21	<b>control</b> 14:20 41:20	66:21 67:2 68:17
<b>concepts</b> 13:5 41:3	193:10 278:11	203:3 293:15	50:16 51:7 79:10	68:22 69:3,6,10
45:9,22 46:8	301:15 302:7	<b>consistency</b> 97:15	88:7 145:7 251:21	69:14,15,18,22
50:12 74:22	303:12	225:10 312:4	<b>controlled</b> 149:12	70:8,13,18 71:3

71:11,15,18 75:16 75:22 77:2,15,20 79:16 80:5 82:1 89:4 90:2 91:20 93:6 94:7 95:4,6 96:15,18 97:11 102:13,17 103:21 104:3,9 105:16 106:12 110:4,9,13 113:10 114:6,11 114:13 115:6 120:18 123:22 128:8,11 131:11 131:12,15 134:18 135:4,10 137:14 140:16 145:20 149:5 150:15 154:22 155:4 164:5 166:6,11 168:12 170:12,21 174:20 178:3,11 178:19 179:5,7 184:4 186:1 187:10 189:2 191:22 193:5 195:4,19 199:16 204:12,14,16 208:9,19 211:9,17 213:8,12 215:1,7 215:11,13 220:15 221:6,12 222:1 224:16 225:18 226:6,13,15,20 227:9,17 230:10 232:2 233:9,12,14 234:18 238:18 240:16 243:7 244:2 245:11 247:20 250:8 252:6,17 255:9,14 262:20 264:16 265:12 266:18 267:7,12 268:2,10 268:12,15 270:14 272:17 273:20 274:21 275:2,12 275:22 278:1	280:22 281:11 283:3,19 288:14 288:19 289:8,21 290:12 291:21 292:1 293:5 296:6 296:9 297:5,16 299:1 302:1 305:5 307:19 309:7 317:2 319:20 320:2,13,21 321:6 321:15 323:12,18 326:1 330:7 <b>coordination-like</b> 74:3 <b>coordinators</b> 318:19 <b>Coordinator's</b> 12:1 <b>copies</b> 256:13 <b>copious</b> 287:16 330:11 <b>core</b> 20:21 103:19 104:15,19 106:13 118:21 135:21 257:7 282:6 <b>Cornell</b> 1:17 17:21 <b>corollaries</b> 146:6 <b>correct</b> 68:1 104:14 301:12 321:5 325:17 335:20 <b>correlate</b> 272:4 <b>correspondence</b> 241:21 <b>cost</b> 2:2 20:13 93:18 146:17 157:16 215:7,10 230:14 248:3,14 249:9,14,18 271:15 274:21 277:11 280:21 288:12,15 <b>costly</b> 102:4 <b>costs</b> 250:19,20 251:22 <b>Council</b> 18:19 241:15 <b>counsel</b> 2:18 5:6 <b>counseling</b> 84:19	<b>counter</b> 158:9 <b>counterbalancing</b> 83:17 <b>country</b> 56:20 163:17 275:19 276:14 <b>County</b> 13:12 <b>couple</b> 15:16 31:22 34:5 68:19 77:16 80:22 165:2 218:10 226:11 241:14 242:9 243:22 253:9 258:7 302:16 316:22 331:21 <b>course</b> 5:19 38:14 65:8 86:7 89:20 90:17 105:19 120:20 262:11 275:20 288:8 319:3 322:5 <b>cover</b> 110:20 155:17 <b>coverage</b> 44:7 102:7,7 <b>covered</b> 183:7 195:3 262:2 <b>co-chair</b> 1:12,13 8:5 9:2 18:18 24:6 57:11 58:15 60:16 61:22 62:17 65:6,8,9 66:19 72:8 75:7 78:1 81:8 82:12 85:15 87:10 89:10 91:15 94:19 98:1 99:2,6 114:2,5 115:1 125:18 126:11 131:8 133:7,13 137:17 142:6 155:13,16 156:1 159:2,7 160:5,13 160:17 161:11 165:5,12 196:17 199:4,14 201:6 203:6,15 205:20 207:16 208:7	210:7 211:12 212:22 213:17 216:19 217:17 219:10,13 222:13 223:1 224:4 227:19 238:7 241:8 245:13 246:21 249:3,8 255:6,16 256:3 266:13 268:22 269:15 279:12,14 282:11 284:16 285:17 286:7,10 287:8 289:16 294:14 295:1,6,14 295:22 296:19 298:17 299:7,22 301:10,13 302:3 303:17 304:13 305:8 308:5 313:1 314:8 315:18 319:6 320:19 321:17,22 322:4,8 322:11,14 324:11 325:13 326:13 327:22 328:9,22 331:10 332:6,12 332:14 333:20 335:4 336:7,22 <b>co-chaired</b> 32:16 118:18 <b>co-chairing</b> 9:4 <b>Co-Chairs</b> 1:10 <b>co-lead</b> 12:3 <b>co-management</b> 129:22 <b>co-PI</b> 13:6 <b>CPE</b> 2:13 <b>CPR</b> 283:14 <b>CPT</b> 79:21 <b>CRAWFORD</b> 2:17 <b>create</b> 154:12 207:6 259:1,6 <b>created</b> 207:9 <b>creating</b> 14:16 67:2 145:6 198:17 224:22 259:17	<b>creative</b> 232:12 <b>credit</b> 319:2 <b>Creek</b> 13:11 <b>criteria</b> 62:11 82:15 84:8 324:19 324:20 <b>critical</b> 70:9 81:13 97:18 117:14 159:20 211:13 214:1,8 249:2 285:15 286:18 305:10 328:14 <b>critically</b> 39:20 44:16 89:7 <b>cross</b> 71:9 102:17 <b>crosscutting</b> 57:22 73:7 75:6 174:9 179:10 194:10 242:16 303:10 311:22 <b>cross-condition</b> 102:16 <b>cross-cultural</b> 18:5 57:4 <b>cross-setting</b> 102:17 <b>CTM</b> 291:8 <b>CTM-3</b> 262:9,19 279:2 <b>CTM3</b> 65:20 <b>cultural</b> 57:4,8 58:1,6 76:14 88:12 <b>culture</b> 18:4 286:1 <b>cure</b> 124:12 <b>curious</b> 316:8 <b>current</b> 19:22 62:2 102:9 103:13 108:1 110:17 127:22 164:4 167:16 168:20 185:14 197:10 198:8 220:20 256:17 277:17 293:4 315:22 327:20 <b>currently</b> 11:4
---	--	---	---	--

12:18 32:16 42:13 86:1 185:16 197:22 279:3 297:18 <b>customer</b> 115:12 <b>cut</b> 175:6 314:19 <b>cutting</b> 230:11 <b>CV</b> 6:11 <b>cycle</b> 29:4 <b>C-O-N-T-E-N-T-S</b> 3:1	198:17,19 201:11 201:12,16 202:6,7 202:8,19,19 206:21 207:5,14 209:17 223:13 228:12 236:12 252:19,21 256:19 256:20 257:7 259:22 260:4,6,7 276:2 291:1 297:8 308:12 315:11,16 318:5 <b>database</b> 102:5 <b>databases</b> 20:13,16 20:18 111:4 170:3 <b>date</b> 119:17 331:18 <b>dates</b> 329:7 334:15 <b>David</b> 28:22 100:6 <b>day</b> 4:12 25:5 27:8 85:22,22 148:12 151:3,4 159:6 171:8 232:6 319:8 <b>days</b> 18:11 79:13 88:18 317:21 329:17 332:4 <b>de</b> 207:7 259:19 <b>deal</b> 11:21 95:2,6 126:20 234:8 250:21 268:15 274:12,16 <b>dealing</b> 73:13 94:22 115:14 <b>death</b> 267:18 273:2 <b>debt</b> 274:19 <b>decade</b> 232:3 <b>decades</b> 270:10 <b>December</b> 329:15 332:1 <b>decide</b> 136:9 149:11 224:1 239:2 325:16 <b>decided</b> 42:15 133:21 <b>decision</b> 44:22 96:19 140:7 145:11,13,15 158:4 170:16	326:8 327:17 <b>decisions</b> 73:15 <b>decision-making</b> 48:5 148:13 156:11 157:10 327:15 <b>declare</b> 324:20 <b>defer</b> 133:8 189:12 <b>define</b> 20:20 66:3 87:13 96:14 174:4 210:10 213:13,15 222:1 299:15 327:1 <b>defined</b> 65:1 119:12 179:10 180:14 243:17 <b>defines</b> 155:10 <b>defining</b> 211:8 213:22 241:19 328:6 <b>definitely</b> 24:21 110:4 117:7 126:10 133:4,17 134:8 136:4 152:13 153:21 194:15 204:19 334:10 335:2 <b>definition</b> 63:6,14 64:7 67:7,20,21 96:13 167:17,20 171:13 180:21 181:4 182:21 183:17 280:17 <b>definitions</b> 64:16 67:2 131:11 201:4 <b>degraded</b> 257:14 <b>degree</b> 69:2 122:6 169:6 180:3 200:11 202:17 204:8 209:3 <b>deja</b> 125:20 <b>deliberate</b> 211:14 <b>deliberated</b> 97:18 <b>deliberating</b> 319:11 <b>deliberation</b> 57:18 72:5,6 81:19	<b>deliberations</b> 161:22 217:16 <b>delighted</b> 9:3 <b>deliver</b> 274:21 276:8,12 <b>deliverable</b> 315:20 <b>delivered</b> 70:1 <b>delivery</b> 14:4 17:7 32:8 35:19 38:10 38:15 41:1 50:4 145:14 233:19 257:11 315:2,6 <b>demand</b> 144:19 <b>demarcation</b> 273:8 <b>demographics</b> 118:20 119:21 <b>demonstrate</b> 52:5 54:6 258:9 <b>demonstrates</b> 87:4 <b>demonstration</b> 20:5 134:21 <b>Denise</b> 2:6 20:8 248:4 290:5 298:17 <b>denominator</b> 191:12 <b>dentist</b> 90:12 <b>department</b> 10:11 172:13 192:8 250:10 <b>departments</b> 10:17 20:22 <b>depended</b> 102:1 <b>depending</b> 39:1 <b>depends</b> 90:2 122:4 299:21 <b>deploying</b> 14:14 <b>depression</b> 247:16 283:17 <b>derived</b> 310:1 <b>describe</b> 167:4,6 308:21,22 310:4 <b>described</b> 68:20 178:17 324:18,19 <b>describing</b> 152:20 <b>description</b> 67:22 <b>descriptive</b> 191:7	<b>design</b> 123:3 307:5 <b>designed</b> 10:2 172:8 <b>designing</b> 12:14 <b>desirable</b> 112:15 294:2 <b>desirous</b> 51:2 <b>desperately</b> 38:6 117:6 <b>despite</b> 87:19 <b>destination</b> 138:6 <b>detail</b> 14:20 39:22 43:22 46:15 47:11 69:21 161:14 <b>detailing</b> 26:10 <b>details</b> 225:21 294:4 335:11 <b>determine</b> 50:1,3 83:3 326:9 <b>determined</b> 272:10 <b>develop</b> 13:4 22:19 28:5 135:21 182:1 207:11 238:20 306:21 310:3 <b>developed</b> 14:13 22:13 30:18 54:11 97:6 180:11 206:21 299:10 316:20 <b>developer</b> 85:17 176:9 192:12 200:7 263:10 314:16 <b>developers</b> 62:3 78:8,13 80:1 159:22 164:1 176:12 200:19 203:1 260:9 316:14 333:5 <b>developing</b> 15:3 17:6 29:21 33:9 45:1 159:13 310:2 <b>development</b> 8:14 16:9 28:21 48:7 83:9 145:4 163:3 166:15 167:14 176:11 181:9
<b>D</b>				
<b>D</b> 320:3 <b>dad</b> 303:19 304:2 <b>damn</b> 76:5 <b>Dana</b> 1:13 21:3 265:2 290:6 320:11 <b>danger</b> 148:16 149:22 <b>dark</b> 176:15 177:2 <b>Darling</b> 32:17 <b>darn</b> 276:18 <b>Dartmouth</b> 17:10 113:12 <b>data</b> 2:6 19:1 20:10 20:11 22:3,15 35:10 56:1 98:17 103:12 106:6,10 106:11,14 107:14 107:22,22 110:13 110:19 111:2,12 111:12 113:3 114:3,12,21 115:9 115:12,13,14 117:16,17 118:21 119:12,16 128:6 128:10 133:2 139:7,10 140:12 142:9,17 143:8,10 144:7,22 145:7 157:21 158:6,6 171:6 174:21 175:3,7 181:21 182:6 187:15 188:7 193:8				

192:14 193:22	296:18 297:17	108:8,10,16 119:1	296:12 298:19	76:7,16 111:8
196:15 199:2	298:3,16 299:3,16	119:3 121:2,3,6	308:7 330:9,21	118:22 122:14,17
200:12,21 293:16	311:14 324:16	121:12,15 122:13	<b>discussions</b> 13:19	123:11 163:16,19
310:14 311:12	325:6,7,19 327:4	122:15 126:16,21	36:3 62:18 88:9	185:22 203:20,22
315:19 316:18	331:2	130:17 188:7	296:1	223:6 286:20
317:11 332:15	<b>differentiate</b> 299:2	236:10 254:16	<b>disease</b> 9:20 14:6	287:21 293:8
<b>device</b> 283:9	<b>differently</b> 281:10	260:17 277:14,18	41:12,15 51:7	<b>documentation</b>
<b>diabetes</b> 242:19	302:20 318:13	283:1,2	110:6 147:14	26:17 121:17
<b>diabetic</b> 253:6	<b>difficult</b> 91:18	<b>discharging</b> 108:17	157:2 245:18	141:8 156:7,9
<b>diagrams</b> 175:1	151:2 158:11	<b>disciplinary</b> 224:18	256:4 263:1,11	158:3,10 227:8
<b>dialogue</b> 96:6	182:1 200:15	<b>discipline</b> 85:16	<b>diseases</b> 50:17	228:11 253:22
97:14	218:14	124:22 233:16	<b>disincentive</b> 144:6	<b>documented</b> 87:5
<b>dialysis</b> 251:18	<b>difficulty</b> 50:8	250:9	<b>disincentives</b>	121:13,14 227:16
252:12	<b>diffused</b> 191:1	<b>disciplines</b> 273:15	144:11	<b>documents</b> 122:10
<b>Diane</b> 269:8	<b>diffuses</b> 190:20	273:21	<b>disparities</b> 47:4	123:3,16 214:21
<b>dictate</b> 38:19	<b>dilemma</b> 309:20	<b>disclose</b> 6:9,14	57:21 58:2,5 76:4	228:5 257:12
<b>die</b> 269:12	310:9	17:13 20:7 23:15	<b>display</b> 158:5	258:19,20 259:5
<b>diet</b> 283:15	<b>dime</b> 7:7	23:20	<b>disrupt</b> 245:14	259:13 269:4
<b>dietary</b> 42:1	<b>dimensions</b> 286:3	<b>disclosed</b> 6:10	<b>distal</b> 85:9 176:22	304:19 330:10
<b>difference</b> 157:9	292:2	<b>disclosure</b> 6:5,17	<b>distilling</b> 329:9	<b>doing</b> 13:3,16
181:3 184:16	<b>direct</b> 258:12 259:1	10:18 14:7 15:1	<b>distinction</b> 201:17	16:10 30:20 37:3
226:1	260:15,16 261:13	23:7	203:10 269:21	50:14 51:5,5,7,8
<b>differences</b> 294:19	261:17 291:5	<b>disclosures</b> 3:3	327:10	52:21 53:1 54:15
297:4 299:20	<b>directed</b> 200:9	5:16 7:3,5 8:4,10	<b>distinguish</b> 92:22	54:22 55:1 57:21
<b>different</b> 4:11	<b>direction</b> 28:20	10:21 11:6 13:2	<b>distinguishing</b>	61:4 80:7,19,21
13:15 27:12 34:7	33:17 34:16 56:5	14:8 17:1 24:14	201:10	86:5 93:16 98:13
40:16 48:10 61:15	59:6 138:16	24:18 166:17	<b>district</b> 10:12	113:6,8 122:20,21
75:4 83:4 85:6	297:17 326:4	<b>discovered</b> 54:10	251:18	125:6 127:15
86:6 90:6 91:13	<b>directions</b> 54:5	<b>discriminate</b> 300:4	<b>ditto</b> 276:21	130:17 131:18
91:22 92:6 94:10	159:19 325:19	<b>discuss</b> 24:16 139:6	<b>dive</b> 39:17	134:18 135:14
97:3 104:5 106:10	<b>directly</b> 73:13	<b>discussed</b> 108:14	<b>diversity</b> 58:20	137:3 140:11,11
107:19 109:2	212:16	189:2	91:19	150:17 161:19
122:9 123:20	<b>director</b> 2:21 5:3	<b>discussing</b> 37:16	<b>division</b> 10:8 100:7	164:3 167:9
130:11,12 134:12	9:17 10:5 11:2	<b>discussion</b> 3:18	<b>DM</b> 253:2	179:19 186:14
135:1,2 137:12	14:2 19:10 20:9	26:7 37:22 48:15	<b>DNR</b> 269:7	197:2 206:22
140:3 141:21	21:18,20 22:1	60:13 64:16 67:15	<b>doable</b> 193:8 333:2	220:22 228:15
169:7 174:12,17	23:9	69:5 75:9 96:3	<b>doc</b> 244:14 245:4	234:12 235:3,5
175:17 179:16,17	<b>directories</b> 259:7	115:4 157:22	266:11	242:2 253:5,20
193:16 194:12	<b>Directors</b> 32:11	165:21 167:11	<b>docs</b> 245:1	258:3 274:2
198:12 201:14	<b>disability</b> 49:6	188:13 194:2,8	<b>doctor</b> 23:18 79:17	276:17 299:8,11
204:19 220:9	<b>disabled</b> 284:7	203:21 211:14	100:4 129:4 133:8	299:18 300:15
221:13 226:4	<b>disadvantaged</b>	215:4,13 218:20	134:1 202:10,12	302:14 305:18
229:19,19 235:9	94:2	219:3 230:7 234:5	202:13 234:18	316:15 318:20
235:13 236:6,7	<b>disaggregate</b>	245:15 263:6	283:20 303:22	319:2,17 320:4
246:5 265:22	176:20	277:14,16 278:7	304:4,7	327:16 329:8
273:16,20 277:22	<b>discharge</b> 48:3	286:12 287:12	<b>doctors</b> 115:22	335:6
286:3 292:1	84:11 107:19	288:11,21 292:14	<b>document</b> 64:8	<b>dollars</b> 230:18

<b>domain</b> 179:12,22 180:14 184:16 187:19 194:8 203:12 205:2,9 207:20 209:11 280:18	<b>dozen</b> 250:12 <b>Dr</b> 4:15 5:9 9:16 11:15 12:21 14:17 15:6,22 16:16 17:14 19:7,19 21:15,22 22:11 23:8,16 27:9 56:13 57:19 73:17 78:21 80:6 83:19 85:20 86:12 88:10 88:17 92:20 93:13 99:14,16 100:3 105:2 111:5,13 112:1,5,8,13,17 112:18 113:1,2,17 114:4,14 115:7,11 115:18,19 116:2,3 116:7,8,14,19 117:1,2,7,12,18 118:9,15 119:10 119:11,14,15,22 120:4,9,14,20 121:8,16,21 124:1 125:3,16 126:10 126:13 127:15 132:13 133:11,17 134:14 136:4,5,8 136:16,17,22 137:11,19,20 138:13,14,17 142:10,18 143:3 143:21 144:16,20 145:10,21 147:8 147:17,18 148:1,5 148:17 149:10,16 149:18,19 150:7 151:8,17 152:1 153:7,9,10,16,17 153:20 154:5,9 155:6,12,15,21 156:3 159:5,9,11 160:4 166:2 197:17 199:5 200:6 201:20 203:8,17 205:5 206:3 207:18 212:4 213:1	214:18 215:18 221:17 222:22 223:2 226:10 228:2,18 234:6 238:15 241:12,13 243:21 246:12 247:9 249:7,10 256:5 260:19 261:8 265:1 272:7 274:18 276:21 285:18 290:3 294:9,20 295:2,11 295:16,18 297:22 301:3,6,12,14 302:10,13 304:17 311:15 313:15 315:1 316:4,12 318:6 321:2,21 322:2,6,10,12,19 324:12 327:8 328:2,11 330:14 333:3 334:7 335:14 336:2	192:6 <b>dual</b> 102:6 <b>due</b> 100:19 329:13 333:6 <b>dynamic</b> 233:13,14 <b>D.C</b> 1:10	<b>educated</b> 285:5 <b>education</b> 31:6 108:16 117:22 118:2 121:11,13 196:4 253:15,16 256:13 283:12 288:11 <b>effect</b> 217:11 <b>effective</b> 40:1 41:9 48:13 57:2 <b>effectively</b> 273:10 <b>effectiveness</b> 225:12 290:1 <b>effects</b> 178:13,14 178:20 <b>efficacy</b> 118:12 <b>Efficiency</b> 16:2 <b>efficient</b> 167:22 223:13 <b>efficiently</b> 171:17 <b>effort</b> 71:16 240:4 244:3 315:9 334:4 <b>efforts</b> 19:16 27:17 33:16 34:18 35:13 87:7 117:10 154:10 259:4 300:9 <b>EHR</b> 11:19 12:7 119:8 155:8 207:6 236:18 237:6 258:21 259:19 271:5 <b>EHRs</b> 14:13 135:13 224:9 317:5 <b>eight</b> 11:21 183:7 186:12 <b>either</b> 86:20 111:14 131:5 136:15 137:16 163:3 164:18 171:12,20 176:12 180:5 222:16 230:15 313:14 329:16 <b>elaborate</b> 236:18 <b>elderly</b> 19:12 37:17 181:12 <b>ElderPlus</b> 2:9
<b>domains</b> 63:14 64:21 67:8,9,17 67:21 95:17,18 131:10 172:22,22 178:6 179:7,21 183:16,19,20 191:4 209:7,8,9 213:2,4,6 216:5 228:20 293:4	214:18 215:18 221:17 222:22 223:2 226:10 228:2,18 234:6 238:15 241:12,13 243:21 246:12 247:9 249:7,10 256:5 260:19 261:8 265:1 272:7 274:18 276:21 285:18 290:3 294:9,20 295:2,11 295:16,18 297:22 301:3,6,12,14 302:10,13 304:17 311:15 313:15 315:1 316:4,12 318:6 321:2,21 322:2,6,10,12,19 324:12 327:8 328:2,11 330:14 333:3 334:7 335:14 336:2	<b>draft</b> 100:19 159:15 282:21 329:12 330:22,22 331:15	<b>E</b>	
<b>Don</b> 8:6 9:4 25:3,13 27:16 29:8 58:13 58:21 59:16 60:14 65:2 68:3 72:7 165:4 279:12 294:9 304:17 336:14	<b>draw</b> 59:21 63:18 135:17 169:19 170:9	<b>drawn</b> 56:22 189:20 233:18 297:8	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7	<b>effect</b> 217:11 <b>effective</b> 40:1 41:9 48:13 57:2 <b>effectively</b> 273:10 <b>effectiveness</b> 225:12 290:1 <b>effects</b> 178:13,14 178:20 <b>efficacy</b> 118:12 <b>Efficiency</b> 16:2 <b>efficient</b> 167:22 223:13 <b>efficiently</b> 171:17 <b>effort</b> 71:16 240:4 244:3 315:9 334:4 <b>efforts</b> 19:16 27:17 33:16 34:18 35:13 87:7 117:10 154:10 259:4 300:9 <b>EHR</b> 11:19 12:7 119:8 155:8 207:6 236:18 237:6 258:21 259:19 271:5 <b>EHRs</b> 14:13 135:13 224:9 317:5 <b>eight</b> 11:21 183:7 186:12 <b>either</b> 86:20 111:14 131:5 136:15 137:16 163:3 164:18 171:12,20 176:12 180:5 222:16 230:15 313:14 329:16 <b>elaborate</b> 236:18 <b>elderly</b> 19:12 37:17 181:12 <b>ElderPlus</b> 2:9
<b>Donabedian</b> 114:18 178:21	<b>driven</b> 56:22 189:20 233:18 297:8	<b>drivers</b> 56:2	<b>early</b> 11:14 33:21 36:14 159:13 164:16 170:15 180:11 181:12 219:12 269:10 333:16	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>Donald</b> 1:10,12 3:10	<b>drive</b> 137:12 145:4 200:11 235:19 236:15 324:2	<b>driving</b> 144:22 145:7 323:22	<b>easy</b> 125:11 168:6 214:13	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>door</b> 61:20	<b>driven</b> 56:22 189:20 233:18 297:8	<b>drivers</b> 56:2	<b>eat</b> 158:16	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>Dorian</b> 2:18 4:3,6 5:7,12,19 6:1,3 24:2,11,20 56:9 58:11 98:22 99:4 99:8,12,15,19 160:7,15,19,22 161:5 165:4,6 287:18 289:5 329:1 330:16 331:8,17 332:10 332:13,17 334:10 335:2,8,20 336:5 336:9,13	<b>drive</b> 137:12 145:4 200:11 235:19 236:15 324:2	<b>driving</b> 144:22 145:7 323:22	<b>eating</b> 161:12	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>Dorman</b> 1:18 13:22 14:1 266:15 269:13,20	<b>driven</b> 56:22 189:20 233:18 297:8	<b>drivers</b> 56:2	<b>Eau</b> 11:4	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>double</b> 140:11	<b>dropped</b> 150:5	<b>driving</b> 144:22 145:7 323:22	<b>echo</b> 60:16 67:4 199:14	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>doubt</b> 273:8 274:11	<b>drop-down</b> 148:9	<b>dropped</b> 150:5	<b>economic</b> 274:1	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
<b>downstream</b> 230:15	<b>drove</b> 69:1	<b>driving</b> 144:22 145:7 323:22	<b>Economics</b> 15:21	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
	<b>drug</b> 192:3	<b>dropped</b> 150:5	<b>economies</b> 221:9	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
	<b>drugs</b> 192:2	<b>drop-down</b> 148:9	<b>Ed</b> 73:21 74:13 79:3,7 137:5,13 174:6 250:19 251:16 263:7,10 291:7	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
	<b>drug-related</b> 192:1	<b>drove</b> 69:1	<b>edge</b> 300:1	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
		<b>drug</b> 192:3	<b>EDs</b> 250:16	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
		<b>drugs</b> 192:2	<b>educate</b> 148:7 250:13	<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7
		<b>drug-related</b> 192:1		<b>earlier</b> 25:10 43:16 48:18 50:13 63:1 156:22 167:18 198:19 220:6 221:18 231:22 272:2 298:13 324:7

<b>electronic</b> 10:6 56:1 102:8 116:16 117:9 122:20 128:22 129:7 130:3,4 139:15 142:1 150:2 152:12 153:19 156:22 171:7 175:4,9 176:3 182:5,7,13,17,22 183:9,15,19 184:5 184:7,21 185:6 186:12 187:6,20 191:8,10,16 195:6 198:1,2,9 203:3,5 203:11 208:3 209:15,17 223:9 259:10,12 306:18	258:17 259:1 329:17 330:3 331:9 <b>emails</b> 330:11 <b>embargoed</b> 283:6 <b>embedded</b> 98:16 315:20 <b>embracing</b> 55:6 <b>eMeasures</b> 197:4,5 197:11 198:16 199:3 <b>emerge</b> 261:3 <b>emergency</b> 5:10 10:11,14 166:4 172:12 192:7 212:15 246:17 250:10,11,12,17 <b>emergent</b> 67:4 <b>emerging</b> 111:1 261:7 306:22 311:21 312:1 <b>Emilio</b> 1:16 17:15 57:22 61:18 76:13 98:14 137:17 285:17 <b>Emilio's</b> 76:4 <b>emphasis</b> 28:9 82:4 <b>emphasize</b> 45:15 49:3 51:18 55:14 58:21 103:19 125:21 234:21 305:1 316:3 <b>emphasized</b> 102:19 <b>emphasizing</b> 35:8 38:17 41:19 42:17 50:16 <b>employer</b> 7:18 <b>employers</b> 44:4 248:8,11 <b>EMR</b> 117:5 <b>EMRs</b> 135:2 <b>enabler</b> 93:4,10 <b>enablers</b> 93:1,3 <b>enabling</b> 45:2 93:7 213:11 <b>encapsulate</b> 145:2 <b>encompasses</b> 54:1	<b>encounter</b> 141:7,10 <b>encourage</b> 26:13 62:17 68:14 98:7 155:3 <b>encouraged</b> 111:8 <b>encouraging</b> 41:4 154:21 <b>endeavor</b> 315:8 <b>endeavors</b> 25:12 <b>ended</b> 72:18 95:12 137:3 337:6 <b>endorse</b> 300:12 327:11,11 <b>endorsed</b> 67:6 77:1 84:9 95:15,18 172:17,19 197:7 209:21 313:14,16 <b>endorsement</b> 55:17 61:7 78:15 84:13 95:15,22 96:8 174:11,14 187:5 206:1 314:22 <b>endorsing</b> 30:12 <b>endpoints</b> 210:14 210:18 <b>ends</b> 285:11 <b>enduring</b> 256:13 <b>energy</b> 281:12 <b>enforce</b> 238:17 <b>engaged</b> 20:17,19 233:20 320:2 <b>engagement</b> 256:10 267:16 321:13 328:14 <b>engaging</b> 32:12 148:11 <b>English</b> 240:19 253:17 <b>enhance</b> 61:17 126:6 293:8 316:1 <b>enhancement</b> 163:9 <b>enhancements</b> 293:10 <b>enlightening</b> 282:12 336:17 <b>enormous</b> 66:14	<b>ensure</b> 44:17 48:17 53:16 64:11 81:6 <b>ensuring</b> 53:6 74:13,14 <b>entering</b> 58:16 <b>enterprise</b> 1:14 55:11 <b>entire</b> 37:19 61:14 107:4 259:8 288:10 289:4 291:3 <b>entirely</b> 189:16 <b>entry</b> 140:12 <b>environment</b> 66:7 148:8 258:11 293:14 327:20 <b>environmental</b> 3:15 26:1 27:3 56:2 167:3 168:3 184:2 <b>envision</b> 103:1 260:8 <b>envisions</b> 259:17 <b>ephemeral</b> 272:12 <b>Epic</b> 139:17,18 <b>episode</b> 273:6 <b>equality</b> 73:11 <b>equity</b> 37:21 <b>ER</b> 275:8 285:12 <b>Eric</b> 16:12 50:21 65:21 <b>error</b> 102:6 <b>escalating</b> 44:11 <b>especially</b> 84:4 87:16 112:9 154:7 269:9 298:21 <b>espousing</b> 45:6 <b>essential</b> 53:15 93:10 <b>essentially</b> 39:4 40:9 52:4 53:9 55:9 84:12 178:6 183:2 213:8 240:7 <b>establish</b> 86:18,18 96:22 188:11,14 189:4 <b>established</b> 68:16	71:8 188:21 <b>establishing</b> 96:12 183:21 188:17 228:9 <b>et</b> 14:6 42:2 94:16 94:17 98:16,16 147:14 212:15 251:22 252:13 308:18,18 <b>Eva</b> 2:10 18:8 89:11,11,16 95:19 210:8 211:12 212:5 222:17 224:4 242:10 266:16 305:19 <b>evaluate</b> 27:5 28:16 62:12 212:10 328:5 <b>evaluated</b> 87:4 <b>evaluates</b> 308:8 <b>evaluating</b> 100:21 309:3 <b>evaluation</b> 59:11 61:12 62:10 63:10 64:4 82:16 335:21 <b>Eva's</b> 89:11 <b>events</b> 127:1 243:4 285:14 <b>Everett</b> 1:25 19:20 20:5 <b>everybody</b> 4:15 69:15 99:20 129:6 188:16 196:12 218:11 219:13 227:4 265:12 273:3 287:22 326:15 330:13 <b>everybody's</b> 135:14 153:14 187:8 247:22 <b>everyone's</b> 162:3 <b>evidence</b> 36:19 54:9 70:14 215:2 215:5,16 216:2,12 216:21 217:5,6,8 217:9,14 234:8,12 235:4 254:10
---	---	---	--	--

264:14 270:21,22 271:10 306:10 307:6,13,14 308:2 308:9,22 309:3,18 311:8,17,19 312:4 312:6,14,22 313:4 313:21 314:12 323:3 <b>evidence-based</b> 53:19 145:17 306:3,5 307:3 313:7 323:1 <b>evidentiary</b> 82:17 252:16 312:2 <b>evolution</b> 204:1 <b>evolve</b> 81:22 <b>evolved</b> 204:6 <b>exact</b> 212:17 <b>exactly</b> 105:8,9,9 121:16 134:15 136:16 137:15 144:20,20 197:18 199:11 237:17 249:11 256:1 326:1 329:4 334:16 336:9 <b>example</b> 28:8 51:13 51:17 54:19 72:22 73:6 75:8 76:20 78:22 79:11 84:21 85:16 86:4 92:1 98:13 110:6 125:4 125:11,22 128:5 128:18 133:18 139:12 157:7 174:16 180:22 185:17 188:6,18 192:1 198:7 202:6 235:10 256:20 261:4 264:6 271:5 312:18 323:7 324:12,13 327:14 <b>examples</b> 55:4 76:19 98:6 134:12 <b>exceed</b> 312:16 <b>excellent</b> 60:22 81:9 91:17	<b>exceptions</b> 34:5 316:19 <b>exchange</b> 117:17 152:12 260:22 <b>exchanged</b> 258:14 <b>exchanges</b> 248:12 288:18 <b>excited</b> 4:8 317:1 <b>exciting</b> 26:22 105:14 <b>excluded</b> 171:19 172:3 <b>excluding</b> 171:11 <b>exclusion</b> 206:2 <b>exclusive</b> 195:2 <b>exclusively</b> 79:20 <b>Excuse</b> 153:7 <b>executive</b> 11:9 20:9 168:10 <b>Executives</b> 21:10 <b>exercise</b> 169:15 177:20 216:6 255:19 <b>exhausted</b> 281:19 <b>exist</b> 185:16 308:11 317:5 <b>existed</b> 69:10 70:1 185:19 <b>existing</b> 22:4 76:11 76:22 101:20 122:5 169:12 <b>exists</b> 125:12 216:13 <b>expand</b> 249:22 <b>expect</b> 91:20 255:11 260:9 300:10 308:19 334:11 <b>expectations</b> 255:2 <b>expected</b> 92:4,6,11 129:18 258:20 294:13 334:7,16 <b>expecting</b> 92:16 334:3 <b>expenditures</b> 44:11 <b>expensive</b> 154:7 221:6	<b>experience</b> 28:10 28:13 44:18 45:10 47:20 49:14,17 50:20 52:7 59:21 70:7 82:5,6,9 86:4 88:14 110:21 111:16 129:16 166:5 176:1 177:12 180:10 184:20 186:18 192:17 193:7,21 196:1,4 199:22 214:2 224:19 225:17 226:3 237:13,14 238:6 238:10 252:22 271:7,12,17 280:8 281:16 291:18 <b>experienced</b> 52:10 <b>experiencing</b> 47:18 <b>experiential</b> 87:18 <b>expert</b> 65:13 66:1 100:13 169:6 204:4 312:10 <b>expertise</b> 8:1 58:20 74:5 219:6 226:18 267:12 <b>experts</b> 7:22 66:1,3 72:14 166:12 <b>explanation</b> 6:2 <b>explicit</b> 103:20 <b>explicitly</b> 66:7 <b>extend</b> 38:7 <b>extended</b> 38:13 <b>extension</b> 154:11 <b>extensive</b> 98:20 <b>extent</b> 32:2 87:13 92:17 116:11 226:15 <b>extra</b> 232:2 <b>extraordinary</b> 59:1 <b>extrapolate</b> 247:6 <b>extremely</b> 127:12 <b>eye</b> 127:5,10 <b>eyes</b> 49:10 94:14 <b>e-Health</b> 11:18 18:19	<b>e-prescribing</b> 22:8 <b>e-referral</b> 242:5 <hr/> <b>F</b> <hr/> <b>f</b> 132:18 <b>FAAN</b> 1:13 2:12 3:11 <b>face</b> 171:21 335:7,7 <b>faced</b> 309:20 <b>FACEP</b> 1:21 <b>face-to-face</b> 187:12 <b>facilities</b> 259:9 <b>fact</b> 13:13 108:15 144:5 149:4 157:13 165:7 215:1 252:11 271:12 274:22 309:8 323:4 <b>factor</b> 28:11 <b>factors</b> 231:16 283:17 <b>faculty</b> 9:5 15:8 19:6 <b>failure</b> 86:3 231:17 243:7,8 253:2 255:12,17 282:20 283:4 284:20 <b>fair</b> 88:4,22 294:22 299:20 <b>fairly</b> 34:4 129:12 159:13 170:12 294:18 321:9 <b>fairness</b> 93:15 <b>fall</b> 89:2 180:5 183:8,11 188:6,10 205:3 263:21 264:3 <b>fallback</b> 267:19 <b>falling</b> 187:1 220:12 <b>falls</b> 43:9 174:2,19 264:5,7,12 <b>familiar</b> 31:12 39:6 62:13,14 66:20 98:8 199:16 249:12 <b>families</b> 2:11 18:10	45:2 47:18 151:14 <b>family</b> 10:19 21:18 70:6 82:7 109:20 120:18 124:16,17 127:3,9 149:6,9 149:15 150:13,19 150:22 151:21 196:8 222:6 237:14,17 239:9 239:20 242:12 262:4 268:1,3 273:21 275:15 280:11 281:11,12 281:13 283:12,14 288:18 321:11 <b>family-centered</b> 37:7 39:22 44:14 <b>fancy</b> 276:17 <b>fantasy</b> 238:9 <b>far</b> 27:7 52:17 54:9 69:21 74:4 92:8 104:13 162:17 182:18 227:10 237:8 251:9 273:1 304:20 <b>FARRIS</b> 1:18 12:21 199:5 265:1 334:7 <b>fashion</b> 274:4 <b>fast</b> 285:13 <b>faster</b> 308:14 <b>fatigue</b> 240:21 247:18 <b>fax</b> 117:12 129:10 <b>faxed</b> 254:17 <b>faxing</b> 117:3 <b>FCCP</b> 2:13 <b>February</b> 335:13 337:5 <b>federal</b> 31:21 32:15 38:19 44:5 55:5 105:20 <b>federally</b> 170:3 <b>feed</b> 53:14 <b>feedback</b> 78:7,13 85:18 100:17 140:10 161:20
--	--	--	---	---

225:13 287:22	<b>final</b> 77:4 243:14	330:4,20 331:15	48:19 69:18 79:21	<b>form</b> 6:6,12 10:22
289:22 314:15	266:7 287:3,11	331:16,18	82:5 83:10 132:9	23:7 240:20 332:7
328:14 337:4	328:1	<b>fishing</b> 230:16	145:13 242:19	333:15
<b>feel</b> 6:9 26:8 45:22	<b>finalized</b> 332:21	<b>fit</b> 74:7 75:22 77:2	321:6	<b>formally</b> 191:9
49:14 55:17 63:13	<b>finally</b> 11:10	95:1 98:7 129:20	<b>focuses</b> 17:6 46:14	<b>format</b> 122:20
74:3 82:8 92:14	169:19 248:18	139:5 154:20	<b>focusing</b> 28:7 42:18	256:14
100:2 105:6,10	253:9 254:2	186:12 224:3	265:11 289:18	<b>formed</b> 32:18
157:20 164:17	265:18	284:2 291:22	<b>folder</b> 101:1	<b>former</b> 204:20,21
183:5 192:13	<b>financial</b> 7:4,5	310:5 311:11	<b>folders</b> 99:22 100:1	<b>formerly</b> 13:7
200:12 206:9	21:13 249:19	<b>fits</b> 132:22 134:15	165:7	<b>forms</b> 168:10 196:7
276:11 281:1	273:22	182:22 200:10,13	<b>folks</b> 29:1 85:21	333:16
311:4 312:10	<b>financially</b> 9:8	302:11 325:3	161:14 246:15	<b>forth</b> 35:15 60:8
323:13 330:8	291:17	<b>five</b> 10:15,17 13:21	250:13 311:18	139:5 245:21
<b>feeling</b> 56:12 74:2	<b>find</b> 107:13,22	66:13 67:7,17	321:13 327:1	296:16 324:2
309:17	112:3 120:1,2	92:6 95:16 103:12	<b>follow</b> 71:21 100:2	<b>fortunate</b> 126:17
<b>feels</b> 46:11	173:16 175:20	103:13,14 172:22	130:19 147:16	<b>fortunately</b> 166:22
<b>fees</b> 6:19	176:4 177:21	178:6 185:22	149:16 190:20	<b>forum</b> 1:1 4:20 5:1
<b>fell</b> 304:18	182:21 314:12	191:1 274:19	200:22 215:18	5:4 21:5 30:9
<b>felt</b> 32:21 42:19	<b>finding</b> 147:4	275:3 276:11	<b>followed</b> 112:21	331:2
43:19 45:12 46:17	<b>findings</b> 3:16 25:22	325:19	269:8	<b>forward</b> 4:9,12
48:6,21 70:6	191:7 201:15	<b>fix</b> 305:12	<b>following</b> 8:14 71:1	20:19 26:6,10
103:7 107:9	<b>fine</b> 43:6 85:11,12	<b>flesh</b> 319:12	71:13 138:10	31:2 46:10 60:6
171:12 238:2	89:4 156:4 158:14	<b>flexibility</b> 38:18,22	186:16 245:20	60:13 61:19 62:3
280:4 288:5 289:2	158:19	<b>flexible</b> 282:18	<b>follow-up</b> 74:13,16	62:22 63:20 65:20
<b>Ferris</b> 12:21	<b>finish</b> 89:14 206:14	<b>flipped</b> 42:4	79:3,7,12 80:14	66:9 75:18 77:3
<b>fertile</b> 96:2	<b>finished</b> 171:8	<b>flow</b> 81:15 143:10	81:2 130:17	78:9,14 79:2
<b>fewer</b> 264:12	206:13	154:17,20 155:2	174:16 180:18	81:21 83:4 85:14
<b>field</b> 28:21 33:4	<b>fired</b> 220:14	157:16 167:11	186:19,21 189:21	89:9 96:21 97:5
45:7 62:3 97:22	<b>first</b> 26:20 30:13	245:14	190:14,14 202:4,5	122:7 145:9
133:1 138:12	34:15 40:5,10	<b>flowing</b> 157:4	204:16 206:17	161:21 165:18
171:20 314:10,14	62:9 64:1 68:4,16	334:5	243:8 260:20	166:16 218:6
316:6 320:14	68:21 69:9 70:5	<b>flywheel</b> 301:7	266:9,10,11	234:21 310:14
<b>Fifteen</b> 287:4	71:19 86:11 95:12	<b>focus</b> 13:13 14:19	283:19	312:9 313:20
<b>fifth</b> 175:10	100:19 106:4	16:19 19:17 36:22	<b>fond</b> 299:6	314:6 317:9 331:4
<b>fight</b> 230:12	108:2 111:18	38:11 39:21 42:19	<b>foods</b> 42:2	336:20 337:3
<b>fighting</b> 230:12	123:6 128:18	61:5 67:15 70:11	<b>force</b> 21:10 80:16	<b>Foster</b> 1:19 11:1,2
<b>figure</b> 39:18 58:9	130:12 135:6	70:13 71:7 83:3	223:19 311:17	252:3 255:15
122:19 129:4	139:7 152:17	97:14 98:10 125:1	312:6	256:1
133:3 170:10	156:20 158:19	136:18,18 140:9	<b>forefront</b> 73:12	<b>found</b> 108:7 128:22
222:5 245:6	175:2 176:14	157:17 180:12	<b>foregoing</b> 99:9	134:17 173:12
<b>figuring</b> 265:14	179:20 185:17	189:13,14 196:22	161:8 287:5 337:8	182:11 194:5
<b>file</b> 258:18	199:9,15 219:12	209:3 214:10	<b>foresee</b> 232:5	203:4 234:10,22
<b>fill</b> 23:7 321:11	228:19 233:8	216:2 238:16	<b>foreseeable</b> 260:11	258:7 282:11
<b>filled</b> 6:7 157:8	267:19 275:20	239:22	<b>forever</b> 85:12	336:16
231:18	277:4 282:21	<b>focused</b> 13:19	<b>forget</b> 153:2 304:4	<b>foundation</b> 1:24
<b>filling</b> 80:20 200:4	283:9 293:3	34:18 35:5 37:11	<b>forgive</b> 225:21	3:19 12:11 96:12
<b>filter</b> 251:17	310:15 329:12	40:14,17,21 44:17	<b>forgot</b> 304:10	165:20 194:10



218:20 223:4 292:15 321:8 327:14 <b>foundational</b> 63:15 68:15 256:7 <b>foundations</b> 166:19 <b>founders</b> 18:6 <b>four</b> 178:7 183:4 191:1 303:2 <b>fourth-year</b> 166:3 <b>fragmented</b> 145:14 <b>frame</b> 61:10 63:9 123:21 163:14 184:12 218:8 219:1 273:4,5,17 277:1 286:15 <b>framed</b> 42:10 63:5 68:17 114:5 178:22 <b>framework</b> 12:3 18:21 54:10 60:22 63:6 64:8 67:7,17 67:20 72:11 89:8 95:17 96:14 118:18 120:5 129:20 131:9 173:2 178:2,5,8 179:15,16 185:2 185:11,13,20 190:12 194:7 259:4 267:14 286:16 291:6 293:12 302:15,17 303:9 316:8 <b>frameworks</b> 76:12 169:14,17,18 172:20 177:17 201:4 <b>framing</b> 3:21 122:17 218:20 249:15 319:20 <b>Francisco</b> 242:5 <b>free</b> 26:8 63:13 100:2 267:11 <b>frequent</b> 21:12 <b>friend</b> 282:14 <b>Frohna</b> 1:21 10:9	10:10 249:17 <b>front</b> 38:1 70:8 110:8 207:12 270:9 <b>frontrunners</b> 128:3 <b>front-runner</b> 136:10 <b>fruit</b> 168:5 <b>fruitful</b> 111:7 <b>fruition</b> 35:19 <b>frustration</b> 77:11 <b>full</b> 77:20 <b>fully</b> 32:13 128:21 129:7 130:2 246:12 <b>fun</b> 336:8 <b>function</b> 64:11 70:1 130:5 152:22 211:22 224:17,18 233:10 <b>functional</b> 210:13 303:15 315:15 324:18 325:11 <b>functionality</b> 109:2 109:14 114:6 119:7 282:2 <b>functions</b> 64:13 93:1 94:13 144:12 224:20 <b>fund</b> 1:15 16:3 47:5 197:5 <b>fundamental</b> 82:20 <b>fundamentals</b> 178:12 <b>funded</b> 15:11,14 16:9 134:7 316:16 <b>funder</b> 16:4 <b>funding</b> 8:21 16:8 16:11 273:22 <b>further</b> 72:12 106:1 149:2 209:2 <b>furthermore</b> 223:7 <b>future</b> 26:21 61:19 62:2 68:6 97:19 111:10 146:20 157:18 164:5 167:13 189:6	190:11 199:3 260:11 295:8 310:1 315:22 336:18,21 <b>futuristic</b> 297:12 <hr/> <b>G</b> <hr/> <b>gaining</b> 285:7 <b>game</b> 88:22 191:20 191:21 <b>gap</b> 38:3 46:16 198:10 204:5 <b>gaps</b> 46:18 47:15 50:19 63:22 138:8 166:16 167:9,13 168:21 169:16 173:20 178:4 179:18,22 182:4 184:6,7,12 185:16 189:12 195:5,22 197:16 198:6 200:3,5 <b>garner</b> 100:16 <b>gather</b> 260:12 <b>GE</b> 1:13 21:4,4 <b>geared</b> 41:14 <b>gender-specific</b> 283:18 <b>general</b> 2:18 5:6,11 23:12 60:2 100:12 128:4,20 152:12 152:18 179:12 186:20 190:3,7,18 242:5 249:13 293:21 298:5 310:19 333:10 334:18 <b>generalist</b> 109:21 <b>generalizable</b> 74:16 <b>generalized</b> 310:6 <b>generally</b> 128:5,17 293:22 <b>generate</b> 307:12 315:10 <b>generated</b> 132:6 286:18 327:4	<b>generating</b> 133:1 308:2 <b>generation</b> 148:7 160:2 237:3 <b>geographic</b> 135:1 274:1 <b>geriatric</b> 19:15 181:13 <b>geriatrician</b> 19:8 <b>geriatrics</b> 324:13 <b>Gerri</b> 1:10,13 3:11 9:3 22:20 25:3,13 27:17 29:7 58:13 62:14 65:6 72:8 98:1 125:20 126:17 137:21 138:16 144:8 216:20 219:10 286:8 297:11 326:6 336:14 <b>Gerri's</b> 60:17 <b>getting</b> 28:6 32:9 41:11 44:19 81:1 81:16 98:5 137:8 140:12 143:18 161:13 189:8 196:8 205:15 251:5 277:21 282:8 285:1 321:18 328:12 <b>give</b> 5:21 22:16 25:20 29:19 78:12 78:16 118:6 123:5 128:13 133:18 140:22 164:21 209:10 218:19 242:17 247:3 249:13 253:15 304:14 319:2,14 333:18 334:12 <b>given</b> 91:18 151:15 161:20 192:18 197:14 252:11 294:5 325:8 <b>gives</b> 26:20 <b>giving</b> 73:5 <b>glad</b> 12:7 61:19	92:21 113:22 212:5 <b>glance</b> 175:2 <b>global</b> 65:16 302:6 <b>globally</b> 198:4 <b>gnashing</b> 90:21 <b>go</b> 5:13,17 6:8,12 25:7 29:21 30:5 34:6 35:15 37:4 40:6 45:14 46:8 47:8 53:20 55:16 58:13 59:15 60:14 62:18 63:2,3 65:10,11 67:18,19 68:10 78:9 80:1 90:12 91:11 93:7 96:5 97:21 103:9 106:2 109:5 114:20 122:2 130:6 131:8 136:21 139:5 145:22 146:16 156:4,15,19 160:2 162:13 163:16 173:16 174:22 175:6 177:2 193:12 197:2 198:9 202:8 203:18 209:2 211:15 212:1 218:6,11 219:12 222:2,18 225:8 231:4 237:9 242:11 243:12 251:13 266:21 280:4 287:3,20 292:12 296:1 304:4,21 312:9,22 314:6 325:20 326:22 331:11 333:8 <b>goal</b> 33:12 41:16 45:21 49:18 52:6 55:13 123:14 124:3,4,4,10 163:14 164:14 167:1 179:18
---	---	--	---	--

241:5 249:16	146:17,17,18,19	337:2	256:8	199:13 204:20
252:1 262:5,5	151:4 152:7	<b>gold</b> 267:14 325:14	<b>granularity</b> 180:22	224:7 241:17
267:5,5,9,10	153:22 154:2	<b>good</b> 4:3,18,21 8:5	199:20 200:2	242:3 243:10
320:11	156:5 157:19	9:2 10:9 11:1,15	<b>grateful</b> 25:1	250:6 263:11,12
<b>goals</b> 30:15,22 31:5	158:17 161:16,20	15:6 17:2,14 21:2	<b>gravitates</b> 123:10	263:15 269:18
31:7 33:1 34:3,11	162:6,10,10,11,13	21:15,22 22:11	<b>gray</b> 70:17 72:4	283:9 284:13
34:21 35:14,21	162:17,20,22	24:18 29:10,11	154:1 182:9	288:7 289:2
36:4,10,18 37:5	163:11,22 164:2	34:3 36:19 49:12	<b>graying</b> 153:22	293:16 299:9
38:13 39:15 45:4	164:17 167:1,12	50:3 54:8 69:21	<b>great</b> 4:10 11:20	303:7 309:3
45:20 46:5 52:6	171:13 198:9,14	72:15 73:2 77:22	52:9 57:12 60:18	312:10 330:8
54:14 57:9 61:9	199:18 203:2	80:12 92:14 97:17	69:20 75:8 78:2	<b>grouping</b> 186:4
62:6 101:15	205:13 206:11	113:21 118:13	87:11 92:13 98:12	<b>groupings</b> 199:19
123:18,19 124:2,2	207:17 208:4,17	121:22 125:4	99:6 112:5,8,8,19	<b>groups</b> 8:13 19:2
124:17 125:7	209:3 212:10	132:3 133:11	113:22 119:14	95:5 113:5 239:2
135:3 227:3,8,12	214:8,17 215:16	134:11 142:19	120:10,12 126:19	245:2
227:22 228:6	215:21 216:1,8,14	147:3 149:10	135:15,20 139:2,3	<b>guess</b> 49:7 65:10
248:21,22 266:2	216:15,15,17	160:16 163:9	156:15 159:14	84:15 122:17
270:4 281:4 300:8	217:10 218:10,13	166:8 210:8	164:10 165:12	127:17 132:17
305:17 321:7	219:18 220:5	215:11,12,15	209:5 210:9 215:6	143:7 148:17
322:2,5,8,9 324:1	221:5,11 222:6,7	217:8 219:14	219:18 266:19	149:20 188:2
324:4,14 328:16	222:18 226:10	223:6 234:7	267:12 293:9	197:13 198:3
<b>godfathers</b> 217:2	227:2 229:20	250:21 252:6,21	301:15 316:12	202:22 203:5
<b>goes</b> 64:7 92:8	236:18 237:9	253:5 264:17	330:8 337:6	204:20 205:20
123:16 132:1	240:16 241:2	266:8 269:3 270:7	<b>greater</b> 251:1	210:12 221:10
175:8 195:11	242:14 246:4,21	270:18 276:19	<b>greatest</b> 32:2	225:22 252:15
254:16 298:2	248:12 249:1,22	278:3,19 282:8,14	<b>green</b> 179:9	264:18 310:7
303:22 304:10	266:14,15 272:3	292:10 295:6	<b>Greenberg</b> 1:21	323:13 334:11
<b>going</b> 5:13 8:2	273:4,9 275:21	297:20 302:8	23:8,9 80:6	<b>guessing</b> 297:19
13:15 20:19 25:6	276:3,8 281:14	304:15 307:10,16	105:12 207:18	<b>guidance</b> 78:16
25:19,22 28:16,17	282:8 283:1	320:19 326:6	212:4 243:21	101:16 192:11
39:21 40:6 42:16	286:11,17,19	329:19 330:6,9,13	246:12 294:9,20	<b>guide</b> 48:12 70:12
44:3 49:22 52:18	287:1 293:13	331:3 335:3	295:2 318:6	105:20 200:18
59:17 60:8 61:5	295:7 296:20	<b>Google</b> 170:7	<b>Grey</b> 169:5 170:4	212:20
61:13 63:18 67:6	300:10,13,13	<b>Gordon</b> 216:21	<b>grist</b> 286:19	<b>guided</b> 64:9 67:10
69:12,17 71:22	301:7,9 303:19	<b>Gordon's</b> 217:1	<b>ground</b> 96:2 242:3	<b>guideline</b> 282:20
75:17 76:5 77:3	304:7 305:10,14	<b>gotten</b> 35:2 157:14	305:18	284:11
81:22 82:18 83:9	306:8 307:12	239:15	<b>group</b> 4:10 7:19	<b>guidelines</b> 71:2,14
91:21 92:9 96:4	309:1,2,20 310:4	<b>government</b> 44:5	9:13,22 10:13	71:21 141:2
100:10,17 101:5,6	310:10,11,12	<b>go-around</b> 71:19	12:4,5 13:12	142:14 245:20
103:9 105:17,21	311:4,13 312:5,20	<b>go-forward</b> 217:22	18:17,21 20:5	<b>guideline-directed</b>
109:22 110:1,16	313:19 315:10,13	296:13	21:8 24:22 29:14	283:8
113:3 114:12	317:3 318:13	<b>grade</b> 217:2	31:21 37:15 43:17	<b>guides</b> 20:20
116:20 117:4	319:8,18,22	<b>grain</b> 189:6	44:2,21 59:19	<b>guiding</b> 36:5 53:2
128:4,12 132:5,11	320:15,17 326:3	<b>grant</b> 11:11 13:7	60:18 72:19	60:7 64:3 163:20
135:12 136:1	327:1,6 329:16	166:18	118:17 168:10	<b>Guyatt</b> 216:22
137:7,16 140:2,8	331:4,13 332:7,9	<b>grants</b> 6:20 17:18	172:11 180:19	313:2,2
142:16 143:19	334:1,2,9 335:17	<b>granular</b> 200:10	187:2,7 194:19	<b>Guyatt's</b> 309:17

<b>guys</b> 26:4 128:1 189:1 313:17 330:7 334:8	208:1 221:4,8 229:10 235:16 309:6 311:5	207:8 210:12 211:2,4 212:13 227:4 228:14,21 231:5,8 232:17 233:11,12 240:11 244:16 248:9,10 250:19,20 253:11 253:16 259:17 260:4,21 267:21 268:13,17 270:16 275:8 277:10 278:18 279:5,8 284:3,5 285:22 288:17,20,22 290:7 296:4,10 307:5 317:17	245:21 253:2 255:17,17 282:20 283:4 284:19	83:6 91:16 201:1 285:22
<b>H</b>	<b>harder</b> 84:8	<b>Healthcare</b> 1:13 21:4	<b>heartened</b> 266:16	<b>hemorrhage</b> 127:7
<b>half</b> 177:11 250:12 258:13	<b>harken</b> 126:3 282:14 309:16	<b>healthcare-associ...</b> 43:4,8	<b>Hearts</b> 41:13	<b>heroes</b> 276:14
<b>hallmark</b> 89:8	<b>harkening</b> 213:18	<b>healthiest</b> 90:11	<b>heat</b> 56:11	<b>Heurtin-Roberts</b> 1:23 14:17,18 149:16,19 272:7 315:1 328:2
<b>Hammersmith</b> 2:18 5:5,6,18,21 6:2,4 23:21 24:5,9 24:13	<b>harmful</b> 43:12	<b>HealthVault</b> 260:14	<b>hectic</b> 275:10	<b>Hey</b> 302:8
<b>hand</b> 58:12 110:22 126:12 244:22 306:1 309:10	<b>harness</b> 276:1	<b>healthy</b> 7:17 32:5 39:8 40:21 41:17 42:2 51:16 54:16	<b>Helen</b> 2:16 4:14,16 29:12 32:16 54:9 58:22 75:7,14 76:7 78:11 163:1 166:7 205:21 207:18 208:14 308:6 310:18,20 314:9 319:18 326:6	<b>He'll</b> 24:11
<b>handle</b> 109:22 110:1	<b>Hasan</b> 100:11	<b>health/mental</b> 88:20	<b>Helen's</b> 296:20	<b>HHS</b> 15:1 29:17 30:1 33:11,19 34:5 41:4,12 42:10,14 43:5,22 45:19 46:21 48:22
<b>handoff</b> 254:13	<b>hat</b> 279:14	<b>health/primary</b> 89:3	<b>Hello</b> 12:9 14:17 120:15	<b>Hi</b> 4:15 13:22 14:10 19:19 23:8 234:6
<b>handout</b> 177:18	<b>head</b> 76:5 210:15	<b>hear</b> 25:9,12,19 27:16 28:8 29:7 52:1 139:17,19 155:7 196:12 238:14 240:22 251:4 266:17 268:12 316:10 320:6	<b>help</b> 28:5,22 29:2 31:8 33:2 34:13 36:6 47:14 48:12 60:21 61:13 62:5 103:4 126:8 128:2 150:18 157:2 159:17 163:4,14 171:16 184:11 198:15 200:3,18 204:11 205:21 207:16 213:19 229:10,15 235:19 244:13 266:3,4,5 284:1 300:3 320:12,14 324:22 325:9 326:8	<b>HIE</b> 261:3,20
<b>hands</b> 7:8 161:21 165:1 321:3	<b>headache</b> 73:22	<b>heard</b> 24:15 27:2 70:5 90:21 162:17 162:19 216:22 221:2 263:7 270:20 271:1 287:14 300:18,20 306:9 329:10	<b>helped</b> 284:9 285:21 293:12	<b>hierarchy</b> 299:5
<b>hang</b> 222:17	<b>headings</b> 104:6	<b>heart</b> 8:17 86:3	<b>helpful</b> 46:11 92:2 97:20 122:2,22 133:5 156:12 158:8 172:11 199:13 208:17 235:6 236:5 282:12 333:21	<b>high</b> 18:12 41:21 41:21 115:14 123:17 163:13 184:19 192:2 251:17 253:5 264:12 276:10 277:7
<b>happen</b> 52:12 91:9 150:15 195:14 224:10 255:2 267:22 268:21 271:10 281:1,3,3 315:3	<b>health</b> 1:20,23 2:1 2:6 8:7 9:20 10:13,16,21 11:3 11:10 12:11 15:10 15:12 16:1,17,19 16:19 17:4,5,16 17:21 18:13,17 19:5,17 20:1,10 20:22 32:5,8,13 37:11,21 38:8,10 38:12,14,15 40:10 41:7,7 44:11 47:3 47:12 50:4 51:12 52:12,21 53:5 57:5 64:12 67:11 88:13,20 93:19 94:5 95:22 96:15 98:15 101:19 107:6 108:12 130:9 131:18 132:7,17,20 133:3 133:14,20,22 134:1 139:16 147:13 148:8 149:13 150:2,16 151:2 152:5,8,10 154:19 155:2 157:12 168:16 172:8 174:4 177:3 177:9 178:15 180:1 183:13 190:1,5 195:8 203:22 205:9		<b>helps</b> 64:11 72:10	<b>higher</b> 255:11 309:15
<b>happened</b> 63:5 194:9 204:1,5 240:1				<b>highest</b> 176:16 238:19 251:18
<b>happening</b> 136:20 138:15 171:1 181:15 248:9 279:9				<b>highlight</b> 64:4
<b>happens</b> 71:12 130:20 131:12 187:17 193:20 195:12 215:22 229:9 250:22 268:2 273:3				<b>highlights</b> 63:8
<b>happy</b> 8:9 40:9 334:2				<b>highly</b> 205:22 216:10
<b>hard</b> 45:16 124:7 135:10 136:20 150:21 196:18 203:13 204:21				<b>high-cost</b> 115:15 289:10
				<b>high-functioning</b> 275:14
				<b>high-impact</b> 55:15
				<b>high-level</b> 212:18
				<b>high-need</b> 94:15
				<b>high-quality</b> 44:19 108:8 142:17
				<b>high-risk</b> 95:1 96:17 244:4,11

251:11 289:9 298:15 318:19 <b>high-service</b> 251:11 <b>Hill</b> 1:9 <b>HIMSS</b> 21:11 <b>hinge</b> 35:7 <b>HIPAA</b> 261:18 <b>Hispanic</b> 18:1 <b>historian</b> 65:10 <b>hit</b> 11:20 18:12 28:9,10 29:2 63:7 68:18 119:4 120:7 201:11,13 206:13 207:9,18,20 213:10 223:4,19 236:18 245:14 256:6 258:5,11 276:2 288:17 290:4 325:14 <b>hold</b> 81:6 190:10 <b>holds</b> 185:2 <b>hole</b> 238:3 <b>home</b> 15:17 17:4 19:18 20:3 23:14 67:11 79:18,18 94:5 95:22 96:15 133:2 164:9 180:1 181:6,6 183:13 190:2 195:8 211:2 211:4 220:6,7,8 221:14,21 228:21 229:4 239:7 241:18 243:16,18 244:16,17 247:1 250:1,3,4 256:19 257:18 262:14 263:7 264:7 270:19 273:18 279:5,8 285:9 305:4 328:17 337:2 <b>homegrown</b> 139:12 <b>homeless</b> 138:3 222:8 <b>homes</b> 9:10 <b>honestly</b> 23:5	<b>hook</b> 87:2 <b>hope</b> 29:9 46:10 48:11 55:3 224:6 260:7 274:20 310:8,18 311:3 317:8 <b>hoped</b> 27:20 <b>hopeful</b> 77:15 111:7 <b>hopefully</b> 13:14 50:9 97:20 198:1 207:21 218:19 232:14 236:22 237:3 287:16 <b>hopes</b> 276:10 <b>hoping</b> 54:7 159:16 159:20 <b>Hopkins</b> 2:9,10 19:9 74:20 <b>horrible</b> 204:14 <b>horse</b> 56:15 <b>hospice</b> 17:4 <b>hospital</b> 1:17,22 2:5,23,24 8:18 10:12 17:17 20:1 23:12 42:17,20 48:4 72:2 74:14 100:5 119:1,3 125:6 131:21 141:13 177:7 181:6 188:8 195:10,14 221:21 224:19 232:4,8 236:9 237:19 238:12 239:7 242:4 246:16 254:15 262:14 270:17 279:8 280:12 284:21 299:19 318:17 <b>hospitalist</b> 100:12 <b>hospitalization</b> 79:14 97:13 174:6 296:16 <b>hospitalizations</b> 141:9 <b>hospitals</b> 9:11	10:15 16:7 115:22 <b>hospital-acquired</b> 243:6 <b>host</b> 65:16 83:1 <b>Hotel</b> 1:9 <b>hours</b> 13:21 250:22 251:3 <b>housing</b> 94:16 <b>Howe</b> 1:22 21:22 21:22 213:1 238:15 241:12 282:14 321:2,21 322:2,6,10,12 328:11 <b>HRSA</b> 1:23 14:18 14:20 <b>hub</b> 239:5 <b>hubs</b> 231:5 <b>huge</b> 37:21 56:19 57:6,7 80:18 88:14 127:3 132:22 143:9 144:14 148:15 152:9,13 157:9 197:12 224:11 240:3 315:10 <b>human-computer</b> 148:20 <b>hundred</b> 16:7 52:9 182:19 200:1 <b>hundreds</b> 287:19 <b>husband</b> 23:4 <b>hypertension</b> 253:3 <b>hypothesis</b> 217:7 <hr/> <b>I</b> <hr/> <b>ICU</b> 125:8 <b>idea</b> 28:4 89:11 92:14 100:19 102:14 107:2 122:14 128:14 133:12 138:1 158:5 189:8 207:3 225:7 252:15 263:17,22 264:4 280:6 281:7 307:10 328:3	<b>ideas</b> 98:12 103:4 162:19 189:1 210:9 219:14 233:4 247:3 253:10 263:14 <b>identified</b> 43:5 67:8 127:21 168:11,15 169:9 170:5 182:8 259:20 294:6 <b>identify</b> 33:2 83:6 96:16 101:17 106:9 163:4 167:16 168:6 173:9,15 188:19 209:6 244:3 <b>identity</b> 119:20 <b>ignore</b> 237:12 <b>ignores</b> 171:1 <b>IHI</b> 19:6 <b>II</b> 27:4 90:20 335:9 335:11,19,21 336:3,19 <b>ill</b> 94:8 304:6 <b>illness</b> 49:5 255:10 269:10 270:7 301:20 <b>illuminated</b> 329:4 <b>imagine</b> 325:4 <b>imaging</b> 261:6 <b>immediate</b> 36:9 329:8 <b>impact</b> 39:12 192:13 214:22 215:12 226:16,22 277:8,9,10,11 297:16 336:17 <b>impactability</b> 241:2 <b>impacted</b> 40:3,22 <b>impaired</b> 94:1 <b>implementation</b> 20:20 62:4 142:14 306:22 <b>implemented</b> 243:12 <b>implementing</b> 14:12 135:5	<b>implications</b> 70:3 <b>implicit</b> 120:15 <b>importance</b> 48:15 49:3 63:9 117:21 169:8 195:15 224:22 <b>important</b> 30:7 33:3 38:16 39:20 42:19 43:20 44:4 44:16,21 45:8 46:1,8,12,19 48:22 53:3 54:21 55:18 62:7,16 66:10 70:14 71:14 71:17 72:2 73:10 74:10,11,17 75:5 75:15 81:14 87:11 87:16 88:8 89:7 97:1,1 104:6 106:12 108:11,17 110:19 112:9,12 112:20 115:4,16 116:10 117:6 127:12 131:19 133:5 147:5 150:12 155:5 168:1 169:1 170:12 173:10,17 187:7 195:16 201:8 207:13 215:20 217:20,22 218:5,8,17 219:2 219:8 222:11 223:15 225:4 226:2,8,19 227:10 235:14 242:15,22 245:14 248:17 265:16 276:22 278:10 289:6,8 314:7 316:2,7 317:9 319:10,16 320:10,12 322:22 326:18 327:9 <b>importantly</b> 70:16 <b>impossible</b> 135:11 205:13 236:21 <b>impressive</b> 24:22
--	--	---	--	---

317:16	173:4 180:13	290:8	253:11 256:16	159:14 163:21
<b>improve</b> 13:9 80:17	188:7,9	<b>individuals</b> 7:17	257:1,3,4,5,6,20	222:19 266:2
101:19 315:2,13	<b>includes</b> 83:1	40:20 59:19	259:11 260:12,22	293:9
320:13	104:10 165:8	187:13 248:11	288:17 298:22	<b>inside</b> 220:20
<b>improved</b> 41:6	167:21 170:13	258:15 259:10	306:18 316:5	<b>insightful</b> 199:12
210:12 214:16	173:5 180:15	265:15 273:14	329:9 330:3	<b>instance</b> 236:9
308:17	184:19 283:11,13	<b>individual's</b> 118:7	<b>informational</b>	319:22
<b>improvement</b> 14:4	283:20	<b>indulgence</b> 258:4	187:13	<b>instinctive</b> 255:7
14:19 22:14 35:13	<b>including</b> 6:18 19:1	<b>industry</b> 32:14	<b>information-shar...</b>	<b>instinctively</b>
38:5 40:16 50:6	53:7 98:13 109:20	142:22 151:9,10	64:13 198:18	255:11
83:5 102:9 196:11	170:7,8 239:2	197:8,19 198:15	<b>informed</b> 34:4	<b>Institute</b> 14:3,21
305:9 306:19	256:16 258:1	<b>inequities</b> 56:20	308:11 325:21	56:18
315:5,15	260:1,4 268:1	<b>inevitable</b> 268:16	327:15	<b>institutions</b> 222:4
<b>improvements</b>	314:1	<b>infants</b> 126:16	<b>informing</b> 292:17	<b>instruction</b> 256:13
229:17 297:5	<b>inclusion</b> 262:4	<b>infections</b> 37:1	309:22	<b>instructions</b> 84:11
<b>improving</b> 38:2	<b>inconsistency</b>	43:8,9 243:6	<b>informs</b> 31:1	119:2 260:17
41:14 52:7 315:6	234:11	<b>inform</b> 55:16 62:2	<b>infrastructure</b> 29:2	330:18
<b>inadvertently</b>	<b>incorporate</b> 50:12	93:22 126:9	35:12,16 96:14	<b>instruments</b> 247:12
220:19 221:15	270:3	159:17 293:12	194:11 224:2	326:8
<b>inappropriate</b>	<b>incorporated</b>	305:18	232:16 244:12	<b>insurance</b> 10:2
43:12,14,15	118:14 292:16	<b>informatics</b> 11:17	288:17	44:7 102:1,4
<b>incent</b> 271:13	<b>incorporating</b>	21:7 132:21	<b>ingredients</b> 214:15	157:3 231:19
<b>incented</b> 271:3,11	200:17	133:20 152:8,10	<b>initial</b> 33:6 59:18	248:10
<b>incensing</b> 270:16	<b>incorporation</b>	<b>information</b> 3:12	158:20 168:14	<b>insurers</b> 157:4
270:18	168:16	12:4,7 16:20 22:6	<b>initially</b> 32:18 77:1	<b>integrate</b> 48:4
<b>incentive</b> 144:5	<b>increased</b> 286:4	34:10 62:5 67:12	104:15,19	<b>integrating</b> 117:16
146:12,13 271:5	<b>increasingly</b>	96:1 101:4,18,19	<b>initiating</b> 13:11	<b>integration</b> 245:9
328:18,21	195:16	103:22 106:17,19	<b>initiation</b> 172:6	265:9 301:9
<b>incentives</b> 143:12	<b>incredibly</b> 336:16	107:6 108:13	<b>initiative</b> 12:1,17	<b>Intelligence</b> 1:14
145:6 290:18	<b>incremental</b> 81:11	110:8 112:14,15	18:20 21:21 22:8	<b>intelligent</b> 141:4
291:16 328:20	105:13	116:18,21,21	22:18 41:13	<b>intended</b> 217:11
<b>inception</b> 30:10	<b>independent</b>	117:4 118:17	198:16 259:6,15	<b>intense</b> 296:5
<b>include</b> 11:7 32:2	255:21	122:8 123:1,4,5	277:17	<b>intensity</b> 69:4,11
54:6 101:3 102:14	<b>index</b> 290:12	123:15 130:9,14	<b>initiatives</b> 11:18	<b>intensive</b> 80:10
102:16 105:10,15	<b>indicate</b> 240:13	131:4 132:6 134:9	12:15 14:4 135:5	246:15,18
110:3 111:9	<b>indicated</b> 41:12	141:9,16,20	<b>inner</b> 10:3	<b>intent</b> 65:2 68:3
119:15 120:18	119:5	144:11 146:4	<b>inner-city</b> 10:1	<b>intention</b> 87:20
132:15 170:11,16	<b>indication</b> 259:12	147:11,15,19,22	<b>innovation</b> 14:5	237:1
175:14 191:22	<b>indicator</b> 47:20	150:1 152:12	258:6 318:8	<b>intentionally</b> 75:19
194:1 257:20,21	84:14,18	156:10 157:4	<b>innovations</b> 62:4	<b>INTERACT</b> 9:9
258:17,18 259:8	<b>indicators</b> 264:17	158:5 168:17	260:8	<b>interactions</b> 18:6
322:22 323:18,20	<b>indirect</b> 137:4	169:4 180:1 183:1	<b>innovative</b> 38:22	187:12 290:14
323:21 328:10	<b>individual</b> 7:15 8:1	183:8 188:1,2	<b>inpatient</b> 130:13	<b>interagency</b> 15:1
<b>included</b> 42:7,11	21:6 70:2 90:3,4	194:6 202:3	131:7	<b>interconnected</b>
46:4 53:5 76:16	95:1 102:15 110:9	203:11,19 204:9	<b>input</b> 29:17,20 30:3	30:17
121:12,14 134:3	124:22 233:11	204:12 205:2,10	33:10,20,22 48:22	<b>interest</b> 3:3 5:16
168:2 171:5,9	246:3 273:15	205:11,18 242:1	66:16 115:13	6:6 7:21 22:21

235:20 327:5	<b>intimately</b> 103:17	94:21 140:1 141:7	<b>JGIM</b> 242:7	57:17 62:8 75:4
<b>interested</b> 6:17,19	<b>intolerance</b> 118:20	142:1,8 143:7,7	<b>Joanne</b> 278:17	78:18 85:17 88:21
93:3 140:4 320:1	<b>intolerances</b>	143:15 144:2,4	324:15	94:14 96:19 121:1
<b>interesting</b> 26:3,14	257:10	146:19 152:13	<b>job</b> 17:9 73:4 147:3	137:16 139:14
108:4 134:5	<b>introduce</b> 4:14 5:8	215:20 216:8	199:17 253:5	164:1 165:13
165:19 166:12	8:3 165:16	228:19 229:15	264:17 269:3	214:12 218:14,18
188:12 193:19	<b>introduced</b> 25:9	279:20 280:15	270:18 297:20	220:20 232:10
196:11 202:22	29:13	284:17	<b>Jobs</b> 232:10	240:15 246:16,17
206:4,19 216:9	<b>introduction</b> 5:22	<b>issues</b> 18:3 57:7	<b>Johns</b> 2:10 19:8	272:6 281:17
228:21 268:4,7	<b>introductions</b> 3:2	79:8 89:3 91:2	<b>join</b> 60:10	296:7 313:2
298:19 311:20	5:14	96:4,7 97:11,18	<b>jot</b> 62:19 217:21	315:16 318:10
<b>interface</b> 148:21	<b>inventory</b> 169:12	131:5 132:11	218:4,10 219:14	326:16
<b>intermediate</b> 264:4	<b>invest</b> 230:10	158:3 229:8,14	<b>jotted</b> 253:13 262:1	<b>keeping</b> 74:9 95:8
264:10,20	<b>invested</b> 7:9	283:18 285:22	<b>Journal</b> 128:19	218:1,12
<b>internal</b> 2:7 9:12	<b>investigation</b>	286:18 303:16	152:17	<b>kept</b> 38:1 103:6
22:13 128:20	107:10	312:17 316:16	<b>journey</b> 161:15	172:7,13
152:18 228:10	<b>investigator</b> 16:17	<b>items</b> 112:13,21	206:13	<b>key</b> 28:11 67:8
<b>internally</b> 30:20	<b>investigators</b> 16:11	<b>iterations</b> 177:15	<b>Jr</b> 1:12 3:10	131:2 172:15
<b>internist</b> 19:20	<b>investing</b> 230:17	<b>it'll</b> 26:3 84:2	<b>Juan</b> 1:16 57:12	191:6 249:20
23:13	<b>investment</b> 230:19	157:22 166:12	<b>judge</b> 216:18 323:3	290:19 328:15
<b>interoperability</b>	248:16 271:15	235:6 282:17,18	323:12	<b>keys</b> 150:4 207:1
12:2 112:11 116:5	291:16	330:6 331:3	<b>judgments</b> 309:6	<b>kick</b> 296:20
120:5 139:11	<b>invisible</b> 320:7	<b>i.e</b> 289:19	<b>juices</b> 334:5	<b>kicks</b> 335:9
<b>interoperable</b>	<b>invite</b> 59:12 60:9		<b>Julie</b> 2:3 17:3	<b>kidding</b> 208:12
119:13 139:20	<b>invited</b> 60:11 64:18	<b>J</b>	289:17	<b>kind</b> 45:18 55:12
148:3	<b>involve</b> 245:22	<b>JAMA</b> 298:1	<b>Julie's</b> 224:12	56:15 62:20 69:9
<b>interpersonal</b>	<b>involved</b> 10:20	301:14,18	<b>July</b> 120:11	74:15 75:12 77:10
183:20 187:11,22	11:11 17:17 20:4	<b>James</b> 1:25 16:12	<b>jump</b> 63:12 103:11	89:12 91:14
<b>interplay</b> 105:18	25:14,17 100:7	19:19 87:6	125:19 214:13	102:22 105:11
221:20	134:2 151:15	<b>Jann</b> 1:18 13:22	238:7 296:20	113:14 117:16
<b>interpret</b> 178:1	217:3 245:3 263:5	268:22 291:14	<b>jumped</b> 297:10	122:3 124:18
<b>interpretation</b> 57:6	263:20 274:6	<b>January</b> 332:19	<b>junctures</b> 81:14	125:2,12 131:8
173:8 235:10	<b>involvement</b> 14:15	333:7	<b>junk</b> 206:22	132:4 140:2
<b>interpreting</b> 114:8	19:22 222:6,8	<b>JD</b> 2:1,18	<b>justification</b> 288:13	141:10,10 144:1
<b>interrelated</b> 39:13	245:1 256:10	<b>Jean</b> 2:8 21:16	<b>justified</b> 298:7	144:18 145:6
45:15	258:1 288:18	306:13 320:11		146:5,22 150:21
<b>intersection</b> 71:12	<b>involves</b> 273:14,15	<b>Jeff</b> 23:8 105:12	<b>K</b>	152:16 158:2
<b>interstices</b> 89:1	325:22	207:17 212:3	<b>Kaiser</b> 1:18 14:1	161:11 166:9
<b>intervention</b> 172:4	<b>involving</b> 245:10	213:6 245:14	231:3 249:11	167:4,11,18 168:4
309:13 313:4	<b>in-depth</b> 95:5	250:1 265:9,10	317:18	168:13 174:8
<b>interventions</b> 41:17	<b>in-person</b> 335:12	272:2 290:15	<b>Karen</b> 1:18 12:21	177:6,19 178:22
299:15	<b>in-point</b> 259:9	294:15	63:11 72:7 199:4	179:3,9,11,17
<b>interventricular</b>	<b>IOM</b> 56:21	<b>JEFFREY</b> 1:21	213:19 291:10,12	180:18 186:20
127:6	<b>Iowa</b> 2:12 13:7	<b>Jeff's</b> 246:22	314:17 334:6	191:20 192:11
<b>interview</b> 266:9	16:18	251:10 298:12	<b>Kathleen</b> 1:14	193:4,8 195:21
<b>interviewed</b> 152:21	<b>isolated</b> 136:11,12	<b>Jerry</b> 16:12	14:10 291:15	196:2 198:4
<b>interviews</b> 169:6	<b>issue</b> 77:14 93:15	<b>Jersey</b> 1:9 22:8	<b>keep</b> 46:5 53:20	203:13 204:9

206:22 207:6	116:10,19,20	236:1,2,4,4,7,10	269:17 282:17	176:2 186:5
218:17,19 219:5	117:8,10 118:3	236:15,16 237:15	315:10	<b>largely</b> 169:22
220:17 221:15,19	125:6,8,18 127:11	237:16,17,19,20	<b>knowledge</b> 118:12	175:11 179:4
225:6 226:11	127:20 128:8,11	237:21,22 238:2	136:2 225:21	189:19
228:21 237:9	128:13,16 129:7	238:22 240:21	242:13	<b>larger</b> 122:17
243:19 247:6	129:12,16,19	241:1,9 244:9,14	<b>knowledgeable</b>	<b>large-scale</b> 20:12
250:13 251:9	131:14,14 132:8	244:17,21 245:3,5	204:4	<b>LASH</b> 2:19
263:4 264:10	132:14,19,22	245:21 246:7,13	<b>known</b> 333:5	<b>lastly</b> 237:8
285:14 286:15,19	133:5,17 134:11	246:18 247:11,22	<b>knows</b> 129:6	<b>late</b> 33:18 180:11
287:3 290:2	135:8,20 136:11	251:4,13,14,16	237:17	284:22
291:18 296:14	136:17 137:4,14	252:20 253:1,14		<b>lately</b> 89:19
301:11 303:9	138:11,20 139:17	253:15 254:5,7,7	<b>L</b>	<b>latitude</b> 306:15
314:4,11 321:3	140:3,4,21 141:3	254:18 255:4	<b>L</b> 2:1,3 3:8 158:20	307:19,22
323:11 326:9	145:5 146:2,4,5	262:9,10 263:4,10	<b>lab</b> 259:21 261:5	<b>Laughter</b> 14:9
<b>kinds</b> 74:22 89:3	146:13,16,21	264:5,14 265:13	317:21	61:21 133:10
133:1 144:10	147:20 148:14,22	266:13 267:7,11	<b>labeled</b> 70:16	304:12
194:12 263:2,14	149:5 150:3,3	267:20 268:20	313:13	<b>launch</b> 43:18 88:19
268:20 303:11	152:19 154:10,14	269:2 270:1,3,10	<b>laboratory</b> 109:6	<b>launched</b> 259:15
<b>Klotz</b> 1:23 12:9,9	154:18 155:6,10	272:18 273:20,22	<b>lack</b> 112:10 139:7	<b>launching</b> 88:18
77:8 117:20 149:3	155:16 156:17	274:3 275:7,9	195:6 225:21	<b>laundry</b> 109:1
151:19 261:22	157:7 158:2,14	276:7,22 277:15	270:21 301:1	157:19
313:10	161:13 162:17	278:15,16 280:2,6	316:17	<b>Lauralei</b> 2:18 4:6
<b>knew</b> 81:1 168:4	164:8,15 165:15	284:16,22 286:22	<b>lacking</b> 306:11	5:18 24:1 29:12
<b>know</b> 30:18 35:2,14	172:1 180:16	290:11 291:4	<b>Lamb</b> 1:10,13 3:11	76:10 98:21 160:5
36:13,14,17,19	186:9,21 191:17	292:3 293:1,17	9:2,4 58:15 62:17	162:20 172:14
37:1,16 38:14	193:22 197:10	294:16 297:1,19	65:8 66:19 81:8	218:12 286:14
39:19 44:10 45:9	199:11,19,20	298:6,14 299:5,16	89:10 94:19 114:2	287:12,17 328:22
46:1,3 47:8,11	200:7 201:3 202:3	300:5,6 301:8,20	114:5 115:1 131:8	331:10 335:4
48:2,22 49:15	202:9,11,14 203:2	302:14 303:15,18	133:13 199:14	<b>law</b> 303:20
50:20 52:7,16,19	204:11 205:15	304:5,14 305:11	211:12 217:17	<b>lay</b> 59:22
55:5,13 56:15,17	206:14 207:11	305:13 307:8,12	219:13 222:13	<b>layers</b> 294:6
57:13 58:7,7	208:1,10 209:12	307:20 308:3,9,13	223:1 224:4	<b>LCSW</b> 1:19
60:18 61:9 64:15	210:3 211:11,20	308:14 309:6,10	227:19 246:21	<b>lead</b> 18:12 60:11
66:8 67:5 68:12	212:7,11,14,16	310:5,19,22	266:13 279:12	73:14 247:18
71:5 74:12,19	213:17 214:3	311:11 313:8	284:16 286:10	248:22
75:1,7,12,16 77:4	215:5,10,12	314:18 315:11,13	295:22 319:6	<b>leader</b> 239:16
78:1,4 79:5 80:2	216:21 217:21	316:7,9 317:1	326:13 331:10	<b>leaders</b> 31:18
80:19,22 81:8,15	218:14 220:11,12	318:9,14,14,17,18	332:6,12,14	<b>leadership</b> 25:3
83:8 85:3 86:2,7	220:13,14 221:8	319:14 320:8	336:22	<b>leading</b> 30:13
87:5,6,18,19 89:5	221:13,21 222:3,9	321:17 322:12	<b>lamplight</b> 207:2	40:12 57:20 79:15
91:12 92:11 93:16	223:10,20 228:9	323:2,16,21 325:6	<b>lamppost</b> 150:4	317:17 318:1
97:6 101:22 102:6	228:12,18 230:16	325:22 326:20	<b>land</b> 295:7	<b>leads</b> 220:17
102:13 103:3,5	230:17 231:4,12	328:11 330:2	<b>language</b> 33:8 57:5	247:19
104:1,13,18	231:13,15,20	333:5,12,14	200:17 204:5	<b>lead-in</b> 320:20
105:19 106:5,14	232:8,19,20 233:7	334:16	253:18,20 256:14	<b>LEAN</b> 20:2
107:9 109:1 110:6	234:7,14,18 235:1	<b>knowing</b> 157:7	286:1	<b>learn</b> 23:1 220:7,9
110:18 113:20	235:3,5,21,22	210:16 214:10	<b>large</b> 12:14 134:19	<b>learned</b> 86:5

<b>learning</b> 307:5	138:2 147:5	292:7	<b>literature</b> 107:13	90:19 124:21
<b>leave</b> 13:10 144:3	163:13 170:22	<b>Linda's</b> 125:18	108:5,6 110:21	141:14 158:6
146:8 164:16,22	176:8,8,16,18,18	<b>Lindeke</b> 2:4 15:6,7	111:15 113:15,19	302:19
167:10 219:11	177:1,4,7,10	126:13 148:5	127:12 134:6	<b>longitudinally</b>
221:14 222:19	243:10,10 258:1	274:18	136:2 148:15	302:18
240:22 304:17	268:6 290:8,9	<b>line</b> 291:22 306:18	152:9 169:5,5,22	<b>long-term</b> 270:19
<b>leaves</b> 74:14 237:19	304:20 305:6,11	<b>linear</b> 272:18	170:4 173:13	<b>look</b> 35:1 36:4 41:2
<b>lecture</b> 18:4	309:15 314:11	273:12 310:6	182:9 199:16	41:4 45:10 47:7
<b>led</b> 267:2	321:12,12,13	<b>lines</b> 124:2 168:2	214:22 215:7,9	51:1,4 52:22 53:2
<b>Lee</b> 1:25 19:19,19	325:22	170:10 208:14	229:13 234:22	58:19 59:3,8
85:20 155:6	<b>leveling</b> 93:16 94:6	257:15 270:10	267:13	61:14 64:21 68:12
228:18 290:3	<b>levels</b> 40:16 56:1	<b>link</b> 209:18 213:15	<b>little</b> 5:22 25:10	68:14 69:13,18
301:4,6,12 304:17	69:8 116:13 164:2	252:7 326:19	34:17 38:12 39:21	72:21 77:6,19
<b>left</b> 72:2 168:19	176:13 305:17	332:3	47:11 48:12 57:3	78:17 81:12 89:6
173:7 230:12	308:10	<b>linkage</b> 82:17	59:17 67:18 72:12	95:16 103:3
289:14 311:1	<b>leverage</b> 260:9	92:18 181:18	74:8 76:9 78:19	110:11 120:2
<b>Leftwich</b> 1:25	<b>leveraging</b> 260:8	187:2 190:17	84:5 88:11 90:6	123:1 126:1 131:9
11:15,16 118:15	<b>Lewis</b> 2:3 17:2,3	195:18 198:8,10	91:13 127:17	131:10 132:5
119:11,15 120:4	219:17	230:21	157:3 162:2,4	134:5 135:17
256:5 261:8	<b>liability</b> 157:16	<b>linkages</b> 83:12	164:16 166:2	136:9 161:21
<b>legacy</b> 139:11	<b>Liaison</b> 1:9	225:11 231:9	171:12 176:3	165:14,18 179:14
146:9	<b>lie</b> 163:5	270:20	177:7 180:4,7,22	179:14,21 184:21
<b>legal</b> 223:6	<b>lieu</b> 102:5 148:2	<b>linked</b> 71:4 96:19	190:16 193:2	186:7 187:17
<b>legible</b> 108:11	<b>life</b> 9:22 37:19	216:10 252:19	195:11 201:19	189:5,21 191:2
112:16	48:20 49:4,16	278:2 323:1	202:21 209:19	200:3 203:18,21
<b>legislative</b> 32:19	51:10 85:13 90:22	<b>linking</b> 70:14 94:15	210:4 219:20	208:15 209:8
<b>legislators</b> 230:8	106:21 136:20	94:16 97:8	220:4 224:14	210:21 211:2
<b>Leib</b> 2:1 24:8	210:13 212:8	<b>links</b> 112:4 181:20	232:12 238:8	215:21 216:1
<b>lend</b> 216:7	247:10,16 269:6	<b>Lipika</b> 2:22 3:13	254:18 269:1	221:4 223:22
<b>let's</b> 27:21 36:15	270:2 283:13	23:16 25:19 28:22	281:10 300:16	227:21 229:14,16
82:10 106:2	290:17 308:17	99:12 100:4 159:2	303:18 311:4	231:16 236:8
122:14 123:1,3	<b>lifestyle</b> 40:21	159:12 160:3	321:18 330:19	247:1,7 250:22
130:6 132:15	41:17 240:10	161:18 293:10	<b>live</b> 38:15,17 85:12	253:4,8 261:4
137:16 138:18	<b>lifetime</b> 107:4	332:11	124:5 230:2	263:2 264:18
156:4 161:11	141:15	<b>list</b> 13:14 24:7	269:12	268:8 270:8
197:1 219:15	<b>light</b> 176:20 177:2	55:15 109:1	<b>living</b> 236:2 269:14	275:13 280:17
255:8 271:17	<b>likelihood</b> 308:16	110:11 118:19,19	<b>local</b> 19:22 20:22	292:7,13,20
272:4 286:10	<b>likened</b> 151:9	118:20 119:18,19	<b>located</b> 101:2	293:17 295:9
287:12 292:12,13	<b>Lilly</b> 13:18	135:7 157:20	<b>locus</b> 305:4	296:14 301:18
304:16 308:9	<b>limitations</b> 288:16	259:20 266:8	<b>logic</b> 303:4	310:11 316:21
332:18 334:12	<b>limited</b> 7:5 13:21	288:9 289:4,14	<b>long</b> 6:11 17:8	319:8,16 320:3
<b>level</b> 38:20 40:18	46:6 51:20 68:8	304:3,10,11 327:4	116:1,1 146:17	326:22 332:9
44:12 47:13 48:9	103:6 171:7	<b>listing</b> 138:21	263:22 311:6	336:20
51:1,16 52:12,13	309:18 324:14	<b>lists</b> 106:16 257:9,9	<b>longer</b> 36:9 336:6	<b>looked</b> 44:5,13
52:14,14,15 53:11	<b>limiting</b> 221:19	<b>literacy</b> 57:5	<b>longevity</b> 324:18	46:22 47:2 54:17
53:14 69:20 70:3	<b>Linda</b> 2:4 15:7	253:17 284:5	325:11	64:19 76:13 77:12
110:9 123:18	126:11 149:20	286:1	<b>longitudinal</b> 48:1	77:14 79:4 84:21



94:3 97:9 107:18 108:5 116:11 172:4 204:2 207:13 228:6 252:18,20 <b>looking</b> 4:9,11 6:13 13:8 16:4,6 22:22 32:7,12 36:1 42:20 46:16,20 48:11 49:4 50:17 65:16 77:17 78:10 92:7 94:3 97:21 107:21 122:4 128:2 131:19 150:4 172:21 173:18 175:7 176:7 181:1 184:14 185:8 186:2 194:16 205:8 207:1 209:4 209:20 210:22 218:7 228:18 231:1 234:8 244:9 251:6 262:16 273:7 276:9 279:6 286:16 320:1 326:18 327:2 337:3 <b>looks</b> 79:7 177:13 179:2 276:19 <b>loop</b> 74:21 77:20 109:12,18 119:1 195:12 225:13 239:8 307:11 316:21 <b>Lorna</b> 2:7 22:11 246:22 290:14 <b>lose</b> 238:6 <b>lost</b> 138:11 <b>lot</b> 16:8 17:11 25:14 26:17 28:9 28:17 31:13 33:4 35:2,16 36:3 37:12,16 43:22 44:3,6 46:4,7,15 48:6,14 49:16,22 51:10,11,13,14	56:21 64:1,15 66:1,16 67:14,16 77:5 79:15 80:12 80:16 86:4 87:7 87:20 88:18 90:22 92:12 96:6 97:14 98:17 103:8 107:15,16 109:17 111:20 113:7,8,19 118:10 122:8,9,12 122:22 125:5 126:2 128:6,6,10 130:21 135:1,2,15 138:22 140:6,10 143:9 146:5,14,19 147:10,10 148:1,3 153:12,17 162:21 165:15 166:11,15 171:1,4 173:3 181:20 183:9 186:5,20 188:10 188:14,22 189:3,7 189:18,20 191:13 193:1,1,7,9 194:9 195:9 196:1,18 197:21 200:22 203:22 207:19 209:5 214:3 215:2 217:8,9 234:11,12 234:12 235:9 243:15,22 244:17 247:19 249:21 252:9,16 270:10 270:14,20 271:1 273:15 275:6 279:18 288:10,15 288:21 290:4 292:8 310:10 313:16 320:7 330:8 331:2 333:17 334:2,3 <b>lots</b> 79:8 85:9 97:18 98:5,11 308:11 <b>Love</b> 2:6 20:8,8 111:1,6,18 112:2 112:6 229:18 298:18 299:18	331:5 <b>low</b> 80:9 217:7,11 <b>lower</b> 117:16 197:5 249:9,14 <b>low-hanging</b> 168:5 <b>lucky</b> 25:13 <b>lumper</b> 301:16 <b>lunch</b> 156:2 158:16 160:8,10,11,14,15 <b>lunchtime</b> 160:6,7 <b>luxury</b> 27:13 29:9 <b>Lynn</b> 2:7 22:11,12 100:13 120:14 241:13 302:10 324:15 <b>Lynn's</b> 278:17 <hr/> <b>M</b> <hr/> <b>M</b> 2:10 <b>MA</b> 1:18 <b>magic</b> 230:16 <b>mailed</b> 202:15 <b>main</b> 79:14 167:1 195:5 <b>maintain</b> 271:22 <b>maintaining</b> 239:18 <b>maintenance</b> 83:22 <b>major</b> 61:8 127:22 163:14 168:15 289:13 <b>majority</b> 174:2 175:22 176:2 192:18,21 224:15 <b>making</b> 41:20 45:1 71:1,5 72:1 73:7 80:13 93:3 109:19 129:20 151:1 225:10 254:21 309:6 326:9 <b>Malouin</b> 2:8 21:15 21:16 134:14 136:5,16,22 234:6 <b>mammogram</b> 90:13 <b>man</b> 270:8 <b>manage</b> 45:13	49:15 110:10 233:10 244:13 <b>manageable</b> 86:21 <b>managed</b> 280:20 <b>management</b> 2:14 9:18,20,20 10:7 11:8 14:2,6 22:2,5 69:7,12,16,20 86:1 94:11,13 135:4 147:13,14 154:18 155:5 187:3,16 188:11 204:17 228:1 263:1 282:2,5 283:10 <b>manager</b> 2:18,19 4:6,20 5:1 10:6 <b>manages</b> 13:13 <b>managing</b> 9:17 12:14 <b>mandate</b> 32:19 <b>mantra</b> 280:20 309:17 <b>manual</b> 91:10 175:5 <b>map</b> 172:19 179:11 180:20 188:14 190:19 191:10 <b>mapped</b> 173:6 185:20 186:15 187:9 205:3 <b>mapping</b> 167:9 169:13 172:20 173:2,3 177:17 186:3 194:17,21 200:2 <b>maps</b> 185:21 <b>MARC</b> 2:1 <b>March</b> 34:1 <b>Mark</b> 24:8 <b>marker</b> 243:9 <b>markers</b> 137:4 243:7 <b>market</b> 20:14 143:13 144:1,18 154:14 <b>marks</b> 169:1	<b>mass</b> 5:11 255:18 <b>master</b> 217:1 256:16 291:2 <b>material</b> 330:12 <b>materials</b> 209:5 <b>Maternal</b> 15:11 <b>maternity</b> 43:15 <b>Matt</b> 19:7 <b>matter</b> 29:6 99:9 161:8 212:19 267:5 287:5 337:8 <b>matters</b> 270:11 <b>Matthew</b> 2:9 93:14 94:18 242:10 290:2 324:11 <b>mature</b> 142:15 <b>Mayo</b> 1:19 11:3,5 254:7,19 <b>MBA</b> 1:12,13,14,18 1:21 2:3,6,13,24 3:10,17 <b>MBA/HCM</b> 1:19 <b>McElveen</b> 2:19 4:18,19 288:4 <b>McKesson</b> 1:14 10:5 11:9 14:11 <b>McNABNEY</b> 2:9 19:7,8 86:12 226:10 228:2 324:12 330:14 <b>MD</b> 1:12,15,16,21 1:21,22,25,25 2:1 2:7,8,9,13,16,22 2:24 3:10,13,17 <b>mean</b> 52:11 79:17 81:20 92:2,5,12 93:17 94:11 102:22 113:17 115:21 117:2,4,12 118:1,9,13 124:2 124:13,13 128:5 130:22 138:6 143:1 146:9,13 148:2 151:8 152:11 184:13 188:15 189:14 191:11 197:11,19
---	--	---	---	---

207:19 208:19	75:13,21 78:8,13	172:18 173:22	66:21 67:10,18	202:1,2 204:8,11
210:8 217:6 220:2	79:1,11,12,19	174:1 176:17	68:18 70:18,19,20	204:13,15 205:8
220:21 228:3,8,20	80:3 84:1,9,10,12	209:15 243:9	71:9,20 73:19	205:16,22 206:2,5
229:22 235:13	84:17,22 85:1,11	275:12 297:5	76:12,14,22 77:13	206:7,9,21 207:7
236:6 237:16	85:13,13,14,17	322:7	78:5,8 79:9 80:11	207:9 209:21
240:11 250:3	86:16 87:3,3 90:7	<b>measurement</b>	82:22 83:4,21	210:5,17 212:11
251:19 267:3	90:7,15 91:11,14	20:16 22:5 35:8	84:7,21 85:7	215:21 218:9,21
273:2 274:13	103:20,21 114:22	35:10 50:8 52:2	95:13,14,19,21	219:4 220:19
281:14 294:15,16	118:5 135:7,9,12	55:11 59:7,13	96:7,18,21 97:4,5	222:2,15 223:14
300:7 303:3 304:5	163:22 167:7	61:7 66:6 70:4,12	97:12 98:10	223:18 225:6
304:15 308:13	170:21 174:3	71:7 76:21 95:2	100:21 101:20	227:21 230:13
309:19 313:16	176:9,12,13,15	100:14 102:6	102:2,8,10,12	232:14 234:3
314:17 317:15,22	181:17 184:11,15	106:13 129:13	104:4 105:15	235:7,18 236:3
320:21 323:6,10	186:3 188:6,20,22	141:20 142:1,17	111:10 113:7,9,11	237:9 238:16
325:13 326:4	190:1 191:14,21	166:15 167:9,13	114:13 118:4,10	240:12 248:1
328:18 334:12	192:5,11,19	168:21 169:15,18	124:9 135:11,21	253:3 256:8 257:2
<b>meaning</b> 173:12	194:21 195:7	169:20 170:20	137:11 160:2	260:5 261:2 263:2
<b>meaningful</b> 10:5	198:7,21 199:1	176:8,13,17	163:3,5,15 164:3	264:4,10,19,20
59:13 71:7 80:8	200:10,16,19,20	177:16 178:3	167:10,16 168:7	265:3,5,8,15
81:16,18 90:20	203:1,3,10 207:4	181:14 182:5,13	168:11,17 169:9	271:2 272:16
103:10,17 104:8	207:22 208:4	184:6,7 185:9,15	169:12 170:16,17	278:13,15,22
104:17 119:7	211:10 213:13	187:3,4 189:13	171:3,5,7,10,10	279:17 282:6,9
122:11 191:20	216:2 217:20	193:6 200:12	171:17,18,19,22	286:17 292:18
204:3 224:9	218:8 223:5,15	229:21 241:4	172:3,7,15 173:4	293:15,22 296:22
236:14 237:1,4,5	225:4,19 226:2,18	242:16 261:10	173:5,10,15,18	297:18 299:11
258:22 276:2	227:14 229:3	262:8,22 263:16	174:8,14 175:3,8	300:2,12,18,22
282:10 317:15	235:16 236:13	267:10 268:7	175:14,19,22	301:2 302:5 303:9
328:3	238:10 251:10,12	289:11 304:20	176:4,7,21 177:3	303:12 305:2,6
<b>means</b> 83:11	252:6 253:12	321:10	177:6,10,14,21	306:2,2,7,14
175:11 204:3	255:8,22 256:12	<b>measurements</b>	179:14,16,21	307:1,2,6,15
209:15 229:2	257:6 260:1,9	98:7 193:10	181:9,16,19 182:1	308:10 309:11
236:6 244:7 275:7	268:18 271:6,21	<b>measurement-wise</b>	182:7,10,16,22	310:11,21 314:13
<b>meant</b> 68:7 100:16	271:22 272:3	180:5	183:3,10,10,11,15	314:18 316:10
154:11 189:14	273:10 274:4,7	<b>measures</b> 2:17 3:9	183:18 184:4,17	317:15,16 318:1
292:14	275:15 277:1,6,7	3:21 4:17 14:12	184:21 185:4,14	320:18 322:21
<b>measurable</b> 213:9	278:6,7,12,22	14:15 18:16 19:2	186:9,10,12,16,21	323:7,17 326:21
233:2 236:8	279:4,6,7 281:11	22:4 25:15,17,18	187:18 188:3,9,14	326:21 327:17
247:11 249:1	285:19,20,21	26:7,11,12,22	189:3,17,18,19,20	329:3,6,20 331:1
252:1 255:5	294:13,18 302:16	27:5,16,19 28:3,7	190:9,11,13,18	331:20 332:8,15
<b>measure</b> 13:5 16:9	304:22 312:9	28:12,16 29:4,6	191:3,8,11,16,18	332:16,18,20,21
20:13 28:20 33:2	313:20 314:10,15	29:22 34:11 41:5	191:18 192:9,16	333:4 334:8 335:5
35:7 41:2 45:8	316:14,18 317:3,6	45:20 46:20,21	192:21 193:1,16	335:18,21 336:3
46:16 47:15,22	317:8 318:21	47:1 50:20 51:3	194:12,13 195:2,6	<b>measuring</b> 63:6
48:7,8 50:11,19	321:19 324:8	51:15 52:3 57:22	195:15 196:13	83:5 134:17
50:21 52:13,20	327:10,12	58:8 59:11,12	197:7,9,11,20,22	135:18 169:11
53:11,16 61:10,12	<b>measured</b> 53:10	63:10,11,19 64:9	198:5,7,9 200:1,7	196:7 204:15
62:2,10 65:20	87:5 97:16 114:10	64:10 65:16,18	200:18 201:21	208:16 211:10

225:8,20 226:22 243:5 253:10 254:20 264:1 272:10 273:5 277:5 290:7 320:5 324:4 328:6 <b>mechanism</b> 220:15 228:9 256:18 260:11 <b>mechanisms</b> 178:10 <b>med</b> 13:14 105:1 266:8 271:4 <b>mediating</b> 147:2 <b>Medicaid</b> 2:2 32:11 276:14 <b>medical</b> 1:17 2:12 8:7,18,20 9:17 10:6 11:16 15:17 17:21 18:1 19:10 21:18,20 22:1 23:9,14 86:2 131:20 153:19 175:9 183:4,6 193:14 241:16,18 243:16,18 244:16 247:1 250:1,3,4 254:4 257:17 262:4 263:3,7,9 263:13 273:18,18 283:8 289:19 290:15 305:4 312:3 327:15 <b>medical-legal</b> 269:22 <b>Medicare</b> 93:20 300:3 318:19 <b>medication</b> 13:5,20 43:14 80:20 104:10,20 106:16 109:4 118:19 119:18 145:19 204:17 231:18 234:19 240:8 257:8 259:21 284:2 <b>medications</b> 262:13	262:17 <b>medicine</b> 2:8 5:10 10:11 17:20 19:9 21:18 22:13 100:12 128:20 152:18 166:4 250:11 <b>Medicine's</b> 9:12 56:18 <b>MedStar</b> 1:21 10:13,15 <b>meet</b> 38:16,22 105:7 319:5 <b>meeting</b> 4:5 24:19 35:3 37:15 132:20 159:4 329:18,22 331:20 335:7,12 337:6 <b>meetings</b> 120:8 <b>meets</b> 85:11 188:16 <b>Meier</b> 269:9 <b>member</b> 3:14 9:5 11:7 21:9,11 23:20 124:14 147:15,16 155:10 247:13 280:11 <b>members</b> 8:13 23:22 63:11 82:7 100:9 147:12 161:1 205:12 225:14 233:19 281:12,13 283:15 <b>membership</b> 21:5 66:17 163:16 <b>Member/Public</b> 3:23 <b>mental</b> 41:6 89:2 177:20 <b>mentally</b> 94:8 <b>mention</b> 34:21 57:7 66:11 111:3 139:2 334:20 <b>mentioned</b> 29:12 61:18 65:17 117:21 172:22 173:1 196:2 211:6 238:9 248:3	249:21 250:11 259:4 282:1 285:19 288:6 289:21 290:13 324:8 <b>mentioning</b> 187:8 <b>menu</b> 104:10 <b>menus</b> 148:9 <b>Merck</b> 13:19 <b>merely</b> 71:13 <b>message</b> 77:5 260:16 <b>messages</b> 259:1 <b>messaging</b> 261:14 <b>messy</b> 179:2 308:19 <b>met</b> 1:8 35:17 64:14 240:5 321:7 325:10 <b>meta</b> 267:7,8,9 268:18 <b>meta-analyses</b> 135:16 <b>methodological</b> 169:2 <b>methods</b> 108:21 167:5 <b>metric</b> 220:1 321:16 <b>metrics</b> 135:7 240:6 <b>Metropolitan</b> 1:9 <b>MI</b> 308:16 <b>mic</b> 89:15 99:13 <b>Michigan</b> 1:19 2:9 13:1 21:16,21 134:19 <b>microphone</b> 142:7 <b>Microsoft</b> 260:14 <b>middle</b> 39:9,11 235:1 <b>midst</b> 282:18 323:9 <b>million</b> 41:13 236:6 236:7 250:16 275:20 <b>mind</b> 53:21 57:17 62:8 78:18 92:2 118:5 121:1 123:9	164:1 214:5,12 219:22 224:15 246:8 248:4 252:7 296:7 315:17 326:16 <b>mindful</b> 93:19,20 93:22 150:6 155:19 217:15 <b>minds</b> 88:6 <b>mindset</b> 62:15 311:14 <b>minimize</b> 224:21 <b>mini-fellowship</b> 166:7 <b>Minnesota</b> 2:4,5 15:7,9 <b>minutes</b> 24:4 99:3 99:5 101:3,9,10 103:12,13,14 160:10 162:12 197:2 217:21 218:9 219:7 220:3 220:8 258:5 275:9 308:13 <b>mirror</b> 45:4 <b>mirrored</b> 54:12 <b>mirrors</b> 42:12 <b>missed</b> 110:18 164:21 225:1 <b>missing</b> 65:1 164:18 <b>mission</b> 30:7,10 31:4 <b>Missouri</b> 2:12 16:22 <b>mis-translated</b> 269:6 <b>mode</b> 91:10 <b>model</b> 12:4 17:11 19:1,13 85:6 118:17 194:20 198:19 207:14 227:17 256:4 263:11,12 291:21 292:6 310:6 312:3 316:20 <b>modeling</b> 299:5	<b>models</b> 17:7 272:15 291:7 292:6 298:3 298:16 310:3 <b>modifications</b> 262:18 <b>modified</b> 261:12 291:8 <b>modify</b> 333:7 <b>module</b> 22:19 <b>modules</b> 22:14 <b>moment</b> 47:10 72:20 73:12 <b>Monday</b> 282:21 <b>money</b> 11:12 166:20 276:19 321:8 <b>monitor</b> 46:21 50:6 <b>monitored</b> 190:14 190:14 <b>monitoring</b> 186:16 186:19 192:3 256:20 <b>Montana</b> 143:18 <b>month</b> 30:3 100:18 100:19 <b>months</b> 11:21 119:4 161:17 198:11 259:16 279:19 333:6,19 <b>moon</b> 36:12 106:7 <b>morbidity</b> 192:1,6 <b>morning</b> 4:3,18,21 8:5 9:2 10:9 11:1 11:15 15:6 17:2 17:14 21:2,15,22 22:11 25:7,8 29:11,19 42:5 59:16 62:19 99:1 171:4 208:21 217:19 221:18 254:4 266:20 <b>mortality</b> 10:3 40:12 296:16 297:14 <b>Motamedi</b> 108:3 <b>mother</b> 279:20 <b>move</b> 61:18 62:22
---	---	--	--	---



<b>notes</b> 62:19 129:19 287:16,19	64:7 76:11 167:17 186:10 187:19 197:9,11 296:21	<b>obvious</b> 201:8 312:15 314:5	117:19 119:10 120:10,12 121:21 121:22 125:16 126:10 127:15,19 129:3 132:13 133:12 137:16 138:18,19 140:20 142:2,3 145:22 148:4 149:2 151:18 152:14 154:16 155:15 156:3,15,16 160:11,16,17 161:5 164:11 166:22 207:17 209:8 217:17 223:1 247:9 249:8 252:3 261:22 271:17 272:2 273:10 305:20 311:10 331:12,12 332:6,12 336:13	308:7 <b>online</b> 120:2 <b>on-the</b> 242:2 <b>open</b> 60:4 107:12 221:12,15 308:15 332:19 333:15 <b>opening</b> 66:22 <b>operated</b> 239:11 <b>operating</b> 207:2 <b>operations</b> 10:16 <b>Operator</b> 160:19 160:21 161:3,7 336:10,11 <b>opinion</b> 169:6 229:16 269:6 295:15 312:10 <b>opportunities</b> 34:12 53:12 66:6 76:21 79:22 83:6 85:10 <b>opportunity</b> 13:17 26:5,20 59:1 77:5 78:4,12 81:10 166:6 208:15 211:15 212:1 217:18 218:12 229:1 298:11 307:17 312:19 <b>opposed</b> 37:11 169:16 174:5 201:1 207:14 210:5 255:10,19 278:10 <b>optimized</b> 156:9 <b>optional</b> 105:1,5,5 105:11 <b>oral</b> 41:7 <b>order</b> 84:22 109:8 127:7 135:16 167:21,22 170:9 274:4 305:12 324:2 <b>ordering</b> 85:3 145:19 <b>organization</b> 21:9 23:11 138:7 146:11
<b>noticed</b> 162:4	<b>NQF-sponsored</b> 285:21	<b>obviously</b> 25:2 28:11 31:8 35:16 40:3 41:2 42:22 44:16 47:9 49:21 84:18 89:7 98:10 105:21 106:19 159:17 177:1 210:14 214:3 217:2 235:15 258:18 260:3 307:1	<b>old</b> 84:10 93:16 139:21 213:4 218:2,2 223:21 291:11 <b>older</b> 9:10 139:15 <b>Omar</b> 100:11 <b>onboard</b> 237:6 <b>ONC</b> 18:15 317:14 <b>once</b> 81:5 105:17 109:18 110:7 140:8 146:22 213:14 239:15 335:5 <b>ones</b> 63:20 107:9 137:12 154:2 170:4 185:6 187:8 196:13 206:14 207:10 216:15 311:22 323:5 <b>one's</b> 107:11 295:4 <b>one-doc</b> 143:18 <b>one-size-fits-all</b> 91:21 <b>ongoing</b> 22:18 223:17 272:20	
<b>notion</b> 49:20 87:17 289:17 290:11 306:5,17 314:9	<b>nuance</b> 201:7 302:4	<b>occasionally</b> 18:2		
<b>November</b> 329:13	<b>nuanced</b> 78:19	<b>occur</b> 255:3 311:3		
<b>novo</b> 207:7	<b>number</b> 15:12 18:22 22:14 46:6 69:3 77:12 104:3 105:3,16 107:18 128:21 130:10 155:11 156:13,15 174:12,13 179:21 184:17 185:7 188:3 191:3 197:5 235:13 296:5 300:17 305:22 319:9	<b>occurred</b> 309:8		
<b>NPP</b> 30:8 31:11 32:15,18 33:6 34:4,10 36:14 41:3 42:6,14,19 45:4,5 46:11,17 46:20 47:15 48:6 48:18,21 49:9 51:2 55:20	<b>numbers</b> 44:10	<b>occurs</b> 272:20		
<b>NPP's</b> 25:11 30:3 43:16	<b>numerator</b> 191:12	<b>October</b> 1:6 323:8 331:13		
<b>NQF</b> 2:15,18 3:5 3:23 4:5,13,17 8:20 18:22 27:11 28:18 29:9,15 30:15 31:9,17 32:21 33:11,19 50:13 55:10 56:4 61:7 63:6 66:18 76:18 82:14 83:14 84:14 131:9 163:16 166:7 168:6,14 169:13 172:16,20 174:11 174:14 176:11 178:5 179:7,21 180:13 182:9,20 184:15 185:19 187:4 190:22 197:6 198:21 205:2 242:15 278:13 300:9 302:11,14 308:8 311:16 316:9 323:9 327:11 330:5	<b>numerous</b> 306:10	<b>odd</b> 200:1		
<b>NQF's</b> 5:6 30:6,10 32:1 59:2	<b>nurse</b> 15:8,16 21:9 133:8,9,14 134:1 138:5 244:8 279:3 283:21 318:18	<b>offense</b> 284:15 291:19		
<b>NQF-endorsed</b>	<b>nurses</b> 15:19 115:22 275:20 283:8	<b>offer</b> 268:5		
	<b>nursing</b> 2:4 9:10,14 15:9,20 16:22 21:3,7,11 121:17 275:20 282:4 286:2	<b>offered</b> 13:17		
	<b>nutrition</b> 242:18	<b>offering</b> 236:20		
	<b>N.W</b> 1:9	<b>offhand</b> 190:7		
	<b>O</b>	<b>office</b> 11:18,22 79:22 220:4,10,11 270:17 303:21 305:3 309:9		
	<b>objective</b> 167:15	<b>officer</b> 8:7 11:17 21:3		
	<b>observation</b> 206:4	<b>offices</b> 221:9		
	<b>observational</b> 308:12	<b>officially</b> 335:9		
	<b>observations</b> 256:19	<b>oh</b> 5:19,19 6:1 24:5 114:1 137:19 156:3 316:11 329:12 332:12		
	<b>obsolete</b> 207:21	<b>okay</b> 6:3 23:21 24:5 24:9,18 58:11,15 62:22 63:3 64:6 69:3,13,21 72:3 75:10 95:11 99:6 99:12,14,15 100:3 104:18 105:2,8 106:2 112:1 113:1 114:14 115:7,10		



<b>pathways</b> 324:17 325:2,4,6,7	266:8 267:4,16,17 268:1,3 271:7,16 277:10,12 279:16 283:12 288:10,12 290:4,8 291:17 302:15 303:14 308:15 309:8,13 321:11 324:20 325:8,16 328:13 328:21	253:4,14 266:2 267:10 270:3 324:6 <b>patient-centered</b> 83:12 138:2 243:17 257:17 <b>patient-centered...</b> 290:3 <b>patient-consumer</b> 52:16 <b>patient-family</b> 321:6 <b>patient-level</b> 87:15 302:5 <b>patient-provider</b> 118:11 <b>patient-reported</b> 102:1,3 113:11 <b>pattern</b> 95:2 <b>pay</b> 98:20 248:4 <b>payer</b> 102:5 111:4 232:21 <b>payers</b> 111:11 328:19 <b>payer-based</b> 20:21 <b>paying</b> 321:14 328:19 <b>payment</b> 17:7 35:19 284:7 300:5 <b>pay-for-perform...</b> 314:2 <b>PCI</b> 308:12 <b>PCMH</b> 21:21 22:7 <b>PCP</b> 129:1 131:20 236:9 237:13,21 239:9 242:17 254:14,16 285:10 285:11 <b>PCPI</b> 170:6 <b>PDF</b> 129:11 258:18 <b>pediatric</b> 15:7,16 <b>Pediatrics</b> 15:19 <b>peeve</b> 217:13 <b>penetrated</b> 154:14 <b>people</b> 4:10 7:3,15 7:17 10:1 24:22 38:14 42:1 51:16	64:13 74:4 77:17 79:15 80:18 81:6 82:4 86:5 87:7 88:4 89:2,13,15 91:10 92:14 103:16 104:7 109:12 110:3 113:22 116:12 124:19 130:13,19 133:1 141:5 146:2 146:10 151:9 153:21 154:1,3,15 154:21 155:17 157:20 158:15 162:4 164:15,22 168:9 175:20 176:4 182:15 196:2 199:9 200:12 206:6 210:9 217:14 234:12 235:2,19 235:21 236:7 246:1,8 248:18 249:13 258:7 264:5,6 265:13 270:8,9 277:17,22 279:1 282:4,19 284:1,20 285:4 290:16 294:3 296:4 300:20 305:15,18 311:8 311:16 316:10 318:10,12,16 319:2,15,19 320:12 333:12,16 333:18 <b>People/Healthy</b> 39:8 54:16 <b>percent</b> 52:9 93:17 93:18 173:19 182:19 226:13 250:18,20 251:1,2 276:5,6 281:17 <b>percentage</b> 172:1 183:14 <b>perception</b> 279:20 <b>perfect</b> 6:3 272:3	284:12 311:9 <b>perfection</b> 92:16 255:12 <b>perfectly</b> 62:1 86:9 <b>perform</b> 144:12,13 <b>performance</b> 2:17 3:9 4:17 25:15 61:6,12 62:10 68:18 220:19 238:13 282:9 <b>performer</b> 277:7 <b>performing</b> 38:4 <b>period</b> 80:14 335:22 <b>Permanente</b> 1:18 14:1 <b>persist</b> 300:11 <b>persistently</b> 94:8 <b>person</b> 24:7 37:7 39:22 75:11,11 91:7 124:22 125:14 139:20 145:18 196:8 220:1,16 221:5 222:11 229:6 248:3 275:10,16 285:12 289:19,20 <b>personal</b> 10:22 132:17 152:5 157:12 281:16 284:3 <b>personally</b> 149:12 199:8 269:2,20 <b>person's</b> 107:3 <b>person-centric</b> 230:21 <b>perspective</b> 70:7 72:17 88:4 120:17 120:19 121:4,6 132:4 140:5,21 143:13 178:14 200:8 219:21 220:7,16 229:20 229:21 252:5 288:9 324:6,6 <b>perspectives</b> 166:13 311:19
---------------------------------------	---	---	---	---

<b>pet</b> 217:13	<b>physician's</b> 12:6	183:13 184:18	<b>plenty</b> 35:3	<b>political</b> 230:1,3
<b>pharmaceutical</b>	23:10 220:3,10	185:18 186:8,10	<b>plucking</b> 39:14	<b>politics</b> 237:3
23:5	221:9 262:5	186:13 189:16	<b>plus</b> 63:22	<b>poll</b> 329:16 332:4
<b>pharmacist</b> 13:6	<b>physician-centric</b>	190:9,20 194:17	<b>point</b> 7:10 30:8	<b>polling</b> 332:2
266:5,10	146:22	199:6 200:14	37:22 55:12 57:12	<b>polypharmacy</b>
<b>pharmacists</b> 13:9	<b>physiology</b> 126:22	223:16 224:22	66:15 81:9,17	43:14
284:1	<b>pick</b> 182:12 292:22	228:17 229:7	82:10,13 83:20	<b>pool</b> 201:21
<b>pharmacy</b> 1:19	<b>pickle</b> 93:20	233:13 235:10,14	90:14 91:8,17	<b>pools</b> 113:14
13:1,4 175:16	<b>pickup</b> 284:22	238:18,21 239:3,4	92:21 94:21 98:2	<b>poor</b> 217:7,12
<b>phase</b> 26:20 27:3,4	<b>picture</b> 22:17 184:1	239:7,11,14,19	101:21 102:10	255:18 296:9
80:9 100:21 258:9	209:10 239:15	240:2,5 242:18	114:2 118:14	302:1 309:19
269:10 287:12	<b>pie</b> 174:21 177:11	245:8,19 248:19	121:1,22 123:6,7	<b>population</b> 38:11
310:16 335:9,11	<b>piece</b> 31:4 81:13,18	256:16,21 257:16	126:14 128:19	48:9 51:1 52:10
335:18,21 336:1,3	145:5 213:21	265:2,20,20 275:8	129:12 138:15,21	54:12,18 110:10
336:19	238:17 275:12	279:21,21 280:1,3	140:9 149:10	181:13 233:12
<b>phases</b> 26:19 80:7,9	<b>pieces</b> 62:21 107:15	280:5,7,10,13	151:12 152:6	251:19,20 260:4
<b>PhD</b> 1:13,18,23 2:4	115:2 123:11	282:17 283:4	155:14 157:6,14	278:16,18,21
2:12 3:11	229:11 244:12	286:5 289:22	162:3 165:13	290:7,9 294:12
<b>phenomenally</b>	252:16	290:10 291:2	196:14 201:7	301:17,22 302:2,7
154:7	<b>pilot</b> 15:3 113:4	321:15,20 322:9	205:7,12 209:18	<b>populations</b> 10:4
<b>phenomenon</b> 154:1	258:9	323:20 325:17,20	210:8 211:13	38:5 39:1 52:20
<b>philosophy</b> 310:19	<b>piloted</b> 22:7	<b>planned</b> 61:22	214:6 221:1	52:22 54:20 88:12
311:6	<b>piloting</b> 17:6 113:9	190:22	224:12 226:8	240:17 289:9,10
<b>phone</b> 24:1 161:1,3	279:4	<b>planning</b> 12:4	234:2 238:16	289:12 296:3
164:19 254:19,22	<b>PIM</b> 9:12	18:15 106:22	245:15 246:2	299:2 304:22
336:12	<b>Pioneer</b> 23:3	269:5,11 270:1	250:14,15 251:8	325:7
<b>phones</b> 24:3	<b>piqued</b> 76:4	283:1,2,14	263:19 272:21	<b>population-orient...</b>
<b>PHR</b> 260:14	<b>place</b> 46:19 81:3	<b>plans</b> 32:13 45:1	275:5 281:18	110:2
<b>phrase</b> 301:1	92:10 108:18	48:1,3 52:21 53:5	283:7 291:19	<b>portals</b> 134:5
322:17	114:9 115:3 123:9	53:6 147:2,15	292:11 295:7	<b>portfolio</b> 14:3
<b>physical</b> 283:16	140:14 189:17	324:14,15	298:12 300:11	278:13,19
<b>physician</b> 12:5 20:4	202:17 208:4	<b>plan-specific</b>	305:1 306:13	<b>portion</b> 56:22
73:2 119:20 121:6	244:12 267:11	228:14	309:22 313:15,19	<b>poses</b> 215:5
121:15 140:8	268:8 270:8	<b>plate</b> 208:1	335:3	<b>position</b> 11:6
221:5,22 224:16	280:21 285:4	<b>platform</b> 56:2	<b>pointed</b> 56:21	<b>positive</b> 44:18
225:2 237:15	317:7 330:9	318:5	199:21 235:12	52:10 53:17 57:10
239:17 241:22	<b>places</b> 107:13	<b>play</b> 47:10 163:4	<b>pointing</b> 185:12	92:18 308:8
250:5,12 255:1,1	110:20 150:20	195:19 326:12	<b>points</b> 72:12 93:14	<b>possibilities</b> 288:16
266:3 270:16	151:14	<b>played</b> 46:14 169:8	107:5 123:2	<b>possibility</b> 308:3
275:18 305:3	<b>plan</b> 52:12 67:11	<b>players</b> 109:19	128:17 146:6	<b>possible</b> 32:2
309:9,12	80:21 90:8,10,15	<b>plays</b> 208:11 227:9	152:15 156:18,19	101:14 123:4
<b>physicians</b> 8:15	90:19 91:4 95:19	<b>please</b> 62:22 63:2	222:10 282:15	224:11 232:9
10:14,17 22:7,15	96:16 121:5	68:11 89:14 158:1	<b>policies</b> 40:19	237:11
140:8 153:11	122:13,15 123:8	161:2 164:7 219:4	261:11	<b>possibly</b> 266:19
224:21 241:17	123:13 124:20,21	222:13 304:3,3	<b>policy</b> 6:6 17:5	268:17
247:5 250:17,18	142:12 145:16,17	<b>pleased</b> 33:22	18:17 20:14 21:8	<b>post</b> 330:12,15,22
259:8 283:7	180:8,9,13,14	<b>pleasure</b> 337:1	120:7 146:3 300:5	330:22 331:6



332:21	301:2 305:11	332:11	<b>print</b> 43:6 52:4	<b>problem</b> 56:19
<b>posts</b> 319:15	<b>precedent</b> 326:2	<b>PRESENT(Cont'...</b>	275:4	80:18 89:21 90:17
<b>potential</b> 16:3	<b>precedes</b> 229:21	2:1	<b>prior</b> 166:5 251:14	106:15 108:12
182:14 223:12	<b>precise</b> 298:4	<b>president</b> 2:17 4:16	<b>priorities</b> 2:21 3:7	113:18 118:19
261:9 262:7	299:12	8:8 16:1 17:5,15	5:3 29:14,16	119:19 122:7
292:13 317:14	<b>predictors</b> 301:19	<b>presiding</b> 1:10	30:15,18,21 31:7	143:9,11,12 147:7
332:8	<b>prefer</b> 86:20	<b>pressure</b> 41:21	31:16 32:22 33:5	147:9 153:6 184:8
<b>potentially</b> 7:8,11	<b>preference</b> 239:10	43:9 172:5	33:12 34:3,21	257:9 309:15
74:18 102:9 160:1	239:10	<b>pretty</b> 34:2 40:6	35:14,21 36:10	<b>problematic</b> 171:5
212:14 261:3	<b>preferences</b> 64:12	242:19 263:22	37:5 55:12 58:18	<b>problems</b> 42:1
263:17	86:15 227:14	273:13 285:5	62:7 105:18	156:7 236:17,19
<b>Powell</b> 2:10 18:8,8	<b>preferential</b> 206:1	302:8 326:6	146:15 238:20	247:20 284:21
89:17 104:22	<b>preferred</b> 76:15	330:19	319:12	<b>procedures</b> 281:5
122:1 124:6	98:3,9,17 126:1	<b>preventable</b> 42:7	<b>prioritization</b>	<b>proceed</b> 60:4
125:10 143:5,22	164:7 165:9 168:7	54:22 79:3 97:12	333:11	<b>process</b> 27:6 29:9
144:17 150:10	203:12 256:14	174:6 276:6	<b>priority</b> 31:3 33:7	45:1 53:20 55:17
151:13 208:13	267:17	<b>preventing</b> 40:11	34:7 36:2 38:11	59:9 61:7 62:16
210:20 224:5	<b>pregnancy</b> 126:19	<b>prevention</b> 14:20	39:9,14,15 40:2,5	83:9,22 85:9 86:5
305:20	<b>premature</b> 126:16	41:8,11 263:21	40:10 42:8 43:19	90:1,7 91:14 92:8
<b>power</b> 149:14	<b>Premier</b> 113:8	<b>preventive</b> 41:1,18	43:21 45:16,20	92:10,13 100:16
<b>PQA</b> 13:16	<b>premise</b> 68:21	240:11 245:19	46:7 48:19 49:1	114:19 115:2
<b>PQR</b> 290:22	69:10 211:17	283:11	<b>priority-setting</b>	126:5 133:3 139:9
<b>PQRI</b> 252:18,21	<b>premises</b> 60:2,6	<b>previous</b> 3:5 57:14	32:20	146:16 148:11,21
<b>practice</b> 10:7 15:20	63:22 64:2 68:15	63:3 67:14 121:10	<b>private</b> 20:11 33:15	149:7 156:11
19:14 22:14 69:12	<b>premium</b> 245:9	170:6 223:3	55:5	157:10 162:22
83:7 141:1 154:8	<b>prep</b> 335:6	331:11	<b>prize</b> 92:5 94:14	163:2 191:18
203:13 210:8	<b>prepare</b> 333:19	<b>previously</b> 20:4	<b>pro</b> 291:11	192:15,22 193:15
228:8,14 243:10	<b>prepared</b> 49:15	119:17 233:17	<b>proactive</b> 185:18	194:3 197:10
243:10 244:18,20	177:19	<b>primarily</b> 170:3	186:7 199:6	206:1 212:7 213:5
277:19,20 283:21	<b>prequel</b> 27:13	182:8 275:17	200:14	213:11,12 214:8
295:4 303:21	<b>Presbyterian</b> 1:17	<b>primary</b> 23:18 73:1	<b>probability</b> 264:12	214:19,20 216:7
321:12	17:16	73:1 100:4 107:10	<b>probably</b> 17:8,11	216:13 227:11
<b>practiced</b> 72:22	<b>prescribe</b> 325:3	107:14 119:20	31:12 39:6 46:18	228:10 229:2
<b>practices</b> 67:11	<b>prescription</b> 157:8	130:16 134:20	48:10 56:16 66:22	238:17 256:8
76:15 98:3,9,17	192:3	135:3 167:15	76:8 112:2 123:15	259:18 264:19
107:17 126:1	<b>presence</b> 293:14	169:4,5,21 173:13	145:11 156:2	265:3,4 267:7,8
128:21 129:7,8,14	<b>present</b> 1:12 2:22	202:12,13 221:21	158:15 177:4	267:16 268:13,18
130:3 134:22	100:10 182:6	241:21 244:18	181:20 188:13,17	272:19,20 274:7
136:13 164:7	232:4,7	245:4 253:18	190:10 196:10	290:2 294:11
165:9 168:7 172:1	<b>presentation</b> 25:20	266:10 283:12	199:7 201:14,22	306:15 307:18
313:17,18	160:8 161:18	<b>prime</b> 28:1	206:12 210:17	311:12 312:21
<b>practice-level</b>	162:12 174:22	<b>priming</b> 29:5	225:18 230:9	320:2 326:19
177:9	196:22 201:18	<b>primo</b> 123:11	234:10 237:9	328:10 335:11
<b>practicing</b> 19:20	208:18 291:3	<b>principle</b> 278:5	255:21 276:3	336:6
23:12,13	<b>presentations</b> 3:15	<b>principles</b> 36:5	281:17 297:20	<b>processes</b> 37:12
<b>practitioner</b> 15:8	123:4	60:7 64:3 178:7	303:21 310:9	59:2 137:9 168:19
<b>practitioners</b> 15:16	<b>presented</b> 119:3	277:2,3	319:9	178:19 179:6

192:7 212:21 216:10,18 243:13 264:16,18 278:2 298:8,10 322:22 323:4 <b>Process-wise</b> 96:20 <b>produce</b> 143:17 <b>produces</b> 276:18 <b>products</b> 144:19 153:5 <b>professional</b> 47:13 132:2 133:14 178:15 239:1 313:3 <b>professionals</b> 32:6 <b>professor</b> 12:22 16:21 17:20 <b>profound</b> 199:7 <b>program</b> 2:2 9:9 10:1 12:10 16:1 18:7,13 19:10,11 86:1 94:5 137:14 263:1 271:5 <b>programs</b> 9:21 17:18 21:17 147:14 <b>progress</b> 46:22 48:8 66:12 229:12 284:14 316:15 <b>progressive</b> 209:19 <b>progressively</b> 80:10 <b>project</b> 2:18,19 3:4 4:6,7,9,19 5:1 20:5 22:7 26:16 26:19 27:8,14 58:9 88:20 100:8 116:20 134:21 166:8,22 167:22 168:13 171:8,14 171:16 173:3 174:17,18 176:11 185:14 193:22 196:16 216:16 258:12 291:5 315:19 323:9,10 330:4 334:18	<b>projects</b> 12:14,16 15:13,14,17 16:4 16:14 88:18 170:6 172:14 174:15 182:9 275:1 <b>promising</b> 55:3 313:13,17 <b>promote</b> 20:16 244:7 <b>promoting</b> 11:19 31:5 295:3 <b>prone</b> 102:6 <b>proof</b> 201:15 <b>proper</b> 155:10 <b>prophylaxis</b> 85:1,2 <b>proposed</b> 105:15 182:18 190:11 <b>proposes</b> 193:20 <b>prostate</b> 325:18 <b>prototype</b> 284:20 <b>proven</b> 83:11 92:15 <b>provide</b> 10:14 18:14 22:17 48:22 101:16 140:15 242:14 270:7 287:13 307:22 309:12 <b>provided</b> 33:22 78:6 165:19 268:17 <b>Providence</b> 20:1 <b>provider</b> 14:11 47:12 52:14 53:12 80:15 109:10 130:16 131:18 147:21 148:19 176:18 177:4,10 180:18 181:7,7 232:18,20 259:7 <b>providers</b> 14:14 32:6 53:1,6 71:9 71:12 80:17 87:1 108:9 111:11 131:13,17 140:21 148:8 152:19 153:18 158:7 240:5 242:22	247:6 265:10,21 276:15,16 280:9 281:1 <b>provider's</b> 241:3 324:5 <b>provider/clinician</b> 53:14 <b>provides</b> 251:1 <b>providing</b> 12:18 25:4 29:17 51:8 141:4 215:10 250:6 252:10,17 253:19 273:21 <b>provisional</b> 313:13 <b>proximal</b> 85:8 <b>pseudo-evidence</b> 307:7 <b>psychosocial</b> 283:16 <b>PT</b> 1:18 121:19 <b>public</b> 3:14 17:21 20:17 21:8 33:15 83:1 161:1,1 163:17 231:5 282:22 300:2 314:1 335:15,15 335:16,22 336:3 <b>publicly</b> 182:11 <b>published</b> 98:6 113:15,19 173:11 175:19 184:13,17 184:21 185:4,5 187:5,20 191:9 254:8 <b>publishing</b> 242:6 <b>PubMed</b> 169:22 <b>pull</b> 51:14,21 62:21 83:13 134:12 163:6 182:14 286:15 291:12 326:20 333:8,17 <b>pulled</b> 98:18 <b>pulmonary</b> 127:6 <b>pump</b> 28:2 <b>punch</b> 320:22 <b>purchased</b> 248:10 <b>purchasers</b> 32:3	<b>purists</b> 169:2 <b>purpose</b> 167:3 179:1 299:4,21 <b>purposefully</b> 103:6 <b>purposes</b> 20:14 71:19 123:12 <b>pursued</b> 86:14 <b>purview</b> 174:19 <b>push</b> 49:20 81:20 83:13 145:9 151:21 206:9 261:19 287:9 <b>pushing</b> 322:17 <b>put</b> 22:15 60:2,20 65:18,20 66:16 72:20 79:2 89:9 89:17 107:1 109:9 112:6 122:19 142:21 149:14 152:2 167:18 178:2,20 194:6 195:2 199:11 203:1 209:5,6 213:18 221:15 229:20 244:12,18 245:21 284:10 285:20 286:14 288:2 292:17 304:11 305:15 306:11 307:19 320:8 329:21 333:11 <b>puts</b> 245:9 <b>putting</b> 72:9 89:11 141:11 159:21 203:14 210:10 281:12 286:19 328:20 334:9 <b>puzzling</b> 272:9 <b>P-R-O-C-E-E-D-...</b> 4:1 <b>p.m</b> 161:9,10 287:6 287:7 337:9	<b>quality</b> 1:1 4:20 5:1 5:4 8:8 13:4 14:12,19 15:2 16:2 18:6,16 19:1 20:13 21:5 22:17 29:18 30:2,9 32:3 33:9,20 34:1,9,15 36:3 39:10 42:9 44:1 48:15,21 49:2,16 51:19 54:2,12,14 55:21 75:5 83:5 100:13 115:6 129:12 135:8 148:16 198:19 210:13 212:8 217:6,10 229:8 247:10,16 260:1,4 261:10 270:22 274:22 275:11 277:9 281:21 283:13 290:17 305:9 306:19 308:17 309:19 311:7 312:3 313:5 315:2 315:4,6,14,15 323:12 327:17 <b>quantitative</b> 133:2 158:6 <b>quantity</b> 312:3 <b>quarter</b> 173:21 174:10 175:4 <b>quarterback</b> 208:9 <b>quarterback's</b> 208:11 <b>quarters</b> 175:5 <b>quasi-anecdotal</b> 98:5 <b>query</b> 259:17,18 260:2 261:16 <b>question</b> 87:11 88:11 128:1 129:21 130:12 132:21 168:20 184:10 189:12 191:15 199:18 208:18,20,22
---	--	---	--	---

209:2 214:17	<b>raked</b> 169:3	28:1,3,15,19 29:6	153:4,22 154:13	322:22 325:14
217:18 228:12,19	<b>ran</b> 122:10	30:10,11,16 31:22	154:14,15 156:17	326:18 327:2
229:10 260:6,20	<b>randomized</b> 308:20	32:6,9,20 33:1,13	156:22 157:9,13	330:6,9 331:6
262:11,15 272:9	<b>rare</b> 127:1	34:10,13,16,20	157:19 158:13	333:13,18 334:3
273:4 289:7 293:4	<b>rarely</b> 27:12 89:22	35:4,8 36:1,10,15	161:20 162:7	336:8,17
293:13 294:1	<b>rate</b> 10:3	36:15 37:2,5,8,10	163:9,13,19	<b>reason</b> 140:6 144:4
295:11 296:21	<b>rates</b> 255:12	37:17 38:5,17,21	165:17,20 168:1	144:21 150:14
297:2,12 304:18	<b>reach</b> 79:20 163:6	40:14,21 41:10,14	168:15 172:10	170:18 174:11
304:19 310:10	267:4	41:18 42:10,12,15	173:19 177:14	177:8 180:9
316:4,13 323:16	<b>react</b> 140:15	42:19 43:10,20,22	179:2,3 180:4	190:21 202:2
<b>questionnaire</b>	<b>reaction</b> 162:15	44:2,14 45:2,5,7	181:9 182:1,2	205:5 296:2
175:11	197:1	45:11,14,16 46:3	187:10 188:4,22	299:12
<b>questions</b> 24:16	<b>read</b> 35:4 53:7	46:3,5,7,20 47:2	189:8 190:2	<b>reasonable</b> 79:10
26:8,9 27:7,8 40:8	126:14 129:18	47:16,17,22 48:5	192:11 193:17	86:9 105:10
56:10 101:10	156:5 164:7 228:3	49:4,10,19,19	194:3 195:16	164:13 281:15
127:17 130:11	235:4	50:1,17,22 51:2	198:6 206:3,15,19	294:7 321:19
155:22 163:11,14	<b>reader</b> 103:5	51:20 52:18 53:8	208:15,16,21	<b>reasons</b> 102:8
164:12 196:20	<b>readiness</b> 118:7	53:22 54:2,7 55:2	209:1,10,13 211:3	157:16
203:6 212:3	<b>reading</b> 35:3	55:2 56:14 57:3	211:8,13,13,17,21	<b>rec</b> 105:1
286:13 292:13,14	<b>readmission</b> 79:5	59:9 61:3,13 62:1	212:19 213:7	<b>recall</b> 6:5 66:15
292:21 293:18,19	172:12 299:11	62:7,20 63:9,15	214:19 215:6,9,11	213:20
319:10 326:16	323:7,8	65:4 66:14 69:19	215:19 217:6,20	<b>receive</b> 27:5 259:1
334:17	<b>readmissions</b> 42:8	73:2,2 74:10,11	221:4 223:10	259:13 331:18
<b>quick</b> 31:11 88:10	42:17 54:19,22	75:15 77:14,18	224:7,16 225:2,4	<b>received</b> 6:5 8:21
148:6 265:1 316:4	55:1 79:2 166:21	78:2 80:5 82:5	229:9,15 230:1,18	26:17 67:16,19
327:8	230:20 254:11,12	85:4,8 87:11,11	232:8 233:9,14,17	99:22 330:2
<b>quickly</b> 34:22 40:7	297:14 298:3	92:7 93:2,7 96:12	234:21 235:21	<b>receiving</b> 129:10
67:5 99:13 167:2	301:19	98:8 100:16	237:6 238:18	256:12
251:17 285:10	<b>readmitted</b> 238:12	102:20 103:6,8	242:7,15,19	<b>recipient</b> 49:11
286:13 288:5	<b>ready</b> 144:3 316:11	104:6 106:12,18	249:21 250:3,18	261:15
305:21	332:22	107:16,21 108:17	251:5 252:5,7,10	<b>recognize</b> 206:6
<b>quite</b> 26:3,14 27:12	<b>real</b> 66:6 83:11	108:18 109:4,13	253:16 254:7,17	285:2 306:1
78:14 98:19	115:20 136:20	109:16 112:11,20	261:1 262:19	<b>recognizing</b> 35:18
206:13 227:6	149:22 227:5	112:20 118:13	264:21 265:6	184:2 285:7
265:8 317:11	228:3 252:1 270:2	121:22 122:12	266:16 268:10	<b>recommend</b> 47:1
<b>quotation</b> 169:1	271:20 276:11	123:13,14 125:4	270:11 271:18	286:6
<b>quote</b> 88:7 270:1	282:16 292:19	126:8,17 128:11	274:8 275:21	<b>recommendation</b>
<b>quoted</b> 128:13	<b>realistic</b> 228:16	129:16,19 130:2	276:1,18 277:13	63:21 119:6
<b>Q&amp;A</b> 3:18	275:18	130:20 131:15	282:5,9 285:15	253:12 312:8
	<b>reality</b> 139:10	132:8,11,15	291:12 292:20	<b>recommendations</b>
	194:8 272:19	133:21 135:17	303:3 304:21,22	97:2 130:1 141:1
<b>raise</b> 81:20 109:5	<b>realize</b> 217:13	136:1,14 137:8	305:17,21 306:4,4	141:5 228:4 237:4
126:13	274:9,16 317:13	138:20 140:4	307:11,16 310:12	315:21
<b>raised</b> 79:15	<b>realized</b> 77:13	144:9,14,22 145:8	311:18 312:4	<b>recommended</b> 34:5
<b>raises</b> 296:19,21	127:4	145:13,14,19	314:5,7,13 315:11	95:15,21 96:8
<b>raising</b> 84:7 110:22	<b>really</b> 4:8 26:4,10	146:8,12 147:5	316:2 317:1,9	<b>recommending</b>
154:21	26:20,22 27:1,14	148:9 150:3,6,21	318:4,9,18 320:15	223:18

<b>reconciled</b> 119:19	240:9 316:21	<b>reiterated</b> 290:3	107:1 246:8	163:8 331:16
<b>reconciliation</b>	<b>referrals</b> 109:16,17	<b>relate</b> 83:2 87:14	273:11	<b>requester</b> 260:2
80:20 104:10,20	129:5	148:18 212:16	<b>reminded</b> 245:15	<b>requests</b> 129:9
109:4 119:18	<b>referred</b> 65:13	263:21 290:16	<b>reminder</b> 64:6	<b>require</b> 95:3
234:19 271:4,9	260:5	297:8	<b>reminding</b> 290:6	209:16 255:21
<b>reconstruct</b> 61:16	<b>refine</b> 65:4	<b>related</b> 9:8,12	<b>reminds</b> 280:19	261:20
<b>record</b> 99:10	<b>refined</b> 229:13	18:11 19:4 68:16	<b>removed</b> 84:13,16	<b>requirement</b> 119:8
104:11,21 108:15	<b>reflect</b> 293:5,7	70:11 104:4 108:3	<b>rendition</b> 39:3	258:21
108:19 139:16	297:4	114:10 115:5	<b>reordering</b> 213:4	<b>requires</b> 202:6
161:9 183:4,6	<b>reflection</b> 228:3	123:22 132:18	<b>repeat</b> 162:19	270:15 312:6
223:8,9,10,11,21	<b>reflections</b> 286:12	166:20 167:16	292:19	<b>research</b> 6:20 8:21
256:21 284:3	<b>reflects</b> 138:8	174:5 197:9	<b>repeated</b> 261:5,6	16:18,21 86:7
287:6 337:9	166:9	201:14 227:21	<b>replicating</b> 86:6	107:10 140:5
<b>recorded</b> 239:10	<b>reform</b> 35:20 93:19	252:16 288:15	<b>report</b> 33:6 46:15	264:15 306:19
<b>recordings</b> 120:8	248:9	292:14 297:13	47:4 63:3,4,16,18	315:9 317:10
<b>records</b> 10:7 51:6	<b>reframe</b> 59:5 164:4	300:4 307:18	68:2,5,13 96:5,11	<b>researcher</b> 23:18
108:19 116:16	165:21 249:4	328:7	100:17 140:12,13	100:5
117:9 132:17	<b>refuse</b> 283:3	<b>relates</b> 98:2 238:11	149:1 168:6	<b>researchers</b> 315:12
149:13 150:2	<b>regard</b> 86:14	263:12	202:15 253:11	315:22
152:5 153:19	227:13	<b>relationship</b> 25:11	299:19 303:6	<b>research-friendly</b>
157:12 175:9	<b>regarding</b> 24:17	93:9 118:11	311:17	315:9
232:7 253:14	121:2 324:14	148:19 239:19	<b>reported</b> 47:3	<b>resend</b> 289:14
<b>record-based</b>	<b>regardless</b> 171:6	240:19	51:15 192:5	<b>resentful</b> 281:19
193:14	<b>region</b> 135:1	<b>relative</b> 89:19	<b>reporting</b> 20:17,21	<b>resident</b> 5:10 166:3
<b>recount</b> 6:10	<b>regional</b> 130:8	169:8 307:15	35:11 63:7 83:1	<b>resistance</b> 146:8
<b>red</b> 179:6	154:11,12	328:3	197:15 300:3	147:1 153:13
<b>redefine</b> 164:4	<b>registering</b> 226:22	<b>relatively</b> 36:19	314:2	<b>resistant</b> 153:12
<b>redesign</b> 154:17	<b>registry</b> 110:6	250:21	<b>reports</b> 47:5	154:4
155:2 223:19	157:2	<b>release</b> 34:8	129:10 337:4	<b>resonate</b> 45:7
<b>redid</b> 198:11	<b>regular</b> 255:19	<b>released</b> 33:6,21	<b>repository</b> 22:4	<b>resource</b> 12:7
<b>reduce</b> 10:3 251:21	<b>regulation</b> 105:20	34:2	260:7	230:14 252:7,14
251:22 254:11	<b>rehab</b> 94:16 138:4	<b>relevant</b> 6:15,18,21	<b>repost</b> 333:12	271:15 288:13
264:2	186:22 209:22	8:12 9:7 23:2	<b>represent</b> 7:18,19	290:22 323:10
<b>reduced</b> 137:5	283:16	68:22 168:12	20:10 21:4	<b>resources</b> 11:10
264:6	<b>rehospitalization</b>	179:8 185:20	<b>representation</b>	50:5 92:1 94:16
<b>reduces</b> 230:14	16:6 192:7 276:3	270:5 320:20	32:5 278:20	115:16 116:6
254:11	276:5 277:18	<b>remember</b> 66:22	<b>representative</b>	127:4 154:12,13
<b>reduction</b> 230:19	<b>rehospitalized</b>	89:13 104:7	128:10 300:6	181:17 183:22
248:15	276:8	130:19 154:6	<b>representatives</b>	190:17 195:19
<b>reevaluation</b> 83:21	<b>reimbursement</b>	155:1 177:11	32:14	239:2 242:13
<b>refer</b> 76:7 111:18	21:14 94:12 145:5	190:6 218:7	<b>represented</b> 133:15	246:18 249:6
<b>reference</b> 123:21	248:5	222:14 280:19	<b>representing</b> 7:16	252:9 281:5 284:8
266:16	<b>reimbursements</b>	303:5 306:16	7:21	288:21
<b>referral</b> 22:6 73:20	94:11	313:11 314:16	<b>reproducible</b>	<b>respect</b> 189:2 195:8
74:21 119:1	<b>reinforce</b> 42:15	<b>remembered</b> 289:6	135:22	<b>respond</b> 156:18
129:17 130:1	<b>reiterate</b> 77:10	<b>remind</b> 7:11,13	<b>request</b> 61:10	224:2 261:16
195:12 239:8	256:11	26:18 76:3 99:19	89:10 129:17	286:20 334:22

<p><b>responded</b> 274:20  <b>responding</b> 331:14  <b>responds</b> 253:21  <b>response</b> 6:13  27:19 130:11  172:5,5 285:13  327:9 331:16  <b>responses</b> 158:3  <b>responsibilities</b>  9:19 22:2 151:6  <b>responsibility</b>  12:13,15 118:8  149:8 189:9  <b>responsible</b> 11:19  14:12 91:7 124:15  282:22  <b>rest</b> 4:13 88:16  159:3 163:17  271:13 276:18  287:10 291:19  <b>result</b> 109:10,11  259:21 329:21  <b>resulted</b> 68:4 308:7  <b>results</b> 197:15  226:4 264:3  279:11 317:21  327:13  <b>resumed</b> 99:10  161:9 287:6  <b>rethink</b> 59:5  <b>retire</b> 154:2  <b>retired</b> 277:15  <b>retool</b> 198:8 206:21  <b>retooled</b> 197:21  <b>retooling</b> 197:10  198:16 206:18  218:2  <b>return</b> 230:19  248:16 271:14  291:16  <b>returned</b> 260:1  <b>reveal</b> 19:13  <b>review</b> 3:4 64:10  68:17 102:2,3  107:11 108:6  133:19 159:16  161:12 164:3</p>	<p>167:6 169:1 170:1  170:1 175:12  176:2 194:2 202:1  214:21 215:6,9  279:10 329:19  <b>reviewed</b> 6:7 84:15  84:16 161:14  167:18  <b>reviewer</b> 23:3  <b>reviewing</b> 67:1  214:20 326:14  <b>revise</b> 59:5  <b>revised</b> 334:15  <b>revisit</b> 68:10  <b>revolutionize</b>  258:10  <b>rework</b> 122:22  <b>re-framing</b> 78:10  <b>re-map</b> 179:15  <b>rich</b> 98:17 252:22  <b>Richard</b> 324:15  <b>right</b> 16:10 24:10  34:16 50:1 52:17  80:15 81:3 82:4  84:16 92:22 98:22  100:10 106:5  110:15,18 113:22  114:22 115:18  116:2,14 117:1,1  120:9 121:8,21,21  125:10 138:13,17  139:9 140:19  145:12 151:8,8,15  151:17 152:1,2,3  153:20 154:9  158:14 166:3  172:18 177:11  181:12,15 183:3  183:14 184:17  185:18 188:20  192:16 193:1,12  193:18 196:21  197:8,19 203:4  208:6,11 216:6,10  219:15 222:22  230:11 249:11,14  255:15 256:1</p>	<p>257:2 262:11  269:13 279:9  280:20,21,21,21  281:2 285:8  289:18 295:1  301:11 302:6  310:11 314:10  320:6 321:16,21  322:5,10,11  325:17 326:5  332:20  <b>RIOs</b> 130:9  <b>risk</b> 69:7,17,20  87:17 115:15  126:21 127:5,7,14  140:18 211:18  231:21 241:6  244:9 252:14  264:2,7 278:16  291:1 294:1,5  295:12,13 296:6,7  296:8,9,11,14,17  296:22 298:3,6,11  298:16,18,19,20  299:1,11 301:22  303:14 318:11  325:18  <b>risks</b> 264:7 312:12  312:17  <b>risk-adjust</b> 298:8  <b>risk-adjusted</b>  297:6 300:2  324:10  <b>risk-adjusting</b>  294:10  <b>risk-specific</b>  278:10 301:17  <b>risk-stratify</b> 294:17  294:22  <b>risk-stratifying</b>  294:11 295:4  <b>RN</b> 1:13,13 2:4,6  2:12 3:11  <b>road</b> 81:5 281:15  <b>roadblock</b> 144:15  <b>roadmap</b> 62:20  <b>robust</b> 27:19</p>	<p><b>role</b> 12:13,17 18:14  74:12 126:15  150:13 257:21,22  260:21 285:11  <b>roles</b> 124:15 159:17  <b>roll</b> 240:7 271:1  <b>rolled</b> 201:13  240:13  <b>rolling</b> 52:2,3  208:20  <b>roof's</b> 220:12  <b>room</b> 5:13 48:6  58:19 61:20 66:2  99:18 103:16  133:15 162:3,8  163:1 166:12  168:9 169:3  188:16 196:10  212:15 234:7  246:17 266:22  313:10  <b>root</b> 251:6  <b>rose</b> 288:6  <b>Rosof</b> 32:16  <b>roster</b> 257:19  <b>round</b> 58:2 162:15  196:21 282:12  313:18 314:22  329:3  <b>rowing</b> 33:16 54:4  <b>RPh</b> 1:18  <b>rudimentary</b> 51:22  53:18  <b>rule</b> 78:18 93:17  <b>ruled</b> 134:4  <b>rules</b> 62:11  <b>run</b> 318:11  <b>running</b> 113:18  <b>runs</b> 211:18  <b>rural</b> 12:19 16:19  143:18  <b>Russ</b> 291:1,3  <b>Russell</b> 1:25 11:16  18:20 265:18  279:22 280:14  281:9</p>	<p style="text-align: center;"><b>S</b></p> <p><b>sad</b> 53:8  <b>sadly</b> 267:11  <b>safe</b> 44:19 293:20  <b>safety</b> 37:1 42:3,10  43:4 54:19 229:8  242:4 276:15  290:4  <b>salt</b> 189:6  <b>salvage</b> 268:13,19  <b>Samal</b> 2:22 3:13  23:16,16 99:14,16  100:3,4 105:2  111:5,13 112:1,5  112:8,17 113:1,17  114:4,14 115:7,18  116:2,7,14 117:1  117:7,18 118:9  119:10,14,22  120:9,20 121:8,16  121:21 124:1  125:3,16 126:10  127:15 132:13  133:11,17 136:4,8  136:17 137:11,19  138:13,17 142:10  142:18 143:3,21  144:16,20 145:21  147:17 148:1,17  149:10,18 150:7  151:8,17 152:1  153:9,16,20 154:9  155:12,15,21  156:3 159:5,9  160:4  <b>SAMHSA</b> 54:21  89:8  <b>SAMHSA's</b> 54:10  <b>San</b> 242:5  <b>SARAH</b> 2:19  <b>sat</b> 9:11 35:22  59:20  <b>satisfaction</b> 135:9  238:11 247:15  <b>save</b> 230:18  <b>savings</b> 248:15  274:21</p>
---	---	--	--	---

<b>saw</b> 24:7 73:19 97:4 120:9 202:10 202:13 326:22	83:16 166:22 171:14 176:3 222:12	114:14 115:7 126:2 127:11 132:15 138:18	<b>send</b> 112:3 129:17 245:4 260:16 287:22 330:17 331:9,19 332:3 333:12 334:13,14	16:17 41:1,18 64:12 115:20,20 117:14 214:4 230:11 245:20 281:5
<b>saying</b> 65:2 77:10 78:16 82:7 83:15 84:14 85:17 93:9 102:18 104:16 106:8 111:14 114:15,16,17 115:8 116:15 136:19 137:6 139:18 145:3,8 156:22 163:18 208:14 217:5 232:10 242:10 246:22 249:18 250:1 311:7 313:6 322:1 326:2,5,10	<b>score</b> 231:10,21 240:8 <b>scratch</b> 65:3 <b>scratching</b> 76:5 <b>screening</b> 127:10 171:22 172:2 247:17 <b>SDM</b> 327:21 <b>se</b> 93:3 216:16 <b>sea</b> 116:5 <b>search</b> 169:21 171:7 <b>Seattle</b> 19:21 <b>sec</b> 222:17 <b>second</b> 30:11 61:6 108:22 123:7 152:6 156:21 184:9 220:18 247:21 268:9 278:5 279:14 283:10 335:7	152:4 156:3 159:14 160:22 166:13 177:1 179:18 180:21 182:7,13 184:16 186:8 187:22 189:3,4,16 190:8 193:19 198:22 199:19 200:16,21 207:13 208:5,7 216:1,12 226:1 231:17 233:13 238:22 243:11,12 275:10,14 283:20 286:11 304:16 305:12 313:5 315:7,8 329:5,17 332:4,18 333:22 334:1,12	<b>sense</b> 29:22 60:5 95:12 115:10 117:18 118:6 125:3,17 128:9 138:18 141:13,17 143:3 145:21 148:2,4 150:7,8 151:18 178:21 179:11 197:18 227:5 297:19 308:4 323:4 <b>sensitive</b> 297:15 309:21 <b>sensitivity</b> 57:8 88:3,8 <b>sent</b> 63:20 71:20 214:21 259:19 316:6 <b>sentence</b> 104:9 <b>sentiments</b> 60:17 <b>separate</b> 88:21 129:2 141:12 187:11 194:7 319:10 <b>separating</b> 95:9 <b>sequencing</b> 280:16 281:2,7 <b>sequential</b> 194:22 <b>series</b> 12:16 <b>seriously</b> 98:8 304:6 <b>serve</b> 7:14,20 18:16 19:5 165:20 199:8 <b>served</b> 8:12 <b>serves</b> 22:20 159:16 <b>services</b> 10:14 13:6	<b>session</b> 18:20 <b>session</b> 25:8,8 26:3 26:3,14 <b>set</b> 26:5 27:15 28:19 31:7 46:2 55:18 59:15 61:6 68:5 69:9 81:5 103:4,20 104:10 104:15,19 105:15 106:17 122:6 128:6 135:20 137:13 181:10 191:16 206:11 234:14 236:22 261:2 265:13 268:9 270:5 304:19 315:20 321:7 329:2 330:16 <b>sets</b> 34:22 <b>setting</b> 3:19 58:17 59:6,10 60:13 102:18 130:13,14 131:18,22 133:22 154:8 171:19 181:4,12 195:9,11 195:13,14 202:11 226:17 231:8 255:3 267:18 279:5 324:1 <b>settings</b> 48:17 71:10,13 107:5 123:17 131:6 157:6 181:2 190:15 233:21,22 234:1 <b>seven</b> 13:2 317:21 <b>severely</b> 94:1,7 <b>severity</b> 301:20 <b>sexual</b> 283:18 <b>shape</b> 26:10,21 314:21
<b>says</b> 83:14 84:22 228:22 304:1 318:21 <b>scale</b> 221:9 <b>scan</b> 3:15 26:1 27:3 167:3 168:3 184:3 216:5 <b>scanning</b> 129:11 <b>scary</b> 179:3 <b>scenario</b> 90:9 <b>Schamp</b> 324:16 <b>schedule</b> 27:7 155:19 275:10 <b>scheduled</b> 329:14 335:13 <b>schedules</b> 25:2 <b>scheduling</b> 129:2,5 <b>scheme</b> 242:17 <b>school</b> 2:4 15:8 16:22 17:22 19:9 275:21 <b>science</b> 229:22 230:3 301:8 315:4 315:14 <b>scientific</b> 107:22 113:3 <b>SCIP</b> 84:21,22 <b>scoop</b> 136:13 <b>scope</b> 32:8 74:4	<b>secondary</b> 283:11 <b>section</b> 102:21 103:2 105:22 106:4 114:3,11 127:18 137:22 158:1 283:2 <b>sections</b> 103:15 <b>sector</b> 20:11 33:15 55:5 <b>secure</b> 117:3 258:14,16 260:16 <b>see</b> 15:13 26:12 27:14 32:14 34:1 37:4 38:12 39:9 39:13,16 40:2 41:5,15 43:13 47:16 50:11,15 51:2 54:7,20 55:3 55:4,11 56:3 57:3 67:3,17 70:19 71:16 74:1 76:12 76:19 91:15 92:5 93:11 96:6 104:18	<b>seeing</b> 46:11 73:21 175:21 186:4 319:20 337:5 <b>seek</b> 250:14 <b>seen</b> 54:8 73:22 96:20 120:11 261:6 296:4 298:2 311:16 316:13 <b>sees</b> 309:8 <b>segment</b> 69:12 <b>segmentation</b> 199:6 278:18 <b>segments</b> 278:21 <b>select</b> 229:1 <b>selected</b> 257:6 <b>selecting</b> 41:4 <b>selection</b> 229:2 <b>self</b> 227:22 <b>self-assessment</b> 180:17 232:22 <b>self-care</b> 282:2,5 <b>self-management</b> 158:9 227:13 <b>sell</b> 248:8,13 <b>semantic</b> 191:19	<b>send</b> 112:3 129:17 245:4 260:16 287:22 330:17 331:9,19 332:3 333:12 334:13,14 <b>sending</b> 126:21 129:9 260:5,6 285:12 330:11 <b>senior</b> 2:16,19,21 4:16,19 5:3 14:2 <b>sense</b> 29:22 60:5 95:12 115:10 117:18 118:6 125:3,17 128:9 138:18 141:13,17 143:3 145:21 148:2,4 150:7,8 151:18 178:21 179:11 197:18 227:5 297:19 308:4 323:4 <b>sensitive</b> 297:15 309:21 <b>sensitivity</b> 57:8 88:3,8 <b>sent</b> 63:20 71:20 214:21 259:19 316:6 <b>sentence</b> 104:9 <b>sentiments</b> 60:17 <b>separate</b> 88:21 129:2 141:12 187:11 194:7 319:10 <b>separating</b> 95:9 <b>sequencing</b> 280:16 281:2,7 <b>sequential</b> 194:22 <b>series</b> 12:16 <b>seriously</b> 98:8 304:6 <b>serve</b> 7:14,20 18:16 19:5 165:20 199:8 <b>served</b> 8:12 <b>serves</b> 22:20 159:16 <b>services</b> 10:14 13:6	16:17 41:1,18 64:12 115:20,20 117:14 214:4 230:11 245:20 281:5 <b>servicing</b> 18:20 <b>session</b> 25:8,8 26:3 26:3,14 <b>set</b> 26:5 27:15 28:19 31:7 46:2 55:18 59:15 61:6 68:5 69:9 81:5 103:4,20 104:10 104:15,19 105:15 106:17 122:6 128:6 135:20 137:13 181:10 191:16 206:11 234:14 236:22 261:2 265:13 268:9 270:5 304:19 315:20 321:7 329:2 330:16 <b>sets</b> 34:22 <b>setting</b> 3:19 58:17 59:6,10 60:13 102:18 130:13,14 131:18,22 133:22 154:8 171:19 181:4,12 195:9,11 195:13,14 202:11 226:17 231:8 255:3 267:18 279:5 324:1 <b>settings</b> 48:17 71:10,13 107:5 123:17 131:6 157:6 181:2 190:15 233:21,22 234:1 <b>seven</b> 13:2 317:21 <b>severely</b> 94:1,7 <b>severity</b> 301:20 <b>sexual</b> 283:18 <b>shape</b> 26:10,21 314:21

<b>share</b> 132:5 144:7 279:15 283:5 284:9 303:7 311:18 333:21	<b>sign</b> 260:13,15 <b>signal</b> 28:20 316:6 318:3 <b>signals</b> 33:4 54:8	178:16 179:1,19 182:3 185:3,9 186:6 187:17 189:10 191:5 193:3 194:4 195:4 331:11	184:14 193:20 199:15 202:4,9,11 218:16 239:17 285:6,10 320:10 321:8 325:1	241:6 243:5 247:15,17 252:3 261:10 284:9 287:13 288:5 290:15,19 292:3 294:12 295:20 298:15 301:11 308:6,10 312:2,17 314:11 316:17 317:22 327:16 330:18
<b>shared</b> 33:1 44:22 48:4 49:21 90:19 102:5 124:21 144:9 189:8 223:16 326:8	<b>significant</b> 18:14 56:22 277:5 316:15 321:15 <b>significantly</b> 312:11,16	<b>slides</b> 42:4 60:14 62:22 101:4 107:7 155:17 162:14 189:5	<b>somebody's</b> 142:20 240:14 262:16 <b>someone's</b> 141:15 <b>somewhat</b> 59:1 88:21 108:9 324:13	<b>sorting</b> 244:7 <b>sorts</b> 80:21 127:1 <b>sound</b> 160:16 330:13 <b>sounds</b> 86:9 319:4 324:22 <b>source</b> 111:2 113:2 171:6 203:11 <b>sources</b> 111:14 131:4 163:2 169:4 170:7 174:21 175:3 202:6,9 209:17 241:9,14
<b>SharePoint</b> 330:4,5 332:2	<b>signs</b> 285:1 <b>siloed</b> 231:12	<b>slight</b> 262:18 <b>slightly</b> 75:3 175:17 180:2	<b>soon</b> 31:18 207:21 234:4 327:7 331:21 332:20,22	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7
<b>sharing</b> 144:11 231:11	<b>similar</b> 80:8 124:8 <b>Similarly</b> 181:15	<b>sliver</b> 177:16 192:22	<b>sorry</b> 5:20 31:4 61:1 120:22 137:17,19 152:4 173:1 188:3 217:9 313:8 332:13	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>sharp</b> 300:1 <b>SHEILA</b> 2:17	<b>simple</b> 144:1 228:8 <b>simplified</b> 274:8 <b>simplistic</b> 274:4	<b>slivers</b> 184:22 <b>slowly</b> 136:13 139:9	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>sound</b> 160:16 330:13 <b>sounds</b> 86:9 319:4 324:22 <b>source</b> 111:2 113:2 171:6 203:11 <b>sources</b> 111:14 131:4 163:2 169:4 170:7 174:21 175:3 202:6,9 209:17 241:9,14
<b>shelf</b> 141:11	<b>simply</b> 170:21 194:13	<b>small</b> 52:3 85:21 106:17 112:13 175:13 177:16 183:15 184:22 185:7 192:22 210:6 252:2 275:4	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>shelter</b> 138:3 222:8	<b>single</b> 172:4 302:19	<b>slowly</b> 136:13 139:9	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>source</b> 111:2 113:2 171:6 203:11 <b>sources</b> 111:14 131:4 163:2 169:4 170:7 174:21 175:3 202:6,9 209:17 241:9,14
<b>shoot</b> 106:7 224:1	<b>sit</b> 7:17 16:13 17:22 249:4	<b>smart</b> 244:8 <b>smear</b> 90:13 <b>smoking</b> 84:16,19	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>shooting</b> 36:12	<b>site</b> 111:19 112:7 330:10 332:2	<b>sniff</b> 310:13 <b>snuck</b> 49:7	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>shop</b> 143:18	<b>sites</b> 64:14	<b>social</b> 115:20 214:4 230:11 266:4 267:16 274:1 283:15	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>short</b> 80:13,14 141:8 221:7 265:16,17	<b>sitting</b> 284:13	<b>society</b> 19:15	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>shortly</b> 27:16 28:8	<b>situation</b> 156:13 283:22	<b>socioeconomic</b> 231:20 301:21	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>shots</b> 220:13	<b>six</b> 33:7 36:2 172:21 277:21	<b>software</b> 10:7 244:10	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>show</b> 53:9 86:8 165:1 166:13 169:7 182:16 184:3 248:14	<b>skilled</b> 270:9	<b>solely</b> 121:5	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>showed</b> 56:19 276:4	<b>sky</b> 224:1	<b>solo</b> 244:14	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33:17 240:18 282:1 <b>speakers</b> 6:19 23:19 <b>speaker's</b> 223:3 <b>speaking</b> 13:17 21:12 89:14 133:8 250:21 263:8 <b>speaks</b> 94:21 134:16 284:17 <b>spec</b> 317:4 <b>special</b> 15:10 88:12 98:15 127:13 190:5 <b>specialist</b> 109:21 109:22 129:21
<b>showing</b> 182:12 298:3	<b>sleeping</b> 280:12	<b>solution</b> 147:6 148:3	<b>sort</b> 27:13 28:1 29:19 30:1,13 33:5,16 34:6 35:5 36:5,9,11 39:16 42:4 44:9 45:18 45:21 46:10 47:17 48:9,12 49:7 50:15 51:3,17 52:16 53:2,22 54:1 55:10,11,18 56:5 60:18,22 61:13 73:11 75:5 79:10 80:9 86:13 87:13 89:1,2 98:5 98:18 106:16 107:5 135:8,17 136:10 137:3,4 140:4 153:13,22 156:18 157:22 161:13 165:8 175:5 202:10 206:11 207:2 208:2 210:19 212:12 213:21 219:22 223:22 228:17 230:21,22 231:8,21 233:2 234:8 237:2 240:7	<b>so-and-so</b> 74:2 <b>space</b> 246:5 269:16 290:6 <b>spaces</b> 51:11 <b>spades</b> 57:15 <b>span</b> 37:19 264:1 <b>spare</b> 35:2 <b>speak</b> 33

131:21 202:13 239:9 258:2 266:12 <b>specialists</b> 73:21 245:1,3 247:5 <b>specialties</b> 8:20 147:2 290:14 <b>specialty</b> 75:3 181:7 251:1 <b>specific</b> 39:1 61:5 73:20 91:5 112:19 123:12,21 171:18 172:9 190:4,4,9 210:2,2,21 211:2 211:5 234:3 237:8 237:11 253:3 266:1 269:4 278:9 278:14,15 292:19 300:19 301:2 305:2 306:3 307:3 322:2,4 <b>specifically</b> 18:15 19:4 58:3 70:22 77:1 249:22 260:20 262:12 265:15 298:2 329:2,20 <b>specification</b> 26:11 191:14 <b>specifications</b> 173:12 <b>specificity</b> 305:7 333:10 <b>specifics</b> 34:11 40:8 234:3 283:6 <b>specified</b> 176:9 191:9 <b>specify</b> 176:12 <b>spectrum</b> 106:21 170:15 185:16 192:20 194:4 241:2 <b>speech</b> 121:19 <b>speed</b> 232:14 <b>spend</b> 103:8,11 197:2 334:3 <b>spending</b> 281:16,20	281:21 <b>spent</b> 11:20 44:2 64:1 148:12 234:7 249:11 259:16 275:6 <b>spoke</b> 281:9 289:17 290:4,15,17 <b>spokes</b> 239:5 <b>spot</b> 230:16 <b>spots</b> 18:12 <b>ST</b> 308:15 <b>staff</b> 2:15 155:9,11 292:17 293:6 <b>stage</b> 60:5 68:5 81:21 90:20 95:13 97:21 103:5 104:9 104:16 105:15 159:13 218:6,22 218:22 258:22 303:16 <b>stages</b> 11:14 59:8 93:8 287:3 <b>standard</b> 53:4 142:20 203:2 212:21 238:20 239:3 248:20 254:6 258:19 290:10 <b>standardization</b> 90:14 198:17 <b>standardize</b> 89:22 <b>standardized</b> 87:14 90:1 313:20 321:10 322:13 <b>standards</b> 12:2 20:21 30:12 119:4 120:4,7 139:7,10 142:9 143:8,10,11 201:11,12,16 202:7,19 207:5 213:10 259:18 267:14 318:7 319:4 <b>standpoint</b> 144:7 245:17 271:16,17 <b>stand-alones</b> 79:8 <b>Stanford</b> 262:22	291:7 <b>star</b> 53:2 <b>start</b> 5:16 8:2 26:9 45:11 54:7 59:17 65:3 70:17 78:9 96:20 97:9,17 100:2 123:14 126:18 132:9 160:1 166:7,9 168:1 173:17,19 175:7,21 178:4 180:21 182:12 186:2,4,14 187:1 187:21 209:13 210:16 213:1 216:17 219:16 266:21 277:20 326:14 333:16 <b>started</b> 4:13 23:13 30:4 58:17,22 76:10 82:2 98:4 105:4 161:13 171:11 193:9 213:14,22 301:8 310:20 <b>starting</b> 50:9 55:6 55:12 66:14 71:8 141:11 233:8 234:16,17 283:7 317:2 <b>starts</b> 175:18 182:16 184:1 185:11 186:5 191:2 195:17 <b>state</b> 1:25 9:5 11:17 16:5 17:19 20:22 44:12 52:12 94:4 116:12 128:15 134:19 164:5 230:9 256:17 259:7 295:8 310:1 <b>stated</b> 227:18 233:17 <b>statement</b> 191:12 227:3 230:1 294:8 322:16 <b>statements</b> 230:3	<b>states</b> 16:8 20:11 20:18 38:21 52:19 111:21 119:6 <b>statewide</b> 21:21 111:3 <b>state-based</b> 32:10 <b>statistical</b> 292:4 <b>statisticians</b> 274:11 274:13 <b>status</b> 210:13 303:15 <b>stay</b> 69:17 75:2 132:9 164:19 <b>stayed</b> 280:13 <b>steering</b> 1:3,8 4:5 31:1 50:14 55:19 57:14 59:18,20 65:14,15 66:9 70:5 77:9 101:17 171:15 245:16 312:8 <b>stem</b> 52:18 <b>step</b> 34:15 59:3 86:11 91:5 122:3 122:21 141:6 208:1 292:21 317:22 <b>steps</b> 3:22 85:10,21 86:9 272:1,5 327:7 329:7 331:12 <b>Steve</b> 16:11 232:10 <b>stewards</b> 198:22 <b>stick</b> 306:4 <b>sticking</b> 46:1 107:5 <b>stimulated</b> 262:18 <b>stone</b> 60:3 <b>stop</b> 46:19 56:7 110:16 130:7 245:12 266:12 <b>stored</b> 141:21 <b>stories</b> 155:7 <b>story</b> 126:18 223:7 223:11,15 254:19 <b>straightforward</b> 285:6 330:19 <b>strategic</b> 34:12	<b>strategies</b> 34:22 62:4 83:2 98:6 248:6 <b>strategy</b> 29:18 30:2 33:10,14,21 34:2 34:9,15 35:9 36:3 39:10 41:16 42:9 44:1 48:21 49:2 51:19 54:2,13,14 55:21 75:6 163:6 182:15 <b>stratification</b> 140:18 244:10 294:2 295:13 296:11,15 298:11 <b>stratify</b> 226:3,8 271:8 303:14 <b>stratifying</b> 298:13 <b>street</b> 220:14 <b>strength</b> 264:8 <b>strengths</b> 63:21 <b>stress</b> 301:16 302:2 <b>stretch</b> 87:2 <b>strictly</b> 10:4 <b>striking</b> 36:8 <b>strive</b> 87:3 <b>stroke</b> 179:20 <b>strong</b> 7:10 22:21 42:22 <b>strong-willed</b> 72:14 <b>struck</b> 199:20 209:4 215:1 319:7 <b>structural</b> 19:1 114:8 204:10,13 213:7 <b>structure</b> 86:8 114:17 126:8 142:13 183:3,11 213:5 214:7,20 240:3 245:10 256:9 269:19 272:19 320:9,17 329:2 <b>structured</b> 171:21 227:7 312:21 <b>structures</b> 178:18 <b>structure-proces...</b>
--	--	---	---	--



114:18	249:2 255:8	145:13,15 151:21	190:1 197:6	108:6 133:19
<b>structure/proces...</b>	323:17 324:9	153:3 158:4	<b>survey</b> 128:12	167:6
215:14	<b>successful</b> 116:4	166:18 198:15	130:8,10 193:21	<b>systems</b> 3:12 62:5
<b>struggle</b> 71:16	150:19 151:5	207:14 217:7	196:1,5	67:12 81:5 87:1
82:13 224:9	155:7 234:15	223:16 248:6	<b>surveyed</b> 130:15,21	96:1 101:18 107:6
<b>struggled</b> 72:16	255:13 321:20	285:9 288:11	<b>surveys</b> 22:16	108:13 119:13
87:12 91:17	<b>sufficient</b> 93:11	300:9 316:18	47:21 102:2 171:9	130:4 135:15
<b>stuck</b> 307:13 313:7	313:21	<b>supported</b> 74:19	176:1 177:12	136:10,15 137:12
<b>studies</b> 134:8	<b>sufficiently</b> 235:8	<b>supporting</b> 199:1	180:10 192:17	139:12,16 141:22
<b>study</b> 15:3 134:4	313:21	317:14	193:7 238:5	146:9 154:6 172:8
252:20 254:8	<b>suggest</b> 81:11	<b>supportive</b> 77:3	<b>Survey-based</b>	180:1 183:1,8
274:15 276:4	145:12 149:4	<b>supports</b> 35:11,20	175:10	194:6 203:20
<b>stuff</b> 91:9 120:11	295:22 326:14	40:18 50:5 114:7	<b>survival</b> 308:17	205:3 206:7,16
164:6 165:15	<b>suggested</b> 163:1	145:16 225:12	<b>suspect</b> 206:10	207:8,10 208:3
217:10 235:3,4	<b>suggesting</b> 282:4	327:21	<b>Suzanne</b> 1:23 2:20	258:15,16,21
242:8 269:7	<b>suggestion</b> 89:18	<b>supposed</b> 155:3	4:22 14:18 288:2	260:13 273:16,21
276:17 292:9	267:6	<b>sure</b> 30:16,20,21	291:20 310:2	273:22,22 274:1,1
301:22 319:13,18	<b>suggestions</b> 107:12	32:4,9 35:5 37:10	<b>Swedish</b> 172:9	276:15 285:4,9
<b>subcategories</b>	<b>suited</b> 194:21	37:18 38:1,8	<b>sweep</b> 78:5	317:17 318:2
186:14 187:22	206:12	40:15 41:20 43:10	<b>sweet</b> 230:16	<b>S&amp;I</b> 18:21 118:17
<b>subcommittee</b>	<b>summaries</b> 107:20	49:8 55:14,18	<b>symptom</b> 282:1,5	259:3
40:14 45:17 54:17	108:8,10 121:2	58:4 64:14 75:17	<b>symptomatic</b>	<b>S-A-M-A-L</b> 158:20
<b>subgroups</b> 78:3	126:20,22 277:15	75:20 80:13,19	201:15	<b>S-9</b> 291:5
<b>subject</b> 85:20 173:8	<b>summarize</b> 6:13	82:16 83:16	<b>synch</b> 317:11	
235:9 244:16	60:19	101:12 109:19	<b>syntax</b> 321:18	
<b>subjective</b> 108:9	<b>summarized</b>	114:16 127:14	<b>system</b> 1:20 2:2	<b>T</b>
<b>submission</b> 61:10	291:10	129:20 134:15	10:16 11:3 13:14	<b>table</b> 72:14 74:5,6
333:15,22 335:17	<b>summarizes</b> 9:1	136:6 147:19	20:1 32:8 35:20	75:1 80:5 160:11
335:18	<b>summary</b> 104:11	151:6 162:2,8	38:8,15 50:4 86:1	162:15 196:21
<b>submit</b> 163:18	104:20 108:16	164:9,20 165:2	109:9 129:1,2	201:2 219:9
182:16 192:13,14	119:2 121:3,7,12	171:16 193:16	132:7 133:4 134:2	282:12 285:20
333:17	121:15 122:13,15	196:19 198:11	136:12,14 139:13	319:14 329:4
<b>submitted</b> 63:19	130:18 138:9	199:11 201:9	139:19,20,22	<b>tabled</b> 74:6
70:20 95:14 96:7	165:8 254:16	204:2 206:5	141:16 145:14	<b>tackled</b> 43:11
<b>subsequent</b> 167:8	260:18 266:14	208:22 212:9	146:11 150:17	<b>take</b> 6:11 27:21
<b>subservient</b> 65:15	<b>summer</b> 31:19	216:14 221:1,10	151:2,20 168:22	29:10 35:1 37:6,8
<b>subset</b> 210:6	276:4 317:14	234:3 242:1 246:6	176:18,19 178:16	59:8 68:14 72:12
<b>subsets</b> 213:13	<b>sundry</b> 90:3 122:9	254:21 280:12	203:12 204:9,13	81:12 89:6 95:16
240:17	<b>supervised</b> 226:16	292:5 304:22	206:22 217:2	100:1 101:1 103:3
<b>Subspecialties</b>	<b>supply</b> 221:7	309:7 313:6 316:2	220:21 230:5	110:7 118:7 122:3
241:16	<b>supplying</b> 328:18	317:4 321:4	232:17,18,21	122:20 127:2
<b>sub-activities</b>	<b>support</b> 3:12 6:20	<b>surely</b> 295:10	242:6 245:10	131:9 132:4,5
194:16	18:15 30:19 35:8	<b>surgeon</b> 245:5	247:8 259:14,19	133:21 143:19
<b>sub-bullets</b> 108:3	47:14 60:6 92:18	<b>surgery</b> 84:20	267:22 268:14	144:2 146:18
<b>sub-plan</b> 125:2	109:2,14 110:14	<b>surprised</b> 320:16	288:20 296:5,10	160:10 164:10
<b>succeed</b> 314:21	114:6 131:17	<b>surprising</b> 28:10	307:5	175:2 185:5,17
<b>success</b> 36:20 214:2	140:7,10 145:11	177:8 189:16	<b>systematic</b> 107:11	189:6 192:21
				195:1 209:7

219:7 242:20	103:14 104:1,7,8	259:9 270:15	71:17 73:7 81:10	<b>thanks</b> 12:8 24:20
272:1,5 279:14	105:8,12 106:20	271:14 275:13,14	91:22 92:3 94:6	25:2 89:17 99:7
281:15 285:8	107:2,3 110:5	275:16 282:19	95:16 96:3 97:7	208:13 224:5
286:8,22 292:2	120:16 121:10	305:3	98:12 114:12	268:21 305:20
297:17 302:15	126:2,4,9 132:20	<b>teams</b> 125:5	115:11 118:15	<b>Thanksgiving</b>
311:14 327:22	137:15 140:19	<b>tease</b> 45:18 211:22	120:16 124:9	334:22
330:9	141:14,19 144:8	<b>tech</b> 117:16	163:8,18,20 169:9	<b>Theberge</b> 2:20 4:21
<b>takeaway</b> 177:5	145:19 150:9	<b>technical</b> 8:13	176:7 179:17	4:22
<b>taken</b> 82:10 123:11	153:21 154:20	12:18 62:9 65:13	191:14 197:14,16	<b>theme</b> 218:1
146:3 210:21	162:16 165:22	139:3,11 143:6	205:2 212:10,20	226:12
223:8 224:20	174:13 181:21	146:4 147:6	213:22 218:1	<b>themes</b> 168:15
251:10 300:11	198:18 212:17	<b>technically</b> 116:9	221:22 225:3	189:1 288:5
<b>takes</b> 14:7	229:3 230:8 231:5	<b>techniques</b> 227:10	244:19 247:4,14	289:13
<b>talk</b> 7:1 25:10,22	239:6 241:11,15	<b>technologies</b> 14:11	249:5 253:7,10	<b>theoretically</b> 92:13
27:1 28:4 34:6	243:15 246:5,9	16:20 271:13	254:3 255:13	204:14
46:19 52:1 57:1	247:22 254:3,5	<b>technology</b> 21:10	262:21 263:16,16	<b>therapy</b> 172:6
82:21 84:6 107:2	263:14 268:12	91:8 101:19	264:3 266:1 267:3	283:9
112:10 114:17,19	272:12 274:10	117:13 134:3	273:17 279:16,18	<b>thereof</b> 270:22
126:19 128:14	275:5,6 278:11,13	149:13 168:17	293:10 302:20	<b>they'd</b> 158:15
136:14 142:11	290:10 291:6	205:10,18	303:14 306:15	196:15
149:12 152:7	293:21 294:10	<b>tee</b> 54:13	313:7,18 320:9	<b>thing</b> 7:1,13 14:22
157:5,12 162:7	298:9 313:8	<b>teeth</b> 90:22	326:7,16 327:2	43:2 71:3 73:18
163:13 211:16	319:13	<b>telephone</b> 175:11	328:15 329:6	89:13 90:18
212:2 214:14	<b>talks</b> 156:6 243:16	<b>tell</b> 4:7 8:3 159:12	331:11,14,22	108:13 117:20
228:5 258:5	<b>tangibly</b> 92:15	235:1 237:18	<b>terrific</b> 243:18	118:1 120:14
288:15 293:1	<b>tap</b> 219:6 241:10	238:8 250:9 273:1	<b>territory</b> 328:12	121:20 135:6
300:13 304:8,10	<b>targeting</b> 298:14	301:17 303:17	<b>test</b> 99:13 113:14	143:1 152:16
330:2	<b>TAROON</b> 2:15	304:1 320:22	113:14 310:13	154:5 178:1
<b>talked</b> 36:8 57:13	<b>task</b> 21:10 157:1	<b>telling</b> 223:7	331:3	179:13 182:5
62:6 67:1 84:5	306:21 311:17	264:21	<b>tested</b> 142:22	183:17 185:1
88:11 96:17 108:9	312:6	<b>tells</b> 254:17	314:14	194:5,14,19
109:17 124:8	<b>tasks</b> 109:2,14	<b>tenable</b> 249:4	<b>testing</b> 99:14 113:7	195:22 214:12
141:18 148:10	110:15 114:7	<b>tend</b> 37:5,8,12,16	171:20 173:22	216:20 219:1
152:19 156:8,13	152:20	225:4	242:3 307:11	233:3 243:14
156:14,20 157:3	<b>tasks/data</b> 104:12	<b>tends</b> 186:18,19	314:10	244:15 247:17,21
157:11 171:3	<b>taught</b> 217:4	<b>Tennessee</b> 1:25	<b>tests</b> 109:7 261:5	249:15 254:2
231:22 236:17	<b>tea</b> 99:1	11:20	281:5	261:14 263:6
248:19 257:8	<b>teach</b> 18:4 216:22	<b>Tennessee's</b> 11:18	<b>thank</b> 5:12 21:14	267:13 278:4
261:1 272:2 289:2	<b>teach-back</b> 286:2,5	<b>tentative</b> 329:14	23:21 24:13,18,21	289:5 309:18
290:18,22 291:1,4	287:13	<b>term</b> 36:9 80:13	56:9 57:18 58:12	311:15 330:1
291:14,15,20	<b>team</b> 4:13 70:2	196:14 227:6	65:12 72:9 99:8	<b>things</b> 18:22 25:16
310:2 316:22	72:21 100:9 121:4	265:16,17 292:4	120:12 159:1,7,9	35:4 36:7 37:1
318:3 320:21	124:14 145:16	<b>terminal</b> 124:11	160:3,4,16 161:5	38:20 40:17,19,19
<b>talking</b> 39:15 44:3	171:18 205:12	<b>terms</b> 30:1 43:20	165:16 196:17	40:22 41:3,5 43:7
46:9 64:2 82:19	210:9 225:14	47:15 48:7 50:19	199:3 234:5	44:6,21 45:5,7
88:1 95:20 98:14	233:19 239:16	59:6,10 64:18,19	316:19 336:13,15	47:2,6,8,12 51:18
102:13 103:12,13	240:20 257:18,22	67:13 70:17,18	336:19 337:5	53:4,8,15 54:4

61:17 71:5 73:3	45:15 46:3,6,8	152:13 153:1,13	239:21 240:1,5	319:4,16,18 320:6
74:8 75:17 78:14	48:9 49:9 50:7,8	155:5,8 156:14	241:13 242:7,11	320:10,15,16,16
80:21 81:4,6 83:3	53:4,12 54:9 55:8	157:9,18 158:11	242:22 243:16	320:21 321:2,5
87:20 95:12 98:12	56:7 57:9,11,15	159:19 160:9	244:1,3,6 245:2	322:14,21 323:1
98:14,18 103:4,18	57:16 58:11,19,21	161:17,19 163:2,8	245:12 246:1,2,6	324:7,8 325:14,21
105:4,19 118:12	59:12 60:20,21,22	163:10 165:18,20	246:10 247:19	326:5,10,20 328:5
123:20 126:4	61:11 62:6,14	167:13 169:15	248:2,3 249:1,15	328:13,16 329:3
127:20 128:12	64:22 65:17,18,19	177:4,18,20 178:4	249:19,22 250:2	329:11 330:5
131:2 135:18	65:20 66:8,10	178:18 181:5,9	250:10 252:13,21	331:3 333:2 334:4
142:12 148:18	70:4 72:10,18	182:6 183:2 184:1	253:6,22 254:8	335:12 336:17
150:17,22 154:22	73:6,18 74:2,12	184:6,12 185:13	255:4,4 256:6,11	<b>thinker</b> 225:5
158:12 167:21	74:17,22 75:1,14	186:11 187:20	257:1 258:10	<b>thinking</b> 27:20
168:5 170:1,2,5	75:19 76:8,17	188:5,12,15 189:3	260:21 261:13	37:18 38:9 47:13
170:14,14,21	77:4,11 78:2,3,11	189:11,19 190:10	262:6,7,11,12,19	66:2 69:1 82:1
171:12 179:10	78:17,19 79:12,13	190:19 191:13,19	264:13,19 265:16	89:19 97:19 109:3
181:20,22 182:8	80:12,15,18 81:2	192:9 193:4,11	266:20 268:5,5	109:15 115:12
182:10 183:4,7	81:4,8,9,18 82:3,6	194:8,13,14,16,19	269:2,15 270:7	121:3 140:20
187:1,5 188:4	82:10,12,19 83:7	195:21 196:9,16	271:20 273:8,13	146:7,7 149:4
189:10 191:13	83:14,15 85:7	196:20 197:7,17	273:17 274:3,5,14	154:19 160:1
192:9 194:1,18	86:22 87:10,15	197:19 198:4,14	274:15,18,22	163:5 169:18
195:13 203:9	88:1,2,7,22 89:4	198:20 199:12,13	277:13,19 278:3,9	185:12 188:17
204:19 207:22	89:11,15 90:7,9	199:17,21 200:2,6	279:12,22 280:15	192:10 193:15
210:1,12,15 211:1	91:16 92:9,13	201:7,8,11,13	281:9,22 282:7,15	205:6,14 207:19
211:6 212:17	93:1,8,21 94:13	202:8,16 203:17	284:11,19,22	210:11,16,19
214:4,5 219:18,21	94:14,21 95:19	204:7 205:1,1	285:19 286:5	213:3 216:18
232:5 233:1	96:10 97:17 98:3	206:4,19 207:6,18	287:14,18 289:14	218:3 227:11
234:13 235:13,15	98:9,21 99:16	208:17 210:20	289:16,17,21	232:10,15 234:4
236:6,8,13 244:1	101:2,8 104:6	211:7,13 212:6	290:5,5,12 291:11	245:6,17 247:9,14
244:4 247:18	105:1 108:20	213:3,6,9,11,14	292:5,9,10,11,16	252:5 262:4,8
248:2,5,16 262:1	109:17 110:3,4,19	213:20 214:7,11	293:3,20 294:6,14	263:15,20 264:3
262:2,8 263:21	111:1 112:9,11,18	214:18 215:13,20	294:20 295:2,3,9	267:1 268:14
264:11 271:11,18	113:4,5 120:17	216:1,7,9,11,16	295:18 296:11,12	272:8,14,14,15,17
272:4 281:3,18	122:18 123:12	217:14 218:5,16	297:1,3,7,11	276:22 277:2
282:1 291:4,13,14	124:6,7 125:4,5	219:8 220:3,18,22	298:5,10,12,12,14	278:17 279:16
292:6 301:8	125:13 126:7	221:4,11,17,22	298:15 300:17,19	291:8 294:21
303:15 304:3,6	127:22 128:17	222:5,17 223:12	301:4,6 302:4,20	298:13,22 300:10
312:14,14 314:4	129:3,5 130:10	223:14,18,22	303:9 304:15,21	302:17 307:14
318:11 319:3,6	131:1,15,19	224:7,13,14 225:3	305:8,16,16	327:5 328:5 333:1
326:15 335:16	132:19 133:4	226:1,7,12,13,18	306:12,12,17	337:2
<b>think</b> 4:9,12 8:10	134:16 135:13,14	226:19 227:6	307:9 308:7,22	<b>thinks</b> 73:3
9:1,7 11:6 14:22	135:19,22 137:2	228:2,6,7,13,13	309:3,5,19,22	<b>third</b> 31:3,4 35:17
17:12 22:9 26:4	137:21 138:11	228:16 229:5,18	311:2,12,14	49:18 156:21
26:17 27:20,22	140:6,19 141:5,17	230:6 232:8,12	312:19 313:16,18	174:9 175:12
28:3 29:1,6 36:6	143:6 144:4,18,21	233:21 234:6	314:5,12,17 315:5	225:15 302:4
36:14,18 37:4,6	146:20 147:1	235:6,11,17,17,20	315:6,7,16 316:2	<b>THOMAS</b> 1:22
37:13 38:6 39:16	148:2 149:2,11	236:16 237:1,5,11	316:13 317:7,10	<b>thoracic</b> 245:5
44:14,22 45:6,13	150:5,8,11 151:4	238:3,5,15,20	317:12 318:4,6	<b>thorough</b> 288:1

<b>thought</b> 30:7 42:5 53:20 66:5 76:6 80:3,7 90:4 97:6 107:15 108:4 117:22 148:11 162:1 169:15 170:11 177:7 178:1,14 179:13 191:20 204:7 207:12 214:1 236:5 242:9 247:21 262:6,21 266:21 267:2 293:18 306:6 325:15 328:18	36:17 44:3 48:2 54:15 56:8 64:2 64:14 73:12,19 77:21 79:4 80:10 80:15 82:14 90:5 91:9 96:18 98:22 99:2 102:15,20 103:8 109:7,8 110:11 116:1 123:2 127:16,16 127:17 130:18 140:14 141:12 142:15,21 155:22 157:16 163:18 188:9 203:13 209:22 219:15 221:7 229:12 234:8 243:12 254:14 263:22 272:20,21 275:6 280:21,22 281:1 281:17,20,21 286:9 308:13 311:3 314:3 315:3 316:5 327:6 329:1 329:19 330:12 334:4 337:7	<b>titrate</b> 69:7 <b>tobacco</b> 41:19 <b>today</b> 20:7 28:17 39:21 59:9 100:8 111:7 164:9 196:2 198:20 219:18 221:2 224:11,14 228:6 229:17 230:7 231:22 250:10 260:14 263:6 270:21 298:1 329:16 333:11 336:16 337:1 <b>today's</b> 329:22 <b>Tom</b> 21:22 212:22 213:18 216:7 241:8,15 265:3 282:14 290:9 321:1 328:10 <b>tomorrow</b> 229:4 230:8 332:3 334:15 <b>ton</b> 319:18 <b>tons</b> 286:18 <b>tool</b> 110:10 198:21 244:10 321:10 322:13 327:10,11 327:13,13,20 332:2 <b>tools</b> 110:2,14 140:7,7 151:16 157:1 247:2 <b>top</b> 52:19 108:2 210:15 288:6 <b>topic</b> 256:22 <b>tossing</b> 80:12 <b>total</b> 66:11 173:9 239:14 <b>totally</b> 72:10 114:16 200:21 212:4 225:1 248:19 282:13 <b>touch</b> 25:16 113:6 133:6 <b>touched</b> 233:18 280:15	<b>touches</b> 170:14 <b>touching</b> 233:20 <b>tough</b> 136:9 146:15 318:4 319:5 <b>tow</b> 62:15 <b>track</b> 89:12 109:6 114:10 115:3 218:13 240:15 280:5 281:18 <b>tracked</b> 115:5 <b>tracking</b> 109:16,17 130:1 157:1 227:12 <b>traction</b> 304:16 <b>tradeoffs</b> 231:6 268:16 <b>traditional</b> 73:8 191:14 233:22 244:13 259:11 288:20 <b>traditionally</b> 181:5 <b>trailing</b> 205:7 <b>trails</b> 50:9 <b>training</b> 153:3 155:8 283:14 <b>trait</b> 294:3 <b>transactional</b> 317:19 <b>transactions</b> 75:20 <b>transcripts</b> 287:20 <b>transfer</b> 103:21 187:14 257:1 <b>transferred</b> 11:5 257:3 <b>transform</b> 230:5 <b>transition</b> 13:9 51:6 118:22 181:3 181:8 186:20 195:20 236:3,4 239:7 240:10 257:11 258:19 259:5 261:19 271:3 279:7 <b>transitional</b> 9:9 97:5 215:3 <b>transitioning</b> 106:18	<b>transitions</b> 3:13 12:1,17,20 13:8 14:5 16:7 18:21 19:3 48:16 49:12 50:16,21 52:11,21 53:17 67:13,15 95:20 103:22 106:22 131:3,6 141:21 180:6 181:1,2 183:12 188:8 190:15 195:8 226:6,7 229:8 232:6 234:20 262:20 <b>translate</b> 301:3 <b>translated</b> 223:9 <b>translating</b> 253:19 <b>translation</b> 57:6 <b>transmitted</b> 147:20 <b>transparent</b> 311:7 <b>transplant</b> 252:12 <b>treasure</b> 76:18 <b>treat</b> 254:14 <b>treating</b> 254:22 <b>treatment</b> 40:12 41:11 71:1,14,21 <b>treatments</b> 263:4 <b>tremendous</b> 58:20 184:18 <b>trends</b> 169:20 <b>trial</b> 308:12 <b>trials</b> 308:20 <b>trickle</b> 55:22 <b>tried</b> 38:13 73:6 88:21 90:19 97:19 293:7 303:8 318:2 <b>tries</b> 137:13 285:10 <b>Triple</b> 19:5 39:4,5 <b>trouble</b> 211:8 215:17 285:2 <b>trove</b> 76:18 <b>true</b> 129:17 153:10 153:21 185:2 190:10 196:8 <b>truncated</b> 105:22 <b>trust</b> 118:11 172:9 240:18
--	---	--	---	---

<b>try</b> 18:12 28:1 46:7 56:4 72:20 75:4 77:6 133:6 135:12 145:1 154:11 161:16 162:18 163:20 181:16 201:2 212:13,21 219:19,20 236:21 291:22 292:19 299:14 311:10 318:13 326:3	123:19 152:15 159:16 164:2 170:19 172:20 186:22 187:9 203:9 204:19 219:21 226:4 229:11,14 255:17 259:15 296:6 303:20 319:9 321:1 328:1 334:14 335:14,15	111:13 118:3,7 124:19 128:4 158:8 173:20 195:3 196:5 220:16 243:1 269:9 299:13 320:12	<b>usable</b> 191:15 208:10	<b>usually</b> 133:12 190:15 298:8 310:6
<b>trying</b> 27:14 46:5 49:20 52:4 53:9 62:1 72:18 75:2 75:14,18 83:2 89:21 92:19 107:22 112:6 113:9 122:6 128:3 134:10,10 136:13 144:9 148:7 149:14 151:20 163:6 164:4 188:5 214:10 218:3 234:9 238:4 246:1 246:16,16 262:7 266:1 274:6 280:12 281:17 284:10,12 291:10 291:12 300:7,8 302:15 303:5 310:16 315:2 318:10 326:17 329:11	<b>two-fifths</b> 175:12 <b>two-pager</b> 165:10 <b>two-part</b> 62:15 <b>two-provider</b> 154:8 <b>two-thirds</b> 174:7 <b>type</b> 32:19 33:1,13 35:9 41:7 47:22 86:13 121:20 141:16 149:13 175:16 188:20 194:11 259:12 261:14 271:4 300:10	<b>understanding</b> 69:19 81:21 83:17 105:3 118:1 195:18 226:20 262:3,13 263:3 310:15 311:9	<b>use</b> 10:5 13:5 22:15 41:19 43:14 47:7 47:20 62:11 79:3 79:7 80:8 81:6 90:20 101:8 103:10,17 104:8 104:17 111:16 119:7 122:11 126:8 134:2 142:6 143:2 153:4,19 155:2 173:16 176:5 179:14 182:12 184:15 185:10 193:18 194:18 204:3 206:6 212:14,15 219:5 224:9 230:15 235:18 237:1,4 249:5 258:22 261:11,18 267:15 279:6 283:17 286:4 288:13 292:4 298:16 315:16 317:15 323:10,11 327:12 330:18 331:2	<b>UTI</b> 43:8 <b>utilization</b> 111:12 248:15 252:8,13 290:22 324:9 <b>utilizer</b> 251:11 <b>utilizing</b> 252:9
<b>turn</b> 89:14 144:17 216:20 287:17	<b>types</b> 40:19 46:20 47:1,11 107:19 173:18 175:7 194:1 232:1 235:9 292:2	<b>understands</b> 129:21	126:8 134:2 142:6 143:2 153:4,19 155:2 173:16 176:5 179:14 182:12 184:15 185:10 193:18 194:18 204:3 206:6 212:14,15 219:5 224:9 230:15 235:18 237:1,4 249:5 258:22 261:11,18 267:15 279:6 283:17 286:4 288:13 292:4 298:16 315:16 317:15 323:10,11 327:12 330:18 331:2	<hr/> <b>V</b> <hr/>
<b>turned</b> 56:12	<b>typically</b> 266:21	<b>understand</b> 21:6 72:21 79:6 109:20	<b>underway</b> 42:14 <b>Unequal</b> 56:18 <b>unfortunately</b> 102:21 <b>unified</b> 54:8 <b>unintended</b> 148:15 <b>unique</b> 126:22 148:13 <b>United</b> 18:1 <b>universal</b> 273:2 276:7 <b>University</b> 1:17,18 2:4,5,8,10,12 9:5 12:22 15:9 16:21 21:16 <b>unnecessary</b> 261:5 261:5 <b>unpaid</b> 232:19 <b>unpublished</b> 174:2 <b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>VA</b> 2:12 16:18 <b>vague</b> 227:6 228:7 235:8 311:13 <b>valid</b> 84:14,18 <b>validated</b> 118:10 <b>validity</b> 171:22 <b>valuable</b> 123:5 179:13 <b>value</b> 28:3 122:13 122:16 200:4 226:21 257:14 <b>values</b> 270:4 <b>value-laden</b> 70:15 <b>variability</b> 236:20 <b>variables</b> 297:9 <b>variation</b> 298:21 <b>varied</b> 69:4 <b>variety</b> 166:18 170:6 184:3 187:9 <b>various</b> 32:3 33:5 45:22 56:1,6 90:3 122:9 125:8 138:22 168:9 177:15 180:12 270:20 278:20 313:22 <b>vast</b> 174:2 175:22 176:2 192:18,18 224:15 <b>vein</b> 9:6 <b>vendor</b> 143:13,15 143:16,19 <b>vendors</b> 144:18 152:21,21 236:20 237:6 <b>Venkatesh</b> 2:24
<b>turning</b> 150:21	<hr/> <b>U</b> <hr/>	<b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>useful</b> 80:3 85:18 101:13 120:13 132:14 147:11 163:7 165:11 177:22 194:14,14 212:7,10 216:6 269:21 293:15 313:4 320:15 331:4	
<b>turn</b> 89:14 144:17 216:20 287:17	<b>UCSF</b> 242:4 <b>UK</b> 267:14 <b>ulcers</b> 43:10 <b>ultimate</b> 124:10 267:4 <b>ultimately</b> 83:8 95:14 170:18 218:22 <b>umbrella</b> 124:20 <b>unable</b> 100:8 255:18 <b>underneath</b> 124:20 145:20 171:1 <b>understand</b> 21:6 72:21 79:6 109:20	<b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>usefulness</b> 84:3 <b>useless</b> 129:12 <b>users</b> 251:17 <b>user-friendly</b> 315:12 <b>uses</b> 22:4 117:10 178:9 <b>usual</b> 28:18 29:9 59:2	
<b>turning</b> 150:21	<b>UCSF</b> 242:4 <b>UK</b> 267:14 <b>ulcers</b> 43:10 <b>ultimate</b> 124:10 267:4 <b>ultimately</b> 83:8 95:14 170:18 218:22 <b>umbrella</b> 124:20 <b>unable</b> 100:8 255:18 <b>underneath</b> 124:20 145:20 171:1 <b>understand</b> 21:6 72:21 79:6 109:20	<b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>useful</b> 80:3 85:18 101:13 120:13 132:14 147:11 163:7 165:11 177:22 194:14,14 212:7,10 216:6 269:21 293:15 313:4 320:15 331:4	
<b>turning</b> 150:21	<b>UCSF</b> 242:4 <b>UK</b> 267:14 <b>ulcers</b> 43:10 <b>ultimate</b> 124:10 267:4 <b>ultimately</b> 83:8 95:14 170:18 218:22 <b>umbrella</b> 124:20 <b>unable</b> 100:8 255:18 <b>underneath</b> 124:20 145:20 171:1 <b>understand</b> 21:6 72:21 79:6 109:20	<b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>useful</b> 80:3 85:18 101:13 120:13 132:14 147:11 163:7 165:11 177:22 194:14,14 212:7,10 216:6 269:21 293:15 313:4 320:15 331:4	
<b>turning</b> 150:21	<b>UCSF</b> 242:4 <b>UK</b> 267:14 <b>ulcers</b> 43:10 <b>ultimate</b> 124:10 267:4 <b>ultimately</b> 83:8 95:14 170:18 218:22 <b>umbrella</b> 124:20 <b>unable</b> 100:8 255:18 <b>underneath</b> 124:20 145:20 171:1 <b>understand</b> 21:6 72:21 79:6 109:20	<b>unquote</b> 88:7 <b>unrelated</b> 166:18 <b>unusual</b> 59:2 <b>update</b> 76:18 <b>updated</b> 223:17 <b>upload</b> 256:19 <b>upset</b> 87:20 <b>upstream</b> 230:15 <b>upwards</b> 251:2	<b>useful</b> 80:3 85:18 101:13 120:13 132:14 147:11 163:7 165:11 177:22 194:14,14 212:7,10 216:6 269:21 293:15 313:4 320:15 331:4	

3:17 5:9,9 100:11 101:11 166:2 197:17 200:6 201:20 203:17 <b>Venn</b> 175:1 <b>venue</b> 132:10 <b>venues</b> 108:14 <b>Vernon</b> 2:21 3:8 5:2,2 25:9 29:11 29:13 106:8 <b>versa</b> 130:16 <b>version</b> 139:22 <b>versions</b> 139:15 <b>versus</b> 36:11 95:8 174:9 187:2 200:13 203:11 211:9 224:10 231:12 262:5 278:8 <b>vessel</b> 308:15 <b>vice</b> 2:16 4:16 8:7 16:1 17:5,15 130:16 <b>view</b> 7:10 60:18 81:17 162:3 166:10 305:1 <b>viewing</b> 288:9 <b>viewpoint</b> 22:22 <b>virtually</b> 131:17 132:7 183:12 <b>vision</b> 54:1 111:9 221:19 264:9 284:10 <b>visit</b> 79:17,18,22 130:17,18 236:9 251:15 <b>visitation</b> 174:6 192:8 <b>visiting</b> 138:4 279:3 <b>visits</b> 137:5 240:9 250:16,19 251:15 251:22 <b>vis-a-vis</b> 61:14 161:15 245:16 <b>voice</b> 277:12 <b>void</b> 32:21	<b>Volk</b> 100:13 <b>volume</b> 143:16 <b>voluntary</b> 10:4 <b>volunteer</b> 9:21 11:22 13:3 <b>voted</b> 66:17 <b>VTE</b> 85:1,2 <b>vu</b> 125:20 <b>vulnerable</b> 265:11 <hr/> <b>W</b> <hr/> <b>Wagner</b> 263:7,10 291:7 <b>wait</b> 304:8 <b>waiting</b> 31:20 <b>Wakefield</b> 2:12 16:16,16 223:2 <b>walls</b> 38:7 <b>want</b> 7:1,11,13 8:8 24:16 26:13 27:1 27:2,9 30:16 32:4 35:1 36:16,21 37:9 48:8 53:16 55:14 59:10,15,22 60:7 63:12 64:22 71:7 72:6 74:7,17 74:22 79:6 87:21 93:7 96:4 97:22 99:3 100:1 101:17 106:9,18 109:3,4 109:6 110:17 113:6 124:4 128:14 129:22 133:6 135:7,9 137:1 139:2,14 144:2 145:1,3 150:3,20 151:5,12 153:2,18 155:13 155:18,18 158:18 162:2,7 163:12,21 163:21 164:19 165:16 174:4 178:20 193:22 196:19,22 201:6 206:4,6,8 207:7 210:16 212:21 216:17 217:12	221:1,10 222:16 224:1,10,12 238:5 240:21 246:6 249:14 251:7 253:8 262:15 265:7 266:3 272:16 273:11 282:14 286:9 288:2 292:12,18 293:1 294:4 295:3 295:8 299:4,20 302:5 304:21,21 305:21 306:11 308:3 309:16,21 310:17 313:6 315:3,4 318:10,16 318:21 319:1 320:6 322:21 323:13 324:21 328:13 331:7 333:13,18 <b>wanted</b> 29:18 34:10 34:21 35:4 37:10 37:22 38:8 40:15 43:3,10 45:11 46:21 48:17 50:12 54:6,20 55:9 58:3 64:4 68:9 70:17 72:3 77:8 93:13 94:17 101:21 103:18 121:1 126:13 153:7 173:15 202:14 222:20 223:2 251:8 254:3 330:1 333:14 <b>wanting</b> 13:13 46:2 47:16 49:8 <b>wants</b> 106:1 <b>warning</b> 285:1 <b>wash</b> 299:19 <b>washes</b> 298:21 <b>Washington</b> 1:9 10:11 19:21 300:17 <b>wasn't</b> 24:7 32:19 36:16 38:2 72:2	266:17 280:11 285:19 291:2 <b>watch</b> 50:6 <b>water</b> 310:18 <b>way</b> 6:11 18:2,3 53:19 56:11 60:3 65:1 71:10 75:4 77:18 79:19 80:8 87:5 90:5,16 91:2 91:19 97:15 101:8 117:15 124:8 138:7,16 147:18 156:7,12 158:7 175:6 178:9,16,22 180:13 188:16 189:22 194:14 204:7,22 206:10 207:15 209:7,13 209:18 215:15 223:21 227:7 228:14 229:9,19 231:7 233:3 235:19 237:7 241:1 242:2 246:11 249:15 253:13 255:3 266:20 268:15 273:13 282:10 293:13 294:17,18 297:6,17 305:13 306:6 307:13 308:1 322:16 328:4 330:6 333:5 <b>ways</b> 13:16 92:6 135:22 147:4 187:9 196:7 216:3 236:11,13 274:15 291:9 303:14 305:13 310:3 314:11 318:20 319:1 331:3 <b>webinar</b> 198:20 <b>website</b> 120:10 134:7 305:15 <b>web-based</b> 12:6 <b>WEDNESDAY</b> 1:5 <b>week</b> 20:19 130:20	186:22 230:9 263:8 334:12,14 334:21 <b>weeks</b> 119:5 303:20 316:22 329:8 331:21 333:1 <b>weeping</b> 90:21 <b>weighed</b> 146:14 <b>weight</b> 285:7 <b>Weill</b> 1:17 17:21 <b>Weit</b> 215:8 <b>welcome</b> 4:4,17 8:8 161:7 <b>welcomes</b> 5:14 <b>wellness</b> 9:21 147:13 245:19,20 328:19 <b>WellPoint</b> 9:18 <b>well-adopted</b> 142:15 <b>well-being</b> 40:11 51:13 <b>well-coordinated</b> 86:22 <b>well-earned</b> 286:8 <b>Wendy</b> 2:21 3:8 5:2 25:9 29:13 56:10 58:12,17 62:6 70:5 106:8 124:8 131:16 238:8 <b>Wendy's</b> 60:20 <b>went</b> 66:2 97:4 99:10 128:21 161:9 202:12 237:18 287:6 304:9 311:18 312:12 317:3 319:13 337:9 <b>weren't</b> 199:11 <b>Western</b> 1:24 12:11 <b>we'll</b> 5:14,15 24:3 26:7,9 28:4,15 63:7 64:17 67:3 67:17 68:18 69:5 77:21 84:6 101:9 127:18 130:6
--	---	--	---	--

149:1 156:1 160:8 165:2 212:1 229:13 287:2,3,19 287:20,22 289:14 293:11 295:9 312:19 329:7 331:19 333:8,11 334:10,13,14 335:10 336:2 <b>we're</b> 4:7,8 5:13 6:13,16,19 8:1,9 11:13 13:15 15:2 16:8,10,11 24:2 24:22 25:13 28:6 28:7 30:17,20 31:19 32:9 37:18 39:5 50:9,22 51:4 52:4 53:9 54:3,4,7 58:15 60:8 61:4 63:18 72:4 75:2 83:5 88:18,19 89:21 91:21 92:7 92:16,19 93:2 98:21 102:13 107:2,3 109:15 112:6 122:19,21 126:21 127:16 129:18 132:10 133:12 134:10,10 134:18,19 135:5 136:1,12 137:6,15 138:19 142:16 144:3,9 145:8 151:6 154:20 155:1,19 159:16 159:19 161:15,20 162:13,17 163:5 163:11,21 164:2 164:14 165:22 167:12 193:16 197:9 198:9 199:18 205:6 206:10 208:4 209:2 211:3 212:17 214:17 215:16 218:2,3,7 218:10,13 219:14	221:12,19 222:6 222:17 229:3 230:12 234:16,16 238:4,15 239:6 243:1,15 246:9,15 251:3 263:20 265:8 268:11 272:3,12,14,17 273:4,9 274:2,6 274:10 276:17 278:11 284:10,11 286:11,22 287:14 291:9 293:13,21 298:9 300:13 305:14 306:7 307:12,13 309:1,2 309:20 310:10,11 310:16 311:6 312:4,20 313:8,19 315:1,13 317:4 320:1,16 321:17 323:9,16,22 324:1 326:17 327:1,2,6 328:5 329:16 334:2 <b>we've</b> 4:10 26:15 31:14 54:8 57:17 66:12 75:16 77:4 77:5,6 84:7 87:18 88:21 101:22 109:5 127:4 137:5 144:14 161:12,14 161:17 162:4 171:3 172:22 173:1 182:8 208:22 211:22 217:19 222:3 223:8 228:5 229:17 234:22 236:17 245:2 252:18 263:14 269:17 271:11 274:7 275:19 282:13,15 286:17 287:15 292:16,20 293:8,9 294:6 296:1,6 306:6,9	307:14 308:1 310:21 316:13 319:10 321:2 323:7 327:4 329:21 <b>wheel</b> 239:5 <b>white</b> 2:13 9:16,16 27:3 88:10 147:8 147:18 153:7,10 153:17 154:5 247:9 249:7,10 295:18 329:13 331:15,18 332:7 332:10 335:16 <b>whoa</b> 84:2 <b>who've</b> 207:9 <b>wide</b> 134:11,22 180:15 <b>widen</b> 222:11 <b>widespread</b> 36:20 <b>wife</b> 10:5 <b>wiki</b> 120:5 <b>Wikipedia</b> 170:8 <b>WILLIAM</b> 1:21 <b>willing</b> 182:15 <b>wind</b> 206:11 <b>window</b> 265:6 <b>winter</b> 215:22 <b>Wisconsin</b> 11:4 <b>wisdom</b> 98:19 <b>wish</b> 42:4 <b>wishes</b> 51:9 <b>woke</b> 42:6 <b>Women</b> 2:11 18:9 <b>Women's</b> 1:22 2:22 2:24 5:11 23:10 23:11,17 100:5 143:14 <b>wonder</b> 80:6 201:16 263:15 <b>wondered</b> 238:13 <b>wonderful</b> 142:12 248:2 <b>wondering</b> 165:14 200:8 243:3 252:18 262:17,22 268:11 302:10	306:20 <b>word</b> 106:15 275:1 292:3 321:1 322:15 <b>words</b> 90:8 92:12 114:15 162:11 245:18 297:7 300:21 <b>work</b> 3:6 6:15,18 6:21 9:18 10:13 12:5,10 13:3,11 14:1 17:3,6 18:16 20:11,15 22:12 27:22 28:18 30:17 30:22 31:2,9,13 32:1,12 35:22 36:7 37:14,15 42:6,12,16 43:16 43:16,20 47:9 48:11,18 49:10,22 50:13,14 51:10 54:15 55:19 56:3 56:6 58:14 59:3,8 59:18 60:9,19 61:4,8,11 63:1,5 63:16 66:11,12 67:9,14 68:6,8 69:9 70:9,12 71:8 74:20 76:9 79:1 81:10,21 82:2 83:16,18 84:1 88:5 90:20 91:1 96:11 97:7,20 118:17 120:6 132:3 135:15,16 138:10 140:11 151:3,11 154:17 154:20 155:2 157:16 161:18 164:10 168:14 171:15 184:20 193:2 196:18 209:6 220:6 229:7 236:1,15 248:6 251:14 258:10 269:8 276:11 287:9,16 297:13	299:8 302:11,14 305:19 311:2 312:5,19 316:1,16 317:7,10,11,13 319:21 320:7 327:16 329:8,17 333:17 334:2 335:6 336:18,18 <b>worked</b> 7:6 13:2 19:3 45:17 76:6 133:19,19 142:16 142:22 232:3 247:7 <b>worker's</b> 266:4 <b>workforce</b> 275:19 <b>working</b> 9:13 15:3 17:10 21:7 24:3 29:15 33:3 54:3 85:18 87:6 94:4 98:4 100:6 116:1 126:15 160:13,15 199:22 224:19 232:18 240:20 241:17 242:5 263:12 264:8 269:18 280:3 293:11 333:16 336:20 337:3 <b>workload</b> 155:10 <b>works</b> 86:8 235:22 267:22 332:5 <b>workshop</b> 97:10 <b>work-arounds</b> 152:20 <b>world</b> 201:4 232:9 276:18 286:3 307:18 <b>worried</b> 310:22 <b>worries</b> 148:9 <b>worry</b> 306:4 307:11 <b>worth</b> 188:13 192:10 213:3 310:13 311:10 328:20 <b>wouldn't</b> 52:8 134:3 172:10 174:17 318:16,21
---	---	--	--	--

<b>wrestling</b> 116:13	<hr/> <b>Z</b> <hr/>	<b>2:37</b> 287:6	<b>4:00</b> 164:15 165:1,3
<b>write</b> 101:5 111:16	<b>Z</b> 83:7 137:8	<b>2:56</b> 287:7	<b>40</b> 67:1 68:13,20
152:5 158:21	235:15 259:21	<b>20</b> 73:1 93:17 101:2	187:18 201:3
219:7 220:19	314:16	101:9	<b>41</b> 68:13,20
283:2 290:20	<b>zero</b> 225:2	<b>20-25</b> 162:12	<b>415</b> 1:9
<b>writing</b> 8:13 64:15	<b>zone</b> 70:17 222:2	<b>20/80</b> 93:17	<b>43</b> 130:21
282:19	<hr/> <b>0</b> <hr/>	<b>2005</b> 12:16	<b>44</b> 130:15
<b>written</b> 109:9	<b>06</b> 204:2	<b>2006</b> 63:5 65:11	<b>450</b> 134:22
163:15 203:19	<hr/> <b>1</b> <hr/>	67:8 178:7 194:7	<b>450-practice</b> 21:20
253:21	<b>1</b> 104:10,16 156:6	194:9 203:20	<b>48</b> 31:17
<b>wrong</b> 133:12	218:6	<b>2007</b> 29:15	<hr/> <b>5</b> <hr/>
237:18 305:12	<b>1(b)</b> 111:2	<b>2008</b> 33:6	<b>5</b> 3:3 127:19 319:9
<b>wrote</b> 152:7	<b>1(e)</b> 132:16	<b>2010</b> 33:7 37:14	<b>51</b> 31:18
<hr/> <b>X</b> <hr/>	<b>10</b> 56:17 79:13	63:4,16,17 68:5	<b>55</b> 10:18 201:4
<b>X</b> 74:1 83:7 137:7	95:14 99:3,4	82:3 96:11 168:6	<b>57</b> 3:10
230:17 235:15	160:10 168:7	174:18	<b>59</b> 130:15
259:20 313:4	174:12 204:2	<b>2011</b> 1:6 33:21	<hr/> <b>6</b> <hr/>
314:16 318:12	220:3,8 275:9	168:8	<b>6</b> 132:16
<b>X12Ns</b> 20:20	<b>10:51</b> 99:10	<b>2013</b> 317:15	<b>60</b> 251:1
<hr/> <b>Y</b> <hr/>	<b>100</b> 3:13	<b>2020</b> 51:16	<b>61</b> 168:11 173:4,6
<b>Y</b> 83:7 137:8	<b>11:12</b> 99:11	<b>219</b> 3:19	<b>66</b> 251:2
235:15 259:21	<b>110</b> 10:17	<b>22</b> 249:11	<hr/> <b>7</b> <hr/>
314:16 318:12	<b>12</b> 198:11	<b>22nd</b> 329:13	<b>7</b> 137:22 138:20
<b>year</b> 13:16 22:18	<b>12:05</b> 161:9	<b>25</b> 3:4 168:7 245:22	<b>7th</b> 329:15 332:1
33:18,19 34:8,19	<b>12:25</b> 161:10	<b>28</b> 60:20	<b>77</b> 70:20 95:13
36:1 78:22 80:22	<b>124</b> 173:10	<b>29</b> 3:8	<hr/> <b>8</b> <hr/>
90:12 165:9 166:8	<b>125</b> 173:5	<b>290</b> 3:21	<b>8</b> 152:6
172:3 236:2	<b>130</b> 250:16	<hr/> <b>3</b> <hr/>	<b>8th</b> 332:1
250:16 253:1	<b>14</b> 299:14	<b>3</b> 102:21 156:15	<b>80</b> 93:18 276:6
254:9 258:13	<b>15</b> 286:22	275:20 300:17	<b>80s</b> 180:11 193:6
311:17	<b>15-20</b> 276:5	304:18	<b>80-some</b> 186:8
<b>years</b> 13:3 31:14	<b>161</b> 3:14	<b>3:00</b> 165:2,2 303:19	<b>86</b> 173:11
45:6 56:18 66:13	<b>166</b> 3:16	<b>3:47</b> 337:9	<b>87</b> 303:20
73:1 77:16 80:22	<b>17</b> 76:20	<b>30</b> 101:10 173:18	<hr/> <b>9</b> <hr/>
83:22 84:2,10,13	<b>18</b> 126:1	174:12	<b>9th</b> 329:15 332:1
84:17 97:2 235:6	<b>19</b> 1:6	<b>30-day</b> 166:20	332:19
249:11 258:11	<b>19th</b> 331:13	172:12 333:4	<b>9:00</b> 1:10
274:19 275:3	<b>197</b> 3:18	<b>31st</b> 323:8	<b>9:11</b> 4:2
276:11 302:16	<hr/> <b>2</b> <hr/>	<b>32</b> 130:21	<b>90</b> 308:13
<b>yesterday</b> 148:11	<b>2</b> 105:15 156:13	<b>329</b> 3:22	<b>90s</b> 180:12 193:6
259:16	218:22 250:20	<b>335</b> 3:23	280:20
<b>York</b> 1:16,24 12:12	258:22 305:22	<b>337</b> 3:24	<b>95</b> 281:17
12:12 17:16,20	<b>2-year-old</b> 270:6	<b>38</b> 76:7	<b>99</b> 226:13
18:2 94:4 116:12	<b>2:30-ish</b> 286:21	<b>39</b> 68:13,20	
279:4		<hr/> <b>4</b> <hr/>	
		<b>4</b> 3:2 106:5 250:18	



C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care Coordination Steering Committee

Before: NQF

Date: 10-19-11

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