

NATIONAL QUALITY FORUM

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DISPARITIES STANDING COMMITTEE

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WEDNESDAY

JUNE 14, 2017

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The Disparities Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Marshall Chin and Ninez Ponce, Co-Chairs, presiding.

PRESENT:

MARSHALL CHIN, MD, MPH, FACP, Co-Chair

NINEZ PONCE, MPP, PhD, Co-Chair

PHILIP ALBERTI, PhD, Association of American
Medical Colleges

SUSANNAH BERNHEIM, MD, MHS, Yale New Haven
Health System Center for Outcomes Research
and Evaluation (CORE) *

MICHELLE CABRERA, SEIU California

JUAN EMILIO CARRILLO, MD, MPH, NewYork-
Presbyterian, Weill Cornell Medical
College

LISA COOPER, MD, MPH, FACP, Johns Hopkins
University School of Medicine

RONALD COPELAND, MD, FACS, Kaiser Permanente

TRACI FERGUSON, MD, MBA, CPE, WellCare Health
Plans, Inc.

KEVIN FISCELLA, MD, University of Rochester *

NANCY GARRETT, PhD, Hennepin County Medical
Center

ROMANA HASNAIN-WYNIA, PhD, Denver Health

LISA IEZZONI, Harvard Medical School,
Massachusetts General Hospital

DAVID NERENZ, PhD, Henry Ford Health System
ROBERT RAUNER, MD, MPH, FAAFP, Partnership for a
Healthy Lincoln
EDUARDO SANCHEZ, MD, MPH, FAAFP, American Heart
Association *
SARAH HUDSON SCHOLLE, MPH, DrPH, National
Committee for Quality Assurance *
THOMAS SEQUIST, MD, MPH, Partners Healthcare
System
CHRISTIE TEIGLAND, PhD, Avalere Health

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ANDREW ANDERSON, PhD, Senior Project Manager
MADISON JUNG, Project Analyst
MAURICIO MENENDEZ, MA, Project Analyst
ELISA MUNTHALI, MPH, Vice President of Quality
Measurement
TARA MURPHY, MA, Project Manager
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

IGNATIUS BAU, JD, Consultant

* present by teleconference

CONTENTS

Welcome Remarks and Review of Meeting Objectives	4
Introductions.	6
Project Overview	10
Review Equity Measurement Framework.	22
Guidance for Developing Equity Measures.	117
Opportunity for Public Comment	174
NCQA and NAM Health Literacy Roundtable.	232
Guidance on Implementing Equity Measures	242
Guidance on Incentivizing the Reduction of Disparities	329
Opportunity for Public Comment	403
Next Steps	403
Adjourn.	422

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

2 9:05 a.m.

3 CO-CHAIR CHIN: Okay. We're going to
4 get started now, so welcome everyone, and Ninez
5 and I would like to first thank you all for your
6 service on the Committee. If you think about it,
7 like about a year ago we started and a lot has
8 happened and we've accomplished a lot, that I
9 think when we first heard this charge of trying
10 to do four reports in one year, that's pretty
11 intimidating.

12 But we're well on our way. I think
13 the first report describing disparities, the
14 second on the effect of interventions, this
15 current one on the conceptual model and the
16 development of the equity domains, and then the
17 last one in September will be the one on the
18 policy recommendations.

19 So really we've come a long way, and
20 I think we're in actually a very good space about
21 being able to complete the work in an effective
22 way. Special shout out to the NQF staff. You

1 think about it, like it's this magic that happens
2 between these meetings or calls when we talk
3 about general principles, and then these
4 detailed, highly-referenced, well-written
5 reports.

6 So I think we all know the great role
7 that the staff is playing in terms of having such
8 a great product in terms of these reports and
9 recommendations. So thank you everyone on the
10 team here. So let me turn over to Tara right
11 now.

12 MS. MURPHY: Good morning, everyone.
13 I'm Tara Murphy, project manager. I'm just going
14 to take us through some quick housekeeping items
15 before we dive in. First of all for those who
16 don't remember, the restrooms are right across
17 the elevator bank to the right. We'll take a
18 break at noon and then another one at 3:15.

19 And if you need to for any reason
20 leave the room, take a call, please do so right
21 outside. If you need an office for a while,
22 we're happy to provide a workspace for you.

1 Next slide. So we're going to start
2 with introductions, just briefly since I know we
3 did the full DOI last time we met. But if we
4 could just go around the room for introductions.

5 We'll start with Nancy.

6 MEMBER GARRETT: Good morning. I'm
7 Nancy Garrett from Hennepin County Medical Center
8 in Minneapolis.

9 MEMBER RAUNER: Bob Rauner from
10 Lincoln, Nebraska with One Health Nebraska ACO.

11 MEMBER COPELAND: Ron Copeland, Kaiser
12 Permanente.

13 MEMBER CABRERA: Michelle Cabrera,
14 with SEIU California.

15 MEMBER TEIGLAND: Christie Teigland
16 with Avalere Health, sorry.

17 MEMBER IEZZONI: Lisa Iezzoni, Harvard
18 Medical Center and the Mongan Institute Health
19 Policy Center at the Mass General Hospital.

20 MEMBER SEQUIST: Tom Sequist at
21 Partners Healthcare.

22 MEMBER CARRILLO: Emilio Carrillo,

1 Weill Cornell Medical Center.

2 MEMBER NERENZ: Dave Nerenz, Henry
3 Ford Health System, Detroit.

4 MEMBER ALBERTI: Philip Alberti, the
5 Association of American Medical Colleges.

6 MEMBER HASNAIN-WYNIA: Romana Hasnain-
7 Wynia, Denver Health.

8 MR. BAU: Ignatius Bau. I'm serving
9 as a consultant to the project.

10 CO-CHAIR PONCE: Ninez Ponce from UCLA
11 Fielding School of Public Health, and I co-chair
12 this with Marshall Chin.

13 MS. MURPHY: Thank you, and if there
14 are any members of the Committee on the phone.

15 MEMBER BERNHEIM: Hi. Susannah
16 Bernheim is here. Can you hear me?

17 MS. MURPHY: Yes, we can hear you.
18 Thank you for joining us.

19 MEMBER SANCHEZ: Good morning. I'm
20 Eduardo Sanchez. I'm calling in from Dallas,
21 Texas.

22 MEMBER FERGUSON: Traci Ferguson,

1 WellCare Health Plan.

2 MEMBER SCHOLLE: Good morning. It's
3 Sarah Scholle from NCQA.

4 CO-CHAIR CHIN: Sarah gets special
5 commendation, because I think it's like 4:00 a.m.
6 in Alaska right now. That's dedication. How
7 about the rest of NQF's staff? Helen.

8 DR. BURSTIN: Good morning, hi
9 everybody. Thanks again. Helen Burstin, Chief
10 Scientific Officer, NQF.

11 MS. MUNTHALI: Good morning, Elisa
12 Munthali, Acting Senior Vice President for
13 Quality Measurement. Welcome back.

14 MS. O'ROURKE: Good morning, everyone.
15 Erin O'Rourke, Senior Director with NQF.

16 DR. ANDERSON: Good morning. Drew
17 Anderson, senior project manager.

18 MS. JUNG: Good morning. Madison
19 Jung, project analyst.

20 MR. MENENDEZ: Hi everyone. Mauricio
21 Menendez, project analyst.

22 CO-CHAIR CHIN: And before I turn it

1 back over to Tara for more of the overview, one
2 thing I'd mention is that the timing of this
3 overall Committee is just really, really good,
4 that besides the NQF work, there's a lot of other
5 work that's happening in CMS, the National
6 Academy of Medicine, Department of Health and
7 Human Services, ASPE. All align very well, and
8 so we have the chance to have an impact.

9 As an example, yesterday at the
10 National Academy of Medicine, they were having
11 one of the panels that we'll talk a little bit
12 more about actually later in the day, about the
13 adjustment for social risk factors in performance
14 measurement, and about six or eight of the people
15 on the Committee were at that particular meeting.

16 But one of the general themes is that
17 in some ways these issues sort of hang in the
18 ether, but more clarity needs to be made both in
19 terms of the social risk factor adjustment issue,
20 as well as the other ways that performance
21 measurement can be used to reduce disparities.

22 So I think it's really important that

1 we come up with a good third and fourth report,
2 because it does have a chance to be particularly
3 impactful, and I think others like later when we
4 have a discussion about that meeting, we can talk
5 a little more also. But again, it is a great
6 opportunity and it's great timing for the overall
7 Committee. So, Tara.

8 MS. MURPHY: Thank you. So I'll just
9 quickly take us through our objectives for today
10 and tomorrow. Today, we'll finalize the
11 conceptual framework. We'll also identify gaps
12 in measurement and identify priority measure
13 concepts that will be follow-up on the pre-work
14 that you all completed.

15 We'll continue our policy
16 recommendation discussion from this afternoon
17 into tomorrow morning, and then tomorrow
18 afternoon we'll discuss the SES risk adjustment
19 trial evaluation period.

20 This next portion, in this next brief
21 portion, I will very quickly take us through a
22 project overview, none of this will be new

1 information. Just a quick recap for those in the
2 room and those on the phone, just kind of a broad
3 overview of our project.

4 So as you're all very familiar by now,
5 we're tasked with providing guidance on how
6 measurement can be used to address disparities in
7 the five selected condition areas.

8 Those conditions are cardiovascular
9 disease, cancer, diabetes and chronic kidney
10 disease, infant mortality and low birth weight,
11 and mental illness. We look at these five
12 conditions across the social risk factors
13 identified in the 2016 National Academies report,
14 Accounting for Social Risk Factors in Medicare
15 Payment: Identifying Social Risk Factors.

16 Those factors are race, ethnicity,
17 gender, social relationship, socioeconomic
18 status, disability, and residential and community
19 context. Over the course of this task order,
20 we'll complete three interim and one final
21 report, which will include an environmental scan
22 for measures, identify gaps in measurement,

1 develop a conceptual framework to guide
2 performance measures.

3 These activities will culminate in a
4 set of recommendations for measure development
5 to assess efforts to reduce disparities in health
6 and health care in the target conditions. To
7 date, we have submitted all three interim
8 reports, which include the conceptual framework,
9 the final version of which will be included in
10 the final report.

11 Next slide. As you can see on our
12 project time line, following this meeting the
13 project team will continue work on the final
14 comprehensive report, which will include the
15 recommendations made here over the next two days.
16 The final report will build upon the three
17 previous reports and present the Committee's
18 final recommendations, and the draft will be
19 posted for a 30-day public commenting period
20 beginning in July.

21 The third report, which was just
22 submitted to CMS yesterday, included an

1 environmental scan for measures as well as the
2 conceptual framework that's been built over the
3 course of the project to date.

4 As part of the third report, the NQF
5 team conducted an environmental scan for measures
6 that address disparities and effective
7 interventions in the five condition areas. The
8 team also reached out to the chairs and other key
9 committee members of relevant NQF standing
10 committees, to serve as key informants to our
11 scan for measures.

12 Here you can see a tally of all the
13 measures that the team found, by condition area
14 and by domain. The team found 886 measures that
15 address one of the five condition areas or cut
16 across condition area to address disparities.
17 The team tagged each measure to one of the
18 domains identified by the Committee and described
19 in the third report.

20 As you can see and as was discussed in
21 the report, the majority of these measures were
22 identified in the high quality care domain.

1 These measures were mainly clinical measures that
2 addressed an effective intervention in one of the
3 condition areas. The fewest measures were found
4 in the partnerships and collaborations domain.

5 Here we have our final five domains of
6 measurement. They are culture of equity,
7 structure for equity, equitable access to care,
8 equitable high quality care, and collaboration in
9 partnerships. Each domain includes sub-domains
10 which you can see on the screen and which are
11 detailed in the third interim report. If there
12 are no other -- no questions on this background
13 information, I'll turn it over to Drew for the
14 main event.

15 DR. ANDERSON: So we can also go back
16 to that slide a little bit later, just so you can
17 see the final list of domains and sub-domains,
18 because we'll be spending a part of this next
19 section discussing those in more detail and how
20 they fit together.

21 So I just wanted to give a brief
22 overview for the public and those online about

1 where we've come from in the measurement
2 framework, and how it's developed to this point,
3 and just to put this up on the slide, this is
4 where we initially started looking at these risk
5 factors that were identified by NAM.

6 And here is the original framework
7 that we have been building over the life of the
8 project, and I'll go over some of the updates
9 that we've made since then. Obviously, we'll be
10 making additional edits through this meeting and
11 leading up to the final report, because this
12 measurement framework will really encapsulate all
13 of the Committee's --- at a high level,
14 illustrate the Committee's recommendations.

15 So this really looked at it in four
16 steps. So it was identifying disparities. We
17 have a measurement development life cycle for
18 health equity measures, and then it goes to
19 incentivizing the reduction of disparities
20 through measurement through several, or five
21 here, policy recommendations that we'll be
22 building out over the course of this meeting.

1 In our revised version of the
2 framework, we've been getting more into the weeds
3 as far as what each one of these steps mean. In
4 the first step, we wanted to differentiate
5 between stratifying measures to look for
6 disparities and then also using -- selecting and
7 using health equity measures.

8 So this first step is looking at
9 disparities by stratifying disparity-sensitive
10 measures, and we included in the meeting
11 materials a previous report that NQF has done
12 looking at communication-sensitive or disparity-
13 sensitive measures. We came up with a -- a
14 previous committee came up with a protocol in
15 2012.

16 So we have adapted it to this project,
17 looking a little bit more broadly. So the
18 protocol is made up of these two tiers. The
19 first tier is looking at the prevalence of the
20 disparity, and then the actual quality gap, how
21 wide is the gap between relative to the group
22 with social risk factors, and then what impact

1 does this -- does the disparity have on the group
2 we're looking at in particular.

3 In the second tier, we look at whether
4 or not it's a communication-sensitive measure.
5 So is it associated with language barriers? Is
6 it associated with care with a high level of
7 discretion?

8 So this was really care that there
9 might not be a standard or there might be
10 multiple options. There were some examples about
11 shared decision-making here, and then the last
12 piece was the social determinant-dependent
13 measures.

14 So this follows nicely with the flow
15 of the project so far. So how we've been having
16 these discussions about how to select health
17 equity measures is to -- we need to have them
18 tied to interventions that are known to reduce
19 disparities or evidence. So Step 2 of the
20 framework now will look at, you know, what
21 research, what research is -- what evidence is
22 available to suggest that certain interventions

1 reduce disparities and what measures do we have
2 to ensure that stakeholders are employing those
3 effective interventions.

4 And then from the first or the second
5 interim report, we identified a number of
6 interventions that cut across all of the
7 condition areas that we looked at, and they were
8 more general looking at patient education,
9 lifestyle modification, culturally-tailored
10 programs. We saw a lot of examples of community-
11 based participatory research, bringing in
12 community members to be a part of developing
13 interventions.

14 We also pulled back a number of
15 recommendations from AHRQ, IHI, RWJF and then
16 also some systematic reviews of intervention just
17 to provide examples of the types of interventions
18 that are out there that could be measured. And
19 then we -- a part of the second step of the
20 framework, we adopted an expanded version of the
21 SEM model to more applied to health care settings
22 and stakeholders, and came up with this

1 recommendation that interventions need to be
2 applied at all levels of the U.S. health care
3 system.

4 So we're looking at the policy level,
5 the organization level, the community level, and
6 provider level. Okay. And so this brings us to
7 Step 3, which is where we came up with the -- or
8 the Committee came up with the priority domains
9 of measurements.

10 And so these are intended to be
11 measures, health equity measures that are tied to
12 those effective interventions, and we have this
13 figure here that is meant to illustrate the
14 relationship between the domains.

15 So we have the culture of equity
16 supporting the structure for equity, then
17 structure for equity making more equitable access
18 to care once -- and then leading to this
19 equitable high quality care, hopefully to then
20 achieve health equity, but recognizing that
21 collaboration and partnerships between the health
22 care system and non-health care sectors are

1 necessary to achieve goals within each one of
2 these domains.

3 And then lastly, Step 4 is to
4 incentivize the reduction of disparities through
5 measurements. So these are really the policy
6 recommendations, and these are the five where we
7 landed since the beginning of the project.

8 So the first is incorporating equity
9 measures into payment and reporting programs,
10 aligning equity measures across pairs,
11 incentivizing preventative care, primary care and
12 addressing social determinants of health,
13 assisting safety net organizations through
14 vulnerable by serving -- assisting safety net
15 organizations serving vulnerable populations, and
16 conducting and funding demonstration projects to
17 test payment and delivery system interventions to
18 reduce disparities.

19 So we will be talking about these and
20 building on these throughout this morning and
21 into the afternoon.

22 Here is just a revised step-wise

1 version of the framework. It is just an
2 illustration of the steps that I just went over,
3 but this is just a draft and we'll continue to
4 make sure that it illustrates all the concepts
5 that we want it to, or conveys the message that
6 we want it to convey for the final report. But
7 it's just kind of a high level overview. And we
8 can come back to this.

9 So as I said before I started giving
10 this overview, we wanted to go over a couple of
11 discussion questions related to the domains, just
12 to get on the same page.

13 These discussion questions are really
14 to figure out what the intended use is for these
15 domains, and then how they fit together. This
16 question here about are they considered a set or
17 can stakeholders pick and choose from them based
18 on their priorities.

19 So I'll turn it over to Ninez and
20 Marshall and walk us through the discussion.
21 Thanks.

22 CO-CHAIR PONCE: Okay, thanks Drew.

1 Nancy Garrett?

2 MEMBER GARRETT: So Drew, I just was
3 a little confused about the disparity-sensitive
4 measure and the materials that we got this report
5 from 2012. Can you just give us a little more
6 context of how this fits together with the work
7 of this Committee? Is this previous work that
8 was done?

9 DR. ANDERSON: Right. So it was
10 previous work, and that's actually a discussion
11 question that should be on the slide. We want to
12 see how we can adapt that criteria or some
13 criteria like it to advise stakeholders, like
14 how, what -- what are the priority measures for
15 stratification, essentially. So this was just a
16 previous project that was done in this area
17 specifically focusing on an area of culturally
18 competent care.

19 But obviously we're looking more
20 broadly than just cultural competence. So we
21 wanted to see if there was ways for us to adapt
22 that criteria to this current work, to provide

1 more guidance on stratification in that initial
2 step.

3 MEMBER GARRETT: So the disparity-
4 sensitive categorization scheme might be
5 something we discuss today, and whether we want
6 to continue it?

7 DR. ANDERSON: Right.

8 MEMBER GARRETT: Okay, that's helpful.

9 CO-CHAIR PONCE: Bob and then Juan,
10 and then Romana.

11 MEMBER RAUNER: As kind of another
12 kind of contextual question like what are we
13 going to with our fourth report, the ASPE and NAM
14 reports I think are going more in this direction,
15 where they're adding more specification
16 recommendations on what should be done.

17 The one thing, you know, when you have
18 this list of measures in the back, most of them
19 are hospital and/or new measures, but there's
20 almost nothing that's from either the Medicare
21 Shared Savings Program or the EDS measures that
22 federally qualified health centers use. And I

1 think we need to -- my understanding of our
2 charge is we're supposed to focus on the things
3 that are in value-based purchasing.

4 Those go back to those measures
5 actually, and I think like for cancer, for
6 example, it's breast, colon, and cervical cancer,
7 HPV vaccination. These are things that FQHCs,
8 the Medicare Shared Savings Program are working
9 on right now and that's what their incentives
10 are, either going to hurt or harm them. Is the
11 fourth report going to start into that area, or
12 is that the next committee or something like
13 that?

14 CO-CHAIR CHIN: I'll take a first
15 crack at it. I think a lot of what we're doing
16 still is fairly high level in terms of like the
17 big general principles. Like for example, the
18 conceptual framework, the equity domains. But
19 when we talk about like the policy
20 recommendations/use of measures part, I guess
21 this can be probably fairly high level also as
22 opposed to really specific.

1 Because there's such a void right now
2 in the overall field, and so much through these
3 general principles need to get out first. But I
4 think that if we do that well, then the next step
5 for like CMS would be like being more specific
6 for specific programs, it will be a great help
7 for them.

8 CO-CHAIR PONCE: And this is Ninez.
9 My understanding too is that so these five
10 domains, and perhaps we can go back to the target
11 with the -- so but this one, I think this gets at
12 the domains, because it's the culture of equity,
13 structure for equity, equitable access to care,
14 equitable high quality care, and then cross-
15 cutting is collaborations and partnerships,
16 right, with the target of achievement of health
17 equity.

18 This came up from all the work we've
19 done in the last meeting, when we all had -- we
20 broke up into small groups and then we went out
21 and got to this point. And then that framework
22 was put with the work that NQF did on what

1 measures are available.

2 So it eliminated where the gaps are,
3 and that's the chart where you have the -- we can
4 go back there, so that we can walk the Committee
5 to refresh.

6 (Pause.)

7 CO-CHAIR PONCE: So that got us to --
8 so the measures that they reviewed got us to this
9 chart, put in the context of the five domains
10 that this committee arrived at. And so from this
11 we see that the partnerships and collaborations
12 is where we need some more work, which is why we
13 think called out a pre-work for those folks here
14 and this structure, actually the structure for
15 equity did pretty well.

16 But then access to care at 52 and
17 culture of equity. So that's kind of the process
18 of the work that you've done to where we're at
19 now. But I do echo your concern, Bob, that then
20 it's what are we going to do with these? We
21 identified gaps. This is what Marshall actually
22 in the back would always keep saying, what are we

1 going to do with this and how we can
2 operationalize this.

3 But we have measures already. But for
4 this exercise, it's what are the domains that
5 this Committee has developed from all of our
6 meetings together, and then incorporating the
7 work that we've been doing for CMS?

8 MEMBER RAUNER: So like for example,
9 because this is NAM's report, where they actually
10 call out -- they use the example of the hospital
11 readmission penalty. Will we have anything like
12 that? Like for example, colorectal cancer
13 screening. We know there's significant
14 disparities, geographic, income-related.

15 You know, David's article last time
16 pretty much highlighted. It has huge effects.
17 Are we going to use that as examples or is the
18 step forward going to be mostly conceptual?

19 MS. O'ROURKE: So I think the next
20 session would be great, when we can call out some
21 specific examples, particularly when you look at
22 this chart how many measures there currently are

1 in this high quality care domain.

2 I think if there are particular
3 measures that we could call out and say these are
4 ones that need focusing on, and then when we get
5 to some of the policy focus conversations in the
6 afternoon of those concrete examples of specific
7 programs or payment incentives that the Committee
8 wants to highlight, I think particularly around
9 where we have the five disease areas that we've
10 been focusing on.

11 So I think colon cancer can be a great
12 example to build out through our conversations
13 today.

14 CO-CHAIR CHIN: Over the next two days
15 Bob, some of us might think of it as three
16 different parts of the meeting, we end the
17 meeting with a discussion of the trial period for
18 SES demographic risk factor adjustment. So
19 that's just one bucket of things. A second
20 bucket would be this morning, so much we tie
21 together -- where we ended up at the last
22 meeting.

1 You remember everyone was in the
2 corner there. I remember Ignatius was on the
3 white board and we had this long list of 25
4 different domains, and it was trying to collapse
5 it down to a reasonable number. So that would be
6 a five up there, as well as hopefully the five
7 having some type of logic to it in terms of how
8 they fit together.

9 So that's part of what you're going to
10 be discussing, and then Evan's point about well,
11 what you have are these measures. Then what does
12 that means in terms of how they're used? Is
13 there a logic or not, or if there is no logic to
14 it, do we need to improve it, that type of thing.
15 That's a second bucket.

16 The third bucket is this afternoon,
17 where it's like the well, now that you have these
18 measures, well what are the different leverage
19 can you use then in terms of measurement to
20 reduce disparities? The social risk factor
21 adjustment is one, but only one of the different
22 levers.

1 One of the interesting things about
2 like this meeting yesterday was that the topic
3 was social risk factor adjustment. But I would
4 say at least half the discussion was really on
5 the other stuff, because people realized that
6 social risk factor adjustment is a piece of the
7 puzzle, but it actually may not be the most
8 powerful lever. And so it also has to sort of
9 fit together so --

10 DR. BURSTIN: Just one quick thing.
11 Specifically, if you look at the high quality
12 care listing there, that's where the majority of
13 measures are. The way we've used the disparity-
14 sensitive measurement approach in the past is as
15 a way to at least identify which measures should
16 actually be stratified.

17 So I think some of it is bringing this
18 back to you. Does that schema make sense? So
19 even if we don't use it to identify every measure
20 today Bob, I think the question would be how do
21 we build this into our process going forward? So
22 the HIV Committee a while back specifically

1 identified viral load suppression as a disparity-
2 sensitive measure.

3 But we felt like it was time to
4 refresh this approach with your guidance, and
5 then build it into our work going forward.

6 CO-CHAIR PONCE: Thank you. I think
7 it is very helpful. Juan, and then Romana and
8 then Michelle.

9 MEMBER CARRILLO: I know it's Juan,
10 but it really is Emilio.

11 CO-CHAIR PONCE: Oh Emilio, sorry.

12 MEMBER CARRILLO: Yes, okay. First,
13 I think that the team did a great job collecting,
14 integrating and just distilling the discussions
15 that we had at the last meeting. The second
16 thing I want to just point out is that the 2012
17 report, the disparity-sensitive measures were
18 looking at the 2011 NQF portfolio of measures.
19 So that was where the -- this particular
20 discrimination was focused on.

21 And the one thing that's missing here
22 is the issue of structural racism, which is

1 something that's been addressed now. I mean
2 right now, NIMHD had a whole meeting on that.
3 People are writing about it, and it's just
4 something that we should consider.

5 CO-CHAIR PONCE: Thank you. Romana.

6 MS. MURPHY: So in terms of the topic
7 of stratification that we're going to address,
8 I'm just wondering, you know, and Dave's here, in
9 terms of the previous committee, our risk
10 adjustment and the guidance on stratification
11 versus risk adjustment.

12 I'm curious how we're going to connect
13 that. I mean there was very explicit guidance
14 and it gets back to Marshall's question of how
15 are these measures going to be used and
16 operationalized. I think the stratification
17 issue is a big one in that in terms of use. So I
18 was just wondering if you could provide some
19 guidance around the previous work, the guidance
20 from that work.

21 I know there were a lot of questions
22 and, you know, I'll just say some controversy

1 about stratification versus risk adjustment. So
2 as we visit risk or stratification, how are we
3 going to make that connection and how are we
4 going to focus on operationalizing and use?

5 CO-CHAIR CHIN: So that's a great
6 question. We'll devote the whole afternoon to
7 those types of issues. In some ways like the
8 Committee has off and on talked about a variety
9 of policy recommendations, but we haven't really
10 systematically marched through the key issues.

11 So like we looked at the agenda for
12 this afternoon. It was the Committee's, well the
13 staff's attempt to basically come up with like
14 some guidance questions to help guide that
15 discussion. But that's a critical one that
16 you're asking so please speak up when we get to
17 that.

18 CO-CHAIR PONCE: Susannah, on the
19 phone and then Michelle. And then Lisa.

20 MEMBER BERNHEIM: Hi thanks. Just a
21 quick question about the category of high quality
22 care, because there are so many measures there

1 and I think I was expecting that that was mostly
2 going to be examples where stratified results are
3 being used to highlight disparities, to sort of
4 incentivize decreasing disparities.

5 But when I look at our domain for
6 that, I see that we include, I think -- so I'm
7 trying to be clear about what we're churning as a
8 measure here, because I'm a little concerned that
9 we're going to say that this domain is fine,
10 whereas in my opinion we're missing a lot in this
11 domain.

12 So I think that if I'm reading this
13 right, we want a lot of things in this domain,
14 which is sort of anything that looks at family
15 and caregiver experiences of care,
16 communications, shared decision-making, support
17 self-care. They're factors in improving equity,
18 but they're not necessarily sort of directly
19 measuring whether there is equity in high quality
20 care.

21 In that second bucket within equitable
22 high quality care speaks to stratified measures,

1 and there's a couple of examples. Then there's
2 also team-based care, care managers. So if the
3 Committee can just or the NQF staff can just
4 confirm that all of this stuff is in here, and so
5 that we could have zero stratified measures. But
6 if we have things that are looking at patient
7 experience and team-based care, they're going to
8 count in these categories, is that right?

9 MS. O'ROURKE: Yes, that's correct.
10 Unfortunately, we didn't always have information
11 about how a measure is used and reported, so
12 Susannah is correct. It might not necessarily
13 have a stratified result out there.

14 MEMBER BERNHEIM: So we may want to
15 think when we're talking about gaps, about
16 whether we want to look a little at the sub-
17 domains, because if we make it look like one
18 domain we've got it nailed, we may be missing key
19 gaps. So I think it's just worth considering
20 some of the sub-domain groups.

21 CO-CHAIR PONCE: That's a good point.
22 Thank you, Susannah. Michelle, and then Lisa.

1 MEMBER CABRERA: Thanks. You know, I
2 just want to kind of build on Bob's point earlier
3 and say that for me, I look at our charge as
4 trying to help guide a process where we're
5 identifying disparities, and through quality
6 measurement, right.

7 So we help -- in the macro sense, we
8 are looking for where the -- assisting people to
9 find where disparities exist, and then we're also
10 -- I think one of the responsibilities for NQF
11 should be to hold itself accountable for the
12 impact of how measures are developed and then
13 applied to either, you know, helping to close the
14 gap on disparities or potentially even harming
15 parts of, you know, these impacted communities.

16 So I think that's the one piece that
17 I feel like it's the big picture piece, and I'm
18 not sure we're quite getting there. I see a lot
19 of contentious debate within some of the measure
20 developer conversations, and I'll admit I don't
21 understand everything that's going on there.

22 But if -- you know, there's a lot --

1 I do understand the tension. I understand the
2 back and forth, and I think the anxiety is about
3 people are concerned that the measures themselves
4 are a tool that when applied, sort of without
5 regard to the impact, can actually themselves be
6 driving further distance in disparities.

7 That's the piece I think we have to
8 -- we do have to get in the weeds, but we also
9 have to pull out and say wait, are we actually
10 achieving this goal of understanding the impact
11 the measures themselves have, and part of the
12 trouble that I see with that is that we are in
13 this interesting moment of a change in how people
14 are thinking about all of this, and while there
15 may be certainly it seems like buy-in that
16 stratification is fine, that it doesn't mess with
17 our tools, so to speak, there is a lot more
18 concern around well, then what happens once you
19 start messing within my tool, right?

20 So I just think that we need to
21 struggle a little bit with that while we're
22 having these other conversations.

1 CO-CHAIR CHIN: Thanks for that
2 comment Michelle, it's a really good comment.
3 The great opportunity on this Committee is that
4 this is the first of the NQF disparities
5 committees that was charged with coming up with
6 the broader road map.

7 In fact as far as I know, all the
8 priority disparities efforts were forbidden from
9 actually sort of crossing that line to talk about
10 exactly what you're addressing, essentially the
11 use of the measures, whether it's like the
12 negative unintended consequences, or better yet
13 how do you use the measures to correct or reduce
14 disparities.

15 That's this afternoon's discussion.
16 So please be an active participant this
17 afternoon, when this is the chance.

18 CO-CHAIR PONCE: Lisa.

19 MEMBER COOPER: So first of all, I
20 think the staff have done a wonderful job on
21 putting together this report, and also I just
22 want to say it's good to be back. I've been away

1 for a while from the group. So I guess what I'm
2 struggling with a little bit is that I am trying
3 to understand whether the measures we select have
4 to have -- not only have some sort of
5 demonstrated disparity that exists in those
6 measures, or whether we actually are also
7 requiring there to be proven interventions that
8 address that gap.

9 So I guess the reason I'm bringing
10 that up is because I really do think the
11 partnership and collaborations measures are very
12 important. However, I don't know that we have
13 the evidence that those measures actually --
14 whether there are actually interventions that
15 exist that document that those measures have an
16 impact on disparities.

17 So I would like us to recommend them
18 and I think they're very important to be
19 developed, but I'm just wondering what criteria
20 we're using for including the measure. Like how
21 rigorous does the evidence need to be? Do we
22 just need to say that it's a measure where

1 there's been a documented disparity, or does
2 there definitely need to be some sort of
3 evidence-based intervention whereby if there's a
4 disparity identified that there's something that
5 people can do to address it?

6 CO-CHAIR PONCE: So Emilio, I'm going
7 to go to Helen, because maybe she'll address
8 this.

9 DR. BURSTIN: It's a great question
10 Lisa, and welcome back. I think you got to the
11 heart of the matter. I think that's something we
12 want you to help us with. I mean one of the
13 things we've put in our prioritization criteria
14 for measures, not that all measures need to be,
15 but there's a preference for measures that are
16 improvable and actionable.

17 That doesn't mean in this particular
18 area I think where the evidence around what is in
19 fact improvable and actionable is often more
20 difficult. It doesn't have to be exclusively
21 what you rely on, but we might actually want to
22 be able to separate those out and say these may

1 be really -- these are incredibly important,
2 perhaps more aspirational because there isn't
3 clear guidance on what could be actionable. But
4 I think this is a great question for the
5 Committee.

6 CO-CHAIR CHIN: And let me reflect a
7 little bit back on the last meeting, and maybe
8 the Committee can tell me if you think I'm
9 interpreting the Committee accurately or not.
10 When we had a brainstorming session at the end
11 about what these example domains for equity, some
12 of that was evidence-based, as Lisa was saying.

13 I think some of that was based upon
14 people's experiences of what does it take to
15 reduce disparities. So for example, all the
16 culture of equity things, that we know that's --
17 well, we know from -- we know from randomized
18 control trials, but we know from the people who
19 do a lot of work with the different
20 organizations, that unless there's buy-in from
21 senior management well you can only go so far, on
22 this culture of equity.

1 I guess from the evidence base for
2 like an RCTF community health worker, but if the
3 -- and my interpretation was if the Committee's
4 -- if the goal is to try to improve equity, well
5 somehow we want to be able to measure and reward
6 institutions that are further along in terms of
7 prioritized equity, for example. So as Helen
8 said, I mean you look at those five different
9 domains and the different sub-domains, there
10 really is a spectrum of different issues.

11 Another example would be like Emilio's
12 point about the structural racism. There was a
13 great discussion about that the last meeting.
14 Well, I don't know any studies that have looked
15 at that particular issue in particular, but then
16 you could extrapolate things like well, if your
17 health care system isn't designed to take certain
18 diverse populations, is that sort of in some ways
19 a sequela of structural racism or what-not?

20 So it gets back to Bob's point about
21 like well, all these different domains. So I
22 think the best -- in some ways the purpose for

1 this morning to figure out well yeah, in this
2 sort of thorny area where we're using some
3 combination of evidence and expert judgment
4 essentially, what do we do?

5 I mean look at the NAM reports. Like
6 the second one was the one about their best
7 practices for caring for socially at risk
8 populations. They admitted up front that well,
9 you know, they're going to do a combination of
10 literature review and expert judgment. It's just
11 the nature of the question is hard.

12 So I guess so similarly, we have to
13 sort of struggle with this this morning about
14 where do we fall.

15 CO-CHAIR PONCE: Emilio, you had --

16 MEMBER CARRILLO: Yes. I just wanted
17 to piggyback on Lisa's point precisely, where she
18 said the actionable is really critical it's not a
19 current consideration when we look at measures in
20 the NQF.

21 But in this case, I think it should be
22 added, and actually about a year ago we

1 circulated a paper on a framework for looking at
2 the health care access barriers and measuring
3 them, which includes the actionable component as
4 one of the key ingredients. I think we can
5 probably send that around again if possible.

6 CO-CHAIR PONCE: I'm sorry, Bob.

7 MEMBER RAUNER: I just want to make a
8 really, really concrete example that addresses
9 this. For example, I made a \$4.7 million gamble
10 last week, by bringing in our two safety net
11 clinics and their ACO. Blue Cross/Blue Shield
12 has seven measures, their clinical measures
13 they're going to judge us on. Brought in the
14 safety net clinics because they need the funding
15 because they're struggling just like your safety
16 net group is for the same reasons.

17 Two of those seven are the very
18 measures that in David's article shows that there
19 are significant differences. The way the Blue
20 Cross/Blue Shield is doing it, our quality
21 measures are all or nothing, and if we miss a
22 certain benchmark we get zero savings actually.

1 If we achieve savings, we lose it all because our
2 quality isn't good enough.

3 And so, you know, the two safety net
4 clinics are only about eight percent of total
5 patient population, but if it's that close,
6 bringing them in could cost us \$4.7 million next
7 year. And so I would argue that we have an
8 ethical ACO and probably we had an ethical duty
9 to bring them in. But if we were purely
10 financially motivated, we would have not brought
11 them in.

12 So this is very real time, and I think
13 there are interventions out there that show that
14 if you do the care coordination reminder systems,
15 you can improve your cancer screening. So the
16 interventions are there, but we're already in a
17 situation where measurement is harming safety net
18 clinics. So I think that's -- I think that's
19 what -- obviously that's why I'm here.

20 I think we need to get to the point
21 where Medicare doesn't do this or Blue Cross/Blue
22 Shield doesn't do this. I think that's a real

1 concrete example and kind of a gut check for
2 everybody that -- get all the models. But the
3 rest, when push comes to shove I got to hire care
4 coordinators. I want to bring in the safety net
5 clinics and I don't want to exclude them from all
6 this.

7 I think a lot of federal programs
8 right now are excluding safety net clinics or the
9 rural health centers, FQHCs, partly because
10 measurement isn't used -- because we're not
11 adjusting for disparities. So I think that's
12 kind of a good gut check to frame the context a
13 little bit.

14 CO-CHAIR PONCE: Thanks, Philip.

15 MEMBER ALBERTI: Just a potential
16 opportunity as you think about this balance
17 between existing interventions and evidence and
18 aspirations.

19 I wonder if this is a chance for us to
20 propose kind of based on where we see the gaps, a
21 formal kind of research agenda to go forward, to
22 say here are the really salient research

1 questions. Here's what we need to know to move
2 this conversation forward, and I think this could
3 be really an opportune time to put something out
4 like that.

5 CO-CHAIR PONCE: Okay, that's noted.
6 Michelle.

7 MEMBER CABRERA: I don't mean to
8 belabor this, but I do think -- I mean just as
9 we're having this conversation about the various
10 five domains, what I want us to be mindful of and
11 try to avoid is again ghettoizing the disparities
12 and equity conversation, right.

13 You know, I feel like prior to this
14 current moment, it was ghettoized in public
15 health, and it was like public health does all
16 this aggregate stuff and it lives way over there,
17 and it's not connected to any of this. I want us
18 to be mindful as we're doing this that people who
19 are using NQF measures don't have the ability to
20 come and say well, those people are working on
21 equity and they apply these things, and I can
22 just ignore it.

1 I mean I think how do we make it so
2 that it's really not avoidable in how you're
3 thinking about and applying measures? It should
4 be part of our charge, giving guidance around
5 that.

6 CO-CHAIR PONCE: Thanks, Michelle.
7 Well, I've heard a lot of opportunity, as Phil
8 said, to enhance NQF's road map and framework.
9 So even Emilio your comment on structural racism,
10 I think the structure for equity bucket could be
11 enhanced to reflect the structural racism, and
12 Bob what you noted about investing in safety net
13 clinics, that could also be another quality
14 measure.

15 So I think all of these -- so we want
16 to hear your frustrations, because this is the
17 forum for this opportunity to codify it in a way
18 to guide NQF moving forward.

19 Well, there were a couple of questions
20 which I just wanted some clarification from Erin.
21 The second question is how do they relate to
22 existing measurement domains.

1 MS. O'ROURKE: Sure. So this one's
2 actually a point of clarification that Tara
3 asked, is how does the Committee see these
4 domains relating to things like the domains of
5 quality, and I think Michelle maybe this touches
6 on your point of how we need to keep these
7 connected, and this is not a separate framework
8 that other people are working on.

9 But how does this relate to some of
10 the other ways we've defined concepts like
11 quality, and does that help elaborate?

12 CO-CHAIR CHIN: I'll give a first
13 interpretation. So like when Susannah mentioned
14 on the phone call that, so some of it is you take
15 some of the existing measures and you just
16 stratify. So some of them are just existing
17 domains that NQF or IOM or others used in the
18 past and stratify.

19 But I think the thing that's different
20 about like the five domains that the Committee
21 has come up with, it also talks about the
22 process. This applies to the process of change

1 also. So things like if you look at -- it's also
2 the order of it also. I mean like that
3 concentric circle, sociological model, where you
4 have the culture of equity, you got to have the
5 structures in place, you've got to have access to
6 key areas.

7 You've got to have everything involved
8 with high quality care and then the partnerships
9 bring it all around. So in some ways it's sort
10 of like -- it's almost like your classic
11 Donabedian structure and process outcome, mixed
12 with dynamic quality improvement in some ways.
13 So to me, that's what is similar and different
14 about this existing CMS ways of thinking about
15 it.

16 CO-CHAIR PONCE: So Kevin.

17 MEMBER FISCELLA: Hi, this is just a
18 broader, a broader question of, you know, one of
19 the challenges as we think about stratification
20 and sub-groups and measures is the proliferation
21 of measures and measurement burden. I guess my
22 first, you know, question in my mind is how to

1 handle that and minimize, minimize the
2 proliferation of measures and the pushback that
3 comes from that, as well as the more measures you
4 have, the less likely there's going to be focus.

5 I guess related to that is the
6 movement towards fewer process measures and more
7 outcome measures that really get at equity, and
8 how we as a committee really think about the
9 tension there between equitable outcome measures
10 and equitable process measures, and where that
11 balance is going to fall and where the
12 opportunities are to leverage, to leverage real
13 change.

14 CO-CHAIR PONCE: Thanks Kevin, and I
15 know David has commented on this, on process
16 versus outcome yesterday at the NAM, and I
17 wondered if you had any comments on this.

18 MEMBER NERENZ: Well, the comment I
19 made yesterday was pretty straightforward.
20 Obviously, there's a distinction and everybody
21 knows what that distinction is. I think as we've
22 had a number of discussions in the predecessor

1 committee and elsewhere.

2 We observed that organizations,
3 particularly hospitals and clinics, find it
4 easier to reduce disparities in process than they
5 do in outcome. They find it easier, others do.
6 The literature's been solid on this forever. You
7 take diabetes, for example. It's not that hard
8 to get rid of the disparity.

9 It's really, really hard to get rid of
10 the disparity in hemoglobin A1c control. So that
11 was my point. I see people nodding. I'm
12 certainly not the first one to make that
13 observation. But then how we use that here, I
14 think, does take us to -- into some interesting
15 directions. I think I would consider both of
16 those broad sets to be legitimately sort of
17 disparity-sensitive measures.

18 But I think as we roll them out into
19 programs for accountability for organizations,
20 that I think is where you start thinking about
21 that distinction. Do you penalize an
22 organization for failing to reduce a disparity

1 that nobody can get rid of? I tend to lean no,
2 but others have different views, and but at the
3 same time as Kevin points out, there's sort of a
4 large shift among those talking about quality
5 measures to move from process to outcome.

6 Process measures have their own
7 downsides. I think in the end, you just have to
8 end up with some kind of thoughtful balance as
9 you populate any particular program. But I guess
10 I'm also leaning to Marshall's point, that we're
11 not at this day around this table sort of
12 specifically populating measures for specific
13 accountability programs.

14 I think we're left with sort of, you
15 know, looking at the big picture and saying that,
16 you know, within these domains, particularly the
17 quality domain, there are and there will be
18 process and outcome measures and then what we
19 write about them we probably can make these
20 comments. Process measures typically are within
21 a provider's control, more -- it makes more sense
22 to hold them accountable, particularly for things

1 that they directly hands on control.

2 So I mean there's phrasing that we can
3 do. But I'm not sure how much farther we can go.
4 I wouldn't take one group out or take the
5 different group out. They both have their place.

6 CO-CHAIR PONCE: Thanks, Dave. Kevin,
7 did you have any follow-up comments?

8 MEMBER FISCELLA: Yeah. I guess my
9 only follow-up comment would be I think that
10 using incentives perhaps on the -- on the outcome
11 end and really beginning to learn from that
12 experience in terms of essentially rewarding
13 improvements in equity and outcomes and what can
14 we learn about how that works.

15 I mean I think given the lack of
16 evidence, particularly at the higher levels here
17 as others have pointed out, I think this is
18 really going to have to be a continuous learning
19 process, where we learn from our experience and
20 learn what works. You know, I mean I share
21 David's concern about penalizing for outcomes
22 where you need multiple partners.

1 On the other hand, I think potentially
2 using incentives may be able to get at some of
3 the community collaborations that, you know, Lisa
4 was mentioning, because in the end we want
5 community collaborations that are going to make a
6 difference, not just on paper.

7 CO-CHAIR PONCE: Thank you. That's a
8 good queue, because Lisa is up next.

9 MEMBER COOPER: I was just going to
10 say that actually I agree with both Kevin and
11 David, the comments about the balance between
12 process and outcome measures. I think that's
13 important that we consider both, and I just
14 wanted to say that I really agree with what
15 Kevin said about us being selective about the
16 measures that we recommend.

17 I think that there's a potential that
18 we could recommend a whole lot of measures, and I
19 can tell you in my current role that I don't know
20 why, but there's a huge amount of pushback to
21 doing anything new, and so -- and I don't even
22 know how much more work it is to stratify like an

1 additional measure. But just the idea that
2 there's something different to do and their sort
3 of questionable ability to act upon it.

4 I think it behooves us to really be
5 very selective about the measure as a process and
6 outcome measures we choose within each domain,
7 that you know, realizing that there are lots of
8 them that are available that people can do, and
9 that they wouldn't be penalized for doing other
10 things.

11 But that there should be a core set of
12 really select measures that we are strongly
13 recommending that everyone include, because
14 otherwise it's going to really just get lost.

15 CO-CHAIR PONCE: Thanks, Lisa. I
16 think that's what the road map will help with
17 that. So Ignatius and then just do the roll on
18 the queue. Ignatius, then Ron, then Susannah on
19 the phone, then Emilio, then Lisa Iezzoni.
20 Ignatius.

21 MR. BAU: So I want to really go back
22 a couple of comments. Marshall posed this

1 question or made the observation that part of
2 what this framework is trying to do is really
3 cover the entire spectrum of issues that need to
4 be addressed from something as basic as the
5 structure and nature of the actual organization,
6 all the way to are we actually influencing
7 outcomes and improving outcomes for disparities
8 populations.

9 I think a lot of times in the equity
10 and disparities conversation we get hung up on
11 both either end of that spectrum, that we really
12 focus on issues like leadership or buy-in and
13 then we don't get to outcomes, or we focus only
14 on specific outcomes like how are your cancer
15 screening rates, and we're not addressing those
16 upstream structural, organizational issues.

17 So I think part of the challenge in
18 the final paper will be out of this framework,
19 what is most important to begin with, that
20 obviously ideally you would want to do it all,
21 but what is important, and to Bob's comment about
22 sort of the inclusion of the safety net. So if

1 we elevated a measure like language concordance
2 between providers and patients, that would
3 actually give credit to the safety net.

4 If that were one of those things that
5 you were incentivizing, as opposed to just
6 colorectal cancer screening. So again, I think
7 this framework gives us that opportunity to say
8 can we give credit to particular organizations,
9 in a way that again historically we haven't, but
10 gets at what we believe will ultimately move us
11 towards equity.

12 CO-CHAIR PONCE: Thank you, and I had
13 a side conversation with Helen and she said we
14 can influence the selection of the measures. So
15 this is what this group will do. So I have Ron
16 next, and then Susannah, Emilio, Lisa and Sarah.
17 You're on the queue too.

18 MEMBER COPELAND: Yeah. I would just
19 echo Ignatius' last comments about two of Lisa's
20 points I'd want to make about this balancing
21 issue between process and outcomes. First of
22 all, I think we just need to be clear of the

1 diversity of systems, based on scale, capacity
2 and so forth that constitute the community care
3 delivery system.

4 And so it's clearly a scenario where
5 one size is not going to fit all. So I think we
6 just need to be clear about what is that core
7 that's relevant to everybody, and how much choice
8 or not is part of the recommendation that we
9 ultimately would deliver, because aligning
10 people's willingness and capacity to adopt versus
11 not is going to be how stringent those approaches
12 are versus how much flexibility there is without
13 disrespecting the core things that we know are
14 essential to achieve the equity outcomes.

15 And then the other thing I would just
16 say in terms of a lesson from the field, at least
17 from a lot of systems that have already started
18 down the path of tying incentives to this work,
19 it is not a binary orientation of do we incent
20 process or do we incent outcomes.

21 Most of it's done in a stage way. The
22 first incentives to encourage strong the adoption

1 of whatever the core practices and principles are
2 is around process. Are you adopting the
3 processes? Are you measuring those? Are they in
4 place? Are you studying your outcomes and what
5 are the trends showing?

6 When people have done that for some
7 defined period and gained their confidence in the
8 data, in the outcomes and get familiar with the
9 processes, and there's been a cultural shift,
10 then there's the opportunity to say that would
11 move from Stage 1 to Stage 2. Now the incentives
12 are disproportionate.

13 Now they're going to be focused on
14 outcomes, because the data shows the processes
15 are in place. They've been adopted. You're
16 tracking those well, and if we believe that these
17 core things really -- you've done it at a high
18 level will result in decreasing disparities, now
19 we're all comfortable going for the outcomes.

20 So there's ways to accommodate both
21 approaches doing it in a stage way rather than
22 the debate of it all has to be on a process or it

1 all has to be on outcomes from the very
2 beginning, because there is an adoption period of
3 the processes and that's what you want to
4 incentivize first, because if those aren't
5 achieved, then there's no hope to get the
6 outcomes.

7 CO-CHAIR CHIN: While you have the
8 floor there Ron, so if you look at like the
9 current five domains, the culture, the structure,
10 the access, the quality and then the
11 partnerships, from what you just said, how does
12 that translate to then like the current five
13 domains the Committee's come up with and how they
14 might be used?

15 MEMBER COPELAND: Well, I think that's
16 an important framework. I like the continuity of
17 them. I think there's not any big buckets
18 missing, if you will, accommodating all five of
19 those domains. I think those are the right
20 domains, particularly in organizations around the
21 notion of culture and the elements that we're
22 trying to populate those with, all the way

1 progressing to outcomes.

2 So I see them as kind of the right
3 linked sequence and all being relative
4 contributors. I almost think of them as a
5 maturity model, that it's hard to -- it's hard to
6 advance some of the infrastructure, for example,
7 if you don't have the culture and orientation
8 around why it's important, how it's tied to
9 quality improvement, carrying out your
10 organizational mission, whatever the case might
11 be.

12 So I think at first pass and to anchor
13 a lot of the measurements or the core
14 measurements that we end up with, I think it's a
15 reasonable framework to start the conversation
16 with.

17 CO-CHAIR PONCE: Sorry, I keep putting
18 you on the hook Ron. Since you're touching on
19 the third question, so you said they were linked.
20 So you think they should be considered as a set
21 or can stakeholders pick and choose from them?

22 MEMBER COPELAND: Well, I think what

1 stakeholders will pick and choose, most would
2 probably start with a self-assessment on where
3 are we on the journey with those five domains?
4 Do we have anything going on in any of those
5 domains at all, and if not then, you know, what's
6 our -- or what is our map at an organizational
7 level to move in that space?

8 But again, because of the
9 fragmentation and diversity of where people are
10 starting the journey, I think they may pick and
11 choose where they start. But I think if we
12 believe to actually get to the outcome of
13 demonstration of achieving equity, all those are
14 essentially core steps that I think they come as
15 a bundle, for lack of a better term.

16 Then it's kind of where you start the
17 process, but recognizing that bundle has to be
18 achieved in real time, and simultaneously to have
19 the best shot at achieving the outcome.

20 CO-CHAIR CHIN: I mean you've raised
21 another -- I mean you're sort of on a roll here
22 Ron. But you sort of raised the issue of like

1 well, are these like five domains to be used more
2 from a quality improvement self-assessment
3 purpose, versus on the other extreme
4 accountability?

5 MEMBER COPELAND: I think it's both.
6 I think it's a way of -- if that's the
7 accountability step, the first thing I'd want to
8 do is where do I stand on that. So it starts
9 with a self-assessment of where you are, based on
10 the metrics or in those areas the framework to
11 give some thought to. I don't think we can ever
12 get so precise that it will be all-encompassing.

13 But I think the most important thing
14 is people have a framework that's got some
15 evidence base to it. They start the journey, and
16 they're committed to continuous learning. I mean
17 at the end of the day, that's what the staying
18 power is, to make impact in this field and so
19 when I think about what's the right starting set,
20 I don't think there's any magic involved. I
21 think it's a reasonable framework for the things
22 we know today probably carry the most impact.

1 So when I think about the most impact,
2 I think those areas are there and probably for
3 the medical care delivery model, and it's been
4 traditionally evolved, the area that's probably
5 most lacking is the culture and the collaboration
6 piece. So when I look at the spreadsheet that
7 was created, I'm really not surprised on how it
8 played out.

9 But I think don't be misled by the
10 number of the things identified in terms of
11 culture of equity, because that's where a lot is
12 lacking big time, and ultimately it's also those
13 other measures. Then it's the quality community,
14 of professionals in the quality improvement space
15 across the systems of care from a cultural
16 standpoint owning this as quality improvement
17 work, as opposed to a sidebar that somebody else
18 does in the organization, but we're too busy
19 doing quality.

20 This is quality. That's the critical
21 paradigm shift in the clinical culture that we
22 own this. It's part of it, and we have to make

1 this a quality measure, bring the same rigor,
2 same discipline to this as we bring to any of the
3 quality measures that we talked about.

4 CO-CHAIR PONCE: Thanks Ron. I have
5 Susannah, then Emilio, Lisa Iezzoni, Sarah and
6 now Nancy Garrett. Susannah, you're on.

7 MEMBER BERNHEIM: Great, hi. Two
8 quick things, my reactions to what folks have
9 said. First, I just want to echo something that
10 Kevin said about with the balance of process
11 measures and outcome measures, not assuming that
12 we can't influence equity and outcomes. I think
13 the experience of readmission measures, which
14 people have strong feelings about but they were
15 brought into a program and not only did hospitals
16 at first think they couldn't really influence
17 them, but nobody was paying that much attention
18 to the equity thing, but the stink that hospitals
19 were going to get heard.

20 What happened was that those national
21 readmission rates came down, and there's now been
22 two and about to be a third publication showing

1 that they went down faster in safety net
2 hospitals than non-safety net hospitals. So we
3 actually decreased the gap. So I think we -- I
4 think one of the powers of outcome measures is
5 that we sometimes learn we can do things once
6 they're incentivized. So I think the same could
7 be true with equity measures.

8 Two is I wanted to go back to Bob's
9 comment. So Bob, I think is really important
10 theme that came out about how do we protect the
11 safety net hospitals on this. I thought Kevin,
12 sorry Marshall said it was important that I think
13 helps us continue to differentiate between issues
14 of protecting and assisting safety net
15 organizations, which has a lot to do with how
16 measures are implemented.

17 So our framework clearly labels that
18 as one of the goals, is to protect the safety net
19 organizations and in fact the argument usually
20 around risk adjustment is kind of in that box,
21 right? How do we protect safety net hospitals
22 from coming through?

1 How do we -- and I've often argued
2 rather than doing it in the measure, how do we
3 build penalty programs to protect safety in
4 hospitals, to differentiate between them with the
5 penalties? That is important, but as I thought
6 Marshall said really well, that's really about
7 preventing unintended consequences so there's not
8 the other stuff that are our community is looking
9 at that I think is really important, which is
10 promoting improved equity, right.

11 Protecting the hospital just prevents
12 the unintended consequences. But these concepts
13 that have, you know, really looking at where
14 there are gaps and eliminating those gaps and
15 then incentivizing providers to close those gaps,
16 that's the more proactive stuff, and that's where
17 stratification of patients comes in, right.

18 So the risk adjustment is more about
19 preventing unintended consequences;
20 stratification if you do it well and you say
21 look, this hospital has a gap in their black
22 versus their non-black patients, and we're going

1 to, you know, incentivize and narrowing that gap,
2 now we're doing something that's really proactive
3 to improve equity. So I think that
4 differentiation, which is important for us to
5 reflect on.

6 And then I just wanted to echo a lot
7 of what Ron just said, which I think was really
8 good, but make one slight difference, because I
9 feel like these domains that we have, and this is
10 finally getting to the question that you guys
11 want us to address, are very complementary and
12 that organizationally you may want to move
13 through them step by step, right.

14 You may need to establish culture in
15 order to achieve those other pieces. But in
16 terms of use of measurement, I'm not convinced
17 that you would -- in fact I'm convinced we would
18 not want to suggest that we start by measuring
19 culture, because often, and sort of relates back
20 to my first comment, if we measure outcomes,
21 organizations dig deep and say that we have to
22 look at our culture, right.

1 So I think that the -- in terms of how
2 you sequence measurement, these can be very
3 complementary. They can, you know, make people
4 look more in areas that they need to, and I think
5 of the third and fourth domain, which are access
6 and quality, which includes in my mind outcomes
7 of being the ends, right.

8 At the end of the day, what we're
9 trying to do is have equal access and equal
10 outcomes, and the first, second and fifth are the
11 means, right. The way we do that is through
12 things like changing culture and establishing
13 partnerships. So if we were going to start about
14 this set, that would be the framework I would
15 use, that these are complementary, but they're
16 sort of measures that are more about the means
17 and measures that are more about the means.

18 So that's my recommendation for how to
19 think about the domains.

20 CO-CHAIR PONCE: Thanks, Susannah. We
21 have Emilio, then Lisa Iezzoni.

22 MEMBER CARRILLO: So going back in the

1 discussion, some of the -- I want to just add to
2 some of the points that were made by Kevin and
3 Lisa about the issues of community collaboration
4 and partnerships. There is an example. I mean
5 there are concrete, measurable frameworks that we
6 can use, and I'd just give an example, collective
7 impact.

8 I mean collective impact is used in
9 the social sciences, it's used in the world of
10 education, it's used in the world of social work.
11 But collective impact has been applied to health,
12 health care and it allows us a set of process
13 measures such as what is the nature of the
14 backbone of the collective impact group, the IT
15 capability? What is the diversity of the
16 constituents? What are the goals, what are the
17 goals that achieved, etcetera?

18 So there are ways to concretized in a
19 measurable framework some of these more abstract
20 concepts, and just for instance, this collective
21 impact straddles the other domains. It also
22 straddles the culture of equity domain. So

1 that's just an example.

2 CO-CHAIR PONCE: Thanks, Emilio and
3 we'll follow up with you as we populate our new
4 measures framework. So next we have Lisa Iezzoni
5 and then Sarah, you're after Lisa.

6 MEMBER IEZZONI: Thanks. This has
7 been a really rich discussion, and I have no idea
8 what to do with the stuff that's been percolating
9 in my brain, so I'm just to going to reveal it.
10 So many of the people that we're talking about
11 who experience disparities are Medicaid
12 recipients, and states differ in terms of the
13 richness of their supplemental services that they
14 support.

15 For example, the extent to which they
16 cover transportation benefits, the extent to
17 which they cover renovations of somebody's home,
18 the extent to which they might allow somebody to
19 get an air conditioner, the extent to which they
20 cover personal care assistance. I just wonder
21 the extent to which we might be -- some of our
22 measures are going to be more dependent upon

1 people in the community getting these kind of
2 supplemental services from Medicaid, so they can
3 actually get the services or achieve their
4 health.

5 I get the transportation. David, you
6 talked about that a lot yesterday, even get to
7 their medical appointments. So to what extent
8 might we be disadvantaging some states where the
9 benefit packages for Medicaid are just really,
10 really thin compared to some other states, and
11 how do we think about that?

12 CO-CHAIR PONCE: We're thinking about
13 it. Thanks, Lisa. That's a great question, and
14 we can come back to this with the Committee
15 members. So we have Sarah and then we have
16 Nancy, Philip. So Sarah, you're on.

17 MEMBER SCHOLLE: Okay, good morning.
18 Thanks very much. This has really been a very
19 helpful conversation. I agree. When I went back
20 and read this was just domains and these
21 descriptions, they resonate very well. I think
22 it really does stand up as a very nice framework.

1 But I am also, I think I'm caught up on how do we
2 measure the things, having a lot of experience
3 trying to articulate what does the organization
4 look like and how do you determine whether that
5 organization has an adequate infrastructure?

6 We know that leadership is important.
7 We can feel it, but it's very hard to measure.
8 So I -- the comments from previous speakers about
9 focusing on the end game, focusing on the
10 achievement of outcomes or achievement of equity
11 in specific measures, process measures that have
12 very strong evidence base. That to me is a way
13 that can generate focus and attention to all the
14 things that have to come before, in terms of --
15 or that go alongside that, of building a culture
16 where there is a desire to improve them and
17 there's not a sense that well, we expect that for
18 different populations we might get lower rates
19 and that's okay because they're different
20 populations with different needs.

21 It generates the impetus to develop
22 the collaboration and partnerships to give -- the

1 idea of trying to think about measures is what
2 are suitable for quality improvement versus what
3 are -- what is better cited as accountability
4 measures.

5 It's important for us to do this
6 because I think while we agree and frankly, you
7 know, there's a lot of I think qualitative
8 researchers or organizations that improve on
9 measures have a -- have strong leadership, have a
10 strong cultural quality, a strong --

11 Those are things that are hard to
12 measure outside of perhaps, I'm most convinced by
13 measures that ask people that work in an
14 organization about the culture in that
15 organization. But even there it can be a
16 challenge to implement on a wide scale in a way
17 that's reputable and allows for fair comparisons
18 across organizations.

19 So I'm a little nervous about saying
20 that we're going to have measures about structure
21 and culture that could be used in accountability,
22 because I think the potential for gaming in those

1 measures is much greater than in the measures of
2 end points. I also think we have to -- that
3 looking at a core set of measures, where we want
4 to focus attention will be much more convincing
5 to a broader range of interests in this area.

6 So I just am very pleased to see this
7 discussion going forward. I'd like for us to
8 think about how measures can be used to achieve
9 the end game, and where do we want to make
10 recommendations about measures that might be
11 useful for some kinds of internal purposes versus
12 external purposes, and how as measures, as we
13 think about trying to achieve equitable high
14 quality care, equitable access that we think
15 about ways that measures could be used to reward
16 improvement or address the improvement that
17 happens over time, rather than just a static
18 comparison at a single point in time as well.
19 Thanks.

20 CO-CHAIR PONCE: Thanks Sarah for
21 raising those issues, and we're presuming you're
22 coming back tomorrow when we get into that

1 discussion. So thank you. Nancy?

2 MEMBER GARRETT: So I just wanted to
3 make a specific recommendation to consider about
4 our framework, kind of building on what Sarah was
5 saying about consideration of how we're actually
6 using measures. Is it for quality improvement,
7 is it for accountability, and then Susannah said
8 we want to be incenting all providers to be
9 improving on these measures, and then also guard
10 against harm to the most vulnerable populations.

11 So if we look in our equitable high
12 quality care category, we've got, you know, kind
13 of our traditional set of quality measures in
14 that category. What I'm wondering is if we want
15 to look at the National Academy of Sciences
16 report. One of the recommendations that they
17 made is that we might want to consider
18 categorizing measures as social determinant-
19 sensitive or not.

20 So the social determinant-dependent
21 measures was one of the subcategories in the
22 previous disparity-sensitive measure category.

1 But I'm wondering if we want to actually consider
2 calling that out and categorizing the measures in
3 that group according to whether they are or are
4 not, because then that provides a framework for
5 starting to think about how are you going to use
6 those measures.

7 And if it's how they -- if it's a
8 measure like blood sugar control for diabetics,
9 you might want to be really cautious about using
10 that as, you know, in Bob's example, of a way
11 that you might be moving large sums of money
12 around away from the populations that need it
13 most. So if we were to have that categorization
14 within that category, that might really help
15 advance the conversation about how the measures
16 are used. So that's a specific idea.

17 CO-CHAIR CHIN: This gets back to your
18 original question about disparity-sensitive
19 measure issue. It may be what happened with it
20 about even now. Part of the review of the
21 disparity-sensitive measure part, I almost have
22 Emilio's reaction also, where in some ways it

1 starting to get outdated, the way it was
2 formulated at that time.

3 It was almost I'd say like very sort
4 of like patient -- well, let's say, blend the
5 patient to the field and that it's too harsh.
6 But it's like it's almost it gives the
7 organization more of a pass, I think, in terms of
8 like that so sort of like communication
9 sensitive. So like very patient-focused.

10 But again this broader issue of like
11 well, if a system isn't designed to take good
12 care of the patients, the way it was worded, some
13 of the disparity-sensitive bullets sort of was
14 straying away from that. So I guess it's like
15 the issue too, like the socially sensitive --

16 CO-CHAIR PONCE: Determinant-
17 sensitive.

18 CO-CHAIR CHIN: The social
19 determinant-sensitive measures, it's almost it's
20 the same challenge of the continuum. So
21 depending on how you -- I mean the words can be
22 very important because some things you might

1 identify as being more obviously socially
2 determinant, sensitive; in others it's more
3 subtle, again, Emilio's point.

4 So I guess that's my major concern
5 about it, the current warning that we need to be
6 a little nuanced about like -- in making sure
7 that it's fair, in terms of like what folk --
8 what is the responsibility of the organizations
9 it is the responsibility, or they don't get a
10 free pass or faced which I think the current
11 wording potentially could miss.

12 CO-CHAIR PONCE: Yeah, I agree,
13 because I think lifestyle was an upstream
14 condition, which does not seem like an upstream
15 condition for me, because that could sit on the
16 patient.

17 MS. O'ROURKE: Just a quick one. This
18 is a great conversation, and again Emilio
19 remembers this. I think he may have chaired the
20 work group at the time that we were doing this
21 work on the disparities. It was a while ago, and
22 the reason why I bring it back up is there's some

1 -- there's some kernels of good stuff in there,
2 but it needs an update.

3 I think actually what several of the
4 comments have been we think we have to get away
5 from saying these are to be used to identify
6 measures that should stratified. I think we've
7 moved beyond that as being the only tool in the
8 shed, and perhaps it's really that we're trying
9 to come up with measures that are equity
10 sensitive, that would fit into these domains.

11 And maybe we then think about the
12 criteria maybe they fit this domain. So just
13 thank you for advancing our thinking, which is
14 why we wanted to put it in front of you again.
15 Thanks.

16 CO-CHAIR PONCE: Thanks Helen.
17 Philip.

18 MEMBER ALBERTI: I'm trying to tie
19 together so many of the threads of this
20 incredible conversation so it will make more
21 sense to me. So I feel like the domains that
22 you've listed, these five or six domains, kind of

1 are the road map. So I mean maybe it's a cul-de-
2 sac, right, kind of loops back in on itself and
3 it's both sequential and self-reinforcing, that
4 the more you do the work, the more the culture
5 improves, etcetera, etcetera, and it's kind of a
6 chicken and egg scenario. So that's kind of one
7 thought.

8 And in terms of, you know,
9 accountability and, you know, I can't imagine
10 that we're going to make recommendations, you
11 know Romana. We're talking that CMS is somehow
12 going to reimburse for fomenting a culture. But
13 I wonder if, you know, in service of the third
14 and fourth domains around access and quality,
15 where that seems to be more on target, there are
16 some concrete recommendations about the kinds of
17 measurements that we propose in the
18 stratification of the adjustment or whatever, and
19 we can provide tools and the resources for the
20 other domains on what, what have other
21 institutions done to kind of create the culture?
22 Where are the systems that we think are in place

1 to do this work, that could be part of the needs
2 assessment that Ron was talking about.

3 So I wonder if it's a balance in this
4 report of both kind of formal recommendations
5 about measurement and accountability programs,
6 but also a set of tools and resources and a
7 research agenda to kind of move the conversation
8 forward.

9 I think to Lisa's point, you know, a
10 strategy I think for all -- and to Michelle's
11 point about making this both central and not
12 trying to add new work. So I think if we really
13 look at kind of -- and I think we've done this
14 already, and thinking about these five health
15 areas that are kind of common community health
16 needs across the country, thinking about the
17 metrics that are already in use in a routine way,
18 identifying those across the country that are
19 being used already, that are central to
20 reporting, to really then identify those that are
21 social determinant-sensitive, disparity-
22 sensitive, whatever we're going to call it, and

1 targeting those as the first pass for measurement
2 could be both a way to make sure that it's
3 central to everyone's work, and we're not asking
4 someone to do something more, just do something
5 different that they're already doing.

6 And then the last point that I wanted
7 to make is really picayune, and I know that the
8 visuals will change. But in terms of the arrow,
9 the collaborative arrow across the five domains,
10 I would really urge that that extend beyond that
11 fifth concentric circle, because right now all
12 the partnerships, it looks like they're internal
13 partnerships, and there's nothing actually
14 extending beyond the institution's walls in kind
15 of the current visual.

16 So it looks like the culture to the
17 quality, all of those are internal kind of
18 measures, but that partnership and collaboration,
19 I think we really need to stress that they extend
20 beyond the hospital and to the community and
21 other sectors. So those are some points.

22 CO-CHAIR PONCE: Thanks, Philip. Very

1 helpful. Traci and then Michelle and then back
2 to Emilio.

3 MEMBER FERGUSON: Yeah. So I was
4 going to address Lisa's comment, in terms of the
5 Medicaid, the state agencies. What we're seeing
6 now is that, you know, depending on what stage,
7 depending on their funding, they may have a
8 richer benefit plan that, you know, looking at
9 fee for service.

10 But then a lot of these states are
11 reaching out and opening up their membership to
12 managed care organizations, and requiring that
13 they have value-added benefits, and looking at
14 ways to innovate in terms of, you know,
15 transportation, looking at health care education,
16 what they're going to do to improve that
17 community connectivity.

18 But I think that this would be a great
19 opportunity for this committee to give a
20 framework of what would be sort of expected if
21 they are looking to try to sort of improve for
22 their Medicaid population.

1 CO-CHAIR PONCE: Lisa on this point.

2 MEMBER IEZZONI: Yeah, and I jumped
3 into the line to answer that. Yes. In
4 Massachusetts, you may have heard of the One Care
5 Program, which is like what you just described on
6 steroids and we, you know, wanted to offer a very
7 rich transportation benefit initially but it just
8 got to be really expensive.

9 And so if you limit the dollars that
10 you give to programs to try to control costs,
11 you're simply not going to be able to cover all
12 these things. So I think that this is actually a
13 very, very important policy context, that we need
14 to wrap everything that we're talking about in
15 because the people who experience social
16 determinants of health and social risk factors
17 are Medicaid recipients.

18 CO-CHAIR PONCE: Thank you. Michelle.

19 MEMBER CABRERA: So building off of
20 this conversation, if I may get into
21 conversation, Traci, I do think that part of what
22 we should be trying to do in how we explore, you

1 know, the packaging of our recommendations is to
2 think about who's buying what we're selling,
3 right.

4 I do engage some with purchasers, live
5 purchasers like our state Medicaid program, as
6 well as payers like health plans. We hear the
7 way that they're thinking about things and
8 talking about things. I think if we put out sort
9 of a road map, it doesn't really impact the
10 conversation at all at that level.

11 And so we really need to hold their
12 hands and I think we need to tailor a lot of what
13 we're doing to different kinds of purchasers. So
14 there's a Medicaid conversation around
15 disparities where maybe adjusting for income is
16 not the point, right. But adjusting for --
17 looking for racial and ethnic disparities is way
18 more influential and important than it was in our
19 conversations about Medicare, right.

20 Where we found yeah, no, the income
21 level stuff is the predominant. But I don't -- I
22 feel like we've barely scratched the surface on

1 the Medicaid side and yet Medicaid is following
2 full throttle the directive of CMS on the
3 Medicare side.

4 So I worry that we are going to kind
5 of miss this, and then that's not even starting
6 to talk about the commercial private side, right,
7 where who knows what's going on, but likely it's
8 some mix of all of the above, right.

9 So I do think that to some degree we
10 do need to be mindful that -- of these two
11 points, that there's a purchaser-specific framing
12 for the conversation, that I don't think that
13 large purchasers and payers understand, or will
14 seek this out for the most part, right, even
15 large purchasers with significant populations,
16 where there are significant disparities.

17 And so we -- I hope that part of what
18 we can do is move a step beyond this to really
19 figuring out a way to walk them through what they
20 should be thinking about, and how they should be
21 applying some of this stuff.

22 CO-CHAIR PONCE: Thanks, Michelle. So

1 building out that road map to hand-holding,
2 tailoring future directions, future areas for
3 research is also what Philip said. Emilio,
4 thanks for waiting so patiently.

5 MEMBER CARRILLO: (off mic) Sure,
6 sure. You're talking about leadership and, you
7 know, how you measure that better. That came in
8 years ago --

9 CO-CHAIR PONCE: Emilio, please put
10 your microphone on, and then repeat what you just
11 said. Back to the future.

12 MEMBER CARRILLO: Yes. The spirit of
13 Back to the Future, to 11 years ago the report "A
14 Comprehensive Framework and Preferred Practices
15 for Measuring and Reporting Cultural Competency,"
16 which Helen was right there ahead of the curve,
17 we had -- the first domain was leadership, and
18 there's actually a set of five preferred
19 practices that help define leadership, for
20 example, which are measurable.

21 For example, seeing that culturally
22 competent care is reflected in the vision goals

1 and mission of the organization, implementing
2 strategies to recruit, retain and promote at all
3 levels of the organization and diverse
4 leadership, ensuring that fiscal and human
5 resources --- et cetera, et cetera.

6 So you know, it's been thought about
7 and it's in the NQF world view, so we can look at
8 that.

9 CO-CHAIR PONCE: Thanks, Emilio. Bob.

10 MEMBER RAUNER: I'm going to follow up
11 on Michelle's comments and then trying to figure
12 out a tactful way to say this, but we can have a
13 really rich discussion around this with this
14 group. But when I'm sitting across the table
15 from the CMO or a commercial plan or somebody
16 from our state Medicaid department, they're
17 starting at a much lower level on these issues.

18 So part of the challenge I think we
19 need to -- although CMS is our primary audience,
20 Blue Cross/Blue Shield needs to hear these and
21 the state Medicaid folks need to understand these
22 disparities issues. But the same with -- you're

1 starting from a much more elementary level when
2 you're talking with your commercial plans and
3 payors about this stuff.

4 So we need to -- I want to -- I'm not
5 sure what the solution is, but they are not in
6 your health plan. You have to like almost
7 explain basic statistics to these people
8 sometimes, and so they don't understand bias and
9 risk adjustment and social determinants. We need
10 something for those groups to bring them up to
11 this level of conversation at some point.

12 CO-CHAIR CHIN: I've got a question
13 for Helen based upon Bob's comment. So we have
14 this immediate September 2017 deadline for
15 finishing this project and report to CMS. Do you
16 have any vision or sort of thought for what the
17 Committee does sort of after that charge?

18 MS. O'ROURKE: I think it's something
19 we'd like to talk to you about. I mean we've
20 made a commitment that this is, and I'll turn to
21 Elisa. This is, you know she runs the place
22 really so we made a commitment. This is a

1 standing committee. It is not -- it has not been
2 stood for this one -- that sounds really bizarre.
3 It was not stood up for this one project. It is
4 intended to have a continuous life at NQF.

5 I think as we did for the year before
6 we got HHS funding, it won't go away. We may
7 just not have dedicated funding in the way we did
8 in the prior year, unless we can find additional
9 funding or talk with our CMS colleagues to
10 thinking about whether there's a Phase 2. Lisa,
11 this is really your bailiwick. Do you want to
12 add anything?

13 MS. MUNTHALI: No, I'm sorry. My
14 voice is almost going. Helen is right. We've
15 had some good conversations with CMS, so we are
16 hopeful that they will continue funding. But
17 this is a commitment through us at NQF, and we'll
18 find the resources, perhaps not to the level that
19 CMS has been able to support us over the last two
20 years. But we are very hopeful about the
21 conversations we've had with them recently.

22 CO-CHAIR CHIN: You know, I guess more

1 specifically, are you going to mention a fairly
2 narrow charge in terms of like internally, like
3 NQF issues and like recommendations of other
4 committees, and the input of this -- by our
5 standing committee, versus some of the things
6 I've just mentioned.

7 So for example like I guess it was Bob
8 and it was like Michelle that were talking about
9 like the wider payer communities, both
10 governmental and non-governmental, and then
11 creating materials or tools or a process that
12 influences that. That's a much more external-
13 looking focus.

14 So is there any guidance regarding
15 internal/external balance, or are we open on this
16 at this point?

17 DR. BURSTIN: I think anything's on
18 the table. I mean I think there's a real
19 opportunity. I know Derek Robinson, HCSC, just
20 did an equity summit recently. So I know there
21 is some interest in the -- certainly we've got
22 Kaiser, we've got other financiers, interest in

1 the payer community. So we'd love to see if
2 that's a possibility.

3 But again, as we think about the work
4 of MAP, The Measures Application Partnership for
5 example, that recommends measures to CMS for
6 different federal payment programs. I very much
7 think this committee would be a critical input
8 into the way that measures are recommended for
9 selection. Does this measure bring an equity
10 balance?

11 Marshall was the subject matter expert
12 on that, to try to bring that perspective. We
13 could build it into the criteria that we use to
14 recommend measures to CMS, you know. Then your
15 work has continued effort through our other core
16 processes. How does this get built into the
17 endorsement of measures? How does this work,
18 we'll talk about tomorrow certainly around social
19 risk adjustment.

20 But even, you know, identifying those
21 top gaps that will emerge out of this is
22 something we can then work with our incubator on,

1 and see we can find external funding to get some
2 of this done. So we really see this, as you guys
3 are intentionally cross-cutting with an
4 expectation that you influence all of our work
5 going forward.

6 So I wouldn't feel limited by internal
7 versus external and again, this year we're really
8 fortunate to have the CMS funding, and I think we
9 are able to kind of build the work you already
10 wanted to do around it. But our hope is that
11 your work is not constrained, that you continue
12 to serve as what we need, which is a cross-
13 cutting influence on our work to make sure
14 disparities are not the after-thought, but are
15 core to the discussions of quality.

16 CO-CHAIR PONCE: Thank you, Helen.
17 Romana.

18 MS. MURPHY: So I wanted to get back
19 to I think a point that Ron raised, in terms of
20 one size will not fit all, and health care
21 organizations that leads to different stages of
22 whether they can actually focus on specific

1 disparities reduction initiatives, or whether
2 they really need to get that buy-in from
3 leadership.

4 And so, you know, I know there were a
5 couple of comments and I can't attribute all of
6 them, but I was kind of just percolating on this,
7 and you know, I think about my role. I started
8 at Denver Health in January, and you know, after
9 all these years of working on disparities, it's
10 the first time I've been, you know, in the room
11 with the C suite listening to what gets reported,
12 going to the board to report to the board.

13 What I can tell you about Denver
14 Health, and I know that there are others here
15 from safety nets and from other health care
16 organizations, what I know is that there is a lot
17 going on, and I think it was a comment that was
18 we can give a road map, but if we don't do some
19 hand-holding there's, there is, you know, we're
20 kind of going to miss the mark a little bit.

21 I think about the road map, because I
22 know there have been other road maps. When I am

1 sitting in, you know, executive staff meetings,
2 nobody is talking about a road map. But we are
3 hearing about all the different initiatives that
4 are taking place within the organization.

5 We are hearing about the contract that
6 we had with Lyft, to bring people to Denver
7 Health. I know Denver Health is involved with
8 the, you know, the 1-2-3 Equity Pledge. So my
9 point being that there are pockets of work taking
10 place in health care organizations, but they
11 don't know how to kind of roll it up to oh, this
12 fits into this framework or this road map, or
13 this is how this connects to payment reform.

14 So my question is, you know Helen, and
15 I think, you know, what you said about this being
16 a standing committee and where we go next. So
17 you know, when our work is done here, I don't
18 know if NQF has ever done this. But is there any
19 capacity to collect information from, you know, a
20 handful of organizations that we know are doing
21 really great work, but it's kind of scattered
22 within the organization and it isn't attributed

1 to or tied back to a framework or to a road map,
2 and really ask them to do that, so we can see the
3 body of work that's taking place.

4 Because I think what I'm recognizing
5 is that there is, but we're not connecting the
6 dots well. We still think about this very much
7 from the deficit model, you know. That's kind of
8 the framework, and I guess I'm kind of saying,
9 you know, is there a way for us to compile some
10 of the good work that is happening and tie it to
11 what our recommendations are and the road map
12 that we're developing, because I think it makes
13 it much more concrete.

14 It also acknowledges a lot of
15 organizations that are doing a lot, but they're
16 not connecting the dots. So you know, when I
17 bring this up in a meeting, I get kind of like
18 "Oh, wow, that's fascinating," because they are
19 so involved in terms of what is working within
20 their own institutions.

21 DR. BURSTIN: It's a great suggestion,
22 Romana. You may have just helped us write the

1 follow-up proposal to CMS to continue this work.
2 I think it's a neat idea to actually see how this
3 road map, how it connects to what people are
4 actually doing on the ground and how it could be
5 useful, and again, we don't want this to just sit
6 on a shelf. We want this to be truly
7 disseminated and used.

8 I think it's a really interesting
9 idea. It would also be great to understand how,
10 for example, if equity measures increasingly get
11 into pay for performance, how does that change
12 the dialogue at some of those meetings? I mean
13 we really need to understand. For a long time
14 we've talked about if only we could push some of
15 these forward in the way people flip out over
16 readmission and sepsis measures at institutions,
17 how do we get them to have the equal response to
18 a measure that says language interpretation
19 skills are available within X number of minutes
20 is I think going to be a really interesting
21 challenge for us. I'd love to better understand
22 the implementation science, not just the here's

1 what needs to happen.

2 CO-CHAIR PONCE: Thank you. Christie.

3 MEMBER TEIGLAND: Yeah. So I was part
4 of yesterday's conversation and today's
5 conversation, and this whole concept of this sort
6 of disparities that we're not seeing in the
7 Medicaid populations, and we call that moral
8 hazard in economics, right, and it's sort of
9 unobserved.

10 But it's this moral hazard idea that,
11 you know, if you have access to more benefits,
12 you're going to probably use them, and that's why
13 we might see, for example, the result I reported
14 yesterday, which is when you look at medication
15 adherence and you adjust for duals yes, they're
16 less likely to be adherent to their medications.

17 But when you add income in there,
18 because of all the disparities in benefits across
19 states and eligibility requirements, a dual does
20 better than a poor person, and I've talked about
21 this before. But I really think -- and then we
22 have this whole debate about Marshall, the

1 business case, and people kind of took affront to
2 that, you know, that well, it shouldn't have to
3 be a business case. It's a moral case, right.

4 Well actually it does, and you know,
5 and in the ACA, for example, there's the lowest
6 level of benefits that you need to provide. It's
7 a minimum. I don't know how they came up with
8 that, but it seems like we need to look at that
9 perhaps as a measure. I mean what is the minimum
10 set of benefits that are required to have good
11 health outcomes, and maybe that's a quality
12 measure.

13 Maybe who's looked at benefits, right?
14 I mean we know what the benefit packages are for
15 Medicare Advantage Plans. We know what the
16 benefit packages are for all of the different
17 choices you have in the current version of the
18 ACA. But no one's studied that very much in
19 terms of how that relates to outcomes, and but we
20 clearly know there's a connection there.

21 Then there's this whole concept of who
22 pays, right? I mean we're talking about

1 providing transportation and education and, you
2 know, helping people get their GED. Well that's
3 saying that HUD isn't doing their job and
4 Education isn't doing their job, so now health
5 care has to pay for that?

6 Really? So who, right? I mean how do
7 we -- how do we connect all those dots? So
8 benefits seems to be critical here, these
9 benefits packages. There might be some minimum
10 level. I mean how do you measure that? How do
11 you quantify that in a way that will assure we
12 can actually close these moral hazard gaps that
13 we're not really able to observe?

14 CO-CHAIR PONCE: I think our standing
15 committee is going to be here forever as we
16 consider this, until it's fixed. Traci and then
17 Phil.

18 MEMBER FERGUSON: Yes. This is a
19 comment just to expand on Romana's comment about,
20 you know, calling for organizations of what NQF
21 can do next, that if you have organizations that
22 are willing to open themselves up, who are doing

1 initiatives may not be sort of connected, then
2 they want to take it to the next level, be able
3 to sign up for NQF consultation to assist in
4 doing an evaluation and assessment once we have
5 again that road map to be able to see, you know,
6 over a period of time.

7 If we give them guidance, will they be
8 able to, you know, whatever the domains that they
9 have to focus on and work on, can we as an
10 organization help them facilitate, because you
11 know, it's hard doing it within the organization,
12 to you know, have that expertise. But if you
13 have all of these minds together being able to
14 say, you know, we have -- whether it's a cohort
15 of people going through this in different
16 organizations, and that I think will make our
17 road map a living document as we see, you know,
18 improvements and this works with this type of
19 organization so --

20 CO-CHAIR PONCE: Thanks, Traci.
21 Philip.

22 MEMBER ALBERTI: I have a really quick

1 point and then maybe a longer point that
2 piggybacks off of what Christie said and some of
3 the conversations yesterday. So the quick point
4 is the AAMC, with some AHRQ funding, has been
5 developing some tools that I think speaks to what
6 Romana was talking about, in terms of how an
7 institution can build a systems approach to
8 community health and health equity.

9 And so I'm happy to share those and we
10 can maybe talk. Maybe that's a next something to
11 leverage going forward. Christie's conversation
12 just now about social services, the partnerships.
13 So I talked a little bit about this yesterday at
14 the NAM event, kind of thinking what our goal is,
15 right? Do we think that the expectation that we
16 should have for hospitals health systems is that
17 there are never any documented disparities in any
18 outcomes?

19 So I don't know if that's a reasonable
20 assumption. So I was tasked yesterday with some
21 others to think about how we would measure health
22 equity, right. So if health equity is this

1 everyone has an equal opportunity to avail him or
2 herself of his or her full health potential isn't
3 hindered because of socially derived
4 circumstances?

5 You know, these process measures we're
6 talking about really speak to a hospital or
7 health system's actions to create that
8 opportunity, right, to create an equal set of
9 traces for all patients, if we're thinking about
10 health care opportunity, or for all members of a
11 community if we're thinking about kind of health
12 opportunity.

13 So even in this perfectly equitable
14 system where Patient A and Patient B from very
15 different SDS backgrounds, if they have the same
16 set of choices available, we've attained a state
17 of health equity or health care equity if we're
18 talking about the choices inside a hospital's
19 walls. But those individuals could still make
20 different choices, right.

21 And so we still might see group
22 differences in health that aren't in equities or

1 not related to social disadvantage, but they're
2 kind of these dry disparities, differences in
3 health that aren't pinned to a decreased set of
4 opportunities or choices due to social advantage.

5 So I just wonder, I don't know if we
6 need to be as philosophical as I tend to be on
7 this issue in the report, but you know, what is
8 the goal, what is the expectation? Is it
9 complete, you know, equality, or is it really
10 equity of choice, opportunity, ability to be as
11 healthy as I personally choose to be and I'm not
12 hindered, and what does that look like in terms
13 of measurement and how do we adequately capture
14 that?

15 I just -- it's kind of a little bit of
16 a monkey wrench, but it's something that's really
17 pressing on my mind on these days.

18 CO-CHAIR PONCE: Philip, I wanted to
19 thank you because I think that helps us segue
20 into the next part, which is the guidance for
21 developing equity measures. So I'm going to ask
22 Erin to continue with that. Oh, I'm sorry. Ron

1 and Michelle. So Ron, then Michelle.

2 MEMBER COPELAND: Good. Just a quick
3 point, that Romana's and Christie's comments just
4 reflected. When we talk about this business case
5 and the traction that sepsis and other things
6 have gotten in the quality community, one of the
7 reasons they've gotten so much traction is
8 because the financial or economic impact, in
9 addition to the quality components of it for
10 people's health, but the economics is a front and
11 center issue because in hospital systems and so
12 forth, people got claims and they can see this is
13 costing X amount of dollars and we've got to --
14 it's a target because of that.

15 When I, the last few times I looked at
16 the literature over the last four or five years
17 around have people put dollar amounts or economic
18 impact of disparities, the literature is almost
19 non-existent.

20 I think part of -- so when we talk
21 about incentivizing focus, accountability and so
22 on, one additional area that's not necessarily

1 part of the scope of this current work, as we
2 think about future contributions and so on,
3 anything we can do or encourage that will help
4 quantify the negative, the impact, the economic
5 impact of allowing disparities I think is --
6 would be another important contribution to this
7 area.

8 Because in a resource-constrained
9 environment, which we certainly are in terms of
10 health care, people are following the money. So
11 if no matter what moral arguments and population
12 health arguments are made, if people don't see
13 it, are unable to translate that into what's the
14 economic impact that is causing me by ignoring
15 and not playing in this space, right now that's
16 an empty set.

17 So people don't get motivated or
18 incentivized. So any way we can contribute or
19 encourage industry or otherwise to put some
20 dollar amounts to this work, I think would help
21 the cause big time.

22 CO-CHAIR PONCE: Michelle, did you

1 have a follow-up on that?

2 MEMBER CABRERA: Yeah, thank you. And
3 just to say to Philip, you know, I want go down
4 that rabbit hole with you so bad, because I
5 think, you know, that this issue of like equal
6 opportunity to access health care, if I am a
7 health system and I'm doing me and the patient
8 shows up and I'm like wow, it didn't work for you
9 so clearly you need to do something different,
10 right, that is not achieving health equity,
11 right?

12 The point of this should be to drive
13 a conversation not about sort of equality to
14 opportunity, but it should be to drive the
15 conversation to uh-oh, there is a problem and I
16 need to look first at what is my role as a
17 provider in that -- in fomenting or supporting or
18 allowing that problem to persist.

19 I think the point should not be for
20 the providers or the systems to take on all of
21 that burden, but for them to see what part of
22 that problem are they able to address, right?

1 And if they put their back into it and if they
2 change things, if they do things differently and
3 they put their everything into that problem as a
4 sub-component of the overall quality picture, can
5 they make a difference for that disparity and
6 then by extension for everybody else they serve,
7 right?

8 So it's somehow trying to incentivize
9 flexibility through that accountability, right,
10 and a willingness to experiment. But I am overly
11 cautious that like we need to be careful about
12 the passive response to some of this work, and
13 the possibility that people could just say well,
14 it's not me, right, because I did everything I
15 could to make sure everybody had the same
16 opportunity.

17 And I know that's not what you were
18 thinking because you are so down, but you know I
19 just -- I just wanted to clarify that.

20 CO-CHAIR PONCE: Bob.

21 MEMBER RAUNER: I know we need to move
22 on, but I do want to throw a little counterpoint

1 in there. You know, two specific examples for
2 Nebraska disparities on seat belt usage and
3 colorectal cancer screening. There's huge
4 disparities east and west, and the reason our
5 longevity in western Nebraska is lower is mainly
6 seat belts actually.

7 Now I'm totally okay with being
8 incentivized on that, but making a physician
9 accountable for that is a little different, and
10 that's the kind of follow-up farthest point off.
11 However, the same thing could be said about
12 colorectal cancer screening. Our usage is 13
13 percent lower west and it's going to hurt those
14 doctors on their MIPS scores. But should they
15 really be accountable, because some of that is
16 cultural actually.

17 Some of it's lower health insurance
18 and lower income levels accounting for that.
19 Most of it's actually cultural. I grew up in
20 western Nebraska. They're very fatalistic about
21 their health. They think it's my time, it's my
22 time, I'm not going to do that. So at what -- so

1 I'm totally okay with incentivizing, but I think
2 you have to be a little careful when you deal
3 with accountability.

4 So that's a little bit of a
5 counterpoint to that, because then you're talking
6 about free will and whatever. It's very
7 philosophical and maybe that's a discussion over
8 a beer tonight but so --

9 CO-CHAIR PONCE: Okay, Erin. Can you
10 take us to the next section? We do not have a
11 break until lunch.

12 MS. O'ROURKE: So if you do need a
13 break, please feel free to step out. We know we
14 scheduled a grueling morning, since we have a lot
15 to get through. So for this next section, I
16 don't want to belabor too much on the slides,
17 because I think we've already started to go
18 there. But we're hoping you can help us think
19 through within each of the domains, on some more
20 concrete ways of how we could measure that, and
21 start to assess what we call measure concepts.

22 So it's getting to a little bit more

1 than just an idea. So we defined it as an idea
2 for a measure that includes a description of the
3 measure, including a planned target and a
4 population, obviously with the caveat that we're
5 not tasked with measure development here, but
6 rather just -- so we'll ask you how we start to
7 assess these domains and what are some measures
8 that belong here.

9 I do want to be cognizant of the point
10 that Bob and Kevin made too, that this is also a
11 bit of a renewing exercise. We don't want to
12 necessarily recommend 150 new measures, but
13 rather how can we maximize what we already have.
14 Are there certain measures in play that the
15 Committee thinks are particularly important to
16 assess, starting to maybe put in place what that
17 core set that a number of you have mentioned
18 would look like, thinking about, from each domain
19 what do we really want to assess, and then what's
20 that right balance of structure versus process
21 versus outcome.

22 So to start you thinking, we did a

1 little bit of a homework exercise that we can
2 screen share. Thank you very much to those who
3 were able to complete it. So we think we just
4 want to walk through a little bit, domain by
5 domain, share what we've learned from the
6 homework. I think Philip you sent in ideas here,
7 so we're going to tell you that you're on point a
8 little bit.

9 Just to start to think about some of
10 your ideas and then perhaps we could open for a
11 full Committee conversation on -- starting with
12 the domain of cultural equity, what would we
13 really want to focus on for developing measures
14 in this domain.

15 MEMBER ALBERTI: Sure. I'll happily
16 kind of walk you through my again convoluted,
17 philosophical tortured thinking here. I don't
18 know if there are any measures that I propose
19 that are really right for like accountability,
20 and most of them are binary and don't really have
21 denominators. So that's not really keeping in
22 the spirit with measurement development.

1 But thinking about an institution's
2 culture that would facilitate kind of a focus on
3 health and health care equity. So it is
4 explicitly included in the institution's mission
5 statement and/or strategic plan, with real
6 accountability that rolls up to senior leaders or
7 the C suite through measurable goals, milestones
8 that are really talking about creating a system
9 that creates health care equity.

10 Is there someone at an institution
11 whose sole job it is, or the lion's share of his
12 or her role, to really think about these system-
13 wide efforts to create connection across the
14 institution that focus on equity.

15 And in terms of an institution's
16 advocacy work or community advocacy/government
17 relations, is the institution kind of walking the
18 walk via comment letters, what it's advocating
19 for locally or federally. Are they targeting
20 community health and health and equities?

21 I mean the only the one that maybe
22 fits into a traditional metric in terms of safe,

1 accessible, a safe and accessible environment for
2 all would be some kind of threshold proportion.
3 I'm not sure what that would look like, in terms
4 of faculty, staff, etcetera, from under-
5 represented groups, however we chose to define
6 it.

7 And so I think I collapsed the sub-
8 domains. There's a lot of overlap between these
9 five domains and so it might not be as clean and
10 clear as we had intended. But those at least are
11 my initial thoughts.

12 I also will say that there's a
13 parallel process, and I think I shared this
14 survey with Marshall and NQF staff, that folks at
15 G.W. are thinking about the social mission, how
16 to measure the social mission of health
17 professional school.

18 So it's not quite the same unit of
19 analysis and that stems from Fitzhugh Mellon's
20 (phonetic) earlier work. They've gotten some
21 funding from RWJF to really think through what a
22 culture of social mission would look like and how

1 you would measure it. Some of these are pulled
2 directly from that.

3 That might be another tool for us to
4 look at if we're thinking about maybe not
5 accountability in this space, but developing
6 tools and resources and guidance and hand-holding
7 to think through some of the actions an
8 institution could take to push forward a culture
9 of equity.

10 CO-CHAIR PONCE: Thanks, Philip. I
11 know as you said, this was a hard exercise, but
12 you got us through this since --- and I thought
13 this exercise, at least for some of the domains,
14 was about discovery. It's still like a discovery
15 phase of can we come up with some concrete
16 measures. So I know the measures I've proposed
17 have no evidence.

18 I mean I'm not sure if there's
19 evidence base to it, but again it was just this
20 first try at trying to come up with a policy
21 handle, an accountability handle. Romana and
22 then Ignatius and then Lisa. Oh I'm sorry, Lisa

1 Cooper first then.

2 MEMBER COOPER: Yes. So thanks Philip
3 for leading us off on this. One thing I would
4 definitely add, having been named as an
5 individual at an institution specifically charged
6 with, is that that's actually not adequate, that
7 I would definitely add something around resources
8 being clearly allocated to the work. So evidence
9 of budget, you know, and resource allocation to
10 the work. So I'd definitely add that.

11 The other ideas that came to mind and
12 I'm not -- I think they fit in this domain,
13 relate to a lot of organization do surveys of
14 organizational culture. So for example, you
15 know, we've actually used measures where we
16 assess perceptions of the staff and faculty, and
17 stratify those perceptions by demographic
18 characteristics.

19 And so some sort of regular assessment
20 of the culture of the organization by the
21 organizational stakeholders or personnel I think
22 would be one that we could easily add to this

1 domain. So I think those are the two things that
2 came to mind.

3 Oh, the other thing I thought about
4 was, and it may have been mentioned in the
5 report, is that I thought that committee that
6 Emilio and I were on that was -- that came up
7 with the different domains for organizational and
8 cultural competency, I thought as part of that
9 work, there was an instrument that was
10 commissioned and developed by G.W. was it?

11 Was that mentioned in the report as a
12 measure that could be used? It is? Pardon me?

13 DR. BURSTIN: The Speaking Together
14 measure set of G.W., or something different?

15 MEMBER COOPER: Is that the name of
16 it? I didn't think it was called --

17 MEMBER CARRILLO: It was the Weisman,
18 Betancourt, myself, Green, MGH, that did a study
19 of the measures and that was a couple of years
20 after we did our work.

21 MEMBER COOPER: Yeah. But they came
22 up -- like somebody at G.W. like got a grant to

1 develop a measure that would map to the domains
2 that we -- oh RAND, okay.

3 DR. BURSTIN: RAND, and that is
4 endorsed, and I believe that's captured here,
5 yes.

6 MEMBER COOPER: Okay all right. So I
7 think that's one that could be used and we could
8 look at scores on that measure.

9 CO-CHAIR PONCE: Okay, thank you.
10 Romana.

11 MS. MURPHY: So I just wanted -- I had
12 whispered to Ignatius, and maybe this was
13 referenced or not. I don't remember, I didn't
14 look. But at least the top three of these, the
15 top three measures here, there is a lot of work
16 that was done that Ignatius funded when he was at
17 the California Endowment, looking at, you know,
18 issues around mission and other aspects of kind
19 of leadership.

20 So those reports are still out. There
21 was one specifically from the Joint Commission on
22 hospitals language and culture, and then a second

1 report on language services. The reason I'm
2 calling that out is because a lot of the work
3 there was qualitative and pulled out what
4 organizations were actually doing in terms of
5 implementation of some of the measures that, you
6 know, that Philip has identified.

7 So that might just be a good resource,
8 and I know the work is -- I can't believe it, but
9 it's in some cases more than ten years old or ten
10 years old. But I think it's still relevant
11 because it pulls up specific examples of
12 organizations that were doing it and tries to
13 make some connections to more downstream metrics.

14 CO-CHAIR PONCE: Thank you. Ignatius.

15 MR. BAU: So to pick up on some of the
16 earlier conversation about Medicaid, I'm
17 wondering whether it fits here or it will fit
18 more in the access. But I do think there is a
19 notion of is the health care organization
20 participating or active in expanding the ability
21 of people to get to them as health care
22 providers.

1 So it could be something like are they
2 a Medicaid provider. So we know in a lot of
3 states a lot of providers are dropping out of the
4 Medicaid program because the reimbursement rates
5 are so low. So again, this would be a way that
6 they would actually get a credit for being --
7 sticking in a program that is obviously expanding
8 access to individuals who experience disparities.

9 Similarly if they're a health plan,
10 are they participating in a state health exchange
11 or the federal health exchange. So again, are
12 they making that affirmative decision to actually
13 expand access to care to folks. And so again, I
14 don't know whether it fits culture or it fits in
15 access, but I think the ability to actually call
16 those things into play would be also different
17 but easily measurable.

18 CO-CHAIR PONCE: Okay, thank you.
19 Lisa and Bob, then Nancy. Oh sorry, Lisa,
20 Emilio, Bob, then Nancy.

21 MEMBER IEZZONI: Okay. I know we've
22 defined equity before, but I think when we talk

1 about the culture of equity, so everybody's on
2 the same page that we need to very clearly define
3 what equity means so people understands that. So
4 Bob, you sent me down the rabbit hole yesterday
5 actually, because you made a comment to me
6 somewhere, or maybe even to the whole group and I
7 just took it personally, about how equity needed
8 to be of -- that if you saw any disparities that
9 related to people's choices, people's preferences
10 were operationalized because everybody had the
11 same opportunities.

12 So if you saw differences between
13 groups, those represented -- if you had achieved
14 equity, those would represent true differences in
15 people's desires for different types of processes
16 of care or outcomes. Is that -- did you say
17 something like that, because I have a follow-up
18 comment if you did.

19 MEMBER ALBERTI: I said there's the
20 potential there, right, so for expecting
21 differences that are based on social
22 disadvantages, you would hope those would go away

1 and if there are any remaining differences, they
2 could be due to all kinds of different things
3 individual or group choice or culture, as Bob
4 said, that it's a possibility.

5 MEMBER IEZZONI: Okay, and that's what
6 sent me down the rabbit hole because I think for
7 people who've been so disadvantaged for so long,
8 thinking that they have a choice or feeling that
9 they have an opportunity is going to be a really
10 hard place to get to. If people would bear with
11 me for just a minute while I give an example.

12 We -- our research group was the only
13 research group to use SEER Medicare data to look
14 at the under 65 population and disparities.
15 Everybody else just says oh we exclude people
16 with disabilities. They never explain why. We
17 were the only group that we did, and we found the
18 following.

19 For women with early stage breast
20 cancer, women with disability under age 65, women
21 with disabilities were 24 percent less likely
22 than other women to have lumpectomies. In other

1 words, after you adjusted for all the cancer
2 characteristics that you could with the SEER
3 Medicare data.

4 Otherwise, women with disabilities
5 were a lot more likely to have mastectomies. Now
6 does that represent their choice or what is the
7 reason for that? And so let me just tie this out
8 a little bit, because we then looked at the women
9 who'd only had lumpectomy, both women with
10 disabilities and women without. People know that
11 for women who have early stage breast cancer, to
12 have the same disease-free survival with
13 lumpectomy, you have to follow up with radiation
14 therapy.

15 That's where we found that women with
16 disabilities were 17 percent less likely to get
17 radiation therapy after lumpectomy than were
18 other women. So that's a clear quality problem.

19 Now then I got another grant from NIH
20 to talk to women who have physical disabilities,
21 who had had early stage breast cancer, and I got
22 for example the following story from a women with

1 cerebral palsy, that every time she got put on
2 the radiation therapy table for her XRT, that
3 they had a velcro strap to strap around her waist
4 to keep her in place.

5 But she had of her arms because of her
6 cerebral palsy, and they masking taped her arms
7 down to the table every day. They didn't have
8 velcro straps; they masking taped her. So for
9 her to think that she has the opportunity to, you
10 know, she might have been so upset about being
11 masking taped down all the time that she might
12 have just -- if she had known that that was going
13 to be the case, she might have just chosen to
14 have the mastectomy, because at least that way
15 she wouldn't have had to have dealt with masking
16 tape every day, you know, after an eight week
17 XRT.

18 And so that's why I think that we need
19 to unpack this notion of equity and around choice
20 and around -- so sorry. That's the rabbit hole
21 you sent me down yesterday.

22 MEMBER ALBERTI: I think that's a

1 perfect example. I mean to me that's an
2 inequity. That is a manifestation of social
3 disadvantage of injustice, and that -- I would
4 expect that the QI processes in place would
5 address those very issues, correct.

6 MEMBER IEZZONI: They just don't get
7 it. They just don't get it, and frankly I'm just
8 going to say this. Especially when it comes to
9 disability, my experience yesterday presenting to
10 the conference is an example of that, that they
11 just don't get it.

12 MEMBER ALBERTI: You know, I think the
13 others that we talked about in service of
14 understanding and unpacking equity was the
15 importance of this Committee's work and all the
16 other various kind of groups tasked with this, to
17 do this work in a patient and community engaged
18 way. I think we will really miss those
19 opportunities to think through the unpacking if
20 we're not actually asking and working with and
21 partnering with the people that we're trying to
22 serve in these processes.

1 MEMBER IEZZONI: And about this
2 qualitative research, I know that people are
3 really embedded and wedded to numbers. But to
4 unpack what's going you actually need to talk to
5 people.

6 And so I would like that to be part of
7 the message of what we're -- what our report is
8 going to come out with here, that if you see a
9 disparity that you need to talk to people, and
10 you need to just not talk to them in a survey,
11 but talk to them in a two hour, open-ended, semi-
12 structured search interviews, you know, where you
13 really give them the opportunity to describe
14 what's going on in their life and their thinking.

15 CO-CHAIR PONCE: As always, thanks
16 Lisa. We have Emilio next, then Bob, Tom, Lisa
17 Cooper, are you still on or on the queue?

18 MEMBER IEZZONI: No, I've had my turn.

19 CO-CHAIR PONCE: Okay, and then
20 Michelle. So Emilio.

21 MEMBER CARRILLO: Philip, thank you
22 for taking the lead. I think that the measure

1 domain, the sub-domains that you have pointed out
2 are right on target. They are institutional.
3 They're all institutional. There are other
4 institutional sub-domains that we can find in the
5 2007 NQF report.

6 But we need to look at institutional.
7 We need to look at systematic, systemic and
8 organizational, and we need to look at the
9 individual.

10 So those three realms of sub-domains
11 should be included and we would work on that. An
12 example of the systemic or organizational would
13 be measures of how to include the various
14 different pieces of the puzzle, like the
15 community integration, the neighborhood as a unit
16 of measurement and what takes part in the
17 neighborhood.

18 Those are things that can be measured
19 through collective impact measures that we talked
20 about earlier, and individual measures again that
21 a lot of them are in the lexicon of cultural
22 competence and patient cross-cultural

1 communications. So I think that we might want to
2 look at those three domains as we look at these
3 sub-domains.

4 CO-CHAIR PONCE: Okay, thank you.
5 Bob.

6 MEMBER RAUNER: Just going to follow-
7 up on Phil, I really like these domains, and then
8 of course Lisa mentioning that there needs to be
9 funding specification. I think a great data
10 source that could accomplish that is the
11 Community Health Needs Assessment for Non-Profit
12 Hospitals. I think that's a way under-utilized
13 policy tool.

14 Right now, some just look at it as a
15 checkbox on their Form 990 and not much more, and
16 if put things like this in it, that would
17 actually accomplish a lot, I think.

18 CO-CHAIR PONCE: All right. Could you
19 talk more about that?

20 MEMBER RAUNER: Well, non-profit
21 hospitals, as part of their Form 990, they have
22 to complete a community health needs assessment,

1 which specifies what they're doing to improve the
2 health of their community. A lot of them it's --
3 I've literally had a hospital CFO tell me that
4 they just did that because it's a checkbox on the
5 Form 990.

6 It should be a real thing that
7 actually specifies what they do, what they're
8 funding. It has a lot of potential, because all
9 non-profits have to fill that out to justify
10 their non-profit status. I think that's a great
11 policy tool and you could use that as a great
12 data source because that's a public document
13 essentially.

14 CO-CHAIR PONCE: I see, for
15 accountability. Okay, thank you. Tom?

16 MEMBER SEQUIST: So this is a great
17 lesson. I just had a couple of questions or --
18 I'm wondering as we think about these are --
19 these measures of the culture of equity and the
20 numerator things which are all great things for
21 an institution to be doing, if we wanted
22 something that could also reflect what we were

1 hoping these upstream activities would lead to.

2 So having health equity as a part of
3 your mission statement, and having senior leaders
4 engaged in this. If we had some measure that
5 they were then -- or having someone whose role is
6 to be accountable for this stuff in the
7 institution. If we had some measure that things
8 were happening because of that, short of reducing
9 disparities, which would be the ultimate thing.

10 So I'm thinking about things like are
11 they actually -- and I don't know which domain
12 this fits into, but I was thinking it may fit
13 into this domain.

14 Are they actually measuring and
15 reporting equity measures? Are they being
16 transparent about equity measures on their public
17 websites? So we all have to be transparent about
18 CMS measures, because CMS is already transparent
19 about them.

20 But right now we don't have to be
21 transparent about stratifying those measures by
22 race and ethnicity. But what one would think, if

1 you have senior leaders engaged in this, you're
2 trying to hold people accountable for this, that
3 things like that would be a reflection of --
4 things like measuring, reporting and being
5 transparent about equity measures would be a
6 reflection of that.

7 The other comment that I was thinking
8 is the bottom one, the diversity of the
9 workforce. I think it's great. I really wonder
10 about faculty I'm assuming means the sort of
11 practicing physicians in sort of an AMC
12 framework.

13 I guess what I would hope for is
14 actually that the board room and the executive
15 leadership actually has that diversity, whether
16 it's women, minorities or other under-represented
17 groups I actually think is just as important as
18 the faculty being diverse or the physicians in
19 your group being -- the physicians, nurses.

20 We probably should change that to
21 clinician. I mean it's all of the clinical
22 areas. But I really think it's actually we want

1 to say specifically that the executive
2 leadership. That is actually I think one of the
3 goals. I think someone referenced that AHA
4 Pledge for Equity, that sort of 1-2-3 pledge, and
5 one of the things is diversity of the executive
6 leadership.

7 CO-CHAIR PONCE: Thanks, Tom.
8 Michelle and then Eduardo on the line, then
9 Nancy.

10 MEMBER CABRERA: I'm sorry to ask
11 this, but I'm trying to understand what is it
12 that we're going to do with this set of concepts?

13 MS. O'ROURKE: Sure. So they're
14 basically some illustrative examples to help us
15 flesh out the domains. CMS was looking for
16 guidance about how they could actually start to
17 implement these. So what would the Committee
18 like measurement to look like in these spaces?

19 MEMBER CABRERA: Okay. So we will be
20 turning a version of this over to CMS?

21 MS. O'ROURKE: Yes. We're collecting
22 all your thoughts and then we'll put that in the

1 fourth report.

2 MEMBER CABRERA: Okay. So I think
3 yeah, I will say we do need to I think work on
4 this obviously a bit more, and add some teeth to
5 it, especially because again I'm not trying to be
6 cynical. I just have seen this play out where
7 organizations will say "We will embrace health
8 equity" on their paper, right? It's like totally
9 there.

10 But then the truth is that it's not.
11 So reduction of disparities as part of quality
12 improvement might be one, you know, proposal for
13 how you effectuate this, right, that your quality
14 improvement strategies, in addition to
15 stratifying include disparities reduction as a
16 subcomponent of quality improvement somewhere.

17 And then yeah, that's helpful. Thank
18 you. Just thanks.

19 CO-CHAIR CHIN: If we look back at the
20 structured sub-domains, I think that some of what
21 you mentioned Michelle and what Tom mentioned are
22 in there, but we can make sure the language is

1 clear, yeah.

2 CO-CHAIR PONCE: Nancy.

3 MEMBER GARRETT: So I wanted to build
4 out Ignatius' comments about the -- some
5 additional measures we might think about that
6 touch on domains beyond the providers. So I
7 think these are great provider level measures.
8 So but looking at our model, what are some
9 community measures that we might think about.

10 And so I like the idea of is it a
11 Medicaid expansion state. So our Medicaid
12 patients, do they have that equal access to
13 benefits, and then kind of building on what
14 Christie said earlier, maybe there's even a
15 measure of kind of an essential benefit set for
16 Medicaid, and does the state have that or not,
17 and that could be an interesting kind of culture,
18 and maybe gets into the structure of equity
19 domain as well.

20 Other ideas might be what's the ratio
21 of Medicaid to commercial payment in the
22 community or in the state? That's a source of a

1 lot of inequity and how resources are
2 distributed, is that for the same services,
3 commercial insurance reimburses much greater than
4 Medicaid.

5 So what's that ratio look like, or
6 Medicaid to Medicare payments. So is the
7 Medicaid payment adequate to cover what that
8 population needs could be a measure, again at a
9 community or state level.

10 Then even thinking beyond health care,
11 what about social service spending in the state
12 or in the community, and what are those levels
13 and are they adequate to really address social
14 determinants of health. So I was talking to
15 David yesterday about Detroit and we were saying,
16 you know, there -- in some cases there just
17 aren't the social services to partner with health
18 care, so what do you do?

19 So that could be a health equity
20 measure. If that community isn't offering those
21 resources, then that's an equity issue. And then
22 thinking about health plans, either private or

1 public, are they offering payment enhancements
2 for vulnerable populations? Like is there a
3 payment enhancement to take care of homeless
4 populations differently than non-homeless
5 populations, and that could be a health equity
6 measure as well.

7 Again, it could be looking at your
8 public payers or even your private payers and
9 that would really change the conversation, if
10 that were something they were measured up
11 against.

12 CO-CHAIR CHIN: I have a quick
13 question for NQF staff. One thing that was asked
14 about is who's the audience? So for example some
15 of these measures may apply to plans, some may
16 apply to individual providers. Some of these you
17 mentioned really are national. You mentioned the
18 point about if you're a Medicaid expansion state
19 or not.

20 So to staff or to Helen or Elisa
21 there, if we're going to -- who are -- who's the
22 audience and if we are going to take a number of

1 stakeholders to describe in more detail, in terms
2 of like relevant measures, how would you
3 prioritize?

4 MS. O'ROURKE: Sure. So what actually
5 Drew and I were just whispering about was that it
6 seems like we're checking a little bit along some
7 of the ways that NQF thinks of measures on level
8 of analysis, like I think Nancy you were just
9 mentioning some great potential population level
10 ideas.

11 But I think there's also a role for
12 health plan measures and what we can assess them
13 on as far as what they're doing to promote
14 equity. And then I think drilling down those
15 measures we would need at the provider level,
16 perhaps even going all the way down to the
17 individual clinician.

18 So I think we can think about this,
19 you know, going back to the socio-ecological
20 model that we showed at each level, and thinking
21 of how NQF assess measurement at various levels
22 of analysis, what concepts, what tracks so that

1 everyone is perhaps being assessed on the same
2 underlying concepts, but in their own way, if you
3 will.

4 DR. BURSTIN: Right, and some of this
5 may get into some of the crispness we talked
6 about this morning. Like do we actually specify,
7 for example, the level of analysis. Do you
8 specify the potential uses might be something
9 this group might want to weigh in on some of
10 these, which could be great at a national level
11 as we mentioned.

12 Some of them could be great as a
13 health plan level measure for improvement. You
14 know, I think that's an opportunity for the
15 Committee to be a bit more detailed.

16 CO-CHAIR PONCE: Eduardo.

17 MEMBER SANCHEZ: Good morning. Thanks
18 for calling on me. Really, really great, great
19 discussion and really, really great points that
20 are being made.

21 I think the idea of the CHNA with core
22 health equity questions might be something that

1 we could and should explore. I really love the
2 idea and the comment not only on participation in
3 Medicaid and Medicare at the individual system
4 and hospital level, but also the payment side.

5 And as the conversation was had about
6 national, state or where the focus is, Medicaid
7 payment is a state-determined policy decision,
8 and I think there's some pretty good evidence
9 that there is an inverse relationship between
10 payment and participation, in addition to other
11 factors that might weigh in.

12 I hadn't heard and I just wonder if
13 the notion of relationships with FQHCs might be
14 something to consider as something that could be
15 measured, to include hospitals and specialty
16 groups on the clinical side of things. As
17 somebody who came up FQHCs and understands that
18 and Bob, please if I'm wrong because I'm out of
19 date, please correct me.

20 But relationships with hospitals are
21 critical, and one of the biggest challenges that
22 FQHCs have is getting access to specialty care.

1 So those individuals who are in FQHCs already are
2 disproportionately challenged populations for a
3 variety of reasons, are sometimes being taken
4 care of by great primary care docs, but who are
5 practicing at a level that is not the standard of
6 care in a community, because access to specialty
7 care makes it difficult for specialty care.
8 Outcomes suffer.

9 And then lastly those -- I think this
10 is consistent with something else I heard. In
11 addition to the relationships with FQHCs are
12 financial arrangements made in such a way that it
13 eases the burden on individuals who may go see a
14 specialist, but isn't necessarily getting FQHCs
15 pricing. The same goes for the hospital. I'll
16 stop there. Thank you.

17 CO-CHAIR PONCE: Thanks, Eduardo. All
18 good thoughts. I think some of them also could
19 apply to the other domains, in terms of access.
20 I did have a question, and I'm not a measure
21 developer. It's triggered by what Nancy said.
22 There are some measures that are built in but

1 then there's binding constraints, for example,
2 you're in a state that didn't expand Medicaid.

3 Can some of the -- what we're trying
4 to achieve be through the measures as an
5 indicator, but then accommodating these
6 constraints, these policy constraints, or you
7 don't have a very strong community infrastructure
8 for the wider net of social services? So can
9 that be part of it?

10 So it's not necessarily built in, but
11 then you account for these policy and local
12 community infrastructure constraints.

13 DR. BURSTIN: It certainly could be.
14 The question is oftentimes is there a better
15 proxy for those that you can build into a measure
16 that would work across the board.

17 Is it really then about income? Is it
18 really about patient risk as opposed to those
19 other factors. But some of those could fit into
20 the access domain as measures as well in and of
21 themselves.

22 MEMBER GARRETT: And if I could just

1 quickly respond, I was also thinking about, you
2 know, United Healthcare does this flashy report
3 about the healthiest -- like they rank all 50
4 states on overall health and then they do a press
5 release and they have all these different
6 measures. Maybe we could do a health equity
7 ranking of states based on one of these health
8 equity dimensions, and you know, something that
9 gives that policy attention to the places where
10 we are actually hurting health equity through
11 some of these macro policies. So that could be a
12 measure set in itself.

13 CO-CHAIR PONCE: It's a good idea.
14 It's just like we have a diversity index for
15 companies, and companies -- I'm on the board of
16 one of them, and they really care about moving up
17 from 49 to 48, you know, they want to be in the
18 top 50. Okay, thank you. Philip and Ron and
19 Emilio.

20 MEMBER ALBERTI: One additional
21 comment on this last little conversation. It
22 could also be a way that these metrics are

1 reported, right? So you could use those
2 variables to stratify reporting. So for Medicaid
3 expansion versus non-expansion states, or for
4 states where there's a more equitable ratio. I
5 mean you could look at it that way as well. So
6 you're actually comparing the right places to the
7 right places.

8 CO-CHAIR PONCE: Thanks, Philip.
9 Emilio.

10 MEMBER CARRILLO: Just harkening back
11 to the discussion about how to measure a sort of
12 community services adequacy, I think a source of
13 data and concepts could be the Accountable Health
14 Communities Program or CMMI, which is just kind
15 of a launching where there could be measures of a
16 connection between a patient and a FQHC or the
17 health center, with a particular, for example, a
18 legal aid CBO that provides support with housing
19 and transportation, et cetera. So there might be
20 some good grist for the mill there.

21 CO-CHAIR PONCE: Thanks. All great
22 ideas. I hope NQF staff have been recording this

1 away, and it's not also over, as Michelle said.
2 This is going to continue to as we populate these
3 tables for the pre-work. There's a comment
4 online. Oh, it's Kevin, sorry. Kevin, go ahead.

5 MEMBER FISCELLA: Hi. Yeah, just to
6 echo some of the thoughts that have already been
7 expressed.

8 Certainly looking at diversity and
9 improvement in diversity over time among the C-
10 suite and certainly the board of directors, I
11 think is an important one, and that would include
12 not just all the standard measures of diversity
13 that we've talked about, but also for example
14 Medicaid participation, given how much of a share
15 that represents in many hospital systems.

16 The other -- the other issue I think
17 that if systems were to report on this and there
18 were some transparency around it, I think it
19 could promote real change, and that is the
20 segregation of care by insurance. I think if
21 that were public, I think the systems would begin
22 to look at how to do that and that not only

1 creates differential access in some cases, for
2 example if you're Medicaid, your wait time might
3 be less.

4 You might -- I know hospitals where if
5 you're commercial you can even get a concierge
6 valet parking. If you're Medicaid, you don't get
7 that. The wait time to get a visit may be
8 different and who you see may be different. It
9 may be a trainee as opposed to a faculty.

10 So I think reporting on that could
11 -- really could help to change both the culture
12 but also equity in terms of resource allocation
13 in meaningful ways.

14 CO-CHAIR PONCE: Thanks, Kevin. So I
15 think you're saying so the stratification helps
16 as what Philip said in comparing like groups to
17 like groups. But then you also want to not lose
18 the stratification of care by insurance by payers
19 will illuminate that there's just different,
20 different access.

21 MEMBER FISCELLA: Well segregation --
22 I'm talking about within the health care system.

1 So segregation of care. Essentially, if you have
2 Medicaid, for example, you would go to a "clinic"
3 as opposed to a faculty practice, where the
4 waiting times, the continuity, the amenities and
5 so on would differ widely. That fosters a hidden
6 curriculum for all trainees in terms of the, you
7 know, patients of different socioeconomic status,
8 different backgrounds are treated differently.

9 But it also results in meaningful
10 differences in access to resources within that
11 system.

12 CO-CHAIR PONCE: Yeah, thank you.

13 MS. O'ROURKE: So I know we started to
14 touch on some other domains, so -- but just to
15 show the ideas that people have come up with,
16 could you scroll to the structure for equity, and
17 there's a volunteer from this group. Christine,
18 maybe you want to share some of your ideas?

19 MEMBER TEIGLAND: Yeah, I agree. This
20 was hard. This was a hard exercise. So I
21 basically started with, you know, the sub-domain
22 of capture resources to promote equity and

1 thought about the whole issue that we just don't
2 have the data, right? So it was mentioned
3 yesterday that perhaps, you know, Medicare would
4 require on admission to Medicare to, you know,
5 capture information about -- capture this
6 information and keep it in the enrollment file,
7 right?

8 And other plans could do that as well.
9 So maybe it's a social risk factor survey and you
10 collect data on income and home ownership and
11 education and race ethnicity. Some of those
12 things change though. So it would have to be
13 sort of an updated thing, but you know, at least
14 maybe we could track with some type of measure.
15 You've got all your health plan members enrolled,
16 and did they complete the survey?

17 I mean how many actually did you
18 collect this data for, so that was just a
19 thought. Went on to the second one about
20 collection of data to monitor the outcomes of
21 individuals with social risk factors, and we had
22 been working on this child core set of measures.

1 So this measure struck me as just an
2 illustrative example of, you know, of how these
3 measures are done. And so, did they even go?
4 Did they see the doctor once a year? Did
5 children ages 1 to 19 have one or more PCP visits
6 during the year?

7 Well, when we looked at that, and so
8 the idea here would be to stratify that obviously
9 by some of these social risk factors, because
10 when we looked at that, you know, people with
11 lower incomes were much less likely to have even
12 at least one PCP visit.

13 But what I started to think about here
14 was the fact that these denominators, to be fair,
15 always these require continuous enrollment in a
16 health plan for 12 months, with a 45 day gap.
17 Well guess what? It's those people who are in
18 Medicaid and in the ACA who are constantly
19 dropping out. They do not have 12 months of
20 continuous enrollment.

21 And guess what else? Those are the
22 people who have the worst outcomes. That's where

1 most of these disparities are. So guess what?
2 They're falling through the safety net. We are
3 not tracking -- these measures are not capturing
4 the full degree to which these disparities exist,
5 because they are not even in your denominator,
6 right? These people are not in that denominator.

7 How do we capture those people? They
8 jump back and forth from Medicare -- Medicaid to
9 ACA, to a health insurance exchange plan.

10 Sometimes they, you know, the qualifications for
11 Medicaid are very, you know -- you make a couple
12 of dollars more on a temporary job you had, you
13 all of the sudden qualify. You're out, right?

14 And so you qualify, you don't. We see
15 a lot of churn back and forth between Medicaid
16 and ACA. We really need population health
17 estimates to get at what the true degree of
18 disparities are for this population who are not
19 enrolled in a health plan for 12 months during a
20 year, and all the measures are defined that way.
21 They all have some enrollment criterion. You
22 have to to make it real.

1 So when we start to then think about
2 the population estimates, that's when we need to
3 start thinking about communities working
4 together. So you know, we really need a variety
5 of health plan, health information exchange,
6 hospital, community level data. We need to
7 actually exchange data to figure out where these
8 two disparities are.

9 I talked a little bit about the hot
10 spot type of analysis. New York City's been
11 doing some of this, you know, and frankly there's
12 some areas where asthma is your biggest issue,
13 right? Some areas it's diabetes, and then to
14 stratify those by these social risk factors. But
15 unless we get to that, you know, population
16 health measurement, where the -- we're not going
17 to capture the full degree of disparity that
18 exists because these folks just aren't enrolled
19 in these health plans.

20 I also started to think about, you
21 know, the ACOs and the development and the trend
22 towards developing these narrow networks, right?

1 Narrow networks really means they're limiting
2 services. They're really controlling access to
3 care, and what happens to people who end up in
4 some of those narrow networks is that when they
5 need access to a specialist, they either don't
6 get it, number one, or they have to go out of
7 network where they can't afford it.

8 They get hit with these very, very
9 large bills because the specialist is charging
10 full price, right, for the services and they're
11 not able to pay that. So that brings us back to
12 the benefit issue, right, and the access issue.
13 So those are just some things I was thinking
14 about. You know, we really need, I think, to
15 think about these population measures and that's
16 sort of what all of the rest of this was focused
17 on.

18 The last one about transparency,
19 public reporting. I mean still you need to do
20 that at the population level. But I really think
21 we need to compare with a set of measures that
22 have the exact same definitions, sort of across

1 these types of insurance, Medicaid, ACA,
2 Medicare, commercial and are your rates different
3 even for the same level of income, even for the
4 same, you know, group that has disparities,
5 because we see a lot of -- we see a lot of
6 disparities and inequities, even within the same
7 health plan across their payer type coverages,
8 right?

9 So -- and we never see that. We never
10 see, you know, a commercial plan on a specific
11 measure compared to the Medicaid plan, because
12 they say oh, well they're going to be worse,
13 right? We don't see that. Maybe we need to
14 suggest that that needs to happen. So those are
15 just some thoughts I had as I was trying to work
16 through this, but it's really hard to measure,
17 right? It's all hard.

18 CO-CHAIR PONCE: Thanks Christie for
19 doing this, and I think just even the last point
20 reflects what Tom said about transparency and
21 what Kevin said about looking through the whole
22 system. Okay. Comments from the group. Bob,

1 Philip, then Lisa Iezzoni.

2 MEMBER RAUNER: I want to echo the --
3 I think one of the biggest sleeping giants for
4 the safety netters is this churn issue, and it's
5 even worse in a non-expansion state because you
6 go to zero coverage essentially for intermittent
7 periods of time. In our state, sometimes it's on
8 a monthly basis even.

9 And so that's one of the biggest
10 obstacles in the FQHC environment, and maybe you
11 get the Alc drawn, but when you lose coverage for
12 meds for three months, you're back again. So
13 this coverage is a huge issue and then on top of
14 that, what you mentioned about the narrow network
15 provider issue, you might get insurance again,
16 but the provider you used to have is not on the
17 new one.

18 So you're bouncing between clinics
19 because of the provider networks being too narrow
20 and inconsistent. We would have this in our
21 community where you get bounced from the GA
22 clinic. Then you'd be over to FQHCs and you're

1 back at the residency program again and that
2 movement added to the problem. And so churn, I
3 think, is one of the big --

4 And again, go back to denominator,
5 it's a year of coverage. Some of these people
6 don't even get measured because they don't even
7 have a full year of coverage and they're not in a
8 place long enough to even get measured. So
9 they're not even in the data a lot of times.

10 CO-CHAIR PONCE: Go ahead, Philip.

11 MEMBER ALBERTI: I think this is a
12 really great start to this structure for equity
13 domains. Just a couple of other things that came
14 to mind would be something that really tops into
15 what Romana I think was talking about is really
16 the connectivity between these efforts. So
17 health care delivery models that formally and
18 explicitly address social determinants of health.

19 So that could be medical-legal
20 partnership or a community health worker model
21 or, you know, home assessments that take place or
22 direct links to the community health improvement

1 work that's based and developed as a result of
2 the CHNA. So kind of seeing movement in the SDOH
3 space.

4 And then maybe something that also
5 speaks to inter-professionalism, kind of inter-
6 professional care teams, might also be an
7 important structure that promotes equity.

8 CO-CHAIR PONCE: Thank you. Lisa
9 Iezzoni.

10 MEMBER IEZZONI: I think that we
11 should also think about the very Donabedian
12 structure when we think about this too, because
13 frankly having enough interpreters around or
14 having wheelchair accessible weight scales. You
15 know, that's something that Mass Health right now
16 is talking to the Disability Law Center and other
17 people representing people with disabilities,
18 making sure that all plans that contract with
19 Medicaid have wheelchair accessible weight scales
20 and height-adjustable exam tables. I think that
21 that's important.

22 I've been weighing whether I should

1 make a political statement or not. Am I allowed
2 to do that? Yeah.

3 (Laughter.)

4 MEMBER IEZZONI: I understand that the
5 13 men locked in the room up on Capitol Hill
6 right now are viewing people who churn out as
7 never returning again, and putting that into the
8 capitation for Medicaid. That's going to be
9 devastating, because as Christie said, those
10 people are the ones who are just uniquely
11 vulnerable.

12 CO-CHAIR PONCE: Thanks Lisa. Tom.

13 MEMBER SEQUIST: So I was just going
14 to, on the structure piece, I was going to
15 mention structural pieces like availability of
16 translator services that other things that would
17 be important for equity. I also, one of the
18 pieces that's I think important in here is our
19 -- when I look at the bucket that was called --
20 it's not on the screen right now, collection of
21 data to monitor the outcomes of individuals with
22 social risk factors.

1 So I think somewhere in there are our
2 ability that we've done two things. So one is
3 we've put in programs to train people or have
4 some process of how we're collecting this
5 information, and then the other is that we have a
6 way, I keep harping to Helen on this, that we
7 have a way to store these information, these data
8 in an electronic health record or some other
9 format, because both of those are key and if you
10 have one without the other it's not that useful
11 to know.

12 On a postcard, everybody's preferred
13 language and then the postcard gets filed away
14 somewhere, which many of us have probably run
15 research projects like that where you have all
16 these data that are not useful, because they're
17 sort of basically stored in your back pocket.

18 But to continue to harp on it, I feel
19 like if you could get it into some measures that
20 EHR vendors would start to have this higher on
21 this list, because it's a really big structural
22 problem in our ability to address this issue.

1 And then it's only through having
2 those kind of data that I would know what kind of
3 interpreter services I need, right? So I don't
4 know if I need Mandarin because I don't know how
5 many people speak Mandarin in my patient
6 population.

7 CO-CHAIR PONCE: If you had a
8 population-based survey, that could tell you.

9 MEMBER SEQUIST: Right, but getting
10 the results to it then have to be stored
11 somewhere, and we just -- most EHR vendors, and I
12 know they're working on it, but it's just not
13 easily stored right now. So it ends up a field
14 called like "social history," which is then like
15 a free text kind of paragraph that people write
16 out all the important information that you would
17 want to know about these risk factors.

18 DR. BURSTIN: I thought it was an MU
19 requirement now. Am I wrong? I thought there
20 was supposed to be --

21 MEMBER SEQUIST: It depends on the
22 factor we're talking about. Some of them are and

1 some of them aren't. So clearly race and
2 ethnicity for a very long time has been required
3 to be collected in certain -- in actually using
4 certain variables.

5 But some of the more nuanced stuff
6 that we've been talking about here, that CMS has
7 been looking at for risk factor adjustment, a lot
8 of those things that we think are maybe even more
9 powerful or just as powerful determinants of
10 health aren't required to be collected.

11 MALE PARTICIPANT: There had been talk
12 in service of Meaningful Use 3 of the National
13 Academies and ONC endorsed a set of social
14 behavioral psychological data points to be
15 included on the vendor side, if and when MU 3,
16 yadda yadda yadda.

17 MR. BAU: So it's actually now not MU
18 3, but it's ONC certification for 2015, and that
19 is going to be a requirement in MIPS. So that's
20 the back door or the side door that those things
21 are going to happen. So I was going to follow up
22 --

1 CO-CHAIR PONCE: Ignatius.

2 MR. BAU: I actually think if we get
3 to the point where we're going to start calling
4 out sort of the highest priorities within each of
5 these domains and sub-domains, I actually think
6 this data point that Tom was talking about is
7 absolutely critical because conversations start
8 and stop with our data systems just aren't able
9 to collect, and so again structurally, that would
10 be for me the absolute first thing any
11 organization has to do is stop making excuses as
12 to why your data isn't reflective of all these
13 social risk factors.

14 And again, I think pointing to the ONC
15 criteria, pointing to all these, you know, all
16 the work that Romana did in the HRET tool kit, we
17 have the tools. It is doable. You may not get
18 to 100 percent, but you can't use that as an
19 excuse anymore, to say that we don't know how to
20 collect the data or it's hard to collect the
21 data.

22 CO-CHAIR PONCE: Lisa Cooper.

1 MEMBER COOPER: No, I'm agreeing and
2 I just -- I think also that -- that because there
3 are so many factors that are now recommended, one
4 of the things -- I mean I'm like for collecting
5 all of them, right.

6 But I think we have to also prioritize
7 what we're going to say is okay or at least
8 provide like different stages of credit that
9 people get for collecting various social risk
10 factor measures, because they're not going --
11 people are just not going to do all of them.

12 I also wanted to ask if anybody else
13 on this group is on the Brain Trust for -- the
14 Epic Brain Trust because -- okay. So I know Epic
15 is working on developing like a whole social risk
16 factor module to be added to systems, and I'm not
17 sure what the cost is going to be to different
18 organizations to purchase that or have that
19 plugged in so --

20 MEMBER SEQUIST: They will be able.
21 So we have some partners, a bunch of people
22 working on that. But it will be a -- it's

1 interesting, because it's going to be built into
2 all these federal requirements. But we're going
3 to have to buy it as a module and you have to buy
4 the thing, and then you have to pay the people to
5 plug the thing in, and as we all know it's not
6 literally a plug and so we have to integrate in
7 all the IT architecture that goes into that.

8 And it's been delayed -- for Epic it's
9 been delayed. We were supposed to get it last
10 year, and then they delayed it about 18 months.
11 So we'll hopefully get it next summer. But we're
12 waiting. We want it.

13 MEMBER SEQUIST: Right. I also want
14 to just say that I agree with you about including
15 some kind of measure of the training of the
16 appropriate staff who do collect the data, and
17 also like just to make sure that like there are
18 -- there are designated people who collect that,
19 because every -- like in our system, it's
20 different people like everywhere.

21 It's not the same group of people, so
22 you know, you need to know who's responsible for

1 collecting it or putting it in there, in order to
2 train the right people.

3 CO-CHAIR PONCE: Lisa Iezzoni.

4 MEMBER IEZZONI: I apologize for
5 sounding like a broken record. But this Epic
6 Brain Trust person, where is that person?

7 MEMBER COOPER: Nancy is on it.

8 MEMBER IEZZONI: Okay. Is disability
9 included in what they're collecting, because I
10 would be actually surprised if it were and I
11 think it needs to be. Again, this is one of the
12 first things that I came onto the Committee
13 saying, that the ONC standards did not include
14 disability.

15 But let me just make the following
16 point. If you have somebody who uses a
17 wheelchair and needs to have a certain exam table
18 and they show up in your clinic, you need to know
19 beforehand to make sure that they're in the room
20 with the right exam table.

21 And so to actually care for people
22 with disabilities, you need to know what

1 accommodations they make, and our Epic model,
2 Tom, from what I understand right now, does not
3 really have a place where you can collect data
4 that would allow the clinic staff that's
5 scheduling patients to know what accommodations
6 somebody's going to need, and so when they come
7 in those accommodations are ready, just like you
8 need to have the interpreter available.

9 And so I think that even though I know
10 people are going to say like Lisa, I heard people
11 say we just don't want to collect disability
12 data. It's too complicated and so on.

13 Well, there are the six questions that
14 the Office of Minority Health came up with as a
15 result of Section 4302 of the Affordable Care
16 Act, the six questions on disability that are a
17 good start, and I would really urge our Committee
18 to just make a -- if we're going to comment on
19 this, to just make sure that that is included.

20 CO-CHAIR PONCE: Thanks, Lisa. Noted.
21 Michelle.

22 MEMBER CABRERA: I don't know if the

1 CAHPS survey has any questions for consumers on
2 an experience of bias or racial discrimination or
3 other kinds of discrimination. Do they? No. So
4 if I understand --

5 (Simultaneous speaking.)

6 MEMBER CABRERA: --you know, how is
7 your experience, like that would be something too
8 that we could suggest could be added as a
9 consumer information.

10 MEMBER SCHOLLE: This is Sarah, just
11 as a point of information. There are items in
12 the CAHPS survey. They're just not used.

13 MEMBER CABRERA: Okay. They're just
14 not used. Thanks. Well I think -- again, I
15 think cultural competency is different like then
16 -- yeah.

17 (Off mic comment.)

18 CO-CHAIR PONCE: Your mic please.

19 MEMBER COOPER: Sorry. Yeah, there
20 are specific questions that ask about
21 discrimination and there are specific behaviors
22 that are assessed, like did people interrupt you

1 while you were talking, you know, act like you
2 weren't like there, you know. I don't remember
3 the specific questions, but they're -- it's
4 included in the cultural competency supplemental
5 item set, and it's a domain within that.

6 But you're right. I don't think every
7 -- I mean people are selectively like not asking
8 those now.

9 MEMBER CABRERA: So that could be one
10 that we encourage the use of those measures to,
11 you know --

12 (Off mic comment.)

13 MEMBER TEIGLAND: I mean I don't think
14 -- it's not in the Star measures. So they may
15 ask them, but it's not in a domain in the Star
16 measure.

17 DR. BURSTIN: It's actually in a
18 supplement, and so that is I believe voluntary.
19 And so because of that, I think it's just not
20 often used. I was just mentioning to Ninez, I
21 think the last time we asked AHRQ to resubmit the
22 supplement, they said they weren't supporting its

1 continued use, because I think it wasn't being
2 used very often. We'll confirm that.

3 There is also one on literacy, is that
4 right, Marshall? I don't know that they're doing
5 that one either.

6 MEMBER COOPER: Well that's too bad,
7 but there are -- the literacy and the cultural
8 competency items are available. I mean, you
9 know, they went through, you know, validity
10 testing and that's where I think -- I've actually
11 looked at the items and find some of them
12 problematic but, you know. I think there was a
13 lot of work done on them. I think it's
14 definitely worth, you know, looking at them again
15 and considering like recommending them, unless we
16 want to propose the development of a whole new
17 set, but you know.

18 MEMBER CABRERA: Right, or giving
19 refresh, right? I mean I think, you know, if
20 they're not being used because it's voluntary and
21 it's a supplement, that gets again to this issue
22 of sort of things not being baked in. If it's

1 that they're problematic and so people have
2 concerns with the actual questions, that's
3 another thing.

4 I think the point is understanding
5 like, aside from other consumer survey questions,
6 whether somebody feels like they've been
7 discriminated against when they've tried to
8 access health care.

9 That might be an important driver of
10 change or conversation within a health system or
11 a plan.

12 CO-CHAIR PONCE: And I think that
13 that's a way of getting at the structure for
14 equity. It's not -- it's unfair treatment within
15 the health care system. It's not structural
16 racism as Emilio raised, but it ensures that that
17 handle is here in the structure for equity. So
18 we can make that recommendation. Romana.

19 MS. MURPHY: So I have a question and
20 a comment. So I know that Denver Health has been
21 trying to implement collection of social risk
22 factors, and it's been a real challenge,

1 partially because of the Epic issue and they just
2 rolled out Epic about a year and a half ago.

3 So what they started to do is collect
4 social risk factors through HRAs, and I know, you
5 know, some of them hit on activities of daily
6 living. They don't have a specific question and
7 it's only in the Medicare piece. But they don't
8 have a specific question on disability, right? I
9 mean they ask about activities and, you know,
10 capacity to carry out activities of daily living.

11 But I don't know how -- I guess that's
12 my question, Lisa. Is that still too tangential
13 in terms of the point that you made?

14 MEMBER IEZZONI: I think it's a place
15 to start maybe. But I think that it would be
16 good to go further, because as I said, as I said
17 before, disabilities are very diverse, and to be
18 able to think about the accommodations or what
19 kind of discriminatory actions people might be
20 confronting you need to know a little bit more,
21 and something very generic like their ADL
22 capacities.

1 CO-CHAIR PONCE: Lisa Cooper.

2 MEMBER COOPER: I'm wondering whether
3 the NCQA required domains that are used for
4 chronic disease measurement. I've seen, you
5 know, the domains and they do, within the ADLs
6 and the IADLs, they do have a lot of questions
7 related to physical and mental health
8 disabilities.

9 And I'm wondering whether -- I mean
10 instead of do we want -- like I guess part of
11 what I think Lisa Iezzoni is saying is that we
12 need to actually ask everyone and not only limit
13 this to people once they get referred into like
14 some sort of special disease management program.
15 Is that what you're getting at?

16 MEMBER IEZZONI: Yeah. Let's put it
17 this way. Twenty percent of the American
18 population has a disability. This is not a small
19 number of people. It's 57 million people, and
20 people might not be able to do their ADLs because
21 of behavioral, serious mental illness, because of
22 physical disability, because of sensory

1 disability, you know. There's going to be all
2 different reasons.

3 That's why, Lisa, I suggest that
4 people just go back to the Office of Minority
5 Health, six questions.

6 (Simultaneous speaking.)

7 MEMBER COOPER: So we actually at
8 Hopkins, we went back to the --

9 MEMBER IEZZONI: -- because you can
10 benchmark from those, because the federal surveys
11 have those questions in them, and so it's the
12 benchmarking thing, yeah, good.

13 CO-CHAIR PONCE: Thank you. Shall we
14 continue? It's five minutes to 12:00. So can
15 you give us some guidance on --

16 MS. O'ROURKE: Absolutely. So we're
17 a little behind, so why don't we do access as a
18 domain, and then perhaps I think everyone looks
19 like they might need a little break and lunch is
20 out.

21 So maybe we could do the access
22 conversation, break for lunch, quickly come back

1 to the table after you've stretched for maybe 15
2 minutes, and then we can finish the others, then
3 have Sarah present and then we focus more on some
4 of the implementation and policy recommendations
5 for the afternoon.

6 Should we -- do you want to do public
7 comment now or after we finish this topic?

8 CO-CHAIR PONCE: For the public who
9 have got the agenda, maybe we should do the
10 public comments now.

11 MS. O'ROURKE: Operator, could you
12 open the line for public comment?

13 OPERATOR: Thank you. At this time,
14 if you'd like to make a comment, please press
15 star then the number one on your telephone
16 keypad. We'll pause for just a moment.

17 (No response.)

18 OPERATOR: And there are no public
19 comments at this time.

20 MS. O'ROURKE: Are there any in the
21 room?

22 (No response.)

1 CO-CHAIR PONCE: Okay, thank you.
2 Let's proceed. Access to care, and David, if
3 you'd get the conversation started.

4 MEMBER NERENZ: I thought these were
5 group assignments.

6 (Laughter.)

7 MEMBER NERENZ: What happened?

8 CO-CHAIR PONCE: There's a selection
9 bias here.

10 MEMBER NERENZ: Where is the rest of
11 my group? No. We can do this quickly, because
12 you know, this was a challenge like others, but I
13 don't think there's anything very remarkable in
14 what I put forward.

15 I'll just say a couple of things in
16 overview. I viewed the task as to come up with
17 examples. That was hard enough. So I don't
18 claim anything more than that. I don't think
19 these are the best. I don't think these are, you
20 know, just they're examples of what I could think
21 of.

22 What I did try to do though is frame

1 the measures in terms of a clear, accountable
2 entity, because you know this is a theme I've
3 mentioned since we started the first meetings.
4 But I think we have to keep talking about it,
5 that when you have a measure, you can use the
6 measure in two distinctly different ways.

7 You can measure a characteristic of a
8 population, like do people in the population have
9 access to care. Now you can do it for any
10 population you want. But when you do that, there
11 is no accountable entity so far. So you've got a
12 measure, but it's not a performance measure and
13 it's not an accountability measure.

14 Now it only becomes a performance or
15 accountability measure when you link it to some
16 named, identifiable entity who is supposed to be
17 doing something. And then the measure is about
18 the doing or the capability for the doing or the
19 result of the doing. So what I tried to do here
20 -- well, let me say. What I could have done or
21 any of us could have done is to say, you know,
22 let's measure some parameters of access in a

1 population, and it actually wouldn't look much
2 different.

3 We have population surveys that do
4 that already. Can you get a primary visit when
5 you want it? Can you do this, can you do that,
6 okay. But what I did do is say let's talk about
7 the characteristics of an organization that
8 relate to access. So that's what I did do. Now
9 I'm not sure I even need to walk through the
10 things. You can read what's on the screen faster
11 than I can talk it.

12 But I was basically trying to come up
13 with measurable properties or actions of an
14 accountable entity, and you might think, for
15 example, of a primary care network. These might
16 apply to an ACO, Bob, you know. They're that
17 kind of thing. They have to do with physical
18 convenience, they have to do with scheduling
19 convenience.

20 So I don't know. I'm not sure there's
21 much more to say about it than that, but that's
22 what I did.

1 CO-CHAIR PONCE: Thanks, David. So
2 from a population perspective, we have a measure
3 on giving an appointment within two days, which
4 is a state, like a California state requirement.
5 So I would set that, and also yeah. And also I
6 think that that there is a role for a population-
7 based measure as an anchor to these
8 organizational measures as well. Michelle.

9 MEMBER CABRERA: You know, I do have
10 to say that while in theory these things are
11 within a provider's control, when you are serving
12 a disproportionately high number of low income
13 people and your margins are much lower or
14 negative, then things like, you know, bricks and
15 mortar where you site things or having
16 availability of appointments, et cetera, I think
17 become a lot more challenging.

18 And so again I think this is something
19 that I struggle with. It's sort of like I think
20 the accountability level for these sorts of
21 things is at the payer level, rather than at the
22 -- I mean if the payer is providing enough

1 resource to the provider and the provider's just
2 sitting on a little pile of money then, you know,
3 that's one thing, yes. Hold them accountable for
4 this.

5 But otherwise I think it's actually a
6 level up to -- otherwise, you're not comparing
7 apples and oranges, you know, based on payer mix.
8 You could have somebody with a fairly healthy
9 payer mix who, you know, is making a choice to
10 open up their brand new state of the art hospital
11 across the street from another brand new state of
12 the art hospital in an affluent area. That's
13 problematic from an access standpoint.

14 But if you are rooted in the safety
15 net, then something like this I feel like it just
16 -- while it may show that there's a problem, it's
17 not holding the appropriate entity accountable I
18 feel like. Does that make sense?

19 MEMBER NERENZ: I guess I can just
20 quickly respond, since my name got accidentally
21 attached to this. No. You know, I would agree
22 with the idea that there are plan level measures

1 that would speak to the broad concept of access.
2 I would chose different ones. They might be
3 payment -- well, different from those.

4 They might be not necessarily
5 different from the ones you set. They might be
6 payment adequacy, they might be the nature of the
7 network, you know, has the plan gone to a narrow
8 network versus not. Clearly there are plan level
9 measures. I just didn't do them for this
10 exercise, but they're there. But I wouldn't
11 choose those measures and then apply them to a
12 health plan.

13 Health plans don't have appointment
14 slots, so can't do it. But other people do have
15 appointment slots. Again, I'm not saying those
16 are great measures.

17 MEMBER CABRERA: It just assumes that
18 -- it assumes that you have something and that
19 you're withholding it, whereas like if it's not
20 there to give or to do something with then that's
21 what I'm struggling with.

22 MEMBER NERENZ: I'll go a little bit

1 in my own defense because this is -- I'm in an
2 organization that's located in the inner city of
3 Detroit. It's what we do. There are a finite
4 number of primary care slots. Some of them are
5 scheduled in advance, some of them are same day
6 or drop-in, and we have intentionally changed
7 that. We've changed the mix.

8 We've changed the mix because we have
9 a high no show rate in our inner city clinics,
10 and this is one way to try to deal with that, and
11 it reflects the fact that folks have
12 transportation challenges, they have child care
13 challenges, they have all kinds of challenges and
14 it has nothing to do with the overall capacity.
15 It just has to do with how do you use what you
16 have. So I don't know. It didn't seem too bad.

17 MEMBER CABRERA: Thank you for
18 educating me on that point.

19 CO-CHAIR PONCE: And David, your group
20 thanks you for doing this. Bob, Nancy and
21 Susannah, and Eduardo.

22 MEMBER RAUNER: Yeah. I just want to

1 talk a little bit more about Michelle's example,
2 because it's a huge problem in our community
3 right now, where we're a refugee resettlement
4 community. So we have dozens of languages, and
5 so the requirement with very good intentions that
6 everybody wants to have, of course, is
7 interpretation services for those appointments.

8 But that's actually unfortunately
9 severely limiting access in our community right
10 now, and the reason that happens is, you know, if
11 you're a private clinic and you know your
12 overhead's \$55 to see a patient and Medicaid pays
13 you \$52 and now you have to hire an interpreter
14 for another 40 that does not get paid by the
15 payer, that that's basically economically
16 impairing access to the very people who need it
17 because of that requirement, because the clinic
18 is supposed to provide it, but the payer does not
19 pay for it.

20 And so what is happening is a lot of
21 providers just simply won't schedule someone who
22 can't speak English, because they know they're

1 going to get stuck with this extra \$40 bill and
2 it's an infrastructural problem, and that's the
3 challenge. So everybody in health care agrees we
4 should have interpreters, but until there's a
5 mechanism to pay for it, that requirement is
6 actually paradoxically decreasing access for
7 these people so --

8 CO-CHAIR PONCE: Thanks, Bob. Nancy.

9 MEMBER GARRETT: So I wonder, Bob, on
10 that point if there wouldn't be some kind of
11 measure around that? So are interpreter services
12 reimbursed in this community, in this state, in
13 this health plan, and to what extent, because
14 that's a really important access issue. You're
15 right, that is a big issue.

16 So and just a couple other thoughts.
17 I'm also thinking about not just care delivered
18 in the clinic, but also to what extent is the
19 provider being creative about getting services to
20 populations. So are there community services
21 being delivered outside the clinic system in some
22 way.

1 Like we have a Healthcare for the
2 Homeless Program where we do a lot at the
3 library, because that's where our population is.
4 So it could be like a binary measure yes or no,
5 is this provider doing something in this
6 category. So just a thought.

7 And then I also wanted to bring up, it
8 came up a little bit earlier but there was a lot
9 of controversy around a statement that the CEO of
10 Mayo made late last year, and I don't know if
11 this was like a national thing or just a
12 Minnesota thing, but okay.

13 He basically said Mayo was going to
14 give priority to privately insured patients over
15 Medicaid and Medicare patients, and a lot of the
16 health care folks in Minnesota were like well, he
17 just said it but I mean most people are doing
18 that, right?

19 So it was kind of this interesting
20 conversation of the outrage of the kind of the
21 reaction, but also the reality that probably
22 there is preference going on because of the

1 economics of how this all works.

2 So I'm wondering if there would be
3 some kind of measure of access within a provider
4 for Medicaid versus commercial patients, whether
5 it's their next available appointment, does that
6 differ by payer type or something like that,
7 where we could take one of our traditional
8 measures and then segment it by insurance type to
9 have an equity measure?

10 CO-CHAIR PONCE: That's a good idea,
11 and I think it could also get at the virtues of
12 stratification. We have Susannah and Eduardo. I
13 have not forgotten you.

14 MEMBER BERNHEIM: Hi thanks. So one
15 of the things I was going to say actually was
16 very similar to what Nancy just said, which is
17 that I think this concept of sort of looking at
18 these access things by provider, as well as
19 social risk factor, I mean by insurance provider
20 and social risk factors would be valuable.

21 But so much of Bob's point, the
22 finances are real and I feel like some of that we

1 can do with measurement. But I wonder if we
2 should start to create a parking lot of, you
3 know, financial policies. I don't think it's
4 really right to measure --

5 I don't think we want to generate a
6 measure that says our interpreter service is paid
7 for, but we might want to have some addendum to
8 what we put out that says here's some things you
9 need to do to make it possible for providers to
10 do this stuff, like ensure that interpreter
11 services are paid for.

12 So I'm not quite sure how to handle
13 that issue, and I don't feel like a measure is
14 the right answer. But I think it's a really
15 important thing to catalogue. And then much more
16 concrete on the accessibility or the access to
17 care and equity issue. One thing that we hear
18 about a lot when we build measures around
19 elective procedures is worry about whether
20 different populations have equal access to
21 appropriate procedures.

22 And so I think it would be good to put

1 that in this realm as a concrete place these
2 could grow, and when we thought about how to do
3 this, it's not easy because what you need to do
4 is understand the population of people who might
5 be appropriate to get that procedure and then
6 look at whether they're sort of similar rates.

7 But I think it's an important place to
8 go with measurement that's pretty concrete and
9 that we could look at.

10 CO-CHAIR CHIN: Susannah this is
11 Marshall, that your point about like some things
12 may be appropriate for performance measurement
13 and some things may be appropriate for other
14 policy levers is a good one. In some ways, that
15 after we have like this afternoon's discussion
16 and then we then sort of put it together, we can
17 have in some ways more of the pieces of the
18 puzzle to play with in some ways, so that --

19 And so David Nerenz's point about like
20 he came up with examples, not designed, intended
21 to be comprehensive. In some ways that's -- you
22 have to be realistic at this point for the time

1 that our Committee was given and all. Hopefully
2 that by the end of this, we're -- we have in the
3 afternoon discussion the use measures and then
4 thinking about the final report, we can have some
5 types of conclusions that look at it as a whole.

6 Then again, one of the problems in the
7 past and challenges in the past has been that
8 because we haven't been able to think about the
9 full set of tools at our disposal, then you get
10 into these weird solutions where you try to
11 basically have a hammer to be a screwdriver. And
12 so also that we'll probably revisit some of these
13 discussions towards the -- at the end of the
14 meeting, in terms of how that all fits together.

15 CO-CHAIR PONCE: Eduardo.

16 MEMBER SANCHEZ: Yeah. Earlier, I
17 mentioned or actually earlier when I made some
18 comments, there was some mention of blend, and
19 blend is something we're going to have to get
20 comfortable with, because I think that, pardon
21 me, there's going to be some carryover and maybe
22 these are -- these domains are not discrete,

1 discrete elements. They bleed over.

2 One example would be as I talked
3 earlier about access to specialty care, for
4 example, people who are in FQHCs. But quite
5 frankly, my experience in Medicaid -- I
6 apologize. I'm in a lobby. My experience with
7 Medicaid is that access to specialty care is an
8 issue there as well.

9 I had to sometimes send my patients
10 hundreds of miles away rather than sending them
11 to a local specialist. So that blends, I think
12 though, not only access to care but the degree to
13 which organizations make a commitment to make
14 that care available is what I thought might be a
15 culture, adopting a culture of equity.

16 Another place where there's blend it
17 seems to me would be looking at things like the
18 provision of clinical preventive services, and
19 while that is a quality of care issue on the one
20 hand, I think it's a proxy measure of access to
21 care because having appointments is really
22 important. But when it's all said and done, the

1 health outcome is really the thing that one is
2 looking for.

3 And then lastly, in the same vein,
4 when hospitals -- when clinic appointments,
5 primary care appointments aren't available, the
6 bleed over is that people end up in hospitals or
7 in emergency rooms, and so I just wonder if we
8 might not have a place for potentially avoidable
9 ER visits and avoidable hospitalization visits as
10 another access measure that actually bleeds over
11 to our patients. I'll stop there. I apologize
12 for the background noise.

13 CO-CHAIR PONCE: No, thanks so much
14 Eduardo, and as you noted, some of those measures
15 could also fit into the high quality care
16 measurements, which we'll have a discussion after
17 lunch. I do think the differentiation between
18 payers, providers, community, maybe we need --
19 maybe under the notes section or another column
20 on what the accountability lever is.

21 I think that would be helpful, and
22 again this is an exercise for us collectively to

1 think about these different measures and again,
2 we thank the groups and the group participants on
3 this. Shall we take a break for lunch? I think
4 lunch is here.

5 MS. O'ROURKE: I think you've all
6 earned your lunch. So why don't we take a break
7 and come back at 12:30, 12:35?

8 CO-CHAIR PONCE: Sounds good.

9 (Whereupon, the above-entitled matter
10 went off the record at 12:14 p.m. and resumed at
11 12:36 p.m.)

12 CO-CHAIR PONCE: I think Traci is
13 ready. I can see her geared up to tee us up in
14 this discussion on high quality care, so go ahead
15 Traci.

16 MEMBER FERGUSON: Yes. So when I was
17 looking at sort of this domain, I realized that
18 there were a lot of outcome measures across all
19 of the conditions.

20 And so in focusing on the sub-domain,
21 what I realized is that most of these measure
22 concepts were process measures and how

1 individuals are performing activities to address
2 or even identify if there were any social risk
3 factors or disparities that should be addressed
4 during the, you know, physician-patient
5 interaction.

6 So I started -- there was three areas
7 I was supposed to focus on. So I started on the
8 person-family centeredness, and again looked to
9 see if, you know, so the first one I thought of
10 is -- is there, you know, the number of adults,
11 again focusing on adults where there was
12 documented, shared decision-making discussion
13 that was occurring, that could be coded, and it
14 would be across all of the patients seen during
15 an annual well visit.

16 So again it's looking, because I'm not
17 sort of on the payer side, again don't know the
18 exact feasibility of how much of that information
19 is captured in the current electronic health
20 record. But if it was or there was a particular
21 code, you know, F code or encounter data that we
22 could document, that that would be something that

1 would be somewhat easier to capture.

2 And then part of the type of survey,
3 you know, looking at kind of surprised that, you
4 know, some of the supplemental questions in the
5 CAHPS survey, in a lot of health plans it's part
6 of the Star measures but being able to say that
7 there are particular questions that should be
8 included in the core set that will link up
9 through the Star measures.

10 So patients who gave the highest
11 rating for their provider when asked to give a
12 rating of their -- the patient care provider
13 relationship. So I was clear not to say
14 necessarily a physician, because it could be a
15 nurse practitioner, it could be a health coach or
16 whomever that they were rating, and then it would
17 then -- the denominator would be the total number
18 of patients surveyed.

19 So, you know, it could be something
20 that's already existing in terms of a particular
21 question in the CAHPS survey or another patient
22 satisfaction survey. Then looking at the social

1 risk factors, I think Christie did mention this,
2 but if there was some documented social risk
3 factor, I think Lisa also, factor assessment in
4 the medical record that how many times of all the
5 patients who had an annual well visit was this
6 assessed.

7 So you're looking at -- again, it's
8 more in terms of the process of identifying. Now
9 again, there's a lot of outcome measurements that
10 could be stratified. So I think this is just one
11 portion of it in terms of the process. Are they
12 doing the activities to identify any social risk
13 factors or disparities?

14 And then effective interventions to
15 reduce disparities. So there is, you know, in
16 terms of how to address disparities when you're
17 talking about community access and outreach and
18 involvement of the community, being able to have,
19 you know, community referrals addressing their
20 transportation issues and what have you, but how
21 can sort of you measure that?

22 So this would be both -- could be seen

1 from the pediatric population and also the adult
2 population of the number of patients that there
3 was, looking at the denominator. But the number
4 of patients who had a community services
5 referral, case management referral or with --
6 that's either within that practice or outside in
7 terms of the health plan, consultation for social
8 work or social services.

9 The denominator would be those with an
10 identified disability, particular ICD-10 code for
11 developmental delay and autism, you know, in
12 terms of income. So that you would look at those
13 who more than likely would need the social, or
14 more community resources, how often -- there's
15 documentation again in the electronic health
16 record that you could see that this is happening
17 at the provider level.

18 Then I picked another one for, you
19 know, effective interventions to reduce
20 disparities. Just looking at one of the -- in
21 terms of hemodialysis. There is a similar
22 measure that just looks at -- it doesn't go and

1 capture a lot of the sort of social determinants,
2 but it does -- it's around that 18 to 75 with end
3 stage kidney disease. So it's similar to
4 another, another measure that's out there.

5 But I said with documented counseling
6 regarding kidney transplantation, referral to a
7 transplant center and being able to capture or
8 stratify whether it's, you know, this rural
9 versus urban, insurance status, race, gender,
10 other comorbidities, ethnicity, primary language.
11 So trying to, you know, see how with existing
12 measures we could add a little bit more, to be
13 able to see and be able to address some of the
14 disparities that we do see in, you know, in terms
15 of African-Americans being referred for renal
16 transplantation.

17 And then I just had some general
18 items, comments. In terms of when you're looking
19 at more of the institutional level or sort of the
20 system level, you know, how easy is it for -- in
21 terms of, you know, talking about high quality
22 care, and again with the person-family

1 centeredness, how easy, the ease with which
2 patients can navigate their website, get
3 information on this, how much they understand the
4 health plan website handbook, benefit manual, the
5 ease with which patients get information about
6 their health and treatment options and how they
7 understand their care, and how often the care
8 provider includes them in decisions about their
9 health care.

10 I would just ask a question in terms
11 of is there any existing risk factor tool that
12 would -- that you can incorporate into the
13 electronic health record. That would be a way to
14 capture transportation, food and shelter
15 concerns, requests for additional help,
16 understanding, you know, how to take their
17 medications and, you know, really incorporating
18 the health literacy screens and the health,
19 electronic health record.

20 So trying to focus on things that
21 providers already have access to in terms of
22 electronic health record, and how we can in terms

1 of the concept in trying to address some of these
2 more process measures. So that's what I came up
3 with.

4 CO-CHAIR PONCE: Thank you. Thanks,
5 Traci. Lisa Cooper.

6 MEMBER COOPER: So this is -- this is
7 a huge domain so thanks for getting us started,
8 Traci. I liked a lot of the measures you
9 included on the person and family-centeredness,
10 and when I heard you talking about the patient
11 portal or something like that, I thought about
12 just something that might be easy to capture
13 would just be what percent of their patients are
14 actually like signed on or logged onto the
15 patient portal.

16 So you know, that's because a lot of
17 times people get that information and then they
18 just walk away and nobody ever uses it. So that
19 might also be an indicator of how, whether
20 they've actually made an attempt to help people
21 make use of that tool. I mean having it is also
22 a good thing, but then making sure that it's

1 actually usable.

2 I think what I'm wondering about is
3 like so most of your measures are on patient and
4 family-centeredness. Did you think about some of
5 the other sort of more typical quality of care
6 measures that might be disparity-sensitive that
7 aren't in that domain? I mean, I'm just thinking
8 about things that for chronic conditions, where
9 we know that there's a disparity in care from the
10 research and from the literature on outcomes.

11 We want to incorporate some of those,
12 just those basic ones like, you know, the number
13 of people who have their hemoglobin A1c like
14 below 8 or 7 or whatever, you know, the number of
15 like diabetes with that, with the number of
16 hypertensives with their blood pressure meeting
17 the goal, stratified by like ethnic groups, you
18 know.

19 MEMBER FERGUSON: Yes. I think that
20 one of the sort of the example --

21 MEMBER COOPER: I just chose one
22 example.

1 MEMBER FERGUSON: That was in terms of
2 the kidney. But being able to take those. Like
3 you said, there are a slew of them that could be
4 stratified fairly easily in terms of that. But
5 then trying to find out well, what other things.
6 So I was just trying to sort of fill in the gaps,
7 the major gaps aside from stratification.

8 MEMBER COOPER: I'm wondering whether
9 there are ways. I think it's great to capture to
10 what extent people who we think might have a need
11 for care management services are getting it. It
12 would be nice if we had some way of measuring
13 exactly some capturing the quality of that, of
14 those services.

15 So I'm wondering whether if they have
16 care management programs in place whether we
17 could have people report on like the success
18 rates of people that are in those programs, you
19 know.

20 MEMBER FERGUSON: Yeah. I notice CMS
21 when they're doing the D-SNP model of care,
22 they're going beyond that. Before it was not

1 really looking at in terms of their auditing, in
2 terms of the quality of the care planning, making
3 sure that it's, you know, actionable outcomes and
4 what, you know, that care manager and that care
5 team is looking to sort of improve, if they have
6 an issue whether it's asthma or diabetes, and
7 making sure that they have, you know, a quality
8 measure that they're aiming to focus on.

9 But that's a small population that,
10 you know, in most health plans you may only of
11 all the care, you know, Medicare Advantage, you
12 only -- they only care manage really two percent
13 of the population. So it is not a large
14 population that is going to be captured. But
15 being able to expand it so that we could see if
16 there is any outcomes.

17 MEMBER COOPER: Right. So I just have
18 one other thing. You asked a question about it,
19 whether there are any key risk factor tools or
20 assessments that would indicate that, and I mean
21 I think there are a few of them out there, but
22 the one that seems pretty good to me is the one

1 that's been developed by Health Leads (phonetic),
2 and I think that's one that could be easily
3 adapted.

4 Like actually we're talking about I
5 guess a couple of different things, but certainly
6 some of the questions from their assessment could
7 be used to assess like needs for specific
8 barriers to be addressed like transportation or
9 housing or financial coverage for medications and
10 things like that.

11 They have a really, I think a really
12 robust measure. There's another one that the CDC
13 came up with that is a little bit wonkier to use.
14 But I think Health Leads really does a nice job.
15 They have -- they've incorporated a lot of well
16 validated measures into their assessment.

17 (Off mic comment.)

18 CO-CHAIR PONCE: Okay, thank you. And
19 for your other question to Traci on how well a
20 member or patient understands what their care
21 provider health plan is, that is the CAHPS
22 cultural competency module, yeah. Emilio and

1 then Christie.

2 MEMBER CARRILLO: So in the realm of
3 high quality care, I think a possible perspective
4 could be adverse outcomes, like medication errors
5 because adverse events is a big part of high
6 quality, and there you could probably come out
7 with two or three branches of safety concerns.

8 CO-CHAIR PONCE: Thanks, Emilio.
9 Christie.

10 MEMBER TEIGLAND: Yeah. I've been
11 thinking about drugs and the high cost drugs.
12 Again, there was a lot of talk about that at the
13 AHIP meeting last week, and one of the things
14 that Joe Swedish, who is the CEO of Anthem, you
15 know said was there's a million dollar drug, and
16 it can cure someone. It literally can, you know,
17 it's life or death.

18 But that, you know, if one-tenth of
19 one percent of his member population needed the
20 drug, that it would add, you know, and this
21 health plan has millions of members, right? It
22 would add a thousand dollars per year in premium.

1 So those are really tough decisions to make. But
2 that's an extreme example. There are even, you
3 know, well known drugs, the EpiPen over the last
4 year.

5 So access to these high cost drugs, I
6 mean we're working with the Cystic Fibrosis
7 Foundation and there are drugs now that can
8 treat, literally cure in certain segments of the
9 population, depending on your biomarkers. But
10 they're hugely expensive, \$90,000 a pill or
11 something like that. So you know, for these high
12 cost treatments, this is an access issue too I
13 guess and back to the benefit design issue.

14 Is it covered? Are we -- are they
15 only available to people who can, you know,
16 afford them? So I think that's something else we
17 kind of need to think about in terms of access
18 and quality of care, for who?

19 CO-CHAIR PONCE: Thanks, Christie.
20 Any comments from our members on the phone?

21 MEMBER FISCELLA: Yeah, this is Kevin.
22 I would just echo the -- having a measure on the

1 cost of medications. We're doing a project on
2 that now and collecting data. But that's a huge
3 -- it's a huge issue and obviously cost related
4 non-adherence is an important driver of
5 disparities. So I would encourage collection on
6 both the cost of -- both the out of pocket cost
7 to patients as well as directly measuring cost-
8 related non-adherence.

9 MEMBER BERNHEIM: And this is
10 Susannah. I would just echo that. I think
11 there's a big opportunity in looking at
12 stratification of current measures, so that you
13 can highlight the disparities that are occurring
14 in current quality measures.

15 CO-CHAIR PONCE: Okay, thank you.
16 Well, the opportunity doesn't stop here. Again,
17 I think this is a big, as Lisa Cooper said, this
18 is a big domain and I'm sure there will be other
19 feedback and input from the Committee members.
20 We're in collaboration partnerships, and I'm
21 going to take chair's prerogative and ask Tom to
22 present his.

1 (Laughter.)

2 MEMBER SEQUIST: So I super-struggled
3 with what this how to translate this domain into
4 -- I'm trying to open mine. Are you going to put
5 it there?

6 CO-CHAIR PONCE: Can you speak a
7 little louder?

8 MEMBER SEQUIST: Sorry. I'll get
9 closer. Okay. So I only came up with very
10 sparing ideas, because I didn't really have a
11 good sense of how we would translate this into
12 actual example measures. So the one was -- which
13 seemed a little bit more straightforward to me in
14 terms of measurement was the improved integration
15 of medical, behavioral and other health services.

16 So you know, this isn't -- the way I
17 defined it was more a -- it wasn't a sort of
18 under-represented group-specific measure. This
19 was just looking at the number of primary care
20 visits that have co-located behavioral health
21 providers, with the denominator being just all
22 primary care visits.

1 So basically a measure that gets at
2 access to integrated behavioral health care, and
3 then the community and health system linkages
4 sub-domain. All I could come up with was the
5 presence of, you know, an actual -- this is sort
6 of like as maybe even more back towards the
7 cultural and structural measures we were looking
8 at.

9 But had put that -- this is the
10 presence of a community health benefits program
11 or an officer, some sort of central
12 accountability program for that. So I came up
13 like really short on this.

14 CO-CHAIR PONCE: Before I call on
15 Philip and Bob, I'd like to say that I have a
16 lot. I came up with a populated list, but again
17 that was just for me an exercise of discovery of
18 what's available out there. I thought it might
19 have been futility like this is measurable, but
20 then when I heard Philip talk yesterday about the
21 way to get to health equity is through community
22 engagement and collaboration, I felt fulfilled

1 that I had done the exercise. So I wanted to
2 thank you for that. So Philip.

3 MEMBER ALBERTI: I think this is a
4 really important and challenging domain, and
5 there's been a lot of scholarship out of the
6 Clinical Transitional Science Award, the CTSA
7 consortium on how to evaluate and measure kind of
8 the quality of community partnerships, in terms
9 of their ability to create local capacity for
10 advocacy or for, you know, to build the capacity
11 of local community based or faith-based
12 organizations through partnership, and also some
13 of the benefits that accrued to the health
14 partner or the academic partner.

15 So that might be one place to look for
16 a very clear metrics. There have been a couple
17 of really great papers published. I'll try to
18 find them and send them.

19 CO-CHAIR PONCE: That would be great.
20 I ended up adding all of the resources as well
21 under the notes section. Bob and Michelle.

22 MEMBER RAUNER: I'm just trying to

1 think of examples. The partnerships in the
2 community health grant that CDC puts out, they
3 actually specify which sectors have to be part of
4 that grant. For example, you have to have
5 education, business, faith community. Those
6 might be some ways to do that.

7 There's a group in our community where
8 the FQHC is pulling ethnicity-specific cancer
9 screening measures, and then the local ethnic
10 community centers, El Centro de las Americas, the
11 Malone Center which is African-American are using
12 those measures to actually monitor their grant.

13 So I think there are some
14 opportunities to do those things, because there's
15 some definitely CDC and DHHS funding out there
16 that kind of fits with that.

17 So it's not necessarily coming from
18 your health insurer, but there's a lot of grant
19 funding that can -- this can work together with.

20 CO-CHAIR PONCE: Michelle.

21 MEMBER CABRERA: I have a formatting
22 suggestion that you can take or leave. But I

1 almost want to flip this chart on its side and
2 put the proposed measures on one side and then
3 the domains that they could fit into on the
4 other, because I think that some of these could
5 go to more than one domain. So you could do like
6 the dot dot for whichever ones could cross
7 different domains.

8 So that's one idea. If other people
9 disagree, you know, that's fine. I do think here
10 too, just so the -- it's a site tweak to some of
11 what's already in here. But this concept of
12 hiring community workers, whether they're
13 promotoras, navigators or community health
14 workers from the communities served is actually
15 an important distinction.

16 I heard about a health plan that hired
17 like recent college grads giving outreach to
18 homeless populations, and I'm like oh, I don't
19 know. So I think there's some of that and the
20 lived experience stuff that we see on the
21 behavioral health side with peer specialists as
22 well. I think just encouraging that kind of -- I

1 understand it's built into culturally tailored or
2 whatever, but sometimes it's -- people don't,
3 right, interpret it that way.

4 CO-CHAIR PONCE: Okay, noted. I think
5 -- how should we go about this? Lisa, Lisa
6 Cooper.

7 MEMBER COOPER: So I think it's
8 implied here but what about just -- well first of
9 all just the existence of a community advisory
10 board, and then you know the representation of it
11 I think is helpful like in terms of like the
12 number of organizations or number of sectors
13 represented.

14 Also, the extent to which or whether
15 or not that board is co-led by a community
16 person, along with the institutional leader,
17 because I think a lot of times what we see is we
18 have the convened groups.

19 They're lead by somebody from within
20 the organization and the agenda is completely
21 driven by that as opposed to actually having co-
22 leadership. So I think those would be, you know,

1 reasonable to capture. There could be some sort
2 of an annual like assessment of the partnership
3 by the stakeholders and if, you know, there are
4 some tools out there and somebody may have said a
5 little bit of this, because I got distracted for
6 a minute.

7 But that could be used for that
8 purpose, and either we could just have the metric
9 be that they have such an assessment that they
10 employ on an annual basis, and/or if we can
11 identify one that we really want to endorse and
12 we can look for some sort of a threshold score or
13 improvement in that partnership assessment.

14 CO-CHAIR PONCE: Great, thank you.
15 Romana.

16 MS. MURPHY: So Lisa, I think that's
17 a great idea. I do think that we -- there might
18 be a need to be specific about this. Again, it
19 depends on the organization and the size of the
20 organization.

21 But a lot of organizations have
22 community advisory boards for specific projects,

1 right? So there may be, you know, six different
2 community advisory board types of entities
3 residing within one organization.

4 But the one that I think in this
5 context is more meaningful almost is a community
6 advisory board that cuts across the organization,
7 and has some kind of reporting mechanism to the
8 C-suite or to the board, because I think that
9 just instrumentally makes a difference, because a
10 lot of the ones that have, you know, we're the
11 community advisory board for this specific R-24
12 project is very different.

13 MEMBER COOPER: Yeah, try like maybe
14 50 or more.

15 MS. MURPHY: Right, yeah, right,
16 right. So again I just think some specificity,
17 because I think that's a really easy checkmark,
18 because a lot of organizations have, you know,
19 either research community advisory boards or
20 community advisory boards for a specific
21 initiative. So that's easy to check but it
22 doesn't actually cut across the organization.

1 MEMBER COOPER: So maybe
2 institutionally supported --

3 (Simultaneous speaking.)

4 MS. MURPHY: Yeah. That's the word.
5 Yeah. That's the word, yeah.

6 CO-CHAIR PONCE: Yeah. I think this
7 is what's getting us to like how do we get these
8 broad constructs to be -- to really show
9 authentic collaboration, and by adding specific
10 language, specific -- that it's promotoras and
11 these community health workers are recruited from
12 the community, I think that would be really
13 helpful for NQF.

14 I think all of the ones that I
15 suggested that are less qualitative but more a
16 handle is whether the organization actually puts
17 dollars in the community. So I think I heard
18 that yesterday and you just said you just
19 incorporated, you know, put dollars in safety
20 net. It may not be at the moment a great
21 business proposition, but it shows a true
22 commitment of your ACO.

1 And the other is, and I also got this
2 idea from not a speaker yesterday but from
3 Michelle Jester from the National Association of
4 Community Health Clinics, Centers, is that it's
5 having community information systems. There are
6 some models. She mentioned San Diego County,
7 which I can't wait to go find out more about
8 that.

9 But this -- the systems where you do
10 have the social welfare agencies with the health
11 agencies have -- not only is the data system
12 unified, but they all get together and do
13 something about it. So it's this learning system
14 of what to do as a county for the most vulnerable
15 population.

16 So I thought investment, you know,
17 actual investment in the community and investment
18 into infrastructure to get at the other sectors
19 of outside health. Philip.

20 MEMBER ALBERTI: Just to build on that
21 a little bit, you know, now you brought to mind
22 kind of the principle of the anchor institution,

1 right.

2 So thinking through an institution's
3 kind of financial investment from its own kind of
4 portfolio and local businesses, in making real
5 efforts for job training and then direct
6 employment at the institution, and then some
7 measure of --

8 And I think this is also tapping into
9 what Lisa Cooper was saying, community residence,
10 you know, real hand in developing these programs
11 so it's truly a partnership. And so I think the
12 financial investment piece is an important one to
13 capture.

14 CO-CHAIR PONCE: Thank you. Traci.

15 MEMBER FERGUSON: I did want to go
16 back to sort of the partnerships, the improved
17 integration for the medical behavioral health and
18 also the oral and I would include pharmacy. I
19 think co-location is the first step, but that
20 doesn't necessarily mean that, you know, a member
21 who may have a serious mental illness or an
22 active dual diagnosis has -- that they both have

1 the information.

2 So I think maybe looking at those and
3 we classify who, you know, actively have some
4 diabetes and schizophrenia what have you, that in
5 -- say if you're going to start with the primary
6 care doctor, that they have record of
7 communication with the behavioral health doctor,
8 or that there's been some type of collaboration
9 between or consultation with.

10 I think co-location is good, then
11 consultation and then being truly integrated,
12 whether it is that, you know, who's taking the
13 primary lead in the case and that they have an
14 active communication with that other entity. It
15 could be at the, you know, physician or
16 institutional level, but is also at the care
17 management level too.

18 So I think truly, truly integration
19 means that there is an active communication and
20 being able to capture that and not just that
21 they're in the same office.

22 CO-CHAIR PONCE: Thank you. Michelle

1 and then Nancy.

2 MEMBER CABRERA: I just want to
3 piggyback off of what Traci is saying. I think
4 the idea of partnership and collaboration kind of
5 needs to start at home, and if you can't, you
6 know, talk to yourselves or across departments,
7 it's going to be really hard to do that outside
8 of your organization.

9 So you know, whether there are
10 interdisciplinary care teams or even workforce
11 engagement around different initiatives, I think,
12 is really important in terms of partnerships and
13 collaboration.

14 Remember with Kaiser, it has a really
15 great model on unit-based teams. But those sorts
16 of things can really help to get you to that, you
17 know, quality of the collaboration that's
18 happening internally and influence what happens
19 externally.

20 CO-CHAIR PONCE: Thank you, Nancy.

21 MEMBER GARRETT: So one of the
22 barriers that we all face in addressing social

1 determinants of health is actually being able to
2 connect to the resources and knowing what the
3 resources are in the community. So I think that
4 might be what you're talking about in San Diego.
5 But we're working on a community resource
6 database sort of that has -- it has lots of
7 different stakeholders helping to build it, and
8 then everyone's going to be able to use it and
9 there's going to be an IT platform with it as
10 well.

11 So maybe that's something to have a
12 measure around, to incent communities to build
13 that kind of database to have it available,
14 because these resources, they change all the
15 time, it's to have like the right resource at the
16 right time is critical to helping people.

17 CO-CHAIR PONCE: Thank you. Any
18 comments from our colleagues on the phone?

19 MEMBER SANCHEZ: Yeah. This is
20 Eduardo. Can y'all hear me?

21 CO-CHAIR PONCE: Yes, we can.

22 MEMBER SANCHEZ: Okay, thanks. I

1 wonder if there isn't some value in thinking
2 about, and I don't know that any measures exist
3 necessarily, but back to CHNAs or any kind of
4 community health reports. Some measurement of to
5 whom that report is reported and to whom that
6 report is accountable, and the degree to which
7 the plan itself has it evolved and as it evolves
8 following a report, has institutionalized,
9 codified, integrated community member and
10 organizational involvement.

11 CO-CHAIR PONCE: All right, thank you.
12 Philip.

13 MEMBER ALBERTI: Just a follow-up on
14 that. So we've at the AMC we've now read through
15 I would say well over two or three hundred
16 community health needs assessments. It's a lot
17 of work to really begin to think of how to
18 standardize. You know, it's part of the
19 requirement (a) that institutions partner with
20 public health experts as well as local community
21 residents, to really understand kind of the depth
22 of that partnership and the collaboration

1 requires maybe hundreds of hours of qualitative
2 coding and phone calls.

3 It's a great idea. The reason that I
4 didn't include it in the culture of equity in
5 that it really only is something through which
6 public health entities and not-for-profit
7 hospitals are beholden to. So it might not
8 impact all the kind of health care providing
9 institutions.

10 There might be some way to think about
11 it, but you know, we might also then think about
12 Schedule H community benefit, community building.
13 You know, there are different ways in which not-
14 for-profit hospitals report their connections and
15 their financial support for community health
16 improvement activities.

17 I'm not sure that, you know,
18 recommending a deep qualitative dive is the easy,
19 smartest way to go.

20 MEMBER SANCHEZ: Yes, this is --

21 CO-CHAIR PONCE: Sorry. Eduardo, can
22 you follow-up on that comment? Or is that Kevin?

1 MEMBER SANCHEZ: I heard my name.

2 CO-CHAIR PONCE: Well, I just thought
3 you might have, you know, you might have -- you
4 might retort back.

5 MEMBER SANCHEZ: Well so despite that,
6 I guess I would say part of what we've talked
7 about is person-centeredness. Part of what we've
8 talked about in terms of disparities is community
9 centeredness, and until and unless there is some
10 sort of accountability relationship that exists
11 between the persons who are the persons and/or
12 communities that are experiencing disparities and
13 their ability to engage in the conversations
14 about how to go about addressing those and how to
15 bring perspective to that conversation, I think
16 that we won't get as far as we could.

17 We can continue making this about
18 we'll do a report and we'll pretend that we are
19 listening and we'll do what we can, and I live in
20 a community where there's lots of that going on,
21 or we can try to figure out how we engage people
22 and actually, as part of our exercise, recommend

1 that the degree to which -- and I don't know what
2 that measure is to CF, the degree to which there
3 is an audience and/or accountability to
4 community, and that can be defined in lots of
5 different ways. We should explore that
6 opportunity.

7 CO-CHAIR PONCE: So I don't know
8 enough about the CHNAs. I know we provide data
9 to hospitals, but I'm not sure who has the
10 authority to dictate the content of the CHNAs.
11 Philip, looks like he knows the answer.

12 MEMBER ALBERTI: So a little. I do,
13 okay. So to dictate what's in there. So the
14 CHNA process is really kind of a tri-partite
15 thing. So first you have to work with these
16 local experts and community residents to identify
17 and prioritize local community health needs, and
18 that's done through primary data collection,
19 surveys, focus groups, interviews, secondary data
20 analysis of public health, vital stats, EHR data,
21 whatever it might be.

22 Then through some other -- and the

1 folks that have leadership over that process is
2 completely different from institution to
3 institution. So it sometimes lives in the
4 community benefit office or in the government
5 relations department or in family medicine, and
6 it could be anywhere. So there's no kind of set
7 place.

8 Then the next step is to identify the
9 prioritized needs that the institution will
10 address and describe how, and what you expect the
11 impact of that intervention to be, and then say
12 which health needs you are not going to address
13 and why, and it could be they don't have the
14 resources, the hospital across the street is
15 taking care of that, whatever it might be, and
16 then develop an evaluation plan and you do that
17 cycle every three years.

18 The requirement is that the CHNA doc
19 that prioritized needs and the methodology in how
20 you arrive at that list is publicly available.
21 There's no such requirement or expectation for
22 the actual implementation strategy or the

1 interventions, to find those which is really
2 where the rubber hits the road so you learn kind
3 of what the investment is and what the programs
4 are.

5 That requires phone calls, emails,
6 trying to really pull some of that information.
7 It's not as kind of widely disseminated as the
8 prioritized need. And the IRS is the body that
9 reviews the CHNA and all of their community
10 health expertise. The IRS kind of decides
11 whether or not the institution is compliant with
12 the regulation, and it's separate from community
13 benefit and community building.

14 CO-CHAIR PONCE: Thank you. I think
15 we have to have some more thought about -- oh,
16 there's more. So Bob and Emilio.

17 MEMBER RAUNER: At the risk of getting
18 in trouble, I'll use contrasting hospitals in our
19 community who one, I think takes their -- has
20 historically taken the community health needs
21 assessment pretty seriously. They do interact
22 with people. They do fund projects outside of

1 themselves.

2 They actually, I think, take it fairly
3 seriously and that's also probably because the
4 leadership, it's the director of nursing who is
5 at the last community health improvement plan
6 meeting, for example. They were very engaged and
7 offered input.

8 The other hospital was the executive
9 who told me this is a checkbox on our Form 990
10 and it's the marketing and development people
11 that show up to the meetings, who have no
12 background in this. They have what looks like a
13 nice thing on their website, but I know in
14 reality there's no dollars and there's risk.
15 It's a checkbox on your 990. They paid for
16 somebody to write a plan for them essentially is
17 what they did so --

18 CO-CHAIR PONCE: Emilio.

19 MEMBER CARRILLO: I just wanted to
20 comment on what Philip said. The IRS 990
21 specifications are quite specific. I mean they
22 really specify with a great deal of detail how

1 the reports are to be done. Now as you point
2 out, people fill them out 100 different ways.
3 But there are the requirements well specified.

4 CO-CHAIR PONCE: Okay, thank you. Now
5 I understand CHNAs now. But I guess for the
6 purpose of what NQF needs, they'll have to think
7 come up with more precise language and how you
8 will use the CHNA information, or how we can
9 inform how to make CHNAs be more accountable to
10 what we need. Ron please.

11 MEMBER COPELAND: Well, yeah. I would
12 just say given all we just heard about how and
13 why they're filled out, I mean that can be
14 anything from the checkmark to something much
15 more impactful. But if we think about this in
16 the context of accountability, then the question
17 is not so much have you done the assessment but
18 what are you going to do with the findings and
19 can you demonstrate some commitment, either in
20 your strategic business plan or whatever business
21 document you use to guide resource allocation and
22 performance. Can you -- do you have an action

1 plan and can you talk about some form of impact
2 measurement over time in that action plan?

3 So that's -- the accountability
4 question is going beyond the compliance
5 requirement to do the assessment. It's then what
6 do you with the findings that's going to improve
7 health for a community or eliminate disparities
8 or whatever. So I think if we're going to use
9 the CHNAs as part of this, the accountability has
10 much to do with it.

11 CO-CHAIR PONCE: Okay. I think
12 somebody on the line wanted to chime in.

13 MEMBER FISCELLA: Yeah. This is
14 Kevin. Yeah. I agree. I think that the
15 measures should focus on the action part of the
16 plan and the impact, and this is a way, I think,
17 to really conduct community-wide interventions.
18 Many of the existing measures here are really
19 individual levels like, you know, at the patient
20 level addressing social determinants and linking
21 them to community health workers, etcetera.

22 But this is an opportunity for systems

1 to really engage in community-wide interventions,
2 whether it's promoting, you know, physical
3 activity or implementing diabetes prevention
4 programs or childhood obesity, violence,
5 whatever, or whatever the community health needs
6 assessment shows.

7 So I think as long as -- we don't need
8 to have all the details of the community health
9 assessment, as long as we focus on actionability
10 and ask that they reference that and they have
11 supporting documents for why they chose that as a
12 priority, referencing back to that community
13 health needs assessment.

14 CO-CHAIR PONCE: Okay, thank you. So
15 we move on?

16 MEMBER SCHOLLE: Hi, it's Sarah. I
17 have a couple of comments.

18 CO-CHAIR PONCE: Oh. Go ahead, Sarah.
19 Sorry.

20 MEMBER SCHOLLE: Yeah. A couple of
21 things. The point is I think this conversation
22 is really interesting, and I agreed with one of

1 the previous speakers who said all these domains
2 seem to be interrelated, or some of them seem
3 interrelated. There are several domains that are
4 really addressing structure, structure for
5 collaboration, structure for culture and there's
6 some foundational components of that.

7 In our experience, actually measuring
8 this becomes very tricky given the whole variety
9 of situations that organizations are in, and in
10 particular since in this conversation it feels
11 like we've been ranging, I believe intentionally
12 ranging from the idea of individual clinicians or
13 practices up to large organizations like health
14 plans, health systems or hospitals.

15 And so the capability of doing things
16 really varies. Also, we have some organizations
17 that are not-for-profit and do have a commitment
18 and responsibility already, and then we have
19 other organizations that don't have that like
20 small physician-owned practices as well as larger
21 for-profit institutions.

22 So the flexibility for being able to

1 address these issues in a way that doesn't --
2 that allows each organization to think about well
3 what could I do on that continuum of work is
4 something we may want to consider.

5 As we've developed standards for
6 health plans and for practices, we've often had
7 to struggle with how specifically where we're
8 talking about structure where some organizations
9 will come up with something that we hadn't
10 envisioned and that doesn't actually meet what we
11 said.

12 So that is really kind of a caution
13 about thinking about specifically where to go,
14 unless we're thinking of a specific
15 implementation and opportunity.

16 CO-CHAIR PONCE: Thanks, Sarah. I
17 think you've raised the question that we have. I
18 think the next job for the Committee --

19 MS. O'ROURKE: To close that out. So
20 I think we've covered most of the questions we've
21 had up on the slide. So I think yeah, we could
22 return to Sarah. We're just bringing up your

1 slides in the room, Sarah.

2 MEMBER SCHOLLE: It's good morning
3 here in Anchorage, but I'm real happy to have a
4 chance to review about some work that we've done
5 that's sponsored by the National Academy of
6 Medicine's Health Literacy Work Group, and they
7 have put together a framework for integrating
8 quality measurement across the areas of health
9 diversity, language access and cultural
10 competency.

11 If you'd got to the next slide. I
12 have a delay in my slides, here we go. So it's
13 interesting. So this was -- came out of the
14 committee that focused on health literacy, and
15 they asked us to think about how does that fit
16 with cultural competence and language access. So
17 our team at NCQA that includes Jessica Briefer
18 French. You saw her name on this, because she
19 was the lead author, and as well as Judy Ng and
20 myself.

21 We started off by looking at the
22 definitions of these three topic areas of health

1 literacy, cultural competence and language
2 access. We looked at where they came from and we
3 sought out some authoritative sources that
4 defined the components of these areas, and then
5 we also looked at existing performance measures
6 that were available and to see how they tracked
7 against these topic areas.

8 I don't think I need to define these
9 terms for you, but it is interesting that these
10 -- they're different constituencies and different
11 origins of each of these topic areas, and but if
12 we go to the next slide, as we look more deeply
13 at the components of what's been captured in
14 those authoritative sources, we see a lot of
15 commonality.

16 Some of these sources include
17 materials from HHS, the HHS Office of Minority
18 Health and the Joint Principles for Patient-
19 Centered Medical Homes and other definitions of
20 patient-centered care. As many of you know, the
21 recent update of the HHS Office of Minority
22 Health cost standards specifically used a more

1 inclusive terminology to include health literacy,
2 cultural competence, communication and language
3 assistance, as well as --

4 And this -- so it broadened the
5 perspective on the previous standards. We used
6 the term patient-centered care because in many
7 areas where we work, we see person-centered
8 care/patient-centered care as also combining an
9 interest and focus on these different topics. So
10 Marshall, we presented these at a roundtable
11 maybe last month, and Marshall attended and I
12 think others were maybe aware of this.

13 You can see there's a lot of
14 commonality with the kinds of domains that we
15 talked about today in our work for this
16 Committee.

17 So if we go to the next slide, so we
18 were asked to think about how do these domains
19 fit together, and you can see they really do
20 capture many of the -- they address many of the
21 same issues. They look at quality measurement
22 and improvement should be directed at health

1 literacy, it should address cultural competence.

2 So we looked to see what structural
3 measures existed that address these topics, and
4 when we looked to available structural measures,
5 we found a couple that are based on survey,
6 including the Communication Climate Assessment
7 Tool, which was developed by the ANA Group that
8 is now stewarded by the University of Colorado I
9 believe, and then RAND, who developed a cultural
10 competence survey that was based on best
11 practices that were identified by the NQF
12 Committee.

13 Both of those tools actually depend on
14 the survey. The interesting thing about the
15 Communication Climate Assessment Tool is that in
16 our two surveys, that is the survey from the
17 perspective of staff and clinicians who work in
18 the health care organization, and then it has
19 survey for patients.

20 Our understanding is that that is used
21 by some organizations for quality improvement.
22 We're not aware that the RAND survey is used.

1 It's a single respondent from an institution.
2 But the other way that we see these concepts
3 being incorporated is through --

4 CO-CHAIR PONCE: Sarah, could you
5 please speak up? I know you have a hoarse
6 throat. Would you try to move closer to the mic?
7 Thank you.

8 MEMBER SCHOLLE: Oh okay. Is that
9 better?

10 CO-CHAIR PONCE: Much better.

11 MEMBER SCHOLLE: Can you hear me
12 better now? Okay. So there are programs in
13 place that are accreditation programs,
14 recognition programs or even from the Medicare,
15 the new merit-based incentive payment program
16 that have structural expectations for
17 organizations, that capture many of these topics
18 around QI and data collection and other areas.

19 And what we found is that among all of
20 these data sources, the only two that really
21 capture broadly health literacy, cultural
22 competence, language needs, communication and

1 language assistance is really the Communication
2 Climate Assessment Tool, and actually NCQA's 2017
3 Patient-Centered Medical Home standards have
4 really captured that as, you know, just one after
5 another. Do you do each of these things? Or
6 questions of QI that address the topics in there.

7 So I think what's interesting about
8 this is that many of the areas that this
9 Committee's been discussing this morning fit into
10 this type of survey, that would be captured on
11 behalf of the organization or reported by its
12 staff or patients, or accreditation or
13 recognition programs where the MIPS, these are
14 the CQIAs, I think, the Clinical Quality
15 Improvement Activities.

16 These are really conditions for
17 participation rather than performance measures.
18 So they're not reported individually for a number
19 of people are who are eligible. It's more about
20 does this organization have this capacity and can
21 they demonstrate that they're actually using it?
22 So you could look at numerators and denominators,

1 but it might not be for all eligible events the
2 way we think about performance measures.

3 Okay, next slide please. So we look
4 at process measures and really found very few
5 that were specifically tailored to the topic
6 areas of interest here. There's a suite of
7 measures that are -- look at language services
8 that G.W. developed. These are no longer -- I
9 believe they're no longer stewarded and we
10 weren't able to find that they are used. We've
11 found there's one measure about TTY services
12 interpretation that's in the famous Stars
13 program.

14 But otherwise, measures that
15 specifically address these topics we didn't find
16 in the process realm, except if we go to the next
17 slide, then we look at outcome measures like
18 patient experiences, and this is where we've
19 actually through previous work that we did for
20 CMS, the same as Office of Minority Health, we
21 catalogued the topic areas that are captured in
22 existing patient surveys.

1 If we look at the domains of the CAHPS
2 supplemental items, you can see that there are
3 -- there's actually three supplemental survey
4 data sets from the CAHPS, that the CAHPS team has
5 developed. One addressing cultural competence,
6 another health literacy the patient-centered
7 medical home, and these capture some of the areas
8 including discrimination, trust are domains in
9 the culture competence measure set.

10 And then health literacy is captured,
11 communication. I think it's communication
12 broadly speaking. So but we were unable to see
13 where any of the cultural competence items are
14 actually used in existing national programs and
15 health literacy I think, medication items are
16 used in the hospital CAHPS, and I believe they
17 might be used in the Medicare Advantage CAHPS.

18 So there's -- so if we go to the next
19 slide, you know, in summary, we found that
20 different groups have articulated the need for
21 focusing on issues of health literacy, culture
22 competence, communication and language support,

1 and what we find is that there are existing
2 structure measures. They're not comprehensive.
3 They need to be updated. They don't always take
4 into account the broad range of topics.

5 But they are available as measures
6 that can help to build capacity. It seems like
7 there is a tremendous opportunity to think about
8 how to use the existing items that have been
9 developed to capture patient experiences. But
10 our own sense of this world is that people want
11 much more streamlined patient survey tools, not
12 longer ones and there's really true concern that
13 our method of capturing data on patient
14 experiences today is based on -- primarily on
15 mail surveys and may not represent the population
16 that we're most concerned about, you know, in our
17 work today.

18 We have heard consistently from
19 stakeholders that there's a need to focus on a
20 core set of measures and to work with what we
21 have to stratify the existing quality measures,
22 to focus, target improvement and we think there

1 might be an opportunity to really think about how
2 we could develop packages of measures for
3 vulnerable subpopulations, that might be a way
4 for organizations to target concerns.

5 We've done this at NCQA. We've just
6 developed a set of standards for long-term
7 services and supports that becomes a required
8 module for health plans when they have
9 responsibility for that benefit. So thinking
10 about if an organization has responsibility for a
11 population, is there a package of measures.

12 So I offer this as work we did for the
13 National Academy of Medicine, but I offer these
14 ideas as strategies that the panel may want to
15 consider in our deliberations.

16 MS. O'ROURKE: Thank you so Sarah. We
17 wanted to have Sarah highlight some of the work
18 that she's been doing, since it had so many
19 synergies with the work of this Committee. So do
20 we have a few minutes in case anyone has
21 questions for Sarah? If not, should we move on
22 and change gears a little bit, and start to think

1 about developing some of the implementation and
2 policy recommendations?

3 (Off mic comment.)

4 CO-CHAIR CHIN: So Sarah, I was just
5 saying that you get a gold star for participating
6 at 4:00 a.m. Alaska time, so thank you very much
7 and there was a lot of overlapping ideas with the
8 NCQA work. So I think that these products can be
9 mutually learned from each other, so that's
10 great.

11 So in terms of where we're at, that so
12 this morning that I think there was general
13 agreement that the five equity domains for the
14 consensual framework are in ballpark, and that
15 seemed to work. People came up with some example
16 ideas of measure concepts that might fill in some
17 of the gaps, although I don't think anyone sort
18 of entered that exercise thinking that their
19 responsibility was to try to be comprehensive and
20 figuring everything out in terms of each of those
21 domains. So in some ways the report should
22 probably reflect that it's not designed to be

1 like this the end-all, be-all, but more designed
2 to give examples and help spur the field.

3 And so now we're going to turn to this
4 issue of use of measures and so now we're in the
5 afternoon. It's almost like 1:45, and here
6 though I think we need to be alert, because this
7 is really the opportunity that like harkens back
8 to what Michelle said about like well, you know,
9 we want the work to be meaningful and to have an
10 impact.

11 It heightened back to what Christie
12 said about well, this has got to be a business
13 case to motivate people. It harkened back to
14 what Ron said about road maps are great, and I
15 think actually the road map we're coming up with
16 is a nice model. But I think the way he put it
17 was that road maps, if they're not used, then
18 they don't -- they don't have an impact.

19 And so really this particular part
20 where you talk about now use of the measures is
21 we're looking basically to make sure it has an
22 impact. When you think about it too, like with

1 the overall work of this Committee, the part that
2 we have most -- the biggest worry we had is this
3 discussion, because the vast majority of the
4 final report are going to be the Committee's
5 recommendations to CMS and others about well,
6 what to do with all this, and again this is the
7 opportunity that we have not had before.

8 And so we're actually going to be sort
9 of brainstorming this afternoon, that it's sort
10 of a big area. And so -- and what's going to
11 happen is that Drew and Erin and the team are
12 going to tonight then make things a little more
13 orderly in terms of like then coming back to us
14 in the morning, sort of like what happened last
15 time.

16 So don't worry too much about having
17 everything sort of fit cleanly and nicely and
18 all, and so that basically we want to get the
19 ideas out there and then we'll have a chance to
20 revisit tomorrow morning. And so we're going to
21 start first with Drew's going to talk a little
22 bit about some existing efforts by NAM and ASPE

1 that help provide a little bit of a framework,
2 that I think we'll sort of go beyond it.

3 But like at least it provides a
4 starting point for some of these ideas, so that
5 we can make our discussion a little more
6 efficient. Then we'll go into the -- on the
7 agenda it's like three different sessions on
8 different topics. In practice, we'll going to
9 meld together. So it would be much like there
10 being like three discrete areas.

11 The three different general topics
12 were how do we leverage existing quality
13 initiatives. So lot of issues in terms of
14 guidance on data and scoring, and then guidance
15 on incentivizing the reduction of disparities.
16 But in practice, this is going to morph together
17 probably, and there are some guides in terms of
18 the bullets.

19 But again, we don't need to be too wed
20 to them in that like I think it's all going to
21 morph together. But I think it will work out
22 fine, I think. But we need to be in sort of

1 brainstorming mode, high energy and I'd also say
2 don't -- we shouldn't constrain ourselves
3 artificially, that we should put on the table
4 whatever we think is going to be effective
5 reducing disparities, and whatever constraints or
6 other issues that are involved, that really is
7 not our concern right now.

8 I'll try to come up with a road map of
9 what we think is going to be most effective.
10 Some which may be implemented in the short term,
11 some of it may end up down the road. But I don't
12 think we should have artificial constraints to
13 what we do. So I'll turn it over to Drew.

14 DR. ANDERSON: So I'm just going to
15 briefly run through the NAM recommendations and
16 ASPE recommendations that was included in the
17 meeting materials, and I'm sure you all are
18 familiar with this at this point. But we wanted
19 to just set the stage for the recommendations
20 that you're about to discuss in this section.

21 So as far as the NAM recommendations,
22 they recommended first that social risk factors

1 be looked at in these four different ways. So
2 they should be basically looked at, identifying
3 these methods of stratifying for public
4 reporting. I feel like my mic keeps going in and
5 out, and for patient characteristics, adjusting
6 performance measure scores, direct adjustment if
7 actual payment and restructuring of payment
8 incentive design.

9 So these are kind of the line-up with
10 some of the recommendations that we already have
11 in the measurement framework. To achieve these
12 goals NAM -- the committee recommended that
13 measures be adjusted, measure scores be adjusted
14 for social risk factors while also including the
15 stratified data within reporting units.

16 Just breaking that out a little bit
17 more, I won't go through each one of these
18 individual examples, but they provided these
19 essentially use cases for how to apply these four
20 different ways or methods of looking at social
21 risk factors.

22 So then jumping ahead to ASPE's

1 recommendations, so you all are familiar with
2 these three big buckets. Essentially the first
3 is to measure and report on quality for
4 beneficiaries, so looking at Medicare
5 beneficiaries. The second is setting high and
6 fair quality standards, and then the third was
7 rewarding and supporting better outcomes.

8 And so within each of these three big
9 buckets, there were several considerations that
10 ASPE laid out. The first was to enhance data
11 collection and develop statistical techniques to
12 allow measurement and reporting of performance
13 for beneficiaries with social risk, and then the
14 second was to introduce health equity measures or
15 domains into existing payment programs, to move
16 measure disparities and incentivize and focus on
17 reducing them.

18 And then the third consideration under
19 Strategy 1 is to monitor the financial impact on
20 Medicare payment programs on providers
21 disproportionately serving beneficiaries with
22 social risk.

1 The second strategy setting high and
2 fair quality standards for all beneficiaries was
3 the first consideration is that measures should
4 be examined to determine if risk adjustment for
5 social risk factors is appropriate, and then the
6 second consideration really focused on whether
7 better adjustment for health status might improve
8 the ability to differentiate true differences in
9 performance between providers.

10 And then lastly, the third strategy
11 was rewarding and supporting better outcomes for
12 beneficiaries with social risk factors. So the
13 first consideration was considering to create
14 targeted financial incentives within value-based
15 purchasing programs, to reward achievement of
16 high quality and good outcomes. The second
17 consideration looked at using new or existing
18 improvement programs to provide targeted support
19 and technical assistance to providers that serve
20 beneficiaries with social risk.

21 And then the third was developing
22 demonstrations or models focused on care

1 innovations. So this is similar to the last
2 recommendation that's already a part of the
3 measurement framework. And then the last, fourth
4 consideration was considering further research to
5 examine the costs of achieving good outcomes for
6 beneficiaries with social risk factors.

7 So that brings us back to the fourth
8 step of the measurement framework, where we
9 included these five recommendations that we have
10 from this committee, and during the break, we
11 were talking a little bit about which ones we
12 would probably need to focus a little bit more
13 time on.

14 And so this first one of incorporating
15 equity measures into payment and reporting
16 programs, we would need to get some more detail
17 on what would look like, and existing safety net
18 providers is another one, and a third one is
19 looking at conducting and funding demonstration
20 projects. But we can walk through these step-
21 wise and we can just start the discussion, start
22 throwing out some ideas. But I'll turn it over

1 to Marshall to lead the discussion.

2 CO-CHAIR CHIN: Yeah. This particular
3 slide, like two of them are fast. So like
4 aligning equity across payers this in some ways
5 what NQF tries to do anyway. The one about demo
6 programs, well demo programs are sort of part and
7 parcel of things. Sort 1, 3 and 4, the ones
8 which are the ones that need to be drilled down
9 on.

10 One is a big one. The third one, in
11 terms of social determinants of health and
12 preventive care is a big one. Safety net
13 organizations is another big one, where some of
14 them are like the others, but there are special
15 issues for safety net also, so pretty
16 complicated.

17 Just a couple of points. Again, that
18 NAM meeting yesterday that it was like David and
19 Philip and Ninez and Nancy and Christie were
20 there, and Lisa. So a lot of people were there.
21 So this is great, and Helen was there. I mention
22 that over half of the discussion I believe was on

1 the reputed topic of the day, which was the
2 social risk factor adjustment. But was on
3 essentially the stuff we'll be talking about this
4 afternoon. So they sort of saw that it was
5 important, critical to address.

6 The other thing that was striking was
7 at the end of the day, there's this issue of what
8 happens next. Well, the NAM, they have a very
9 contracted basis, so that they're not doing
10 further work in this area per se. There is the
11 Department of Health and Human Services, assist
12 the Secretary for Planning and Evaluation.

13 So they are continuing to do some
14 work, so they're sort of one of the factors that
15 are involved. But there aren't necessarily other
16 groups that are really sort of plowing ahead with
17 this. So again, we have an important role
18 potentially in terms of like just keeping the
19 momentum going.

20 So when we start then with the
21 brainstorming, Tara's going to be recording this
22 in a real time so everybody can sort of follow

1 along in terms of the brainstorming that exists.
2 But maybe the place to start is like if you look
3 at the 12:45 agenda item, the second and third
4 bullets, there's two general questions. I'll
5 start things going.

6 What are the existing programs, tools,
7 policies, etcetera that can be leveraged to
8 incentivize the use of measures in this area, and
9 then very generally also how can equity measures
10 be incorporated into existing CMS programs. If
11 we start with those two, we'll probably get a
12 general template out there that we can start
13 following with the other bullets and drill down
14 on the questions.

15 So numbers 1 and 2 then. Actually,
16 numbers -- yeah, numbers 1 and 2 up there, yeah.
17 Start ahead, Bob.

18 MEMBER RAUNER: And maybe this is just
19 redundant, but out of those first two, I think
20 the big one comes down to there's the measures
21 are already in use by HRSA, by CMS. It's the
22 biggest thing is stratification because that data

1 just isn't there, although it actually is most of
2 the time in the EHR. It's just not in the claims
3 data, and that's I think our big obstacle.

4 A lot of FQHCs have meaningful use
5 compliant EHRs, where you can pull about
6 ethnicity, by language preference, all that in.
7 It's just that it's in their EHR which doesn't --
8 - isn't brought in centrally. I think the big
9 challenge is bringing in that -- the social
10 factors that can adjust for this, because if we
11 could adjust for that, we can prevent the harm.

12 And that's -- for me, that's the
13 single biggest priority, is adjusting our
14 currently used input measures for this type of
15 stuff along those lines, and that's our big
16 obstacle.

17 CO-CHAIR CHIN: Two things there, Bob.
18 So one is to use the existing programs, the
19 various existing value-based programs as well as
20 some HRSA programs, and then you also applied two
21 different things.

22 One is the social risk factor

1 adjustment issue, which we'll talk about I guess
2 tomorrow afternoon in terms of the trial period,
3 and then the other thing I heard was well then
4 stratifying by social risk factors for a variety
5 of purposes. So we have -- is that Emilio out
6 there? Yep, Emilio. Emilio, you're up. Oh
7 sorry. Or we'll do Ignatius and then Michelle
8 and circle back to Emilio, and then Nancy.

9 MR. BAU: So the way I would answer is
10 that unfortunately it does go back to payers,
11 that I think within Medicare --

12 (Off mic comment.)

13 CO-CHAIR CHIN: We thought you were a
14 deep thinker.

15 (Laughter.)

16 CO-CHAIR CHIN: So we'll do a dramatic
17 effect.

18 (Off mic comments.)

19 MR. BAU: So in Medicare, CMS has done
20 a lot obviously with Accountable Care, with
21 Comprehensive Primary Care Plus, lots of
22 initiatives that are trying to do value-based

1 purchasing and outcomes, but hasn't had an
2 explicit focus on equity. So again, could CMS in
3 some of those Medicare innovation programs design
4 something specifically to incentivize the
5 reduction of disparities and the achievement of
6 equity?

7 The other, as many people have noted
8 though, the disparities population is more likely
9 though in the Medicaid population, and again it's
10 obviously problematic now with all the politics
11 around Medicaid. But if there were ways that CMS
12 could also leverage the Medicaid program, again
13 to specifically call for state innovation grants
14 that weren't just about value-based purchasing,
15 but actually about the reduction, the explicit
16 reduction of equity as part of innovation.

17 And again, there may be a way to
18 structure CMS or ACA Section 1332 waiver around
19 that, which is as long as you don't increase
20 costs, you can do some additional things with
21 Medicaid within the state. And then on the
22 commercial side, back to the California example

1 which is that covered California as a state
2 insurance marketplace is now placing explicit
3 requirements on the qualified health plans within
4 the exchange to not only improve quality but also
5 make progress on equity.

6 So that's again an example that I
7 doubt the federal marketplace ever will do,
8 because it's having problems just keeping plans
9 in. But that would be a strategy as well.

10 CO-CHAIR CHIN: Thank you, Ignatius.
11 We have Michelle and Nancy.

12 MEMBER CABRERA: Well, I think one of
13 my biggest pleas on sort of how we think about
14 crafting policies to make sure that as we're
15 aligning across different purchasers, that the
16 alignment doesn't drop this issue. So we have to
17 think about strategies to make sure that that
18 doesn't happen, like you know, even as simple as
19 talking about Quadruple Aims that includes health
20 equity instead of just Triple Aims, right. So
21 stuff like that.

22 Everything that Ignatius just said

1 plus I have a crazy idea I wanted to throw out,
2 which is for NQF's work, I know there was really
3 good conversation around SDS risk adjustment that
4 centered around an agreement, it seems, that
5 there are certain quality measures that in no
6 case should be adjusted, because there is no --
7 absolutely no connection whatsoever to SDS,
8 right.

9 Like you leave a sponge in a body,
10 that's on you, right. Like nobody can blame that
11 on anything else. So can we pull out those
12 measures that are known that we can agree to and
13 say these are the things that have absolutely no
14 relationship to SDS, and then leave everything
15 else in the we don't know yet category, right?
16 Or with explicit caveats where we may know that
17 there may be a relationship to disparities,
18 either in how it's applied.

19 So warning policymaker or payer, you
20 may want to be careful about how you apply this
21 measure, because it could in fact have unintended
22 consequences on certain subpopulations or

1 something. Like I'm trying to think of how to
2 get, how to engage people in a conversation
3 around the actual measures, and what we know
4 about their relationship to disparities.

5 Because I feel like we're going to
6 have this conversation tomorrow about the trial
7 period, and I understand that's different. But
8 this is sort of the -- in my view measures are
9 policies, you know. There is a policy angle to
10 any measure because we're not developing them for
11 the sake of developing them. We're developing
12 them for the sake of creating some sort of
13 change. I think this is sort of a filter that
14 can be applied to all of NQF's measures.

15 CO-CHAIR CHIN: Thanks, Michelle.
16 We'll do Nancy, and then rotate to whoever on the
17 phone wants to comment, and then we'll take back
18 up to the in person panel.

19 MEMBER GARRETT: So I'm going to take
20 your prerogative to not have limits here on the
21 conversation, and just say I'm not sure that the
22 question is quite broad enough. So I would say

1 our question that we should really consider is
2 what existing programs, tools, policies can be
3 leveraged to incentivize disparities reduction?
4 And so that's even a little bit bigger, but use
5 of measures feels a little bit limiting to me.

6 And so an example is the -- in the NAM
7 report, one of their four methods for kind of for
8 social risk factors is direct adjustment of
9 payments, and so how might that be done? Well, a
10 payer like Medicare could look at what are the
11 vulnerable populations where we know that there's
12 going to be additional resources needed and how
13 do we have some payment enhancements for that.

14 One of the quickest places to change
15 is in some of the models, especially like the ACO
16 models. That could be a place where some of this
17 could start. But it doesn't have to be. It
18 could also be a fee for service kind of payment
19 enhancement that's looked at. There is some work
20 going on in Minnesota with our state ACO through
21 our state Medicaid agency, where they've just
22 proposed a new model, where there will be some

1 additional payment enhancement for population for
2 social risk factors in an upfront payment if you
3 participate in the model.

4 So there's, you know, specific policy
5 work that you can do within those models that can
6 be a little bit faster. The one thing I just
7 wanted to bring up from the conversation
8 yesterday was my favorite quote of the day, was
9 one of the -- I think it was the person from
10 Boston University who was talking about some work
11 that was done on the original ACC model as well
12 as some work with another.

13 He said there's a precedent for
14 overriding what the data wants to tell you, and
15 so basically he was saying if you do empirical
16 models and you find out that the factor that you
17 really want to incent and have more resources
18 going to that particular factor, if it doesn't
19 come out in your model as significant and you
20 have sort of a policy reason to do it, you can
21 still weight that variable in a different way.

22 I thought that was really helpful and

1 something we need to think about, especially with
2 something like trying to figure out, you know, a
3 payment enhancements or additional resources
4 needed because the data is not there. I mean
5 it's not -- a lot of the resources that are going
6 to those populations right now, there's no
7 reimbursement for it so it's not in the claims
8 data.

9 So if you do a model, you're not going
10 to find what that resource should be. You're
11 going to have to come up with another way to find
12 it.

13 CO-CHAIR CHIN: Thanks Nancy, and
14 that's one of the issues that we're going to come
15 back with, right. Once we have the menu options
16 of out there, there may be some that may be
17 appropriate in certain situations, more
18 appropriate in certain situations for certain
19 goals.

20 So for example, one thing that came up
21 yesterday was this issue of like -- of a safety
22 net just being so under-resourced that you might

1 need to have a variety of different ways to sort
2 of fill in that gap. So it's one example. So
3 next, anyone on the call? Now's your first
4 chance to jump in. So anyone on the call want to
5 comment?

6 MEMBER BERNHEIM: This is Susannah.
7 Go ahead Kevin.

8 CO-CHAIR CHIN: Go ahead, Susannah,
9 then Kevin.

10 MEMBER BERNHEIM: So I want to defer
11 to you guys about when to bring this up, but I
12 had mentioned to you and Ninez that there's two
13 things that CMS has actually put in their rule
14 this year related to this topic, and I wanted to
15 make sure the community was aware. So you tell
16 me. Is this a good time to bring that up or
17 should we get to it later?

18 CO-CHAIR CHIN: I think it's fine,
19 yeah. Go ahead, Susannah.

20 MEMBER BERNHEIM: It relates to this
21 concept that -- part of why I thought of it is
22 that it relates to the concept that Nancy brought

1 up. So CMS put out their proposed ICPS rules, a
2 rule that relates to hospital payment but also
3 quality programs, and they will put a final rule
4 out in August. So all of this is just in the
5 sort of out for comment. Actually, the comment
6 period just ended.

7 And one is, and I mentioned this
8 before, but the Cures Act specifically did
9 exactly what Nancy just said, which is it changed
10 payment policy. So CMS now has said how they're
11 going to enact that. So this is in the context
12 of the hospital readmission reduction program.
13 CMS has proposed the approach they're going to
14 take to stratify hospitals into groups.

15 So not patient-level stratification,
16 but put hospitals into different groups based on
17 the proportion of patients that a hospital serves
18 that are dual-eligible, and then leave the
19 readmission measures untouched. But after those
20 are calculated, they will set different payment
21 thresholds for hospitals on the basis of the
22 hospital's proportion of dual-eligible patients.

1 So this is a, I think in that sort of
2 fourth mechanism, which is sort of directly
3 affecting payment adjustments based on a
4 hospital's case mix. So I wanted to make sure
5 people knew. I don't actually remember when
6 they're proposing to put this into place.
7 There's a lot of details about exactly how they
8 do the calculation and set the thresholds.

9 But just as a high level concept
10 important for this committee to know that CMS has
11 made a next step on that.

12 The second reason, I think this will
13 get way too in the weeds, so I'm going to stay
14 very high level, but happy to talk about it some
15 more as I'm thinking about it is we worked with
16 CMS and they have put out not even a proposal,
17 just sort of a signal like what do people think
18 of this. But the signal was to include in
19 reporting eventually, but initially just
20 privately report to hospitals mortality and
21 readmission rates when you get your overall
22 mortality and readmission, but you also get an

1 indicator of within hospital disparities in your
2 mortality and readmission rates, again using
3 dual-eligible as a factor.

4 We could talk endlessly about what the
5 right factor is, but essentially ASPE's report
6 said dual-eligible is one of the most feasible of
7 the things Medicare has, so that's where they're
8 starting. So this would give an overall score.

9 You know, your pneumonia readmission
10 rate is this, and then it would give an indicator
11 of the difference in the pneumonia readmission
12 rates for your dual-eligible versus non-dual
13 eligibles who are included in that measure, and
14 that indicator obviously varies across hospitals.

15 So there's some hospitals that have
16 very close rates between the two, and some that
17 have more much more distant rates. The
18 statistics of this were complicated for us
19 because the outcome measures have to be case mix-
20 adjusted. So we didn't want to come up with a
21 disparities indicator that basically said your
22 dual-eligible patients are sicker than your non-

1 dual-eligible patients.

2 So we had to do it in the context of
3 a model that also kept the case mix adjustment
4 constant for the two groups. So that's what they
5 -- they didn't even propose. They sort of, they
6 said we're thinking about doing this and we're
7 seeking comment on that.

8 And so that is also in the rule, but
9 also I've seen CMS take the step towards inequity
10 measures. So I wanted to make sure the group was
11 aware that both of those things were in proposals
12 from CMS right now.

13 CO-CHAIR CHIN: Thanks very much
14 Susannah, and stratification is a big topic we'll
15 need to come back to, because it there's a lot of
16 complicated things that are really important.
17 The actual NAM report, like their recommendation
18 was to use social risk factor adjustment when
19 appropriate and then also they said you need to
20 also then report stratified data as one of the
21 work-arounds to make sure you don't mask
22 disparities or explain them away. So that's one

1 example.

2 In Susannah's first example, it raises
3 like one approach for trying to deal with some of
4 the problems. So like this issue of like well,
5 if you have like some type of absolute threshold
6 for performance, well the hospitals that take
7 care of more difficult populations are
8 disadvantaged compared to the more advantaged
9 populations.

10 So they -- they have sort of like
11 decile issue where you're compared to hospitals
12 with a similar decile as you. So comparing like
13 with like, so that in a healthy program, you'd
14 have then the penless hospitals spread out across
15 these deciles as opposed to just putting them on
16 the safety net, as one example. Which raises
17 other issues.

18 But so stratification I'm going to
19 come back to. How it also relates is an issue
20 too because it's something that these committees
21 at NQF has also sort of grappled with, is some
22 more clarity about how we think about

1 stratification would be useful. So we'll
2 definitely come back to this, because it's a big
3 one. Kevin.

4 MEMBER FISCELLA: I agree with what
5 Nancy was saying, that we want to -- I think
6 measures are an important part, but we don't want
7 to necessarily start with measures and then look
8 a little more broadly and then think about how
9 measurement can be integrated and then to -- into
10 thinking more broadly.

11 You know, the other example is -- is
12 really the out of pocket costs and value-based
13 design, you know, where evidence-based procedures
14 and drugs have much lower out of pocket costs,
15 co-payments.

16 And, you know, that could even be
17 extended as, you know, some employers do to, you
18 know, reducing those -- those co-payments based
19 on, you know, employee job category or income or
20 what have you. But that would be another,
21 another lever that is not really necessarily
22 measurement-based, although measurement could

1 play a role in looking at it.

2 CO-CHAIR CHIN: Thanks, Kevin. Anyone
3 else on the phone before we go back to Bob?

4 MEMBER SCHOLLE: Hi, it's Sarah. I
5 just wanted to suggest that in the programs for
6 Medicare Advantage and for like the CPC, the
7 shared savings programs for ACOs, that there's an
8 opportunity to put more teeth and the MIPS
9 program. There's some opportunity to put some
10 more teeth into expectations about having
11 complete data on the accuracy and completeness of
12 the data about social risk needs, and about how
13 that's used and the quality improvement, and so
14 that could be drawn on by --

15 There are pieces in the Joint
16 Commission Accreditation for Hospitals, there are
17 pieces in NCQA's programs for different kinds of
18 entities, where by calling on those -- calling on
19 organizations to actually meet the existing
20 standards, would be a way for CMS to move that
21 and also to make some requirements in programs
22 like MIPS.

1 I think somebody mentioned the special
2 needs programs and their model of care, where
3 those could be strengthened as well, to get as
4 many of the structural kinds of topics we
5 discussed this morning.

6 CO-CHAIR CHIN: Just to make sure I
7 understood what you said there Sarah, so one, you
8 meant like having some measure of like -- or
9 basically for reporting programs, somehow
10 rewarding them better data collection of social
11 risk factors as one. Then the second you
12 mentioned was quality improvement, and I didn't
13 quite see what you meant there.

14 MEMBER SCHOLLE: So where
15 organizations as part of participation would be
16 able to participate in a program would need to
17 demonstrate that they're actually working to
18 reduce disparities in their population, that they
19 not only know about the social risk of their
20 population but they're actually -- they've
21 identified areas where they can target their
22 quality improvement on equity.

1 CO-CHAIR CHIN: Great.

2 MEMBER SCHOLLE: And those types of
3 expectations already exist in some of the
4 accreditation programs or they can be added that
5 way.

6 CO-CHAIR CHIN: Thanks, Sarah. Anyone
7 else on the phone before going to Bob, Lisa
8 Iezzoni, then David and Emilio?

9 (No response.)

10 CO-CHAIR CHIN: Okay, Bob.

11 MEMBER RAUNER: Can I just talk a
12 little bit about Michelle's idea of having the
13 STS measures noted in categories? You know,
14 somewhere it just shouldn't like the sponge in
15 the body, and the other extreme being where we
16 know some measures really do have a strong
17 component, like what David said on the A1c and
18 blood pressure control and colorectal cancer
19 screening.

20 There's pretty good evidence that
21 those should be. Then you have really I think
22 one or two middle categories. There's somewhere

1 is a conceptual basis, but the evidence doesn't
2 support it like Alc testing. That's a pretty
3 close cross. And then there's the category of
4 sort of unknown and mixed, like I think some of
5 the hospital readmission measures have mixed
6 results.

7 I think part of the problem is because
8 they're not using patient level data. They're
9 using zip code or something like that and that's
10 probably clouding the data a little bit. So I
11 think it might be good to start putting those in
12 categories, just like with all kinds of medical
13 recommendations.

14 You have levels of evidence A, B, C,
15 D, you know, that kind of thing, that maybe we
16 should list that so that if somebody like a payer
17 is going to pick a measure and it's something
18 that's relevant like colorectal cancer screening,
19 they really should listen to somebody when they
20 say no, this FQHC should be adjusted and paid
21 differently because of this, because the evidence
22 is out there and we've already got some of it.

1 So --

2 CO-CHAIR CHIN: Thanks Bob. So we
3 have Lisa Iezzoni, David, Emilio, Michelle.

4 MEMBER IEZZONI: My apologies for
5 ducking out of the room. I hope I'm not
6 repeating something that somebody's already said.
7 Marshall, you challenged us to think out of the
8 box. I'm from Massachusetts. I have an example
9 that I think is kind of out of the box.

10 I know that many of the people we're
11 talking about today have chaotic lives and kind
12 of organizing around quality measurement in their
13 health care is not a priority for them. But in
14 Massachusetts when the One Care program was
15 designed, and for those of you who don't know,
16 this was the Medicare/Medicaid demonstration
17 program for dually eligible individuals ages 21
18 to 64.

19 So every single one of these people
20 was eligible for Medicare because of disability.
21 The local disability community was at the table,
22 and the advocates were very, very involved. And

1 so I know we have talked about other
2 constituencies, but we haven't really talked
3 about advocates and people who have these
4 disparities conditions.

5 So let me just give you the one
6 example that I think is just so telling, the One
7 Care program is dually capitated, and during the
8 first year the capitation payments were falling
9 way short of what they needed to be, primarily
10 around the beneficiaries with serious mental
11 illness and substance use disorders. Their costs
12 were just through the roof, and the state was
13 literally about to pull out of the program.

14 But where Mary Lou Sutter, who is the
15 secretary of the Executive Office of Health and
16 Human Services, so Charlie Baker's health
17 secretary, took two persons with disabilities,
18 Dennis Heaphy, who's quadriplegic from a spinal
19 cord injury and Olivia Richard, who is
20 paraplegic, down to CMS and those two
21 constituents talked in front of the CMS officials
22 about what One Care had been doing for them, and

1 CMS raised the capitation rates.

2 And so you had consumers who directly
3 saved the program, and Mary Lou Sutter talks
4 about that. I know that that might be kind of an
5 extraordinary example. But I think if you want
6 to talk out of the box, that maybe we should
7 start thinking about how can we engage the
8 advocacy side of the consumer representatives.

9 CO-CHAIR CHIN: Thanks, Lisa. So we
10 have David and Emilio and Michelle.

11 MEMBER NERENZ: Yeah thanks. Small
12 point here, but I think maybe in a preface piece
13 leading up to however this plays out in a report,
14 it's probably worth noting that many or even all
15 of the current P4P programs already in their
16 current structure include incentives for
17 disparities reduction by the entities being
18 measured.

19 You know, this is a track we started
20 on over 20 years ago when we worked with health
21 plans on their HEDIS measures. If any given
22 HEDIS measure within your plan you have groups

1 with disparate rates, one way to get the overall
2 rate up is to get rid of the disparity. Now of
3 course it's also mathematically true that you can
4 take the advantaged group and bring that down.
5 Then your disparity is gone, but people don't
6 typically do that.

7 But we typically don't talk about
8 that, and it's not quite in line with the phrase
9 "leverage." But I think it's worth just noting
10 they're both for our own -- in our own heads in
11 whatever document we write, because in the 20
12 years that have gone by since I started working
13 with plans on this, the incentive has not gone
14 away.

15 It's still there, and whether it's
16 your hospital, whether your clinic, whether
17 you're an ACO, the incentive is still there. The
18 user of the stratified data would be the entity
19 being measured, and maybe that's why it doesn't
20 quite rise to prominence. But I think it's still
21 worth holding on to.

22 CO-CHAIR CHIN: Just a question for

1 you Dave, and maybe a question for the wider
2 committee is the current system where basically
3 you're trying to improve an aggregate number and
4 Dave is right, that well if you do improve the
5 numbers of the lowest-performing population, well
6 that's going to help your aggregate number.

7 Is the kind of program that's designed
8 you think adequate, or are there ways to tweak or
9 supplement or changes that were more likely to
10 lead to equity?

11 MEMBER NERENZ: Well, I'm trying to
12 frame the comment to imply I didn't think it's
13 adequate, because if I thought that, then with
14 this whole list I'd just say forget about it.
15 You don't need anything else.

16 But I don't want to imply that it's
17 zero, because it may be active and driving
18 improvement right now in ways that we probably
19 don't see because it's sort of out there hidden
20 in ongoing daily, you know, non-trumpeted key
21 line activities. But it's worth noting. It's
22 not zero.

1 CO-CHAIR CHIN: Thanks, David. So we
2 have Emilio, Michelle. Emilio and Michelle.

3 MEMBER CARRILLO: In terms of
4 measures, federal measures and others that have
5 teeth, I think that we should focus on the NHMA,
6 the benefits that are basically -- have a lot of
7 teeth because, you know, the tax exemption for
8 hospitals is tied to them. And I think that
9 these measures could -- this could be a good
10 leverage.

11 CO-CHAIR CHIN: So Michelle, then
12 after Michelle I'm going to ask if the committee
13 can specifically address the second bullet that
14 we talked about, how can equity measures be
15 incorporated into existing CMS programs, again
16 just as a template for getting some of the
17 general ideas out there. Michelle.

18 MEMBER CABRERA: This is restating,
19 but it's because this isn't -- I don't think yet
20 on the list here. It came up earlier in
21 conversation, but I do think it's important in
22 terms of policy levers, to make sure that we are

1 targeting our conversation to different payers or
2 large purchasers. So that's one piece I want to
3 make sure is in there.

4 Obviously, I mean I think anything NQF
5 and other groups can do to kind of join together
6 across the quality and measurement community, now
7 that there's so much synergy, to kind of like
8 maybe create a joint call to action or a joint
9 initiative, urging people to actually collect the
10 damn data, you know.

11 That would be good. We could try
12 something like that. Collect the damn data. But
13 you know I think that we've all been clear that
14 like that's a major nonsensical stumbling block
15 in all of this. I think that's all I have.

16 CO-CHAIR CHIN: Some of the things we
17 might put into a parking lot of like -- some of
18 these are implementation issues, some things you
19 raised, some of Lisa's points also that we should
20 at some point come back to. Let's let Helen jump
21 in -- okay. Okay, so you're now third. So
22 Philip and Lisa, and people start to transition

1 it into this bullet about how can equity measures
2 be incorporated into existing programs.

3 MEMBER ALBERTI: I'm not going to
4 quite start that transition. So we were talking
5 about this at the last meeting, I think, but
6 another important lever is really the ACGME, kind
7 of expectations that now exist around training
8 residents and fellows around health care
9 disparities and quality improvement.

10 So I think incorporating kind of that
11 need and that stakeholder group into this
12 conversation as other advocates. I know that
13 they are thirsty for ideas on how to actually
14 meet those expectations. Not many places are
15 doing it well, and this could be a real
16 opportunity to add some voices.

17 CO-CHAIR CHIN: Thanks, Philip. So
18 Lisa Cooper and then Helen.

19 MEMBER COOPER: Okay. Mine will be
20 quick, or I hope anyway. So well one -- both of
21 them are actually questions, so I don't know what
22 people are responding to, but I know at my

1 institution, someone came to me I honestly don't
2 remember which organization was coming through to
3 assess how well we were doing.

4 But there was all of a sudden a panic
5 that we did need to have training for the
6 residents, and how to address. So you think it
7 was the ACGME? Okay, all right. So that just
8 happened like, I don't know, about a couple of
9 months ago. It was like this big panic. We've
10 got to get this training in place. You know,
11 it's like oh. Like I've been saying this like
12 for a long time.

13 So anyway, so that. So it's good to
14 know that, and then -- but my other question is
15 almost is to David, like if these incentives have
16 been in place for so long, what do you think is
17 the missing factor? Like why is it that that
18 hasn't risen to greater awareness or prominence
19 or whatever? Like what -- is there anything that
20 we haven't said already that could help to
21 address whatever that missing link is?

22 MEMBER NERENZ: Well I guess, you

1 know, I'll give two types of answers. One is
2 that, you know, there's a business case
3 challenge, there's a how do you do it challenge,
4 there's difficulty and people may try and not
5 succeed challenge. Okay, there are a number of
6 things. That would be a part of the answer.

7 But I guess the other thing I'll throw
8 back to you, how do we know that people are not
9 doing this? Do we know that people are not doing
10 this already? Not just case -- but nationally as
11 a pattern, do we know that people are not doing
12 this?

13 MEMBER CABRERA: California is a
14 largely managed care state. We've been asking
15 this kind of stuff for years at these payer-
16 purchaser tables. Some health plans are is the
17 answer, and no one's asking them to do it as far
18 as I can tell. They're doing it for I think your
19 HEDIS kind of reasons.

20 But it's so -- it is so discrete. It
21 is so not shared. So this is again California,
22 lots of managed care plans and people doing this

1 stuff. But it's not, in no way getting discussed
2 and it's not a set priority of whoever's paying.
3 So whether it's the employer or the Medicaid
4 program, they're not the ones asking for it. So
5 we don't have a good handle.

6 We have anecdotal, a CEO of a MediCal
7 managed care plan saying we did something on this
8 once, but that's about it.

9 MEMBER NERENZ: Yeah. Well, I said it
10 that way. I do it a little tongue in cheek. I'm
11 intentionally trying to tweak us but, you know, a
12 lot of these discussions seem to be based on the
13 idea that health plans are doing nothing. We're
14 totally ignorant and ACOs are doing nothing and
15 they're totally ignorant. Hospitals are sitting
16 around there and they don't know anything.

17 (Simultaneous speaking.)

18 MEMBER COOPER: Right, right, right.
19 No, I don't think they're not doing anything.
20 Well here's been my experience. They're -- the
21 health equity people and the population health
22 people are in completely different silos, and

1 although the health equity people can see the
2 connection to the population health work that's
3 going on, the population health people don't seem
4 to see the connection to health equity.

5 So it's like how do we articulate that
6 so that all these different siloed efforts come
7 together and are more explicit about addressing
8 this issue, because they're doing things but
9 they're not doing them explicitly to address this
10 problem.

11 MEMBER NERENZ: Yeah, and then I'll
12 tweak and then I'll quit tweaking. Does it need
13 to be explicit? You know, is that always the way
14 you solve problems? Part of our thinking a while
15 ago is if you go to work on improving quality and
16 X measure, you know, you may -- you may need to
17 explicitly focus on a disparity, but you may find
18 yourself doing the right things and getting the
19 right result and reducing the disparity, without
20 having a so-called disparity person or an equity
21 person ever touch it. So I'd just --

22 MEMBER COOPER: Well, the only thing

1 is that then -- well, this is not working, that
2 you would -- then we'd then have to measure -- I
3 mean the only way we'll know, even if it's not
4 explicit, whether it's having its intended
5 consequences is if there's some kind of
6 measurement around that. Right now, there's not
7 so --

8 MEMBER NERENZ: Well, who's the "we"?

9 MEMBER CABRERA: Can I just say that
10 when you look at maternal infant mortality for
11 African-Americans in California compared to
12 everybody else, when you look at diabetic
13 amputations, when you look at all these -- asthma
14 rates, etcetera, like that is the impetus, right?
15 What you measure on HEDIS and whether or not
16 you're doing well on that report card certainly
17 matters to a purchaser. Good for them.

18 The reason why we should have a
19 disparities-focused conversation is for black
20 people in California, because it is our
21 responsibility to make sure that if there's
22 something that can be fixed about that problem,

1 that we at least try.

2 CO-CHAIR CHIN: This is a great
3 discussion here. So Helen and then Tom.

4 DR. BURSTIN: Just one point, and I
5 apologize if I was out of the room trying to make
6 the room warmer, and you mentioned this, that
7 it's kind of freezing in here, but I wasn't sure
8 where this would fit. But there's been a lot of
9 discussion over the years that if we had more
10 measures that reflected percent improvement or
11 trajectory of improvement over threshold, that
12 might be another pathway.

13 It's probably here. It doesn't fit in
14 the other boxes I think. But I just don't want
15 to lose sight of that, because I think, you know,
16 it certainly is somebody's practice in the safety
17 net. I can get somebody's Alc from 15 to 9, but
18 I couldn't get him to eight without insurance,
19 right? I mean it was just the reality of some of
20 the practice, and being able to incentivize some
21 of that might be really helpful.

22 CO-CHAIR CHIN: Yeah. That's a great

1 example of some issues that I think we need to
2 get out over the next hour, that we can return
3 to. That's a classic one, thresholds, absolute
4 improvement, combinations and all. Tom.

5 MEMBER SEQUIST: So I have a bunch of
6 different comments, but they're sort of
7 interrelated to each other, sort of building on
8 what Helen said, just said, more of a measurement
9 concept question which was I think we should be
10 clear about what the goal is that we're hoping to
11 achieve.

12 We've been talking a lot about
13 elimination of disparities. So that's a
14 different concept and Marshall, you know well the
15 RWJ work. You've fully aware of this. But
16 that's a different concept than improving
17 minority health. So you can have two populations
18 who are one performs at ten percent, you know,
19 the white group, and the other performs at five
20 percent, the black group.

21 If you get the black group to ten
22 percent, everyone's still getting crappy care,

1 and is that victory? Did we claim victory and
2 sort put the flag in the ground, or are you
3 actually trying to drive improvement to minority
4 health? They're probably both important, but I'm
5 just -- like we should just be clear when we're
6 developing the measures or making
7 recommendations, what it is that we're hoping to
8 achieve.

9 That gets into your question, Helen,
10 of are we trying to do percent improvement here?
11 Because you're right. Like if you get the A1c
12 from 13 to 8, you've really achieved something in
13 everyone's eyes except -- and I'm not picking on
14 NCQA, except like a HEDIS measure, in whose eyes
15 you haven't achieved anything because you haven't
16 gotten the measure that we're thinking about.

17 But you've -- so you wouldn't have
18 improved your disparity measure if it was based
19 on a HEDIS goal, but you have improved minority
20 health. So I think just throughout all of these
21 measures, we should be just more explicit about
22 which goal we're hoping to achieve. Were you

1 going to say something or --

2 CO-CHAIR CHIN: Yes sir. So keep in
3 mind Tom and Helen's combined point. Three
4 different things that are different and related.
5 Absolute thresholds, relative improvement, so
6 that's improve minority health, and then
7 disparity reduction, so actually think of black-
8 white disparity reduction. All three are
9 possibilities.

10 MEMBER SEQUIST: Yeah, and that
11 disparity reduction statistically turns out just
12 to be the hardest thing for us to achieve or to
13 demonstrate that we've achieved. For the CMS
14 programs, and so I was just looking at this -- at
15 the second question that you wanted to start to
16 get into Marshall, and I'm thinking we should be
17 a little more clear about what we mean by
18 existing CMS programs, and I'm sort of dividing
19 this in two frames in my mind, and just to bounce
20 this off of people.

21 So one is hospital versus ambulatory,
22 and then the other is process versus outcome

1 measures. The problem with tagging on
2 disparities measures or health equity to CMS
3 programs that are in the hospital space right now
4 is they're all popped off. So if my hospital
5 performs at 97 percent for AMI, you know, hyphen
6 whatever measure that we're -- and I promise I'm
7 not trying to make fun of the NQF names for the
8 measures.

9 But like if I'm at 96 percent on that,
10 there are -- like just to David's point. There
11 can't be a disparity that's not important, right,
12 unless you have some crazy outlier hospital that
13 just is, you know, and probably doesn't exist
14 anymore for most of these measures. Most of
15 those measures are topped out because they're
16 quite old or they're process measures.

17 So that's different than CMS, newer
18 CMS programs, ACO programs, MACRA, MIPS, APM,
19 that are going to move into the ambulatory
20 setting and are going to push us towards outcome
21 measures. I feel like that's the area where you
22 could get some real value we're trying to think

1 about building in equity measures.

2 I don't think -- I just don't think
3 you're going to get a lot of value out of equity
4 measures that focus on disparities and process
5 measures, whether it be in the ambulatory space
6 or the hospital space, because also hemoglobin
7 A1c annual rates for diabetics are very, very
8 high, regardless of the plan right now.

9 So the disparities that are going to
10 be kind of not that -- even if they're there,
11 they're going to be statistical phenomenon and
12 not clinical phenomenon. But the A1c control
13 rates like Helen is referring to or the blood
14 pressure control rates or things like that, I
15 actually think are going to be really important
16 and I agree with what David is saying, which is
17 that joining an ACO program --

18 So the fact if a health system joins
19 an ACO program and an accountable care program,
20 and you hold them accountable for outcomes
21 measures, they will focus on disparities, because
22 that is the only way that they will reduce trend

1 and improve outcomes, which is what these
2 programs are holding them accountable to.

3 So I actually think, and I know you
4 were sort of being devil's advocate or trying to
5 prod us, but if you develop an accountable care
6 program that focuses on outcomes, it will drive
7 people to address disparities because they will
8 have 20-30 percent of their patient population
9 not achieving care goals, being readmitted a lot,
10 you know, getting all kinds of complications in
11 the ambulatory hospital setting, and they'll
12 focus on it without an equity program.

13 But if you -- if you focus on process
14 measures in the CMS program, and don't have an
15 equity program, they won't focus on it because
16 they don't need to, because the rates are so high
17 and you don't need an equity program necessarily
18 for most of those measures.

19 CO-CHAIR CHIN: Very helpful comments,
20 Tom. Thank you. So I think it was Romana, Lisa
21 Cooper, then Philip, then Nancy.

22 (Off mic comments.)

1 MS. MURPHY: So I have a lot of
2 comments. I really appreciated everything that
3 Tom said, and I agree with everything you said,
4 except I -- I guess I do question the ACO's focus
5 on outcome measures. They'll be focusing on
6 equity measures or disparity measures. I think
7 it's dependent on, you know, how the ACO, who is
8 in the ACO.

9 MEMBER SEQUIST: Well, I should caveat
10 at least (a), they'll focus on it if they want to
11 succeed, and then (b), if they have the
12 population, if they have the right population.

13 MS. MURPHY: That's exactly right,
14 because I think there's, you know, I think
15 Katarina Armstrong I think maybe wrote a really
16 good piece about how ACOs have come together. I
17 know there are some that, you know, that have
18 populations, but a lot of them from my
19 understanding, and I haven't looked at the
20 literature in a while, just don't. So I just
21 want to kind of raise that.

22 But I wanted to get back to Lisa's and

1 Dave's kind of discussion. So Lisa starting
2 with, you know, population health people don't
3 really necessarily talk to the equity people in
4 the organization, and then Dave's comment about,
5 you know, does it have -- Lisa saying, you know,
6 we have to be explicit about addressing
7 disparities, and Dave kind of -- Dave's rebuttal
8 about well, does it have to be explicit?

9 So I just thought that was
10 fascinating, because in some ways I think I do
11 agree with Dave, but I don't know that it always
12 has to be explicit. I'm going to bring the
13 Denver Health example up because I've been
14 fascinated by what I have learned, you know, in
15 six months at Denver Health.

16 So yeah again, there's so many
17 initiatives. There's a really great initiative
18 focusing on population health. You know, they
19 did some mapping, geomapping, to see where the
20 disparities hot spots were. One of the issues
21 that, you know, came up very, very starkly was
22 the issue of obesity, saying there's this sense

1 that Denver is the healthiest city in the country
2 and it's --

3 Yeah, it is really healthy and, you
4 know, as people at Denver Health say it's really
5 healthy because Denver imports really healthy
6 people. We don't grow them. So there is an
7 obesity problem in Denver.

8 So Denver Health focused on an
9 initiative to address obesity in neighborhoods
10 that are, you know, low income, minority, but
11 addressed it from a population health perspective
12 and are looking at everything from sugary
13 beverages to really looking at these multi-level
14 interventions in terms of what the health system
15 can do, what you know, what community
16 organizations can do, what schools can do
17 etcetera, and they are showing great results.

18 I mean you're seeing, you know, these
19 really great outcomes, but they're not talking
20 about it as an equity initiative at all. It's
21 not even being discussed in the realm of equity,
22 even though the populations are disparities

1 populations. So it's absolutely happening. So
2 that brings me to my last point, which gets back
3 to, and I know that you've already expressed
4 support for this.

5 In some ways that tells me that
6 organizations are in fact doing things. Clearly,
7 there's not a tidal wave of change. Clearly,
8 there's a lot of room for improvement. So in no
9 way am I saying oh, you know, we've arrived. But
10 there are organizations that are focusing without
11 being explicit on initiatives that focus on
12 equity.

13 So I think it brings me back to this
14 notion that if we create a road map, we need to
15 kind of start to extract those examples, and show
16 organizations how to put them into a framework to
17 show that there is this work taking place,
18 because I think we're losing the opportunity to
19 learn from the organizations that are doing it.

20 You know, so my work at Denver Health
21 and then, you know, going back a decade; my work
22 at AHA, at the American Hospital Association, I

1 think that there is this tendency for
2 organizations to -- there's kind of almost a
3 domino effect. There's recognition that, you
4 know, so many are doing it; why are we not? It
5 propels change.

6 So I just -- I wanted to connect those
7 dots, because I think it's just really -- I think
8 that conversation that both of you had was just
9 incredibly insightful.

10 MEMBER COOPER: I agree, and now I do
11 have my card all of the sudden. And I'd just
12 respond just briefly.

13 CO-CHAIR CHIN: Go ahead, Lisa, yeah.

14 MEMBER COOPER: I agree and I don't
15 know that I have the answer. The concern that I
16 have with not being explicit is that the
17 interventions that are put in place are not the
18 appropriate ones. So if we're not being explicit
19 that it's an equity issue, then the intervention
20 could be a generic intervention for any community
21 or any group of people with a particular problem,
22 but without taking into consideration the special

1 cultural issues, the special social issues that
2 need to be addressed, so that they aren't really
3 tailored or targeted appropriately.

4 So that's the main concern. I mean
5 you can call it whatever you want to call it, but
6 as long as it's really addressing the critical
7 issue.

8 CO-CHAIR CHIN: Fascinating
9 discussion. This sort of harkens back to Tom's
10 point about well, improving health in minority
11 population versus disparity reduction, or Lisa's
12 point, look -- a little bit earlier about well,
13 how are you defining equity.

14 If you use Lisa's sort of definition
15 there, then we're on the same page that the care
16 is tailored for the patient population in mind,
17 which when you look at the example of like the
18 targeting of specific neighborhoods and that is
19 very tailored, as opposed to well the one-size-
20 fits-all approach. So some of this may be the
21 terminology issue in terms of the discussion.

22 So I think it was Bob, Philip, Nancy.

1 MEMBER RAUNER: Just want to follow up
2 a little bit more on Tom's thing about you need
3 to make sure the safety net clinics are brought
4 into these programs in the first place. So with
5 the ACOs, they can work, but only if the FQHCs
6 are invited in and there's a leap of faith to
7 bring them in.

8 The two other big groups that are left
9 out are the critical access hospitals. Because
10 of their cost-based reimbursement, there's
11 actually -- they're often out of any incentive or
12 disincentive programs. The same thing happens
13 with rural health centers, because through a
14 quirk of Medicare rules, they actually get paid
15 through Part A instead of being paid through Part
16 B like most physicians do.

17 And a lot of the incentive programs
18 are tied to Part B payments. To the rural health
19 clinics are often written out. They're actually
20 written out of meaningful use, for example. They
21 didn't get the incentives because of that. So
22 the Medicare -- this was something in the rural

1 and small provider panel a couple of years ago we
2 put out that still has not been changed.

3 And so your rural folks are still left
4 behind in all of these discussions because
5 they're written out of the incentive programs,
6 and until Congress or CMS changes that, we're
7 still leaving rural behind.

8 CO-CHAIR CHIN: Thanks, Bob. So we
9 have Philip and then Nancy.

10 MEMBER ALBERTI: I just want to do two
11 quick comments. One to make a pitch for being
12 explicit. I was at a conference last week that
13 was focused on quality improvement, population
14 health management. Presentation after
15 presentation after presentation, all of the pop
16 health efforts were completely internal. There
17 were no connections to community health. There
18 was no partnership and understanding the special
19 needs of populations.

20 I feel like we are not explicit in the
21 work. It doesn't usually get done and the
22 example that I was telling Michelle earlier,

1 there is a population health textbook, second
2 edition, 500 pages, 1-1/2 page is dedicated to
3 disparities, zero pages dedicated to community
4 health.

5 So I think we are going to miss the
6 boat if we're not at least educating, thinking
7 through in an explicit fashion how to connect
8 population health management to community health
9 to health equity. So that's one plea, and I
10 think that's -- I know we parking lotted the kind
11 of the demonstration project question.

12 But I think a demonstration project
13 that shows, you know, in an ACO setting the
14 benefits, the shared savings benefits that you
15 gain from doing that and in an explicit kind of
16 community health-oriented way would be an amazing
17 study to do.

18 My second point is really more of a
19 question and a response to what Tom had said, in
20 terms do we focus on process or outcome or both.
21 I wonder if there's a rhetorical value to focus
22 on process as well as outcome. So one of the

1 other -- one of the presenters at the same
2 conference was amazed.

3 She was a community health person,
4 said you know, we are top 100 quality and on
5 these different rating systems. But yet our
6 county is like bottom of the barrel in the state.
7 So how can both of those two things be true?

8 So it might be that despite the fact
9 that you have all these great quality processes
10 in place and there might not be an inequity, when
11 you actually look outside of the hospital and
12 think about the health equity issues, it's hard
13 to square that circle. We're doing a great job
14 with our processes, yet our community health
15 outcomes are so disparate.

16 I think there might be some kind of
17 art value or conversation area, a talking point
18 value to say despite the fact that you have great
19 processes and we can demonstrate that because you
20 don't have that gap, look at these other gaps and
21 how do you begin to reconcile those two facts,
22 and there could be some rhetorical value there.

1 CO-CHAIR CHIN: Thanks, Philip. So
2 we'll go Nancy, Ninez and then we'll circle back
3 to the phone folks. So phone folks, think of
4 your questions or comments.

5 MEMBER GARRETT: So I really
6 appreciate the conversation of Romana and Lisa.
7 I think at my organization, we also have that
8 similar conversation, because a lot of the work
9 that we're doing for our various populations, it
10 really is health equity work. But because
11 populations are so unequally distributed across
12 providers, it ends up being our whole population
13 if you add it all up that we're working on,
14 right?

15 So if we can reduce, if we can improve
16 outcomes for our safety net population, we're
17 reducing disparities, right? So but at the same
18 time, we want to be sure we're culturally
19 competent and sensitive to the very diverse needs
20 within the subpopulation. So it's an
21 interesting, important question I think.

22 I just wanted to offer a really

1 specific recommendation that I feel like we could
2 make within the National Academy of Medicine
3 report, in terms of the question about how equity
4 can be incorporated into existing CMS programs.
5 So we have add-on payments for social risk for
6 hospitals, the disproportionate share payment.
7 There's not an equivalent for outpatient settings
8 for physician groups.

9 So I think there should be. That
10 would be a way to get resources to the
11 populations that need them the most, and I think
12 we could make that recommendations. So I offer
13 that as a suggestion.

14 CO-CHAIR CHIN: Thanks, Nancy. So
15 Ninez and then the phone.

16 CO-CHAIR PONCE: I'd just suggest that
17 for the NQF reports and for this committee that
18 we get at definitions, because I'm from public
19 health. We do population health and I think
20 health equity is pretty rampant in my circles.
21 But -- which is so population health I think is
22 different from population health management.

1 Just again that discernment, and then
2 equity, as Philip described it this morning in
3 terms of that is about, you know, access to
4 opportunity that's not disadvantaged by socially
5 constructive factors is one definition, and then
6 the definition of the tailored. It's not about
7 giving everybody equal things and access, but
8 it's about giving them what they need and hearing
9 from them about what they need.

10 So I just think that we need to have
11 more definitions, because even in the reports
12 that we've submitted to CMS, I think that there
13 was -- we use disparities, inequities and
14 equities, equality and if we could be -- if we
15 could get a consensus on the definitions, it
16 would -- that understanding can actually better
17 inform policies in what we're trying to do.

18 CO-CHAIR CHIN: Maybe that's one thing
19 staff can do that for the final report, that the
20 definitions of some of these key terms like Lisa
21 said, and we can do it by email in terms of the
22 consensus, those iterations and all. Phone now.

1 So anyone on the phone have comments or things
2 they need to say?

3 MEMBER SANCHEZ: Yeah. This is
4 Eduardo. I want to underscore what I think is
5 important to continue to explicitly call out,
6 disparities and equity, and that I'm not a
7 believer that rising tides raise all boats,
8 because some boats have lead weights and some of
9 them don't.

10 And in that vein, I do think that the
11 conversation that's being had in addition, not in
12 that vein, in addition, the conversation about
13 the different ways that population health is
14 used, and that health systems use population
15 health in a very, very different way. I mean
16 they're talking about population medicine, not
17 what I would call population health, and so
18 explicitly defining population health in any of
19 our documents I think is really, really
20 important.

21 CO-CHAIR CHIN: Thanks Eduardo. Are
22 there others on the phone that would like to

1 comment?

2 MS. BURWELL: Yes. This is LaWanda
3 Burwell from CMS, and I'm not speaking as the
4 person who works with some of the programs that
5 reimburse for quality and what-not. But I am
6 also a National Baldrige Examiner and I think
7 that in this discussion and other people have
8 made the point also, that that's the gap between
9 this looking at disparities and minority health.
10 It has to do with looking at outcomes.

11 This is very hard in the medical area.
12 It's very possible to have a successful operation
13 and the patient died. So I think that there
14 needs to be more of a focus on outcomes, looking
15 at those outcomes, stratifying those outcomes and
16 then doing the root cause analysis to decide why
17 we think are differences in the outcomes.

18 CO-CHAIR CHIN: Thank you. Others on
19 the phone?

20 MEMBER FISCELLA: Yeah, this is Kevin.
21 I think this may be an opportunity to begin
22 moving measurement to outcomes using an equity

1 lens as others have suggested. But beginning to
2 really focus on using measurement of rates of
3 changes in smoking cessation, you know, reduction
4 in obesity and improvements in physical activity,
5 as well as other measures that have population
6 impact like, you know, HPV coverage or HIV viral
7 load and so on.

8 But I think that this could be an area
9 for, you know, for piloting of these by CMS,
10 particularly if there were, you know, significant
11 dollars, you know, attached to it, enough to
12 really incentivize the kind of partnerships that
13 we've all been talking about.

14 My second point is I don't think we
15 should forget about while still keeping a broad
16 lens, the socioeconomic disparities across the
17 spectrum, and Bob has already alluded to this in
18 terms of the rural population.

19 But you know, this really applies
20 across the spectrum and I think being able to
21 track those and measure those using the best
22 available measures we have while continuing to

1 work for -- to get individual levels collected.

2 But I think we need both a
3 socioeconomic disparities focus as well as a
4 broader racial, ethnic, minority, linguistic and
5 disability focus.

6 CO-CHAIR CHIN: Thanks, Kevin. Others
7 on the phone.

8 MEMBER BERNHEIM: This is Susannah.
9 Two quick things. One is I really appreciate
10 people emphasizing the importance of our
11 definitions and the ways in which different
12 concepts of population health get really mixed
13 up. As we talk about health equity, I think it
14 was Ninez pointed out that, you know, there's
15 been a couple of pieces that I think we really
16 have to incorporate those.

17 One is the concept of access and
18 opportunity but the other is tailoring care, that
19 ultimately what you're looking for when you're
20 talking about health equity is that if two
21 individuals are in the same circumstance except
22 for a social risk factor, that they have equal

1 chance of a good outcome.

2 That's what we're aiming for, and so
3 tailoring of care is important to that. So
4 that's just affirming what people said, and then
5 I have one recommendation for us, and this goes
6 back to something I think Tom, and I don't
7 remember somebody said, about how if you just
8 focus on narrowing gaps, you can narrow gaps by
9 bringing the more -- the population with fewer
10 social risk factors down to a level of a
11 population with social risk factors. You can do
12 it by getting equal outcomes that are equally
13 bad.

14 So I think one of the things on this
15 bullet about how can equity measures be
16 incorporated into existing CMS programs, I would
17 think it would be good if this committee stated
18 clearly that equity should not be rewarded in the
19 absence of a measure of overall quality, that you
20 have to look at equity in the context of overall
21 quality, to prevent incentivizing the wrong
22 thing. So I think that's a principle we should

1 state in our work.

2 CO-CHAIR CHIN: Thanks Susannah.

3 That's a nice example of like a deeper dive into
4 some of the issues that like I think it was
5 initially Tom and Helen raised, and so we'll
6 probably do that for some of the other issues
7 also. Anyone else on the phone?

8 MEMBER SCHOLLE: Hi, it's Sarah. I
9 just wanted to comment. I agree with a lot of
10 the things that are coming through here. I
11 wanted to highlight a couple of ideas.

12 So we've tended to think more about
13 these issues and ways to prevent harm for
14 organizations that take on safety nets, and I
15 think we've turned it around to making it more
16 about incentives to providers for taking on more
17 difficult and challenging populations, that that
18 might be a framing that would actually go beyond
19 looking at, you know, predicting the needs of a
20 group but actually expanding the expectations for
21 all providers or organizations because the safety
22 net provider is not big enough to do it all and

1 isn't doing it all now. So I wonder if that
2 reframing could be helpful.

3 The other thing that, you know, we've
4 thought about in some of our work, we've tooled
5 around this question of collaboration with
6 community organizations, and not wanting on the
7 one hand everybody to reinvent the wheel by
8 creating their own connection or their own
9 special collaborative with one group or another.

10 But -- and also trying to build up the
11 resources. So in that discussion earlier today,
12 we talked about collaborations and partnership.
13 I wonder if what might be the ways to encourage
14 collaboration among entities that might otherwise
15 be competing. It's a little challenging because
16 health plans in the same market will compete
17 against each other.

18 One way that we're seeing some health
19 plans deduct or seek NCQA's Multicultural Health
20 Care accreditation, and I gather it is because
21 they feel like that will set themselves apart
22 from others. It's really a market advantage to

1 them to focus, say they have this focus on
2 multicultural health care.

3 But there's also an opportunity to try
4 to encourage, especially in smaller practices or
5 smaller organizations, collaborations within a
6 community, and participating in those
7 collaborations focused on equity issues since
8 some communities will have more resources
9 available than others, and it may require, you
10 know, greater investment in the community and
11 greater collaboration to serve some of these
12 needs.

13 CO-CHAIR CHIN: Yes. To the same
14 point Sarah that I thought you were going
15 somewhere else with that also, that is also
16 raises the issue of there may be some things with
17 some of the public health social determinants
18 which are part of the commons, that it may
19 necessarily in the interest of any one
20 organization, but you know, you can -- as a
21 commons issue unless there's sort of a group
22 effort to -- for everyone to play the role.

1 So I know Kevin wants to speak. We'll
2 do anyone else on the phone. Then we have
3 Emilio, Tom and then we're also going to circle
4 around the people that haven't spoken yet, except
5 in the introductory parts. So I know it's like
6 Lisa Iezzoni, Christie, Ron, I think Ignatius,
7 and then we'll rotate from there. So, Kevin?

8 MEMBER FISCELLA: No, I'll pass. I
9 spoke. Thank you.

10 CO-CHAIR CHIN: Anyone else on the
11 phone that hasn't spoken that would like to
12 comment?

13 (No response.)

14 CO-CHAIR CHIN: Okay, Emilio.

15 MEMBER CARRILLO: Yes. Going back a
16 few bullets, the discussion that we had on
17 promoting connections between, you know,
18 population health, community health disparities,
19 how does it all align, and I think that the model
20 of the neighborhood as a unit of measurement is
21 where population health meets community health,
22 because basically you have a well-demarcated

1 community that has certain demographics, that has
2 X number of social services, Y number of health
3 care services and has already existing
4 collaborations or lack of collaborations.

5 And this can be studied and the
6 multiple factors can be deconstructed in doing
7 so. That also speaks to the next rubric about
8 the CMS programs, and you have the Accountable
9 Health Communities program, which is precisely
10 that.

11 It's basically, you know, determining
12 geographic areas that are confluent and that
13 basically share certain characteristics, and then
14 interventions are made and measured. So I think
15 that that could be a way to bring the two
16 together.

17 CO-CHAIR CHIN: Yeah thanks, Emilio.
18 One thing we should probably then circle back a
19 little bit later is this issue of specifically,
20 how do we address some of these social
21 determinants of health. So it's a little bit
22 separate then, a little bit separate from the

1 issue of like the in-hospital system things. So
2 it's a related but sort of different set of
3 issues to sort of think through. So Tom, and
4 then we'll march through the remaining folks.

5 MEMBER SEQUIST: I just quickly wanted
6 to say from what I was saying before, I wasn't
7 suggesting we shouldn't do race stratified
8 reporting or equity measures in particular. But
9 when you're asking to your question of how should
10 CMS approach incentivizing or others, I was
11 suggesting that doing accountable care programs
12 but weighting them towards outcomes is a way of
13 incentivizing action on equity.

14 CO-CHAIR CHIN: Thanks, Tom. Lisa.

15 MEMBER IEZZONI: Massachusetts just
16 got an enormous Medicaid waiver, and CMS has
17 something like 26 quality measures that they're
18 kind of requiring for their -- let's see, it's
19 called the Delivery System Reform Incentive
20 Program. The acronym is DSRIP, and I'm on their
21 quality measure committee.

22 So CMS has actually been very, very

1 participatory with Massachusetts in coming up
2 with what these measures are. I am on the
3 committee and we have a kind of cone of
4 confidentiality around us, that we're not allowed
5 to talk about it. But they actually have awesome
6 measures for community-based organizations that
7 are collaborating with these Medicaid waiver
8 organizations.

9 And so once that cone of silence is
10 kind of breached, it might be worth people
11 looking at what some of those measures might be,
12 that might give some examples of what CMS is
13 interested in.

14 MEMBER CARRILLO: Actually the New
15 York program has been going on for almost three
16 years, and we have those measures that can be
17 shared. They're open now.

18 MEMBER IEZZONI: Yeah. I don't know
19 whether the Massachusetts measures are any
20 different. I have no idea about that, yeah.

21 MEMBER CARRILLO: They should be very
22 -- CBO's connections.

1 CO-CHAIR CHIN: Emilio, if you can
2 either email the link to the website to staff,
3 and maybe you can share it. Yeah, okay. Thanks,
4 Lisa. So Christie.

5 MEMBER TEIGLAND: I'm still -- I'm
6 still way up here thinking about all the people
7 who have fallen through the cracks, who aren't
8 even insured so they're not even being measured.
9 So we're not even sure what the level of
10 disparity is, and you know, we're now talking
11 about the -- I'll get a little political too,
12 since Lisa did, you know.

13 The 24 million people that we just
14 insured for the first time losing their health
15 insurance, and you know, a lot of statements
16 about homelessness is a choice and not everybody
17 deserves health insurance. You know, what do we
18 do about that? What do we do about the bigger
19 education issue? Okay, so I know you're not
20 going to answer that.

21 That's what I'm sitting here
22 struggling with, because this stuff all seems

1 like these people are pretty advantaged compared
2 to the people I'm talking about, right.

3 CO-CHAIR CHIN: Okay. Thanks,
4 Christie. Ron.

5 MEMBER COPELAND: So I'm not sure what
6 we're responding to but --

7 CO-CHAIR CHIN: Just your
8 introductory. So everyone has an opportunity to
9 whatever you want to say in terms of this issue
10 of like how should these measures be used and
11 public reporting and payment programs.

12 MEMBER COPELAND: Okay. So just based
13 on the conversation we've been having probably
14 the last 15, 20 minutes, I think there's a -- I
15 think there's a set of quality standards that an
16 organization defines for the population it cares
17 for, and how it defines its scope of
18 responsibility.

19 So that could be our official patient
20 population that we care for, that are patient
21 members and in our system alone, or it can be
22 that as well as the broader community

1 neighborhoods that our geographic footprint is
2 in.

3 We have an obligation to our patients
4 and we have an obligation to improving the health
5 of the overall community, and we have different
6 strategies in collaboration of how you do both of
7 those as opposed to one.

8 But I think on the context of your
9 accountable population, I think you have to have
10 a set of standards, quality standards for what
11 you want all your population to achieve. That's
12 how I think you keep the organization honest from
13 the quality improvement standpoint, and any
14 groups that are not meeting your standards,
15 however you stratify, you have an obligation to
16 get that population, that segment at your
17 standard level, whatever that takes.

18 Whether you call it equity or not,
19 that activity is going to help eliminate
20 disparities if you have standards and you're
21 trying to move those groups. But I think the
22 comments around whether it's explicit or not, I

1 think that's relevant because I think part of
2 what this activity is doing is one, recognizing
3 that there's a need for socializing and
4 understanding the concept of equity.

5 Number two, you're going to find that
6 when you're tailoring interventions when you see
7 these gaps through stratification, including
8 socioeconomic stratification and you want to
9 intervene, you're going to find that one solution
10 does not fit all, because the root causes for
11 different population, different individuals are
12 going to be different.

13 So you have to have a mechanism by
14 which you're willing to invest in those
15 solutions, build the collaborations, the skills
16 and through incentives or otherwise to tailor
17 those solutions to those segments, to move
18 everybody up at your quality standards or above
19 and continue to work on that. The reason why I
20 think that's important is using our organization,
21 for example, in our efforts to close the gaps on
22 hypertension control, based on -- and our target

1 was African-American populations because that's
2 where we saw the biggest disparity group among
3 all of our segments in our overall.

4 But those gaps were -- everybody was
5 still at the 90th percentile or higher, including
6 our African-American population. So if we just
7 said we're doing quality work and all populations
8 are at the 90th percentile or higher, we've met
9 our baseline quality standard, we're done.

10 But we saw gaps, and so if our
11 aspiration from an equity lens is we want
12 everybody to get optimal outcomes, we felt it was
13 necessary and appropriate to go to the next level
14 to understand the gaps around control, and then
15 to tailor interventions to begin to close that.

16 We found tailored solutions based on
17 a lot of the tools and interventions that we've
18 been talking about today, and we've been able to
19 narrow that gap almost to nothing, even though it
20 was started at the 90th percentile and higher
21 above. So I think it really depends on how an
22 organization defines its mission, its values and

1 its playing field, and there's some minimum
2 standards I'm sure we all have to achieve.

3 But then I think organizations, based
4 on their capacity, their mission and so on, they
5 decide how much more aggressive they want to be
6 in trying to close those gaps or is it worth it
7 or not, and people answer those questions
8 differently.

9 So I think what we're talking about in
10 terms of CMS, CMS would have to be in a position
11 to say everybody that we pay to provide care to
12 populations, we've got to have some minimum
13 standards that we expect everybody to achieve and
14 be worthy of those payments and so on, and gaps
15 that are measurable have to be closed if they're
16 not at that level, et cetera, et cetera.

17 That's kind of the minimum playing
18 field that everybody has to be addressing. So
19 for us, is that the context of which we're
20 talking about measures and interventions, and
21 recommendations, or is it something more
22 aspirational than that? I think that's something

1 we just have to decide.

2 CO-CHAIR CHIN: Thanks Ron. Those
3 comments synthesize a lot of the current
4 discussion in terms of the next package there.
5 So we'll do Ignatius and Michelle, and then we'll
6 have a break time. We'll take a 15 minute break
7 at 3:00, so Ignatius.

8 MR. BAU: So I just wanted to raise a
9 question that has come up, which is is there a
10 single measure or set of measures, if a payer or
11 a provider were looking at to work on equity, and
12 I've always -- my response has always been to
13 resist that, to say that there isn't like one
14 magic measure to add.

15 So I think in this framework at some
16 point we should have that discussion of do we
17 want to explicitly sort of take that on, because
18 in a lot of program design, innovation programs,
19 Medicaid programs, they're saying we know we want
20 to work on chronic care. We know we want to work
21 on hospital measures. Is there an equity
22 measure, and again it's more that standalone

1 rather than the integrated approach.

2 But I do think that question comes up
3 enough that we may want to explicitly address it
4 at some point.

5 CO-CHAIR CHIN: That's a good point
6 Ignatius. We should probably come back to that.
7 It's come up a little bit in the discussion
8 today, people saying well, people want actionable
9 items. So that's going to be more specific.

10 There is an existing CMS project that
11 I think NCQA has contracted with right now to
12 look at that question of is it a good idea to
13 come up with an equity measure, single composite
14 equity measure or not, or I think maybe that's a
15 simplistic question.

16 It's more are there purposes for which
17 a single measure is the right thing, and then are
18 there other purposes for which other measures are
19 the right thing? So Michelle, you get the last
20 comment before break, and we'll break.

21 MEMBER CABRERA: Thanks, okay. You
22 know, I think on the question of should it be

1 explicit or not, Dr. Copeland just kind of did a
2 great job of explaining some things. I also
3 think that there -- one of the things that I've
4 noticed in this conversation is the tension
5 around sort of whether you're a provider who's
6 interacting with demands for quality improvement
7 and measures, or whether you're at a higher level
8 payer-purchaser.

9 It's striking to me that considering
10 that I work primarily at Medicaid, it's in-state
11 level, to hear like Medicare is still running
12 programs that are around hospital quality. That
13 sounds overwhelming from like a numbers
14 standpoint and trying to drive, you know, change
15 over a ton of individual health systems.

16 I think because the trend is away from
17 that kind of relationship and more towards the
18 managed care relationship, we also need to think
19 about how we put pressure on large purchasers
20 like CMS and state Medicaid programs to not
21 explore health equity because of simply the
22 business case. I think the business case does

1 need to be made, right.

2 But because of the moral imperative to
3 them, right? That they are the target for the
4 moral imperative argument. On the private
5 commercial health plan side, I think that's going
6 to be a little bit harder. But if you start with
7 large public purchasers, I think it's a little
8 bit more in alignment with who they are, what
9 they're supposed to be doing, et cetera, and I
10 think that's part of where we do need to sort of
11 target this emphasis on you need to be the one to
12 set the goals and hold people accountable because
13 why? Because of moral imperative.

14 CO-CHAIR CHIN: Yeah, thanks Michelle.
15 That's one of the issues that actually we have
16 not talked about at all, that I think we do need
17 to talk about before the end of the day, this
18 fear that if you design the payment programs or
19 incentives poorly, you could actually be
20 counterproductive in terms of basically removing
21 people's moral sense and it could actually be
22 counterproductive.

1 People are going to start being driven
2 purely by money as opposed to the moral mission
3 also. So it's really worth coming back to. So
4 let's break and come back at 3:15. Great
5 discussion.

6 (Whereupon, the above-entitled matter
7 went off the record at 3:03 p.m. and resumed at
8 3:19 p.m.)

9 CO-CHAIR CHIN: Okay, guys. This is
10 I think a great start, a great start to the
11 discussion. If you can go to -- I'm going to
12 jump around a little bit. If you go to like page
13 five -- well, the 3:15 agenda item, which is the
14 Guidance on Incentivizing the Reduction of
15 Disparities.

16 So it may make sense to segue to the
17 discussion of bullets 3, 4 and 5, and then we'll
18 go back to some of the more granular items that
19 were in the previous agenda item. And so the
20 third bullet is how do we most effectively use
21 payment to reduce disparities?

22 The fourth bullet is how do you ensure

1 adequate flow of funds to address social
2 determinants of health and preventive
3 infrastructure under different payment
4 mechanisms, ranging from P4P type value-based
5 payment programs, the different forces of global,
6 capitated and bundled payment.

7 Then the last bullet was are there
8 other ways measurement can be leveraged to reduce
9 disparities. So we'll segue from the 30,000 foot
10 discussion to this next level. It's still
11 reasonably high level, and then later we'll do
12 like the more granular type of more
13 methodological things.

14 So let's open it up. So we have
15 Michelle and maybe Bob. Want to go? Okay so --
16 you want to start or go ahead.

17 MEMBER RAUNER: I was going to follow-
18 up on someone. I think it was Ignatius talking
19 about like how should we group measures and one
20 way of prioritization, there was a report a few
21 months ago updating some of the clinical
22 intervention strategies, where they actually

1 looked at the qualities of if we improve these
2 measures, what will be the biggest impact on our
3 population?

4 There are really four buckets where
5 the qualities were greater than 50,000, and it
6 was substance abuse, alcohol and tobacco. It was
7 lifestyle things like obesity and nutrition,
8 fitness. There was cancer measures like
9 colorectal cancer screening and vaccinations like
10 HPV and flu.

11 And so maybe, you know, if you want to
12 really improve the health of a population, maybe
13 focusing those as the measures to study first,
14 rather than readmissions for this one minute
15 subgroup. Maybe we should prioritize on the big
16 buckets first.

17 CO-CHAIR CHIN: Especially on the
18 issue of like that discussion about disparity-
19 sensitive measures and the priority targets.
20 Part of that, the calculus of formula had to do
21 with like the prevalence of the condition and the
22 morbidity and the degree it was ameliorable, that

1 kind of thing. But maybe that's part of that
2 discussion of like when we talk about some of
3 the prioritization and all.

4 So other comments. Again, focusing
5 upon now how do we most effectively use payments
6 to reduce disparities, the flow of funds through
7 the social determinants of health, and other ways
8 measurement can be used. We've got Philip and
9 then --

10 MEMBER ALBERTI: So yesterday --

11 MEMBER SANCHEZ: Marshall, this is
12 Eduardo. I just want to underscore at least some
13 focus on those things that impact lots of people,
14 and that have potentially high impact, and that
15 are somewhat in the middle of the continuum. You
16 know, we've had many discussions about how some
17 of the issues that affect disparities are far
18 upstream.

19 But I will put on the table blood
20 pressure control. It affects one out of three
21 adults. There is disparity and prevalence and
22 awareness and control, and it is one of those top

1 five contributors to life lost on any list you
2 ever look at. It's in the middle there.

3 Not hospital care and not totally
4 community-based, but absolutely something that
5 could be helped by community clinic linkages.

6 CO-CHAIR CHIN: Great point Eduardo,
7 and maybe that's going to be one of the topics
8 for tomorrow morning. Again, what's going to
9 happen is after this afternoon, the staff's going
10 to do their magic in terms of like sort of
11 organizing some of these comments into a coherent
12 whole, prioritizing some things.

13 And then it gets back to -- ultimately
14 it's the issue of like I think Lisa Cooper had
15 mentioned that well yeah. When it comes down to
16 it, you have to be careful about then like tons
17 of measures versus selecting the priority ones
18 and issues that you and Bob and Helen raised
19 earlier about then the -- I guess the
20 prioritization and criteria for disparities
21 measure.

22 So I think we have what? Was it

1 Philip and then Romana, and then Kevin I think
2 was in the queue too.

3 MEMBER ALBERTI: So yesterday at the
4 NAM meeting, Karen Joint was talking about trying
5 to develop an equity bonus, and so I spent a lot
6 of time thinking about what an equity bonus might
7 be.

8 So before I kind of make something up
9 and kind of throw it out there, I was thinking
10 another issue is, you know, how do we make the
11 measures community relevant, right? Every
12 community's different. Every hospital entity
13 treats different populations.

14 So kind of it's hard to envision one
15 that might be applicable across all communities,
16 where the data are available for all the
17 different populations that might be on the short
18 end of the inequity set. So with that in mind, I
19 wonder if there's a possibility given the five
20 domains that we've created, to think about the
21 equity bonuses, you know, (a) first an
22 institution has to demonstrate a need for the

1 equity bonus.

2 So that would kind of automatically
3 tap into that they have a structure for equity in
4 place because they've been able to do the
5 analysis to demonstrate some relevant, salient
6 inequity. And then the bonus would be applied
7 based on a self-referent kind of way, as they
8 improve that one targeted inequity that's most
9 germane for their community.

10 They would be rewarded for actually
11 showing progress both in terms of the overall
12 metric as well as that gap metric. So I wonder
13 if that's a way to kind of work that bonus idea
14 into the framework that we've set forth.

15 CO-CHAIR CHIN: So Romana and then
16 Kevin, then Michelle and Ninez.

17 MS. MURPHY: So I was just thinking
18 about when I think it might have been our first
19 meeting when Cara James was here, and I'm also
20 reflecting on other conversations I had with Cara
21 when I was at PCORI, and asking Cara about, you
22 know, what does it take for something to flow

1 through CMS in terms of uptake around payment?

2 What she said over and over again, I
3 think she said it when she was at our meeting,
4 our committee meeting here but I can't remember,
5 is that we need evidence. We need really, really
6 good evidence that, you know, this is the right
7 thing for CMS to be paying for.

8 So you know, it begs the question of,
9 you know, strength of evidence and I'm thinking
10 about for example the, you know, the partnership
11 or collaboration metrics where, you know, we
12 don't have randomized control trials. But I
13 think we do have evidence that shows that even if
14 there isn't, you know, an intervention that shows
15 that partnerships work, that interventions that
16 use collaboration and partnerships have better
17 outcomes, you know, may be a way to think about
18 this.

19 But I do want to kind of hit upon the
20 notion of the evidentiary standard, in terms of
21 the measures that we're, you know, that we're
22 going to be supporting and, you know, how the

1 report, if CMS is an audience for us and I
2 believe it is, how do we make sure that we are
3 speaking to the decision-makers at CMS who make,
4 you know, decisions about payment around
5 evidentiary standards?

6 I say that, and I also know that CMS,
7 you know, a few years ago said that they would
8 pay for obesity counseling in primary care, and
9 there was no evidence for primary care docs doing
10 behavioral, you know, counseling for obesity.
11 There were a couple of really nice papers written
12 about it. We actually ended up when I was at
13 PCORI funding two large trials, because we knew
14 there was payment for this but there was no
15 evidence.

16 So I just want to kind of raise the
17 issue of strength of evidence and what that means
18 for payment, because I think that's how we're
19 going to move the needle, is if there's update
20 around the payment.

21 CO-CHAIR CHIN: I mean your question
22 raises two different issues that are related, but

1 a little bit different. One is the use of
2 evidence based interventions, and that's part of
3 the PCORI professional framework. So if there
4 was funding for health workers or what-not, or
5 care management.

6 The second though is more what does it
7 take to get an organization to care about this,
8 to the point where they're going to invest in it
9 and they're going to devote their resources and
10 their front line staff and their management to
11 thinking about how do we do that.

12 Well then, it's not again RCT, but
13 it's going to be more to say well, what drives
14 behavior? So I think there's like two different
15 issues you're raising, one of which I think is
16 the traditional paradigm of well, you know, an
17 evidence-based intervention.

18 The other is more well, it really is
19 well frankly, like Lisa said, Lisa Iezzoni said,
20 advocacy to say well equity is an important
21 enough issue that well, we need to have the money
22 flow there in terms of like will the incentives

1 flow there in terms of the attention. So I think
2 it's a little bit different.

3 MS. MURPHY: I think it's connected
4 though. I do think -- I mean so if I heard your
5 interpretation correctly, in terms of, you know,
6 health care organizations focusing on equity, the
7 notion that dollars need to flow there. So
8 dollars in this case through CMS. Yeah, I do
9 think that that drives change.

10 But so going upstream, what is -- what
11 does it take for CMS to say yes, we will pay for
12 this? That's the piece that I'm saying that Cara
13 emphasized, which is evidence, evidence,
14 evidence. Not just evidence-based interventions,
15 but evidence, evidence, evidence. I don't really
16 know what she was, you know, in terms of kind of
17 holding her to a definition.

18 So I think they are connected. I mean
19 I don't think -- I'm trying to draw the
20 connection, but I don't think they're two
21 different --

22 CO-CHAIR CHIN: The CMS person on the

1 phone. I guess like all the behavior people
2 here, there's a lot of evidence in terms of like
3 support of senior management or buy-in is
4 essentially an essential prerequisite to change.
5 So if you have evidence-based proof, I guess you
6 can point to that. But I think I've heard
7 there's a CMS person on the phone that would like
8 to speak.

9 MS. GRAVES: I think I'm being
10 potentially volunteered.

11 MS. MURPHY: What I would like is
12 clarity around, you know, what is that pathway
13 and I don't know if it's a clean pathway. But I
14 think for this Committee, it would be really
15 important to understand that.

16 MS. GRAVES: Hi. This is Darci
17 Graves, and I'm slightly terrified to try to take
18 on this question. I have no doubt that Cara once
19 has talked about evidence. She frequently
20 talked, you know. The times that I hear her use
21 the word three times is usually data, data, data,
22 but I know data data data drives a lot of, you

1 know, the evidence.

2 So I think there's that certain --
3 there's certainly that validity I think. But as
4 you pointed out, there's multiple examples of
5 what's going on. I think we just -- what you all
6 need to work on is that anything we recommend or
7 anything that you all recommend used to being on
8 that side of the thing. I'm still getting used
9 to this side, so when I say "we," I mean "you."
10 Not speaking on behalf of the government, but I
11 am.

12 Not very well at the moment, but
13 trying. You know, we have to have solid ground.
14 We have to be able to point -- you have to be
15 able to point to something and say we recommend
16 this and this is why we think this is more
17 important or this is the important one over X,
18 and if you have either the evidence or I don't
19 necessarily want to say the anecdotes.

20 But if we have that kind of consensus,
21 that these are the things where we need to go,
22 you know, as a field, I think that's -- I think

1 that's important. So hopefully that covered
2 enough.

3 CO-CHAIR CHIN: I'm sorry to put Darci
4 on the spot, but I think also too I mean like we
5 shouldn't limit ourselves to what we think is
6 feasible now. Part of this is like a road map
7 that is your generic road map, and part of it's
8 contingent on what can be done now. Some of the
9 recommendations may be that these need to be in
10 demo mode, that some of the stuff has not been
11 studied before but should be studied, and then
12 -- and so is appropriate for demos.

13 But again, if the standard of evidence
14 is well, we know that again, you need to have the
15 attention of senior management to get things
16 done. We'd have to have just extensive proof of
17 that, so I think we're past that bar.

18 MS. MURPHY: We'll come back to this.
19 I think -- I think I'm also being very mindful of
20 how many measures you've already, you know,
21 you've summarized this. We don't want to have so
22 many measures that we just create another, you

1 know, measure glut. So I think there is -- you
2 know, I would like this Committee is just, you
3 know, full of very, very smart strategic people.

4 So I would like to think about how we
5 can be very strategic in terms of -- I love the
6 demo idea. We don't have evidence for some of
7 these things, we just don't. So a demo might be
8 a great recommendation from, you know, from this
9 Committee. So I'm just going to push on that a
10 little bit, because I worry about the outcome of
11 this report being a really great intellectual
12 exercise, and that's not what we're here to do.

13 I mean that's fun for us. We want it
14 to have some, you know, real world application so
15 --

16 CO-CHAIR CHIN: Yeah, and it's just a
17 tricky balance to that. Part of the discussion
18 that we've had today has been thinking about how
19 do we help with implementation. I think some of
20 Lisa's points and Lisa in particular, maybe
21 Christie, some of Christie's points too and Ron's
22 points would sum it up also.

1 But also we need to provide the menu
2 of options and as you said the evidence base and
3 some of our recommendations. But in terms of
4 predicting the tea leaves of possibility, I don't
5 know if that's really sort of the most fruitful
6 use of our time as a committee anyway, yeah.

7 So anyway, but before we leave, maybe
8 when you get more sort of like the tools out and
9 maybe that's something we revisit tomorrow
10 morning, and maybe thereafter. So let's get our
11 substance first in terms of what we have to work
12 with. So I think, what was it? It was like
13 Romana and then it was Kevin on the phone, and
14 then it was Michelle and then a bunch of cards
15 popped up. We'll say Traci, Christie and Ron.
16 Oh sorry, and Ninez will pop in -- Ninez will pop
17 in when it's her turn, yeah.

18 CO-CHAIR PONCE: I'll see with the tea
19 leaves.

20 CO-CHAIR CHIN: Okay. In fact, Ninez,
21 just pop in.

22 CO-CHAIR PONCE: Okay. So I think

1 this is an opportunity to comment or make
2 suggestions to the ASPE study B report, and where
3 they are linking -- the Part B is linking the
4 claims data with Medicare community beneficiary
5 survey, and then some American Community Survey,
6 Community Effects.

7 Because they're doing policy
8 simulations, so this is my tea leaf suggestions.
9 So I think if there's a way to, you know,
10 somewhere between an RCT, an anecdote and demos,
11 I think a policy simulation of how community
12 collaboration could moderate or mediate some of
13 the domains that we're trying to get at I think
14 would be one way, and then also again based on
15 what Philip raised that Karen raised about the
16 equity bonus, which she said we just made it up.

17 We just added this equity bonus and it
18 ended up, whatever it was, it ended up reducing
19 the disparity between safety net and non-safety
20 net hospitals the most.

21 So it made me think another way of
22 looking at it, a measurement way is what's the

1 most cost effective way? Like what's the way
2 that you're maximizing, you're optimizing the
3 reduction of disparities with whatever the
4 investment is of that equity bonus?

5 Again, working with -- since there's
6 already an infrastructure in place with ASPE, but
7 we have some ideas to help them and they were
8 always please feed us, email us, tell us on some
9 ideas moving to Study B.

10 CO-CHAIR CHIN: Okay, so Kevin.

11 MEMBER FISCELLA: Yeah. I was
12 recently reading some papers on the
13 comprehensive health list indices, you know, that
14 produced mortality. Stephen Lim and others have
15 developed that, Joseph Massaro recently have
16 validated some of them using NHANES. But you
17 know, the idea is that you go after a series of
18 modifiable risk factors, and then these are added
19 to a broader health index.

20 And you know, one idea would be to use
21 the -- to use the index as a rough burden on at
22 least a bunch of preventable morbidity and

1 mortality, by getting an up-front payment
2 essentially based on need using that -- using
3 those indices.

4 And then beginning to reward both
5 overall improvement as well as equitable
6 improvement in those indices. That would --
7 that's one way of reducing measurement burden by
8 having a comprehensive index.

9 And I guess the latest that I -- I
10 haven't heard many others on the phone know would
11 be what was learned so far regarding the
12 implementation of this big trial that CMS was
13 doing, the Million Hearts trial, that uses a
14 narrow index, ASCDD index as an outcome and what
15 we've learned from that so far and how we might
16 apply some of those lessons either to doing a
17 similar ASCDD index or a broader health index in
18 that way.

19 CO-CHAIR CHIN: So thanks, Kevin.
20 Kevin's comment was one of the first to address
21 this bullet, the fourth one about like addressing
22 social determinants of health and the issue of

1 different payment programs. So Kevin suggested
2 essentially a mixed payment model.

3 So up-front per member per month,
4 bonus payments based upon the social risk that
5 can then fund, presumably, upfront preventive
6 infrastructure, in addition to having some type
7 of, what sounded like some type of P4P based upon
8 absolute thresholds and improvement that would
9 reward then a more piecemeal base of process and
10 outcome measures.

11 So that's one example of trying to get
12 at this issue of how do you both fund
13 infrastructure up front, as well as potentially
14 desirable activities and outcomes along the way
15 and down the road. So now we can go back to
16 Michelle and we said it was like Traci, Christie
17 and Ron.

18 MEMBER CABRERA: I think whatever we
19 recommend here, it has to be flexible obviously,
20 because there's so much variation in who might be
21 experiencing a disparity and our members change
22 in that over time as well, right, as you know

1 from your example with refugees and coming into
2 your community and, you know.

3 Populations change, priorities change
4 and so I think part of what we want to do is we
5 want to say, you know, to the folks who are
6 interested in this, that they need to allow for
7 there to be experimentation using these tools,
8 these payment tools, the same way that they do
9 for trying to bend the cost curve or improve
10 overall quality, right.

11 I mean there's tons of experimentation
12 happening there. As our state was rolling out
13 value-based events and P4P and the safety net and
14 then Medicaid, you know, there weren't a lot of
15 examples when that kicked off of successful
16 evidence-based, you know, P4P or VBP in the
17 safety net.

18 So we're just -- we are experimenting
19 in a lot of different fields. There isn't proof
20 that it's going to work with these populations,
21 and I think, you know, one thing that I do want
22 to flag that I'm concerned about is this hyper-

1 intense focus on trying to constrain cost to the
2 payers, you know. We have to be mindful, I
3 think, that one, it comes to the goal of
4 improving health for populations that may be just
5 out of reach, as Tom was talking about earlier,
6 right.

7 But there's the sort of frustration
8 that no matter what we do or throw at this
9 problem, we may never get there. I mean I think
10 there has to be both an acknowledgment of yeah,
11 we may fail and that's okay, and yet we have to
12 reach. We have to try and, you know, that in
13 doing so it actually may cost more. Now if it's
14 going to cost more, there should be
15 accountability, right.

16 And so the payment system should be
17 designed to attach some strings, not in a
18 punitive way, right, but in a did you really try
19 kind of way. Did you really -- and then if you
20 tried, what can we learn about that example,
21 understanding that it's going to be specific to
22 your population? That's it.

1 CO-CHAIR CHIN: That's the best
2 edition, Michelle. So one way of thinking about
3 it, maybe that is a different prospectus for any
4 cost analysis. So maybe you're talking about
5 societally being cost effective, yet still having
6 a business case for the plan or the provider.
7 Traci, Christie and Ron.

8 MEMBER FERGUSON: So going back to
9 Romana's statement about, you know, what we
10 should do as a committee in terms of how we want
11 CMS to act, I believe that they would, and I'm
12 not going to speak for them, but for my own
13 company, as long as an initiative is budget-
14 neutral and we can show that it's budget-neutral
15 in the very beginning then -- and we can show
16 that there are some outcomes, either whether
17 through a demo process, then they'll be willing
18 to put the money up later, when we see that it's
19 working.

20 So I think that, you know, if look at
21 some of the -- I think the intersection between
22 the federal government in terms of the safety net

1 for the EPSDT services and what they, you know,
2 Medicaid can say whatever benefits in terms of
3 fee for service. But they have -- there's an
4 extra, you know, federal protection for Medicaid
5 beneficiaries that if it is medically necessary
6 in terms of treatment, that no matter the state
7 agency or the managed care organizations still
8 have to provide that service.

9 So in a sense, if we can say that at
10 a federal level there is some minimal standard
11 that we expect the state agencies to adhere to
12 the managed care organizations who do the
13 government programs, that that is a way. But
14 again, that's with policy and they -- well, in
15 terms of if -- and we have those that are only do
16 government plans. If it's in the policy, they
17 will do that.

18 It may not have the funds there, but
19 they will find other ways. They will remove
20 funds from initiatives that aren't showing
21 benefit and now syphon it over to those other
22 initiatives.

1 So I think going in the stance that it
2 can happen being budget-neutral to begin with, if
3 we instead of doing a whole bunch of measures
4 that really don't show and now we're going to
5 -- the same resources, the money to collect the
6 data and also the human resources now doing a
7 better set of measures and not a lot of extra
8 data and IT work, then that I think will be an
9 easier pill for them to swallow.

10 CO-CHAIR CHIN: Thanks, Traci. So
11 Christie and Ron.

12 MEMBER TEIGLAND: So this builds on
13 all three of the last speakers, Romana, Michelle
14 and Traci, and I'm thinking about back to the
15 value-based purchasing, back to making the
16 business case. Every value-based contract is
17 asking you to save money, right? That's the
18 whole premise. Yes, they want to improve
19 outcomes, but they want you to save money.

20 The fact is a lot of these programs,
21 you know, and issues are not going to save money,
22 but they are going to improve someone's quality

1 of life. So how do we put some value on quality
2 of life? I mean we have talked a little bit
3 about some quality of life measures, but we
4 haven't talked about quantifying, you know, the
5 value.

6 I mean we were just approached by a
7 big health plan who has a C-SNP, chronic care
8 SNP, and they're in jeopardy of losing, you know,
9 their status. The D-SNPs seem to have proved the
10 evidence, the I-SNPs too, the C-SNPs not so much.
11 But so, you know, we can certainly do a study and
12 show that people with this chronic condition have
13 better outcomes than people in Medicare Advantage
14 that are not in a C-SNP.

15 I said and how about cost, we'll look
16 at cost. They said no, no, no. We don't want to
17 look at cost, but pretty sure they already know
18 it costs more. But these people with this
19 chronic condition have a much better quality of
20 life. We worked with another organization that,
21 you know, made a deal about an MS drug, right,
22 that's very expensive but it's keeping people

1 stable, right?

2 They're not having those flare-ups of
3 MS that are putting them in the hospital. So
4 part of what the measuring was avoidable
5 hospitalizations, really hard to measure, right.
6 How do you quantify -- and you can do it, but the
7 time horizon has to be a lot longer. So this
8 concept of a measurement year when you're trying
9 to quantify value, it doesn't work.

10 You need longer than a year probably
11 for someone with MS who's taking this -- your
12 costs are going to be higher. This drug is
13 expensive, but guess what? Your quality of life
14 is way better and maybe there will be cost
15 savings two years, if you look at two years of
16 spending, but not in that one year measurement
17 period.

18 So you know, these are just some
19 thoughts about quality of life measures number
20 one, and putting some weight on those, but then
21 can we put some value on those as well?

22 CO-CHAIR CHIN: Your point Christie

1 made me think of something else, that the
2 programs are in such flux that the issue like
3 cost depends upon the program. Something like
4 MACRA, for example. Well, on the alternative
5 payment model track, then clearly costs are going
6 to be important. The MIPS track, while cost
7 doesn't even enter until what, 2018 or '19, so --
8 and this is part of the formula for payment.

9 And so -- and at the level that we
10 have right now, I mean like probably at a minimum
11 we want a menu of options that then can be like
12 applied to specific programs and all. Some of
13 these details probably is going to be beyond what
14 we can do as a committee.

15 But I think this is getting at some of
16 these general principles and options, and CMS. I
17 mean that's their job in terms of like figuring
18 out how you operationalize, yeah. But it was a
19 good point in terms of one of the points Traci
20 also made in terms of the value also meets the
21 benefits side, yeah. Ron.

22 MEMBER COPELAND: You asked a question

1 earlier about how, one of the goals with these
2 recommendations is how do we get organizations to
3 take this work seriously. I think it was
4 something to that effect, and I think my answer
5 to that is that CMS and all health care
6 organizations care about two things at a high
7 priority level, with rare variation, and one is
8 quality improvement.

9 Any way you cut it in health care
10 organizations and systems, one thing they care
11 about is quality improvement, and the second is
12 they care about cost care management because of
13 resource limitations. So I think how do you make
14 it relevant? I think it's got to touch one of
15 those two areas in terms of how it's constructed
16 and the narrative that's created.

17 But when we talk about this piece
18 about ensuring or CMS, how do we impact their
19 payment system to drive a reduction in
20 disparities, there's a ton of growing portfolio
21 programs, payment programs that already exist and
22 are emerging now from the CMS lens. So one

1 question I would have as we contemplate that
2 question is what are those programs designed to
3 accomplish?

4 Do any of them, if they're as high
5 uptake and they're successful, based on what the
6 criteria and who's eligible to participate,
7 etcetera, do we have any evidence or is it built
8 into the ROI for those that disparities will be
9 one of the intentional or collateral benefits of
10 those programs if they're successful?

11 So I don't know the answer to that
12 question, but it would seem to me for this
13 Committee if we're zeroing in on how do we
14 enhance and help CMS particularly focus on
15 disparities, what are those current payment
16 programs doing that help this work, and if
17 they're doing some of it but leaving gaps, is
18 that where we should focus our energy in terms of
19 further enhancement?

20 So that's a question rather than an
21 answer, and then the final thing about this flow
22 of funds to address social determinants. I think

1 we have to propose some process that makes you
2 eligible to request "investment funds" for taking
3 on social determinants.

4 So and I'm making this up. It might
5 be demonstrate that you've done a comprehensive
6 needs assessment, whether you're doing it for IRS
7 purposes or not, whether you're not-for-profit or
8 not. We're talking about a different scenario
9 here.

10 So have you done a comprehensive needs
11 assessment, and as a result of that what
12 priorities have been identified as the priority
13 things to take on and have you demonstrated that
14 those priorities as gaps are based on or
15 significantly influenced by social determinant
16 factors as opposed to not, because this whole
17 notion about -- the inequity really is based on
18 these are things that are one, unjust, unfair,
19 and two, are not -- are removable or preventable.

20 So theoretically, the things that are
21 barriers that meet those criteria are the things
22 we describe as inequities. There are some

1 disparities that are based on things that are not
2 reversible, and so you're not going to eliminate
3 those because you can't reverse. So you can't
4 put, lump all disparities together. You've got
5 to be very specific. Those that we feel are
6 predominantly driven by inequity, social
7 inequities. That can be addressed in some
8 fashion.

9 So if you've done a needs assessment
10 and you've made the case and done the analysis to
11 say these priority areas that we're focused on
12 that have a big impact on lots of people are
13 preventable and can be addressed, and to do that
14 we're going to need -- we're putting together a
15 plan that says we're going to first need to build
16 infrastructure.

17 We're going to need to do some time
18 determined pilot to address these things over
19 time, and the reward system or payment system
20 needs to be thought about maybe as a certain
21 amount up front to fund an investment of
22 activities, based on a prioritization and a time

1 frame for achieving measurable results.

2 That might be tiered results, but
3 getting those results after appropriate
4 deployment of infrastructure is going to result
5 in a bonus payment if you will, because you've
6 done the process improvement. You've addressed
7 it and proven that it's social determinants, and
8 you've achieved an outcome that is measurable and
9 therefore sustainable.

10 Whether you use collaborative models
11 and all the other tools in the tool kit to get
12 there, that's up to you in deciding on putting it
13 in your plan to bring in what you're trying to
14 take on. So that's just, that's just, you know,
15 kind of fly by night thinking. But I think that
16 type of approach allows for the flexibility or
17 the diversity.

18 We know everybody is not starting this
19 journey in the same place. It's incorporating or
20 integrating some of the key constructs that are
21 in our framework about collaborating, leadership
22 and so forth and the role of measurement, and

1 it's putting incentives in the context of
2 investment is the first component of the
3 incentives, where do you have investment and an
4 expectation that there's additional dollars if
5 the outcomes are improved, and it's targeting
6 those things that we've already pre-determined
7 have a social determinant connection as a driver,
8 as opposed to just anything that falls in the
9 disparity gap.

10 CO-CHAIR CHIN: Thanks Ron, and like
11 Philip is probably saying amen, that there's some
12 synergies with what he said a little bit earlier
13 in terms of the quality of human process and
14 looking to some other conceptual model that we
15 have a little bit. So a lot of things to push
16 the work there.

17 Your point about like the different
18 CMS programs, I mean you raise the point about
19 need for individualization. The ASPE report that
20 looked at social risk factor adjustment, it's a
21 400 page report and they looked at like 12
22 different of the CMS programs divided by like

1 hospital, ambulatory, long-term care and what-
2 not, and the results differ depending upon the
3 program.

4 So your point about the need for
5 individualization to program specifics probably
6 is worth looking at.

7 MEMBER COPELAND: Does anybody have
8 insight on whether any of these, the current
9 programs that are part of the portfolio, payment
10 portfolio have in their constructs or there's a
11 strong belief that they will have some measurable
12 impact on "disparities"?

13 MS. O'ROURKE: The only one that comes
14 to mind is maybe MIPS that a teeny bit has a
15 couple of equity measures. But I could be wrong
16 on that. That might not even be there.

17 MALE PARTICIPANT: It's being very
18 generous.

19 (Off mic comments.)

20 MEMBER COPELAND: Yeah, and so the
21 reason I ask that question is because so is it
22 taking the things we're proposing and thinking

1 about recommending, and going back to say they
2 should be integrating to those payment programs?
3 Or have those ships already sailed and therefore
4 there's got to be --

5 CO-CHAIR CHIN: I think you hit it
6 right on the head, that essentially without
7 groups like us, it ain't going to happen. So
8 this is the chance to basically try to get it on
9 the agenda, yeah.

10 MEMBER CABRERA: I will just note that
11 there are examples beyond what we have in our
12 field of vision right now. So like we're, you
13 know, we're talking a lot about the Medicare
14 stuff rightfully because it's driving the VBP.
15 But on the 1115 waiver side, I'm aware that
16 because of some ruthless advocacy, there was some
17 stuff baked into what is now called Prime in
18 California.

19 It used to be -- oh, I looked for it
20 in the ASPE report. It's in there? Oh, okay.
21 The waiver stuff you're going to send them?
22 Okay, good. Yeah, because I didn't see it in the

1 ASPE report. But so anyhow, there's stuff like
2 that too that I think we need to pull in as
3 examples to CMS of see, you're doing a tiny
4 little thing here or you might --

5 I think New York's waiver may be. I'm
6 not an expert on New York's waiver, but they
7 might have some stuff too and just pulling those
8 examples out I think will be helpful.

9 CO-CHAIR CHIN: Great stuff about
10 state examples. So we have David, Philip, Bob,
11 then we'll cycle to the phone people after that.

12 MEMBER NERENZ: Just wanted to caution
13 about our wording here. I'm looking at the words
14 and I'm kind of a person who takes things very
15 literally. So when we talk about adequate and
16 then we talk about address social determinants,
17 I'm reading a fairly high bar here in both ways.
18 I'm thinking that is we -- lots of our work
19 reports cites about things that are effective.

20 I don't think that we really apply the
21 cost effectiveness criterion to any of those
22 things, that for a relatively small investment

1 that big results would be achieved. I just don't
2 think we looked at it that way, and I certainly
3 don't think we only talked about things that were
4 net cost saving. I'm not sure there any of
5 those, maybe.

6 Okay. So with that as background, if
7 what we mean by the words here is that we're
8 talking about a flow of funds that will allow the
9 providers paid by CMS to address social
10 determinants in such a way that health equities
11 are eliminated, the amount we're talking about is
12 astronomical I think. So big that nobody will
13 discuss it seriously.

14 So either we say that's not really
15 what these words mean and then we put a limit and
16 say here's what they do mean, or we choose some
17 different words. Because I'm just afraid that
18 if, you know, it sort of hinges on the word
19 "address." If that means solve, fix, eliminate,
20 I have no idea what amount of money we're talking
21 about.

22 You know, fix housing problems, fix

1 literacy problems, fix poverty problems, fix
2 local transportation problems? There's not
3 enough money in the federal budget to do all that
4 stuff. So what do we mean? What do these words
5 mean?

6 CO-CHAIR CHIN: That's a question for
7 the Committee, yeah. Philip.

8 MEMBER ALBERTI: So I wasn't going to
9 address that first. So you know, the CHNA has
10 spent a lot of time talking about it. That's a
11 completely unfunded mandate, right. So there are
12 not-for-profit hospitals across the country who
13 are turning their gazes upstream because they
14 have to. They received no money. They're being
15 very innovative and thinking about how they
16 address the social determinants of health.

17 They're actually launching a suite of
18 resources this month focused on how academic
19 health centers are doing that work upstream
20 without any extra funding. So it's possible.
21 Innovative things like using their telehealth
22 capacity to reduce school absences and truancy by

1 providing care in schools. I mean there are ways
2 that actually don't cost a lot of money.

3 But the point that I was going to make
4 harkens back to this definition conversation we
5 have about tightening up language, and also kind
6 of some of the bullets up here about mixed
7 payment models and the equity bonus idea that Ron
8 expanded on. So you know, thinking about our
9 structure and the five domains, it seems like
10 domains 1, 2 and 5, right?

11 So the culture of equity, the
12 structure for equity and the partnerships and
13 collaborations really are kind of our equity
14 measures, right? They're separate from the
15 disparities measure, disparity surveillance that
16 are really in the access and quality bucket when
17 we're talking these differences.

18 So I wonder if there is some way to
19 kind of merge all these ideas, to think about the
20 idea that Ron had on this bonus idea, the up
21 front payment being tied to a demonstration of
22 need, a demonstration of some aspect of the

1 culture of equity, the partnerships in place to
2 do the work, the structure of equity in terms of
3 the disparities and the stuff that we sort of
4 bake into these CMS programs that are more
5 universal and central, as Michelle was pointing
6 out earlier, working on these disparities
7 tracking metrics we're identifying gaps, we're
8 incentivizing reduction.

9 But you could actually go above and
10 beyond and seek some up-front bonus money because
11 you have all these other supporting structures in
12 place. So I wonder if this hybrid model is
13 actually already in the structure that this group
14 has defined in some way.

15 CO-CHAIR CHIN: Thanks, Philip. So we
16 have Bob, the phone folks and if people can start
17 thinking about -- we're going to start segueing
18 pretty soon into some of the more granular
19 methodological issues, of which maybe the first
20 one to start off is this bullet about when to
21 stratify, when to risk-adjust, when to consider
22 both. So if people can just be starting to

1 thinking about that. In the meantime we have,
2 did I say what? Was it Bob and then phone. Yep,
3 Bob.

4 MEMBER RAUNER: Yes. I was kind of
5 thinking about, because of the MIPS comment and
6 then I started thinking more about David's
7 comment earlier that within the structures of the
8 ACO, there is an inherent incentive to improve
9 your safety net clinics, assuming you bring that
10 in, because just from an allocation of resources,
11 if I can bring this clinic that's 35 and 55
12 percent up versus the other one's 60, it's better
13 bang for my buck to focus on the safety net for
14 the quality improvement side.

15 There's also sort of an example within
16 MIPS. So MIPS, if you're reporting as a primary
17 care provider in MIPS and you're within an ACO,
18 you actually get bonus points on your MIPS,
19 because you're an ACO. You get full credit for
20 clinical practice improvement. You do get some I
21 think extra, but based on your quality score.

22 Well you could -- I think it wouldn't

1 be hard for CMS to incorporate some type of
2 disparities reduction, that if you do this, you
3 might get extra credit on MIPS, or within the ACO
4 you're insured savings percentage is just about
5 the quality score. You could get a bonus for
6 your quality score if you do some of the ground
7 disparities.

8 So it wouldn't be hard for them to add
9 something bolted onto either MIPS or the Medicare
10 insured savings program around disparities at a
11 later date so --

12 CO-CHAIR CHIN: Thanks, Bob. So do we
13 have anyone on the phone, and if Susannah is
14 there, if part of your comments maybe you can
15 start some of the discussion on the risk
16 adjustment versus stratification and uses of both
17 type of thing. Anyone on the phone?

18 MEMBER BERNHEIM: I'm here. But go
19 ahead, please.

20 MEMBER SCHOLLE: This is Sarah. I
21 have a couple of comments I wanted to make. So
22 I'm actually -- I really like this idea about up-

1 front payments for infrastructure versus metrics
2 for incentivizing reduction in disparities. I
3 think that's very useful and I apologize if
4 people are hearing fuzziness on the phone,
5 because I just started to hear that.

6 I did want to make a couple of
7 comments about evidence. One way to think about
8 this is that when we create measures that say --
9 that are process measures that say you have to do
10 something, then we hit a stronger evidence bar
11 than when we say for an outcome you need to
12 demonstrate that you're achieving similar
13 outcomes or you're reducing disparities and
14 outcomes, because when we say you have to do X,
15 then people will come and say "and Y" and how
16 many community health workers and how do you
17 know, how do you decide what's the right number
18 per person, what's the credentialing that goes
19 along with it?

20 So as you get, you know, go deeper
21 into that measurement of the infrastructure, it
22 gets -- it gets more complex and the evidence,

1 while it may say leadership is important, there's
2 what kind of leadership and how you demonstrate
3 and what's sufficient becomes really challenging
4 for a measure developer.

5 And so it's easier to say, think about
6 that as an infrastructure that's going to support
7 an outcome improvement or reduction of
8 disparities. One of the things that we've been
9 asked to do is to really say that there is a way
10 to reduce disparities, that we know that there
11 are effective interventions.

12 So I think we know that there are
13 differences in cancer screening rates or cancer
14 mortality rates, the question will be how much
15 evidence do we know about what causes those
16 differences and what -- whether there are
17 effective interventions that can reduce those
18 disparities? So I just want to offer those
19 ideas.

20 CO-CHAIR CHIN: Thanks, Sarah. Others
21 on the phone?

22 MEMBER BERNHEIM: This is Susannah.

1 I'm happy to talk a little bit about the
2 stratification as a definite question. But if
3 others have stuff on this earlier thing, I just
4 want to make space for that first. Okay. I said
5 something earlier, so I don't want to really
6 rehash it.

7 But there's one key differentiation
8 between the way I think this Committee intends to
9 use patient level stratification in order to
10 eliminate disparities and incentivize equity and
11 risk adjustment. So and I'm thinking
12 particularly the outcome measures, right,
13 measures that are already risk-adjusted for a
14 number of clinical factors to try to "level the
15 playing field" between providers.

16 When we add a measure for economic
17 status, race or any other social risk factor to
18 those measures, the purpose of that in the
19 context of thinking about equity is, as I said
20 earlier, primarily to reduce unintended
21 consequences, right. That's where it comes up in
22 this conversation. For some people it makes

1 comparisons among providers more fair.

2 But the only way it promotes health
3 equity is if it in fact has an impact on sort of
4 the payment for safety net providers, and we've
5 debated that forever. But stratification has the
6 potential to do something else. There's two ways
7 to think about stratification and I want to just
8 say a word about that, because I think --

9 I'm aware that I'm in the weeds of
10 measurement, that this is a high enough level
11 concept that is worth the Committee's thinking
12 about.

13 So if you were to produce a report as
14 a process measure, really simplified that shows
15 that Hospital A was in the -- you know, had a 20
16 percent rate of something for their minority
17 patients and a 30 percent rate for their non-
18 minority patients, you can highlight that there
19 is a difference between those two rates.

20 However, and so that might help
21 incentivize disparities. It doesn't achieve
22 disparity reduction. It doesn't tell you much

1 about how they're doing overall unless you know
2 the proportion of those patients. But at least
3 you can see what the differences are.

4 But there are many measures you can't
5 look at sort of a straight rate, and that's
6 looking at basically our ranking, and if you look
7 at rankings, you may lose the ability to
8 understand within an institution how they
9 compare.

10 So there's a key issue with
11 stratification that has to do with whether you do
12 it based on how an institution looks compared to
13 other institutions on their social at risk
14 patients, or if you look at how an institution
15 does on their own social at risk patients
16 compared to another one.

17 So when we talk about stratification,
18 we're going to have to pay a little bit of
19 attention to that. But the bigger picture thing
20 is the thing I said before, which is that I think
21 stratification in general can be used to
22 eliminate and incentivize disparities, and that

1 primarily serves to decrease unintended
2 consequences.

3 In that setting, you can use them
4 together. I mean I don't think -- our original
5 committee suggested these are what I'm talking
6 about. But I think it's perfectly reasonable to
7 use them together.

8 CO-CHAIR CHIN: Thanks, Susannah. So
9 Nancy.

10 MEMBER GARRETT: I just want to offer
11 a bit more specific idea under the different
12 payment mechanisms that was actually one of the
13 ASPE recommendations, which is to consider new
14 quality improvement programs to provide target-
15 supported technical assistance to safety net
16 providers.

17 So what that does is it helps reduce
18 the burden of penalties potentially on those
19 populations, but also improves care for the most
20 socially at risk beneficiaries. So it's a
21 specific idea of potentially new quality
22 improvement programs that are targeted at those

1 providers, given the high concentration of
2 vulnerable populations at those providers.

3 CO-CHAIR CHIN: Thanks, Nancy. Are
4 there others on the phone besides Sarah and
5 Susannah who want to speak?

6 (No response.)

7 CO-CHAIR CHIN: Okay. We'll circle
8 back to Michelle.

9 MEMBER CABRERA: I have a question
10 actually for all of the smart people in this
11 room. When do you not want to stratify? Because
12 stratification seems great to me. Help me
13 understand when you would not do that.

14 MEMBER NERENZ: Just can I -- there's
15 a point we have to semantic clarification and now
16 is the point. The word "stratify" can be used in
17 two entirely different ways, and we're going to
18 trip over ourselves over and over if we don't
19 sort it out.

20 Your use of it implied I think
21 stratification by patient characteristic within
22 an entity, like a given hospital. What's your

1 infection rate versus black versus white, rich
2 versus poor, okay. That's one way to stratify.

3 The NQF panel report three years ago,
4 explicitly recommended that along with risk
5 adjustment when it's appropriate, and there are
6 reasons for doing that. But there's an entirely
7 different way to stratify, which is actually
8 what's now in the inpatient proposed rule, which
9 is where you stratify the performing units.

10 Like you take all the hospitals in the
11 country, divide them up into quintiles based on
12 their percent. Now that's also stratified. The
13 English word applies to that. But Stratify A and
14 Stratify B are two entirely different things.
15 They have different functions for different
16 purposes, different answers yes or no. They're
17 both stratified.

18 So somehow we need some words that
19 distinguish as we talk about it, which kind of
20 stratify are we talking about.

21 MEMBER COPELAND: Well, you just did,
22 and I think in the setting of accountability at

1 an institutional level and accountability at a
2 unit level, or in some cases down to an
3 individual provider level, all those are
4 relevant. We stratify by individual practices,
5 we stratify by medical center, we stratify by our
6 global entity. We benchmark. We stratify in
7 multiple ways.

8 So it shouldn't be assumed because
9 we're talking about inequity or equity that
10 stratification only talks about ethnic categories
11 or demographic groupings. Stratify is stratify,
12 and you just be clear I'm talking about this
13 combination or this version of it. But it
14 applies all the same.

15 MEMBER NERENZ: Okay well --

16 MEMBER BERNHEIM: And David to be
17 clear, I was talking about what we refer to in my
18 group as patient level stratification. So it's
19 stratifying subgroups of patients within an
20 institution for a measure.

21 MEMBER NERENZ: Yeah, and Susannah I
22 understood it that way. But just in my left ear

1 I think I heard Phil quietly say we could talk
2 about stratified within or stratified between as
3 a way of keeping the concepts clear. I don't
4 mind that. Actually Ron your suggestion, so
5 there's sort of a middle ground that, you know,
6 let's say that an ACO is your unit of
7 measurement.

8 Now within an ACO, you can stratify a
9 whole bunch of different ways. You can stratify
10 in patient characteristics, but you could
11 stratify on clinic sites. But that still is
12 different from taking 100 ACOs and stratifying
13 them by some feature.

14 MEMBER COPELAND: Sure.

15 MEMBER NERENZ: So I sort of like the
16 within- between. But somehow we've got to sort
17 this out. Otherwise, we're going to be here
18 until midnight and we still don't even know what
19 we're talking about.

20 CO-CHAIR CHIN: So thank you David,
21 and maybe when people use the word, if they can
22 be specific about their terminology, what they're

1 stratifying by. I love Michelle's question
2 because it really is a fundamental question, and
3 before we sort of move on to other points, let's
4 have the Committee answer that question. So
5 Lisa.

6 MEMBER COOPER: So well I mean I'm --
7 I don't know that I'm the expert in this. I
8 would say one real reason to not stratify is if
9 you don't have enough people in the different
10 categories that would give you a meaningful idea
11 of what you're trying to capture.

12 So if you have numbers that are too
13 small in your different subcategories,
14 stratifying is not helpful in that case. That's
15 one and there probably are others but --

16 CO-CHAIR CHIN: Other comments on this
17 particular issue. Nancy, did you want to comment
18 on this issue?

19 MEMBER GARRETT: Yeah. I would just
20 say so in the-- what's proposed in the CMS rule
21 of stratifying hospitals into groups and then
22 making comparisons within those groups, I think

1 that that is an advance in terms of better
2 comparability of trying to get at what you're
3 really doing, which is a promotion -- trying to
4 measure the performance on readmissions and not
5 underlying population characteristics.

6 The danger is that within each of
7 those groups, there's still heterogeneity. So
8 there's still going to be a difference in the
9 underlying population characteristics within each
10 strata. So different proportions of people who
11 are homeless, different income levels.

12 And so you even with ten in the
13 strata, with 15 strata, you're still going to
14 have that within each of them, and so you're
15 still struggling with that issue. So that's the
16 -- I think that's the danger of it and the
17 difficulty.

18 CO-CHAIR CHIN: Ron.

19 MEMBER COPELAND: Yeah. The other
20 category or rationale for not stratifying is when
21 you want to maintain anonymity. Sometimes we're
22 gathering inputs from different units, and Unit A

1 may have 100 people in it. Unit B may have 20
2 people in it, and if you're stratifying by any of
3 the demographic categories, people may want to
4 maintain anonymity.

5 And so you just say you can't stratify
6 below a certain number to protect that, because
7 if there's only one person of a demographic in a
8 group of three or four, that person's going to be
9 identified by virtue of those categories. So
10 that's another reason that comes up.

11 CO-CHAIR CHIN: More comments on this
12 particular issue like the stratification
13 definition. So Philip and Ninez. Okay. Your
14 comment was like beforehand, another issue or --
15 you're first then so --

16 MEMBER ALBERTI: First thing, if I
17 remember, this is before I was on this panel.
18 But I think the original fear is that if you
19 stratified you might hide. I think that's more
20 of a risk adjustment thing that, you know, you
21 might give permission for a particular health
22 center to look bad by bumping their number up

1 because they risk-adjusted based on their
2 demographics and therefore would hide the
3 disparity.

4 I think that was the main fear
5 originally of not allowing, or was it just that
6 you might hide the disparity? I think that was
7 just the big, and also it happens in education as
8 well. They don't like to do that for the low
9 income school versus the high income school
10 because they don't want to hide the disparity.

11 The problem comes when you use it for
12 accountability, because you get penalized for
13 taking care of the poor people essentially. I
14 think that's the biggest fear, is that you might
15 hide a disparity if you stratify or risk-adjust I
16 think.

17 I think the final two things. I think
18 the final fear of stratification was I forget
19 what they called it at the NAM. It was really an
20 elegant turn of phrase yesterday, where you
21 actually make it seem like it's okay to have
22 different levels of quality of care across levels

1 of either people, if you're doing this within
2 stratification, or across institution type if
3 you're doing it between institutions.

4 So it's some, I forget what they
5 called it. It was like psychic something or
6 marketing. I forget what it was. But I think
7 Nancy's point is really well taken. You know if
8 you have within, just between institution or
9 across institution stratification, and the
10 underlying populations are so different, you
11 really do get muddled unless the kinds of things
12 you're adjusting for, right?

13 So we're talking about this mixed
14 model, where you're stratifying across already
15 adjusted analyses, right? So the adjustment's
16 happening across all the strata. So you're
17 trying to control if you had good community level
18 adjusters, which we sadly don't.

19 You would be able to kind of clean up
20 a little bit some of those underlying community
21 differences within the strata, so then the
22 comparisons are more legitimate, right?

1 So I think it's really dependent upon
2 making sure the strata that you're using are
3 well-defined and kind of evidence-based with your
4 histoplots, whatever you're doing. But also the
5 adjusters that you're using within each strata
6 really help you kind of normalize and equalize
7 those comparisons in valid and reliable ways.

8 CO-CHAIR CHIN: This is an example of
9 like using both then?

10 MEMBER ALBERTI: Yep.

11 CO-CHAIR CHIN: Ninez.

12 CO-CHAIR PONCE: I just want to point
13 those who are not in the SDS, in the risk
14 adjustment group that Dave and Kevin led, that
15 there is a definitions page on stratification,
16 and how that's also different from peer groups
17 for comparison. I mean it's related, but there's
18 a peer groups for comparison and then adjusted
19 for sociodemographic status in like a regression
20 equation.

21 I think to Bob's point, the latter
22 part where you adjust is actually harder. It

1 does hide the disparity. The stratification does
2 in some ways, but at least you see how -- I mean
3 you understand that the composition within
4 strata, for each stratum are different.

5 MEMBER CABRERA: I guess the follow-up
6 to this is do we as a body want to recommend that
7 folks stratify when they have the data and it's
8 not going to violate HPAA, you know. Do we want
9 to just encourage people to, as much as possible
10 in the spirit of both transparency but also
11 moving a conversation around health equity,
12 encourage lots of stratification?

13 CO-CHAIR CHIN: Go ahead.

14 CO-CHAIR PONCE: So that gets into the
15 other issue of sample size, right. That's the
16 general question on sample size and I think that
17 that's, you know, each entity is going to have
18 data disclosure review, I mean. So I think that
19 that's, you know, it's a tool to get at a fair
20 way of measuring performance, given the
21 composition of the patients, but it's not --
22 again, it's not the ends, it's not like it's that

1 you have to do it.

2 Although I want to make sure -- I'm
3 going to check with Drew. What did NAM suggest?
4 Didn't NAM suggest to both stratify and to --

5 DR. ANDERSON: Yeah, both stratify and
6 risk adjust.

7 CO-CHAIR CHIN: You are of the NAM
8 camp.

9 CO-CHAIR PONCE: Sign me up.

10 CO-CHAIR CHIN: Stratification from
11 Helen, because that's one of the specific things
12 that she wanted guidance from the Committee on,
13 this issue of like stratification. What further
14 -- what were you looking for in particular? What
15 kind of guidance?

16 DR. BURSTIN: I think one question for
17 us as we've struggled over the last -- had this
18 journey over the last several years of this
19 question of adjustment for SES, has been this
20 question of whether at times, as we think about
21 equity measurement, the actual requirement to
22 stratify or peer group comparisons should be put

1 into the measure specifications we endorse.

2 Again, if we put it into the
3 specifications there's a higher likelihood it
4 will be used. Actually, back to our early
5 readmission report, which some of you may
6 remember, it specifically was guidance from the
7 Committee that said we believe these results
8 should be used to compare like to like hospitals.

9 But that was a line in a report that
10 actually had no sort of teeth, as Michelle said
11 earlier, to actually have it used. So we would
12 just -- we just thought it would be useful for
13 the Committee to actually give us guidance here
14 about when these issues come forward and we think
15 this is a really important measure to look at
16 some of these issues.

17 Should we actually work with
18 developers to bake it into the measure itself,
19 and I know that may -- there may be some
20 downsides we've not considered, and certainly
21 Susannah or other developers should weigh in
22 here. But that would be helpful guidance. Does

1 that sound right? Good.

2 CO-CHAIR CHIN: Let's try a couple of
3 Helen's questions right now then, in terms of
4 people's thoughts about her question. Lisa
5 Cooper.

6 MEMBER COOPER: So I would say yes.
7 I think that if we make a whole separate issue,
8 that that's usually what results in like inaction
9 and inertia. So I think if it's placed like up
10 front when the measure is being developed and we
11 are giving input as to how it ought to be used,
12 and then it's just part of doing regular
13 business, you know.

14 DR. BURSTIN: Just to follow-up on
15 what you guys answer, and then we would need some
16 clear criteria, which I think part of this we can
17 extract from what you guys have been talking
18 about, determine then based on what is submitted
19 to us, when then we think that needs to be baked
20 in.

21 MEMBER SCHOLLE: This is Sarah. I
22 represent the measure developers here in terms of

1 (phone interruption).

2 CO-CHAIR CHIN: Go ahead, Sarah.

3 We'll do Sarah, Bob. Romana are you still in the
4 queue?

5 MEMBER HASNAIN-WYNIA: Yeah.

6 CO-CHAIR CHIN: Okay. So we'll go
7 Sarah, Bob, Romana. Go ahead, Sarah. You're on
8 mute, Sarah. We can't hear you. So Sarah, when
9 you come back on, please pipe in. We'll go Bob,
10 Romana and we'll fit in Sarah when she's
11 available again.

12 MEMBER RAUNER: This might be a
13 question of distinction of who's stratifying. So
14 a typical NQF measure, it's me and XYZ clinic
15 running a measure on colon cancer screening. For
16 me as the clinic, it's probably not that
17 important to stratify that much. But a payer
18 should really stratify, like Medicaid.

19 So if I'm comparing in the Ridge where
20 the wealthy people are versus clinics in this
21 safety net area, it's them that need to stratify
22 more than me internally. So I don't know if

1 that's distinct in an NQF. It's how the NQF
2 measure is used by payers, not how it's used by a
3 particular clinic, for example.

4 DR. BURSTIN: I think that's an open
5 question. I think at times if you know there are
6 disparities in care, we would want internal
7 examination as well, to see if you're in fact
8 providing equitable care.

9 CO-CHAIR CHIN: Yeah. So Romana.

10 MEMBER HASNAIN-WYNIA: So I just need
11 a little clarification. So Helen, your question
12 is about recommendation, this Committee
13 recommending to CMS or to NQF rather, whether
14 going forward in measure development around
15 equity that stratification be put up front. But
16 this Committee itself is not in the business of
17 measure development.

18 So this is a recommendation for future
19 measure development, not in terms of
20 stratification or not, or a combination of
21 stratification and risk adjustment for what we're
22 recommending within this report. I just want to

1 be clear.

2 DR. BURSTIN: Correct.

3 MEMBER HASNAIN-WYNIA: Okay.

4 DR. BURSTIN: This is really more --
5 again, one of our reasons for having you be here
6 is you're the cross-cutting guidance to us on
7 equity and disparities, and so as we look at
8 measure, our core processes of measure
9 endorsement as well as measure selection, you
10 know, might there be opportunities.

11 Rather than saying, you know, consider
12 adjusting, you know, consider stratification, we
13 would actually say based on A, B and C, when this
14 measure is used it should be stratified. When
15 this measure is used like providers should be
16 -- I'm just speaking. We'd just love your
17 guidance there.

18 CO-CHAIR CHIN: Sarah, are you back on
19 line or are you still not here?

20 MS. O'ROURKE: She lost her signal, so
21 she's going to provide comments by email when she
22 gets back to a computer. She said her key points

1 were around flexibility and transparency.

2 CO-CHAIR CHIN: Okay.

3 MEMBER BERNHEIM: And Marshall, can I
4 say something when you get a point in the queue?
5 It's Susannah.

6 CO-CHAIR CHIN: Sure, we will.
7 Philip, Christie, then Susannah.

8 MEMBER ALBERTI: I think a question of
9 who should be doing the stratification and what
10 the requirements should be really depend on the
11 purpose of the measure, right? So if we propose
12 today to help institutions think about racking
13 their own disparities with the idea of narrowing
14 those gaps.

15 So in that case, the institution would
16 necessarily have to do some within-institutional
17 stratification to identify those gaps and track
18 it forward over time. If we're thinking about
19 kind of incentive payments across strata between
20 different organization types like Bob was taking
21 about, then those kinds of metrics would have to
22 be stratified by a payer across or between,

1 whatever the word we're using.

2 So I think it really depends on the
3 measure itself, how it's being used and who's
4 using it, and for what purpose.

5 CO-CHAIR CHIN: So we have Christie,
6 then Susannah. The other thing I'll just give
7 you a heads up, that we've covered most of the
8 bullets. The one we haven't covered yet that
9 we'll then turn to maybe after Sarah's comments
10 are -- if you look at the agenda, there were two
11 sort of implementation questions. It's sort of
12 like how do we secure buy-in for those things
13 measured, how we minimize the burden of
14 additional measures and ensure equity measurement
15 is meaningful.

16 It's going to be a nice segue into
17 tomorrow morning's discussion about
18 prioritization and operationalization and all.
19 So we'll do again like did I say, it was like
20 Christie, Susannah, and then we can turn to those
21 two sort of implementation bullets.

22 MEMBER TEIGLAND: Yeah. I just wanted

1 to underscore about stratification. You just
2 have to be really careful. Maybe it's really
3 useful internally for organizations to see
4 disparities, but if we're using it for public
5 reporting or we're using it for payment and say
6 we say stratify by duals and non-duals.

7 Now because I could be a dual plan
8 that serves under age 65, disabled, mentally ill
9 behavior-challenged patients and you could be a
10 dual plan that serves 65 plus relatively healthy
11 with some chronic conditions, it's not an apples
12 to apples comparison, but that's what people will
13 do.

14 So you need to have more than -- and
15 then it gets really complicated. We're going to
16 stratify by duals who are under age 65, who have,
17 you know, physical disabilities versus mental
18 issues. Where does it stop, right? So you get
19 back to the question of you have to risk-adjust
20 before you stratify almost, because once you
21 start to stratify my three or four or five things
22 to make them comparable, you're already down that

1 path so --

2 CO-CHAIR CHIN: Sort of the Philip
3 Alberti combined approach, yeah. Susannah.

4 MEMBER BERNHEIM: Yeah. This is
5 something that happened earlier, was said earlier
6 and I'm kind of going back to David's point. I
7 think we're still not being consistent in our
8 language and it's causing some confusion in the
9 recommendations. And so I'm going to just
10 reiterate something I said earlier, trying to be
11 more precise.

12 So I think there is a place for what
13 I would call patient level stratification, which
14 is sort of looking at within institution
15 disparities, and I'm trying to use the NAM
16 language. They call this stratified reporting
17 for patient characteristics. That's the language
18 they use in their summary.

19 What that provides is some information
20 potentially about looking at institutional
21 disparities, and I totally agree with the concept
22 earlier that if you've got small sample sizes,

1 there's issues of confidentiality, there's issues
2 of whether differences are meaningful, and quite
3 honestly there's issues of whether it's
4 important.

5 But in the case where there's
6 meaningful sample sizes of two subgroups, using
7 patient level stratification within an
8 institution can reveal within-institution
9 disparities, and could be a useful tool. But the
10 comment I made earlier that I'll now make now
11 that I put it in that context is looking at those
12 results, without looking at overall performance.

13 So if you're only looking at the
14 difference between two groups in an institution
15 and showing whether it's narrow or broad, you
16 need to pair that with how the institution is
17 doing generally, so that you don't put up an
18 incentive to narrow disparities in the context of
19 overall poor quality for those groups.

20 Peer group comparisons, somebody
21 mentioned that's how we ended up dealing with
22 this issue in the last report, which I had

1 forgotten. That's the concept of stratifying
2 groups of entities, you know, hospitals with lots
3 of these patients compared to hospitals with
4 fewer service of a different purpose, and is a
5 little bit less connected to the measures.

6 So what I would recommend we say is
7 that, as Philip said, depending on your purpose
8 and the measure, there is a role for patient-
9 level stratification if you show within-
10 institution disparities alongside of raw
11 performance on that quality measure.

12 So I don't -- and I don't know quite
13 what we should say about care group comparisons,
14 but that's sort of trying to get at these
15 between-institution disparities. But I think
16 it's a little hard to bake it into a measure. So
17 that would be my recommendations.

18 CO-CHAIR CHIN: Thanks, Susannah. So
19 okay. We're now going to turn towards like those
20 two bullets on like how to secure buy-in from
21 those being measured, how we minimize the burden
22 of additional measures and ensure equity

1 measurement is meaningful, and okay. And Tom is
2 first up.

3 MEMBER SEQUIST: So on the -- on the
4 burden, I think one of the essentials things is
5 not in the control of this group, but the way to
6 make this not seem like it's a stressful
7 additional burden is you have to take the burden
8 off of all the other domains that are being
9 measured.

10 Not domains in equity, but safety
11 effectiveness, experience, all the other things
12 where there are hundreds of measures. You have
13 to -- there's just not going to be a way to make
14 this program, equity, efficiently measured enough
15 that you're not going to get people riled up
16 about more measures.

17 So the only way to do this, I think as
18 a first step is you've got to cut back on all the
19 other measures that aren't equity. I'm not
20 saying they're not important. Everything's
21 important and we have to focus on everything.
22 But I just think that has to be a fundamental

1 recommendation here, because there's no other way
2 to do it without adding more burden, you know
3 what I mean?

4 CO-CHAIR CHIN: Thanks, Tom. Lisa
5 Iezzoni.

6 MEMBER IEZZONI: I concur with the
7 burden concern, and it's not just burden for the
8 plan; it's also burden for the respondents. In
9 Massachusetts, CMS and Medicaid, Mass Health
10 administered 12 different surveys to the
11 recipients of one care, and the population just
12 got exhausted, and so I think that we have to
13 think about the respondents as well.

14 CO-CHAIR CHIN: Thanks, Lisa, and
15 Nancy?

16 MEMBER GARRETT: So just reflecting
17 back on some of the discussions we had earlier
18 about the levels of analysis, and we did talk
19 about some potentially state level measures or
20 community level measures, and some of those could
21 be calculated with data that's very widely
22 available. Like is your state Medicaid expansion

1 or not?

2 So one way to minimize burden is to
3 think about some of those macro-measures, and
4 maybe there's a way to calculate that with really
5 very little burden, but still have some impact
6 from a policy perspective.

7 CO-CHAIR CHIN: Thank you, Nancy.

8 Anyone on the phone want to comment upon this,
9 the burden and feasibility issues?

10 (No response.)

11 I'm going to ask are there any public
12 comments, either people on the line or people
13 here in the room?

14 OPERATOR: If you would like to make
15 a public comment, press star 1.

16 (No response.)

17 OPERATOR: And there are no comments
18 at this time.

19 CO-CHAIR CHIN: Okay. So wow. A lot
20 covered, so a lot to work with here. So the
21 current plan is that like so tonight then, like
22 Drew and Erin and the staff are going to look

1 over these notes and try to cull us into --

2 FEMALE PARTICIPANT: The magic trick.

3 CO-CHAIR CHIN: --yeah, and do the
4 magic, in terms of coherent whole. We have some
5 flexibility. So tomorrow morning it's sort of
6 general. We've got this general, I mean like
7 finalize implementation recommendations, finalize
8 the road map. I think in practice what we want
9 to do is in the course of the morning, we want to
10 get far enough along so that we have a reasonable
11 sense of what the general recommendations are
12 going to be, the policy recommendations.

13 Some of this -- some of us we've been
14 balancing these different factors. So for
15 example, now we've sort of raised this burden and
16 feasibility issue, and the issue that Lisa said
17 up front about, like trying to have a relatively
18 parsimonious measurement set. So how does that
19 jibe in with like this very detailed like five
20 domain conceptual model and these hundreds of
21 measures we have here?

22 So it will be some type of

1 prioritization, sort of balancing these different
2 issues. Ninez pointed out like one of the things
3 was to finalize the road map. Well, I mean the
4 road map is always still in evolution, so this
5 will be I guess like an update of the road map,
6 and there will probably keep being evolution
7 through to the September final report.

8 I just want to ask Erin and Drew, so
9 I guess you're thinking about now like what
10 you're going to be doing tonight in terms of like
11 this -- do you have any questions for the group
12 or any thoughts you have right now before we sort
13 of break here?

14 MS. O'ROURKE: Sure. So I think my
15 first thought was, I guess Tara if we can go back
16 to the slide on the five over-arching
17 recommendations or implementation activities that
18 we have in our current framework? Keep
19 scrolling. It's actually -- keep going then, or
20 down, down, down, other way, other way. It was
21 the last slide before we started this one, sorry.

22 So do these still feel like generally

1 the right large buckets of activities for us to
2 start organizing the conversation we had today? I
3 guess my vision for how we might go about this,
4 to bring you something in the morning, was to put
5 some of the ideas under these larger types of
6 guidance.

7 But I wanted to get a pulse check with
8 the group before we go down that path, that these
9 still feel appropriate for an organizing
10 structure.

11 MEMBER GARRETT: Can I --

12 CO-CHAIR CHIN: Nancy.

13 MEMBER GARRETT: So one comment is
14 just around the first one, incorporate equity
15 measures. Maybe it's really incorporate equity
16 into payment and reporting programs. So we kind
17 of talked about that earlier, but that might just
18 be a little bit too narrowing for us.

19 MS. O'ROURKE: Yeah. That's a good
20 edit.

21 MEMBER SEQUIST: I'm sorry. When you
22 say how will -- when you say when this look

1 right, can you just reframe again what is it
2 right for, like what --

3 MS. O'ROURKE: Sure. So basically
4 taking all the ideas that we put out this
5 afternoon, and then trying to organize them
6 perhaps under these -- I don't want to say
7 domains, since we already have domains, but for
8 different types of potential implementation
9 guidance.

10 MEMBER SEQUIST: Will this be some
11 kind of like a -- these would be -- both would be
12 turned into some kind of recommendation statement
13 you're saying?

14 MS. O'ROURKE: I think yeah. That's
15 right, that that might be a high level
16 recommendation with some sub-recommendations
17 underneath.

18 MEMBER SEQUIST: When you say -- I'm
19 sorry.

20 MEMBER NERENZ: Well, I'll just -- I
21 always take things literally. Is this a good
22 framework? I would just observe, as I think back

1 on everything we've done today, very much of it
2 goes to the first bullet. I think we've talked
3 very little about the second bullet, almost none
4 but --

5 On the third bullet, I don't think
6 we've talked at all about the first two points.
7 We've talked a lot about the third. I'm not sure
8 we've really talked explicitly about the fourth
9 bullet, a little bit about the fifth. So to me
10 it's sort of --

11 MEMBER SEQUIST: That's what I was
12 going to say. I don't remember talking about
13 some of these things.

14 FEMALE PARTICIPANT: Is it just that
15 we forgot that, you know, to do these things. So
16 I don't -- I'm not thinking that we should scrap
17 these things, because I think they're pretty
18 important, even though they may not have come up
19 today.

20 MEMBER SEQUIST: No, they're
21 important. I guess what I was -- I'm not
22 disagreeing that they're important. I was just

1 -- that's what I was asking, because I don't
2 remember talking about some of these things. But
3 I was wondering like the third bullet, does that
4 mean that we would be recommending -- we really
5 think the first area of focus should be
6 preventive care and not hospital care and
7 disparities in hospital care.

8 Like we just didn't talk about that.
9 That may be what the group wants, but or chronic
10 disease care over preventive care or --

11 CO-CHAIR CHIN: Maybe what we can do
12 is that maybe the first X minutes, 30 minutes or
13 so we can go into more detail then on some of
14 these things that haven't been discussed as much.
15 I guess it's what two, you said the first bullet,
16 two bullets of like number three. The fourth we
17 talked a little bit about but not -- it hasn't
18 come together systematically.

19 But that would be helpful. Then we
20 can just add that point too, whether or not it
21 makes sense or not.

22 MEMBER SEQUIST: And yeah. I'm not

1 disagreeing with that. I just didn't know --

2 CO-CHAIR PONCE: Right, and just to
3 again, another refresh. These items are in our
4 framework the bottom part. So just these -- it
5 all connects.

6 MS. O'ROURKE: And I think these
7 really came to fruition out of the Committee's
8 first meeting maybe back in January of 2016.

9 CO-CHAIR PONCE: Right. So we can
10 keep what's good, we can add, we can delete.

11 CO-CHAIR CHIN: Part of the purpose
12 was to have things which are different enough
13 that it's just a lumping versus separating
14 function and thinking about NQF's levers. So
15 clearly number one is a big one. Two is one of
16 the fundamental purpose, I guess, of what NQF is
17 designed to do in general, in terms of the
18 alignment. Three in some way is a subset of one,
19 but then if you put a lot into one, then one gets
20 really big.

21 Four, this is an interesting one where
22 I guess the assumption was that like if you just

1 apply like some of these fixes more generally,
2 you may not be really addressing some of the key
3 issues of the safety net that may need to have
4 like bullet one plus other stuff or else
5 contextualize the safety net, that fits with the
6 demo functions in terms of like recommending
7 demos.

8 MEMBER SEQUIST: And are these part of
9 the recommendations to CMS, or these are just
10 sort of broad-based recommendations?

11 CO-CHAIR PONCE: This is the road map.
12 This is part of the --

13 MEMBER SEQUIST: For CMS.

14 CO-CHAIR CHIN: And that's a great
15 question. I mean like --

16 MEMBER SEQUIST: Because I'm just
17 wondering like it's CMS has probably relatively
18 less levers for primary and preventive care than
19 for hospital care, let's say if we wanted to
20 focus on where it could have a lot of immediate
21 impact. Just because it already has more
22 programs in that space and --

1 CO-CHAIR CHIN: I mean why don't I
2 suggest, I mean like CMS commissioned a report,
3 but I think also this is a chance to have like
4 the road map that applies more generally to a lot
5 of the payers and what-not. Like if we add a
6 third bullet to the preventive part, I think that
7 language is in there because of like the social
8 determinants of health and wanted to like prevent
9 the hospitalization in an ACO. So that will
10 announce the idea of preventive, so you have the
11 preventive infrastructures.

12 So as opposed to everyone investing in
13 like the coronary care cardiology team, you have
14 some money up front for the team that keeps
15 people out of the hospital. So some of this is
16 going to be sort of a language/terminology issue.
17 But again, that could be useful in discussing
18 tomorrow.

19 DR. BURSTIN: Just as I look at this
20 and I look at this was a nice handout we're happy
21 to share from the meeting yesterday at the
22 National Academy of Medicine. One of the

1 elements they talk about beyond the payment and
2 adjustment, etcetera, is one element that
3 specifically says restructure payment incentive
4 design.

5 I think we talked about that a fair
6 amount, and I'm not sure that's captured in that
7 first bullet. So I wonder if we want to bring
8 something like that, because I think you're going
9 to need something to put a lot of those things
10 into. So this idea of payment incentive design
11 might be a way to frame it, to get at some of
12 those. I thought that was good language.

13 CO-CHAIR CHIN: Yeah. I mean that
14 bullet in some ways is part of one, part of three
15 and actually part of four, but maybe somehow
16 making it explicit in what we eventually come up
17 with.

18 DR. BURSTIN: Yep.

19 MEMBER HASNAIN-WYNIA: Yeah. I
20 thought that was about four, right, because NAM's
21 suggestion is about incentive payments for safety
22 net organizations, right. So I think it fits

1 there.

2 DR. BURSTIN: They will work their
3 magic.

4 MS. O'ROURKE: Yes. We got what we
5 wanted here, which is that this needs revision
6 too, and so we'll revise these and then add some
7 additional sub-bullets under these to flesh it
8 out. But we did want to -- since this is a part
9 of the road map we haven't checked in on, we
10 wanted to make sure of that before we went too
11 far.

12 CO-CHAIR CHIN: Okay. So maybe we'll
13 spend the first half an hour or so or what-not on
14 fleshing out in more detail. Romana.

15 MEMBER HASNAIN-WYNIA: I'm wondering
16 if we're going to -- if we're going to refine
17 bullet number one around payment design,
18 etcetera, where we might want to loop the last
19 bullet with that same kind of refinement. It
20 kind of then sandwiches.

21 CO-CHAIR CHIN: For example, what
22 would that mean in terms of -- like a wording

1 change or --

2 MEMBER HASNAIN-WYNIA: Yeah, a wording
3 change. So basically to -- in some way to, you
4 know, so the first is to incorporate, and I can't
5 remember the words you used, Helen. But I was
6 scanning back through and listening, and I liked
7 it. But to then -- so that's the incorporate
8 piece, and then the last bullet would be to
9 conduct and fund demonstration projects to test,
10 you know, what we're stating in number one, just
11 to anchor the two.

12 CO-CHAIR CHIN: So just like the five
13 equity domains, there was designed to be some
14 type of like logic holding this together, us
15 thinking through like whatever bullets we
16 eventually have here, that make sure that like
17 whether it's the order or how the word that hangs
18 in terms of overall conceptual hold. Okay. Bob,
19 did you have --

20 MEMBER RAUNER: I kind of want to add
21 to what Tom and David said about I don't think we
22 put enough time into the preventive care and

1 primary care, partly because if you look at all
2 the measures that were in that report, they're
3 almost all hospital-based or very narrowly
4 focused. But most of what the UDS, HRSA measures
5 and the MSSP measures, they're almost all
6 preventive and primary care measures.

7 They're also the same ones that if you
8 look at the impact on the population qualities,
9 those are the same ones and we have to -- and so
10 I think number four is I think that's why -- what
11 I would hope that we most see out of this next
12 report, is what specific things do we want to put
13 in for safety net organizations, to work on those
14 specific measures, that there should be some
15 incentives.

16 I think we should make some specific
17 recommendations to do something like add it to
18 MSSP or HRSA or something like that, that we -- I
19 think we need to make some explicit things to
20 incentivize those.

21 CO-CHAIR CHIN: Thanks, Bob. So we
22 have Lisa Cooper and then Romana.

1 MEMBER COOPER: So I'm just going to
2 echo what you just said, because that's exactly
3 what I was going to say. The outpatient metrics
4 and the preventive metrics are the ones that are
5 most sensitive to social determinants of health,
6 and the ones that are probably driving
7 disparities much more so than things that happen
8 once people are already in the hospital. So I'm
9 all for that.

10 CO-CHAIR CHIN: Okay. So I'm sure
11 that will come up again when we talk about it in
12 the morning, in terms of the overall modeling.
13 Romana.

14 MEMBER HASNAIN-WYNIA: So along the
15 same lines, Nancy made a very specific
16 recommendation around that. So Nancy, I'm going
17 to ask you to restate it, but I want to make sure
18 it got incorporated. I don't know if it did in
19 the recommendations.

20 MEMBER GARRETT: Are you talking about
21 the add-on payment?

22 MEMBER HASNAIN-WYNIA: Uh-huh.

1 MEMBER GARRETT: Yeah. So a specific
2 recommendation of having add-on payments for
3 outpatient services, not just the hospitals. So
4 the dish concept but in outpatient settings for
5 physician practices.

6 CO-CHAIR CHIN: Okay, and Michelle.

7 MEMBER CABRERA: I just want to know
8 on this preventive and primary care thing that --
9 part of what I've noticed and y'all can tell me
10 if this is right or wrong, but I've actually
11 heard a person, I think -- no, I don't want to
12 name names. He was from an organization that
13 promotes payment reform, and he said you know,
14 primary care, you know, it's not a really big
15 cost saver. We don't really invest in primary
16 care.

17 There's been a lot of focus in terms
18 of these payment reforms on the hospital,
19 inpatient, yadda yadda, because they think that's
20 where you can drive the, you know. So I do think
21 that as part of the big picture, it is important
22 for us to say no, let's pull some resources over

1 here because of that longer-term horizon being
2 that I think it was Christie was talking about
3 earlier.

4 There's not been a lot of play in that
5 space, and for that reason that they don't think
6 that there's ROI in the short term in this sort
7 of fervor to get these experiments done. So I do
8 think it's important for us to lift this up and
9 say put some resources into this. Let's play in
10 this space because, you know, the pre-diabetic of
11 today is potentially the diabetic amputee who's
12 now disabled of tomorrow so --

13 CO-CHAIR CHIN: Yeah. Thanks for
14 saying that. There's an extension of primary
15 care literature, Barbara Starfield et al., in
16 terms of like the value of primary care and
17 preventive care, and this is just what you said.
18 It's because the way the system is set up, it's
19 not a business case because of the way the
20 finance is set up. So that was the purpose of
21 that. Anyone on the phone?

22 (No response.)

1 CO-CHAIR CHIN: Thank you everyone for
2 remaining so engaged. It's almost like five
3 o'clock and people are still firing ahead with
4 great ideas, and so essentially I think that's
5 the whole purpose. The whole time of this
6 committee has been really great and everyone's
7 been really mission-driven and value-driven and
8 it's really been great working with everyone.

9 So people, please relax tonight and so
10 tomorrow, what will happen then we'll start off
11 with a discussion of like some of these bullets
12 we didn't go over in as much detail. We'll flesh
13 that out. Also then like the NQF team will be
14 presenting their magic in terms of like bringing
15 coherence to all the great ideas that people
16 brought today.

17 And then we'll try to do some in the
18 morning, some of this comment further in terms of
19 like the recommendations, for the policy
20 recommendations, balancing all these realistic
21 things in terms of prioritization, feasibility,
22 what's most important etcetera. Most of the

1 afternoon will be then looking at the trial
2 period course, and what we want to say about
3 that. You guys have other things to say?

4 CO-CHAIR PONCE: Just thank you and we
5 did send you the report on the trial period, and
6 are we able to share that (off mic), or have we
7 done that already?

8 (Off mic comment.)

9 CO-CHAIR PONCE: Okay, and we may be
10 sending some more materials that will develop
11 into good discussion tomorrow.

12 CO-CHAIR CHIN: Helen, anything you
13 want to say? Okay. So tomorrow breakfast again
14 at 8:30, and then the meeting itself will start
15 at 9:00? Yeah, okay, great.

16 MS. MURPHY: And for those who are
17 interested, we have a dinner reception at 5:30 at
18 P.J. Clarke's. So could we get a quick show of
19 hands to see who plans on attending, just so we
20 know?

21 (Show of hands.)

22 MS. MURPHY: P.J. Clarke's, oh sorry.

1 P.J. Clarke, for those who aren't familiar is
2 just one block over. It's -- we can kind of
3 caravan over there. It's just out the building
4 to the right, and then a right down K Street and
5 it's like right across the street.

6 It's a delight. Just Bob and Ninez?
7 We'll join you. No pressure, okay, all right.
8 So we have a group. Thank you all.

9 (Whereupon, the above-entitled matter
10 went off the record at 4:50 p.m.)
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A			
a.m 1:9 4:2 8:5 242:6	182:16 183:6,14	achievement 25:16	163:16 167:8 272:4
A1c 52:10 155:11	185:3,18 186:16,20	74:10,10 249:15	345:17 346:18
199:13 272:17 273:2	189:3,7,12,20 190:10	256:5	addendum 186:7
287:17 289:11 292:7	194:17 197:21 204:5	achieving 37:10 63:13	adding 23:15 208:20
292:12	204:12,17 207:2	63:19 109:10 250:5	214:9 402:2
AAMC 104:4	232:9,16 233:2 300:9	293:9 361:1 372:12	addition 107:9 135:14
ability 47:19 56:3	306:3,7 310:17	acknowledges 98:14	141:10 142:11 307:11
106:10 121:20 122:15	368:16	acknowledgment	307:12 348:6
159:2,22 208:9	accessibility 186:16	350:10	additional 15:10 56:1
222:13 249:8 376:7	accessible 116:1,1	ACO 6:10 44:11 45:8	92:8 107:22 136:5
able 4:21 40:22 42:5	157:14,19	177:16 214:22 260:15	144:20 197:15 256:20
55:2 86:11 92:19 95:9	accidentally 179:20	260:20 277:17 291:18	260:12 261:1 262:3
102:13 103:2,5,8,13	accommodate 60:20	292:17,19 294:7,8	362:4 396:14 400:22
109:22 114:3 153:11	accommodating 61:18	302:13 370:8,17,19	401:7 414:7
162:8 163:20 171:18	143:5	371:3 381:6,8 412:9	address 11:6 13:6,15
172:20 188:8 193:6	accommodations	ACO's 294:4	13:16 32:7 39:8 40:5
194:18 196:7,13,13	166:1,5,7 171:18	ACOs 152:21 270:7	40:7 69:11 76:16 85:4
200:2 201:15 217:20	accomplish 130:10,17	284:14 294:16 300:5	109:22 127:5 137:13
219:1,8 230:22	358:3	381:12	156:18 159:22 192:1
238:10 271:16 287:20	accomplished 4:8	acronym 317:20	194:16 196:13 198:1
309:20 323:18 335:4	account 143:11 240:4	act 56:3 166:16 168:1	224:10,12 231:1
341:14,15 386:19	accountability 52:19	264:8 351:11	234:20 235:1,3 237:6
421:6	53:13 64:4,7 75:3,21	Acting 8:12	238:15 252:5 279:13
above-entitled 191:9	77:7 82:9 83:5 107:21	action 227:22 228:2,15	282:6,21 285:9 293:7
329:6 422:9	110:9 112:3 114:19	280:8 317:13	296:9 316:20 326:3
absence 311:19	115:6 117:5,21	actionability 229:9	330:1 347:20 358:22
absences 367:22	131:15 176:13,15	actionable 40:16,19	360:18 365:16 366:9
absolute 162:10 268:5	178:20 190:20 207:12	41:3 43:18 44:3 201:3	366:19 367:9,16
288:3 290:5 348:8	222:10 223:3 227:16	326:8	addressed 14:2 32:1
absolutely 162:7	228:3,9 350:15	actions 105:7 117:7	57:4 192:3 202:8
173:16 258:7,13	379:22 380:1 385:12	171:19 177:13	296:11 299:2 360:7
297:1 333:4	accountable 36:11	active 38:16 121:20	360:13 361:6
abstract 71:19	53:22 111:9,15 132:6	216:22 217:14,19	addresses 44:8
abuse 331:6	133:2 145:13 176:1	278:17	addressing 20:12 38:10
ACA 101:5,18 150:18	176:11 177:14 179:3	actively 217:3	57:15 194:19 218:22
151:9,16 154:1	179:17 220:6 227:9	activities 12:3 132:1	222:14 228:20 230:4
256:18	255:20 292:19,20	171:5,9,10 192:1	239:5 285:7 295:6
academic 208:14	293:2,5 316:8 317:11	194:12 221:16 237:15	299:6 324:18 347:21
367:18	321:9 328:12	278:21 348:14 360:22	411:2
Academies 11:13	accounting 11:14	405:17 406:1	adequacy 145:12 180:6
161:13	111:18	activity 229:3 309:4	adequate 74:5 118:6
Academy 9:6,10 77:15	accreditation 236:13	321:19 322:2	137:7,13 278:8,13
232:5 241:13 305:2	237:12 270:16 272:4	actual 16:20 57:5 170:2	330:1 365:15
412:22	313:20	206:12 207:5 215:17	adequately 106:13
ACC 261:11	accrued 208:13	224:22 247:7 259:3	adhere 352:11
access 14:7 19:17	accuracy 270:11	267:17 389:21	adherence 100:15
25:13 26:16 44:2 50:5	accurately 41:9	adapt 22:12,21	adherent 100:16
61:10 70:5,9 76:14	ACGME 281:6 282:7	adapted 16:16 202:3	Adjourn 3:18
82:14 100:11 109:6	achieve 19:20 20:1 45:1	add 71:1 83:12 92:12	adjust 100:15 254:10
121:18 122:8,13,15	59:14 69:15 73:3 76:8	100:17 118:4,7,10,22	254:11 387:22 389:6
136:12 141:22 142:6	76:13 143:4 247:11	135:4 196:12 203:20	adjusted 125:1 247:13
142:19 143:20 147:1	288:11 289:8,22	203:22 281:16 304:13	247:13 258:6 266:20
147:20 148:10 153:2	290:12 321:11 324:2	325:14 371:8 374:16	273:20 386:15 387:18
153:5,12 170:8	324:13 375:21	409:20 410:10 412:5	adjusters 386:18 387:5
173:17,21 175:2	achieved 61:5 63:18	414:6 415:20 416:17	adjusting 46:11 87:15
176:9,22 177:8	71:17 123:13 289:12	add-on 305:5 417:21	87:16 247:5 254:13
179:13 180:1 182:9	289:15 290:13 361:8	418:2	386:12 394:12
	366:1	added 43:22 156:2	adjustment 9:13,19

10:18 28:18 29:21
 30:3,6 32:10,11 33:1
 67:20 68:18 82:18
 91:9 94:19 161:7
 247:6 249:4,7 252:2
 255:1 258:3 260:8
 267:3,18 362:20
 371:16 374:11 379:5
 384:20 387:14 389:19
 393:21 413:2
adjustment's 386:15
adjustments 265:3
ADL 171:21
ADLs 172:5,20
administered 402:10
admission 149:4
admit 36:20
admitted 43:8
adopt 59:10
adopted 18:20 60:15
adopting 60:2 189:15
adoption 59:22 61:2
adult 195:1
adults 192:10,11
 332:21
advance 62:6 78:15
 181:5 383:1
advancing 81:13
advantage 101:15
 106:4 201:11 239:17
 270:6 313:22 354:13
advantaged 268:8
 277:4 320:1
adverse 203:4,5
advise 22:13
advisory 211:9 212:22
 213:2,6,11,19,20
advocacy 115:16
 208:10 276:8 338:20
 364:16
advocacy/government
 115:16
advocate 293:4
advocates 274:22
 275:3 281:12
advocating 115:18
affect 332:17
affirmative 122:12
affirming 311:4
affluent 179:12
afford 153:7 204:16
Affordable 166:15
affront 101:1
afraid 366:17
African-American
 209:11 323:1,6
African-Americans
 196:15 286:11

after-thought 95:14
afternoon 10:16,18
 20:21 28:6 29:16 33:6
 33:12 38:17 174:5
 188:3 243:5 244:9
 252:4 255:2 333:9
 407:5 421:1
afternoon's 38:15
 187:15
age 124:20 397:8,16
agencies 85:5 215:10
 215:11 352:11
agency 260:21 352:7
agenda 33:11 46:21
 83:7 174:9 211:20
 245:7 253:3 329:13
 329:19 364:9 396:10
ages 150:5 274:17
aggregate 47:16 278:3
 278:6
aggressive 324:5
ago 4:7 43:22 80:21
 89:8,13 171:2 276:20
 282:9 285:15 301:1
 330:21 337:7 379:3
agree 55:10,14 73:19
 75:6 80:12 148:19
 164:14 179:21 228:14
 258:12 269:4 292:16
 294:3 295:11 298:10
 298:14 312:9 398:21
agreed 229:22
agreeing 163:1
agreement 242:13
 258:4
agrees 183:3
AHA 134:3 297:22
ahead 89:16 146:4
 156:10 191:14 229:18
 247:22 252:16 253:17
 263:7,8,19 298:13
 330:16 371:19 388:13
 392:2,7 420:3
AHIP 203:13
AHRQ 18:15 104:4
 168:21
aid 145:18
aiming 201:8 311:2
Aims 257:19,20
ain't 364:7
air 72:19
al 419:15
Alaska 8:6 242:6
Alberti 1:12 7:4,4 46:15
 81:18 103:22 114:15
 123:19 126:22 127:12
 144:20 156:11 208:3
 215:20 220:13 223:12

281:3 301:10 332:10
 334:3 367:8 384:16
 387:10 395:8 398:3
alcohol 331:6
alert 243:6
align 9:7 315:19
aligning 20:10 59:9
 251:4 257:15
alignment 257:16 328:8
 410:18
all-encompassing
 64:12
allocated 118:8
allocation 118:9 147:12
 227:21 370:10
allow 72:18 166:4
 248:12 349:6 366:8
allowed 158:1 318:4
allowing 108:5 109:18
 385:5
allows 71:12 75:17
 231:2 361:16
alluded 309:17
alongside 74:15 400:10
alternative 356:4
amazed 303:2
amazing 302:16
ambulatory 290:21
 291:19 292:5 293:11
 363:1
AMC 133:11 220:14
ameliorable 331:22
amen 362:11
amenities 148:4
American 1:12 2:2 7:5
 172:17 297:22 345:5
Americas 209:10
AMI 291:5
amount 55:20 107:13
 360:21 366:11,20
 413:6
amounts 107:17 108:20
amputations 286:13
amputee 419:11
ANA 235:7
analyses 386:15
analysis 116:19 139:8
 139:22 140:7 152:10
 223:20 308:16 335:5
 351:4 360:10 402:18
analyst 2:9,9 8:19,21
anchor 62:12 178:7
 215:22 415:11
Anchorage 232:3
and/or 23:19 115:5
 212:10 222:11 223:3
Anderson 2:8 8:16,17
 14:15 22:9 23:7

246:14 389:5
ANDREW 2:8
anecdotal 284:6
anecdote 345:10
anecdotes 341:19
angle 259:9
announce 412:10
annual 192:15 194:5
 212:2,10 292:7
anonymity 383:21
 384:4
answer 86:3 186:14
 223:11 255:9 283:6
 283:17 298:15 319:20
 324:7 357:4 358:11
 358:21 382:4 391:15
answers 283:1 379:16
Anthem 203:14
anxiety 37:2
anybody 163:12 363:7
anymore 162:19 291:14
anything's 93:17
anyway 251:5 281:20
 282:13 344:6,7
apart 313:21
APM 291:18
apologies 274:4
apologize 165:4 189:6
 190:11 287:5 372:3
apples 179:7 397:11,12
applicable 334:15
application 94:4 343:14
applied 18:21 19:2
 36:13 37:4 71:11
 254:20 258:18 259:14
 335:6 356:12
applies 49:22 309:19
 379:13 380:14 412:4
apply 47:21 138:15,16
 142:19 177:16 180:11
 247:19 258:20 347:16
 365:20 411:1
applying 48:3 88:21
appointment 178:3
 180:13,15 185:5
appointments 73:7
 178:16 182:7 189:21
 190:4,5
appreciate 304:6 310:9
appreciated 294:2
approach 30:14 31:4
 104:7 264:13 268:3
 299:20 317:10 326:1
 361:16 398:3
approached 354:6
approaches 59:11
 60:21
appropriate 164:16

179:17 186:21 187:5
187:12,13 249:5
262:17,18 267:19
298:18 323:13 342:12
361:3 379:5 406:9
appropriately 299:3
architecture 164:7
area 13:13,16 22:16,17
24:11 40:18 43:2 65:4
76:5 107:22 108:7
179:12 244:10 252:10
253:8 291:21 303:17
308:11 309:8 392:21
409:5
areas 11:7 13:7,15 14:3
18:7 28:9 50:6 64:10
65:2 70:4 83:15 89:2
133:22 152:12,13
192:6 232:8,22 233:4
233:7,11 234:7
236:18 237:8 238:6
238:21 239:7 245:10
271:21 316:12 357:15
360:11
argue 45:7
argued 68:1
argument 67:19 328:4
arguments 108:11,12
arms 126:5,6
Armstrong 294:15
arrangements 142:12
arrive 224:20
arrived 26:10 297:9
arrow 84:8,9
art 179:10,12 303:17
article 27:15 44:18
articulate 74:3 285:5
articulated 239:20
artificial 246:12
artificially 246:3
ASCDD 347:14,17
aside 170:5 200:7
asked 49:3 138:13
168:21 193:11 201:18
232:15 234:18 356:22
373:9
asking 33:16 84:3
127:20 168:7 283:14
283:17 284:4 317:9
335:21 353:17 409:1
ASPE 9:7 23:13 244:22
246:16 248:10 345:2
346:6 362:19 364:20
365:1 377:13
ASPE's 247:22 266:5
aspect 368:22
aspects 120:18
aspiration 323:11

aspirational 41:2
324:22
aspirations 46:18
assess 12:5 112:21
113:7,16,19 118:16
139:12,21 202:7
282:3
assessed 140:1 167:22
194:6
assessment 83:2 103:4
118:19 130:11,22
194:3 202:6,16 212:2
212:9,13 225:21
227:17 228:5 229:6,9
229:13 235:6,15
237:2 359:6,11 360:9
assessments 156:21
201:20 220:16
assignments 175:5
assist 103:3 252:11
assistance 72:20 234:3
237:1 249:19 377:15
assisting 20:13,14 36:8
67:14
associated 17:5,6
Association 1:12 2:3
7:5 215:3 297:22
assumed 380:8
assumes 180:17,18
assuming 66:11 133:10
370:9
assumption 104:20
410:22
Assurance 2:4
assure 102:11
asthma 152:12 201:6
286:13
astronomical 366:12
attach 350:17
attached 179:21 309:11
attained 105:16
attempt 33:13 198:20
attended 234:11
attending 421:19
attention 66:17 74:13
76:4 144:9 339:1
342:15 376:19
attribute 96:5
attributed 97:22
audience 90:19 138:14
138:22 223:3 337:1
auditing 201:1
August 264:4
authentic 214:9
author 232:19
authoritative 233:3,14
authority 223:10
autism 195:11

automatically 335:2
avail 105:1
availability 158:15
178:16
available 17:22 26:1
56:8 99:19 105:16
166:8 169:8 185:5
189:14 190:5 204:15
207:18 219:13 224:20
233:6 235:4 240:5
309:22 314:9 334:16
392:11 402:22
Avalere 2:5 6:16
avoid 47:11
avoidable 48:2 190:8,9
355:4
Award 208:6
aware 234:12 235:22
263:15 267:11 288:15
364:15 375:9
awareness 282:18
332:22
awesome 318:5

B

b 105:14 273:14 294:11
300:16,18 345:2,3
346:9 379:14 384:1
394:13
backbone 71:14
background 14:12
190:12 226:12 366:6
backgrounds 105:15
148:8
bad 109:4 169:6 181:16
311:13 384:22
bailiwick 92:11
bake 369:4 390:18
400:16
baked 169:22 364:17
391:19
Baker's 275:16
balance 46:16 51:11
53:8 55:11 66:10 83:3
93:15 94:10 113:20
343:17
balancing 58:20 404:14
405:1 420:20
Baldrige 308:6
ballpark 242:14
bang 370:13
bank 5:17
bar 342:17 365:17
372:10
Barbara 419:15
barely 87:22
barrel 303:6
barriers 17:5 44:2

202:8 218:22 359:21
base 42:1 64:15 74:12
117:19 344:2 348:9
based 18:11 21:17
41:13 46:20 59:1 64:9
91:13 123:21 144:7
157:1 178:7 179:7
208:11 235:5,10
240:14 264:16 265:3
269:18 284:12 289:18
320:12 322:22 323:16
324:3 335:7 338:2
345:14 347:2 348:4,7
358:5 359:14,17
360:1,22 370:21
376:12 379:11 385:1
391:18 394:13
baseline 323:9
basic 57:4 91:7 199:12
basically 33:13 134:14
148:21 159:17 177:12
182:15 184:13 188:11
207:1 243:21 244:18
247:2 261:15 266:21
271:9 278:2 279:6
315:22 316:11,13
328:20 364:8 376:6
407:3 415:3
basis 155:8 212:10
252:9 264:21 273:1
Bau 2:15 7:8,8 56:21
121:15 161:17 162:2
255:9,19 325:8
be-all 243:1
bear 124:10
beer 112:8
beginning 12:20 20:7
54:11 61:2 309:1
347:4 351:15
begs 336:8
behalf 237:11 341:10
behavior 338:14 340:1
behavior-challenged
397:9
behavioral 161:14
172:21 206:15,20
207:2 210:21 216:17
217:7 337:10
behaviors 167:21
beholden 221:7
behooves 56:4
belabor 47:8 112:16
belief 363:11
believe 58:10 60:16
63:12 120:4 121:8
168:18 230:11 235:9
238:9 239:16 251:22
337:2 351:11 390:7

believer 307:7	300:8 312:22 331:15	boat 302:6	Briefer 232:17
belong 113:8	347:12 354:7 360:12	boats 307:7,8	briefly 6:2 246:15
belt 111:2	366:1,12 385:7	Bob 6:9 23:9 26:19	298:12
belts 111:6	410:15,20 418:14,21	28:15 30:20 44:6	bring 45:9 46:4 50:9
benchmark 44:22	bigger 260:4 319:18	48:12 67:9 90:9 93:7	66:1,2 80:22 91:10
173:10 380:6	376:19	110:20 113:10 122:19	94:9,12 97:6 98:17
benchmarking 173:12	biggest 141:21 152:12	122:20 123:4 124:3	184:7 222:15 261:7
bend 349:9	155:3,9 244:2 253:22	128:16 130:5 141:18	263:11,16 277:4
beneficiaries 248:4,5	254:13 257:13 323:2	154:22 177:16 181:20	295:12 300:7 316:15
248:13,21 249:2,12	331:2 385:14	183:8,9 207:15	361:13 370:9,11
249:20 250:6 275:10	bill 183:1	208:21 225:16 253:17	406:4 413:7
352:5 377:20	bills 153:9	254:17 270:3 272:7	bringing 18:11 30:17
beneficiary 345:4	binary 59:19 114:20	272:10 274:2 299:22	39:9 44:10 45:6
benefit 73:9 85:8 86:7	184:4	301:8 309:17 330:15	231:22 254:9 311:9
101:14,16 136:15	binding 143:1	333:18 365:10 369:16	420:14
153:12 197:4 204:13	biomarkers 204:9	370:2,3 371:12 392:3	brings 19:6 153:11
221:12 224:4 225:13	birth 11:10	392:7,9 395:20	250:7 297:2,13
241:9 352:21	bit 9:11 14:16 16:17	415:18 416:21 422:6	broad 11:2 52:16 180:1
benefits 72:16 85:13	37:21 39:2 41:7 46:13	Bob's 36:2 42:20 57:21	214:8 240:4 259:22
100:11,18 101:6,10	96:20 104:13 106:15	67:8 78:10 91:13	309:15 399:15
101:13 102:8,9	112:4,22 113:11	185:21 387:21	broad-based 411:10
136:13 207:10 208:13	114:1,4,8 125:8 135:4	body 98:3 225:8 258:9	broadened 234:4
279:6 302:14,14	139:6 140:15 152:9	272:15 388:6	broader 38:6 50:18,18
352:2 356:21 358:9	171:20 180:22 182:1	bolted 371:9	76:5 79:10 310:4
Bernheim 1:13 7:15,16	184:8 196:12 202:13	bonus 334:5,6 335:1,6	320:22 346:19 347:17
33:20 35:14 66:7	206:13 212:5 215:21	335:13 345:16,17	broadly 16:17 22:20
185:14 205:9 263:6	241:22 244:22 245:1	346:4 348:4 361:5	236:21 239:12 269:8
263:10,20 310:8	247:16 250:11,12	368:7,20 369:10	269:10
371:18 373:22 380:16	260:4,5 261:6 272:12	370:18 371:5	broke 25:20
395:3 398:4	273:10 299:12 300:2	bonuses 334:21	broken 165:5
best 42:22 43:6 63:19	316:19,21,22 326:7	Boston 261:10	brought 44:13 45:10
175:19 235:10 309:21	328:6,8 329:12 338:1	bottom 133:8 303:6	66:15 215:21 254:8
351:1	339:2 343:10 354:2	410:4	263:22 300:3 420:16
Betancourt 119:18	362:12,15 363:14	bounce 290:19	buck 370:13
better 38:12 63:15 75:3	374:1 376:18 377:11	bounced 155:21	bucket 28:19,20 29:15
89:7 99:21 100:20	386:20 400:5 406:18	bouncing 155:18	29:16 34:21 48:10
143:14 236:9,10,12	408:9 409:17	box 67:20 274:8,9	158:19 368:16
248:7 249:7,11	bizarre 92:2	276:6	buckets 61:17 248:2,9
271:10 306:16 336:16	black 68:21 286:19	boxes 287:14	331:4,16 406:1
353:7 354:13,19	288:20,21 379:1	brain 72:9 163:13,14	budget 118:9 367:3
355:14 370:12 383:1	black- 290:7	165:6	budget- 351:13
between-institution	blame 258:10	brainstorming 41:10	budget-neutral 351:14
400:15	bleed 189:1 190:6	244:9 246:1 252:21	353:2
beverages 296:13	bleeds 190:10	253:1	build 12:16 28:12 30:21
beyond 81:7 84:10,14	blend 79:4 188:18,19	branches 203:7	31:5 36:2 68:3 94:13
84:20 88:18 136:6	189:16	brand 179:10,11	95:9 104:7 136:3
137:10 200:22 228:4	blends 189:11	breached 318:10	143:15 186:18 208:10
245:2 312:18 356:13	block 280:14 422:2	break 5:18 112:11,13	215:20 219:7,12
364:11 369:10 413:1	blood 78:8 199:16	173:19,22 191:3,6	240:6 313:10 322:15
bias 91:8 167:2 175:9	272:18 292:13 332:19	250:10 325:6,6	360:15
big 24:17 32:17 36:17	Blue 44:11,19 45:21	326:20,20 329:4	building 15:7,22 20:20
53:15 61:17 65:12	90:20	405:13	74:15 77:4 86:19 89:1
108:21 156:3 159:21	board 29:3 96:12,12	breakfast 421:13	136:13 221:12 225:13
183:15 203:5 205:11	133:14 143:16 144:15	breaking 247:16	288:7 292:1 422:3
205:17,18 244:10	146:10 211:10,15	breast 24:6 124:19	builds 353:12
248:2,8 251:10,12,13	213:2,6,8,11	125:11,21	built 13:2 94:16 142:22
253:20 254:3,8,15	boards 212:22 213:19	bricks 178:14	143:10 164:1 211:1
267:14 269:2 282:9	213:20	brief 10:20 14:21	358:7

bullet 279:13 281:1
311:15 329:20,22
330:7 347:21 369:20
408:2,3,5,9 409:3,15
411:4 412:6 413:7,14
414:17,19 415:8
bullets 79:13 245:18
253:4,13 315:16
329:17 368:6 396:8
396:21 400:20 409:16
415:15 420:11
bumping 384:22
bunch 163:21 288:5
344:14 346:22 353:3
381:9
bundle 63:15,17
bundled 330:6
burden 50:21 109:21
142:13 346:21 347:7
377:18 396:13 400:21
401:4,7,7 402:2,7,7,8
403:2,5,9 404:15
Burstin 2:8 8:8,9 30:10
40:9 93:17 98:21
119:13 120:3 140:4
143:13 160:18 168:17
287:4 389:16 391:14
393:4 394:2,4 412:19
413:18 414:2
Burwell 308:2,3
business 101:1,3 107:4
209:5 214:21 227:20
227:20 243:12 283:2
327:22,22 351:6
353:16 391:13 393:16
419:19
businesses 216:4
busy 65:18
buy 164:3,3
buy-in 37:15 41:20
57:12 96:2 340:3
396:12 400:20
buying 87:2

C

C 96:11 115:7 273:14
394:13
C- 146:9
C-SNP 354:7,14
C-SNPs 354:10
C-suite 213:8
Cabrera 1:15 6:13,13
36:1 47:7 86:19 109:2
134:10,19 135:2
166:22 167:6,13
168:9 169:18 178:9
180:17 181:17 209:21
218:2 257:12 279:18

283:13 286:9 326:21
348:18 364:10 378:9
388:5 418:7
CAHPS 167:1,12 193:5
193:21 202:21 239:1
239:4,4,16,17
calculate 403:4
calculated 264:20
402:21
calculation 265:8
calculus 331:20
California 1:15 6:14
120:17 178:4 256:22
257:1 283:13,21
286:11,20 364:18
call 5:20 27:10,20 28:3
49:14 83:22 100:7
112:21 122:15 207:14
256:13 263:3,4 280:8
299:5,5 307:5,17
321:18 398:13,16
called 26:13 119:16
158:19 160:14 317:19
364:17 385:19 386:5
calling 7:20 78:2
102:20 121:2 140:18
162:3 270:18,18
calls 5:2 221:2 225:5
camp 389:8
cancer 11:9 24:5,6
27:12 28:11 45:15
57:14 58:6 111:3,12
124:20 125:1,11,21
209:8 272:18 273:18
331:8,9 373:13,13
392:15
capability 71:15 176:18
230:15
capacities 171:22
capacity 59:1,10 97:19
171:10 181:14 208:9
208:10 237:20 240:6
324:4 367:22
capitated 275:7 330:6
capitation 158:8 275:8
276:1
Capitol 158:5
capture 106:13 148:22
149:5,5 151:7 152:17
193:1 196:1,7 197:14
198:12 200:9 212:1
216:13 217:20 234:20
236:17,21 239:7
240:9 382:11
captured 120:4 192:19
201:14 233:13 237:4
237:10 238:21 239:10
413:6

capturing 151:3 200:13
240:13
Cara 335:19,20,21
339:12 340:18
caravan 422:3
card 286:16 298:11
cardiology 412:13
cardiovascular 11:8
cards 344:14
care/patient-centered
234:8
careful 110:11 112:2
258:20 333:16 397:2
caregiver 34:15
cares 320:16
caring 43:7
Carrillo 1:15 6:22,22
31:9,12 43:16 70:22
89:5,12 119:17
128:21 145:10 203:2
226:19 279:3 315:15
318:14,21
carry 64:22 171:10
carrying 62:9
carryover 188:21
case 43:21 62:10 101:1
101:3,3 107:4 126:13
195:5 217:13 241:20
243:13 258:6 265:4
266:19 267:3 283:2
283:10 327:22,22
339:8 351:6 353:16
360:10 382:14 395:15
399:5 419:19
cases 121:9 137:16
147:1 247:19 380:2
catalogue 186:15
catalogued 238:21
categories 35:8 272:13
272:22 273:12 380:10
382:10 384:3,9
categorization 23:4
78:13
categorizing 77:18 78:2
category 33:21 77:12
77:14,22 78:14 184:6
258:15 269:19 273:3
383:20
caught 74:1
cause 108:21 308:16
causes 322:10 373:15
causing 108:14 398:8
caution 231:12 365:12
cautious 78:9 110:11
caveat 113:4 294:9
caveats 258:16
CBO 145:18
CBO's 318:22

CDC 202:12 209:2,15
center 1:14,20 6:7,18
6:19 7:1 107:11
145:17 157:16 196:7
209:11 380:5 384:22
centered 233:19 258:4
centeredness 192:8
197:1 222:9
centers 23:22 46:9
209:10 215:4 300:13
367:19
central 83:11,19 84:3
207:11 369:5
centrally 254:8
Centro 209:10
CEO 184:9 203:14
284:6
cerebral 126:1,6
certain 17:22 42:17
44:22 113:14 161:3,4
165:17 204:8 258:5
258:22 262:17,18,18
316:1,13 341:2
360:20 384:6
certainly 37:15 52:12
93:21 94:18 108:9
143:13 146:8,10
202:5 286:16 287:16
341:3 354:11 366:2
390:20
certification 161:18
cervical 24:6
cessation 309:3
cetera 90:5,5 145:19
178:16 324:16,16
328:9
CF 223:2
CFO 131:3
chair's 205:21
chaired 80:19
chairs 1:9 13:8
challenge 57:17 75:16
79:20 90:18 99:21
170:22 175:12 183:3
254:9 283:3,3,5
challenged 142:2 274:7
challenges 50:19
141:21 181:12,13,13
188:7
challenging 178:17
208:4 312:17 313:15
373:3
chance 9:8 10:2 38:17
46:19 232:4 244:19
263:4 311:1 364:8
412:3
change 37:13 49:22
51:13 84:8 99:11

110:2 133:20 138:9
146:19 147:11 149:12
170:10 219:14 241:22
259:13 260:14 297:7
298:5 327:14 339:9
340:4 348:21 349:3,3
415:1,3
changed 181:6,7,8
264:9 301:2
changes 278:9 301:6
309:3
changing 70:12
chaotic 274:11
characteristic 176:7
378:21
characteristics 118:18
125:2 177:7 247:5
316:13 381:10 383:5
383:9 398:17
charge 4:9 24:2 36:3
48:4 91:17 93:2
charged 38:5 118:5
charging 153:9
Charlie 275:16
chart 26:3,9 27:22
210:1
check 46:1,12 213:21
389:3 406:7
checkbox 130:15 131:4
226:9,15
checked 414:9
checking 139:6
checkmark 213:17
227:14
cheek 284:10
chicken 82:6
Chief 2:8 8:9
child 149:22 181:12
childhood 229:4
children 150:5
chime 228:12
CHNA 140:21 157:2
223:14 224:18 225:9
227:8 367:9
CHNAs 220:3 223:8,10
227:5,9 228:9
choice 59:7 106:10
124:3,8 125:6 126:19
179:9 319:16
choices 101:17 105:16
105:18,20 106:4
123:9
choose 21:17 56:6
62:21 63:1,11 106:11
180:11 366:16
chose 116:5 180:2
199:21 229:11
chosen 126:13

Christie 2:5 6:15 100:2
104:2 136:14 154:18
158:9 194:1 203:1,9
204:19 243:11 251:19
315:6 319:4 320:4
343:21 344:15 348:16
351:7 353:11 355:22
395:7 396:5,20 419:2
Christie's 104:11 107:3
343:21
Christine 148:17
chronic 11:9 172:4
199:8 325:20 354:7
354:12,19 397:11
409:9
churn 151:15 155:4
156:2 158:6
churning 34:7
circle 50:3 84:11 255:8
303:13 304:2 315:3
316:18 378:7
circles 305:20
circulated 44:1
circumstance 310:21
circumstances 105:4
cited 75:3
cites 365:19
city 181:2,9 296:1
City's 152:10
claim 175:18 289:1
claims 107:12 254:2
262:7 345:4
clarification 48:20 49:2
378:15 393:11
clarify 110:19
clarity 9:18 268:22
340:12
Clarke 422:1
Clarke's 421:18,22
classic 50:10 288:3
classify 217:3
clean 116:9 340:13
386:19
cleanly 244:17
clear 34:7 41:3 58:22
59:6 116:10 125:18
136:1 176:1 193:13
208:16 280:13 288:10
289:5 290:17 380:12
380:17 381:3 391:16
394:1
clearly 59:4 67:17
101:20 109:9 118:8
123:2 161:1 180:8
297:6,7 311:18 356:5
410:15
Climate 235:6,15 237:2
clinic 148:2 155:22

165:18 166:4 182:11
182:17 183:18,21
190:4 277:16 333:5
370:11 381:11 392:14
392:16 393:3
clinical 14:1 44:12
65:21 133:21 141:16
189:18 208:6 237:14
292:12 330:21 370:20
374:14
clinician 133:21 139:17
clinicians 230:12
235:17
clinics 44:11,14 45:4,18
46:5,8 48:13 52:3
155:18 181:9 215:4
300:3,19 370:9
392:20
close 36:13 45:5 68:15
102:12 231:19 266:16
273:3 322:21 323:15
324:6
closed 324:15
closer 206:9 236:6
clouding 273:10
CMMI 145:14
CMO 90:15
CMS 9:5 12:22 25:5
27:7 50:14 82:11 88:2
90:19 91:15 92:9,15
92:19 94:5,14 95:8
99:1 132:18,18
134:15,20 161:6
200:20 238:20 244:5
253:10,21 255:19
256:2,11,18 263:13
264:1,10,13 265:10
265:16 267:9,12
270:20 275:20,21
276:1 279:15 290:13
290:18 291:2,17,18
293:14 301:6 305:4
306:12 308:3 309:9
311:16 316:8 317:10
317:16,22 318:12
324:10,10 326:10
327:20 336:1,7 337:1
337:3,6 339:8,11,22
340:7 347:12 351:11
356:16 357:5,18,22
358:14 362:18,22
365:3 366:9 369:4
371:1 382:20 393:13
402:9 411:9,13,17
412:2
co- 1:9 211:21
co-led 211:15
co-located 206:20

co-location 216:19
217:10
co-payments 269:15,18
coach 193:15
code 192:21,21 195:10
273:9
coded 192:13
codified 220:9
codify 48:17
coding 221:2
cognizant 113:9
coherence 420:15
coherent 333:11 404:4
cohort 103:14
collaborating 318:7
361:21
collaboration 14:8
19:21 65:5 71:3 74:22
84:18 205:20 207:22
214:9 217:8 218:4,13
218:17 220:22 230:5
313:5,14 314:11
321:6 336:11,16
345:12
collaborations 14:4
25:15 26:11 39:11
55:3,5 313:12 314:5,7
316:4,4 322:15
368:13
collaborative 84:9
313:9 361:10
collapse 29:4
collapsed 116:7
collateral 358:9
colleagues 92:9 219:18
collect 97:19 149:10,18
162:9,20,20 164:16
164:18 166:3,11
171:3 280:9,12 353:5
collected 161:3,10
310:1
collecting 31:13 134:21
159:4 163:4,9 165:1,9
205:2
collection 149:20
158:20 170:21 205:5
223:18 236:18 248:11
271:10
collective 71:6,8,11,14
71:20 129:19
collectively 190:22
college 1:16 210:17
Colleges 1:13 7:5
colon 24:6 28:11
392:15
Colorado 235:8
colorectal 27:12 58:6
111:3,12 272:18

273:18 331:9
column 190:19
combination 43:3,9
 380:13 393:20
combinations 288:4
combined 290:3 398:3
combining 234:8
come 4:19 10:1 15:1
 21:8 33:13 47:20
 49:21 61:13 63:14
 73:14 74:14 81:9
 117:15,20 128:8
 148:15 166:6 173:22
 175:16 177:12 191:7
 203:6 207:4 227:7
 231:9 246:8 261:19
 262:11,14 266:20
 267:15 268:19 269:2
 280:20 285:6 294:16
 325:9 326:6,7,13
 329:4 342:18 372:15
 390:14 392:9 408:18
 409:18 413:16 417:11
comes 46:3 51:3 68:17
 127:8 253:20 326:2
 333:15 350:3 363:13
 374:21 384:10 385:11
comfortable 60:19
 188:20
coming 38:5 67:22
 76:22 209:17 243:15
 244:13 282:2 312:10
 318:1 329:3 349:1
commendation 8:5
comment 3:7,14 38:2,2
 48:9 51:18 54:9 57:21
 67:9 69:20 85:4 91:13
 96:17 102:19,19
 115:18 123:5,18
 133:7 141:2 144:21
 146:3 166:18 167:17
 168:12 170:20 174:7
 174:12,14 202:17
 221:22 226:20 242:3
 255:12 259:17 263:5
 264:5,5 267:7 278:12
 295:4 308:1 312:9
 315:12 326:20 345:1
 347:20 370:5,7
 382:17 384:14 399:10
 403:8,15 406:13
 420:18 421:8
commented 51:15
commenting 12:19
comments 51:17 53:20
 54:7 55:11 56:22
 58:19 74:8 81:4 90:11
 96:5 107:3 136:4

154:22 174:10,19
 188:18 196:18 204:20
 219:18 229:17 255:18
 288:6 293:19,22
 294:2 301:11 304:4
 307:1 321:22 325:3
 332:4 333:11 363:19
 371:14,21 372:7
 382:16 384:11 394:21
 396:9 403:12,17
commercial 88:6 90:15
 91:2 136:21 137:3
 147:5 154:2,10 185:4
 256:22 328:5
Commission 120:21
 270:16
commissioned 119:10
 412:2
commitment 91:20,22
 92:17 189:13 214:22
 227:19 230:17
committed 64:16
committee 1:3,7 2:4 4:6
 7:14 9:3,15 10:7 13:9
 13:18 16:14 19:8 22:7
 24:12 26:4,10 27:5
 28:7 30:22 32:9 33:8
 35:3 38:3 41:5,8,9
 49:3,20 51:8 52:1
 73:14 85:19 91:17
 92:1 93:5 94:7 97:16
 102:15 113:15 114:11
 119:5 134:17 140:15
 165:12 166:17 188:1
 205:19 231:18 232:14
 234:16 235:12 241:19
 244:1 247:12 250:10
 265:10 278:2 279:12
 305:17 311:17 317:21
 318:3 336:4 340:14
 343:2,9 344:6 351:10
 356:14 358:13 367:7
 374:8 377:5 382:4
 389:12 390:7,13
 393:12,16 420:6
Committee's 12:17
 15:13,14 33:12 42:3
 61:13 127:15 237:9
 244:4 375:11 410:7
committees 13:10 38:5
 93:4 268:20
common 83:15
commonality 233:15
 234:14
commons 314:18,21
communication 79:8
 217:7,14,19 234:2
 235:6,15 236:22

237:1 239:11,11,22
communication-sens...
 16:12 17:4
communications 34:16
 130:1
communities 36:15
 93:9 145:14 152:3
 210:14 219:12 222:12
 314:8 316:9 334:15
community's 334:12
community- 18:10
community-based
 318:6 333:4
community-wide
 228:17 229:1
comorbidities 196:10
companies 144:15,15
company 351:13
comparability 383:2
comparable 397:22
compare 153:21 376:9
 390:8
compared 73:10 154:11
 268:8,11 286:11
 320:1 376:12,16
 400:3
comparing 145:6
 147:16 179:6 268:12
 392:19
comparison 76:18
 387:17,18 397:12
comparisons 75:17
 375:1 382:22 386:22
 387:7 389:22 399:20
 400:13
compete 313:16
competence 22:20
 129:22 232:16 233:1
 234:2 235:1,10
 236:22 239:5,9,13,22
competency 89:15
 119:8 167:15 168:4
 169:8 202:22 232:10
competent 22:18 89:22
 304:19
competing 313:15
compile 98:9
complementary 69:11
 70:3,15
complete 4:21 11:20
 106:9 114:3 130:22
 149:16 270:11
completed 10:14
completely 211:20
 224:2 284:22 301:16
 367:11
completeness 270:11
complex 372:22

compliance 228:4
compliant 225:11 254:5
complicated 166:12
 251:16 266:18 267:16
 397:15
complications 293:10
component 44:3
 272:17 362:2
components 107:9
 230:6 233:4,13
composite 326:13
composition 388:3,21
comprehensive 12:14
 89:14 187:21 240:2
 242:19 255:21 346:13
 347:8 359:5,10
computer 394:22
concentration 378:1
concentric 50:3 84:11
concept 100:5 101:21
 180:1 185:17 198:1
 210:11 263:21,22
 265:9 288:9,14,16
 310:17 322:4 355:8
 375:11 398:21 400:1
 418:4
concepts 10:13 21:4
 49:10 68:12 71:20
 112:21 134:12 139:22
 140:2 145:13 191:22
 236:2 242:16 310:12
 381:3
conceptual 4:15 10:11
 12:1,8 13:2 24:18
 27:18 273:1 362:14
 404:20 415:18
concern 26:19 37:18
 54:21 80:4 240:12
 246:7 298:15 299:4
 402:7
concerned 34:8 37:3
 240:16 349:22
concerns 170:2 197:15
 203:7 241:4
concierge 147:5
conclusions 188:5
concordance 58:1
concrete 28:6 44:8 46:1
 71:5 82:16 98:13
 112:20 117:15 186:16
 187:1,8
concretized 71:18
concur 402:6
condition 11:7 13:7,13
 13:15,16 14:3 18:7
 80:14,15 331:21
 354:12,19
conditioner 72:19

conditions 11:8,12 12:6
191:19 199:8 237:16
275:4 397:11
conduct 228:17 415:9
conducted 13:5
conducting 20:16
250:19
cone 318:3,9
conference 1:8 127:10
301:12 303:2
confidence 60:7
confidentiality 318:4
399:1
confirm 35:4 169:2
confluent 316:12
confronting 171:20
confused 22:3
confusion 398:8
Congress 301:6
connect 32:12 102:7
219:2 298:6 302:7
connected 47:17 49:7
103:1 339:3,18 400:5
connecting 98:5,16
connection 33:3 101:20
115:13 145:16 258:7
285:2,4 313:8 339:20
362:7
connections 121:13
221:14 301:17 315:17
318:22
connectivity 85:17
156:16
connects 97:13 99:3
410:5
consensual 242:14
consensus 306:15,22
341:20
consequences 38:12
68:7,12,19 258:22
286:5 374:21 377:2
consider 32:4 52:15
55:13 77:3,17 78:1
102:16 141:14 231:4
241:15 260:1 369:21
377:13 394:11,12
consideration 43:19
77:5 248:18 249:3,6
249:13,17 250:4
298:22
considerations 248:9
considered 21:16 62:20
390:20
considering 35:19
169:15 249:13 250:4
327:9
consistent 142:10
398:7

consistently 240:18
consortium 208:7
constant 267:4
constantly 150:18
constituencies 233:10
275:2
constituents 71:16
275:21
constitute 59:2
constrain 246:2 350:1
constrained 95:11
constraints 143:1,6,6
143:12 246:5,12
constructed 357:15
constructive 306:5
constructs 214:8
361:20 363:10
consultant 2:15 7:9
consultation 103:3
195:7 217:9,11
consumer 167:9 170:5
276:8
consumers 167:1 276:2
contemplate 358:1
content 223:10
contentious 36:19
CONTENTS 3:1
context 11:19 22:6 26:9
46:12 86:13 213:5
227:16 264:11 267:2
311:20 321:8 324:19
362:1 374:19 399:11
399:18
contextual 23:12
contextualize 411:5
contingent 342:8
continue 10:15 12:13
21:3 23:6 67:13 92:16
95:11 99:1 106:22
146:2 159:18 173:14
222:17 307:5 322:19
continued 94:15 169:1
continuing 252:13
309:22
continuity 61:16 148:4
continuous 54:18
64:16 92:4 150:15,20
continuum 79:20 231:3
332:15
contract 97:5 157:18
353:16
contracted 252:9
326:11
contrasting 225:18
contribute 108:18
contribution 108:6
contributions 108:2
contributors 62:4 333:1

control 41:18 52:10
53:21 54:1 78:8 86:10
178:11 272:18 292:12
292:14 322:22 323:14
332:20,22 336:12
386:17 401:5
controlling 153:2
controversy 32:22
184:9
convened 211:18
convenience 177:18,19
conversation 47:2,9,12
57:10 58:13 62:15
73:19 78:15 80:18
81:20 83:7 86:20,21
87:10,14 88:12 91:11
100:4,5 104:11
109:13,15 114:11
121:16 138:9 141:5
144:21 170:10 173:22
175:3 184:20 222:15
229:21 230:10 258:3
259:2,6,21 261:7
279:21 280:1 281:12
286:19 298:8 303:17
304:6,8 307:11,12
320:13 327:4 368:4
374:22 388:11 406:2
conversations 28:5,12
36:20 37:22 87:19
92:15,21 104:3 162:7
222:13 335:20
convey 21:6
conveys 21:5
convinced 69:16,17
75:12
convincing 76:4
convoluted 114:16
Cooper 1:17 38:19 55:9
118:1,2 119:15,21
120:6 128:17 162:22
163:1 165:7 167:19
169:6 172:1,2 173:7
198:5,6 199:21 200:8
201:17 205:17 211:6
211:7 213:13 214:1
216:9 281:18,19
284:18 285:22 293:21
298:10,14 333:14
382:6 391:5,6 416:22
417:1
coordination 45:14
coordinators 46:4
Copeland 1:18 6:11,11
58:18 61:15 62:22
64:5 107:2 227:11
320:5,12 327:1
356:22 363:7,20

379:21 381:14 383:19
cord 275:19
core 1:14 56:11 59:6,13
60:1,17 62:13 63:14
76:3 94:15 95:15
113:17 140:21 149:22
193:8 240:20 394:8
Cornell 1:16 7:1
corner 29:2
coronary 412:13
correct 35:9,12 38:13
127:5 141:19 394:2
correctly 339:5
cost 45:6 163:17
203:11 204:5,12
205:1,3,6,6 233:22
346:1 349:9 350:1,13
350:14 351:4,5
354:15,16,17 355:14
356:3,6 357:12
365:21 366:4 368:2
418:15
cost- 205:7
cost-based 300:10
costing 107:13
costs 86:10 250:5
256:20 269:12,14
275:11 354:18 355:12
356:5
counseling 196:5 337:8
337:10
count 35:8
counterpoint 110:22
112:5
counterproductive
328:20,22
country 83:16,18 296:1
367:12 379:11
county 1:20 6:7 215:6
215:14 303:6
couple 21:10 35:1
48:19 56:22 96:5
119:19 131:17 151:11
156:13 175:15 183:16
202:5 208:16 229:17
229:20 235:5 251:17
282:8 301:1 310:15
312:11 337:11 363:15
371:21 372:6 391:2
course 11:19 13:3
15:22 130:8 182:6
277:3 404:9 421:2
cover 57:3 72:16,17,20
86:11 137:7
coverage 155:6,11,13
156:5,7 202:9 309:6
coverages 154:7
covered 204:14 231:20

257:1 342:1 396:7,8
403:20
CPC 270:6
CPE 1:18
CQIAs 237:14
crack 24:15
cracks 319:7
crafting 257:14
crappy 288:22
crazy 258:1 291:12
create 82:21 105:7,8
115:13 186:2 208:9
249:13 280:8 297:14
342:22 372:8
created 65:7 334:20
357:16
creates 115:9 147:1
creating 93:11 115:8
259:12 313:8
creative 183:19
credentialing 372:18
credit 58:3,8 122:6
163:8 370:19 371:3
crispness 140:5
criteria 22:12,13,22
39:19 40:13 81:12
94:13 162:15 333:20
358:6 359:21 391:16
criterion 151:21 365:21
critical 33:15 43:18
65:20 94:7 102:8
141:21 162:7 219:16
252:5 299:6 300:9
cross 210:6 273:3
cross- 25:14 95:12
cross-cultural 129:22
cross-cutting 95:3
394:6
Cross/Blue 44:11,20
45:21 90:20
crossing 38:9
CTSA 208:6
cul-de- 82:1
cull 404:1
culminate 12:3
cultural 22:20 60:9
65:15 75:10 89:15
111:16,19 114:12
119:8 129:21 167:15
168:4 169:7 202:22
207:7 232:9,16 233:1
234:2 235:1,9 236:21
239:5,13 299:1
culturally 22:17 89:21
211:1 304:18
culturally-tailored 18:9
culture 14:6 19:15
25:12 26:17 41:16,22

50:4 61:9,21 62:7
65:5,11,21 69:14,19
69:22 70:12 71:22
74:15 75:14,21 82:4
82:12,21 84:16 115:2
116:22 117:8 118:14
118:20 120:22 122:14
123:1 124:3 131:19
136:17 147:11 189:15
189:15 221:4 230:5
239:9,21 368:11
369:1
cure 203:16 204:8
Cures 264:8
curious 32:12
current 4:15 22:22
43:19 47:14 55:19
61:9,12 80:5,10 84:15
101:17 108:1 192:19
205:12,14 276:15,16
278:2 325:3 358:15
363:8 403:21 405:18
currently 27:22 254:14
curriculum 148:6
curve 89:16 349:9
cut 13:15 18:6 213:22
357:9 401:18
cuts 213:6
cutting 25:15 95:13
cycle 15:17 224:17
365:11
cynical 135:6
Cystic 204:6

D

D 273:15
D-SNP 200:21
D-SNPs 354:9
D.C 1:8
daily 171:5,10 278:20
Dallas 7:20
damn 280:10,12
danger 383:6,16
Darci 340:16 342:3
data 60:8,14 124:13
125:3 130:9 131:12
145:13 149:2,10,18
149:20 152:6,7 156:9
158:21 159:7,16
160:2 161:14 162:6,8
162:12,20,21 164:16
166:3,12 192:21
205:2 215:11 223:8
223:18,19,20 236:18
236:20 239:4 240:13
245:14 247:15 248:10
253:22 254:3 261:14
262:4,8 267:20

270:11,12 271:10
273:8,10 277:18
280:10,12 334:16
340:21,21,21,22,22
340:22 345:4 353:6,8
388:7,18 402:21
database 219:6,13
date 12:7 13:3 141:19
371:11
Dave 7:2 54:6 278:1,4
295:7,11 387:14
Dave's 32:8 295:1,4,7
David 2:1 51:15 55:11
73:5 137:15 175:2
178:1 181:19 187:19
251:18 272:8,17
274:3 276:10 279:1
282:15 292:16 365:10
380:16 381:20 415:21
David's 27:15 44:18
54:21 291:10 370:6
398:6
day 9:12 53:11 64:17
70:8 126:7,16 150:16
181:5 252:1,7 261:8
328:17
days 12:15 28:14
106:17 178:3
de 209:10
deadline 91:14
deal 112:2 181:10
226:22 268:3 354:21
dealing 399:21
dealt 126:15
death 203:17
debate 36:19 60:22
100:22
debated 375:5
decade 297:21
decide 308:16 324:5
325:1 372:17
decides 225:10
deciding 361:12
decile 268:11,12
deciles 268:15
decision 122:12 141:7
decision-makers 337:3
decision-making 17:11
34:16 192:12
decisions 197:8 204:1
337:4
deconstructed 316:6
decrease 377:1
decreased 67:3 106:3
decreasing 34:4 60:18
183:6
dedicated 92:7 302:2,3
dedication 8:6

deduct 313:19
deep 69:21 221:18
255:14
deeper 312:3 372:20
deeply 233:12
defense 181:1
defer 263:10
deficit 98:7
define 89:19 116:5
123:2 233:8
defined 49:10 60:7
113:1 122:22 151:20
206:17 223:4 233:4
369:14
defines 320:16,17
323:22
defining 299:13 307:18
definite 374:2
definitely 40:2 118:4,7
118:10 169:14 209:15
269:2
definition 299:14 306:5
306:6 339:17 368:4
384:13
definitions 153:22
232:22 233:19 305:18
306:11,15,20 310:11
387:15
degree 88:9 151:4,17
152:17 189:12 220:6
223:1,2 331:22
delay 195:11 232:12
delayed 164:8,9,10
delete 410:10
deliberations 241:15
delight 422:6
deliver 59:9
delivered 183:17,21
delivery 20:17 59:3
65:3 156:17 317:19
demands 327:6
demo 251:5,6 342:10
343:6,7 351:17 411:6
demographic 28:18
118:17 380:11 384:3
384:7
demographics 316:1
385:2
demonstrate 227:19
237:21 271:17 290:13
303:19 334:22 335:5
359:5 372:12 373:2
demonstrated 39:5
359:13
demonstration 20:16
63:13 250:19 274:16
302:11,12 368:21,22
415:9

demonstrations 249:22
demos 342:12 345:10
 411:7
Dennis 275:18
denominator 151:5,6
 156:4 193:17 195:3,9
 206:21
denominators 114:21
 150:14 237:22
Denver 1:21 7:7 96:8,13
 97:6,7 170:20 295:13
 295:15 296:1,4,5,7,8
 297:20
department 9:6 90:16
 224:5 252:11
departments 218:6
depend 235:13 395:10
dependent 72:22 294:7
 387:1
depending 79:21 85:6,7
 204:9 363:2 400:7
depends 160:21 212:19
 323:21 356:3 396:2
deployment 361:4
depth 220:21
Derek 93:19
derived 105:3
describe 128:13 139:1
 224:10 359:22
described 13:18 86:5
 306:2
describing 4:13
description 113:2
descriptions 73:21
deserves 319:17
design 204:13 247:8
 256:3 269:13 325:18
 328:18 413:4,10
 414:17
designated 164:18
designed 42:17 79:11
 187:20 242:22 243:1
 274:15 278:7 350:17
 358:2 410:17 415:13
desirable 348:14
desire 74:16
desires 123:15
despite 222:5 303:8,18
detail 14:19 139:1
 226:22 250:16 409:13
 414:14 420:12
detailed 5:4 14:11
 140:15 404:19
details 229:8 265:7
 356:13
determinant 80:2
 359:15 362:7
determinant- 77:18

79:16
determinant-depend...
 17:12 77:20
determinant-sensitive
 79:19 83:21
determinants 20:12
 86:16 91:9 137:14
 156:18 161:9 196:1
 219:1 228:20 251:11
 314:17 316:21 330:2
 332:7 347:22 358:22
 359:3 361:7 365:16
 366:10 367:16 412:8
 417:5
determine 74:4 249:4
 391:18
determined 360:18
determining 316:11
Detroit 7:3 137:15
 181:3
devastating 158:9
develop 12:1 74:21
 120:1 224:16 241:2
 248:11 293:5 334:5
 421:10
developed 15:2 27:5
 36:12 39:19 119:10
 157:1 202:1 231:5
 235:7,9 238:8 239:5
 240:9 241:6 346:15
 391:10
developer 36:20 142:21
 373:4
developers 390:18,21
 391:22
developing 3:6 18:12
 98:12 104:5 106:21
 114:13 117:5 152:22
 163:15 216:10 242:1
 249:21 259:10,11,11
 289:6
development 4:16 12:4
 15:17 113:5 114:22
 152:21 169:16 226:10
 393:14,17,19
developmental 195:11
devil's 293:4
devote 33:6 338:9
DHHS 209:15
diabetes 11:9 52:7
 152:13 199:15 201:6
 217:4 229:3
diabetic 286:12 419:11
diabetics 78:8 292:7
diagnosis 216:22
dialogue 99:12
dictate 223:10,13
died 308:13

Diego 215:6 219:4
differ 72:12 148:5 185:6
 363:2
difference 55:6 69:8
 110:5 213:9 266:11
 375:19 383:8 399:14
differences 44:19
 105:22 106:2 123:12
 123:14,21 124:1
 148:10 249:8 308:17
 368:17 373:13,16
 376:3 386:21 399:2
differential 147:1
differentiate 16:4 67:13
 68:4 249:8
differentiation 69:4
 190:17 374:7
differently 110:2 138:4
 148:8 273:21 324:8
difficult 40:20 142:7
 268:7 312:17
difficulty 283:4 383:17
dig 69:21
dimensions 144:8
dinner 421:17
direct 156:22 216:5
 247:6 260:8
directed 234:22
direction 23:14
directions 52:15 89:2
directive 88:2
directly 34:18 54:1
 117:2 205:7 265:2
 276:2
director 2:11 8:15
 226:4
directors 146:10
disabilities 124:16,21
 125:4,10,16,20
 157:17 165:22 171:17
 172:8 275:17 397:17
disability 11:18 124:20
 127:9 157:16 165:8
 165:14 166:11,16
 171:8 172:18,22
 173:1 195:10 274:20
 274:21 310:5
disabled 397:8 419:12
disadvantage 106:1
 127:3
disadvantaged 124:7
 268:8 306:4
disadvantages 123:22
disadvantaging 73:8
disagree 210:9
disagreeing 408:22
 410:1
discernment 306:1

discipline 66:2
disclosure 388:18
discovery 117:14,14
 207:17
discrete 188:22 189:1
 245:10 283:20
discretion 17:7
discriminated 170:7
discrimination 31:20
 167:2,3,21 239:8
discriminatory 171:19
discuss 10:18 23:5
 246:20 366:13
discussed 13:20 271:5
 284:1 296:21 409:14
discussing 14:19 29:10
 237:9 412:17
discussion 10:4,16
 21:11,13,20 22:10
 28:17 30:4 33:15
 38:15 42:13 71:1 72:7
 76:7 77:1 90:13 112:7
 140:19 145:11 187:15
 188:3 190:16 191:14
 192:12 244:3 245:5
 250:21 251:1,22
 287:3,9 295:1 299:9
 299:21 308:7 313:11
 315:16 325:4,16
 326:7 329:5,11,17
 330:10 331:18 332:2
 343:17 371:15 396:17
 420:11 421:11
discussions 17:16
 31:14 51:22 95:15
 188:13 284:12 301:4
 332:16 402:17
disease 11:9,10 28:9
 172:4,14 196:3
 409:10
disease-free 125:12
dish 418:4
disincentive 300:12
disorders 275:11
disparate 277:1 303:15
disparities-focused
 286:19
disparity 16:20 17:1
 39:5 40:1,4 52:8,10
 52:22 110:5 128:9
 152:17 199:9 277:2,5
 285:17,19,20 289:18
 290:7,8,11 291:11
 294:6 299:11 319:10
 323:2 332:21 345:19
 348:21 362:9 368:15
 375:22 385:3,6,10,15
 388:1

disparity- 16:12 23:3
30:13 31:1 83:21
331:18
disparity-sensitive
16:9 22:3 31:17 52:17
77:22 78:18,21 79:13
199:6
disposal 188:9
disproportionate 60:12
305:6
disproportionately
142:2 178:12 248:21
disrespecting 59:13
disseminated 99:7
225:7
distance 37:6
distant 266:17
distilling 31:14
distinct 393:1
distinction 51:20,21
52:21 210:15 392:13
distinctly 176:6
distinguish 379:19
distracted 212:5
distributed 137:2
304:11
dive 5:15 221:18 312:3
diverse 42:18 90:3
133:18 171:17 304:19
diversity 59:1 63:9
71:15 133:8,15 134:5
144:14 146:8,9,12
232:9 361:17
divide 379:11
divided 362:22
dividing 290:18
doable 162:17
doc 224:18
docs 142:4 337:9
doctor 150:4 217:6,7
doctors 111:14
document 39:15 103:17
131:12 192:22 227:21
277:11
documentation 195:15
documented 40:1
104:17 192:12 194:2
196:5
documents 229:11
307:19
DOI 6:3
doing 24:15 27:7 44:20
47:18 55:21 56:9
60:21 65:19 68:2 69:2
80:20 84:5 87:13
97:20 98:15 99:4
102:3,4,22 103:4,11
109:7 121:4,12 131:1

131:21 139:13 152:11
154:19 169:4 176:17
176:18,18,19 181:20
184:5,17 194:12
200:21 205:1 230:15
241:18 252:9 267:6
275:22 281:15 282:3
283:9,9,11,18,22
284:13,14,19 285:8,9
285:18 286:16 297:6
297:19 298:4 302:15
303:13 304:9 308:16
313:1 316:6 317:11
322:2 323:7 328:9
337:9 345:7 347:13
347:16 350:13 353:3
353:6 358:16,17
359:6 365:3 367:19
376:1 379:6 383:3
386:1,3 387:4 391:12
395:9 399:17 405:10
dollar 107:17 108:20
203:15
dollars 86:9 107:13
151:12 203:22 214:17
214:19 226:14 309:11
339:7,8 362:4
domain 13:14,22 14:4,9
28:1 34:5,9,11,13
35:18 53:17 56:6 70:5
71:22 81:12 89:17
113:18 114:4,5,12,14
118:12 119:1 129:1
132:11,13 136:19
143:20 168:5,15
173:18 191:17 198:7
199:7 205:18 206:3
208:4 210:5 404:20
domains 4:16 13:18
14:5,17 19:8,14 20:2
21:11,15 24:18 25:10
25:12 26:9 27:4 29:4
35:17 41:11 42:9,21
47:10 48:22 49:4,4,17
49:20 53:16 61:9,13
61:19,20 63:3,5 64:1
69:9 70:19 71:21
73:20 81:10,21,22
82:14,20 84:9 103:8
112:19 113:7 116:8,9
117:13 119:7 120:1
130:2,7 134:15 136:6
142:19 148:14 156:13
162:5 172:3,5 188:22
210:3,7 230:1,3
234:14,18 239:1,8
242:13,21 248:15
334:20 345:13 368:9

368:10 401:8,10
407:7,7 415:13
domino 298:3
Donabedian 50:11
157:11
door 161:20,20
dot 210:6,6
dots 98:6,16 102:7
298:7
doubt 257:7 340:18
downsides 53:7 390:20
downstream 121:13
dozens 182:4
Dr 8:8,16 14:15 22:9
23:7 30:10 40:9 93:17
98:21 119:13 120:3
140:4 143:13 160:18
168:17 246:14 287:4
327:1 389:5,16
391:14 393:4 394:2,4
412:19 413:18 414:2
draft 12:18 21:3
dramatic 255:16
draw 339:19
drawn 155:11 270:14
Drew 8:16 14:13 21:22
22:2 139:5 244:11
246:13 389:3 403:22
405:8
Drew's 244:21
drill 253:13
drilled 251:8
drilling 139:14
drive 109:12,14 289:3
293:6 327:14 357:19
418:20
driven 211:21 329:1
360:6
driver 170:9 205:4
362:7
drives 338:13 339:9
340:22
driving 37:6 278:17
364:14 417:6
drop 257:16
drop-in 181:6
dropping 122:3 150:19
DrPH 2:3
drug 203:15,20 354:21
355:12
drugs 203:11,11 204:3
204:5,7 269:14
dry 106:2
DSRIP 317:20
dual 100:19 216:22
397:7,10
dual-eligible 264:18,22
266:3,6,12,22 267:1

dually 274:17 275:7
duals 100:15 397:6,16
ducking 274:5
due 106:4 124:2
duty 45:8
dynamic 50:12

E

ear 380:22
earlier 36:2 116:20
121:16 129:20 136:14
184:8 188:16,17
189:3 279:20 299:12
301:22 313:11 333:19
350:5 357:1 362:12
369:6 370:7 374:3,5
374:20 390:11 398:5
398:5,10,22 399:10
402:17 406:17 419:3
early 124:19 125:11,21
390:4
earned 191:6
ease 197:1,5
eases 142:13
easier 52:4,5 193:1
353:9 373:5
easily 118:22 122:17
160:13 200:4 202:2
east 111:4
easy 187:3 196:20
197:1 198:12 213:17
213:21 221:18
echo 26:19 58:19 66:9
69:6 146:6 155:2
204:22 205:10 417:2
economic 107:8,17
108:4,14 374:16
economically 182:15
economics 100:8
107:10 185:1
edit 406:20
edition 302:2 351:2
edits 15:10
EDS 23:21
Eduardo 2:2 7:20 134:8
140:16 142:17 181:21
185:12 188:15 190:14
219:20 221:21 307:4
307:21 332:12 333:6
educating 181:18 302:6
education 18:8 71:10
85:15 102:1,4 149:11
209:5 319:19 385:7
effect 4:14 255:17
298:3 357:4
effective 4:21 13:6 14:2
18:3 19:12 194:14
195:19 246:4,9 346:1

351:5 365:19 373:11
373:17
effectively 329:20
332:5
effectiveness 365:21
401:11
effects 27:16 345:6
effectuate 135:13
efficient 245:6
efficiently 401:14
effort 94:15 314:22
efforts 12:5 38:8 115:13
156:16 216:5 244:22
285:6 301:16 322:21
egg 82:6
EHR 159:20 160:11
223:20 254:2,7
EHRs 254:5
eight 9:14 45:4 126:16
287:18
either 23:20 24:10
36:13 57:11 137:22
153:5 169:5 195:6
212:8 213:19 227:19
258:18 319:2 341:18
347:16 351:16 366:14
371:9 386:1 403:12
EI 209:10
elaborate 49:11
elective 186:19
electronic 159:8 192:19
195:15 197:13,19,22
elegant 385:20
element 413:2
elementary 91:1
elements 61:21 189:1
413:1
elevated 58:1
elevator 5:17
eligibility 100:19
eligible 237:19 238:1
274:17,20 358:6
359:2
eligibles 266:13
eliminate 228:7 321:19
360:2 366:19 374:10
376:22
eliminated 26:2 366:11
eliminating 68:14
elimination 288:13
Elisa 2:10 8:11 91:21
138:20
email 306:21 319:2
346:8 394:21
emails 225:5
embedded 128:3
embrace 135:7
emerge 94:21

emergency 190:7
emerging 357:22
Emilio 1:15 6:22 31:10
31:11 40:6 43:15 48:9
56:19 58:16 66:5
70:21 72:2 80:18 85:2
89:3,9 90:9 119:6
122:20 128:16,20
144:19 145:9 170:16
202:22 203:8 225:16
226:18 255:5,6,6,8
272:8 274:3 276:10
279:2,2 315:3,14
316:17 319:1
Emilio's 42:11 78:22
80:3
emphasis 328:11
emphasized 339:13
emphasizing 310:10
empirical 261:15
employ 212:10
employee 269:19
employer 284:3
employers 269:17
employing 18:2
employment 216:6
empty 108:16
enact 264:11
encapsulate 15:12
encounter 192:21
encourage 59:22 108:3
108:19 168:10 205:5
313:13 314:4 388:9
388:12
encouraging 210:22
end-all 243:1
ended 28:21 208:20
264:6 337:12 345:18
345:18 399:21
endlessly 266:4
endorse 212:11 390:1
endorsed 120:4 161:13
endorsement 94:17
394:9
Endowment 120:17
ends 70:7 160:13
304:12 388:22
energy 246:1 358:18
engage 87:4 222:13,21
229:1 259:2 276:7
engaged 127:17 132:4
133:1 226:6 420:2
engagement 207:22
218:11
English 182:22 379:13
enhance 48:8 248:10
358:14
enhanced 48:11

enhancement 138:3
260:19 261:1 358:19
enhancements 138:1
260:13 262:3
enormous 317:16
enrolled 149:15 151:19
152:18
enrollment 149:6
150:15,20 151:21
ensure 18:2 186:10
329:22 396:14 400:22
ensures 170:16
ensuring 90:4 357:18
enter 356:7
entered 242:18
entire 57:3
entirely 378:17 379:6
379:14
entities 213:2 221:6
270:18 276:17 313:14
400:2
entity 176:2,11,16
177:14 179:17 217:14
277:18 334:12 378:22
380:6 388:17
environment 108:9
116:1 155:10
environmental 11:21
13:1,5
envision 334:14
envisioned 231:10
Epic 163:14,14 164:8
165:5 166:1 171:1,2
EpiPen 204:3
EPSDT 352:1
equal 70:9,9 99:17
105:1,8 109:5 136:12
186:20 306:7 310:22
311:12
equality 106:9 109:13
306:14
equalize 387:6
equally 311:12
equation 387:20
equitable 14:7,8 19:17
19:19 25:13,14 34:21
51:9,10 76:13,14
77:11 105:13 145:4
347:5 393:8
equities 105:22 115:20
306:14 366:10
equivalent 305:7
ER 190:9
Erin 2:11 8:15 48:20
106:22 112:9 244:11
403:22 405:8
errors 203:4
especially 127:8 135:5

260:15 262:1 314:4
331:17
essential 59:14 136:15
340:4
essentially 22:15 38:10
43:4 54:12 63:14
131:13 148:1 155:6
226:16 247:19 248:2
252:3 266:5 340:4
347:2 348:2 364:6
385:13 420:4
essentials 401:4
establish 69:14
establishing 70:12
estimates 151:17 152:2
et 90:5,5 145:19 178:16
324:16,16 328:9
419:15
etcetera 71:17 82:5,5
116:4 228:21 253:7
286:14 296:17 358:7
413:2 414:18 420:22
ether 9:18
ethical 45:8,8
ethnic 87:17 199:17
209:9 310:4 380:10
ethnicity 11:16 132:22
149:11 161:2 196:10
254:6
ethnicity-specific 209:8
evaluate 208:7
evaluation 1:14 10:19
103:4 224:16 252:12
Evan's 29:10
event 14:14 104:14
events 203:5 238:1
349:13
eventually 265:19
413:16 415:16
everybody 8:9 46:2
51:20 59:7 110:6,15
123:10 124:15 182:6
183:3 252:22 286:12
306:7 313:7 319:16
322:18 323:4,12
324:11,13,18 361:18
everybody's 123:1
159:12
everyone's 84:3 219:8
288:22 289:13 420:6
Everything's 401:20
evidence 17:19,21
39:13,21 40:18 42:1
43:3 46:17 54:16
64:15 74:12 117:17
117:19 118:8 141:8
272:20 273:1,14,21
336:5,6,9,13 337:9,15

337:17 338:2 339:13
 339:13,14,15,15,15
 340:2,19 341:1,18
 342:13 343:6 344:2
 354:10 358:7 372:7
 372:10,22 373:15
evidence-based 40:3
 41:12 269:13 338:17
 339:14 340:5 349:16
 387:3
evidentiary 336:20
 337:5
evolution 405:4,6
evolved 65:4 220:7
evolves 220:7
exact 153:22 192:18
exactly 38:10 200:13
 264:9 265:7 294:13
 417:2
exam 157:20 165:17,20
examination 393:7
examine 250:5
examined 249:4
Examiner 308:6
example 9:9 24:6,17
 27:8,10,12 28:12
 41:11,15 42:7,11 44:8
 44:9 46:1 52:7 62:6
 71:4,6 72:1,15 78:10
 89:20,21 93:7 94:5
 99:10 100:13 101:5
 118:14 124:11 125:22
 127:1,10 129:12
 138:14 140:7 143:1
 145:17 146:13 147:2
 148:2 150:2 177:15
 182:1 189:2,4 199:20
 199:22 204:2 206:12
 209:4 226:6 242:15
 256:22 257:6 260:6
 262:20 263:2 268:1,2
 268:16 269:11 274:8
 275:6 276:5 288:1
 295:13 299:17 300:20
 301:22 312:3 322:21
 336:10 348:11 349:1
 350:20 356:4 370:15
 387:8 393:3 404:15
 414:21
examples 17:10 18:10
 18:17 27:17,21 28:6
 34:2 35:1 111:1
 121:11 134:14 175:17
 175:20 187:20 209:1
 243:2 247:18 297:15
 318:12 341:4 349:15
 364:11 365:3,8,10
exchange 122:10,11

151:9 152:5,7 257:4
exclude 46:5 124:15
excluding 46:8
exclusively 40:20
excuse 162:19
excuses 162:11
executive 97:1 133:14
 134:1,5 226:8 275:15
exemption 279:7
exercise 27:4 113:11
 114:1 117:11,13
 148:20 180:10 190:22
 207:17 208:1 222:22
 242:18 343:12
exhausted 402:12
exist 36:9 39:15 151:4
 220:2 272:3 281:7
 291:13 357:21
existed 235:3
existence 211:9
existing 46:17 48:22
 49:15,16 50:14
 193:20 196:11 197:11
 228:18 233:5 238:22
 239:14 240:1,8,21
 244:22 245:12 248:15
 249:17 250:17 253:6
 253:10 254:18,19
 260:2 270:19 279:15
 281:2 290:18 305:4
 311:16 316:3 326:10
exists 39:5 152:18
 222:10 253:1
expand 102:19 122:13
 143:2 201:15
expanded 18:20 368:8
expanding 121:20
 122:7 312:20
expansion 136:11
 138:18 145:3 402:22
expect 74:17 127:4
 224:10 324:13 352:11
expectation 95:4
 104:15 106:8 224:21
 362:4
expectations 236:16
 270:10 272:3 281:7
 281:14 312:20
expected 85:20
expecting 34:1 123:20
expensive 86:8 204:10
 354:22 355:13
experience 35:7 54:12
 54:19 66:13 72:11
 74:2 86:15 122:8
 127:9 167:2,7 189:5,6
 210:20 230:7 284:20
 401:11

experiences 34:15
 41:14 238:18 240:9
 240:14
experiencing 222:12
 348:21
experiment 110:10
experimentation 349:7
 349:11
experimenting 349:18
experiments 419:7
expert 43:3,10 94:11
 365:6 382:7
expertise 103:12
 225:10
experts 220:20 223:16
explain 91:7 124:16
 267:22
explaining 327:2
explicit 32:13 256:2,15
 257:2 258:16 285:7
 285:13 286:4 289:21
 295:6,8,12 297:11
 298:16,18 301:12,20
 302:7,15 321:22
 327:1 413:16 416:19
explicitly 115:4 156:18
 285:9,17 307:5,18
 325:17 326:3 379:4
 408:8
explore 86:22 141:1
 223:5 327:21
expressed 146:7 297:3
extend 84:10,19
extended 269:17
extending 84:14
extension 110:6 419:14
extensive 342:16
extent 72:15,16,18,19
 72:21 73:7 183:13,18
 200:10 211:14
external 76:12 95:1,7
external- 93:12
externally 218:19
extra 183:1 352:4 353:7
 367:20 370:21 371:3
extract 297:15 391:17
extraordinary 276:5
extrapolate 42:16
extreme 64:3 204:2
 272:15
eyes 289:13,14

F

F 192:21
FAAFP 2:1,2
face 218:22
faced 80:10
facilitate 103:10 115:2

FACP 1:11,17
FACS 1:18
fact 38:7 40:19 67:19
 69:17 150:14 181:11
 258:21 292:18 297:6
 303:8,18 344:20
 353:20 375:3 393:7
factor 9:19 28:18 29:20
 30:3,6 149:9 160:22
 161:7 163:10,16
 185:19 194:3,3
 197:11 201:19 252:2
 254:22 261:16,18
 266:3,5 267:18
 282:17 310:22 362:20
 374:17
factors 9:13 11:12,14
 11:15,16 15:5 16:22
 34:17 86:16 141:11
 143:19 149:21 150:9
 152:14 158:22 160:17
 162:13 163:3 170:22
 171:4 185:20 192:3
 194:1,13 246:22
 247:14,21 249:5,12
 250:6 252:14 254:10
 255:4 260:8 261:2
 271:11 306:5 311:10
 311:11 316:6 346:18
 359:16 374:14 404:14
facts 303:21
faculty 116:4 118:16
 133:10,18 147:9
 148:3
fail 350:11
failing 52:22
fair 75:17 80:7 150:14
 248:6 249:2 375:1
 388:19 413:5
fairly 24:16,21 93:1
 179:8 200:4 226:2
 365:17
faith 209:5 300:6
faith-based 208:11
fall 43:14 51:11
fallen 319:7
falling 151:2 275:8
falls 362:8
familiar 11:4 60:8
 246:18 248:1 422:1
family 34:14 224:5
family-centeredness
 198:9 199:4
famous 238:12
far 16:3 17:15 38:7
 41:21 139:13 176:11
 222:16 246:21 283:17
 332:17 347:11,15

404:10 414:11
farther 54:3
farthest 111:10
fascinated 295:14
fascinating 98:18
 295:10 299:8
fashion 302:7 360:8
fast 251:3
faster 67:1 177:10
 261:6
fatalistic 111:20
favorite 261:8
fear 328:18 384:18
 385:4,14,18
feasibility 192:18 403:9
 404:16 420:21
feasible 266:6 342:6
feature 381:13
federal 46:7 94:6
 122:11 164:2 173:10
 257:7 279:4 351:22
 352:4,10 367:3
federally 23:22 115:19
fee 85:9 260:18 352:3
feed 346:8
feedback 205:19
feel 36:17 47:13 69:9
 74:7 81:21 87:22 95:6
 112:13 159:18 179:15
 179:18 185:22 186:13
 247:4 259:5 291:21
 301:20 305:1 313:21
 360:5 405:22 406:9
feeling 124:8
feelings 66:14
feels 170:6 230:10
 260:5
fellows 281:8
felt 31:3 207:22 323:12
FEMALE 404:2 408:14
Ferguson 1:18 7:22,22
 85:3 102:18 191:16
 199:19 200:1,20
 216:15 351:8
fervor 419:7
fewer 51:6 311:9 400:4
fewest 14:3
Fibrosis 204:6
field 25:2 59:16 64:18
 79:5 160:13 243:2
 324:1,18 341:22
 364:12 374:15
Fielding 7:11
fields 349:19
fifth 70:10 84:11 408:9
figure 19:13 21:14 43:1
 90:11 152:7 222:21
 262:2

figuring 88:19 242:20
 356:17
file 149:6
filed 159:13
fill 131:9 200:6 227:2
 242:16 263:2
filled 227:13
filter 259:13
final 11:20 12:9,10,13
 12:16,18 14:5,17
 15:11 21:6 57:18
 188:4 244:4 264:3
 306:19 358:21 385:17
 385:18 405:7
finalize 10:10 404:7,7
 405:3
finally 69:10
finance 419:20
finances 185:22
financial 107:8 142:12
 186:3 202:9 216:3,12
 221:15 248:19 249:14
financially 45:10
financiers 93:22
find 36:9 52:3,5 92:8,18
 95:1 129:4 169:11
 200:5 208:18 215:7
 225:1 238:10,15
 240:1 261:16 262:10
 262:11 285:17 322:5
 322:9 352:19
findings 227:18 228:6
fine 34:9 37:16 210:9
 245:22 263:18
finish 174:2,7
finishing 91:15
finite 181:3
firing 420:3
first 4:5,9,13 5:15 16:4
 16:8,19 18:4 20:8
 24:14 25:3 31:12 38:4
 38:19 49:12 50:22
 52:12 58:21 59:22
 61:4 62:12 64:7 66:9
 66:16 69:20 70:10
 84:1 89:17 96:10
 109:16 117:20 118:1
 162:10 165:12 176:3
 192:9 211:8 216:19
 223:15 244:21 246:22
 248:2,10 249:3,13
 250:14 253:19 263:3
 268:2 275:8 300:4
 319:14 331:13,16
 334:21 335:18 344:11
 347:20 360:15 362:2
 367:9 369:19 374:4
 384:15,16 401:2,18

405:15 406:14 408:2
 408:6 409:5,12,15
 410:8 413:7 414:13
 415:4
fiscal 90:4
FISCELLA 1:19 50:17
 54:8 146:5 147:21
 204:21 228:13 269:4
 308:20 315:8 346:11
fit 14:20 21:15 29:8
 30:9 59:5 81:10,12
 95:20 118:12 121:17
 132:12 143:19 190:15
 210:3 232:15 234:19
 237:9 244:17 287:8
 287:13 322:10 392:10
fitness 331:8
fits 22:6 97:12 115:22
 121:17 122:14,14
 132:12 188:14 209:16
 411:5 413:22
fits-all 299:20
Fitzhugh 116:19
five 11:7,11 13:7,15
 14:5 15:20 20:6 25:9
 26:9 28:9 29:6,6 42:8
 47:10 49:20 61:9,12
 61:18 63:3 64:1 81:22
 83:14 84:9 89:18
 107:16 116:9 173:14
 242:13 250:9 288:19
 329:13 333:1 334:19
 368:9 397:21 404:19
 405:16 415:12 420:2
fix 366:19,22,22 367:1,1
fixed 102:16 286:22
fixes 411:1
flag 289:2 349:22
flare-ups 355:2
flashy 144:2
flesh 134:15 414:7
 420:12
fleshing 414:14
flexibility 59:12 110:9
 230:22 361:16 395:1
 404:5
flexible 348:19
flip 99:15 210:1
floor 1:8 61:8
flow 17:14 330:1 332:6
 335:22 338:22 339:1
 339:7 358:21 366:8
flu 331:10
flux 356:2
fly 361:15
focus 24:2 28:5 33:4
 51:4 57:12,13 74:13
 76:4 93:13 95:22

103:9 107:21 114:13
 115:2,14 141:6 174:3
 192:7 197:20 201:8
 223:19 228:15 229:9
 234:9 240:19,22
 248:16 250:12 256:2
 279:5 285:17 292:4
 292:21 293:12,13,15
 294:4,10 297:11
 302:20,21 308:14
 309:2 310:3,5 311:8
 314:1,1 332:13 350:1
 358:14,18 370:13
 401:21 409:5 411:20
 418:17
focused 31:20 60:13
 153:16 232:14 249:6
 249:22 296:8 301:13
 314:7 360:11 367:18
 416:4
focuses 293:6
focusing 22:17 28:4,10
 74:9,9 191:20 192:11
 239:21 294:5 295:18
 297:10 331:13 332:4
 339:6
folk 80:7
folks 26:13 66:8 90:21
 116:14 122:13 152:18
 181:11 184:16 224:1
 301:3 304:3,3 317:4
 349:5 369:16 388:7
follow 72:3 90:10
 125:13 161:21 252:22
 300:1
follow- 130:6 330:17
follow-up 10:13 54:7,9
 99:1 109:1 111:10
 123:17 220:13 221:22
 388:5 391:14
following 12:12 88:1
 108:10 124:18 125:22
 165:15 220:8 253:13
follows 17:14
fomenting 82:12
 109:17
food 197:14
foot 330:9
footprint 321:1
for-profit 221:14 230:21
forbidden 38:8
forces 330:5
Ford 2:1 7:3
forever 52:6 102:15
 375:5
forget 278:14 309:15
 385:18 386:4,6
forgot 408:15

forgotten 185:13 400:1
form 130:15,21 131:5
 226:9 228:1
formal 46:21 83:4
formally 156:17
format 159:9
formatting 209:21
formula 331:20 356:8
formulated 79:2
forth 37:2 59:2 107:12
 151:8,15 335:14
 361:22
fortunate 95:8
forum 1:1,8 48:17
forward 27:18 30:21
 31:5 46:21 47:2 48:18
 76:7 83:8 95:5 99:15
 104:11 117:8 175:14
 390:14 393:14 395:18
fosters 148:5
found 13:13,14 14:3
 87:20 124:17 125:15
 235:5 236:19 238:4
 238:11 239:19 323:16
Foundation 204:7
foundational 230:6
four 4:10 15:15 107:16
 247:1,19 260:7 331:4
 384:8 397:21 410:21
 413:15,20 416:10
fourth 10:1 23:13 24:11
 70:5 82:14 135:1
 250:3,7 265:2 329:22
 347:21 408:8 409:16
FQHC 145:16 155:10
 209:8 273:20
FQHCs 24:7 46:9
 141:13,17,22 142:1
 142:11,14 155:22
 189:4 254:4 300:5
fragmentation 63:9
frame 46:12 175:22
 278:12 361:1 413:11
frames 290:19
framework 3:5 10:11
 12:1,8 13:2 15:2,6,12
 16:2 17:20 18:20 21:1
 24:18 25:21 44:1 48:8
 49:7 57:2,18 58:7
 61:16 62:15 64:10,14
 64:21 67:17 70:14
 71:19 72:4 73:22 77:4
 78:4 85:20 89:14
 97:12 98:1,8 133:12
 232:7 242:14 245:1
 247:11 250:3,8
 297:16 325:15 335:14
 338:3 361:21 405:18

407:22 410:4
frameworks 71:5
framing 88:11 312:18
frankly 75:6 127:7
 152:11 157:13 189:5
 338:19
free 80:10 112:6,13
 160:15
freezing 287:7
French 232:18
frequently 340:19
front 43:8 81:14 107:10
 275:21 338:10 348:13
 360:21 368:21 372:1
 391:10 393:15 404:17
 412:14
fruitful 344:5
fruition 410:7
frustration 350:7
frustrations 48:16
fulfilled 207:22
full 6:3 88:2 105:2
 114:11 151:4 152:17
 153:10 156:7 188:9
 343:3 370:19
fully 288:15
fun 291:7 343:13
function 410:14
functions 379:15 411:6
fund 225:22 348:5,12
 360:21 415:9
fundamental 382:2
 401:22 410:16
funded 120:16
funding 20:16 44:14
 85:7 92:6,7,9,16 95:1
 95:8 104:4 116:21
 130:9 131:8 209:15
 209:19 250:19 337:13
 338:4 367:20
funds 330:1 332:6
 352:18,20 358:22
 359:2 366:8
further 37:6 42:6
 171:16 250:4 252:10
 358:19 389:13 420:18
futility 207:19
future 89:2,2,11,13
 108:2 393:18
fuzziness 372:4

G

G.W 116:15 119:10,14
 119:22 238:8
GA 155:21
gain 302:15
gained 60:7
gamble 44:9

game 74:9 76:9
gaming 75:22
gap 16:20,21 36:14
 39:8 67:3 68:21 69:1
 150:16 263:2 303:20
 308:8 323:19 335:12
 362:9
gaps 10:11 11:22 26:2
 26:21 35:15,19 46:20
 68:14,14,15 94:21
 102:12 200:6,7
 242:17 303:20 311:8
 311:8 322:7,21 323:4
 323:10,14 324:6,14
 358:17 359:14 369:7
 395:14,17
Garrett 1:20 6:6,7 22:1
 22:2 23:3,8 66:6 77:2
 136:3 143:22 183:9
 218:21 259:19 304:5
 377:10 382:19 402:16
 406:11,13 417:20
 418:1
gather 313:20
gathering 383:22
gazes 367:13
geared 191:13
gears 241:22
GED 102:2
gender 11:17 196:9
general 1:22 5:3 6:19
 9:16 18:8 24:17 25:3
 196:17 242:12 245:11
 253:4,12 279:17
 356:16 376:21 388:16
 404:6,6,11 410:17
generally 253:9 399:17
 405:22 411:1 412:4
generate 74:13 186:5
generates 74:21
generic 171:21 298:20
 342:7
generous 363:18
geographic 27:14
 316:12 321:1
geomapping 295:19
germane 335:9
getting 16:2 36:18
 69:10 73:1 112:22
 141:22 142:14 160:9
 170:13 172:15 183:19
 198:7 200:11 214:7
 225:17 279:16 284:1
 285:18 288:22 293:10
 311:12 341:8 347:1
 356:15 361:3
ghettoized 47:14
ghettoizing 47:11

giants 155:3
give 14:21 22:5 49:12
 58:3,8 64:11 71:6
 74:22 85:19 86:10
 96:18 103:7 124:11
 128:13 173:15 180:20
 184:14 193:11 243:2
 266:8,10 275:5 283:1
 318:12 382:10 384:21
 390:13 396:6
given 54:15 146:14
 188:1 227:12 230:8
 276:21 334:19 378:1
 378:22 388:20
gives 58:7 79:6 144:9
giving 21:9 48:4 169:18
 178:3 210:17 306:7,8
 391:11
global 330:5 380:6
glut 343:1
goal 37:10 42:4 104:14
 106:8 199:17 288:10
 289:19,22 350:3
goals 20:1 67:18 71:16
 71:17 89:22 115:7
 134:3 247:12 262:19
 293:9 328:12 357:1
gold 242:5
gotten 107:6,7 116:20
 289:16
government 224:4
 341:10 351:22 352:13
 352:16
governmental 93:10
grads 210:17
grant 119:22 125:19
 209:2,4,12,18
grants 256:13
granular 329:18 330:12
 369:18
grappled 268:21
Graves 340:9,16,17
greater 76:1 137:3
 282:18 314:10,11
 331:5
Green 119:18
grew 111:19
grist 145:20
ground 99:4 289:2
 341:13 371:6 381:5
group 16:21 17:1 39:1
 44:16 54:4,5 58:15
 71:14 78:3 80:20
 90:14 105:21 123:6
 124:3,12,13,17
 133:19 140:9 148:17
 154:4,22 163:13
 164:21 175:5,11

181:19 191:2 209:7
 232:6 235:7 267:10
 277:4 281:11 288:19
 288:20,21 298:21
 312:20 313:9 314:21
 323:2 330:19 369:13
 380:18 384:8 387:14
 389:22 399:20 400:13
 401:5 405:11 406:8
 409:9 422:8
group-specific 206:18
groupings 380:11
groups 25:20 35:20
 91:10 116:5 123:13
 127:16 133:17 141:16
 147:16,17 191:2
 199:17 211:18 223:19
 239:20 252:16 264:14
 264:16 267:4 276:22
 280:5 300:8 305:8
 321:14,21 364:7
 382:21,22 383:7
 387:16,18 399:14,19
 400:2
grow 187:2 296:6
growing 357:20
grueling 112:14
guard 77:9
guess 24:20 39:1,9
 42:1 43:12 50:21 51:5
 53:9 54:8 79:14 80:4
 92:22 93:7 98:8
 133:13 150:17,21
 151:1 171:11 172:10
 179:19 202:5 204:13
 222:6 227:5 255:1
 282:22 283:7 294:4
 333:19 340:1,5 347:9
 355:13 388:5 405:5,9
 405:15 406:3 408:21
 409:15 410:16,22
guidance 3:6,9,11 11:5
 23:1 31:4 32:10,13,19
 32:19 33:14 41:3 48:4
 93:14 103:7 106:20
 117:6 134:16 173:15
 245:14,14 329:14
 389:12,15 390:6,13
 390:22 394:6,17
 406:6 407:9
guide 12:1 33:14 36:4
 48:18 227:21
guides 245:17
gut 46:1,12

H

H 221:12
half 30:4 171:2 251:22

414:13
hammer 188:11
hand 55:1 189:20
 216:10 313:7
hand-holding 89:1
 96:19 117:6
handbook 197:4
handful 97:20
handle 51:1 117:21,21
 170:17 186:12 214:16
 284:5
handout 412:20
hands 54:1 87:12
 421:19,21
hang 9:17
hangs 415:17
happen 100:1 154:14
 161:21 244:11 257:18
 333:9 353:2 364:7
 417:7 420:10
happened 4:8 66:20
 78:19 175:7 244:14
 282:8 398:5
happening 9:5 98:10
 132:8 182:20 195:16
 218:18 297:1 349:12
 386:16
happens 5:1 37:18
 76:17 153:3 182:10
 218:18 252:8 300:12
 385:7
happily 114:15
happy 5:22 104:9 232:3
 265:14 374:1 412:20
hard 43:11 52:7,9 62:5
 62:5 74:7 75:11
 103:11 117:11 124:10
 148:20,20 154:16,17
 162:20 175:17 218:7
 303:12 308:11 334:14
 355:5 371:1,8 400:16
harder 328:6 387:22
hardest 290:12
harkened 243:13
harkening 145:10
harkens 243:7 299:9
 368:4
harm 24:10 77:10
 254:11 312:13
harming 36:14 45:17
harp 159:18
harping 159:6
harsh 79:5
Harvard 1:21 6:17
Hasnain- 7:6
HASNAIN-WYNIA 1:21
 7:6 392:5 393:10
 394:3 413:19 414:15

415:2 417:14,22
Haven 1:13
hazard 100:8,10 102:12
HCSC 93:19
head 364:6
heads 277:10 396:7
health-oriented 302:16
Healthcare 2:4 6:21
 144:2 184:1
healthiest 144:3 296:1
healthy 2:2 106:11
 179:8 268:13 296:3,5
 296:5 397:10
Heaphy 275:18
hear 7:16,17 48:16 87:6
 90:20 186:17 219:20
 236:11 327:11 340:20
 372:5 392:8
heard 4:9 48:7 66:19
 86:4 141:12 142:10
 166:10 198:10 207:20
 210:16 214:17 222:1
 227:12 240:18 255:3
 339:4 340:6 347:10
 381:1 418:11
hearing 97:3,5 306:8
 372:4
heart 2:2 40:11
Hearts 347:13
HEDIS 276:21,22
 283:19 286:15 289:14
 289:19
height-adjustable
 157:20
heightened 243:11
Helen 2:8 8:7,9 40:7
 42:7 58:13 81:16
 89:16 91:13 92:14
 95:16 97:14 138:20
 159:6 251:21 280:20
 281:18 287:3 288:8
 289:9 292:13 312:5
 333:18 389:11 393:11
 415:5 421:12
Helen's 290:3 391:3
help 25:6 33:14 36:4,7
 40:12 49:11 56:16
 78:14 89:19 103:10
 108:3,20 112:18
 134:14 147:11 197:15
 198:20 218:16 240:6
 243:2 245:1 278:6
 282:20 321:19 343:19
 346:7 358:14,16
 375:20 378:12 387:6
 395:12
helped 98:22 333:5
helpful 23:8 31:7 73:19

85:1 135:17 190:21
 211:11 214:13 261:22
 287:21 293:19 313:2
 365:8 382:14 390:22
 409:19
helping 36:13 102:2
 219:7,16
helps 67:13 106:19
 147:15 377:17
hemodialysis 195:21
hemoglobin 52:10
 199:13 292:6
Hennepin 1:20 6:7
Henry 2:1 7:2
heterogeneity 383:7
HHS 92:6 233:17,17,21
hi 7:15 8:8,20 33:20
 50:17 66:7 146:5
 185:14 229:16 270:4
 312:8 340:16
hidden 148:5 278:19
hide 384:19 385:2,6,10
 385:15 388:1
high 13:22 14:8 15:13
 17:6 19:19 21:7 24:16
 24:21 25:14 28:1
 30:11 33:21 34:19,22
 50:8 60:17 76:13
 77:11 178:12 181:9
 190:15 191:14 196:21
 203:3,5,11 204:5,11
 246:1 248:5 249:1,16
 265:9,14 292:8
 293:16 330:11 332:14
 357:6 358:4 365:17
 375:10 378:1 385:9
 407:15
higher 54:16 159:20
 323:5,8,20 327:7
 355:12 390:3
highest 162:4 193:10
highlight 28:8 34:3
 205:13 241:17 312:11
 375:18
highlighted 27:16
highly-referenced 5:4
Hill 158:5
hindered 105:3 106:12
hinges 366:18
hire 46:3 182:13
hired 210:16
hiring 210:12
histoplots 387:4
historically 58:9 225:20
history 160:14
hit 153:8 171:5 336:19
 364:5 372:10
hits 225:2

HIV 30:22 309:6
hoarse 236:5
hold 36:11 53:22 87:11
 133:2 179:3 292:20
 328:12 415:18
holding 179:17 277:21
 293:2 339:17 415:14
hole 109:4 123:4 124:6
 126:20
home 72:17 149:10
 156:21 218:5 237:3
 239:7
homeless 138:3 184:2
 210:18 383:11
homelessness 319:16
Homes 233:19
homework 114:1,6
honest 321:12
honestly 282:1 399:3
hook 62:18
hope 61:5 88:17 95:10
 123:22 133:13 145:22
 274:5 281:20 416:11
hopeful 92:16,20
hopefully 19:19 29:6
 164:11 188:1 342:1
hoping 112:18 132:1
 288:10 289:7,22
Hopkins 1:17 173:8
horizon 355:7 419:1
hospital 1:22 6:19
 23:19 27:10 68:11,21
 84:20 105:6 107:11
 131:3 141:4 142:15
 146:15 152:6 179:10
 179:12 224:14 226:8
 239:16 264:2,12,17
 266:1 273:5 277:16
 290:21 291:3,4,12
 292:6 293:11 297:22
 303:11 325:21 327:12
 333:3 334:12 355:3
 363:1 375:15 378:22
 409:6,7 411:19
 412:15 417:8 418:18
hospital's 105:18
 264:22 265:4
hospital-based 416:3
hospitalization 190:9
 412:9
hospitalizations 355:5
hospitals 52:3 66:15,18
 67:2,2,11,21 68:4
 104:16 120:22 130:12
 130:21 141:15,20
 147:4 190:4,6 221:7
 221:14 223:9 225:18
 230:14 264:14,16,21

265:20 266:14,15
 268:6,11,14 270:16
 279:8 284:15 300:9
 305:6 345:20 367:12
 379:10 382:21 390:8
 400:2,3 418:3
hot 152:9 295:20
hour 128:11 288:2
 414:13
hours 221:1
housekeeping 5:14
housing 145:18 202:9
 366:22
HPAA 388:8
HPV 24:7 309:6 331:10
HRAs 171:4
HRET 162:16
HRSA 253:21 254:20
 416:4,18
HUD 102:3
HUDSON 2:3
huge 27:16 55:20 111:3
 155:13 182:2 198:7
 205:2,3
hugely 204:10
human 9:7 90:4 252:11
 275:16 353:6 362:13
hundred 220:15
hundreds 189:10 221:1
 401:12 404:20
hung 57:10
hurt 24:10 111:13
hurting 144:10
hybrid 369:12
hyper- 349:22
hypertension 322:22
hypertensives 199:16
hyphen 291:5

I

I-SNPs 354:10
IADLs 172:6
ICD-10 195:10
ICPS 264:1
idea 56:1 72:7 75:1
 78:16 99:2,9 100:10
 113:1,1 136:10
 140:21 141:2 144:13
 150:8 179:22 185:10
 210:8 212:17 215:2
 218:4 221:3 230:12
 258:1 272:12 284:13
 318:20 326:12 335:13
 343:6 346:17,20
 366:20 368:7,20,20
 371:22 377:11,21
 382:10 395:13 412:10
 413:10

ideally 57:20
ideas 114:6,10 118:11
 136:20 139:10 145:22
 148:15,18 206:10
 241:14 242:7,16
 244:19 245:4 250:22
 279:17 281:13 312:11
 346:7,9 368:19
 373:19 406:5 407:4
 420:4,15
identifiable 176:16
identified 11:13 13:18
 13:22 15:5 18:5 26:21
 31:1 40:4 65:10 121:6
 195:10 235:11 271:21
 359:12 384:9
identify 10:11,12 11:22
 30:15,19 80:1 81:5
 83:20 192:2 194:12
 212:11 223:16 224:8
 395:17
identifying 11:15 15:16
 36:5 83:18 94:20
 194:8 247:2 369:7
lezzoni 1:21 6:17,17
 56:19 66:5 70:21 72:4
 72:6 86:2 122:21
 124:5 127:6 128:1,18
 155:1 157:9,10 158:4
 165:3,4,8 171:14
 172:11,16 173:9
 272:8 274:3,4 315:6
 317:15 318:18 338:19
 402:5,6
Ignatius 2:15 7:8 29:2
 56:17,18,20 117:22
 120:12,16 121:14
 162:1 255:7 257:10
 257:22 315:6 325:5,7
 326:6 330:18
Ignatius' 58:19 136:4
ignorant 284:14,15
ignore 47:22
ignoring 108:14
IHI 18:15
ill 397:8
illness 11:11 172:21
 216:21 275:11
illuminate 147:19
illustrate 15:14 19:13
illustrates 21:4
illustration 21:2
illustrative 134:14
 150:2
imagine 82:9
immediate 91:14
 411:20
impact 9:8 16:22 36:12

37:5,10 39:16 64:18
 64:22 65:1 71:7,8,11
 71:14,21 87:9 107:8
 107:18 108:4,5,14
 129:19 221:8 224:11
 228:1,16 243:10,18
 243:22 248:19 309:6
 331:2 332:13,14
 357:18 360:12 363:12
 375:3 403:5 411:21
 416:8
impacted 36:15
impactful 10:3 227:15
impairing 182:16
imperative 328:2,4,13
impetus 74:21 286:14
implement 75:16
 134:17 170:21
implementation 99:22
 121:5 174:4 224:22
 231:15 242:1 280:18
 343:19 347:12 396:11
 396:21 404:7 405:17
 407:8
implemented 67:16
 246:10
implementing 3:9 90:1
 229:3
implied 211:8 378:20
imply 278:12,16
importance 127:15
 310:10
important 9:22 39:12
 39:18 41:1 55:13
 57:19,21 61:16 62:8
 64:13 67:9,12 68:5,9
 69:4 74:6 75:5 79:22
 86:13 87:18 108:6
 113:15 133:17 146:11
 157:7,21 158:17,18
 160:16 170:9 183:14
 186:15 187:7 189:22
 205:4 208:4 210:15
 216:12 218:12 252:5
 252:17 265:10 267:16
 269:6 279:21 281:6
 289:4 291:11 292:15
 304:21 307:5,20
 311:3 322:20 338:20
 340:15 341:17,17
 342:1 356:6 373:1
 390:15 392:17 399:4
 401:20,21 408:18,21
 408:22 418:21 419:8
 420:22
imports 296:5
improvable 40:16,19
improve 29:14 42:4

45:15 69:3 74:16 75:8 85:16,21 131:1 201:5 228:6 249:7 257:4 278:3,4 290:6 293:1 304:15 331:1,12 335:8 349:9 353:18 353:22 370:8 improved 68:10 206:14 216:16 289:18,19 362:5 improvement 50:12 62:9 64:2 65:14,16 75:2 76:16,16 77:6 135:12,14,16 140:13 146:9 156:22 212:13 221:16 226:5 234:22 235:21 237:15 240:22 249:18 270:13 271:12 271:22 278:18 281:9 287:10,11 288:4 289:3,10 290:5 297:8 301:13 321:13 327:6 347:5,6 348:8 357:8 357:11 361:6 370:14 370:20 373:7 377:14 377:22 improvements 54:13 103:18 309:4 improves 82:5 377:19 improving 34:17 57:7 77:9 285:15 288:16 299:10 321:4 350:4 in-hospital 317:1 in-state 327:10 inaction 391:8 incent 59:19,20 219:12 261:17 incenting 77:8 incentive 236:15 247:8 277:13,17 300:11,17 301:5 317:19 370:8 395:19 399:18 413:3 413:10,21 incentives 24:9 28:7 54:10 55:2 59:18,22 60:11 249:14 276:16 282:15 300:21 312:16 322:16 328:19 338:22 362:1,3 416:15 incentivize 20:4 34:4 61:4 69:1 110:8 248:16 253:8 256:4 260:3 287:20 309:12 374:10 375:21 376:22 416:20 incentivized 67:6 108:18 111:8 incentivizing 3:11	15:19 20:11 58:5 68:15 107:21 112:1 245:15 311:21 317:10 317:13 329:14 369:8 372:2 include 11:21 12:8,14 34:6 56:13 129:13 135:15 141:15 146:11 165:13 216:18 221:4 233:16 234:1 265:18 276:16 included 12:9,22 16:10 115:4 129:11 161:15 165:9 166:19 168:4 193:8 198:9 246:16 250:9 266:13 includes 14:9 44:3 70:6 113:2 197:8 232:17 257:19 including 39:20 113:3 164:14 235:6 239:8 247:14 322:7 323:5 inclusion 57:22 inclusive 234:1 income 87:15,20 100:17 111:18 143:17 149:10 154:3 178:12 195:12 269:19 296:10 383:11 385:9,9 income-related 27:14 incomes 150:11 inconsistent 155:20 incorporate 197:12 199:11 310:16 371:1 406:14,15 415:4,7 incorporated 202:15 214:19 236:3 253:10 279:15 281:2 305:4 311:16 417:18 incorporating 20:8 27:6 197:17 250:14 281:10 361:19 increase 256:19 increasingly 99:10 incredible 81:20 incredibly 41:1 298:9 incubator 94:22 index 144:14 346:19,21 347:8,14,14,17,17 indicate 201:20 indicator 143:5 198:19 266:1,10,14,21 indices 346:13 347:3,6 individual 118:5 124:3 129:9,20 138:16 139:17 141:3 228:19 230:12 247:18 310:1 327:15 380:3,4	individualization 362:19 363:5 individually 237:18 individuals 105:19 122:8 142:1,13 149:21 158:21 192:1 274:17 310:21 322:11 industry 108:19 inequities 154:6 306:13 359:22 360:7 inequity 127:2 137:1 267:9 303:10 334:18 335:6,8 359:17 360:6 380:9 inertia 391:9 infant 11:10 286:10 infection 379:1 influence 58:14 66:12 66:16 95:4,13 218:18 influenced 359:15 influences 93:12 influencing 57:6 influential 87:18 inform 227:9 306:17 informants 13:10 information 11:1 14:13 35:10 97:19 149:5,6 152:5 159:5,7 160:16 167:9,11 192:18 197:3,5 198:17 215:5 217:1 225:6 227:8 398:19 infrastructural 183:2 infrastructure 62:6 74:5 143:7,12 215:18 330:3 346:6 348:6,13 360:16 361:4 372:1 372:21 373:6 infrastructures 412:11 ingredients 44:4 inherent 370:8 initial 23:1 116:11 initially 15:4 86:7 265:19 312:5 initiative 213:21 280:9 295:17 296:9,20 351:13 initiatives 96:1 97:3 103:1 218:11 245:13 255:22 295:17 297:11 352:20,22 injury 275:19 injustice 127:3 inner 181:2,9 innovate 85:14 innovation 256:3,13,16 325:18 innovations 250:1	innovative 367:15,21 inpatient 379:8 418:19 input 93:4 94:7 205:19 226:7 254:14 391:11 inputs 383:22 inside 105:18 insight 363:8 insightful 298:9 instance 71:20 Institute 6:18 institution 104:7 115:10,14,17 117:8 118:5 131:21 132:7 215:22 216:6 224:2,3 224:9 225:11 236:1 282:1 334:22 376:8 376:12,14 380:20 386:2,8,9 395:15 398:14 399:8,14,16 400:10 institution's 84:14 115:1,4,15 216:2 institutional 129:2,3,4 129:6 196:19 211:16 217:16 380:1 398:20 institutionalized 220:8 institutionally 214:2 institutions 42:6 82:21 98:20 99:16 220:19 221:9 230:21 376:13 386:3 395:12 instrument 119:9 instrumentally 213:9 insurance 111:17 137:3 146:20 147:18 151:9 154:1 155:15 185:8 185:19 196:9 257:2 287:18 319:15,17 insured 184:14 319:8 319:14 371:4,10 insurer 209:18 integrate 164:6 integrated 207:2 217:11 220:9 269:9 326:1 integrating 31:14 232:7 361:20 364:2 integration 129:15 206:14 216:17 217:18 intellectual 343:11 intended 19:10 21:14 92:4 116:10 187:20 286:4 intends 374:8 intense 350:1 intentional 358:9 intentionally 95:3 181:6 230:11 284:11
--	---	--	--

intentions 182:5
inter- 157:5
inter-professionalism
 157:5
interact 225:21
interacting 327:6
interaction 192:5
interdisciplinary
 218:10
interest 93:21,22 234:9
 238:6 314:19
interested 318:13 349:6
 421:17
interesting 30:1 37:13
 52:14 99:8,20 136:17
 164:1 184:19 229:22
 232:13 233:9 235:14
 237:7 304:21 410:21
interests 76:5
interim 11:20 12:7
 14:11 18:5
intermittent 155:6
internal 76:11 84:12,17
 95:6 301:16 393:6
internal/external 93:15
internally 93:2 218:18
 392:22 397:3
interpret 211:3
interpretation 42:3
 49:13 99:18 182:7
 238:12 339:5
interpreter 160:3 166:8
 182:13 183:11 186:6
 186:10
interpreters 157:13
 183:4
interpreting 41:9
interrelated 230:2,3
 288:7
interrupt 167:22
interruption 392:1
intersection 351:21
intervene 322:9
intervention 14:2 18:16
 40:3 224:11 298:19
 298:20 330:22 336:14
 338:17
interventions 4:14 13:7
 17:18,22 18:3,6,13,17
 19:1,12 20:17 39:7,14
 45:13,16 46:17
 194:14 195:19 225:1
 228:17 229:1 296:14
 298:17 316:14 322:6
 323:15,17 324:20
 336:15 338:2 339:14
 373:11,17
interviews 128:12

223:19
intimidating 4:11
introduce 248:14
introductions 3:3 6:2,4
introductory 315:5
 320:8
inverse 141:9
invest 322:14 338:8
 418:15
investing 48:12 412:12
investment 215:16,17
 215:17 216:3,12
 225:3 314:10 346:4
 359:2 360:21 362:2,3
 365:22
invited 300:6
involved 50:7 64:20
 97:7 98:19 246:6
 252:15 274:22
involvement 194:18
 220:10
IOM 49:17
IRS 225:8,10 226:20
 359:6
issue 9:19 31:22 32:17
 42:15 58:21 63:22
 78:19 79:10,15 106:7
 107:11 109:5 137:21
 146:16 149:1 152:12
 153:12,12 155:4,13
 155:15 159:22 169:21
 171:1 183:14,15
 186:13,17 189:8,19
 201:6 204:12,13
 205:3 243:4 252:7
 255:1 257:16 262:21
 268:4,11,19 285:8
 295:22 298:19 299:7
 299:21 314:16,21
 316:19 317:1 319:19
 320:9 331:18 333:14
 334:10 337:17 338:21
 347:22 348:12 356:2
 376:10 382:17,18
 383:15 384:12,14
 388:15 389:13 391:7
 399:22 404:16,16
 412:16
issues 9:17 33:7,10
 42:10 57:3,12,16
 67:13 71:3 76:21
 90:17,22 93:3 120:18
 127:5 194:20 231:1
 234:21 239:21 245:13
 246:6 251:15 262:14
 268:17 280:18 288:1
 295:20 299:1,1
 303:12 312:4,6,13

314:7 317:3 328:15
 332:17 333:18 337:22
 338:15 353:21 369:19
 390:14,16 397:18
 399:1,1,3 403:9 405:2
 411:3
item 168:5 253:3
 329:13,19
items 5:14 167:11
 169:8,11 196:18
 239:2,13,15 240:8
 326:9 329:18 410:3
iterations 306:22

J

James 335:19
January 96:8 410:8
JD 2:15
jeopardy 354:8
Jessica 232:17
Jester 215:3
jibe 404:19
job 31:13 38:20 102:3,4
 115:11 151:12 202:14
 216:5 231:18 269:19
 303:13 327:2 356:17
Joe 203:14
Johns 1:17
join 280:5 422:7
joining 7:18 292:17
joins 292:18
joint 120:21 233:18
 270:15 280:8,8 334:4
Joseph 346:15
journey 63:3,10 64:15
 361:19 389:18
Juan 1:15 23:9 31:7,9
judge 44:13
judgment 43:3,10
Judy 232:19
July 12:20
jump 151:8 263:4
 280:20 329:12
jumped 86:2
jumping 247:22
JUNE 1:5
Jung 2:9 8:18,19
justify 131:9

K

K 422:4
Kaiser 1:18 6:11 93:22
 218:14
Karen 334:4 345:15
Katarina 294:15
keep 26:22 49:6 62:17
 126:4 149:6 159:6
 176:4 290:2 321:12

405:6,18,19 410:10
keeping 114:21 252:18
 257:8 309:15 354:22
 381:3
keeps 247:4 412:14
kept 267:3
kernels 81:1
Kevin 1:19 50:16 51:14
 53:3 54:6 55:10,15
 66:10 67:11 71:2
 113:10 146:4,4
 147:14 154:21 204:21
 221:22 228:14 263:7
 263:9 269:3 270:2
 308:20 310:6 315:1,7
 334:1 335:16 344:13
 346:10 347:19 348:1
 387:14
Kevin's 347:20
key 13:8,10 33:10 35:18
 44:4 50:6 159:9
 201:19 278:20 306:20
 361:20 374:7 376:10
 394:22 411:2
keypad 174:16
kicked 349:15
kidney 11:9 196:3,6
 200:2
kinds 76:11 82:16
 87:13 124:2 167:3
 181:13 234:14 270:17
 271:4 273:12 293:10
 386:11 395:21
kit 162:16 361:11
knew 265:5 337:13
knowing 219:2
known 17:18 126:12
 204:3 258:12
knows 51:21 88:7
 223:11

L

labels 67:17
lack 54:15 63:15 316:4
lacking 65:5,12
laid 248:10
landed 20:7
language 17:5 58:1
 99:18 120:22 121:1
 135:22 159:13 196:10
 214:10 227:7 232:9
 232:16 233:1 234:2
 236:22 237:1 238:7
 239:22 254:6 368:5
 398:8,16,17 412:7
 413:12
language/terminology
 412:16

languages 182:4	176:22 177:6 280:20	limits 259:20	107:18 199:10 294:20
large 53:4 78:11 88:13	317:18 329:4 330:14	Lincoln 2:2 6:10	419:15
88:15 153:9 201:13	344:10 381:6 382:3	line 12:12 38:9 86:3	literature's 52:6
230:13 280:2 327:19	391:2 411:19 418:22	134:8 174:12 228:12	little 9:11 10:5 14:16
328:7 337:13 406:1	419:9	277:8 278:21 338:10	16:17 22:3,5 34:8
largely 283:14	letters 115:18	390:9 394:19 403:12	35:16 37:21 39:2 41:7
larger 230:20 406:5	level 15:13 17:6 19:4,5	line-up 247:9	46:13 75:19 80:6
las 209:10	19:5,6 21:7 24:16,21	lines 254:15 417:15	96:20 104:13 106:15
lastly 20:3 142:9 190:3	60:18 63:7 87:10,21	linguistic 310:4	110:22 111:9 112:2,4
249:10	90:17 91:1,11 92:18	link 176:15 193:8	112:22 114:1,4,8
late 184:10	101:6 102:10 103:2	282:21 319:2	125:8 139:6 144:21
latest 347:9	136:7 137:9 139:7,9	linkages 207:3 333:5	152:9 171:20 173:17
Laughter 158:3 175:6	139:15,20 140:7,10	linked 62:3,19	173:19 179:2 180:22
206:1 255:15	140:13 141:4 142:5	linking 228:20 345:3,3	182:1 184:8 196:12
launching 145:15	152:6 153:20 154:3	links 156:22	202:13 206:7,13
367:17	178:20,21 179:6,22	lion's 115:11	212:5 215:21 223:12
Law 157:16	180:8 195:17 196:19	Lisa 1:17,21 6:17 33:19	241:22 244:12,21
LaWanda 308:2	196:20 217:16,17	35:22 38:18 40:10	245:1,5 247:16
lead 128:22 132:1	228:20 265:9,14	41:12 55:3,8 56:15,19	250:11,12 260:4,5
211:19 217:13 232:19	273:8 311:10 319:9	58:16 66:5 70:21 71:3	261:6 269:8 272:12
251:1 278:10 307:8	321:17 323:13 324:16	72:4,5 73:13 86:1	273:10 284:10 290:17
leader 211:16	327:7,11 330:10,11	92:10 117:22,22	299:12 300:2 313:15
leaders 115:6 132:3	352:10 356:9 357:7	122:19,19 128:16,16	316:19,21,22 319:11
133:1	374:9,14 375:10	130:8 155:1 157:8	326:7 328:6,7 329:12
leadership 57:12 74:6	380:1,2,3,18 386:17	158:12 162:22 165:3	338:1 339:2 343:10
75:9 89:6,17,19 90:4	398:13 399:7 400:9	166:10,20 171:12	354:2 362:12,15
96:3 120:19 133:15	402:19,20 407:15	172:1,11 173:3 194:3	365:4 374:1 376:18
134:2,6 211:22 224:1	levels 19:2 54:16 90:3	198:5 205:17 211:5,5	386:20 393:11 400:5
226:4 361:21 373:1,2	111:18 137:12 139:21	212:16 216:9 251:20	400:16 403:5 406:18
leading 15:11 19:18	228:19 273:14 310:1	272:7 274:3 276:9	408:3,9 409:17
118:3 276:13	383:11 385:22,22	280:22 281:18 293:20	live 87:4 222:19
leads 95:21 202:1,14	402:18	295:1,5 298:13 304:6	lived 210:20
leaf 345:8	lever 30:8 190:20	306:20 315:6 317:14	lives 47:16 224:3
lean 53:1	269:21 281:6	319:4,12 333:14	274:11
leaning 53:10	leverage 29:18 51:12	338:19,19 343:20	living 103:17 171:6,10
leap 300:6	51:12 104:11 245:12	382:5 391:4 402:4,14	load 31:1 309:7
learn 54:11,14,19,20	256:12 277:9 279:10	404:16 416:22	lobby 189:6
67:5 225:2 297:19	leveraged 253:7 260:3	Lisa's 43:17 58:19 83:9	local 143:11 189:11
350:20	330:8	85:4 280:19 294:22	208:9,11 209:9 216:4
learned 114:5 242:9	levers 29:22 187:14	299:11,14 343:20	220:20 223:16,17
295:14 347:11,15	279:22 410:14 411:18	list 14:17 23:18 29:3	274:21 367:2
learning 54:18 64:16	lexicon 129:21	159:21 207:16 224:20	locally 115:19
215:13	library 184:3	273:16 278:14 279:20	located 181:2
leave 5:20 209:22 258:9	life 15:7,17 92:4 128:14	333:1 346:13	locked 158:5
258:14 264:18 344:7	203:17 333:1 354:1,2	listed 81:22	logged 198:14
leaves 344:4,19	354:3,20 355:13,19	listen 273:19	logic 29:7,13,13 415:14
leaving 301:7 358:17	lifestyle 18:9 80:13	listening 96:11 222:19	long 4:19 29:3 99:13
led 387:14	331:7	415:6	124:7 156:8 161:2
left 53:14 300:8 301:3	lift 419:8	listing 30:12	229:7,9 256:19
380:22	liked 198:8 415:6	literacy 3:8 169:3,7	282:12,16 299:6
legal 145:18	likelihood 390:3	197:18 232:6,14	351:13
legitimate 386:22	Lim 346:14	233:1 234:1 235:1	long-term 241:6 363:1
legitimately 52:16	limit 86:9 172:12 342:5	236:21 239:6,10,15	longer 104:1 238:8,9
lens 309:1,16 323:11	366:15	239:21 367:1	240:12 355:7,10
357:22	limitations 357:13	literally 131:3 164:6	longer-term 419:1
lesson 59:16 131:17	limited 95:6	203:16 204:8 275:13	longevity 111:5
lessons 347:16	limiting 153:1 182:9	365:15 407:21	look 11:11 16:5 17:3,20
let's 79:4 172:16 175:2	260:5	literature 43:10 107:16	27:21 30:11 34:5

35:16,17 36:3 42:8
 43:5,19 50:1 61:8
 65:6 68:21 69:22 70:4
 74:4 77:11,15 83:13
 90:7 100:14 101:8
 106:12 109:16 113:18
 116:3,22 117:4 120:8
 120:14 124:13 129:6
 129:7,8 130:2,2,14
 134:18 135:19 137:5
 145:5 146:22 158:19
 177:1 187:6,9 188:5
 195:12 208:15 212:12
 233:12 234:21 237:22
 238:3,7,17 239:1
 250:17 253:2 260:10
 269:7 286:10,12,13
 299:12,17 303:11,20
 311:20 326:12 333:2
 351:20 354:15,17
 355:15 376:5,6,14
 384:22 390:15 394:7
 396:10 403:22 406:22
 412:19,20 416:1,8
looked 15:15 18:7
 33:11 42:14 101:13
 107:15 125:8 150:7
 150:10 169:11 192:8
 233:2,5 235:2,4 247:1
 247:2 249:17 260:19
 294:19 331:1 362:20
 362:21 364:19 366:2
looking 15:4 16:8,12,17
 16:19 17:2 18:8 19:4
 22:19 31:18 35:6 36:8
 44:1 53:15 68:8,13
 76:3 85:8,13,15,21
 87:17 93:13 120:17
 134:15 136:8 138:7
 146:8 154:21 161:7
 169:14 185:17 189:17
 190:2 191:17 192:16
 193:3,22 194:7 195:3
 195:20 196:18 201:1
 201:5 205:11 206:19
 207:7 217:2 232:21
 243:21 247:20 248:4
 250:19 270:1 290:14
 296:12,13 308:9,10
 308:14 310:19 312:19
 318:11 325:11 345:22
 362:14 363:6 365:13
 376:6 389:14 398:14
 398:20 399:11,12,13
 421:1
looks 34:14 84:12,16
 173:18 195:22 223:11
 226:12 376:12

loop 414:18
loops 82:2
lose 45:1 147:17 155:11
 287:15 376:7
losing 297:18 319:14
 354:8
lost 56:14 333:1 394:20
lots 56:7 219:6 222:20
 223:4 255:21 283:22
 332:13 360:12 365:18
 388:12 400:2
lotted 302:10
Lou 275:14 276:3
louder 206:7
love 94:1 99:21 141:1
 343:5 382:1 394:16
low 11:10 122:5 178:12
 296:10 385:8
lower 74:18 90:17
 111:5,13,17,18
 150:11 178:13 269:14
lowest 101:5
lowest-performing
 278:5
lump 360:4
lumpectomies 124:22
lumpectomy 125:9,13
 125:17
lumping 410:13
lunch 112:11 173:19,22
 190:17 191:3,4,6
Lyft 97:6

M

MA 2:9,11
MACRA 291:18 356:4
macro 36:7 144:11
macro-measures 403:3
Madison 2:9 8:18
magic 5:1 64:20 325:14
 333:10 404:2,4 414:3
 420:14
mail 240:15
main 14:14 299:4 385:4
maintain 383:21 384:4
major 80:4 200:7
 280:14
majority 13:21 30:12
 244:3
making 15:10 19:17
 80:6 83:11 111:8
 122:12 157:18 162:11
 179:9 198:22 201:2,7
 216:4 222:17 289:6
 312:15 353:15 359:4
 382:22 387:2 413:16
MALE 161:11 363:17
Malone 209:11

manage 201:12
managed 85:12 283:14
 283:22 284:7 327:18
 352:7,12
management 41:21
 172:14 195:5 200:11
 200:16 217:17 301:14
 302:8 305:22 338:5
 338:10 340:3 342:15
 357:12
manager 2:8,11 5:13
 8:17 201:4
managers 35:2
Mandarin 160:4,5
mandate 367:11
manifestation 127:2
manual 197:4
map 38:6 48:8 56:16
 63:6 82:1 87:9 89:1
 94:4 96:18,21 97:2,12
 98:1,11 99:3 103:5,17
 120:1 243:15 246:8
 297:14 342:6,7 404:8
 405:3,4,5 411:11
 412:4 414:9
mapping 295:19
maps 96:22 243:14,17
march 317:4
marched 33:10
margins 178:13
mark 96:20
market 313:16,22
marketing 226:10 386:6
marketplace 257:2,7
Marshall 1:9,11 7:12
 21:20 26:21 56:22
 67:12 68:6 94:11
 100:22 116:14 169:4
 187:11 234:10,11
 251:1 274:7 288:14
 290:16 332:11 395:3
Marshall's 32:14 53:10
Mary 275:14 276:3
mask 267:21
masking 126:6,8,11,15
Mass 6:19 157:15 402:9
Massachusetts 1:22
 86:4 274:8,14 317:15
 318:1,19 402:9
Massaro 346:15
mastectomies 125:5
mastectomy 126:14
materials 16:11 22:4
 93:11 233:17 246:17
 421:10
maternal 286:10
mathematically 277:3
matter 40:11 94:11

108:11 191:9 329:6
 350:8 352:6 422:9
matters 286:17
maturity 62:5
Mauricio 2:9 8:20
maximize 113:13
maximizing 346:2
Mayo 184:10,13
MBA 1:18
MD 1:11,13,15,17,18,18
 1:19 2:1,2,4,8
mean 16:3 32:1,13
 40:12,17 42:8 43:5
 47:7,8 48:1 50:2 54:2
 54:15,20 63:20,21
 64:16 71:4,8 79:21
 82:1 91:19 93:18
 99:12 101:9,14,22
 102:6,10 115:21
 117:18 127:1 133:21
 145:5 149:17 153:19
 163:4 168:7,13 169:8
 169:19 171:9 172:9
 178:22 184:17 185:19
 198:21 199:7 201:20
 204:6 216:20 226:21
 227:13 262:4 280:4
 286:3 287:19 290:17
 296:18 299:4 307:15
 337:21 339:4,18
 341:9 342:4 343:13
 349:11 350:9 354:2,6
 356:10,17 362:18
 366:7,15,16 367:4,5
 368:1 377:4 382:6
 387:17 388:2,18
 402:3 404:6 405:3
 409:4 411:15 412:1,2
 413:13 414:22
meaningful 147:13
 148:9 161:12 213:5
 243:9 254:4 300:20
 382:10 396:15 399:2
 399:6 401:1
means 29:12 70:11,16
 70:17 123:3 133:10
 153:1 217:19 337:17
 366:19
meant 19:13 271:8,13
measurable 71:5,19
 89:20 115:7 122:17
 177:13 207:19 324:15
 361:1,8 363:11
measured 18:18 129:18
 138:10 141:15 156:6
 156:8 276:18 277:19
 316:14 319:8 396:13
 400:21 401:9,14

measurement 2:10 3:5
8:13 9:14,21 10:12
11:6,22 14:6 15:1,12
15:17,20 29:19 30:14
36:6 45:17 46:10
48:22 50:21 69:16
70:2 83:5 84:1 106:13
114:22 129:16 134:18
139:21 152:16 172:4
186:1 187:8,12
206:14 220:4 228:2
232:8 234:21 247:11
248:12 250:3,8 269:9
269:22 274:12 280:6
286:6 288:8 308:22
309:2 315:20 330:8
332:8 345:22 347:7
355:8,16 361:22
372:21 375:10 381:7
389:21 396:14 401:1
404:18
measurement-based
269:22
measurements 19:9
20:5 62:13,14 82:17
190:16 194:9
measuring 34:19 44:2
60:3 69:18 89:15
132:14 133:4 200:12
205:7 230:7 355:4
388:20
mechanism 183:5
213:7 265:2 322:13
mechanisms 330:4
377:12
mediate 345:12
Medicaid 72:11 73:2,9
85:5,22 86:17 87:5,14
88:1,1 90:16,21 100:7
121:16 122:2,4
136:11,11,16,21
137:4,6,7 138:18
141:3,6 143:2 145:2
146:14 147:2,6 148:2
150:18 151:8,11,15
154:1,11 157:19
158:8 182:12 184:15
185:4 189:5,7 256:9
256:11,12,21 260:21
284:3 317:16 318:7
325:19 327:10,20
349:14 352:2,4
392:18 402:9,22
medical 1:13,16,20,21
6:7,18 7:1,5 65:3 73:7
194:4 206:15 216:17
233:19 237:3 239:7
273:12 284:6 308:11

380:5
medical-legal 156:19
medically 352:5
Medicare 11:14 23:20
24:8 45:21 87:19 88:3
101:15 124:13 125:3
137:6 141:3 149:3,4
151:8 154:2 171:7
184:15 201:11 236:14
239:17 248:4,20
255:11,19 256:3
260:10 266:7 270:6
274:20 300:14,22
327:11 345:4 354:13
364:13 371:9
Medicare/Medicaid
274:16
medication 100:14
203:4 239:15
medications 100:16
197:17 202:9 205:1
medicine 1:17 9:6,10
224:5 241:13 305:2
307:16 412:22
Medicine's 232:6
meds 155:12
meet 231:10 270:19
281:14 359:21
meeting 3:2 9:15 10:4
12:12 15:10,22 16:10
25:19 28:16,17,22
30:2 31:15 32:2 41:7
42:13 98:17 188:14
199:16 203:13 226:6
246:17 251:18 281:5
321:14 334:4 335:19
336:3,4 410:8 412:21
421:14
meetings 5:2 27:6 97:1
99:12 176:3 226:11
meets 315:21 356:20
meld 245:9
Mellon's 116:19
members 7:14 13:9
18:12 73:15 105:10
149:15 203:21 204:20
205:19 320:21 348:21
membership 85:11
men 158:5
Menendez 2:9 8:20,21
mental 11:11 172:7,21
216:21 275:10 397:17
mentally 397:8
mention 9:2 93:1
158:15 188:18 194:1
251:21
mentioned 49:13 93:6
113:17 119:4,11

135:21,21 138:17,17
140:11 149:2 155:14
176:3 188:17 215:6
263:12 264:7 271:1
271:12 287:6 333:15
399:21
mentioning 55:4 130:8
139:9 168:20
menu 262:15 344:1
356:11
merge 368:19
merit-based 236:15
mess 37:16
message 21:5 128:7
messaging 37:19
met 1:7 6:3 323:8
method 240:13
methodological 330:13
369:19
methodology 224:19
methods 247:3,20
260:7
metric 115:22 212:8
335:12,12
metrics 64:10 83:17
121:13 144:22 208:16
336:11 369:7 372:1
395:21 417:3,4
MGH 119:18
MHS 1:13
mic 89:5 167:17,18
168:12 202:17 236:6
242:3 247:4 255:12
255:18 293:22 363:19
421:6,8
Michelle 1:15 6:13 31:8
33:19 35:22 38:2 47:6
48:6 49:5 85:1 86:18
88:22 93:8 107:1,1
108:22 128:20 134:8
135:21 146:1 166:21
178:8 208:21 209:20
215:3 217:22 243:8
255:7 257:11 259:15
274:3 276:10 279:2,2
279:11,12,17 301:22
325:5 326:19 328:14
330:15 335:16 344:14
348:16 351:2 353:13
369:5 378:8 390:10
418:6
Michelle's 83:10 90:11
182:1 272:12 382:1
microphone 89:10
middle 272:22 332:15
333:2 381:5
midnight 381:18
miles 189:10

milestones 115:7
mill 145:20
million 44:9 45:6
172:19 203:15 319:13
347:13
millions 203:21
mind 50:22 70:6 106:17
118:11 119:2 156:14
215:21 290:3,19
299:16 334:18 363:14
381:4
mindful 47:10,18 88:10
342:19 350:2
min 103:13
mine 206:4 281:19
minimal 352:10
minimize 51:1,1 396:13
400:21 403:2
minimum 101:7,9 102:9
324:1,12,17 356:10
Minneapolis 6:8
Minnesota 184:12,16
260:20
minorities 133:16
minority 166:14 173:4
233:17,21 238:20
288:17 289:3,19
290:6 296:10 299:10
308:9 310:4 375:16
375:18
minute 124:11 212:6
325:6 331:14
minutes 99:19 173:14
174:2 241:20 320:14
409:12,12
MIPS 111:14 161:19
237:13 270:8,22
291:18 356:6 363:14
370:5,16,16,17,18
371:3,9
misled 65:9
missing 31:21 34:10
35:18 61:18 62:10
282:17,21
mission 90:1 115:4
116:15,16,22 120:18
132:3 323:22 324:4
329:2
mission-driven 420:7
mix 88:8 179:7,9 181:7
181:8 265:4 267:3
mix- 266:19
mixed 50:11 273:4,5
310:12 348:2 368:6
386:13
mode 246:1 342:10
model 4:15 18:21 50:3
62:5 65:3 98:7 136:8

139:20 156:20 166:1
 200:21 218:15 243:16
 260:22 261:3,11,19
 262:9 267:3 271:2
 315:19 348:2 356:5
 362:14 369:12 386:14
 404:20
modeling 417:12
models 46:2 156:17
 215:6 249:22 260:15
 260:16 261:5,16
 361:10 368:7
moderate 345:12
modifiable 346:18
modification 18:9
module 163:16 164:3
 202:22 241:8
moment 37:13 47:14
 174:16 214:20 341:12
momentum 252:19
money 78:11 108:10
 179:2 329:2 338:21
 351:18 353:5,17,19
 353:21 366:20 367:3
 367:14 368:2 369:10
 412:14
Mongan 6:18
monitor 149:20 158:21
 209:12 248:19
monkey 106:16
month 234:11 348:3
 367:18
monthly 155:8
months 150:16,19
 151:19 155:12 164:10
 282:9 295:15 330:21
moral 100:7,10 101:3
 102:12 108:11 328:2
 328:4,13,21 329:2
morbidity 331:22
 346:22
morning 5:12 6:6 7:19
 8:2,8,11,14,16,18
 10:17 20:20 28:20
 43:1,13 73:17 112:14
 140:6,17 232:2 237:9
 242:12 244:14,20
 271:5 306:2 333:8
 344:10 404:5,9 406:4
 417:12 420:18
morning's 396:17
morph 245:16,21
mortality 11:10 265:20
 265:22 266:2 286:10
 346:14 347:1 373:14
mortar 178:15
motivate 243:13
motivated 45:10 108:17

move 47:1 53:5 58:10
 60:11 63:7 69:12 83:7
 88:18 110:21 229:15
 236:6 241:21 248:15
 270:20 291:19 321:21
 322:17 337:19 382:3
moved 81:7
movement 51:6 156:2
 157:2
moving 48:18 78:11
 144:16 308:22 346:9
 388:11
MPH 1:11,15,17 2:1,2,3
 2:4,8,10
MPP 1:12
MSSP 416:5,18
MU 160:18 161:15,17
muddled 386:11
multi-level 296:13
multicultural 313:19
 314:2
multiple 17:10 54:22
 316:6 341:4 380:7
Munthali 2:10 8:11,12
 92:13
Murphy 2:11 5:12,13
 7:13,17 10:8 32:6
 95:18 120:11 170:19
 212:16 213:15 214:4
 294:1,13 335:17
 339:3 340:11 342:18
 421:16,22
mute 392:8
mutually 242:9

N

N.W 1:8
nailed 35:18
NAM 3:8 15:5 23:13
 43:5 51:16 104:14
 244:22 246:15,21
 247:12 251:18 252:8
 260:6 267:17 334:4
 385:19 389:3,4,7
 398:15
NAM's 27:9 413:20
name 119:15 179:20
 222:1 232:18 418:12
named 118:4 176:16
names 291:7 418:12
Nancy 1:20 6:5,7 22:1
 66:6 73:16 77:1
 122:19,20 134:9
 136:2 139:8 142:21
 165:7 181:20 183:8
 185:16 218:1,20
 251:19 255:8 257:11
 259:16 262:13 263:22

264:9 269:5 293:21
 299:22 301:9 304:2
 305:14 377:9 378:3
 382:17 402:15 403:7
 406:12 417:15,16
Nancy's 386:7
narrative 357:16
narrow 93:2 152:22
 153:1,4 155:14,19
 180:7 311:8 323:19
 347:14 399:15,18
narrowing 69:1 311:8
 395:13 406:18
narrowly 416:3
national 1:1,8 2:3 9:5
 9:10 11:13 66:20
 77:15 138:17 140:10
 141:6 161:12 184:11
 215:3 232:5 239:14
 241:13 305:2 308:6
 412:22
nationally 283:10
nature 43:11 57:5 71:13
 180:6
navigate 197:2
navigators 210:13
NCQA 3:8 8:3 172:3
 232:17 241:5 242:8
 289:14 326:11
NCQA's 237:2 270:17
 313:19
neat 99:2
Nebraska 6:10,10 111:2
 111:5,20
necessarily 34:18
 35:12 107:22 113:12
 142:14 143:10 180:4
 193:14 209:17 216:20
 220:3 252:15 269:7
 269:21 293:17 295:3
 314:19 341:19 395:16
necessary 20:1 323:13
 352:5
needed 123:7 203:19
 260:12 262:4 275:9
needle 337:19
needs 9:18 74:20 81:2
 83:1,16 90:20 100:1
 130:8,11,22 137:8
 154:14 165:11,17
 202:7 218:5 220:16
 223:17 224:9,12,19
 225:20 227:6 229:5
 229:13 236:22 270:12
 271:2 301:19 304:19
 308:14 312:19 314:12
 359:6,10 360:9,20
 391:19 414:5

negative 38:12 108:4
 178:14
neighborhood 129:15
 129:17 315:20
neighborhoods 296:9
 299:18 321:1
Nerenz 2:1 7:2,2 51:18
 175:4,7,10 179:19
 180:22 276:11 278:11
 282:22 284:9 285:11
 286:8 365:12 378:14
 380:15,21 381:15
 407:20
Nerenz's 187:19
nervous 75:19
net 20:13,14 44:10,14
 44:16 45:3,17 46:4,8
 48:12 57:22 58:3 67:1
 67:2,11,14,18,21
 143:8 151:2 179:15
 214:20 250:17 251:12
 251:15 262:22 268:16
 287:17 300:3 304:16
 312:22 345:19,20
 349:13,17 351:22
 366:4 370:9,13 375:4
 377:15 392:21 411:3
 411:5 413:22 416:13
nets 96:15 312:14
netters 155:4
network 153:7 155:14
 177:15 180:7,8
networks 152:22 153:1
 153:4 155:19
neutral 351:14
never 104:17 124:16
 154:9,9 158:7 350:9
new 1:13 10:22 23:19
 55:21 72:3 83:12
 113:12 152:10 155:17
 169:16 179:10,11
 236:15 249:17 260:22
 318:14 365:5,6
 377:13,21
newer 291:17
NewYork- 1:15
Ng 232:19
NHANES 346:16
NHMA 279:5
nice 73:22 200:12
 202:14 226:13 243:16
 312:3 337:11 396:16
 412:20
nicely 17:14 244:17
night 361:15
NIH 125:19
NIMHD 32:2
Ninez 1:9,12 4:4 7:10

21:19 25:8 168:20
 251:19 263:12 304:2
 305:15 310:14 335:16
 344:16,16,20 384:13
 387:11 405:2 422:6
nodding 52:11
noise 190:12
non- 266:22 375:17
non-adherence 205:4,8
non-black 68:22
non-dual 266:12
non-duals 397:6
non-existent 107:19
non-expansion 145:3
 155:5
non-governmental
 93:10
non-health 19:22
non-homeless 138:4
non-profit 130:11,20
 131:10
non-profits 131:9
non-safety 67:2 345:19
non-trumpeted 278:20
nonsensical 280:14
noon 5:18
normalize 387:6
not- 221:13
not-for-profit 221:6
 230:17 359:7 367:12
note 364:10
noted 47:5 48:12
 166:20 190:14 211:4
 256:7 272:13
notes 190:19 208:21
 404:1
notice 200:20
noticed 327:4 418:9
noting 276:14 277:9
 278:21
notion 61:21 121:19
 126:19 141:13 297:14
 336:20 339:7 359:17
Now's 263:3
NQF 2:7 4:22 8:10,15
 9:4 13:4,9 16:11
 25:22 31:18 35:3
 36:10 38:4 43:20
 47:19 48:18 49:17
 90:7 92:4,17 93:3
 97:18 102:20 103:3
 116:14 129:5 138:13
 139:7,21 145:22
 214:13 227:6 235:11
 251:5 268:21 280:4
 291:7 305:17 379:3
 392:14 393:1,1,13
 410:16 420:13

NQF's 8:7 48:8 258:2
 259:14 410:14
nuanced 80:6 161:5
number 18:5,14 29:5
 51:22 65:10 99:19
 113:17 138:22 153:6
 172:19 174:15 178:12
 181:4 192:10 193:17
 195:2,3 199:12,14,15
 206:19 211:12,12
 237:18 278:3,6 283:5
 316:2,2 322:5 355:19
 372:17 374:14 384:6
 384:22 409:16 410:15
 414:17 415:10 416:10
numbers 128:3 253:15
 253:16,16 278:5
 327:13 382:12
numerator 131:20
numerators 237:22
nurse 193:15
nurses 133:19
nursing 226:4
nutrition 331:7

O

o'clock 420:3
O'Rourke 2:11 8:14,15
 27:19 35:9 49:1 80:17
 91:18 112:12 134:13
 134:21 139:4 148:13
 173:16 174:11,20
 191:5 231:19 241:16
 363:13 394:20 405:14
 406:19 407:3,14
 410:6 414:4
obesity 229:4 295:22
 296:7,9 309:4 331:7
 337:8,10
objectives 3:2 10:9
obligation 321:3,4,15
observation 52:13 57:1
observe 102:13 407:22
observed 52:2
obstacle 254:3,16
obstacles 155:10
obviously 15:9 22:19
 45:19 51:20 57:20
 80:1 113:4 122:7
 135:4 150:8 205:3
 255:20 256:10 266:14
 280:4 348:19
occurring 192:13
 205:13
offer 86:6 241:12,13
 304:22 305:12 373:18
 377:10
offered 226:7

offering 137:20 138:1
office 5:21 166:14
 173:4 217:21 224:4
 233:17,21 238:20
 275:15
officer 2:8 8:10 207:11
official 320:19
officials 275:21
oftentimes 143:14
old 121:9,10 291:16
Olivia 275:19
ONC 161:13,18 162:14
 165:13
once 19:18 37:18 67:5
 103:4 150:4 172:13
 262:15 284:8 318:9
 340:18 397:20 417:8
one's 49:1 101:18
 283:17 370:12
one-size- 299:19
one-tenth 203:18
ones 28:4 158:10 180:2
 180:5 199:12 210:6
 213:10 214:14 240:12
 250:11 251:7,8 284:4
 298:18 333:17 416:7
 416:9 417:4,6
ongoing 278:20
online 14:22 146:4
open 93:15 102:22
 114:10 174:12 179:10
 206:4 318:17 330:14
 393:4
open-ended 128:11
opening 85:11
operation 308:12
operationalization
 396:18
operationalize 27:2
 356:18
operationalized 32:16
 123:10
operationalizing 33:4
Operator 174:11,13,18
 403:14,17
opinion 34:10
opportune 47:3
opportunities 51:12
 106:4 123:11 127:19
 209:14 394:10
opportunity 3:7,14 10:6
 38:3 46:16 48:7,17
 58:7 60:10 85:19
 93:19 105:1,8,10,12
 106:10 109:6,14
 110:16 124:9 126:9
 128:13 140:14 205:11
 205:16 223:6 228:22

231:15 240:7 241:1
 243:7 244:7 270:8,9
 281:16 297:18 306:4
 308:21 310:18 314:3
 320:8 345:1
opposed 24:22 58:5
 65:17 143:18 147:9
 148:3 211:21 268:15
 299:19 321:7 329:2
 359:16 362:8 412:12
optimal 323:12
optimizing 346:2
options 17:10 197:6
 262:15 344:2 356:11
 356:16
oral 216:18
oranges 179:7
order 11:19 50:2 69:15
 165:1 374:9 415:17
orderly 244:13
organization 19:5
 52:22 57:5 65:18 74:3
 74:5 75:14,15 79:7
 90:1,3 97:4,22 103:10
 103:11,19 118:13,20
 121:19 162:11 177:7
 181:2 211:20 212:19
 212:20 213:3,6,22
 214:16 218:8 231:2
 235:18 237:11,20
 241:10 282:2 295:4
 304:7 314:20 320:16
 321:12 322:20 323:22
 338:7 354:20 395:20
 418:12
organizational 57:16
 62:10 63:6 118:14,21
 119:7 129:8,12 178:8
 220:10
organizationally 69:12
organizations 20:13,15
 41:20 52:2,19 58:8
 61:20 67:15,19 69:21
 75:8,18 80:8 85:12
 95:21 96:16 97:10,20
 98:15 102:20,21
 103:16 121:4,12
 135:7 163:18 189:13
 208:12 211:12 212:21
 213:18 230:9,13,16
 230:19 231:8 235:21
 236:17 241:4 251:13
 270:19 271:15 296:16
 297:6,10,16,19 298:2
 312:14,21 313:6
 314:5 318:6,8 324:3
 339:6 352:7,12 357:2
 357:6,10 397:3

413:22 416:13
organize 407:5
organizing 274:12
 333:11 406:2,9
orientation 59:19 62:7
original 15:6 78:18
 261:11 377:4 384:18
originally 385:5
origins 233:11
ought 391:11
outcome 50:11 51:7,9
 51:16 52:5 53:5,18
 54:10 55:12 56:6
 63:12,19 66:11 67:4
 113:21 190:1 191:18
 194:9 238:17 266:19
 290:22 291:20 294:5
 302:20,22 311:1
 343:10 347:14 348:10
 361:8 372:11 373:7
 374:12
outcomes 1:14 54:13
 54:21 57:7,7,13,14
 58:21 59:14,20 60:4,8
 60:14,19 61:1,6 62:1
 66:12 69:20 70:6,10
 74:10 101:11,19
 104:18 123:16 142:8
 149:20 150:22 158:21
 199:10 201:3,16
 203:4 248:7 249:11
 249:16 250:5 256:1
 292:20 293:1,6
 296:19 303:15 304:16
 308:10,14,15,15,17
 308:22 311:12 317:12
 323:12 336:17 348:14
 351:16 353:19 354:13
 362:5 372:13,14
outdated 79:1
outlier 291:12
outpatient 305:7 417:3
 418:3,4
outrage 184:20
outreach 194:17 210:17
outside 5:21 75:12
 183:21 195:6 215:19
 218:7 225:22 303:11
over-arching 405:16
overall 9:3 10:6 25:2
 110:4 144:4 181:14
 244:1 265:21 266:8
 277:1 311:19,20
 321:5 323:3 335:11
 347:5 349:10 376:1
 399:12,19 415:18
 417:12
overhead's 182:12

overlap 116:8
overlapping 242:7
overly 110:10
overriding 261:14
overview 3:4 9:1 10:22
 11:3 14:22 21:7,10
 175:16
overwhelming 327:13
ownership 149:10
owning 65:16

P

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

4:1
P.J 421:18,22 422:1
p.m 191:10,11 329:7,8
 422:10
P4P 276:15 330:4 348:7
 349:13,16
package 241:11 325:4
packages 73:9 101:14
 101:16 102:9 241:2
packaging 87:1
page 21:12 123:2
 299:15 302:2 329:12
 362:21 387:15
pages 302:2,3
paid 182:14 186:6,11
 226:15 273:20 300:14
 300:15 366:9
pair 399:16
pairs 20:10
palsy 126:1,6
panel 241:14 259:18
 301:1 379:3 384:17
panels 9:11
panic 282:4,9
paper 44:1 55:6 57:18
 135:8
papers 208:17 337:11
 346:12
paradigm 65:21 338:16
paradoxically 183:6
paragraph 160:15
parallel 116:13
parameters 176:22
paraplegic 275:20
parcel 251:7
pardon 119:12 188:20
parking 147:6 186:2
 280:17 302:10
parsimonious 404:18
part 13:4 14:18 18:12
 18:19 24:20 29:9
 37:11 48:4 57:1,17
 59:8 65:22 78:20,21
 83:1 86:21 88:14,17
 90:18 100:3 106:20

107:20 108:1 109:21
 119:8 128:6 129:16
 130:21 132:2 135:11
 143:9 172:10 193:2,5
 203:5 209:3 220:18
 222:6,7,22 228:9,15
 243:19 244:1 250:2
 251:6 256:16 263:21
 269:6 271:15 273:7
 283:6 285:14 300:15
 300:15,18 314:18
 322:1 328:10 331:20
 332:1 338:2 342:6,7
 343:17 345:3 349:4
 355:4 356:8 363:9
 371:14 387:22 391:12
 391:16 410:4,11
 411:8,12 412:6
 413:14,14,15 414:8
 418:9,21
partially 171:1
participant 38:16
 161:11 363:17 404:2
 408:14
participants 191:2
participate 261:3
 271:16 358:6
participating 121:20
 122:10 242:5 314:6
participation 141:2,10
 146:14 237:17 271:15
participatory 18:11
 318:1
particular 9:15 17:2
 28:2 31:19 40:17
 42:15,15 53:9 58:8
 145:17 192:20 193:7
 193:20 195:10 230:10
 243:19 251:2 261:18
 298:21 317:8 343:20
 382:17 384:12,21
 389:14 393:3
particularly 10:2 27:21
 28:8 52:3 53:16,22
 54:16 61:20 113:15
 309:10 358:14 374:12
partly 46:9 416:1
partner 137:17 208:14
 208:14 220:19
partnering 127:21
partners 2:4 6:21 54:22
 163:21
partnership 2:1 39:11
 84:18 94:4 156:20
 208:12 212:2,13
 216:11 218:4 220:22
 301:18 313:12 336:10
partnerships 14:4,9

19:21 25:15 26:11
 50:8 61:11 70:13 71:4
 74:22 84:12,13
 104:12 205:20 208:8
 209:1 216:16 218:12
 309:12 336:15,16
 368:12 369:1
parts 28:16 36:15 315:5
pass 62:12 79:7 80:10
 84:1 315:8
passive 110:12
path 59:18 398:1 406:8
pathway 287:12 340:12
 340:13
patient 18:8 35:6 45:5
 79:4,5 80:16 105:14
 105:14 109:7 127:17
 129:22 143:18 145:16
 160:5 182:12 193:12
 193:21 198:10,15
 199:3 202:20 228:19
 238:18,22 240:9,11
 240:13 247:5 273:8
 293:8 299:16 308:13
 320:19,20 374:9
 378:21 380:18 381:10
 398:13,17 399:7
patient- 233:18 400:8
patient-centered
 233:20 234:6 237:3
 239:6
patient-focused 79:9
patient-level 264:15
patiently 89:4
patients 58:2 68:17,22
 79:12 105:9 136:12
 148:7 166:5 184:14
 184:15 185:4 189:9
 190:11 192:14 193:10
 193:18 194:5 195:2,4
 197:2,5 198:13 205:7
 235:19 237:12 264:17
 264:22 266:22 267:1
 321:3 375:17,18
 376:2,14,15 380:19
 388:21 397:9 400:3
pattern 283:11
pause 26:6 174:16
pay 99:11 102:5 153:11
 164:4 182:19 183:5
 324:11 337:8 339:11
 376:18
payer 93:9 94:1 154:7
 178:21,22 179:7,9
 182:15,18 185:6
 192:17 258:19 260:10
 273:16 325:10 392:17
 395:22

payer- 283:15	percentage 371:4	118:2 121:6 128:21	piggybacks 104:2
payer-purchaser 327:8	percentile 323:5,8,20	144:18 145:8 147:16	pile 179:2
payers 87:6 88:13	perceptions 118:16,17	155:1 156:10 207:15	pill 204:10 353:9
138:8,8 147:18	percolating 72:8 96:6	207:20 208:2 215:19	pilot 360:18
190:18 251:4 255:10	perfect 127:1	220:12 223:11 226:20	piloting 309:9
280:1 350:2 393:2	perfectly 105:13 377:6	251:19 280:22 281:17	pinned 106:3
412:5	performance 9:13,20	293:21 299:22 301:9	pipe 392:9
paying 66:17 284:2	12:2 99:11 176:12,14	304:1 306:2 332:8	pitch 301:11
336:7	187:12 227:22 233:5	334:1 345:15 362:11	place 50:5 54:5 60:4,15
payment 11:15 20:9,17	237:17 238:2 247:6	365:10 367:7 369:15	82:22 91:21 97:4,10
28:7 94:6 97:13	248:12 249:9 268:6	384:13 395:7 398:2	98:3 113:16 124:10
136:21 137:7 138:1,3	383:4 388:20 399:12	400:7	126:4 127:4 156:8,21
141:4,7,10 180:3,6	400:11	philosophical 106:6	166:3 171:14 187:1,7
236:15 247:7,7	performing 192:1 379:9	112:7 114:17	189:16 190:8 200:16
248:15,20 250:15	performs 288:18,19	phone 7:14 11:2 33:19	208:15 224:7 236:13
260:13,18 261:1,2	291:5	49:14 56:19 204:20	253:2 260:16 265:6
262:3 264:2,10,20	period 10:19 12:19	219:18 221:2 225:5	282:10,16 297:17
265:3 305:6 320:11	28:17 60:7 61:2 103:6	259:17 270:3 272:7	298:17 300:4 303:10
328:18 329:21 330:3	255:2 259:7 264:6	304:3,3 305:15	335:4 346:6 361:19
330:5,6 336:1 337:4	355:17 421:2,5	306:22 307:1,22	369:1,12 398:12
337:14,18,20 347:1	periods 155:7	308:19 310:7 312:7	placed 391:9
348:1,2 349:8 350:16	Permanente 1:18 6:12	315:2,11 340:1,7	places 144:9 145:6,7
356:5,8 357:19,21	permission 384:21	344:13 347:10 365:11	260:14 281:14
358:15 360:19 361:5	persist 109:18	369:16 370:2 371:13	placing 257:2
363:9 364:2 368:7,21	person 100:20 165:6,6	371:17 372:4 373:21	plan 8:1 85:8 90:15
375:4 377:12 397:5	198:9 211:16 259:18	378:4 392:1 403:8	91:6 115:5 122:9
406:16 413:1,3,10	261:9 285:20,21	419:21	139:12 140:13 149:15
414:17 417:21 418:13	303:3 308:4 339:22	phonetic 116:20 202:1	150:16 151:9,19
418:18	340:7 365:14 372:18	phrase 277:8 385:20	152:5 154:7,10,11
payments 137:6 260:9	384:7 418:11	phrasing 54:2	170:11 179:22 180:7
275:8 300:18 305:5	person's 384:8	physical 125:20 172:7	180:8,12 183:13
324:14 332:5 348:4	person-centered 234:7	172:22 177:17 229:2	195:7 197:4 202:21
372:1 395:19 413:21	person-centeredness	309:4 397:17	203:21 210:16 220:7
418:2	222:7	physician 111:8 193:14	224:16 226:5,16
payors 91:3	person-family 192:8	217:15 305:8 418:5	227:20 228:1,2,16
pays 101:22 182:12	196:22	physician-owned	276:22 284:7 292:8
PCORI 335:21 337:13	personal 72:20	230:20	328:5 351:6 354:7
338:3	personally 106:11	physician-patient	360:15 361:13 397:7
PCP 150:5,12	123:7	192:4	397:10 402:8 403:21
pediatric 195:1	personnel 118:21	physicians 133:11,18	planned 113:3
peer 210:21 387:16,18	persons 222:11,11	133:19 300:16	planning 201:2 252:12
389:22 399:20	275:17	picayune 84:7	plans 1:19 87:6 91:2
penalize 52:21	perspective 94:12	pick 21:17 62:21 63:1	101:15 137:22 138:15
penalized 56:9 385:12	178:2 203:3 222:15	63:10 121:15 273:17	149:8 152:19 157:18
penalizing 54:21	234:5 235:17 296:11	picked 195:18	180:13 193:5 201:10
penalties 68:5 377:18	403:6	picking 289:13	230:14 231:6 241:8
penalty 27:11 68:3	pharmacy 216:18	picture 36:17 53:15	257:3,8 276:21
penless 268:14	phase 92:10 117:15	110:4 376:19 418:21	277:13 283:16,22
people's 41:14 59:10	PhD 1:12,12,20,21 2:1,5	piece 17:12 30:6 36:16	284:13 313:16,19
107:10 123:9,9,15	2:8	36:17 37:7 65:6	352:16 421:19
328:21 391:4	phenomenon 292:11	158:14 171:7 216:12	platform 219:9
percent 45:4 111:13	292:12	276:12 280:2 294:16	play 113:14 122:16
124:21 125:16 162:18	Phil 48:7 102:17 130:7	339:12 357:17 415:8	135:6 187:18 270:1
172:17 198:13 201:12	381:1	piecemeal 348:9	314:22 419:4,9
203:19 287:10 288:18	Philip 1:12 7:4 46:14	pieces 69:15 129:14	played 65:8
288:20,22 289:10	73:16 81:17 84:22	158:15,18 187:17	playing 5:7 108:15
291:5,9 293:8 370:12	89:3 103:21 106:18	270:15,17 310:15	324:1,17 374:15
375:16,17 379:12	109:3 114:6 117:10	piggyback 43:17 218:3	plays 276:13

plea 302:9
pleas 257:13
please 5:20 33:16 38:16
 89:9 112:13 141:18
 141:19 167:18 174:14
 227:10 236:5 238:3
 346:8 371:19 392:9
 420:9
pleased 76:6
pledge 97:8 134:4,4
plowing 252:16
plug 164:5,6
plugged 163:19
plus 255:21 258:1
 397:10 411:4
pneumonia 266:9,11
pocket 159:17 205:6
 269:12,14
pockets 97:9
point 15:2 25:21 29:10
 31:16 35:21 36:2
 42:12,20 43:17 45:20
 49:2,6 52:11 53:10
 76:18 80:3 83:9,11
 84:6 86:1 87:16 91:11
 93:16 95:19 97:9
 104:1,1,3 107:3
 109:12,19 111:10
 113:9 114:7 138:18
 154:19 162:3,6
 165:16 167:11 170:4
 171:13 181:18 183:10
 185:21 187:11,19,22
 227:1 229:21 245:4
 246:18 276:12 280:20
 287:4 290:3 291:10
 297:2 299:10,12
 302:18 303:17 308:8
 309:14 314:14 325:16
 326:4,5 333:6 338:8
 340:6 341:14,15
 355:22 356:19 362:17
 362:18 363:4 368:3
 378:15,16 386:7
 387:12,21 395:4
 398:6 409:20
pointed 54:17 129:1
 310:14 341:4 405:2
pointing 162:14,15
 369:5
points 53:3 58:20 71:2
 76:2 84:21 88:11
 140:19 161:14 251:17
 280:19 343:20,21,22
 356:19 370:18 382:3
 394:22 408:6
policies 144:11 186:3
 253:7 257:14 259:9

260:2 306:17
policy 4:18 6:19 10:15
 15:21 19:4 20:5 24:19
 28:5 33:9 86:13
 117:20 130:13 131:11
 141:7 143:6,11 144:9
 174:4 187:14 242:2
 259:9 261:4,20
 264:10 279:22 345:7
 345:11 352:14,16
 403:6 404:12 420:19
policymaker 258:19
political 158:1 319:11
politics 256:10
poor 100:20 379:2
 385:13 399:19
poorly 328:19
pop 301:15 344:16,16
 344:21
popped 291:4 344:15
populate 53:9 61:22
 72:3 146:2
populated 207:16
populating 53:12
population 45:5 85:22
 108:11 113:4 124:14
 137:8 139:9 151:16
 151:18 152:2,15
 153:15,20 160:6
 172:18 176:8,8,10
 177:1,3 178:2 184:3
 187:4 195:1,2 201:9
 201:13,14 203:19
 204:9 215:15 240:15
 241:11 256:8,9 261:1
 271:18,20 278:5
 284:21 285:2,3 293:8
 294:12,12 295:2,18
 296:11 299:11,16
 301:13 302:1,8
 304:12,16 305:19,21
 305:22 307:13,14,16
 307:17,18 309:5,18
 310:12 311:9,11
 315:18,21 320:16,20
 321:9,11,16 322:11
 323:6 331:3,12
 350:22 383:5,9
 402:11 416:8
population- 178:6
population-based
 160:8
populations 20:15
 42:18 43:8 57:8 74:18
 74:20 77:10 78:12
 88:15 100:7 138:2,4,5
 142:2 183:20 186:20
 210:18 260:11 262:6

268:7,9 288:17
 294:18 296:22 297:1
 301:19 304:9,11
 305:11 312:17 323:1
 323:7 324:12 334:13
 334:17 349:3,20
 350:4 377:19 378:2
 386:10
portal 198:11,15
portfolio 31:18 216:4
 357:20 363:9,10
portion 10:20,21
 194:11
posed 56:22
position 324:10
possibilities 290:9
possibility 94:2 110:13
 124:4 334:19 344:4
possible 44:5 186:9
 203:3 308:12 367:20
 388:9
postcard 159:12,13
posted 12:19
potential 46:15 55:17
 75:22 105:2 123:20
 131:8 139:9 140:8
 375:6 407:8
potentially 36:14 55:1
 80:11 190:8 252:18
 332:14 340:10 348:13
 377:18,21 398:20
 402:19 419:11
poverty 367:1
power 64:18
powerful 30:8 161:9,9
powers 67:4
practice 148:3 195:6
 245:8,16 287:16,20
 370:20 404:8
practices 43:7 60:1
 89:14,19 230:13,20
 231:6 235:11 314:4
 380:4 418:5
practicing 133:11 142:5
practitioner 193:15
pre-determined 362:6
pre-diabetic 419:10
pre-work 10:13 26:13
 146:3
precedent 261:13
precise 64:12 227:7
 398:11
precisely 43:17 316:9
predecessor 51:22
predicting 312:19
 344:4
predominant 87:21
predominantly 360:6

preface 276:12
preference 40:15
 184:22 254:6
preferences 123:9
preferred 89:14,18
 159:12
premise 353:18
premium 203:22
prerequisite 340:4
prerogative 205:21
 259:20
Presbyterian 1:16
presence 207:5,10
present 1:10 2:13,21
 12:17 174:3 205:22
presentation 301:14,15
 301:15
presented 234:10
presenters 303:1
presenting 127:9
 420:14
President 2:10 8:12
presiding 1:9
press 144:4 174:14
 403:15
pressing 106:17
pressure 199:16 272:18
 292:14 327:19 332:20
 422:7
presumably 348:5
presuming 76:21
pretend 222:18
pretty 4:10 26:15 27:16
 51:19 141:8 187:8
 201:22 225:21 251:15
 272:20 273:2 305:20
 320:1 354:17 369:18
 408:17
prevalence 16:19
 331:21 332:21
prevent 254:11 311:21
 312:13 412:8
preventable 346:22
 359:19 360:13
preventative 20:11
preventing 68:7,19
prevention 229:3
preventive 189:18
 251:12 330:2 348:5
 409:6,10 411:18
 412:6,10,11 415:22
 416:6 417:4 418:8
 419:17
prevents 68:11
previous 12:17 16:11
 16:14 22:7,10,16 32:9
 32:19 74:8 77:22
 230:1 234:5 238:19

329:19
price 153:10
pricing 142:15
primarily 240:14 275:9
 327:10 374:20 377:1
primary 20:11 90:19
 142:4 177:4,15 181:4
 190:5 196:10 206:19
 206:22 217:5,13
 223:18 255:21 337:8
 337:9 370:16 411:18
 416:1,6 418:8,14,15
 419:14,16
Prime 364:17
principle 215:22 311:22
principles 5:3 24:17
 25:3 60:1 233:18
 356:16
prior 47:13 92:8
priorities 21:18 162:4
 349:3 359:12,14
prioritization 40:13
 330:20 332:3 333:20
 360:22 396:18 405:1
 420:21
prioritize 139:3 163:6
 223:17 331:15
prioritized 42:7 224:9
 224:19 225:8
prioritizing 333:12
priority 10:12 19:8
 22:14 38:8 184:14
 229:12 254:13 274:13
 284:2 331:19 333:17
 357:7 359:12 360:11
private 88:6 137:22
 138:8 182:11 328:4
privately 184:14 265:20
proactive 68:16 69:2
probably 24:21 44:5
 45:8 53:19 63:2 64:22
 65:2,4 100:12 133:20
 159:14 184:21 188:12
 203:6 226:3 242:22
 245:17 250:12 253:11
 273:10 276:14 278:18
 287:13 289:4 291:13
 312:6 316:18 320:13
 326:6 355:10 356:10
 356:13 362:11 363:5
 382:15 392:16 405:6
 411:17 417:6
problem 109:15,18,22
 110:3 125:18 156:2
 159:22 179:16 182:2
 183:2 273:7 285:10
 286:22 291:1 296:7
 298:21 350:9 385:11

problematic 169:12
 170:1 179:13 256:10
problems 188:6 257:8
 268:4 285:14 366:22
 367:1,1,2
procedure 187:5
procedures 186:19,21
 269:13
proceed 175:2
process 26:17 30:21
 36:4 49:22,22 50:11
 51:6,10,15 52:4 53:5
 53:6,18,20 54:19
 55:12 56:5 58:21
 59:20 60:2,22 63:17
 66:10 71:12 74:11
 93:11 105:5 113:20
 116:13 159:4 191:22
 194:8,11 198:2
 223:14 224:1 238:4
 238:16 290:22 291:16
 292:4 293:13 302:20
 302:22 348:9 351:17
 359:1 361:6 362:13
 372:9 375:14
processes 60:3,9,14
 61:3 94:16 123:15
 127:4,22 303:9,14,19
 394:8
prod 293:5
produce 375:13
produced 346:14
product 5:8
products 242:8
professional 116:17
 157:6 338:3
professionals 65:14
program 23:21 24:8
 53:9 66:15 86:5 87:5
 122:4,7 145:14 156:1
 172:14 184:2 207:10
 207:12 236:15 238:13
 256:12 264:12 268:13
 270:9 271:16 274:14
 274:17 275:7,13
 276:3 278:7 284:4
 292:17,19,19 293:6
 293:12,14,15,17
 316:9 317:20 318:15
 325:18 356:3 363:3,5
 371:10 401:14
programs 18:10 20:9
 25:6 28:7 46:7 52:19
 53:13 68:3 83:5 86:10
 94:6 159:3 200:16,18
 216:10 225:3 229:4
 236:12,13,14 237:13
 239:14 248:15,20

249:15,18 250:16
 251:6,6 253:6,10
 254:18,19,20 256:3
 260:2 264:3 270:5,7
 270:17,21 271:2,9
 272:4 276:15 279:15
 281:2 290:14,18
 291:3,18,18 293:2
 300:4,12,17 301:5
 305:4 308:4 311:16
 316:8 317:11 320:11
 325:18,19 327:12,20
 328:18 330:5 348:1
 352:13 353:20 356:2
 356:12 357:21,21
 358:2,10,16 362:18
 362:22 363:9 364:2
 369:4 377:14,22
 406:16 411:22
progress 257:5 335:11
progressing 62:1
project 2:8,9,9,11 3:4
 5:13 7:9 8:17,19,21
 10:22 11:3 12:12,13
 13:3 15:8 16:16 17:15
 20:7 22:16 91:15 92:3
 205:1 213:12 302:11
 302:12 326:10
projects 20:16 159:15
 212:22 225:22 250:20
 415:9
proliferation 50:20 51:2
prominence 277:20
 282:18
promise 291:6
promote 90:2 139:13
 146:19 148:22
promotes 157:7 375:2
 418:13
promoting 68:10 229:2
 315:17
promotion 383:3
promotoras 210:13
 214:10
proof 340:5 342:16
 349:19
propels 298:5
properties 177:13
proportion 116:2
 264:17,22 376:2
proportions 383:10
proposal 99:1 135:12
 265:16
proposals 267:11
propose 46:20 82:17
 114:18 169:16 267:5
 359:1 395:11
proposed 117:16 210:2

260:22 264:1,13
 379:8 382:20
proposing 265:6
 363:22
proposition 214:21
prospectus 351:3
protect 67:10,18,21
 68:3 384:6
protecting 67:14 68:11
protection 352:4
protocol 16:14,18
proved 354:9
proven 39:7 361:7
provide 5:22 18:17
 22:22 32:18 82:19
 101:6 163:8 182:18
 223:8 245:1 249:18
 324:11 344:1 352:8
 377:14 394:21
provided 247:18
provider 19:6 109:17
 122:2 136:7 139:15
 155:15,16,19 179:1
 183:19 184:5 185:3
 185:18,19 193:11,12
 195:17 197:8 202:21
 301:1 312:22 325:11
 327:5 351:6 370:17
 380:3
provider's 53:21 178:11
 179:1
providers 58:2 68:15
 77:8 109:20 121:22
 122:3 136:6 138:16
 182:21 186:9 190:18
 197:21 206:21 248:20
 249:9,19 250:18
 304:12 312:16,21
 366:9 374:15 375:1,4
 377:16 378:1,2
 394:15
provides 78:4 145:18
 245:3 398:19
providing 11:5 102:1
 178:22 221:8 368:1
 393:8
provision 189:18
proxy 143:15 189:20
psychic 386:5
psychological 161:14
public 3:7,14 7:11
 12:19 14:22 47:14,15
 131:12 132:16 138:1
 138:8 146:21 153:19
 174:6,8,10,12,18
 220:20 221:6 223:20
 247:3 305:18 314:17
 320:11 328:7 397:4

403:11,15
publication 66:22
publicly 224:20
published 208:17
pull 37:9 225:6 254:5
 258:11 275:13 365:2
 418:22
pulled 18:14 117:1
 121:3
pulling 209:8 365:7
pulls 121:11
pulse 406:7
punitive 350:18
purchase 163:18
purchaser 283:16
 286:17
purchaser-specific
 88:11
purchasers 87:4,5,13
 88:13,15 257:15
 280:2 327:19 328:7
purchasing 24:3
 249:15 256:1,14
 353:15
purely 45:9 329:2
purpose 42:22 64:3
 212:8 227:6 374:18
 395:11 396:4 400:4,7
 410:11,16 419:20
 420:5
purposes 76:11,12
 255:5 326:16,18
 359:7 379:16
push 46:3 99:14 117:8
 291:20 343:9 362:15
pushback 51:2 55:20
put 15:3 25:22 26:9
 40:13 47:3 81:14 87:8
 89:9 107:17 108:19
 110:1,3 113:16 126:1
 130:16 134:22 159:3
 172:16 175:14 186:8
 186:22 187:16 206:4
 207:9 210:2 214:19
 232:7 243:16 246:3
 263:13 264:1,3,16
 265:6,16 270:8,9
 280:17 289:2 297:16
 298:17 301:2 327:19
 332:19 342:3 351:18
 354:1 355:21 360:4
 366:15 389:22 390:2
 393:15 399:11,17
 406:4 407:4 410:19
 413:9 415:22 416:12
 419:9
puts 209:2 214:16
putting 38:21 62:17

158:7 165:1 268:15
 273:11 355:3,20
 360:14 361:12 362:1
puzzle 30:7 129:14
 187:18

Q

QI 127:4 236:18 237:6
quadriplegic 275:18
Quadruple 257:19
qualifications 151:10
qualified 23:22 257:3
qualify 151:13,14
qualitative 75:7 121:3
 128:2 214:15 221:1
 221:18
qualities 331:1,5 416:8
quantify 102:11 108:4
 355:6,9
quantifying 354:4
question 21:16 22:11
 23:12 30:20 32:14
 33:6,21 40:9 41:4
 43:11 48:21 50:18,22
 57:1 62:19 69:10
 73:13 78:18 91:12
 97:14 138:13 142:20
 143:14 170:19 171:6
 171:8,12 193:21
 197:10 201:18 202:19
 227:16 228:4 231:17
 259:22 260:1 277:22
 278:1 282:14 288:9
 289:9 290:15 294:4
 302:11,19 304:21
 305:3 313:5 317:9
 325:9 326:2,12,15,22
 336:8 337:21 340:18
 356:22 358:1,2,12,20
 363:21 367:6 373:14
 374:2 378:9 382:1,2,4
 388:16 389:16,19,20
 391:4 392:13 393:5
 393:11 395:8 397:19
 411:15
questionable 56:3
questions 14:12 21:11
 21:13 32:21 33:14
 47:1 48:19 131:17
 140:22 166:13,16
 167:1,20 168:3 170:2
 170:5 172:6 173:5,11
 193:4,7 202:6 231:20
 237:6 241:21 253:4
 253:14 281:21 304:4
 324:7 391:3 396:11
 405:11
queue 55:8 56:18 58:17

128:17 334:2 392:4
 395:4
quick 5:14 11:1 30:10
 33:21 66:8 80:17
 103:22 104:3 107:2
 138:12 281:20 301:11
 310:9 421:18
quickest 260:14
quickly 10:9,21 144:1
 173:22 175:11 179:20
 317:5
quietly 381:1
quintiles 379:11
quirk 300:14
quit 285:12
quite 36:18 116:18
 186:12 189:4 226:21
 259:22 271:13 277:8
 277:20 281:4 291:16
 399:2 400:12
quote 261:8

R

R-24 213:11
rabbit 109:4 123:4
 124:6 126:20
race 11:16 132:22
 149:11 161:1 196:9
 317:7 374:17
racial 87:17 167:2
 310:4
racism 31:22 42:12,19
 48:9,11 170:16
racking 395:12
radiation 125:13,17
 126:2
raise 294:21 307:7
 325:8 337:16 362:18
raised 63:20,22 95:19
 170:16 231:17 276:1
 280:19 312:5 333:18
 345:15,15 404:15
raises 268:2,16 314:16
 337:22
raising 76:21 338:15
rampant 305:20
RAND 120:2,3 235:9,22
randomized 41:17
 336:12
range 76:5 240:4
ranging 230:11,12
 330:4
rank 144:3
ranking 144:7 376:6
rankings 376:7
rare 357:7
rate 181:9 266:10 277:2
 375:16,17 376:5

379:1
rates 57:15 66:21 74:18
 122:4 154:2 187:6
 200:18 265:21 266:2
 266:12,16,17 276:1
 277:1 286:14 292:7
 292:13,14 293:16
 309:2 373:13,14
 375:19
rating 193:11,12,16
 303:5
ratio 136:20 137:5
 145:4
rationale 383:20
Rauner 2:1 6:9,9 23:11
 27:8 44:7 90:10
 110:21 130:6,20
 155:2 181:22 208:22
 225:17 253:18 272:11
 300:1 330:17 370:4
 392:12 415:20
raw 400:10
RCT 338:12 345:10
RCTF 42:2
reach 350:5,12
reached 13:8
reaching 85:11
reaction 78:22 184:21
reactions 66:8
read 73:20 177:10
 220:14
reading 34:12 346:12
 365:17
readmission 27:11
 66:13,21 99:16
 264:12,19 265:21,22
 266:2,9,11 273:5
 390:5
readmissions 331:14
 383:4
readmitted 293:9
ready 166:7 191:13
real 45:12,22 51:12
 63:18 93:18 115:5
 131:6 146:19 151:22
 170:22 185:22 216:4
 216:10 232:3 252:22
 281:15 291:22 343:14
 382:8
realistic 187:22 420:20
reality 184:21 226:14
 287:19
realized 30:5 191:17,21
realizing 56:7
realm 187:1 203:2
 238:16 296:21
realms 129:10
reason 5:19 39:9 80:22

111:4 121:1 125:7
 182:10 221:3 261:20
 265:12 286:18 322:19
 363:21 382:8 384:10
 419:5
reasonable 29:5 62:15
 64:21 104:19 212:1
 377:6 404:10
reasonably 330:11
reasons 44:16 107:7
 142:3 173:2 283:19
 379:6 394:5
rebuttal 295:7
recap 11:1
received 367:14
reception 421:17
recipients 72:12 86:17
 402:11
recognition 236:14
 237:13 298:3
recognizing 19:20
 63:17 98:4 322:2
recommend 39:17
 55:16,18 94:14
 113:12 222:22 341:6
 341:7,15 348:19
 388:6 400:6
recommendation 10:16
 19:1 59:8 70:18 77:3
 170:18 250:2 267:17
 305:1 311:5 343:8
 393:12,18 402:1
 407:12,16 417:16
 418:2
recommendations 4:18
 5:9 12:4,15,18 15:14
 15:21 18:15 20:6
 23:16 33:9 76:10
 77:16 82:10,16 83:4
 87:1 93:3 98:11 174:4
 242:2 244:5 246:15
 246:16,19,21 247:10
 248:1 250:9 273:13
 289:7 305:12 324:21
 342:9 344:3 357:2
 377:13 398:9 400:17
 404:7,11,12 405:17
 411:9,10 416:17
 417:19 420:19,20
recommendations/use
 24:20
recommended 94:8
 163:3 246:22 247:12
 379:4
recommending 56:13
 169:15 221:18 364:1
 393:13,22 409:4
 411:6

recommends 94:5
reconcile 303:21
record 159:8 165:5
 191:10 192:20 194:4
 195:16 197:13,19,22
 217:6 329:7 422:10
recording 145:22
 252:21
recruit 90:2
recruited 214:11
reduce 9:21 12:5 17:18
 18:1 20:18 29:20
 38:13 41:15 52:4,22
 194:15 195:19 271:18
 292:22 304:15 329:21
 330:8 332:6 367:22
 373:10,17 374:20
 377:17
reducing 132:8 246:5
 248:17 269:18 285:19
 304:17 345:18 347:7
 372:13
reduction 3:11 15:19
 20:4 96:1 135:11,15
 245:15 256:5,15,16
 260:3 264:12 276:17
 290:7,8,11 299:11
 309:3 329:14 346:3
 357:19 369:8 371:2
 372:2 373:7 375:22
redundant 253:19
refer 380:17
reference 229:10
referenced 120:13
 134:3
referencing 229:12
referral 195:5,5 196:6
referrals 194:19
referred 172:13 196:15
referring 292:13
refine 414:16
refinement 414:19
reflect 41:6 48:11 69:5
 131:22 242:22
reflected 89:22 107:4
 287:10
reflecting 335:20
 402:16
reflection 133:3,6
reflective 162:12
reflects 154:20 181:11
reform 97:13 317:19
 418:13
reforms 418:18
reframe 407:1
reframing 313:2
refresh 26:5 31:4
 169:19 410:3

refugee 182:3
refugees 349:1
regard 37:5
regarding 93:14 196:6
 347:11
regardless 292:8
regression 387:19
regular 118:19 391:12
regulation 225:12
rehash 374:6
reimburse 82:12 308:5
reimbursed 183:12
reimbursement 122:4
 262:7 300:10
reimburses 137:3
reinvent 313:7
reiterate 398:10
relate 48:21 49:9
 118:13 177:8
related 21:11 51:5
 106:1 123:9 172:7
 205:3,8 263:14 290:4
 317:2 337:22 387:17
relates 69:19 101:19
 263:20,22 264:2
 268:19
relating 49:4
relations 115:17 224:5
relationship 11:17
 19:14 141:9 193:13
 222:10 258:14,17
 259:4 327:17,18
relationships 141:13
 141:20 142:11
relative 16:21 62:3
 290:5
relatively 365:22
 397:10 404:17 411:17
relax 420:9
release 144:5
relevant 13:9 59:7
 121:10 139:2 273:18
 322:1 334:11 335:5
 357:14 380:4
reliable 387:7
rely 40:21
remaining 124:1 317:4
 420:2
remarkable 175:13
Remarks 3:2
remember 5:16 29:1,2
 120:13 168:2 218:14
 265:5 282:2 311:7
 336:4 384:17 390:6
 408:12 409:2 415:5
remembers 80:19
reminder 45:14
removable 359:19

remove 352:19
removing 328:20
renal 196:15
renewing 113:11
renovations 72:17
repeat 89:10
repeating 274:6
report 4:13 10:1 11:13
 11:21 12:10,14,16,21
 13:4,19,21 14:11
 15:11 16:11 18:5 21:6
 22:4 23:13 24:11 27:9
 31:17 38:21 77:16
 83:4 89:13 91:15
 96:12 106:7 119:5,11
 121:1 128:7 129:5
 135:1 144:2 146:17
 188:4 200:17 220:5,6
 220:8 221:14 222:18
 242:21 244:4 248:3
 260:7 265:20 266:5
 267:17,20 276:13
 286:16 305:3 306:19
 330:20 337:1 343:11
 345:2 362:19,21
 364:20 365:1 375:13
 379:3 390:5,9 393:22
 399:22 405:7 412:2
 416:2,12 421:5
reported 35:11 96:11
 100:13 145:1 220:5
 237:11,18
reporting 20:9 83:20
 89:15 132:15 133:4
 145:2 147:10 153:19
 213:7 247:4,15
 248:12 250:15 265:19
 271:9 317:8 320:11
 370:16 397:5 398:16
 406:16
reports 4:10 5:5,8 12:8
 12:17 23:14 43:5
 120:20 220:4 227:1
 305:17 306:11 365:19
represent 123:14 125:6
 240:15 391:22
representation 211:10
representatives 276:8
represented 116:5
 123:13 211:13
representing 157:17
represents 146:15
reputable 75:17
reputed 252:1
request 359:2
requests 197:15
require 149:4 150:15
 314:9

required 101:10 161:2
161:10 172:3 241:7
requirement 160:19
161:19 178:4 182:5
182:17 183:5 220:19
224:18,21 228:5
389:21
requirements 100:19
164:2 227:3 257:3
270:21 395:10
requires 221:1 225:5
requiring 39:7 85:12
317:18
research 1:14 17:21,21
18:11 46:21,22 83:7
89:3 124:12,13 128:2
159:15 199:10 213:19
250:4
researchers 75:8
resettlement 182:3
residence 216:9
residency 156:1
residential 11:18
residents 220:21
223:16 281:8 282:6
residing 213:3
resist 325:13
resonate 73:21
resource 118:9 121:7
147:12 179:1 219:5
219:15 227:21 262:10
357:13
resource-constrained
108:8
resources 82:19 83:6
90:5 92:18 117:6
118:7 137:1,21
148:10,22 195:14
208:20 219:2,3,14
224:14 260:12 261:17
262:3,5 305:10
313:11 314:8 338:9
353:5,6 367:18
370:10 418:22 419:9
respond 144:1 179:20
298:12
respondent 236:1
respondents 402:8,13
responding 281:22
320:6
response 99:17 110:12
174:17,22 272:9
302:19 315:13 325:12
378:6 403:10,16
419:22
responsibilities 36:10
responsibility 80:8,9
230:18 241:9,10

242:19 286:21 320:18
responsible 164:22
rest 8:7 46:3 153:16
175:10
restate 417:17
restating 279:18
restrooms 5:16
restructure 413:3
restructuring 247:7
resubmit 168:21
result 35:13 60:18
100:13 157:1 166:15
176:19 285:19 359:11
361:4
results 34:2 148:9
160:10 273:6 296:17
361:1,2,3 363:2 366:1
390:7 391:8 399:12
resumed 191:10 329:7
retain 90:2
retort 222:4
return 231:22 288:2
returning 158:7
reveal 72:9 399:8
reverse 360:3
reversible 360:2
review 3:2,5 43:10
78:20 232:4 388:18
reviewed 26:8
reviews 18:16 225:9
revise 414:6
revised 16:1 20:22
revision 414:5
revisit 188:12 244:20
344:9
reward 42:5 76:15
249:15 347:4 348:9
360:19
rewarded 311:18
335:10
rewarding 54:12 248:7
249:11 271:10
rhetorical 302:21
303:22
rich 72:7 86:7 90:13
379:1
Richard 275:19
richer 85:8
richness 72:13
rid 52:8,9 53:1 277:2
Ridge 392:19
rightfully 364:14
rigor 66:1
rigorous 39:21
riled 401:15
rise 277:20
risen 282:18
rising 307:7

risk 9:13,19 10:18
11:12,14,15 15:4
16:22 28:18 29:20
30:3,6 32:9,11 33:1,2
43:7 67:20 68:18
86:16 91:9 94:19
143:18 149:9,21
150:9 152:14 158:22
160:17 161:7 162:13
163:9,15 170:21
171:4 185:19,20
192:2 194:1,2,12
197:11 201:19 225:17
226:14 246:22 247:14
247:21 248:13,22
249:4,5,12,20 250:6
252:2 254:22 255:4
258:3 260:8 261:2
267:18 270:12 271:11
271:19 305:5 310:22
311:10,11 346:18
348:4 362:20 371:15
374:11,17 376:13,15
377:20 379:4 384:20
387:13 389:6 393:21
risk-adjust 369:21
385:15 397:19
risk-adjusted 374:13
385:1
road 38:6 48:8 56:16
82:1 87:9 89:1 96:18
96:21,22 97:2,12 98:1
98:11 99:3 103:5,17
225:2 243:14,15,17
246:8,11 297:14
342:6,7 348:15 404:8
405:3,4,5 411:11
412:4 414:9
ROBERT 2:1
Robinson 93:19
robust 202:12
Rochester 1:19
ROI 358:8 419:6
role 5:6 55:19 96:7
109:16 115:12 132:5
139:11 178:6 252:17
270:1 314:22 361:22
400:8
roll 52:18 56:17 63:21
97:11
rolled 171:2
rolling 349:12
rolls 115:6
Romana 1:21 7:6 23:10
31:7 32:5 82:11 95:17
98:22 104:6 117:21
120:10 156:15 162:16
170:18 212:15 293:20

304:6 334:1 335:15
344:13 353:13 392:3
392:7,10 393:9
414:14 416:22 417:13
Romana's 102:19 107:3
351:9
Ron 6:11 56:18 58:15
61:8 62:18 63:22 66:4
69:7 83:2 95:19
106:22 107:1 144:18
227:10 243:14 315:6
320:4 325:2 344:15
348:17 351:7 353:11
356:21 362:10 368:7
368:20 381:4 383:18
Ron's 343:21
RONALD 1:18
roof 275:12
room 1:8 5:20 6:4 11:2
96:10 133:14 158:5
165:19 174:21 232:1
274:5 287:5,6 297:8
378:11 403:13
rooms 190:7
root 308:16 322:10
rooted 179:14
rotate 259:16 315:7
rough 346:21
roundtable 3:8 234:10
routine 83:17
rubber 225:2
rubric 316:7
rule 263:13 264:2,3
267:8 379:8 382:20
rules 264:1 300:14
run 159:14 246:15
running 327:11 392:15
runs 91:21
rural 46:9 196:8 300:13
300:18,22 301:3,7
309:18
ruthless 364:16
RWJ 288:15
RWJF 18:15 116:21

S

sac 82:2
sadly 386:18
safe 115:22 116:1
safety 20:13,14 44:10
44:14,15 45:3,17 46:4
46:8 48:12 57:22 58:3
67:1,11,14,18,21 68:3
96:15 151:2 155:4
179:14 203:7 214:19
250:17 251:12,15
262:21 268:16 287:16
300:3 304:16 312:14

312:21 345:19 349:13
 349:17 351:22 370:9
 370:13 375:4 377:15
 392:21 401:10 411:3
 411:5 413:21 416:13
sailed 364:3
sake 259:11,12
salient 46:22 335:5
sample 388:15,16
 398:22 399:6
San 215:6 219:4
Sanchez 2:2 7:19,20
 140:17 188:16 219:19
 219:22 221:20 222:1
 222:5 307:3 332:11
sandwiches 414:20
Sarah 2:3 8:3,4 58:16
 66:5 72:5 73:15,16
 76:20 77:4 167:10
 174:3 229:16,18
 231:16,22 232:1
 236:4 241:16,17,21
 242:4 270:4 271:7
 272:6 312:8 314:14
 371:20 373:20 378:4
 391:21 392:2,3,7,7,8
 392:8,10 394:18
Sarah's 396:9
satisfaction 193:22
save 353:17,19,21
saved 276:3
saver 418:15
saving 366:4
savings 23:21 24:8
 44:22 45:1 270:7
 302:14 355:15 371:4
 371:10
saw 18:10 123:8,12
 232:18 252:4 323:2
 323:10
saying 26:22 41:12
 53:15 75:19 77:5 81:5
 98:8 102:3 137:15
 147:15 165:13 172:11
 180:15 216:9 218:3
 242:5 261:15 269:5
 282:11 284:7 292:16
 295:5,22 297:9 317:6
 325:19 326:8 339:12
 362:11 394:11 401:20
 407:13 419:14
says 99:18 124:15
 186:6,8 360:15 413:3
scale 59:1 75:16
scales 157:14,19
scan 11:21 13:1,5,11
scanning 415:6
scattered 97:21

scenario 59:4 82:6
 359:8
schedule 182:21
 221:12
scheduled 112:14
 181:5
scheduling 166:5
 177:18
schema 30:18
scheme 23:4
schizophrenia 217:4
scholarship 208:5
Scholle 2:3 8:2,3 73:17
 167:10 229:16,20
 232:2 236:8,11 270:4
 271:14 272:2 312:8
 371:20 391:21
school 1:17,21 7:11
 116:17 367:22 385:9
 385:9
schools 296:16 368:1
science 99:22 208:6
sciences 71:9 77:15
Scientific 2:8 8:10
scope 108:1 320:17
score 212:12 266:8
 370:21 371:5,6
scores 111:14 120:8
 247:6,13
scoring 245:14
scrap 408:16
scratched 87:22
screen 14:10 114:2
 158:20 177:10
screening 27:13 45:15
 57:15 58:6 111:3,12
 209:9 272:19 273:18
 331:9 373:13 392:15
screens 197:18
screwdriver 188:11
scroll 148:16
scrolling 405:19
SDOH 157:2
SDS 105:15 258:3,7,14
 387:13
se 252:10
search 128:12
seat 111:2,6
second 4:14 17:3 18:4
 18:19 28:19 29:15
 31:15 34:21 43:6
 48:21 70:10 120:22
 149:19 248:5,14
 249:1,6,16 253:3
 265:12 271:11 279:13
 290:15 302:1,18
 309:14 338:6 357:11
 408:3

secondary 223:19
secretary 252:12
 275:15,17
section 14:19 112:10
 112:15 166:15 190:19
 208:21 246:20 256:18
sectors 19:22 84:21
 209:3 211:12 215:18
secure 396:12 400:20
seeing 85:5 89:21
 100:6 157:2 296:18
 313:18
seek 88:14 313:19
 369:10
seeking 267:7
seen 135:6 172:4
 192:14 194:22 267:9
SEER 124:13 125:2
segment 185:8 321:16
segments 204:8 322:17
 323:3
segregation 146:20
 147:21 148:1
segue 106:19 329:16
 330:9 396:16
segueing 369:17
SEIU 1:15 6:14
select 17:16 39:3 56:12
selected 11:7
selecting 16:6 333:17
selection 58:14 94:9
 175:8 394:9
selective 55:15 56:5
selectively 168:7
self-assessment 63:2
 64:2,9
self-care 34:17
self-referent 335:7
self-reinforcing 82:3
selling 87:2
SEM 18:21
semantic 378:15
semi- 128:11
send 44:5 189:9 208:18
 364:21 421:5
sending 189:10 421:10
senior 2:8,11 8:12,15
 8:17 41:21 115:6
 132:3 133:1 340:3
 342:15
sense 30:18 36:7 53:21
 74:17 81:21 179:18
 206:11 240:10 295:22
 328:21 329:16 352:9
 404:11 409:21
sensitive 16:13 23:4
 30:14 31:2 77:19 79:9
 79:15,17 80:2 81:10

83:22 304:19 331:19
 417:5
sensory 172:22
sent 114:6 123:4 124:6
 126:21
separate 40:22 49:7
 225:12 316:22,22
 368:14 391:7
separating 410:13
sepsis 99:16 107:5
September 4:17 91:14
 405:7
sequela 42:19
sequence 62:3 70:2
sequential 82:3
Sequist 2:4 6:20,20
 131:16 158:13 160:9
 160:21 163:20 164:13
 206:2,8 288:5 290:10
 294:9 317:5 401:3
 406:21 407:10,18
 408:11,20 409:22
 411:8,13,16
series 346:17
serious 172:21 216:21
 275:10
seriously 225:21 226:3
 357:3 366:13
serve 13:10 95:12
 110:6 127:22 249:19
 314:11
served 210:14
serves 264:17 377:1
 397:8,10
service 4:6 82:13 85:9
 127:13 137:11 161:12
 186:6 260:18 352:3,8
 400:4
services 9:7 72:13 73:2
 73:3 104:12 121:1
 137:2,17 143:8
 145:12 153:2,10
 158:16 160:3 182:7
 183:11,19,20 186:11
 189:18 195:4,8
 200:11,14 206:15
 238:7,11 241:7
 252:11 275:16 316:2
 316:3 352:1 418:3
serving 7:8 20:14,15
 178:11 248:21
SES 10:18 28:18 389:19
session 27:20 41:10
sessions 245:7
set 12:4 21:16 56:11
 62:20 64:19 70:14
 71:12 76:3 77:13 83:6
 89:18 101:10 105:8

105:16 106:3 108:16 113:17 119:14 134:12 136:15 144:12 149:22 153:21 161:13 168:5 169:17 178:5 180:5 188:9 193:8 224:6 239:9 240:20 241:6 246:19 264:20 265:8 284:2 313:21 317:2 320:15 321:10 325:10 328:12 334:18 335:14 353:7 404:18 419:18 419:20 sets 52:16 239:4 setting 248:5 249:1 291:20 293:11 302:13 377:3 379:22 settings 18:21 305:7 418:4 seven 44:12,17 severely 182:9 share 54:20 104:9 114:2,5 115:11 146:14 148:18 305:6 316:13 319:3 412:21 421:6 shared 17:11 23:21 24:8 34:16 116:13 192:12 270:7 283:21 302:14 318:17 she'll 40:7 shed 81:8 shelf 99:6 shelter 197:14 Shield 44:11,20 45:22 90:20 shift 53:4 60:9 65:21 ships 364:3 short 132:8 207:13 246:10 275:9 334:17 419:6 shot 63:19 shout 4:22 shove 46:3 show 45:13 148:15 165:18 179:16 181:9 214:8 226:11 297:15 297:17 351:14,15 353:4 354:12 400:9 421:18,21 showed 139:20 showing 60:5 66:22 296:17 335:11 352:20 399:15 shows 44:18 60:14 109:8 214:21 229:6 302:13 336:13,14 375:14	sicker 266:22 side 58:13 88:1,3,6 141:4,16 161:15,20 192:17 210:1,2,21 256:22 276:8 328:5 341:8,9 356:21 364:15 370:14 sidebar 65:17 sight 287:15 sign 103:3 389:9 signal 265:17,18 394:20 signed 198:14 significant 27:13 44:19 88:15,16 261:19 309:10 significantly 359:15 silence 318:9 siloed 285:6 silos 284:22 similar 50:13 185:16 187:6 195:21 196:3 250:1 268:12 304:8 347:17 372:12 similarly 43:12 122:9 simple 257:18 simplified 375:14 simplistic 326:15 simply 86:11 182:21 327:21 simulation 345:11 simulations 345:8 Simultaneous 167:5 173:6 214:3 284:17 simultaneously 63:18 single 76:18 236:1 254:13 274:19 325:10 326:13,17 sir 290:2 sit 80:15 99:5 site 178:15 210:10 sites 381:11 sitting 90:14 97:1 179:2 284:15 319:21 situation 45:17 situations 230:9 262:17 262:18 six 9:14 81:22 166:13 166:16 173:5 213:1 295:15 size 59:5 95:20 212:19 388:15,16 sizes 398:22 399:6 skills 99:19 322:15 sleeping 155:3 slew 200:3 slide 6:1 12:11 14:16 15:3 22:11 231:21	232:11 233:12 234:17 238:3,17 239:19 251:3 405:16,21 slides 112:16 232:1,12 slight 69:8 slightly 340:17 slots 180:14,15 181:4 small 25:20 172:18 201:9 230:20 276:11 301:1 365:22 382:13 398:22 smaller 314:4,5 smart 343:3 378:10 smartest 221:19 smoking 309:3 SNP 354:8 so-called 285:20 socializing 322:3 socially 43:7 79:15 80:1 105:3 306:4 377:20 societally 351:5 socio-ecological 139:19 sociodemographic 387:19 socioeconomic 11:17 148:7 309:16 310:3 322:8 sociological 50:3 sole 115:11 solid 52:6 341:13 solution 91:5 322:9 solutions 188:10 322:15,17 323:16 solve 285:14 366:19 somebody 65:17 72:18 90:15 119:22 141:17 165:16 170:6 179:8 211:19 212:4 226:16 228:12 271:1 273:16 273:19 311:7 399:20 somebody's 72:17 166:6 274:6 287:16 287:17 someone's 353:22 somewhat 193:1 332:15 soon 369:18 sorry 6:16 31:11 44:6 62:17 67:12 92:13 106:22 117:22 122:19 126:20 134:10 146:4 167:19 206:8 221:21 229:19 255:7 342:3 344:16 405:21 406:21 407:19 421:22 sorts 178:20 218:15 sought 233:3	sound 391:1 sounded 348:7 sounding 165:5 sounds 92:2 191:8 327:13 source 130:10 131:12 136:22 145:12 sources 233:3,14,16 236:20 space 4:20 63:7 65:14 108:15 117:5 157:3 291:3 292:5,6 374:4 411:22 419:5,10 spaces 134:18 sparing 206:10 speak 33:16 37:17 105:6 160:5 180:1 182:22 206:6 236:5 315:1 340:8 351:12 378:5 speaker 215:2 speakers 74:8 230:1 353:13 speaking 119:13 167:5 173:6 214:3 239:12 284:17 308:3 337:3 341:10 394:16 speaks 34:22 104:5 157:5 316:7 special 4:22 8:4 172:14 251:14 271:1 298:22 299:1 301:18 313:9 specialist 142:14 153:5 153:9 189:11 specialists 210:21 specialty 141:15,22 142:6,7 189:3,7 specific 24:22 25:5,6 27:21 28:6 53:12 57:14 74:11 77:3 78:16 95:22 111:1 121:11 154:10 167:20 167:21 168:3 171:6,8 202:7 212:18,22 213:11,20 214:9,10 226:21 231:14 261:4 299:18 305:1 326:9 350:21 356:12 360:5 377:11,21 381:22 389:11 416:12,14,16 417:15 418:1 specifically 22:17 30:11,22 53:12 93:1 118:5 120:21 134:1 231:7,13 233:22 238:5,15 256:4,13 264:8 279:13 316:19 390:6 413:3
--	--	---	---

specification 23:15 130:9	270:20 320:15 321:10 321:10,14,20 322:18 324:2,13 337:5	stated 311:17 statement 115:5 132:3 158:1 184:9 351:9 407:12	248:19 249:1,10 257:9
specifications 226:21 390:1,3	standing 1:3,7 13:9 92:1 93:5 97:16 102:14	statements 319:15 states 72:12 73:8,10 85:10 100:19 122:3 144:4,7 145:3,4	stratification 22:15 23:1 32:7,10,16 33:1 33:2 37:16 50:19 68:17,20 82:18 147:15,18 185:12 200:7 205:12 253:22 264:15 267:14 268:18 269:1 322:7,8 371:16 374:2,9 375:5,7 376:11,17,21 378:12 378:21 380:10,18 384:12 385:18 386:2 386:9 387:15 388:1 388:12 389:10,13 393:15,20,21 394:12 395:9,17 397:1 398:13 399:7 400:9
specificity 213:16 specifics 363:5 specified 227:3 specifies 131:1,7 specify 140:6,8 209:3 226:22	standpoint 65:16 179:13 321:13 327:14 star 168:14,15 174:15 193:6,9 242:5 403:15 Starfield 419:15 starkly 295:21 Stars 238:12	static 76:17 stating 415:10 statistical 248:11 292:11 statistically 290:11 statistics 91:7 266:18 stats 223:20 status 11:18 131:10 148:7 196:9 249:7 354:9 374:17 387:19	stratified 30:16 34:2,22 35:5,13 81:6 194:10 199:17 200:4 247:15 267:20 277:18 317:7 379:12,17 381:2,2 384:19 394:14 395:22 398:16
spectrum 42:10 57:3,11 309:17,20 spend 414:13 spending 14:18 137:11 355:16 spent 334:5 367:10 spinal 275:18 spirit 89:12 114:22 388:10 spoke 315:9 spoken 315:4,11 sponge 258:9 272:14 sponsored 232:5 spot 152:10 342:4 spots 295:20 spread 268:14 spreadsheet 65:6 spur 243:2 square 303:13 stable 355:1 staff 2:7 4:22 5:7 8:7 35:3 38:20 97:1 116:4 116:14 118:16 138:13 138:20 145:22 164:16 166:4 235:17 237:12 306:19 319:2 338:10 403:22 staff's 33:13 333:9 stage 59:21 60:11,11 60:21 85:6 124:19 125:11,21 196:3 246:19 stages 95:21 163:8 stakeholder 281:11 stakeholders 18:2,22 21:17 22:13 62:21 63:1 118:21 139:1 212:3 219:7 240:19 stance 353:1 stand 64:8 73:22 standalone 325:22 standard 17:9 142:5 146:12 321:17 323:9 336:20 342:13 352:10 standardize 220:18 standards 165:13 231:5 233:22 234:5 237:3 241:6 248:6 249:2	star 168:14,15 174:15 193:6,9 242:5 403:15 Starfield 419:15 starkly 295:21 Stars 238:12 start 6:1,5 24:11 37:19 52:20 62:15 63:2,11 63:16 64:15 69:18 70:13 112:21 113:6 113:22 114:9 134:16 152:1,3 156:12 159:20 162:3,7 166:17 171:15 186:2 217:5 218:5 241:22 244:21 250:21,21 252:20 253:2,5,11,12 253:17 260:17 269:7 273:11 276:7 280:22 281:4 290:15 297:15 328:6 329:1,10,10 330:16 369:16,17,20 371:15 397:21 406:2 420:10 421:14 started 4:4,7 15:4 21:9 59:17 96:7 112:17 148:13,21 150:13 152:20 171:3 175:3 176:3 192:6,7 198:7 232:21 276:19 277:12 323:20 370:6 372:5 405:21 starting 63:10 64:19 78:5 79:1 88:5 90:17 91:1 113:16 114:11 245:4 266:8 295:1 361:18 369:22 starts 64:8 state 85:5 87:5 90:16 90:21 105:16 122:10 136:11,16,22 137:9 137:11 138:18 141:6 143:2 155:5,7 178:4,4 179:10,11 183:12 256:13,21 257:1 260:20,21 275:12 283:14 303:6 312:1 327:20 349:12 352:6 352:11 365:10 402:19 402:22 state-determined 141:7	step 16:4,8 17:19 18:19 19:7 20:3 23:2 25:4 27:18 64:7 69:13,13 88:18 112:13 216:19 224:8 250:8 265:11 267:9 401:18 step- 250:20 step-wise 20:22 Stephen 346:14 steps 3:16 15:16 16:3 21:2 63:14 steroids 86:6 steward 235:8 238:9 sticking 122:7 stink 66:18 stood 92:2,3 stop 142:16 162:8,11 190:11 205:16 397:18 store 159:7 stored 159:17 160:10 160:13 story 125:22 straddles 71:21,22 straight 376:5 straightforward 51:19 206:13 strap 126:3,3 straps 126:8 strata 383:10,13,13 386:16,21 387:2,5 388:4 395:19 strategic 115:5 227:20 343:3,5 strategies 90:2 135:14 241:14 257:17 321:6 330:22 strategy 83:10 224:22	stratify 49:16,18 55:22 118:17 145:2 150:8 152:14 196:8 240:21 264:14 321:15 369:21 378:11,16 379:2,7,9 379:13,14,20 380:4,5 380:5,6,11,11 381:8,9 381:11 382:8 384:5 385:15 388:7 389:4,5 389:22 392:17,18,21 397:6,16,20,21 stratifying 16:5,9 132:21 135:15 247:3 255:4 308:15 380:19 381:12 382:1,14,21 383:20 384:2 386:14 392:13 400:1 stratum 388:4 straying 79:14 streamlined 240:11 street 1:8 179:11 224:14 422:4,5 strength 336:9 337:17 strengthened 271:3 stress 84:19 stressful 401:6 stretched 174:1 striking 252:6 327:9 stringent 59:11 strings 350:17 strong 59:22 66:14 74:12 75:9,10,10

143:7 272:16 363:11
stronger 372:10
strongly 56:12
struck 150:1
structural 31:22 42:12
 42:19 48:9,11 57:16
 158:15 159:21 170:15
 207:7 235:2,4 236:16
 271:4
structurally 162:9
structure 14:7 19:16,17
 25:13 26:14,14 48:10
 50:11 57:5 61:9 75:20
 113:20 136:18 148:16
 156:12 157:7,12
 158:14 170:13,17
 230:4,4,5 231:8 240:2
 256:18 276:16 335:3
 368:9,12 369:2,13
 406:10
structured 128:12
 135:20
structures 50:5 369:11
 370:7
struggle 37:21 43:13
 178:19 231:7
struggled 389:17
struggling 39:2 44:15
 180:21 319:22 383:15
STS 272:13
stuck 183:1
studied 101:18 316:5
 342:11,11
studies 42:14
study 119:18 302:17
 331:13 345:2 346:9
 354:11
studying 60:4
stuff 30:5 35:4 47:16
 68:8,16 72:8 81:1
 87:21 88:21 91:3
 132:6 161:5 186:10
 210:20 252:3 254:15
 257:21 283:15 284:1
 319:22 342:10 364:14
 364:17,21 365:1,7,9
 367:4 369:3 374:3
 411:4
stumbling 280:14
sub- 35:16 116:7
sub-bullets 414:7
sub-component 110:4
sub-domain 35:20
 148:21 191:20 207:4
sub-domains 14:9,17
 42:9 129:1,4,10 130:3
 135:20 162:5
sub-groups 50:20

sub-recommendations
 407:16
subcategories 77:21
 382:13
subcomponent 135:16
subgroup 331:15
subgroups 380:19
 399:6
subject 94:11
submitted 12:7,22
 306:12 391:18
subpopulation 304:20
subpopulations 241:3
 258:22
subset 410:18
substance 275:11
 331:6 344:11
subtle 80:3
succeed 283:5 294:11
success 200:17
successful 308:12
 349:15 358:5,10
sudden 151:13 282:4
 298:11
suffer 142:8
sufficient 373:3
sugar 78:8
sugary 296:12
suggest 17:22 69:18
 154:14 167:8 173:3
 270:5 305:16 389:3,4
 412:2
suggested 214:15
 309:1 348:1 377:5
suggesting 317:7,11
suggestion 98:21
 209:22 305:13 381:4
 413:21
suggestions 345:2,8
suitable 75:2
suite 96:11 115:7
 146:10 238:6 367:17
sum 343:22
summarized 342:21
summary 239:19
 398:18
summer 164:11
summit 93:20
sums 78:11
super-struggled 206:2
supplement 168:18,22
 169:21 278:9
supplemental 72:13
 73:2 168:4 193:4
 239:2,3
support 34:16 72:14
 92:19 145:18 221:15
 239:22 249:18 273:2

297:4 340:3 373:6
supported 214:2
 377:15
supporting 19:16
 109:17 168:22 229:11
 248:7 249:11 336:22
 369:11
supports 241:7
supposed 24:2 160:20
 164:9 176:16 182:18
 192:7 328:9
suppression 31:1
surface 87:22
surprised 65:7 165:10
 193:3
surveillance 368:15
survey 116:14 128:10
 149:9,16 160:8 167:1
 167:12 170:5 193:2,5
 193:21,22 235:5,10
 235:14,16,19,22
 237:10 239:3 240:11
 345:5,5
surveyed 193:18
surveys 118:13 173:10
 177:3 223:19 235:16
 238:22 240:15 402:10
survival 125:12
Susannah 1:13 7:15
 33:18 35:12,22 49:13
 56:18 58:16 66:5,6
 70:20 77:7 181:21
 185:12 187:10 205:10
 263:6,8,19 267:14
 310:8 312:2 371:13
 373:22 377:8 378:5
 380:21 390:21 395:5
 395:7 396:6,20 398:3
 400:18
Susannah's 268:2
sustainable 361:9
Sutter 275:14 276:3
swallow 353:9
Swedish 203:14
synergies 241:19
 362:12
synergy 280:7
synthesize 325:3
syphon 352:21
system 1:14 2:1,5 7:3
 19:3,22 20:17 42:17
 59:3 79:11 105:14
 109:7 115:8 141:3
 147:22 148:11 154:22
 164:19 170:10,15
 183:21 196:20 207:3
 215:11,13 278:2
 292:18 296:14 317:1

317:19 320:21 350:16
 357:19 360:19,19
 419:18
system's 105:7
system- 115:12
systematic 18:16 129:7
systematically 33:10
 409:18
systemic 129:7,12
systems 45:14 59:1,17
 65:15 82:22 104:7,16
 107:11 109:20 146:15
 146:17,21 162:8
 163:16 215:5,9
 228:22 230:14 303:5
 307:14 327:15 357:10

T

table 53:11 90:14 93:18
 126:2,7 165:17,20
 174:1 246:3 274:21
 332:19
tables 146:3 157:20
 283:16
tactful 90:12
tagged 13:17
tagging 291:1
tailor 87:12 322:16
 323:15
tailored 211:1 238:5
 299:3,16,19 306:6
 323:16
tailoring 89:2 310:18
 311:3 322:6
taken 142:3 225:20
 386:7
takes 129:16 225:19
 321:17 365:14
talk 5:2 9:11 10:4 24:19
 38:9 88:6 91:19 92:9
 94:18 104:10 107:4
 107:20 122:22 125:20
 128:4,9,10,11 130:19
 161:11 177:6,11
 182:1 203:12 207:20
 218:6 228:1 243:20
 244:21 255:1 265:14
 266:4 272:11 276:6
 277:7 295:3 310:13
 318:5 328:17 332:2
 357:17 365:15,16
 374:1 376:17 379:19
 381:1 402:18 409:8
 413:1 417:11
talked 33:8 66:3 73:6
 99:14 100:20 104:13
 127:13 129:19 140:5
 146:13 152:9 189:2

222:6,8 234:15 275:1
 275:2,21 279:14
 313:12 328:16 340:19
 340:20 354:2,4 366:3
 406:17 408:2,6,7,8
 409:17 413:5
talking 20:19 35:15
 53:4 72:10 82:11 83:2
 86:14 87:8 89:6 91:2
 93:8 97:2 101:22
 104:6 105:6,18 112:5
 115:8 137:14 147:22
 156:15 157:16 160:22
 161:6 162:6 168:1
 176:4 194:17 196:21
 198:10 202:4 219:4
 231:8 250:11 252:3
 257:19 261:10 274:11
 281:4 288:12 296:19
 303:17 307:16 309:13
 310:20 319:10 320:2
 323:18 324:9,20
 330:18 334:4 350:5
 351:4 359:8 364:13
 366:8,11,20 367:10
 368:17 377:5 379:20
 380:9,12,17 381:19
 386:13 391:17 408:12
 409:2 417:20 419:2
talks 49:21 276:3
 380:10
tally 13:12
tangential 171:12
tap 335:3
tape 126:16
taped 126:6,8,11
tapping 216:8
Tara 2:11 5:10,13 9:1
 10:7 49:2 405:15
Tara's 252:21
target 12:6 25:10,16
 82:15 107:14 113:3
 129:2 240:22 241:4
 271:21 322:22 328:3
 328:11
target- 377:14
targeted 249:14,18
 299:3 335:8 377:22
targeting 84:1 115:19
 280:1 299:18 362:5
targets 331:19
task 11:19 175:16
tasked 11:5 104:20
 113:5 127:16
tax 279:7
tea 344:4,18 345:8
team 5:10 12:13 13:5,8
 13:13,14,17 31:13

201:5 232:17 239:4
 244:11 412:13,14
 420:13
team-based 35:2,7
teams 157:6 218:10,15
technical 249:19
 377:15
techniques 248:11
tee 191:13
teeny 363:14
teeth 135:4 270:8,10
 279:5,7 390:10
Teigland 2:5 6:15,15
 100:3 148:19 168:13
 203:10 319:5 353:12
 396:22
teleconference 2:21
telehealth 367:21
telephone 174:15
tell 41:8 55:19 96:13
 114:7 131:3 160:8
 261:14 263:15 283:18
 346:8 375:22 418:9
telling 275:6 301:22
tells 297:5
template 253:12 279:16
temporary 151:12
ten 121:9,9 288:18,21
 383:12
tend 53:1 106:6
tended 312:12
tendency 298:1
tension 37:1 51:9 327:4
term 63:15 234:6
 246:10 419:6
terminology 234:1
 299:21 381:22
terrified 340:17
test 20:17 415:9
testing 169:10 273:2
Texas 7:21
text 160:15
textbook 302:1
thank 4:5 5:9 7:13,18
 10:8 31:6 32:5 35:22
 55:7 58:12 77:1 81:13
 86:18 95:16 100:2
 106:19 109:2 114:2
 120:9 121:14 122:18
 128:21 130:4 131:15
 135:17 142:16 144:18
 148:12 157:8 173:13
 174:13 175:1 181:17
 191:2 198:4 202:18
 205:15 208:2 212:14
 216:14 217:22 218:20
 219:17 220:11 225:14
 227:4 229:14 236:7

241:16 242:6 257:10
 293:20 308:18 315:9
 381:20 403:7 420:1
 421:4 422:8
thanks 8:9 21:21,22
 33:20 36:1 38:1 46:14
 48:6 51:14 54:6 56:15
 66:4 70:20 72:2,6
 73:13,18 76:19,20
 81:15,16 84:22 88:22
 89:4 90:9 103:20
 117:10 118:2 128:15
 134:7 135:18 140:17
 142:17 145:8,21
 147:14 154:18 158:12
 166:20 167:14 178:1
 181:20 183:8 185:14
 190:13 198:4,7 203:8
 204:19 219:22 231:16
 259:15 262:13 267:13
 270:2 272:6 274:2
 276:9,11 279:1
 281:17 301:8 304:1
 305:14 307:21 310:6
 312:2 316:17 317:14
 319:3 320:3 325:2
 326:21 328:14 347:19
 353:10 362:10 369:15
 371:12 373:20 377:8
 378:3 400:18 402:4
 402:14 416:21 419:13
the-- 382:20
theme 67:10 176:2
themes 9:16
theoretically 359:20
theory 178:10
therapy 125:14,17
 126:2
thin 73:10
thinker 255:14
thinks 113:15 139:7
third 10:1 12:21 13:4,19
 14:11 29:16 62:19
 66:22 70:5 82:13
 248:6,18 249:10,21
 250:18 251:10 253:3
 280:21 329:20 408:5
 408:7 409:3 412:6
thirsty 281:13
THOMAS 2:4
thorny 43:2
thought 64:11 67:11
 68:5 82:7 90:6 91:16
 117:12 119:3,5,8
 149:1,19 160:18,19
 175:4 184:6 187:2
 189:14 192:9 198:11
 207:18 215:16 222:2

225:15 255:13 261:22
 263:21 278:13 295:9
 313:4 314:14 360:20
 390:12 405:15 413:12
 413:20
thoughtful 53:8
thoughts 116:11
 134:22 142:18 146:6
 154:15 183:16 355:19
 391:4 405:12
thousand 203:22
threads 81:19
three 11:20 12:7,16
 28:15 120:14,15
 129:10 130:2 155:12
 192:6 203:7 220:15
 224:17 232:22 239:3
 245:7,10,11 248:2,8
 290:3,8 318:15
 332:20 340:21 353:13
 379:3 384:8 397:21
 409:16 410:18 413:14
threshold 116:2 212:12
 268:5 287:11
thresholds 264:21
 265:8 288:3 290:5
 348:8
throat 236:6
throttle 88:2
throw 110:22 258:1
 283:7 334:9 350:8
throwing 250:22
tidal 297:7
tides 307:7
tie 28:20 81:18 98:10
 125:7
tied 17:18 19:11 62:8
 98:1 279:8 300:18
 368:21
tier 16:19 17:3
tiered 361:2
tiers 16:18
tightening 368:5
times 57:9 107:15
 148:4 156:9 194:4
 198:17 211:17 340:20
 340:21 389:20 393:5
timing 9:2 10:6
tiny 365:3
tobacco 331:6
today 10:9,10 23:5
 28:13 30:20 64:22
 234:15 240:14,17
 274:11 313:11 323:18
 326:8 343:18 395:12
 406:2 408:1,19
 419:11 420:16
today's 100:4

told 226:9	Traci 1:18 7:22 85:1 86:21 102:16 103:20 191:12,15 198:5,8 202:19 216:14 218:3 344:15 348:16 351:7 353:10,14 356:19	tried 170:7 176:19 350:20	tweaking 285:12
Tom 6:20 128:16 131:15 134:7 135:21 154:20 158:12 162:6 166:2 205:21 287:3 288:4 290:3 293:20 294:3 302:19 311:6 312:5 315:3 317:3,14 350:5 401:1 402:4 415:21	track 149:14 276:19 309:21 356:5,6 395:17	tries 121:12 251:5	Twenty 172:17
Tom's 299:9 300:2	tracked 233:6	triggered 142:21	two 12:15 16:18 28:14 44:10,17 45:3 58:19 66:7,22 67:8 88:10 92:19 111:1 119:1 128:11 152:8 159:2 176:6 178:3 201:12 203:7 220:15 235:16 236:20 251:3 253:4 253:11,19 254:17,20 263:12 266:16 267:4 272:22 275:17,20 283:1 288:17 290:19 300:8 301:10 303:7 303:21 310:9,20 316:15 322:5 337:13 337:22 338:14 339:20 355:15,15 357:6,15 359:19 375:6,19 378:17 379:14 385:17 396:10,21 399:6,14 400:20 408:6 409:15 409:16 410:15 415:11
tomorrow 10:10,17,17 76:22 94:18 244:20 255:2 259:6 333:8 344:9 396:17 404:5 412:18 419:12 420:10 421:11,13	tracking 60:16 151:3 369:7	trip 378:18	tying 59:18
ton 327:15 357:20	tracks 139:22	Triple 257:20	type 29:7,14 103:18 149:14 152:10 154:7 185:6,8 193:2 217:8 237:10 254:14 268:5 330:4,12 348:6,7 361:16 371:1,17 386:2 404:22 415:14
tongue 284:10	traction 107:5,7	trouble 37:12 225:18	types 18:17 33:7 123:15 154:1 188:5 213:2 272:2 283:1 395:20 406:5 407:8
tonight 112:8 244:12 403:21 405:10 420:9	traditional 77:13 115:22 185:7 338:16	truancy 367:22	typical 199:5 392:14
tons 333:16 349:11	traditionally 65:4	true 67:7 123:14 151:17 214:21 240:12 249:8 277:3 303:7	typically 53:20 277:6,7
tool 37:4,19 81:7 117:3 130:13 131:11 162:16 197:11 198:21 235:7 235:15 237:2 361:11 388:19 399:9	train 159:3 165:2	truly 99:6 216:11 217:11,18,18	
tooled 313:4	trainee 147:9	trust 163:13,14 165:6 239:8	U
tools 37:17 82:19 83:6 93:11 104:5 117:6 162:17 188:9 201:19 212:4 235:13 240:11 253:6 260:2 323:17 344:8 349:7,8 361:11	training 164:15 216:5 281:7 282:5,10	truth 135:10	U.S 19:2
top 94:21 120:14,15 144:18 155:13 303:4 332:22	trajectory 287:11	try 42:4 47:11 85:21 86:10 94:12 117:20 175:22 181:10 188:10 208:17 213:13 222:21 236:6 242:19 246:8 280:11 283:4 287:1 314:3 340:17 350:12 350:18 364:8 374:14 391:2 404:1 420:17	UCLA 7:10
topic 30:2 32:6 174:7 232:22 233:7,11 238:5,21 252:1 263:14 267:14	transition 280:22 281:4	trying 4:9 29:4 34:7 36:4 39:2 57:2 61:22 70:9 74:3 75:1 76:13 81:8,18 83:12 86:22 90:11 110:8 117:20 127:21 133:2 134:11 135:5 143:3 154:15 170:21 177:12 196:11 197:20 198:1 200:5,6 206:4 208:22 225:6 255:22 259:1 262:2 268:3 278:3,11 284:11 287:5 289:3 289:10 291:7,22 293:4 306:17 313:10 321:21 324:6 327:14 334:4 339:19 341:13 345:13 348:11 349:9 350:1 355:8 361:13 382:11 383:2,3 386:17 398:10,15 400:14 404:17 407:5	UDS 416:4
topics 234:9 235:3 236:17 237:6 238:15 240:4 245:8,11 271:4 333:7	Transitional 208:6	turn 5:10 8:22 14:13 21:19 91:20 128:18 243:3 246:13 250:22 344:17 385:20 396:9 396:20 400:19	uh-oh 109:15
topped 291:15	translate 61:12 108:13 206:3,11	turned 312:15 407:12	ultimate 132:9
tops 156:14	translator 158:16	turning 134:20 367:13	ultimately 58:10 59:9 65:12 310:19 333:13
tortured 114:17	transparency 146:18 153:18 154:20 388:10 395:1	turns 290:11	unable 108:13 239:12
total 45:4 193:17	transparent 132:16,17 132:18,21 133:5	tweak 210:10 278:8 284:11 285:12	under- 116:4
totally 111:7 112:1 135:8 284:14,15 333:3 398:21	transplant 196:7		under-represented 133:16 206:18
touch 136:6 148:14 285:21 357:14	transplantation 196:6 196:16		under-resourced 262:22
touches 49:5	transportation 72:16 73:5 85:15 86:7 102:1 145:19 181:12 194:20 197:14 202:8 367:2		under-utilized 130:12
touching 62:18	treat 204:8		underlying 140:2 383:5 383:9 386:10,20
tough 204:1	treated 148:8		underneath 407:17
traces 105:9	treatment 170:14 197:6 352:6		underscore 307:4
	treatments 204:12		
	treats 334:13		
	tremendous 240:7		
	trend 152:21 292:22 327:16		
	trends 60:5		
	tri-partite 223:14		
	trial 10:19 28:17 255:2 259:6 347:12,13 421:1,5		
	trials 41:18 336:12 337:13		
	trick 404:2		
	tricky 230:8 343:17		

332:12 397:1
understand 36:21 37:1
 37:1 39:3 88:13 90:21
 91:8 99:9,13,21
 134:11 158:4 166:2
 167:4 187:4 197:3,7
 211:1 220:21 227:5
 259:7 323:14 340:15
 376:8 378:13 388:3
understanding 24:1
 25:9 37:10 127:14
 170:4 197:16 235:20
 294:19 301:18 306:16
 322:4 350:21
understands 123:3
 141:17 202:20
understood 271:7
 380:22
unequally 304:11
unfair 170:14 359:18
unfortunately 35:10
 182:8 255:10
unfunded 367:11
unified 215:12
unintended 38:12 68:7
 68:12,19 258:21
 374:20 377:1
uniquely 158:10
unit 116:18 129:15
 315:20 380:2 381:6
 383:22 384:1
unit-based 218:15
United 144:2
units 247:15 379:9
 383:22
universal 369:5
University 1:17,19
 235:8 261:10
unjust 359:18
unknown 273:4
unobserved 100:9
unpack 126:19 128:4
unpacking 127:14,19
untouched 264:19
up- 371:22
up-front 347:1 348:3
 369:10
update 81:2 233:21
 337:19 405:5
updated 149:13 240:3
updates 15:8
updating 330:21
upfront 261:2 348:5
upset 126:10
upstream 57:16 80:13
 80:14 132:1 332:18
 339:10 367:13,19
uptake 336:1 358:5

urban 196:9
urge 84:10 166:17
urging 280:9
usable 199:1
usage 111:2,12
use 21:14 23:22 27:10
 27:17 29:19 30:19
 32:17 33:4 38:11,13
 52:13 69:16 70:15
 71:6 78:5 83:17 94:13
 100:12 124:13 131:11
 145:1 161:12 162:18
 168:10 169:1 176:5
 181:15 188:3 198:21
 202:13 219:8 225:18
 227:8,21 228:8 240:8
 243:4,20 247:19
 253:8,21 254:4,18
 260:4 267:18 275:11
 299:14 300:20 306:13
 307:14 329:20 332:5
 336:16 338:1 340:20
 344:6 346:20,21
 361:10 374:9 377:3,7
 378:20 381:21 385:11
 398:15,18
useful 76:11 99:5
 159:10,16 269:1
 372:3 390:12 397:3
 399:9 412:17
user 277:18
uses 140:8 165:16
 198:18 347:13 371:16
usually 67:19 301:21
 340:21 391:8

V

vaccination 24:7
vaccinations 331:9
valet 147:6
valid 387:7
validated 202:16
 346:16
validity 169:9 341:3
valuable 185:20
value 220:1 291:22
 292:3 302:21 303:17
 303:18,22 354:1,5
 355:9,21 356:20
 419:16
value-added 85:13
value-based 24:3
 249:14 254:19 255:22
 256:14 269:12 330:4
 349:13 353:15,16
value-driven 420:7
values 323:22
variable 261:21

variables 145:2 161:4
variation 348:20 357:7
varies 230:16 266:14
variety 33:8 142:3
 152:4 230:8 255:4
 263:1
various 47:9 127:16
 129:13 139:21 163:9
 254:19 304:9
vast 244:3
VBP 349:16 364:14
vein 190:3 307:10,12
velcro 126:3,8
vendor 161:15
vendors 159:20 160:11
version 12:9 16:1 18:20
 21:1 101:17 134:20
 380:13
versus 32:11 33:1
 51:16 59:10,12 64:3
 68:22 75:2 76:11 93:5
 95:7 113:20,21 145:3
 180:8 185:4 196:9
 266:12 290:21,22
 299:11 333:17 370:12
 371:16 372:1 379:1,1
 379:2 385:9 392:20
 397:17 410:13
Vice 2:10 8:12
victory 289:1,1
view 90:7 259:8
viewed 175:16
viewing 158:6
views 53:2
violate 388:8
violence 229:4
viral 31:1 309:6
virtue 384:9
virtues 185:11
vision 89:22 91:16
 364:12 406:3
visit 33:2 147:7 150:12
 177:4 192:15 194:5
visits 150:5 190:9,9
 206:20,22
visual 84:15
visuals 84:8
vital 223:20
voice 92:14
voices 281:16
void 25:1
voluntary 168:18
 169:20
volunteer 148:17
volunteered 340:10
vulnerable 20:14,15
 77:10 138:2 158:11
 215:14 241:3 260:11

378:2

W

waist 126:3
wait 37:9 147:2,7 215:7
waiting 89:4 148:4
 164:12
waiver 256:18 317:16
 318:7 364:15,21
 365:5,6
walk 21:20 26:4 88:19
 114:4,16 115:18
 177:9 198:18 250:20
walking 115:17
walls 84:14 105:19
wanted 14:21 16:4
 21:10 22:21 43:16
 48:20 55:14 67:8 69:6
 77:2 81:14 84:6 86:6
 95:10,18 106:18
 110:19 120:11 131:21
 136:3 163:12 184:7
 208:1 226:19 228:12
 241:17 246:18 258:1
 261:7 263:14 265:4
 267:10 270:5 290:15
 294:22 298:6 304:22
 312:9,11 317:5 325:8
 365:12 371:21 389:12
 396:22 406:7 411:19
 412:8 414:5,10
wanting 313:6
wants 28:8 182:6
 259:17 261:14 315:1
 409:9
warmer 287:6
warning 80:5 258:19
Washington 1:8
wasn't 169:1 206:17
 287:7 317:6 367:8
wave 297:7
ways 9:17,20 22:21
 33:7 42:18,22 49:10
 50:9,12,14 60:20
 71:18 76:15 78:22
 85:14 112:20 139:7
 147:13 176:6 187:14
 187:17,18,21 200:9
 209:6 221:13 223:5
 227:2 242:21 247:1
 247:20 251:4 256:11
 263:1 278:8,18
 295:10 297:5 307:13
 310:11 312:13 313:13
 330:8 332:7 352:19
 365:17 368:1 375:6
 378:17 380:7 381:9
 387:7 388:2 413:14

wealthy 392:20
website 197:2,4 226:13
 319:2
websites 132:17
wed 245:19
wedded 128:3
WEDNESDAY 1:5
weeds 16:2 37:8 265:13
 375:9
week 44:10 126:16
 203:13 301:12
weigh 140:9 141:11
 390:21
weighing 157:22
weight 11:10 157:14,19
 261:21 355:20
weighting 317:12
weights 307:8
Weill 1:16 7:1
weird 188:10
Weisman 119:17
welcome 3:2 4:4 8:13
 40:10
welfare 215:10
well-defined 387:3
well-demarcated
 315:22
well-written 5:4
WellCare 1:18 8:1
went 21:2 25:20 67:1
 73:19 149:19 169:9
 173:8 191:10 329:7
 414:10 422:10
weren't 168:2,22
 238:10 256:14 349:14
west 111:4,13
western 111:5,20
what- 363:1
what-not 42:19 308:5
 338:4 412:5 414:13
whatsoever 258:7
wheel 313:7
wheelchair 157:14,19
 165:17
whichever 210:6
whispered 120:12
whispering 139:5
white 29:3 288:19 290:8
 379:1
who've 124:7
whoever's 284:2
wide 16:21 75:16
 115:13
widely 148:5 225:7
 402:21
wider 93:9 143:8 278:1
willing 102:22 322:14
 351:17

willingness 59:10
 110:10
wise 250:21
withholding 180:19
within- 381:16 400:9
within-institution 399:8
within-institutional
 395:16
women 124:19,20,20
 124:22 125:4,8,9,10
 125:11,15,18,20,22
 133:16
wonder 46:19 72:20
 82:13 83:3 106:5
 133:9 141:12 183:9
 186:1 190:7 220:1
 302:21 313:1,13
 334:19 335:12 368:18
 369:12 413:7
wondered 51:17
wonderful 38:20
wondering 32:8,18
 39:19 77:14 78:1
 121:17 131:18 172:2
 172:9 185:2 199:2
 200:8,15 409:3
 411:17 414:15
wonkier 202:13
word 214:4,5 340:21
 366:18 375:8 378:16
 379:13 381:21 396:1
 415:17
worded 79:12
wording 80:11 365:13
 414:22 415:2
words 79:21 125:1
 365:13 366:7,15,17
 367:4 379:18 415:5
work-arounds 267:21
worked 265:15 276:20
 354:20
worker 42:2 156:20
workers 210:12,14
 214:11 228:21 338:4
 372:16
workforce 133:9 218:10
working 24:8 47:20
 49:8 96:9 98:19
 127:20 149:22 152:3
 160:12 163:15,22
 204:6 219:5 271:17
 277:12 286:1 304:13
 346:5 351:19 369:6
 420:8
works 54:14,20 103:18
 185:1 308:4
workspace 5:22
world 71:9,10 90:7

240:10 343:14
worry 88:4 186:19
 244:2,16 343:10
worse 154:12 155:5
worst 150:22
worth 35:19 169:14
 276:14 277:9,21
 278:21 318:10 324:6
 329:3 363:6 375:11
worthy 324:14
wouldn't 54:4 56:9 95:6
 126:15 177:1 180:10
 183:10 289:17 370:22
 371:8
wow 98:18 109:8
 403:19
wrap 86:14
wrench 106:16
write 53:19 98:22
 160:15 226:16 277:11
writing 32:3
written 300:19,20 301:5
 337:11
wrong 141:18 160:19
 311:21 363:15 418:10
wrote 294:15
Wynia 7:7

X

X 99:19 107:13 285:16
 316:2 341:17 372:14
 409:12
XRT 126:2,17
XYZ 392:14

Y

Y 316:2 372:15
yadda 161:16,16,16
 418:19,19
Yale 1:13
year 4:7,10 43:22 45:7
 92:5,8 95:7 150:4,6
 151:20 156:5,7
 164:10 171:2 184:10
 203:22 204:4 263:14
 275:8 355:8,10,16
years 89:8,13 92:20
 96:9 107:16 119:19
 121:9,10 224:17
 276:20 277:12 283:15
 287:9 301:1 318:16
 337:7 355:15,15
 379:3 389:18
yesterday 9:9 12:22
 30:2 51:16,19 73:6
 100:14 104:3,13,20
 123:4 126:21 127:9
 137:15 149:3 207:20

214:18 215:2 251:18
 261:8 262:21 332:10
 334:3 385:20 412:21
yesterday's 100:4
York 152:10 318:15
York's 365:5,6

Z

zero 35:5 44:22 155:6
 278:17,22 302:3
zeroing 358:13
zip 273:9

0

1

1-1/2 302:2
1-2-3 97:8 134:4
1:45 243:5
10 3:4
100 162:18 227:2 303:4
 381:12 384:1
1030 1:8
11 89:13
1115 364:15
117 3:6
12 150:16,19 151:19
 362:21 402:10
12:00 173:14
12:14 191:10
12:30 191:7
12:35 191:7
12:36 191:11
12:45 253:3
13 111:12 158:5 289:12
1332 256:18
14 1:5
15 174:1 287:17 320:14
 325:6 383:13
150 113:12
15th 1:8
17 125:16
174 3:7
18 164:10 196:2
19 150:5 356:7

2

2 17:19 60:11 92:10
 253:15,16 368:10
20 276:20 277:11
 320:14 375:15 384:1
20-30 293:8
2007 129:5
2011 31:18
2012 16:15 22:5 31:16
2015 161:18
2016 11:13 410:8
2017 1:5 91:14 237:2

2018 356:7
21 274:17
22 3:5
232 3:8
24 124:21 319:13
242 3:9
25 29:3
26 317:17

3

3 19:7 161:12,15,18
 251:7 329:17
3:00 325:7
3:03 329:7
3:15 5:18 329:4,13
3:19 329:8
30 375:17 409:12
30-day 12:19
30,000 330:9
329 3:12
35 370:11

4

4 3:2 20:3 251:7 329:17
4.7 44:9 45:6
4:00 8:5 242:6
4:50 422:10
40 182:14 183:1
400 362:21
403 3:14,16
422 3:18
4302 166:15
45 150:16
48 144:17
49 144:17

5

5 329:17 368:10
5:30 421:17
50 144:3,18 213:14
50,000 331:5
500 302:2
52 26:16 182:13
55 182:12 370:11
57 172:19

6

6 3:3
60 370:12
64 274:18
65 124:14,20 397:8,10
 397:16

7

7 199:14
75 196:2

8

8 199:14 289:12
8:30 421:14
886 13:14

9

9 287:17
9:00 1:9 421:15
9:05 4:2
90,000 204:10
90th 323:5,8,20
96 291:9
97 291:5
990 130:15,21 131:5
 226:9,15,20
9th 1:8

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Before: NQF

Date: 06-14-17

Place: Washington, DC

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