

NATIONAL QUALITY FORUM

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EYE CARE, EAR, NOSE AND THROAT CONDITIONS (EENT) STANDING COMMITTEE

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THURSDAY
JUNE 4, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Daniel Merenstein and Kathleen Yaremchuk, Co-Chairs, presiding.

PRESENT:

DANIEL MERENSTEIN, MD, Co-Chair
KATHLEEN YAREMCHUK, MD, MSA, Co-Chair
TAMALA BRADHAM, PhD, CCC-A, Vanderbilt University
Medical Center
MATTHEW CARNAHAN, MD, MS, The Permanente Medical
Group
SCOTT FRIEDMAN, MD, Florida Retina Consultants
SETH GOLDBERG, MD, Aetna Insurance Company
JUDITH LYNCH, NP, American Association of Nurse
Practitioners
RICHARD MADONNA, OD, SUNY College of Optometry
VAISHALI PATEL, PharmD, MS, US Health Outcomes,
Allergan Inc. *
TODD RAMBASEK, MD, ENT & Allergy Health Services
ANDREW SCHACHAT, MD, Cole Eye Institute,
Cleveland
Clinic
JOSHUA STEIN, MD, MS, University of Michigan
MICHAEL STEWART, MD, MPH, Weill Cornell Medical
College
STEVEN STRODE, MD, MEd, MPH, FAAFP, AR Disability
Determination Services

JACQUELYN YOUDE, AuD, CCC-A, Healthcare
Performance
Partners

NQF STAFF:

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REVA WINKLER, MD, MPH, Senior Director

ALSO PRESENT:

NALINI AMBROSE

JOHN EICHWALD

MARCUS GAFFNEY

KENDRA HANLEY

FLORA LUM

WILLIAM RICH

DANIEL ROMAN

* present by teleconference

C O N T E N T S

	Page
Welcome, Recap of Day 1.	4
Consideration of Candidate Measures	
0087 Age-Related Macular Degeneration: Dilated Macular Examination (American Academy of Ophthalmology).	5
0566 Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement (American Academy of Ophthalmology)39
0088 Diabetic Retinopathy: Documentation Of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (AMA-PCPI)55
0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (AMA-PCPI)73
2721 Visual Acuity Screening and Referral in Children (CMS).95
1354 Hearing screening prior to hospital discharge (EGDI-1a) (CDC)	159
NQF Member and Public Comment.	184
Consideration of Candidate Measures (Continued)	
1360 Audiological Evaluation no later than 3 months of age (EHDI-3) (CDC)	186
1361 Intervention no later than 6 months of age (EHDI-1a) (CDC).	198
Additional Discussion Topics - Harmonization, Gaps, etc.	241
NQF Member and Public Comment.	263
Adjourn.	265

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

2 8:29 a.m.

3 DR. WINKLER: Good morning everyone.

4 Thank you for joining us for day two. It's going
5 to look a lot like day one as we continue the
6 evaluation of eight more Measures.

7 So, yesterday I think there was a good
8 day. I hope you all had a pleasant evening. I
9 know a goodly number of you went out to dinner.
10 And I hope that was enjoyable for everybody.

11 Any comments, questions from the group
12 before we get started for today?

13 (No response)

14 DR. WINKLER: All right. Well then,
15 comments from our Co-Chairs?

16 CO-CHAIR YAREMCHUK: Welcome. We'll
17 get started moving into the Measures. The first
18 one that we're going to be looking at today is
19 the Diabetic Retinopathy.

20 No, sorry, I had an Age-Related
21 Macular Degeneration, 0087, Dilated Macular
22 Examination. And that's Bill Rich is -- and

1 Flora Lum. Again, any comments?

2 DR. RICH: Yes, I think -- thank you
3 very much. Today we're going to look at the
4 other two leading causes of blindness in the
5 elderly. And that's age-related macular
6 degeneration and diabetic retinopathy.

7 The -- as we discussed yesterday, the
8 natural time line for quality improvement and
9 better outcomes is good science, education
10 guidelines and finally, measurement and
11 registries to actually collapse the rate of
12 adoption from Beth McGlynn's Article that shows
13 only a 50 percent uptick in ten years.

14 Both of these, the first two Measures
15 deal with macular degeneration. They're
16 bolstered by Level One evidence. And again, the
17 difference in these examinations of the retina is
18 that we are able to completely stage the course
19 of a disease, unlike cancer or even diabetes
20 where you want to look at kidney function.

21 We can actually see all the pathology,
22 stage it. And how effective is that in affecting

1 the natural course of the disease, again the
2 diabetic blindness from diabetes after the
3 publication of the DRS trial was down 50 percent
4 in five years.

5 The same dramatic results with the
6 diabetic macular edema. And with macular
7 degeneration, we've decreased the leading cause
8 of blindness in the western world by 90 percent.
9 Which is pretty dramatic.

10 There is still gaps in care. And
11 we're also going to deal with a counseling
12 Measure. And probably has the most, I think all
13 of us at NQF are a little leery about counseling
14 measures.

15 This one has Level One evidence of the
16 efficacy of the counseling. Decreasing number --
17 new cases of wet macular degeneration within five
18 years if the adoption of appropriate antioxidants
19 is used.

20 That decrease of 300 thousand patients
21 results in a savings depending upon the use of
22 anti-VEGF agents between \$2 and \$12 billion over

1 five years. So, not only are we decreasing the
2 cost, but we're dramatically saving vision.

3 So, and the last two are diabetic
4 measures. And we'll address them when we get to
5 them. Thank you, Ms. Chairman.

6 CO-CHAIR YAREMCHUK: And discussants,
7 Scott?

8 MEMBER FRIEDMAN: Good morning. So,
9 the first Measure deals with age-related macular
10 degeneration, dilated macular exam. Age-related
11 macular degeneration is the most common cause --
12 briefly the most common cause of legal blindness
13 in adults over 75 in the United States.

14 And basically there's two types.
15 There's a wet type, which is the least common or
16 more severe type. And a dry type, which is the
17 more common and least severe type.

18 So, people go through a progression.
19 They develop mild changes. And then the natural
20 history is it typically gets worse.

21 And you can develop abnormal blood
22 vessels, which are treatable. In order to

1 diagnose the wet type of macular degeneration,
2 one needs to do testing. Including but not
3 limited to actually looking in the back of the
4 eye.

5 And so, what this Measure, basically
6 looks at is, did you look at the back of the eye.
7 And did you define the level of degeneration,
8 i.e., absence of macular thickening, which can be
9 a sign of wet macular degeneration and/or
10 hemorrhage.

11 It can also be a sign of wet macular
12 degeneration. There's no scientific proof
13 through randomized clinical trials that actually
14 looking at the back of the eye saves vision.

15 But it just makes sense that in order
16 to diagnose it, one needs to actually look at the
17 eye and document the findings. I guess in theory
18 you could do other ancillary tests without
19 looking at the eye, but nobody in my opinion does
20 that or should be doing that.

21 So, there is fairly good evidence that
22 looking in the back of the eye and documenting

1 the level of retinopathy is advantageous in
2 diagnosing and treating macular degeneration.

3 CO-CHAIR YAREMCHUK: Okay. So this is
4 a process measure. And if you want, we're ready
5 to vote for evidence? Or is there any
6 discussion?

7 MEMBER MADONNA: I have nothing to
8 add.

9 CO-CHAIR YAREMCHUK: Okay.
10 Discussion? Go ahead Matt.

11 MEMBER CARNAHAN: So, just to clarify,
12 we're saying the value of this Measure is that
13 we're doing staging. And therefore, can add an
14 intervention like an AREDS 2 supplement
15 recommendation.

16 As opposed to diagnosing wet, which I
17 would think the odds of diagnosing wet in a
18 timely fashion, where you see an actual
19 improvement, would be unlikely.

20 MEMBER FRIEDMAN: So I think it's two
21 fold. I think if they have -- if you look in and
22 they have mac -- well, it says they already have

1 macular degeneration.

2 So if you look in the back of the eye
3 and they have moderate to severe dry macular
4 degeneration, which again, is the more common
5 type, then one should recommend vitamin
6 antioxidants for treating that condition.

7 But if you look in and they previously
8 have been dry and they've been stable. Then they
9 come in and they're still -- they're still
10 asymptomatic.

11 They have no change in their symptoms.
12 But you see a little bit of bleeding in the eye
13 that requires more testing and possibly different
14 types of treatments.

15 So in order to actually diagnose early
16 stage of wet macular degeneration, which can
17 occasionally present without new symptoms, you
18 actually need to look in the eye to see if
19 there's new bleeding which wasn't there before.

20 CO-CHAIR YAREMCHUK: Yes, Andrew?

21 MEMBER FRIEDMAN: If that answers your
22 question.

1 MEMBER SCHACHAT: Right. And so as
2 far as the issue about whether you have to look
3 in the eye to see any of this. There are
4 alternative ways of doing it, which is screening
5 with photographs.

6 That's done for diabetes. It's not
7 been shown to work very well yet, and so it's not
8 an option for AMD.

9 So this is the only option. And as
10 far as the comment about not detecting wet, I
11 echo what Scott says. Wet can definitely be
12 asymptomatic. So you can see it by looking in.

13 And there's evidence from a number of
14 trials that earlier treatment gets better
15 outcomes. So, it makes sense.

16 MEMBER CARNAHAN: Right. I was just
17 suggesting that perhaps the likelihood of
18 catching a person at wet, if you're trying to do
19 a cost effective intervention, that this would
20 likely not -- I would say that the highest
21 percentile not capture wet patients.

22 MEMBER SCHACHAT: That's right. But

1 it's cost effective for dry. And this is just an
2 extra added benefit for those wets that you
3 catch, make it even more cost effective.

4 Because you get the free thing. Once
5 they're looking in, you can find the wet.

6 CO-CHAIR YAREMCHUK: Are we ready to
7 vote?

8 MS. ROBINSON-ECTOR: Voting is now
9 open for evidence for Measure 0087. And for
10 those on the call, option one is high, two is
11 moderate, three is low and four is insufficient
12 evidence.

13 MS. LUONG: And Judith, you can send
14 me an email for the voting. Thanks.

15 MEMBER LYNCH: I don't know that I
16 should vote. Is this the Measure that we just
17 started talking about?

18 I just got on. They kept me on hold
19 for a very long time.

20 MS. LUONG: Oh, they did. Okay. All
21 right then, thank you.

22 MS. ROBINSON-ECTOR: So, it looks like

1 we're waiting for three more votes in the room.

2 If you guys could point your clickers at this

3 laptop. Thank you.

4 Okay. Great. All the votes are in.

5 62 percent voted high. 31 percent voted

6 moderate. Eight percent voted low. Zero voted

7 insufficient evidence. So for evidence, Measure

8 0087 passes.

9 CO-CHAIR YAREMCHUK: Opportunity for
10 improvement?

11 MEMBER FRIEDMAN: So the Developers
12 gave us some data using PQRS data from 2009 to
13 2012. And the meaningful performance results
14 range from 94 to 96.1 percent.

15 So, the people that are reporting are
16 doing an awesome job. But out of the number of
17 eligible professionals, only 14 to 19 percent of
18 people are reporting.

19 So, it is a small number of people
20 that are reporting. And this is a couple of
21 things. So this is a very common condition.

22 And even if you increase the mean

1 performance result by one or two percent, you're
2 still going to save a vision in several thousand
3 patients.

4 And so as Bill alluded, save billions
5 of dollars, depending on which anti-VEGF that you
6 use. So it is very cost effective. You're going
7 to save money on the back end.

8 And the other issue is that we think
9 with the changes in reporting, that more people
10 will report. And we think maybe the people that
11 are reporting are doing a better job.

12 So, it's certainly plausible that the
13 mean performance will be lower as more people
14 report. So I think there is room for
15 improvement.

16 And even if there wasn't room for
17 improvement, a small percentage would mean a
18 large amount of saved vision over the course of
19 time.

20 DR. RICH: Just to augment Scott's
21 comments. Again, an issue you have to report on
22 nine measures instead of three.

1 And so in IRIS we're able to look at
2 the three that were selected. But we also look
3 and can see their performance on other measures.

4 And it's dramatically lower for
5 measures that you are not focused on. And we'll
6 be glad to supply some data if you'd like, but.

7 MEMBER MADONNA: Yes. I would only
8 add to what Scott said about detecting wet AMD
9 and saving vision there. But additionally, you
10 get this -- you will stage persons with dry AMD
11 and then appropriately counsel them about
12 antioxidants, which also will lead to vision --
13 savings of vision.

14 And also, reduce the number of side
15 effects for people who should not be taking
16 antioxidants but do nevertheless.

17 DR. LUM: Just to follow up with Dr.
18 Rich. We did actually collect information on the
19 AMD measures.

20 As we said, the severity should be
21 according to the AREDS scale. And we've known
22 that in medicine it probably takes 17 years for

1 clinical trials to actually reach the bedside.

2 So, our performance rate, looking at
3 electronic records and the real documentation
4 that practices do is only ten percent. And
5 that's because they aren't using the right
6 severity scale.

7 They're not looking -- they're not
8 documenting macular thickening. And we give them
9 the practice pattern and it's really at the point
10 of care and that they're being measured that
11 they're going to change their practices.

12 Even though we have wonderful practice
13 guidelines and a lot of great education, we do
14 really find that a lot of our ophthalmologists
15 aren't following the latest guidelines and the
16 latest severity scales.

17 So that's the performance that we've
18 seen just looking at EHR documentation across
19 2722 physicians in 2014.

20 DR. RICH: One last comment. We've
21 all talked about physician support. Well, when a
22 physician -- physicians are pretty competitive.

1 And when they see their performance
2 rate is ten percent they howl. And we have a
3 practice person assigned to that practice that
4 will explain to them why their performance is
5 terrible.

6 They're not meeting the guidelines.
7 And you talk about a turnaround in the adoption
8 of guidelines.

9 We were one of the first three
10 societies to develop them in 1985. Well, all of
11 a sudden, they get adopted pretty quickly when
12 they see their score.

13 DR. WINKLER: I guess, Flora's
14 beginning to ask this, but if the way you get
15 into the measures is because there's an encounter
16 with the clinician, and so, I guess I'm trying to
17 understand the quality problem.

18 Because exactly around -- because
19 aren't they examining these patients? And is it
20 the not examining? Or is it the not documenting
21 the staging?

22 And that's what I'm -- and I want --

1 and this Measure can differentiate that.

2 MEMBER SCHACHAT: Actually some of
3 both. Because you have to put drops in. And so
4 this will encourage putting more drops in.

5 So it changes the existing.

6 CO-CHAIR YAREMCHUK: Any other
7 comments?

8 (No response)

9 CO-CHAIR YAREMCHUK: Ready to vote?

10 MS. ROBINSON-ECTOR: Voting is now
11 open for performance gap for Measure 0087. And
12 for those on the call, option one is high, two is
13 moderate, three is low and four is insufficient.

14 MS. LUONG: Hi Vaishali, I know you
15 just got on the line. Will you be voting?

16 MEMBER PATEL: I'll just sit out this
17 one since I didn't hear the discussion.

18 MS. LUONG: Okay. And Judith?

19 MEMBER LYNCH: Yes. I'm going to wait
20 probably until the next one as well.

21 MS. LUONG: Okay. Great. Thanks.

22 MS. ROBINSON-ECTOR: So, all the votes

1 are in. 69 percent voted high. 31 percent voted
2 moderate. Zero voted low and zero voted
3 insufficient. So for performance gap, Measure
4 0087 passes.

5 CO-CHAIR YAREMCHUK: Reliability?

6 MEMBER FRIEDMAN: So the Developer
7 presented two types of testing. The first one is
8 measure score reliability using the 500 docs from
9 the IRIS Registry.

10 And the reliability rates were 0.89 to
11 1, which is extremely high. They also looked at
12 data element reliability using inter-rater
13 reliability from a single doc.

14 And for the denominator PQRS versus
15 gold standard was 96 percent, extremely high.
16 But the numerator was only 45 percent, which is
17 moderate.

18 And then they used reliability, the
19 EHR chart extraction versus gold standard. And
20 the numerator was, this time was 97 percent.
21 Which is extremely high.

22 So with exception of the one numerator

1 45 percent, reliability was extremely high.

2 CO-CHAIR YAREMCHUK: Richard?

3 MEMBER MADONNA: Nothing to add.

4 CO-CHAIR YAREMCHUK: Any other
5 comments?

6 (No response)

7 CO-CHAIR YAREMCHUK: Are we ready to
8 vote?

9 MS. ROBINSON-ECTOR: Voting for
10 reliability for Measure 0087 is now open.

11 Okay. All the votes are in. 54
12 percent voted high. 46 percent voted moderate.
13 Zero voted low and zero voted insufficient. So
14 for reliability for Measure 0087, the measure
15 passes.

16 CO-CHAIR YAREMCHUK: Validity?

17 MEMBER FRIEDMAN: So, the developers
18 examined validity using a -- using face validity
19 with an expert panel of 16 members who agree that
20 the measure was valid.

21 And there are no threats to validity
22 with this Measure.

1 CO-CHAIR YAREMCHUK: Go ahead, Reva?

2 DR. WINKLER: I just want to point out
3 that the data that Flora just gave us, which says
4 that only ten percent of the folks in the
5 registry would meet the measure looking at their
6 EHRs.

7 Yet PQRS is reporting 95 percent. And
8 so to me that 95 percent probably doesn't
9 represent what we think we're measuring.

10 So, to me that is a -- I would
11 question the validity of the results you get in
12 this Measure.

13 DR. RICH: Okay. Actually I brought
14 that up yesterday in my initial comments. That
15 we -- we're finding dramatically different
16 results from PQRS, where people misinterpret it
17 as just dilating and looking at the eye.

18 When you actually look at what they're
19 doing, they're not -- we don't think they're even
20 measuring.

21 So I made that point yesterday that if
22 we're going to look at all these issues, and we

1 look at claims, I think you're going to find out
2 with -- we're going to see a lot of -- we're
3 probably the first ones to come before you with a
4 lot of new registry measures.

5 We're going to see dramatic
6 differences between the claims. And this is a
7 great example. Docs think they're doing things
8 and it's not fraud.

9 But they don't understand the demands
10 of staging the diseases. And they don't get a
11 score.

12 MEMBER STEIN: I think that's one
13 possibility. The other possibility is whether
14 the IRIS Registry is fully capturing the
15 information adequately enough.

16 So there may be an underestimate on
17 that end.

18 DR. LUM: That is true. So because it
19 is ten percent, but because it's not counting for
20 PQRS, people haven't been working on the
21 documentation as much as the other measures,
22 which are counting for PQRS this year.

1 So that it is probably an
2 underestimate from the first initial mapping and
3 extractions from electronic methods. We probably
4 could dig deeper and there would be some better
5 compliance.

6 DR. RICH: The data is the data. You
7 know, they're not doing it.

8 DR. WINKLER: I guess from a criteria
9 perspective, when we're assessing validity, what
10 we're hearing is, depending on how the data is
11 collected, we get wildly different results.

12 So, the question I would ask you is,
13 what do we think, or how could we know what
14 provides us with the most valid results? Because
15 that's what we're looking for.

16 And that's the measurement that works.
17 I mean, we don't really want to continue
18 promoting a measure that doesn't provide us with
19 valid results.

20 So, if there's truly an issue around,
21 you know, different data sources give us
22 different results, I think we need to have a

1 better understanding of which ones gives us, you
2 know, valid results. If we can possibly know
3 that.

4 DR. RICH: Great point. You're not
5 going to see any claims data for this thing from
6 now on. Because no one -- it's physically
7 impossible for someone in practice to by claims
8 make nine measures.

9 I don't know anyone in the United
10 States that's trying to do it. It's all going to
11 be EHR or it's going to be registry reported.

12 So, again and I made that point
13 yesterday and now we're seeing the manifestation
14 of that.

15 DR. WINKLER: Essentially this Measure
16 before us is the registry measure. You're not
17 bringing an E-Measure for this particular
18 version.

19 So, we're looking at the registry.
20 Are you saying that you're not recommending a
21 claims version of it be part of this endorsed
22 Measure?

1 DR. RICH: No. I'm saying that
2 practically, I don't know anyone that's going to
3 do claims.

4 But I think the option should be
5 available to them that physicians are trying to
6 do a good job. They're close to retirement.
7 They don't have an EHR, which you need to do an
8 extraction of data.

9 I just -- I couldn't do it physically.
10 But I hate to take away that option from them.

11 DR. LUM: The other thing I think is
12 we could do better education about how to use
13 this Measure. And the Measure specification does
14 specifically state the disease severity and the
15 macular thickening.

16 And that all has to be documented.
17 So, we could do a better job of educating people
18 using the Measure through claims and the registry
19 to do all those things.

20 That's what it means -- it means to
21 meet the measure.

22 CO-CHAIR YAREMCHUK: Scott?

1 MEMBER FRIEDMAN: Well, one of the
2 other possible scenarios is that the people that
3 are reporting through PQRS are retina docs. And
4 retina docs deal primarily with treating mac
5 degeneration.

6 And general ophthalmologists may not
7 be reporting on this. Maybe very little or not
8 at all.

9 But then when we look at the registry
10 data, we can capture that. And maybe they're
11 doing a poor job of reporting it. That's where
12 we need to have our emphasis and move them
13 forward.

14 But clearly, all the retina doctors
15 and I report on this Measure for example, I do
16 not dilate 100 percent of my patients. It's kind
17 of ridiculous for me not to because I couldn't do
18 my job.

19 So I dilate 100 percent of my
20 patients. And I'm probably in the 96th
21 percentile because this is what I do them all. I
22 don't do -- I do a poor job of documenting the

1 anterior stuff because I don't really care about
2 it for example, as much, because it gets in my
3 way.

4 So, maybe we need to get our general
5 ophthalmologists to do a better job of
6 documenting the findings for macular degeneration
7 as well as the retina specialists.

8 CO-CHAIR YAREMCHUK: I was wondering
9 if the PQRS would also be early adopters of both
10 that might be the ones that are reporting. And
11 therefore doing a better job of it.

12 And that's only a question. Go ahead
13 Richard.

14 DR. RICH: I don't think so. As a
15 general ophthalmologist I think Scott is right.
16 We have 12 in my group. I don't think any of us
17 reported this Measure. We report on other
18 measures.

19 MEMBER MADONNA: Yes, I just have a
20 couple of questions about the Measure. The first
21 one is, we specify a dilated macular examination.
22 But we don't specify how the dilated macular

1 examination is performed.

2 And I would think that the retina
3 specialists would agree that that should be done
4 stereoscopically. And so that's question one.

5 And the second one is that there
6 appears to be the ability to have exclusions from
7 -- and I just don't have a sense of how often
8 those exclusions have been used.

9 You know, how often is it being
10 reported that I didn't dilate because the patient
11 didn't want it? Or something like that?

12 Patients with AMD need to be dilated.
13 So the exclusions should be rare.

14 MEMBER SCHACHAT: There are all kinds
15 of good reasons for exclusions. And some of
16 these patients are coming monthly and don't want
17 the other eye dilated each visit or something
18 like that.

19 The other eye may already have the
20 disc reform scarring and they don't need to be
21 checking the other eye on that day and so on.

22 And as far as the first question about

1 a stereoscopic exam, I think that's generally
2 covered in the preferred practice patterns and
3 general recommendations about how to examine the
4 retina. It's sort of basic teaching in
5 ophthalmology.

6 You know, in the hemoglobin A1C
7 measures, do you discuss how they should achieve
8 better blood sugar? So I'm not sure the Measures
9 get into the detail of how to do steps in the
10 exam or the treatment or something else.

11 MEMBER MADONNA: Understood. But,
12 still would be able to get a positive check on
13 this measure by just putting drops in the eyes
14 and not doing the appropriate examination.

15 MEMBER SCHACHAT: I think it says to
16 look at the macular and make some observations.
17 And so it would be fraud not to look.

18 MEMBER MADONNA: But again, without
19 doing it stereoscopically, it's probably not
20 going to get done.

21 MEMBER STEIN: The high percentages,
22 you know, that the PQRS is generating, it's not

1 something specific to this particular Measure
2 comes up. With all these measures.

3 It's more of a global problem of, you
4 know, who's using PQRS to report what. And I
5 don't think that -- I mean, I think that people
6 are going to report on the things that they're
7 doing a lot. And that they feel they're doing
8 most appropriately.

9 But I don't think it's an issue with
10 any of these particular Measures. It's just, you
11 know, how the system is capturing it.

12 And whether, you know, by going to an
13 IRIS Registry where you can look beyond just the
14 folks who are choosing to report on that measure,
15 you're going to see more variability. And you're
16 going to probably capture quality better.

17 The question is whether IRIS is there
18 yet. So, I mean, I think it's important.

19 CO-CHAIR YAREMCHUK: Thank you.
20 Steve?

21 MEMBER STRODE: I'd also like to
22 follow up as a non-eye doctor on the stereoscopic

1 eye process. Is that necessary -- is that the
2 ideal?

3 Or is that necessary for an adequate
4 exam? If it's adequate, should it not be added
5 as a specification?

6 MEMBER SCHACHAT: So, you can look in
7 the direct ophthalmoscope and see the features of
8 wet AMD not as well. You can see the hemorrhage.
9 You see the lipid.

10 You can't appreciate the elevations.
11 So you get two-thirds of the information. And
12 for the drusen, we can see them for grading dry
13 AMD, either way.

14 It doesn't matter a whole lot to me.
15 If you want to examine the eye better, you
16 examine the eye better. But, again, I'm not --
17 in the other Measures, I don't see specifications
18 on how you do things.

19 So, in blood pressure measures do you
20 specify what kind of cuff you use and how many
21 measurements you do? And whether you do it four
22 places or once or twice? I'm not aware.

1 But I don't think so. So, I don't
2 think these measures generally go to those levels
3 of specificity.

4 DR. RICH: Steve, I'll answer. I'm a
5 general ophthalmologist. They think over the
6 last 30 years since the introduction of the
7 widely available Zeiss and Volk lenses, I don't
8 know anyone that doesn't look at the macular
9 stereoscopically.

10 It's easy to do. Perhaps people that
11 were somehow missed that, they're practicing
12 longer than I am, and I'm almost 70, they might
13 not do it.

14 But, everyone -- it's just what you
15 do.

16 CO-CHAIR YAREMCHUK: I -- okay, go
17 ahead Tammy.

18 MEMBER BRADHAM: I just have a simple
19 question. So we're being asked to look at
20 validity. And so, are we taking administrative
21 claims, electronic clinical records, the registry
22 and pulling it all together and taking off the

1 duplicates for this Measure?

2 Or, are you only looking at the
3 registry? Or are you only looking at
4 administrative claims in doing this Measure?

5 I'm just trying to figure out how
6 you're measuring this. And I think the
7 discussion's been great on the medical. But I
8 need help understanding what we're measuring.

9 CO-CHAIR YAREMCHUK: I appreciate what
10 you're saying. And Reva, you can correct me.
11 But, when it says data source, it doesn't mean
12 and. I mean, it means any one of those can be
13 used.

14 And so, what the original question is,
15 is that administrative claims fulfills this, but
16 it doesn't really fulfill it.

17 You know, it should be easier.

18 DR. RICH: I think I introduced huge
19 confusion. When I was talking about the lack of
20 performance, when we're look -- we can actually
21 look at the performance of someone that wants to
22 submit this.

1 But we can also look at everyone's
2 performance on these other measures. So, the
3 performance is, these are not -- I'm not saying
4 there's a difference between what's in the
5 registry for a submitted one of the three.

6 It's the other ones that they're not
7 reporting. That's where we see variations.

8 So, I think I introduced a lot of
9 confusion. I think it was Josh or Scott said
10 that when you report it, you do a good job.

11 We're saying what the other people are
12 not reporting that measure, if they're not
13 concentrating on it, that's where we see the
14 performance very low.

15 CO-CHAIR YAREMCHUK: All right. Go
16 ahead Josh.

17 MEMBER STEIN: I just want to add one
18 comment. I think it's important to capture the
19 source of where it's coming from. Especially if
20 there's going to be comparison of provider A
21 versus provider B.

22 Because I think, some of the sources

1 may do a better or worse job than others at this
2 point.

3 CO-CHAIR YAREMCHUK: Go ahead Matt.

4 MEMBER CARNAHAN: Just a question
5 around the measurement in terms of the staging.
6 Is it the old staging or the new staging?

7 And is there a way with current coding
8 to do the new staging, it's a 0, 1, 2? And would
9 that effect the recommendations you give to a
10 patient in relation to the staging you could give
11 based on the coding available?

12 MEMBER SCHACHAT: Do you mean the
13 Beckman classification as opposed to the AREDS?
14 Well, the 0, 1, 2, is the simplified AREDS scale.

15 MEMBER CARNAHAN: Document that based
16 on coding?

17 MEMBER SCHACHAT: No. But, in ICD-10
18 you can do better on all of these than you can do
19 on them with ICD-9. But I think the idea is
20 people are being asked to look.

21 And if you can't look and write
22 something down, can't get to that point, you're

1 lost.

2 I don't think that the Measure
3 specifies how to grade the retinopathy severity.

4 DR. RICH: That raises an important
5 point. And that's the granularity of our current
6 coding system.

7 So, Flora's made recommendations to
8 our health policy committee to actually do
9 exactly that. To actually -- we're going to be
10 able to be staged -- different stages of open
11 angle glaucoma that was one.

12 And we're actually doing this with
13 diabetic retinopathy macular degeneration. But
14 it's a laborious process. What does it take,
15 about three years to get something back?

16 But we've already submitted it. But
17 there is not enough granularity if you really
18 want to risk adjust things in even ICD-10.

19 It's going to be a lot thinner than
20 ICD-9.

21 CO-CHAIR YAREMCHUK: Are we ready to
22 vote?

1 MS. ROBINSON-ECTOR: Voting is now
2 open for validity for Measure 0087.

3 Okay. All the votes are in. 15
4 percent voted high. 69 percent voted moderate.
5 15 percent voted low. And zero voted
6 insufficient. So for validity for Measure 0087,
7 the measure passes.

8 CO-CHAIR YAREMCHUK: Feasibility?

9 MEMBER FRIEDMAN: So, the Measure is
10 specified for several data sources as we
11 discussed. Claims data, registry and extraction.

12 And then all data elements are well
13 defined. So I don't think there's any issues
14 with feasibility for this measure.

15 CO-CHAIR YAREMCHUK: Rich?

16 MEMBER MADONNA: Nothing to add.

17 CO-CHAIR YAREMCHUK: Any discussion?

18 (No response)

19 CO-CHAIR YAREMCHUK: Ready to vote.

20 MS. ROBINSON-ECTOR: Voting is now
21 open for feasibility for Measure 0087.

22 Okay. It looks like all the votes are

1 in. 46 percent voted high. 38 percent voted
2 moderate. 15 percent voted low. And zero voted
3 insufficient. So for feasibility, Measure 0087
4 passes.

5 CO-CHAIR YAREMCHUK: Usability and
6 use?

7 MEMBER FRIEDMAN: So the Measure has
8 been discussed, is currently being used in the
9 PQRS program. And PQRS will be publically
10 reported.

11 And it's also being used, I think, in
12 the IRIS Registry. Well, it's also used in the
13 IRIS Registry. So, it's currently being used and
14 will have more use in the future.

15 CO-CHAIR YAREMCHUK: Rich?

16 MEMBER MADONNA: Nothing to add.

17 CO-CHAIR YAREMCHUK: Any discussion?

18 (No response)

19 CO-CHAIR YAREMCHUK: Ready to vote.

20 MS. ROBINSON-ECTOR: Voting is now
21 open for usability and use for Measure 0087.

22 All the votes are in. 77 percent

1 voted high. 23 percent voted moderate. Zero
2 voted low and zero voted insufficient
3 information. So for usability and use, Measure
4 0087 passes.

5 CO-CHAIR YAREMCHUK: So, to vote for
6 suitable for endorsement.

7 MS. ROBINSON-ECTOR: Voting is now
8 open for recommendation for overall suitability
9 for endorsement for Measure 0087.

10 Okay. All the votes are in. 92
11 percent voted yes. And eight percent voted no.
12 So for recommendation for overall suitability for
13 endorsement for Measure 0087, the Measure passes.

14 CO-CHAIR YAREMCHUK: Okay. Moving
15 onto the next one, Age-Related Macular
16 Degeneration: Counseling on Antioxidant
17 Supplement. Richard? You're up.

18 MEMBER MADONNA: This is kind of an
19 ideal follow up to the last Measure. Because the
20 staging of macular degeneration, which we've
21 mentioned as part of the dilated exam becomes
22 very important here.

1 The Measure looks at the percentage of
2 patients age 50 or older with a diagnosis of AMD.
3 There are care givers who are counseled within 12
4 months of the benefits and/or risks of the AREDS
5 formulation for the progression of AMD.

6 What's interesting is that the
7 information can be discussed with all patients
8 with AMD, even those who don't meet the criteria
9 for supplementation. Which is intermediate AMD
10 in at least one eye.

11 As there are risks in using
12 supplements in some patients, for example in
13 smokers, and there's no evidence of proof that
14 supplementation is useful in persons with early
15 AMD, counseling must be provided to all patients.

16 If we look at the evidence, this is a
17 process measure based on a systematic review of
18 two randomized clinical trials. Age-related eye
19 disease study with AREDS and then AREDS 2.

20 In which treatment with antioxidants
21 and minerals is recommended for patients who have
22 intermediate or advanced AMD in at least one eye.

1 And the evidence is rated as strong.

2 CO-CHAIR YAREMCHUK: And our co-
3 discussants?

4 MEMBER STRODE: Nothing to add.

5 CO-CHAIR YAREMCHUK: Okay. Any
6 comments? So, go ahead Tammy.

7 MEMBER BRADHAM: What is AREDS?

8 MEMBER MADONNA: That's the Age-
9 Related Eye Disease Study. So that looked at
10 age-related diseases, macular degeneration and
11 cataract. We're specifically looking at macular
12 degeneration.

13 And it looked specifically at using
14 antioxidants or nutritional supplementation in
15 slowing the progression of macular degeneration.

16 MEMBER SCHACHAT: And so the vitamins
17 cost about \$15.00 or \$20.00 a month. And for
18 patients with a certain amount of AMD, it reduces
19 their risk of progression and losing vision over
20 time by about a quarter to a third.

21 So it's a very cost effective and safe
22 way of preventing blindness.

1 MEMBER FRIEDMAN: But, we also did a
2 study to show, and they gave, you know, we had a
3 placebo control group. So, we did a well-
4 designed Phase III randomized, multi-center Phase
5 III randomized clinical trial.

6 And there's clear evidence that it's
7 beneficial.

8 CO-CHAIR YAREMCHUK: Go ahead Matt.

9 MEMBER CARNAHAN: I wasn't clear. Is
10 this saying that the recommendation for the
11 patients is a face to face doctor's office visit?

12 Or is it just education that can be
13 given if you already know what the staging was?
14 Say they were advanced enough to need the
15 supplements.

16 DR. RICH: I'm not sure of the Measure
17 description, but this occurs face to face. You
18 look in, 20 percent of the time they're
19 inappropriately taking vitamins.

20 And there's a gap in care of 40
21 percent that's been documented. So, you sit down
22 and you explain the trial to them. You no longer

1 have to discuss the risk of it with smokers
2 because with AREDS 2, that's been eliminated.

3 So it occurs face to face at the time
4 of the visit. And every time you see them, you
5 ask them, you know, are you taking them? Are you
6 taking them as prescribed?

7 And it's face to face. I'm not sure
8 the Measure describes.

9 DR. LUM: That's correct. It's, you
10 know, counseling. So it would be during the
11 encounter with the -- between the physician and
12 the patient.

13 CO-CHAIR YAREMCHUK: And how would you
14 collect the data? Is there a code for this? For
15 counseling for antioxidants?

16 DR. LUM: There's a G code for
17 reporting it. That the counseling was performed
18 or not performed.

19 CO-CHAIR YAREMCHUK: Tammy?

20 MEMBER BRADHAM: Does it matter if
21 they're a past smoker? Or that they have to be
22 currently smoking?

1 MEMBER SCHACHAT: So, once you've not
2 been smoking for two or three years, that begins
3 to count as a non-smoker. But --

4 MEMBER MADONNA: Just in following up
5 from the last Measure. That's why it's so
6 important that that dilated macular exam be done.
7 And staging will be done appropriately.

8 Because if you have early AMD, there's
9 been -- there's no benefit shown from taking the
10 supplementation. And of course then you -- the
11 risk benefit is such that you only have risk and
12 no real benefits show.

13 CO-CHAIR YAREMCHUK: Okay. Are we
14 ready to vote on evidence?

15 MS. ROBINSON-ECTOR: Voting for
16 evidence, Measure 0566 is now open. And for
17 those on the call, option one is high, two is
18 moderate, three is low and four is insufficient
19 evidence.

20 Okay. All the votes are in. 60
21 percent voted high. 40 percent voted moderate.
22 Zero voted low and zero voted insufficient

1 evidence. So for evidence, Measure 0566 passes.

2 CO-CHAIR YAREMCHUK: Okay.

3 Opportunity for improvement.

4 MEMBER MADONNA: PQRS data indicates
5 that an increasing but still small number of
6 practitioners report. With an increase of 7.8
7 percent in 2010 to 13.9 percent in 2012.

8 And a mean performance of about 92
9 percent for each year. Data submitted to the
10 IRIS Registry for 2014 give a performance rate of
11 82 percent.

12 Considering the huge number of persons
13 with AMD, improvements in performance will likely
14 result in saving many persons from significant
15 vision loss.

16 CO-CHAIR YAREMCHUK: Steve? Any
17 discussion?

18 CO-CHAIR MERENSTEIN: I just have a
19 question. Do you have any data on inappropriate
20 use? It seems like people might be using it too
21 early.

22 DR. RICH: Yes. It's only going to be

1 20 percent. As you can tell from talking to your
2 patients, there's wide lately available
3 advertisements to take your eye vitamins.

4 We see people 35 year old and spending
5 \$20.00 a month. So actually we spend just about
6 as much time counseling people, should I be
7 taking these vitamins? And they're perfectly
8 healthy.

9 So, the overuse is 20 percent.

10 CO-CHAIR YAREMCHUK: This won't get to
11 overuse or under-use however. It's just that
12 there's been counseling done.

13 MEMBER SCHACHAT: Yes. One of the
14 largest overuse groups are family members. Like
15 children of patients with AMD and they see the
16 trouble their parents have and they take the
17 vitamins hoping they won't get it.

18 But it doesn't make any difference
19 because they don't have any yet.

20 CO-CHAIR YAREMCHUK: Are we ready to
21 vote?

22 MS. ROBINSON-ECTOR: Voting for

1 performance gap is now open for Measure 0566.

2 For those on the call, option one is high, two is
3 moderate, three is low and four is insufficient.

4 CO-CHAIR YAREMCHUK: Reliability?

5 MS. ROBINSON-ECTOR: Oh, we're still
6 waiting for two more.

7 CO-CHAIR YAREMCHUK: Oh, sorry.

8 Sorry.

9 MS. LUONG: Judith, if you can just
10 email me your vote. Thanks.

11 MS. ROBINSON-ECTOR: Okay. All the
12 votes are in at 14 votes. 71 percent voted high.
13 29 percent voted moderate. Zero voted low and
14 zero voted insufficient. So for performance gap
15 for Measure 0566, the measure passes.

16 CO-CHAIR YAREMCHUK: Okay.
17 Reliability.

18 MEMBER MADONNA: We just mentioned the
19 specifications for the Measure. The numerator is
20 specified by CPT code. And the denominator by
21 new ACT code. There are not exceptions.

22 The Developer presented two types of

1 testing. The Measure score reliability from 490
2 ophthalmologists submitted to the IRIS Registry
3 for 2014 to PQRS reporting.

4 Reliability ranged from .46 to 1.0.
5 Data element reliability was tested by an inter-
6 rater reliability from a single ophthalmologist's
7 office.

8 Reliability of PQRS claims versus
9 chart review, the denominator was 96.1 percent
10 agreement. And the numerator 39.2 percent
11 agreement.

12 Reliability of the EHR chart
13 extraction, which is the gold standard, was a
14 numerator of 75.5 percent agreement.

15 CO-CHAIR YAREMCHUK: Steve?

16 MEMBER STRODE: Nothing to add. Thank
17 you.

18 CO-CHAIR YAREMCHUK: Any comments?
19 Todd?

20 MEMBER RAMBASEK: I'm sorry, can you
21 clarify what 39 percent agreement means?

22 MEMBER MADONNA: The numerator is the

1 CPT code, which is the counseling. So that was
2 the comparison of the -- this was in a single
3 ophthalmologist's office.

4 So that was the claim made by the
5 ophthalmologist versus chart review of the
6 ophthalmologist's charts. I believe that's
7 correct.

8 CO-CHAIR YAREMCHUK: Any other
9 comments?

10 DR. RICH: The 39 percent is low
11 because a lot of times that is, we don't say we
12 sat down and discussed, we usually have little
13 mnemonics, you know. AREDS plus, AMSLER plus,
14 you know, that means that we discussed it.

15 So, sometimes chart extractors, you
16 know, I think everyone documents how they did
17 this differently. I don't know if you have a
18 standard form, but.

19 MEMBER FRIEDMAN: So, this -- the
20 reason I'm smiling is this maybe me,
21 unfortunately. Only 39 percent.

22 As you said, I'm the -- I want to be

1 100 percent. So, what I think we do is our EHR
2 in our discussion, we put in that we counsel the
3 patient with AREDS or some verbiage.

4 It's probably documented in the
5 discussion if it's a generic discussion for a
6 typical dry AMD, it's pretty simple. If it was
7 dictated, it's possible that it was missed.

8 It's also possible that the abstractor
9 missed it as well. But certainly, that's where
10 it is.

11 So, I counsel everybody on vitamins.
12 I may not 100 percent of the time document that
13 it was done on a routine basis.

14 It's possible it was done on one visit
15 and not on another visit. And the patient was
16 seen as Andy suggested, once a month.

17 So, seen 12 times, maybe 24 times
18 because they come in twice a month.

19 CO-CHAIR YAREMCHUK: The specification
20 just says counseled within 12 months. So if you
21 did it once in 24 visits, and it was every two
22 weeks, it should still be --

1 MEMBER FRIEDMAN: Right. If you did
2 it -- if you even did it one time in months per
3 year, it qualifies. If you didn't do it the
4 other 23 times for this Measure, it still
5 qualifies.

6 If you didn't document it the other 23
7 times, it still qualifies.

8 CO-CHAIR YAREMCHUK: Any other
9 comments?

10 (No response)

11 CO-CHAIR YAREMCHUK: Ready to vote?

12 MS. ROBINSON-ECTOR: Voting is now
13 open for reliability for Measure 0566. And for
14 those on the call, option one is high, two is
15 moderate, three is low and four is insufficient.

16 All the votes are in of 15 votes. 20
17 percent voted high. 73 percent voted moderate.
18 Seven percent voted low. And zero voted
19 insufficient. So for reliability, Measure 0566
20 passes.

21 CO-CHAIR YAREMCHUK: Our next is the
22 validity.

1 MEMBER MADONNA: The supplements used
2 were the same ones used in the AREDS 2 study in
3 patients of the appropriate age, age 50 and
4 older. Validity was assessed by systematic
5 assessment of face validity.

6 An expert panel with 16 members have
7 generally agreed that the Measure could extend
8 this quality of care. There were no exclusions
9 and there was the Measures risk-adjusted.

10 MEMBER STRODE: Nothing to add. Thank
11 you.

12 CO-CHAIR YAREMCHUK: Any comments?

13 (No response)

14 MS. ROBINSON-ECTOR: Voting for
15 validity for Measure 0566 is now open. For those
16 on the call, option one is high, two is moderate,
17 three is low and four is insufficient.

18 Okay. All the votes are in of 15
19 votes. 33 percent voted high. 60 percent voted
20 moderate. Seven percent voted low. And zero
21 voted insufficient. So for validity, Measure
22 0566 passes.

1 CO-CHAIR YAREMCHUK: Feasibility.

2 MEMBER MADONNA: Excuse me. Data is
3 self-apparent and readily available by the EHR.
4 Very straightforward.

5 CO-CHAIR YAREMCHUK: Steve?

6 MEMBER STRODE: Nothing to add.

7 CO-CHAIR YAREMCHUK: Any comments?

8 (No response)

9 CO-CHAIR YAREMCHUK: Ready to vote.

10 MS. ROBINSON-ECTOR: Voting is now
11 open for feasibility for Measure 0566. And for
12 those on the call, option one is high, two is
13 moderate, three is low and four is insufficient.

14 All the votes are in of 15 votes. 80
15 percent voted high. 20 percent voted moderate.
16 Zero voted low and zero voted insufficient. So
17 for feasibility, Measure 0566 passes.

18 CO-CHAIR YAREMCHUK: Usability.

19 MEMBER MADONNA: The Measure is
20 publically used in PQRS. And it appears to do
21 what it's supposed to do. Just to further the
22 goal of high quality, efficient health care.

1 CO-CHAIR YAREMCHUK: Okay. Steve?

2 MEMBER STRODE: Nothing to add.

3 CO-CHAIR YAREMCHUK: Any comments?

4 (No response)

5 CO-CHAIR YAREMCHUK: Vote.

6 MS. ROBINSON-ECTOR: Voting for

7 usability and use for Measure 0566 is now open.

8 And for those on the call option one is high, two

9 is moderate, three is low and four is

10 insufficient information.

11 All votes are in. 67 percent voted

12 high. 33 percent voted moderate. Zero voted low

13 and zero voted insufficient information. For

14 usability and use of Measure 0566, the measure

15 passes.

16 CO-CHAIR YAREMCHUK: All right. Thank

17 you. And now to vote whether to recommend the

18 Measure as suitable for endorsement.

19 MS. ROBINSON-ECTOR: Voting is now

20 open recommendation for overall suitability for

21 endorsement for Measure 0566. For those on the

22 call, option one is yes and option two is no.

1 All the votes are in. 93 percent
2 voted yes. Seven percent voted no. So for
3 recommendation for overall suitability for
4 endorsement for Measure 0566, the measure passes.

5 CO-CHAIR YAREMCHUK: Okay. Our next
6 measure is 0088, Diabetic Retinopathy:
7 Documentation of Presence of Absence of Macular
8 Edema and Level of Severity of Retinopathy.

9 DR. RICH: Just a brief comment. So
10 I think this is a Measure that shows the events
11 in the coordination of care between a specialty
12 and primary care.

13 And this is a great story and a great
14 science. The DRS study and the ETDRS study were
15 done on the '80s.

16 The guidelines were developed in '85.
17 And within five years there's a -- was a 50
18 percent decrease in blindness.

19 Most importantly, the DCCT trial came
20 out in '92. The Diabetic Computations of Control
21 Trial. And the constant interaction with
22 appropriate visits, indication with primary care,

1 blindness was down 70 percent.

2 Statements from the NEI saying that we
3 could get up to 90 to 95 percent prevention of
4 blindness. And having practiced long enough
5 where I would have someone go blind about every
6 two months in the '70s.

7 And my father died blind from diabetes
8 on dialysis, it's a remarkable story. And again,
9 science, education, time lines, instruments.

10 CO-CHAIR YAREMCHUK: Okay. So 0088
11 Diabetic Retinopathy: Documentation of Presence
12 or Absence of Macular Edema and Level of Severity
13 of Retinopathy. So, this -- yes, so -- okay.

14 Okay. All right. So, to discuss,
15 Andrew Schachat.

16 MEMBER SCHACHAT: So actually, Bill's
17 comments are very appropriate about coordinating.
18 Because if you don't assess the stuff, you don't
19 have anything to coordinate.

20 See this is what you end up telling
21 people. And so this is a process Measure. And
22 as Bill said, there's been an amazing advance

1 since the completion of these studies.

2 I actually cite slightly different
3 numbers. The 50 percent five year blindness
4 rates from before the studies. And now, if
5 there's timely detection and appropriate
6 treatment, the blindness rate ought to be one to
7 two percent.

8 So, it's an amazing reduction in
9 avoidable blindness. There are numerous
10 randomized control clinical trials.

11 And then also large, representative
12 national populations based natural history
13 studies. And that has shown that these are the
14 causes of blindness. And that the blindness can
15 be reduced by timely treatment.

16 The treatment is cost effective. And
17 the retinopathy level reliably predicts the
18 development of proliferative diabetic retinopathy
19 with high likelihood.

20 So these are relevant things to look
21 at. Both can be asymptomatic. It's clear from
22 randomized trials that treatment is beneficial.

1 And the screening that's being asked
2 for the examinations that would be asked for
3 here, is to identify patients for whom treatment
4 is indicating that's the macular edema, or
5 patients for whom there would be a benefit for
6 closer follow up.

7 So for more advanced retinopathy, you
8 get told to come back sooner. And less advanced
9 come back later because the idea is to catch
10 proliferative disease at the time you would treat
11 that.

12 Just like AMD is the leading cause of
13 new blindness in older people, diabetic
14 retinopathy is the leading cause of new blindness
15 in working age Americans. And so it's a huge
16 problem.

17 CO-CHAIR YAREMCHUK: Steve? Were you
18 finished?

19 MEMBER SCHACHAT: I was -- can I have
20 a --

21 CO-CHAIR YAREMCHUK: Sorry, go ahead,
22 sorry, Andrew.

1 MEMBER SCHACHAT: No, the rest is a --
2 there was one more point. And that is that the
3 numerator is the dilated macular fundus exam.
4 And we're all doing this.

5 And all ophthalmologists would accept
6 that detection is not possible without that.
7 Only that one could do screening photos if photos
8 replaced doctors.

9 MEMBER STRODE: I've got a question.
10 This is percentage of patients 18 years and older
11 with a diagnosis of diabetic retinopathy. Not 18
12 and older with a diagnosis of diabetes?

13 Is there another measure that would
14 cover the larger population of all diabetics?

15 MEMBER SCHACHAT: I think there is in
16 the general medicines space that is the annual
17 eye exam. I mean, you're -- so, the primary care
18 provider is being informed, do your diabetes
19 patients get an annual exam.

20 So there's a measure for that.

21 CO-CHAIR YAREMCHUK: Yes, there is in
22 the portfolio. The overall for the eye exam.

1 Other comments?

2 (No response)

3 CO-CHAIR YAREMCHUK: All right. Ready
4 to vote.

5 MS. ROBINSON-ECTOR: Voting for
6 evidence is now open for Measure 0088. And for
7 those on the call, option one is high, two is
8 moderate, three is low and four is insufficient
9 evidence.

10 Okay. It looks like we're missing one
11 vote in the room. Thank you.

12 Okay. All the votes are in. 93
13 percent voted high. Seven percent voted
14 moderate. Zero voted low and zero voted
15 insufficient evidence. So for evidence for
16 Measure 0088, the measure passes.

17 MS. LUONG: And I just want to note
18 that this is part of the claims and registry
19 version of the Measure. This applies to both the
20 evidence. Sorry about that.

21 CO-CHAIR YAREMCHUK: Okay. For
22 opportunity for improvement.

1 MEMBER SCHACHAT: So I really think
2 it's the same story we heard for AMD because the
3 score rates are very high already at 96 percent,
4 95 percent, that kind of level. But again, it's
5 the PQRS doctors who are reporting. And I think
6 there is data in the IRIS Registry that this is
7 not scored reliably for the doctors who are
8 reporting that. Flora, do you have that?

9 DR. LUM: I have a rate of about 36
10 percent.

11 MEMBER SCHACHAT: So, it's exactly the
12 same story as the other. This is actually harder
13 to do and so the scores ought to be lower,
14 because there are more categories here and the
15 findings can be more subtle.

16 CO-CHAIR YAREMCHUK: Any other
17 comments? Oh, excuse, me Steve?

18 MEMBER STRODE: Nothing to add.

19 CO-CHAIR YAREMCHUK: Any comments in
20 general? Go ahead Todd.

21 MEMBER RAMBASEK: I know we talked
22 about it. Why are the PQRS putting doctors so

1 different from the claims doctors? Is it just
2 retinopathy has more specialists?

3 MEMBER SCHACHAT: I can't say. I
4 guess it's retina specialists. I think it's a
5 more basic thing. If you're getting paid more to
6 do something, you do it. And if you're not
7 getting paid, you do it less. I mean, that's the
8 point of the -- this pay for performance stuff.

9 DR. RICH: I think again, what we're
10 looking at in the registry, we're not looking at
11 just the three measures the doctors are
12 reporting. We're actually looking at the
13 performance of the other nine measures that
14 they're not reporting. So that's -- does that
15 make sense?

16 CO-CHAIR MERENSTEIN: But again, as
17 was mentioned, they might be doing it. They're
18 just not documenting it.

19 DR. RICH: Yes. But what we can
20 document -- so in other words, if they're
21 reporting on these, we only had to do three
22 before. But we actually are able to measure the

1 performance on all of them. All the measures.
2 And that's why you see the performance rate of
3 about 36 percent. Next year when they have to
4 report on nine, I would imagine it will be a
5 little bump up. Flora?

6 DR. LUM: Okay. It's what you get
7 measured on that you can focus on and improve.
8 And as Dr. Friedman said, it's probably mainly
9 retina specialists that are reporting on the
10 measure. I think it was -- it's only 20 -- 16 --
11 26 percent now of eligible providers are
12 reporting in the PQRS system on this Measure.

13 DR. RICH: Again, a lot of docs are
14 doing it. But since they're not reporting on it,
15 they're not documenting it. I don't know anyone
16 that doesn't look at the diabetic retinal exam,
17 but, if they're not going to be reporting on it,
18 they're not going to meet the criteria.

19 CO-CHAIR YAREMCHUK: Are we ready to
20 vote?

21 MS. ROBINSON-ECTOR: Voting is now
22 open for performance gap for Measure 0088. And

1 for those on the call, option one is high, two is
2 moderate, three is low and four is insufficient.

3 All the votes are in. 53 percent
4 voted high. 47 percent voted moderate. Zero
5 voted low and zero voted insufficient. So for
6 performance gap for Measure 0088, the measure
7 passes.

8 CO-CHAIR YAREMCHUK: Reliability.

9 DR. WINKLER: And as Vy did mention,
10 this Measure does have an e-Measure version. So
11 as we did yesterday, we'll right now look at the
12 criteria for the claims registry version. And
13 we'll go back to the e-Measure.

14 MEMBER SCHACHAT: So for reliability,
15 using claims reporting, the developer reported
16 good reliability when the average number of
17 quality events were reported. Looking through --
18 pulling data from the registry, there was high
19 reliability across the board. Whether it was
20 low, moderate or high at numbers of the reporting
21 rates.

22 I have one question, comment or small

1 issue to mention to the developers. The
2 denominator is defined in a group of ICD-9 codes
3 that denote the presence of diabetic retinopathy.
4 And I wasn't sure if 362.07 was included, because
5 I didn't see it on the list. And I think that's
6 one of the codes that gets used for diabetic
7 macular degeneration.

8 DR. LUM: Yes. I believe we noted
9 this comment in the pre-meeting evaluation. And
10 we reviewed that and, in consultation with the
11 AA, will make that determination to add that.

12 MEMBER STRODE: Nothing to add.

13 CO-CHAIR YAREMCHUK: Discussion?

14 (No response.)

15 CO-CHAIR YAREMCHUK: Ready to vote.

16 MS. ROBINSON-ECTOR: Voting is now
17 open for reliability for the claims and registry
18 version of 0088. For those on the call, option
19 one is high, two is moderate, three is low and
20 four is insufficient.

21 Okay. All the votes are in. 20
22 percent voted high. 80 percent voted moderate.

1 Zero voted low and zero voted insufficient. So,
2 for reliability for the claims and registry
3 version of Measure 0088, the measure passes.

4 CO-CHAIR YAREMCHUK: Validity.

5 MEMBER SCHACHAT: So an expert panel
6 of 16 members strongly agreed that the Measure
7 could distinguish quality of care. So that much
8 for face validity.

9 There was moderate agreement on the e-
10 Measure testing. But that is for the e-Measure
11 discussion. Exception rates are low. One
12 percent to five percent, respectively, based on
13 whether you are looking at one way of reporting
14 or another. And exceptions are the kinds of
15 things where you can't look at the fundus because
16 there's a vitreous hemorrhage or a cataract or
17 something like that. Those are examples.

18 MEMBER STRODE: Nothing to add.

19 CO-CHAIR YAREMCHUK: Any comments or
20 discussion?

21 (No response.)

22 CO-CHAIR YAREMCHUK: Ready to vote.

1 MS. ROBINSON-ECTOR: Voting is now
2 open for the claims and registry version of 0088
3 for validity. And for those on the call, option
4 one is high, two is moderate, three is low and
5 four is insufficient.

6 Okay. 33 percent voted high. 60
7 percent voted moderate. Seven percent voted low.
8 And zero voted insufficient. So, for the
9 registry and claims version of 0088, the measure
10 passes for validity.

11 CO-CHAIR YAREMCHUK: Feasibility.

12 MEMBER SCHACHAT: So, it's based on
13 codes. So it's quite feasible.

14 MS. ROBINSON-ECTOR: Voting for
15 feasibility for the claims and registry version
16 of Measure 0088 is now open. And for those on
17 the call, option one is high, two is moderate,
18 three is low and four is insufficient.

19 All the votes are in. 80 percent
20 voted high. 20 percent voted moderate. Zero
21 voted low and zero voted insufficient. So for
22 feasibility for the registry and claims version

1 of Measure 0088, the measure passes.

2 CO-CHAIR YAREMCHUK: Usability and
3 use.

4 MEMBER SCHACHAT: It's currently used
5 in PQRS. And will be currently reported. And
6 it's been successfully used in IRIS.

7 CO-CHAIR YAREMCHUK: Steve?

8 MEMBER STRODE: Nothing to add.

9 CO-CHAIR YAREMCHUK: Any discussion?

10 (No response.)

11 CO-CHAIR YAREMCHUK: Vote.

12 MS. ROBINSON-ECTOR: Voting is now
13 open for usability and use for the claims and
14 registry version of Measure 0088. And for those
15 on the call, option one is high, two is moderate,
16 three is low and four is insufficient
17 information.

18 Okay. All the votes are in. 93
19 percent voted high. Seven percent voted
20 moderate. Zero voted low and zero voted
21 insufficient information. So for usability and
22 use for the claims and registry version of

1 Measure 0088, the measure passes.

2 CO-CHAIR YAREMCHUK: Now to vote for
3 whether to recommend the Measure as suitable for
4 endorsement.

5 MS. ROBINSON-ECTOR: Voting for
6 recommendation for overall suitability for
7 endorsement for the claims and registry version
8 of Measure 0088 is now open. For those on the
9 call, option one is yes and option two is no.

10 All the votes are in. 100 percent
11 voted yes. And zero voted no. So for
12 recommendation for overall suitability of
13 endorsement for the claims and registry version
14 of Measure 0088, the measure passes.

15 CO-CHAIR YAREMCHUK: And now we need
16 to vote on the e-Measure form of this?

17 DR. WINKLER: Yes. And similar to
18 yesterday, we've got some limited testing at the
19 data element -- or data element validity testing.
20 And we're expecting to see the BONNIE testing in
21 the simulated data set for the e-Measure as well
22 when next we regroup.

1 CO-CHAIR YAREMCHUK: So, any issues or
2 comments? Questions around E-Measure
3 specifications or anything that might be
4 different from the registry Measure on the e-
5 Measure?

6 (No response.)

7 CO-CHAIR YAREMCHUK: Okay. So, are we
8 now ready to vote?

9 MS. ROBINSON-ECTOR: Voting is now
10 open for the e-version of Measure 0088 for
11 reliability and validity. And for those on the
12 call, option one is yes with conditions and
13 option two is no.

14 Okay. So it looks like we're missing
15 one vote in the room. So if you all could revote
16 please. Oh, she's not -- oh, okay. Thank you.
17 Thanks. So, all the votes are in at 14 votes.
18 100 percent voted yes with conditions. And zero
19 voted no. So for reliability and validity for
20 the e-version of Measure 0088, the measure
21 passes.

22 CO-CHAIR YAREMCHUK: Okay. We're

1 going to go ahead to the next measure of this --
2 oh, sorry.

3 DR. WINKLER: We have to do the
4 feasibility and use voting. And then we'll go to
5 the others.

6 CO-CHAIR YAREMCHUK: Okay.

7 DR. WINKLER: Anything around
8 feasibility for an e-Measure? Any discussions
9 any concerns about the data elements being
10 capturable in electronic health records?

11 (No response.)

12 MS. ROBINSON-ECTOR: Okay. Voting is
13 now open for feasibility for the e-version of
14 Measure 0088. And for those on the call, option
15 one is high, two is moderate, three is low and
16 four is insufficient.

17 Okay. All the votes are in at 14
18 votes. Feasibility -- oh, sorry. 93 percent
19 voted high. Seven percent voted moderate. Zero
20 voted low and zero voted insufficient. So for
21 feasibility of the e-version of Measure 0088, the
22 measure passes.

1 DR. WINKLER: For usability and use,
2 do you feel that you're votes would be different
3 for the e-Measure, versus the registry Measure?
4 Want us to carry it over?

5 (No response.)

6 DR. WINKLER: So the last one would be
7 your vote on suitability for endorsement of the
8 e-Measure. And again, this would have the same
9 conditions we talked about with the testing
10 they're going to do in the simulated data set and
11 bring back the results in the post-comment call.

12 MS. ROBINSON-ECTOR: So, voting is now
13 open for recommendation for overall suitability
14 for endorsement for e-Measures for the E-version
15 of Measure 0088. And for those on the call,
16 option one is yes with conditions and option two
17 is no.

18 All the votes are in at 15 votes. 100
19 percent voted yes with conditions. And zero
20 voted no. So for recommendation for overall
21 suitability for endorsement of e-Measure 0088,
22 the measure passes.

1 CO-CHAIR YAREMCHUK: Okay. We're
2 going to go ahead to the next measure at this
3 point in time. And it is the 0089, Diabetic
4 Retinopathy, Communication with the Physician
5 Managing Ongoing Diabetes Care. Discussant is
6 Scott Friedman.

7 MEMBER FRIEDMAN: So this is a process
8 measure. Looking at communicating with the
9 primary care physician with patients with
10 diabetic retinopathy. And we all know that as
11 has been discussed, we know that higher levels of
12 hemoglobin A1C and poor control of diabetes leads
13 to more retinopathy. Better control leads to
14 less retinopathy.

15 So basically, there's no level one
16 evidence showing that if you communicate with a
17 primary care physician that you're saving vision.
18 But it just makes sense to me that if the patient
19 is poorly controlled and you communicate with the
20 doc saying that the eyes are getting worse that
21 they would possibly encourage the patient to have
22 better control, or change their regimen to have

1 better control of their diabetes, which in fact
2 will lead to less progression of the retinopathy.
3 But again, there is no level one evidence for
4 that, but it just make sense to do.

5 I certainly do it in my practice. I
6 think if that this is pretty obvious, that docs
7 want to know what the level of the retinopathy is
8 in their patients. And they certainly want to
9 know that if the eyes are getting worse. One
10 thing that I mention the phone call. We actually
11 did a study where in our office, we consult the
12 patients as to treatment for diabetes and we
13 measured the hemoglobin A1C as a primary outcome
14 trying to lower the level of hemoglobin A1C over
15 a couple of years.

16 Our paper's been accepted but not in
17 print yet. So I can't discuss the results yet.
18 So, we are very as a retinal community and as an
19 ophthalmology community, in trying to do whatever
20 we can do to lower the level of diabetic
21 retinopathy. And this would be one way to get at
22 that.

1 MEMBER STRODE: I've got some
2 questions for the Developers. Does this have an
3 e-Measure associated? It does. Okay. And what
4 is the acceptable level of documentation? Would
5 it be a check mark saying yes, I communicated?
6 Or would you expect to find a copy of the written
7 communication that that was form?

8 MS. HANLEY: We actually do have in
9 the Measure, e-Measures inadvertently left out of
10 the submission form, a definition of
11 communication. So, I'll read it verbatim. It
12 may include documentation that the results were
13 communicated verbally, by letter, EG. It could
14 be any type of communication with the clinician
15 managing the patient's diabetic care.

16 Or a copy of the letter in the medical
17 record to the clinician managing the patient's
18 diabetic care. So we would look for that
19 documentation in the eye care provider's patient
20 record that that information had been sent.

21 MEMBER FRIEDMAN: So, just to clarify,
22 in my practice, typically I know patients are

1 referred. I sent a letter to the referring
2 doctor, and I sent a copy to the primary care
3 physician. And that's included in my EHR. It's
4 clearly defined.

5 CO-CHAIR YAREMCHUK: Any other
6 discussion?

7 DR. WINKLER: On the phone call, it
8 was a conversation we talked about a little bit
9 of different people's experiences. Because this
10 is a traditional area where this coordination of
11 care is really challenging. And I remember when
12 this Measure was first discussed, it was how hard
13 this communication issue really was.

14 And so, I guess a sense of how -- of
15 whether we're really making improvements in that
16 communication among providers. Andy, I thought
17 it was you that maybe volunteered on the call,
18 the way you do it in your office that's very
19 automated. And with that, both primary care
20 folks on the Committee as well as the
21 specialists, we got both ends. And I'm curious
22 to know what your experiences are. What's going

1 on out there in the world? How well this
2 communication is truly happening?

3 MEMBER SCHACHAT: Well, with many of
4 the new electronic medical records, it's pretty
5 easy to do. And I can do it in an extra two
6 seconds, and I am very pleasantly surprised with
7 how often I get messages in my inbox that say
8 thank you. So, messages are appreciated. I
9 don't count how many of the letters I send that
10 are not even looked at. We can actually look at
11 that.

12 DR. RICH: It's a great question. I
13 remember the discussion years ago. And I have
14 document management system. And at the end of
15 that examination, after I've discussed and
16 counseled with the patient, emphasizing that
17 little stuff is the big stuff, if you eliminate
18 one's retention of lipids it can have a dramatic
19 impact on the natural course of the disease.

20 We actually augment what the primary
21 care doctor is saying. I would then have a copy
22 of that that the patient can carry out.

1 Unfortunately, because of interoperability and we
2 are dealing with many different EHRs, I have a
3 practice, I actually fax it. It's a more
4 reliable way. So, the ability to make this
5 happen is dramatically better than just five or
6 just seven years ago.

7 CO-CHAIR YAREMCHUK: Go ahead, Steve.

8 MEMBER STRODE: As again, of one
9 family doc, that experience doesn't go very far.
10 But actually in my current role, I'm doing lots
11 of chart review. And it does seem that from
12 retina specialists, general ophthalmologists and
13 DO -- OD's that this is becoming much more of a
14 standard of care. And it may be written, it may
15 be electronic, but it seems increasingly to be
16 getting out to either the endocrinologist or the
17 primary care doctor.

18 CO-CHAIR YAREMCHUK: Any other
19 comments?

20 MEMBER STEIN: I just one to add one
21 more point for all this. In the discussion that
22 came up about how communicating with the PCP is

1 helpful in terms of letting them know about the
2 status of retinopathy. But the status of the
3 retinopathy is often the surrogate for what is
4 going on with, you know, kidney function,
5 neurologic function and various other organ
6 systems. So, I think it's helpful. Just
7 focusing on evidence, it's helpful in many ways.
8 I'd like to think. I'm not a PCP, but I'd like
9 to think they find it useful.

10 CO-CHAIR YAREMCHUK: All right. Are
11 we ready to vote on evidence?

12 MS. ROBINSON-ECTOR: So voting for
13 evidence for Measure 0089 is now open. And for
14 those on the call, option one is high, two is
15 moderate, three is low and four is insufficient
16 evidence. It looks like we're missing one vote.
17 So if everyone could point their clickers. There
18 we go.

19 So, all 15 votes are in. 47 percent
20 voted high. 47 percent voted moderate. Seven
21 percent voted low. And zero voted insufficient.
22 So for evidence for Measure 0089, the measure

1 passes.

2 CO-CHAIR YAREMCHUK: Okay. Now
3 discuss opportunity for improvement.

4 MEMBER FRIEDMAN: So the developers
5 provided data from the PQRS from 2009 to 2012.
6 And they're about 92 percent, up to 93 percent.
7 So, again, the same -- it's the same story. The
8 people that are reporting it are doing an
9 excellent job. Most likely the people that are
10 reporting are a paucity of the possibilities.

11 And those are the people that care the
12 most, so if you look at the IRIS Registry, it may
13 be lower. But again, it's possible there's still
14 room for improvement. There's lots of people out
15 there with diabetes, so if you can move the bar
16 up a couple percents, you'd be saving --
17 potentially saving lots of vision on tens of
18 thousands of patients. And it's also possible
19 that if more people report on it, the numbers
20 would be a lot lower. So there is ample room for
21 improvement in my opinion.

22 CO-CHAIR YAREMCHUK: Steve?

1 MEMBER STRODE: I just wanted to
2 follow up on what Josh said. Certainly, whoever
3 is the ongoing diabetes provider,
4 endocrinologist, or primary care is also expected
5 to screen and follow the neuropathy and
6 nephropathy. But it just seems easier to scare
7 people into perhaps better diabetes care if
8 you're talking about their vision. It's great
9 ammunition.

10 DR. RICH: Steve is absolutely
11 correct. I've worked with a training program
12 that says that's the only practice for over 20
13 years. And people blow off heart disease now,
14 the diabetics. And we have the discussion with
15 them that the hemoglobin A1C, which is your
16 hypertension control, you're going to actually
17 decrease any retinopathy 70 percent, and 90
18 percent prevent blindness. They listen. So, we
19 do -- we are able to scare them.

20 CO-CHAIR YAREMCHUK: I guess I have a
21 question. When we look at from 2009 to 2012, it
22 hasn't changed in terms of in the PQRS meeting

1 that. And so I guess my question is, with people
2 thinking this is a slam dunk and very important,
3 it hasn't changed at all.

4 MS. HANLEY: I would comment that the
5 number of physicians reporting has also increased
6 from 2009 to -- the day that we have through
7 2013. The reporting rate in 2010 was ten percent
8 of eligible professionals were reporting on this
9 measure, of those for whom this measure were
10 eligible were reporting on this measure. And
11 that has increased up in 2013 to 16.5 percent.
12 So, as the numbers of eligible professionals
13 reporting on the measures increases, that's going
14 to have an effect on the performance rate as
15 well.

16 CO-CHAIR YAREMCHUK: I mean, it's just
17 kind of interesting because we've mentioned the
18 electronic record has made it somewhat easier to
19 be able to do some of these things. And so, with
20 that change in availability, I would think that
21 it would also then improve the likelihood of
22 doing well, notwithstanding the fact that you had

1 more people reporting. So I don't know if
2 there's any comments from the providers in the
3 room regarding this?

4 DR. RICH: Well, I think the biggest
5 thing is that you only had to report on three.
6 And so when you report on nine, I think you'll
7 see a dramatic jump in 2015.

8 CO-CHAIR YAREMCHUK: All right. Ready
9 to vote.

10 MS. ROBINSON-ECTOR: Voting is now
11 open for performance gap for Measure 0089. For
12 those on the call, option one is high, two is
13 moderate, three is low and four is insufficient.

14 All the votes are in. 27 percent
15 voted high. 73 percent voted moderate. Zero
16 voted low and zero voted insufficient. So for
17 performance gap for Measure 0089, the measure
18 passes.

19 CO-CHAIR YAREMCHUK: Reliability.

20 MEMBER FRIEDMAN: So the Developers
21 reported reliability testing on claims and
22 registry data. And just to summarize, the

1 reliability on the claims data, looking at lots
2 of docs, was very high. And then looking at the
3 registry data, they also had a high level of
4 reliability. So I don't think there's going to
5 be any issues with reliability for this Measure.

6 MEMBER STRODE: Nothing to add.

7 CO-CHAIR YAREMCHUK: Ready to vote.

8 MS. ROBINSON-ECTOR: Voting for
9 reliability for Measure 0089 is now open. Oh,
10 and for those on the call, option one is high,
11 two is moderate, three is low and four is
12 insufficient.

13 MS. LUONG: And to note, this is for
14 the claims and registry version.

15 MS. ROBINSON-ECTOR: All the votes are
16 in. 20 percent vote high. 80 percent voted
17 moderate. Zero voted low and zero voted
18 insufficient. And so for reliability for the
19 claims and registry version of Measure 0089, the
20 measure passes.

21 CO-CHAIR YAREMCHUK: All right. And
22 we can talk about validity.

1 MEMBER FRIEDMAN: So the -- again, the
2 Developers presented data for both claims
3 registry and e-Measure. Do I discuss e-Measure
4 at this time?

5 MS. LUONG: No, not the e-Measures.

6 MEMBER FRIEDMAN: Okay, so the claims
7 and registry is done by face validity, an expert
8 panel of 16 members. And they strongly agree the
9 Measure could distinguish quality of care. So,
10 from claims and registry data, there's good
11 validity testing.

12 MEMBER STRODE: Nothing to add.

13 CO-CHAIR YAREMCHUK: Comments?

14 (No response.)

15 CO-CHAIR YAREMCHUK: I guess I have
16 question. How do you get this from claims?

17 DR. RICH: I think there's a --

18 MS. HANLEY: You collect measure from
19 claims. There's a CPT-2 code that's recorded on
20 the claim.

21 DR. RICH: A code that says I sent the
22 letter.

1 CO-CHAIR YAREMCHUK: Okay. All right.
2 Ready to vote.

3 MS. ROBINSON-ECTOR: Voting is now
4 open for the claims and registry version of
5 Measure 0089 for validity. And for those on the
6 call, option one is high, two is moderate, three
7 is low and four is insufficient.

8 All the votes are in. 40 percent
9 voted high. 60 percent voted moderate. Zero
10 voted low and zero voted insufficient. So for
11 validity of the claims and registry version of
12 Measure 0089, the measure passes.

13 CO-CHAIR YAREMCHUK: Scott?

14 MEMBER FRIEDMAN: So feasibility?

15 CO-CHAIR YAREMCHUK: Right,
16 feasibility.

17 MEMBER FRIEDMAN: The Measure is
18 specified for several data sources including
19 claims registry and e-Measure. And there
20 shouldn't be any issues with feasibility for this
21 Measure.

22 MEMBER STRODE: Nothing to add.

1 CO-CHAIR YAREMCHUK: Any discussion?

2 (No response.)

3 CO-CHAIR YAREMCHUK: Vote.

4 MEMBER CARNAHAN: Just a quick
5 question?

6 CO-CHAIR YAREMCHUK: Yes. Go ahead
7 Matt. Sorry.

8 MEMBER CARNAHAN: Wouldn't the 50 10F
9 or 2P, the patient reason for not communicating,
10 is that a fail for the provider then? What would
11 be an example of a patient? If they didn't have
12 a primary care? I don't know.

13 MS. HANLEY: It would be -- yes. If
14 they didn't have a primary care physician, it
15 would not be considered a Measure failure. It
16 would be removed from the denominator as an
17 eligible piece.

18 MEMBER FRIEDMAN: So, unfortunately,
19 some of my patients don't know who their primary
20 care doctor is. This is reality of medicine.
21 For some reason, some patients don't want you to
22 send the letter to the referral doctor or to the

1 primary care doctor. Why don't you want to do
2 that? No, who knows. So, you can't make them do
3 that. That could be one of the other reasons.

4 MS. ROBINSON-ECTOR: Voting is now
5 open for feasibility for the claims and registry
6 version of Measure 0089. And for those on the
7 call, option one is high, two is moderate, three
8 is low and four is insufficient.

9 Okay. All the votes are in. 80
10 percent voted high. 20 percent voted moderate.
11 Zero voted low and zero voted insufficient. So
12 for the claims and registry version of Measure
13 0089, the measure passes for feasibility.

14 CO-CHAIR YAREMCHUK: Usability.

15 MEMBER FRIEDMAN: So, the Measure is
16 currently used in the PQRS program. It will soon
17 be publically reported. And it's also used in
18 the IRIS Registry.

19 MEMBER STRODE: Nothing to add.

20 MS. ROBINSON-ECTOR: Voting is now
21 open for usability and use for the claims and
22 registry version of Measure 0089. And for those

1 on the call, option one is high, two is moderate,
2 three is low and four is insufficient
3 information.

4 All the votes are in. 100 percent
5 voted high. Zero voted moderate. Zero voted low
6 and zero voted insufficient information. So for
7 usability and use for Measure 0089, the registry
8 and claims version, passes.

9 Voting is open for recommendation for
10 overall suitability for endorsement for the
11 claims and registry version of Measure 0089. For
12 those on the call, option one is yes and option
13 two is no.

14 Okay. All the votes are in. 100
15 percent voted yes. And zero voted no. So, for
16 recommendation for overall suitability for
17 endorsement for the registry and claims version
18 of Measure 0089, the measure passes.

19 CO-CHAIR YAREMCHUK: Now for the e-
20 Measures?

21 DR. WINKLER: Yes. We'll look at the
22 e-Measures. The scientific acceptability again,

1 as we've done with the other e-Measures, the fact
2 that there was a submitted data element validity
3 testing on these measures, but we do expect to
4 review the results of the simulated data set
5 testing at the post-comment call. So that would
6 be your decision to accept that and pass the
7 criteria with the condition of review note in a
8 few weeks.

9 MS. ROBINSON-ECTOR: So voting is now
10 open for reliability and validity for the e-
11 Measure version of Measure 0089. Oh yes, and for
12 those on the call, option one is yes with
13 conditions and option two is no.

14 All the votes are in. 100 percent
15 voted yes with conditions. And zero percent
16 voted no. So for reliability and validity of the
17 e-Measure version of Measure 0089, the measure
18 passes.

19 DR. WINKLER: Okay. We're kind of --
20 you can see we're sort of going through the same
21 thing. So for feasibility and use and usability,
22 is there anything new or different about this e-

1 Measure compared to the other diabetic
2 retinopathy e-Measure? In terms of your sense of
3 feasibility, use in an e-measure and use and
4 usability? Should we carry those over from the
5 previous vote? Great. So we can go to the last
6 vote.

7 MS. ROBINSON-ECTOR: Voting is now
8 open for overall -- recommendation for overall
9 suitability for endorsement for the e-Measure
10 0089. And for those on the call, option one is
11 yes with conditions and option two is no.

12 Okay. All the votes are in. 100
13 percent voted yes with conditions. And zero
14 voted no. So for recommendation for overall
15 suitability for endorsement for the e-Measure
16 0089, the measure passes.

17 DR. WINKLER: All right, thank you.
18 Now it's time for a break. So we will do a ten
19 minute break and then back. Thank you.

20 DR. RICH: I'd just like to thank the
21 -- on behalf of the Academy, IRIS and PCPI, I'd
22 like to thank the staff and the Members of the

1 Panel for their attention and their
2 professionalism and tough stuff. Thank you very
3 much.

4 (Whereupon, the above-entitled matter
5 went off the record at 10:04 a.m. and
6 resumed at 10:20 a.m.)

7 DR. WINKLER: We've got everybody
8 together. Thank you. The last of the measures
9 in the eye care category is a new e-Measure.
10 This is our only new measure that has come to us,
11 that's never been seen and used before.

12 As e-Measures are in the development,
13 and I talked yesterday about, you know, this
14 whole evolutionary process, part of NQF's support
15 of the development of e-Measures is an approval
16 for trial use, sort of halfway option whatever,
17 for measures --

18 They're for new measures that are
19 coming in for sort of an initial review around
20 the importance criteria, around some of the
21 issues and potential use and usability of the
22 measure. But these measures have not yet been

1 fully tested, and so -- but by providing the
2 approval for trial use, it allows them to have
3 been looked at by you all, and we'll be putting
4 them out for public comment and getting feedback.

5 So that it allows them to be vetted,
6 and this supports their use in some of the
7 meaningful use programs going forward. So we are
8 trying to promote the implementation of the
9 ability to conduct more robust testing
10 afterwards. So the approval for trial use
11 designation is not the same as endorsement.

12 It is just, as it says, approval for
13 trial use, and these are free measures that are
14 ready for implementation but not yet adequately
15 tested, and so it applies to these new measures.
16 We are looking for e-Measures that address
17 important areas for performance measurement and
18 quality improvement.

19 So the importance criteria is what
20 we're going to look at. We're going to see what
21 the evidence is and what do we know about the
22 quality problem and performance at this point in

1 time, from the literature or whatever potential
2 sources of data. We won't have anything from the
3 measure itself.

4 We do want to -- they have been
5 reviewed internally by our e-Measure technical
6 review for the specifications, to determine that
7 they are least technically sound for
8 implementation, but we really have nothing in the
9 realm of reliability and validity.

10 The feasibility assessment for e-
11 Measures has been performed, and these measures
12 are not intended to be used for accountability,
13 not intended to be used for public reporting or
14 payment. This is meant to just say this is an
15 important measure still in, you know, the later
16 stages of development, but that we do feel that
17 it's an important measure that has great promise,
18 and NQF will be granting approval for its trial
19 use, to gain more experience, to understand how
20 the measure will function going forward.

21 So that's how we're going to ask you
22 to evaluate this upcoming measure. So you're

1 going to look at it with somewhat different lens,
2 all right. Do you have any questions about the
3 differences between what you have been doing for
4 two days, and what we're looking for here.

5 MEMBER FRIEDMAN: So down the road,
6 what would be the use for this measure?

7 DR. WINKLER: I think that's one of
8 the things we can talk about when we get to use
9 and usability, okay. All right. Anything about
10 the process? Okay. Then we go on to look at the
11 measure itself, which is -- bring up the next
12 slide, please.

13 Good, all right. We've still got the
14 old slide and we talk about the name of the
15 measure. But it is Measure 2721, renamed Visual
16 Acuity Screening in Children. And so Andy and
17 Scott were the discussants for this measure. So
18 we do want to, as we've done with all the
19 measures, go through. So we'll start with
20 evidence.

21 CO-CHAIR MERENSTEIN: The developers
22 don't speak to this?

1 DR. WINKLER: I'm sorry, absolutely.
2 Let our developers speak.

3 MS. AMBROSE: Well good morning,
4 everyone. This measure, Amblyopia Screening in
5 Children, was the original measure title and
6 description, and the evidence actually came from
7 the United States Task Force, the Preventive
8 Services Task Force and the AAP. And it was
9 initially developed as visual screening for the
10 medical home by the AAP, and our team took the
11 measure and actually specified it for amblyopia,
12 based on recommendations, initial recommendations
13 from the AAP expert group.

14 But in review with the NQF, we got
15 some great feedback from our reviewers, that it
16 will be more appropriate as a visual acuity
17 screening measure because really the algorithm
18 and the measure specifications were attuned to
19 visual acuity screening and vision, to identify
20 and detect vision problems.

21 So that's how the measure is being
22 presented today, and there's -- we conducted an

1 evidence review, and Dan, feel free to give
2 details. Dan is our specification lead. But
3 there is quite a bit of evidence that visual
4 acuity testing in kids will prevent issues like
5 amblyopia, strabismus, etcetera.

6 And the measure also includes a
7 referral component so it's not just the
8 screening, but if a child is identified as
9 positive, the child would then be referred to
10 either a pediatric ophthalmologist or an eye care
11 specialist for further eye examination.

12 CO-CHAIR MERENSTEIN: Andrew.

13 MEMBER SCHACHAT: So this was
14 originally presented as an amblyopia screening
15 measure, and that's a very difficult space to
16 work in. The idea was to screen for amblyopia
17 and if there was a concern that it was present to
18 refer. It's clear that this is something that
19 can be asymptomatic. It's clear that there's a
20 large prevalence of it, and it's clear the
21 treatment is beneficial and that there are cost-
22 effective treatments, and the harms of missing it

1 are high, because you have poor vision for the
2 rest of your life, and it's pretty preventable.

3 So the whole rationale of screening
4 and detection for amblyopia is there and it makes
5 sense. The trouble with working in this space is
6 that state by state, there are laws on how this
7 is done, and so to provide one measure and if the
8 law says something else, they're going to follow
9 the law, and so there will be variation in the
10 scores across states. So that's a problem.

11 Another problem is that there's --
12 screening is done at school or by other places,
13 often not in the health care system, and getting
14 the data into the health care record is a
15 challenge. And the data could just be entered as
16 screening done, but I'm not sure that that's what
17 the thing specified.

18 And then exactly how to screen is
19 pretty complicated, and I'm not even sure I know
20 how to screen for amblyopia the right way.
21 Pediatric ophthalmologists do it. I just sort of
22 screen for the risk of it, and then send them to

1 the pediatric ophthalmologist to figure it out.

2 This was asked to be done by the pediatricians,

3 who probably can't do it right.

4 So after this discussion, the
5 developers agreed that maybe they wanted to
6 suggest something else, and they suggested visual
7 acuity screening, which is reasonable, because
8 it's a first step, and if kids have normal
9 vision, they don't have amblyopia, and if they
10 have reduced vision, they have something, and the
11 most common something they have is that they need
12 glasses.

13 But you have to go to an eye care
14 provider to get that worked out, and if glasses
15 don't solve it, then there's a testing algorithm
16 to figure out if someone has amblyopia and so on.
17 So I support the whole idea, but the devil is in
18 the details.

19 CO-CHAIR MERENSTEIN: Scott, anything
20 to add?

21 MEMBER FRIEDMAN: Yes, and one quick
22 thing. Since we have our discussions and they

1 modified it, for example, denominators exclusions
2 terminating with an active diagnosis of amblyopia
3 or blindness during the measurement period. So
4 you're going to have kids that have an active
5 diagnosis of refractive error. So the question
6 is, again what Andy just said, most kids are
7 going to have refractive error, and do you want
8 to exclude those as well.

9 MR. ROMAN: We can definitely add
10 those exclusions. Just with the timing that we
11 had from the discussion until today, we didn't
12 want to just add in anything that, you know -- we
13 wanted to make sure that it was something that
14 made sense to add.

15 I think that additional exclusions
16 would be something that we would test for, with
17 the additional testing that this measure needs.
18 We only looked at blindness when we tested. We
19 included amblyopia as an exclusion because
20 originally, based off the USPSTF, this was --
21 that's what the measure was really, or that's
22 what the focus was.

1 It made sense if a child already had
2 amblyopia diagnosed in the record, that you
3 wouldn't do this additional screening from. So
4 that's why those two are included. We want 100
5 percent agree that there would be additional
6 visual problems that it might include, given that
7 this is visual acuity screening now, and at least
8 something that we would look for in additional
9 testing.

10 CO-CHAIR MERENSTEIN: And are there
11 questions about this, because that's more of a
12 Libby issue. Are there questions about the
13 evidence or comments about the evidence, because
14 we could vote on that first and then -- it's a
15 good discussion. Josh.

16 MEMBER STEIN: I'm still trying to
17 understand the new measure, or the revised
18 measure. But is this intended for pediatricians?
19 Can you clarify what providers would be --

20 MS. AMBROSE: Yes. It's intended for
21 use in a primary care setting, so it would
22 essentially be pediatricians.

1 MEMBER STEIN: So if a child is
2 getting school screening as part of the state
3 program, the pediatricians also are supposed to
4 do this in addition? How are you reconciling the
5 screenings that are going on in the schools, in
6 that whole infrastructure with this?

7 MS. AMBROSE: That's one of the
8 questions that actually came up in our
9 discussion. So that could potentially be an
10 exclusionary criteria for when the measure is
11 tested in real life settings. We're also looking
12 to test in other settings, like a school-based
13 clinic perhaps, or even -- you know, exploring
14 the possibility of obtaining data from school
15 systems and EDHR systems. I think those are for
16 the future but definitely under consideration.

17 MR. ROMAN: I think another thing to
18 consider here is how the measure's implemented.
19 So this measure is only an e-Measure, and it was
20 developed for consideration for use in the EHR
21 incentive program, which is only looking at what
22 eligible professionals are doing.

1 So what happens in the school, I'm not
2 sure how we'd factor that in. When we look at
3 the programs across states, they vary when
4 screening's supposed to occur. Some are not --
5 some don't have any policies at all actually some
6 states. Some states have very specific
7 guidelines or recommendations, or just they're --
8 these are the policies. It does again vary
9 whether or not it's just a recommendation or it's
10 an actual policy.

11 Some are very specific at what age it
12 should occur, some are not. Some do not include
13 pre-school vision screening. So I think the goal
14 with this measure is that we're looking for when
15 a physician is seeing a child any time from ages
16 three to five, that they do the visual acuity
17 screening at least once.

18 So the hope is that, or the goal is
19 that it's getting children screened before
20 school. So the school programs, again, don't all
21 include the age that this measure is focused on,
22 which is ages three to five, or before they turn

1 six.

2 MEMBER STEIN: The other key
3 component to this is, you know, doing the
4 screening is one thing, and the key thing is
5 whether the child actually gets to the provider,
6 the pediatric ophthalmologist or the, you know,
7 the eye care specialist, and the active screening
8 and evaluating, and even saying you need to see
9 an eye care specialist, if you don't close the
10 loop than that's still problematic.

11 MR. ROMAN: So in our testing, the
12 limited testing that we were able to do, since
13 this is an e-Measure, our data source is the
14 electronic health record. We asked the sites
15 that we tested with for feasibility, I think we
16 had -- what they had available.

17 So getting information about whether
18 or not visual acuity screening occurred yes, that
19 was easy. Whether or not there was a referral
20 that you could actually track the data to see
21 that a referral was made when one was needed,
22 that was also a possibility. I don't believe all

1 the sites were able to do it, but EHR vendors
2 said it is possible.

3 As far as the follow-up, that third
4 crucial piece, that's the piece that in the EHR,
5 it's difficult to see whether or not it occurred.
6 I think if you were doing a plan level measure,
7 where you're looking at claims data and kind of
8 the whole, everything that's available, you could
9 do that.

10 With the EHR data and from the
11 perspective of one provider reporting the data
12 that occurred, what they did for one patient,
13 it's really tough to get that data. So for this
14 measure's purpose, there wasn't -- we decided not
15 to include that follow-up, just because we don't
16 think that the data's actually there.

17 MEMBER STEIN: Do you think this
18 would be better as a plan measure than as an
19 individual provider measure? We discussed a
20 plan measure yesterday, right?

21 MR. ROMAN: I think there also
22 potential for a plan level measure. I mean

1 that's not really -- that wasn't in the purview
2 of the work that we were doing. We were focused
3 on the EHR measures. I think it's possible, and
4 potentially the plan level measure you would do
5 even more than just a visual acuity screening.
6 But again, that's kind of outside the scope of
7 this measure or what we were contracted to do.

8 MS. AMBROSE: There's also under
9 Meaningful Use, there are other measures.
10 There's a measure for closing the referral loop.
11 So when we looked at developing this measure and
12 adding that follow-up component, one of the
13 recommendations from our team was that this
14 measure could be used in conjunction with a
15 measure like closing the referral loop, which
16 will then capture what you're talking about.

17 CO-CHAIR MERENSTEIN: Any further
18 comments before we vote on evidence? Sorry.

19 MEMBER SCHACHAT: I'm not even clear.
20 Are we voting on whether screening helps vision,
21 helps avoid vision loss in the future, or are we
22 voting on whether --

1 DR. WINKLER: Yeah. This is a process
2 measure that is about visual acuity screening in
3 children. So the evidence you're looking for is
4 what do we know about the relationship between
5 doing that screening and outcomes for children,
6 assuming it's indeed a vision outcome. So think
7 of other screening measures. There are many of
8 them, and obviously it relies on the appropriate
9 follow-up of the abnormal screen.

10 But screening is a commonly measured
11 concept, screening of various things, blood
12 pressure screening, pap smear screening,
13 mammography screening, you know, all of them. So
14 this is a similar kind of thing. So you're
15 looking what's the relationship to the outcome or
16 vision outcomes for patients?

17 MEMBER SCHACHAT: I'll just say that
18 it's absolutely clear that some children are
19 helped. What we don't really know is the
20 sensitivities, specificity and efficiency of the
21 whole thing and so on.

22 MEMBER CARNAHAN: Yes, and I would

1 echo that. I think we've done testing looking at
2 glaucoma screening, and they found it really
3 wasn't cost effective. You do capture some
4 people that have glaucoma, but a huge percentage
5 of patients don't, and a huge percentage of these
6 children will be falsely identified as having
7 vision problems. Or a lot of them just, I mean
8 the ones that I see just weren't screened, and
9 most of them have perfect vision.

10 MEMBER BRADHAM: So this is Tammy. So
11 what is our false positive rate for sensitivity,
12 specificity for screening?

13 MR. ROMAN: So really it depends on
14 what screening method is used, and it's all over
15 the place.

16 MEMBER STEIN: I think it's an
17 evolving area, and there are different screening
18 tools that are being tested. I think the cost
19 effectiveness is a little different than with
20 glaucoma, because identifying a child with a
21 potentially sight-threatening condition early in
22 life, that they're going to live the rest of

1 their life with poor vision is different than
2 identifying someone in their 60's and 70's with
3 peripheral vision loss. So I think -- I'm sure
4 that the study is looking at cost effectiveness,
5 and it should be very cost effective. I don't
6 think that's the issue here.

7 MEMBER BRADHAM: So this is Tammy
8 again. So does this measure specify which
9 hearing screening tool that will be used?
10 Vision, I'm sorry. I'm an audiologist here, what
11 vision screening tool will be used?

12 MR. ROMAN: Currently, it does not.
13 It only is looking at that a visual acuity study
14 is done. That's the code that it is using.
15 There are no codes specific to the different
16 types of wall charts or eye acuity screening test
17 that you might do. We have one code that is
18 capturing kind of all the visual acuity that
19 might -- visual acuity studies that might occur.

20 The other, the only other option we
21 have right now I think would be to put in some
22 additional guidance around what type would be

1 acceptable. Currently the e-Measure, the text of
2 the e-Measure provides some guidance linking to
3 some of the specialty societies and what they
4 recommend on what's passing, what's failing and
5 what tests to use.

6 MEMBER MADONNA: I'm not sure. Excuse
7 me, I'm not sure this is the right time, but I'll
8 bring it up anyway. In listening to the comments
9 and in listening to all of the problems that
10 screenings are subject to, doesn't it make sense
11 to consider that visual acuity screening may not
12 be the right thing to do for children, but that
13 children should have complete eye exams done by
14 an eye care professional at some point between,
15 in this case, three and six years old, as opposed
16 to screenings?

17 CO-CHAIR MERENSTEIN: Follow-up to
18 that, Michael?

19 MEMBER STEWART: I guess if I'm
20 looking in this, the measure worksheet here, it
21 looks like the AAP had simply an expert opinion
22 guideline or recommendation, but the USPSTF said

1 there is at least Grade B evidence to support
2 this. So if we're just talking about the
3 evidence, I'm sorry, maybe I missed it, I haven't
4 heard that presented yet.

5 Everybody keeps saying oh, but this is
6 good. Well, who's against it right? But I mean
7 what's the evidence? Looks like Grade B, but am
8 I interpreting that correctly, because it also
9 kind of sounds like everybody thinks this is so
10 obvious that it's not really been looked at from
11 a cost effectiveness or an evidence-based
12 perspective --

13 MS. AMBROSE: Yeah. I mean I think --
14 I think this measure was initially conceptualized
15 as being able to capture possible vision problems
16 in the primary care setting, and an eye exam
17 measure I think will be very valid, but probably
18 could be a follow-on measure to a referral
19 screening measure.

20 And as far as evidence and then there
21 were other studies that pointed to, I think, the
22 reason why we selected this measure and was also

1 initially a measure that been developed by the
2 AAP, that we can follow through.

3 MEMBER STEWART: I mean I'm for this,
4 okay. I'm not against it. I'm just saying every
5 time the question gets asked about evidence, the
6 answer is well, everybody thinks this is a good
7 idea. I'm just asking is there -- what is the
8 level of the evidence to support it, because we
9 have to at least vote on that. That doesn't mean
10 we don't do it. I'm for doing it, but --

11 CO-CHAIR MERENSTEIN: Although a Level
12 B from the task force is pretty high.

13 MR. ROMAN: And some of the other
14 specialty organizations have their
15 recommendations that are very similar to this,
16 and it's because they're all based -- they all
17 kind of point back to the USPSTF recommendations.
18 So the level of evidence is B, and it doesn't
19 really matter what organization you look at,
20 because most of them all point back to the USPSTF
21 and their review of the evidence.

22 CO-CHAIR MERENSTEIN: Any other

1 comments?

2 MEMBER FRIEDMAN: Does that evidence
3 come with a certain type of vision screening as
4 was questioned before?

5 MR. ROMAN: So the guideline, sorry.
6 The recommendation says amblyopia screening, but
7 everything -- this is why our measure, the
8 wording on our measure was difficult, and why we
9 used amblyopia screening. They're essentially
10 recommending visual acuity screening before age
11 six.

12 They say amblyopia screening and they
13 qualify it in a lot of ways. But the evidence
14 they look at is visual acuity screening in those
15 ages. I think that they have -- there's some
16 additional testing evidence that they reviewed,
17 but it's essentially it's talking about visual
18 acuity screening in the early ages.

19 CO-CHAIR MERENSTEIN: It says ages
20 three to five I think. Rich.

21 MEMBER MADONNA: Yes, just a comment
22 on that. Again, for the group who weren't privy

1 to the initial conversations on this, you really
2 can't screen for amblyopia. You're screening for
3 visual acuity, and if visual acuity is decreased,
4 then you have to send somebody for an eye exam,
5 who then that person does a refraction, which
6 again, as Andy said before, is the most likely
7 reason why the vision is reduced.

8 You screen for binocular problems, you
9 screen for ocular health problems, and after
10 that, that's the only time that you can really
11 say someone has amblyopia or not. So I think
12 it's really important that we make that
13 distinction between visual acuity screening,
14 which could be done under the set up that we have
15 here, versus actually making a diagnosis of
16 amblyopia, which can only be done by an eye care
17 professional.

18 CO-CHAIR MERENSTEIN: You took
19 amblyopia out, right? There's no mention of
20 amblyopia --

21 MR. ROMAN: Yes, yes, we removed it,
22 and again that's our fault for following kind of

1 the wording of the USPSTF recommendation, which
2 talks -- it says amblyopia screening. So that's
3 the wording we used. What we tested in the
4 limited testing we did is whether or not visual
5 acuity testing was done. That's the coding that
6 was used at the sites we worked with. That's
7 what they were looking at when they considered
8 whether or not a child needed a referral or not,
9 is visual acuity study.

10 So the wording change that we made
11 really aligns with what was done and the intent
12 anyway, because it is that you do this visual
13 acuity. There are basic screening that primary
14 care, in the primary care setting first, so you
15 can find some indication that there might be a
16 problem that needs to be examined, that needs to
17 be looked at by an eye care professional.

18 CO-CHAIR MERENSTEIN: So I think
19 there's going to be a lot more discussion points
20 as we go on, but let's vote on the evidence, so
21 we can move on.

22 MS. ROBINSON-ECTOR: Voting for

1 evidence for e-Measure 2721 is now open, and for
2 those on the phone, Option 1 is high, 2 is
3 moderate, 3 is low and 4 is insufficient
4 evidence.

5 MS. LUONG: And this is about the
6 trial use approval?

7 MS. ROBINSON-ECTOR: Yes.

8 MS. ROBINSON-ECTOR: All votes are in.
9 7 percent voted high, 60 percent voted moderate,
10 20 percent voted low and 13 percent voted
11 insufficient evidence. So for evidence, for the
12 trial use e-Measure 2721, the measure passes.

13 CO-CHAIR MERENSTEIN: Opportunity for
14 improvement, Andrew.

15 MEMBER SCHACHAT: There is ample data
16 that a tremendous amount of treatable diseases
17 are overlooked, and that's the reason that states
18 have passed laws requiring it.

19 CO-CHAIR MERENSTEIN: Anything to add?

20 MS. ROBINSON-ECTOR: Voting is now
21 open for --

22 CO-CHAIR MERENSTEIN: Would you like

1 to add something? Yes, sorry.

2 MEMBER FRIEDMAN: No, I have nothing
3 to add.

4 CO-CHAIR MERENSTEIN: Oh, okay.

5 DR. WINKLER: I'm just going to ask
6 one question. Is there anything about
7 disparities issues in what we know about access
8 to screening and visual care follow-up?

9 MEMBER SCHACHAT: So if you mean in
10 poorer, poorer children and disadvantaged
11 families, absolutely. So in the Cleveland area,
12 for example, we have a whole big screening
13 program, and determined that the screening didn't
14 work because we detected all kinds of stuff and
15 they didn't get the care.

16 And so we changed the program to take
17 -- stop screening, and it's now screening and
18 treatment sort of on the spot. So as the
19 screening, when they found the problem, they do
20 the next exam and give them free glasses. So by
21 putting all the care in with the screening, it
22 solves that problem. But there are huge

1 disparities.

2 MEMBER STEIN: Yes. We had a similar
3 experience in Michigan, that closing the loop is
4 the biggest issue, and there are in the
5 literature reports of disparities between
6 different -- children of different races and
7 socioeconomic levels.

8 MEMBER MADONNA: So again it sounds to
9 me like it makes sense to promote eye
10 examinations and not screenings, because that
11 immediately closes the loop.

12 CO-CHAIR MERENSTEIN: Then again, I
13 think that the usability issue that's going to,
14 yeah. So if we go to opportunity for
15 improvement.

16 MS. ROBINSON-ECTOR: The voting's now
17 open for performance gap with the trial use e-
18 Measure 2721. For those on the phone, Option 1
19 is high, 2 is moderate, 3 is low and 4 is
20 insufficient.

21 All the votes are in. 67 percent
22 voted high, 27 percent voted moderate, zero voted

1 low and 7 percent voted insufficient. So for
2 performance gap for the trial use e-Measure 2721,
3 the measure passes.

4 DR. WINKLER: Just in terms of this
5 measure, we're talking about an e-Measure who
6 does not have testing for reliability and
7 validity particularly. We do want to look at the
8 specifications, though, and you know, what
9 exactly is being measured, who's the denominator
10 population, what exactly is being captured in the
11 numerator. So that's what you're really looking
12 at for this part of the evaluation under this
13 conditions.

14 MEMBER SCHACHAT: Okay. So the
15 numerator is children who received visual acuity
16 screening to detect the presence of vision
17 problems between their third and sixth birthdays
18 and necessarily were referred, and if that means
19 receives screening by the pediatrician, fine. If
20 it means received screening at all and that they
21 had screening done at school and the pediatrician
22 could just check off mom said they did it, I

1 could accept that.

2 But I don't know if that's what's
3 specified, and so maybe -- maybe we can answer in
4 a second. And in the denominator, it's children
5 who turn six of age during the measurement period
6 and had at least one of these done during the
7 measurement period. So the denominator is okay.

8 MEMBER YOUDE: So when I'm looking at
9 this, I'm almost seeing two process measures, the
10 first one being children who are screened, and
11 the second one being children who needed of
12 referral against children who are screened. I'm
13 not clear how the metric looks, or when we say
14 and if necessary, what does that mean in terms of
15 looking at the data and can -- if that data is
16 what we're using, how is that actionable?
17 Separating out the two would make it very clear
18 and understandable and actionable, where we could
19 say are they getting screened, are they getting
20 referred.

21 MR. ROMAN: Okay. So this measure,
22 again it's an e-Measure. So the way that that

1 works is all in the e-Measure logic. So first
2 you're looking to see that screening was done,
3 and if it was -- if the physician said that the
4 child's vision was normal, or if there was a
5 referral needed.

6 So it's kind of screening, and then
7 the second tier is normal or a referral needed,
8 and it's only e-Measure logic. This again
9 originally was a screening measure. We had some
10 suggestions from experts to expand it and try to
11 include that follow-up component, because
12 screening it fine, but it would be nice to see
13 that if there was a problem found, that there's a
14 referral made.

15 So it is -- it's one process, and it's
16 kind of options of what you do once you have your
17 findings, is why it looks when you read it like
18 that. But it's in the e-Measure logic that it,
19 kind of all the work happens.

20 MEMBER YOUDE: I like where it's
21 going. I just think that because we have that
22 second step in, it seems natural to separate the

1 two, so that you can clearly look at Part 1 and
2 then clearly look at Part 2.

3 CO-CHAIR MERENSTEIN: Tammy, then
4 Scott.

5 MEMBER BRADHAM: So wouldn't the
6 denominator be the children who failed the
7 screen, and then the numerator be the referral?

8 MR. ROMAN: No. The denominator right
9 now is all children who turned six during the
10 measurement year, and because of the requirement
11 with CMS and the e-Measure program, we also
12 include in there that they have a visit with the
13 physician during the year. That's not for any
14 reason other than it's a requirement of the e-
15 Measure program. I think it's to establish
16 eligibility and kind of a relationship with the
17 provider. So it's all children before the age of
18 six, and it's whether or not they got screened.

19 If they -- if they're screened and
20 they're normal, then that passes. If they screen
21 and they fail that screening, then they have to
22 have a referral to pass. So it's the provider.

1 The provider passes if the screening happened and
2 it's normal, or if the screening needed a
3 referral and a referral was made. So that's the
4 two ways that the physician passes the measure.

5 MS. AMBROSE: Right. That was one of
6 the reason why we combined the two together,
7 because it just wasn't enough if a physician was
8 screening a children, but also taking the next
9 step and referring.

10 MEMBER FRIEDMAN: So it's kind of
11 semantics. So patients -- what we want to do is
12 want to prevent vision loss. So the way to do
13 that is to screen kids. You screen kids and it's
14 abnormal. You hope to get referred, and then
15 they get referred and then they get treated.

16 So there's all these different
17 processes for a kid to ultimately prevent vision
18 loss. So you hope that patients that are
19 screened that had abnormal vision are referred.
20 So I mean you hope that docs aren't saying oh,
21 you're vision's blurry, but I'm not going to do
22 anything about it. That's kind of ridiculous.

1 So you could even do this -- you could
2 even say, I mean, that they were just screened,
3 and so you want to make sure all the kids were
4 screened properly, because if they're screened
5 and it's abnormal, then they're going to take a
6 step. But what they added is if they're
7 screened, were referred appropriately. Well
8 again, you can say well, were they referred
9 inappropriately. That's kind of ridiculous too.
10 But so I mean it's kind of all these different
11 steps.

12 But you can -- it's kind of semantics
13 and again, I think we could even leave out were
14 referred appropriately, and just kids that were
15 screened, because if they're screened and their
16 vision is blurry, I would hope that they're being
17 referred appropriately and treated appropriately.

18 CO-CHAIR MERENSTEIN: Josh.

19 MEMBER STEIN: I'm still not clear
20 how this overlaps or deals with what's going on
21 in the schools in each of the states. Is the
22 idea if a kid got screened at school, that the

1 pediatrician's going to check off a box saying I
2 don't need to screen them today, because they got
3 -- they had a school screening? Or are they
4 going to replicate and do more unnecessary
5 evaluation of that kid, so they can meet the
6 measure? How do you reconcile what's going on
7 outside the pediatrician's office?

8 MS. AMBROSE: I think at this point,
9 the measure specifications do not address that.
10 But I think there's opportunity to expand the
11 specifications to include just that. If there is
12 documentation from the school, for instance, that
13 a vision screening has been done, then there
14 could potentially be a data element included in
15 the EHR to capture that.

16 I think we talked about it, and there
17 were several other questions that came up. I
18 mean is it enough if there's documentation that
19 the school completed the screening? Should there
20 be evidence of what the screening entailed, what
21 the scores were, and how those scores were
22 interpreted and so on? So I think because of

1 those questions, we decided to keep it simple, at
2 least for this level of the measure. But I think
3 there's opportunity to expand.

4 MEMBER MADONNA: Excuse me. Can the
5 referral come from the school directly?

6 MS. AMBROSE: Yes. I mean I think
7 that's another possibility that we thought about.
8 There could be a school clinic, for instance,
9 that's screening kids and making that referral
10 directly to an eye practitioner.

11 MEMBER MADONNA: How would that be
12 captured then?

13 MS. AMBROSE: That would have to be
14 captured through information that's provided from
15 the school to a primary care physician and
16 recorded as such.

17 MR. ROMAN: It sort of -- for the
18 purpose of this e-Measure, it really does depend
19 on where it's implemented. So if it's
20 implemented in the CMS/EHR Meaningful Use
21 Program, the school is not an eligible
22 professional who can be included. So there's --

1 that's not a source of data for the program.

2 The source of data are eligible
3 professionals, which include medical doctors, I
4 think ophthalmologists and optometrists. So
5 those would really be the only providers who
6 could be a source of data for that program. If
7 this were implemented in a Medicaid/CHIP program,
8 I think that would be something that we would
9 have to consider, of how we would expand it, and
10 it's also something we'd have to look at in
11 testing.

12 So like Melanie said, I think it's
13 something that in the future of this measure we
14 could look at. For the purposes of it, how it's
15 specified right now, it is not something that the
16 measure can handle, school referrals.

17 MEMBER MADONNA: I'm just a little
18 concerned, because there's the school system and
19 then this measure, that kids are going to fall
20 through the cracks, and it's going to look like
21 they got properly screened when they didn't have
22 it at either place. So I'm just posing that

1 concern.

2 MEMBER BRADHAM: Since most kids don't
3 start school until they're five, and this measure
4 is from three to five, we're talking about pre-
5 schoolers or we're talking about kids in daycare
6 settings. So I don't think that that is much of
7 an issue.

8 MEMBER MADONNA: But detecting
9 amblyopia earlier has much better outcomes. So
10 they should be getting screened in preschool.

11 MEMBER BRADHAM: It depends on like if
12 a parent has them in a private daycare setting,
13 they may not be doing screenings. So it would be
14 back to the pediatrician to do it. Plus with the
15 poor sensitivity and specificity outlined in the
16 U.S. Preventative Service Task Force
17 recommendation, I can still see the pediatricians
18 repeating the screenings.

19 MEMBER STEIN: I just think the key
20 to this whole thing, for it to be successful, is
21 the coordination of care, and if there's not good
22 coordination among the pediatrician, the school,

1 the patient and their parents, and the eye care
2 providers, then it's not going to be successful.

3 And I'm not sure whether this is going
4 to get us there. I mean certainly the idea that
5 pediatricians are checking vision is a good
6 thing. I just am a little concerned about
7 unintended consequences and people coding things
8 and it making it look like a kid really got
9 adequate attention. That kind of gets to
10 Richard's point a little bit.

11 MEMBER STRODE: As a family doctor, I
12 just feel obliged to remind the group that in
13 addition to pediatricians, that family doctors
14 and physician assistants and advanced practice
15 nurses care for kids. I understand this is a
16 pilot EHR, but I think these issues make it all
17 the more germane, since it's a pilot, a pilot's
18 measure that we're discussing here.

19 I understand what you all contracted
20 to do, but working for CMS, I would hope that you
21 might take the message back to CMS, that here
22 we're looking at the future of checking the

1 electronic health record of the optometrist, the
2 ophthalmologist, the pediatricians, the family
3 docs and the midlevel surveyor, with people who
4 not only may be getting screened in schools, but
5 it may just be a community effort that isn't
6 involved with the school district at all.

7 And each state has their own rules.
8 But who has more influence over this mess than
9 CMS? But I hope that they might be able to carry
10 the message back, that we see this as messy but
11 real, and the more than CMS can influence all of
12 those entities, schools, I mean the Medicaid
13 rules for each of 50 states and encouraging the
14 schools and community screenings and whoever's
15 doing the screenings, Lions Club, to feed that
16 into the providers.

17 The problem with the providers is that
18 I could see when it does move from is there the
19 measure built into your EHR to document that
20 there has been a screening, there has been a
21 referral, if proper, to being paid on the basis
22 of that, then I would expect that most of us as

1 primary care physicians would turn out with
2 horrible scores, because people are being
3 screened elsewhere and we're not getting the
4 information about it.

5 MR. ROMAN: Yeah. I think a
6 recommendation for future testing for the measure
7 would be how we'd incorporate information from
8 the school, or evidence, and this is a suggestion
9 we had from our original expert who helped us
10 develop it, is just how you incorporate that the
11 patient might already be seeing an eye care
12 professional.

13 We did look at that in the limited
14 testing we had, and there was -- that data is not
15 in the EHR. But that the child might be already
16 under the care of another eye care professional.
17 So we're limited and we didn't include that. But
18 I think that with additional testing, those two
19 things would be something that we would look at.

20 CO-CHAIR MERENSTEIN: So I don't know
21 if really you want to add anything, but all these
22 points are usability still, I think. I mean

1 they're all really important points, but I don't
2 know if we've talked about specificity yet, the
3 specifications. I guess we did at the very
4 beginning, so if people want to vote on it.
5 Seeing no other questions, we'll vote on it now.

6 MS. ROBINSON-ECTOR: So voting for
7 measure specifications for trial use e-Measure
8 2721 is now open. For those on the phone, Option
9 1 is high, 2 is moderate, 3 is low and 4 is
10 insufficient.

11 All the votes are in. 7 percent voted
12 high, 47 percent voted moderate, 27 percent voted
13 low and 20 percent voted insufficient. So this
14 would fall in the gray.

15 DR. WINKLER: So I think there's a lot
16 of concerns about the way the measure is
17 specified. You've heard the conversation. So I
18 think we would certainly be willing to entertain,
19 you know, revisions in the future that might can
20 deal with some of these issues. But that's sort
21 of the purpose for this kind of preliminary
22 review, is to get this sort of feedback for you.

1 But Todd.

2 MEMBER RAMBASEK: I'm just hoping
3 someone can explain to me, and as Dan pointed
4 out, there seemed to be some conflation between
5 the usability discussion and maybe the evidence
6 discussion. But why does the U.S. Preventative
7 Services Task Force say vision screening for
8 children is level of evidence B? But we're
9 voting that the specifications are not consistent
10 with the evidence. I'm -- perhaps I'm missing
11 it.

12 DR. WINKLER: A question.

13 CO-CHAIR MERENSTEIN: Sounds like the
14 ophthalmologists in the room did not agree with
15 the task force, because the task force didn't say
16 visual acuity. They said amblyopia screening,
17 and it sounds like your discussion on the call
18 was that you disagree with that, right?

19 MEMBER RAMBASEK: But we just said
20 that you can't do amblyopia screening, because
21 you can't do it. A pediatrician can't do that.

22 MEMBER FRIEDMAN: So we all agree

1 that screening for -- treating amblyopia is
2 beneficial. Amblyopia is a rare condition and it
3 certainly is treatable, and you can save a
4 lifetime's worth of vision. And so in order to
5 diagnose the amblyopia, you need to detect it.
6 You need to screen for vision.

7 So is screening for vision ultimately
8 going to potentially save vision from amblyopia?
9 The answer is yes. So in my perspective, I think
10 the measure is getting better, but it still needs
11 to be tweaked a little bit. So you're heading in
12 the right direction. Keep it up. Eventually I
13 think we'll find something that's palatable.

14 And one other thing. So we talked
15 about coordination of care. The question is
16 whether the sensitivity specificity of screening
17 in schools and whether screening extra twice as
18 much is going to be deleterious, and maybe it's
19 better. Maybe the sensitivity will go up if
20 there's more screening done. Presumably from a
21 statistical viewpoint, that could be beneficial.
22 But I mean I think we all agree that screening

1 for vision loss, amblyopia and rarely other even
2 bad diseases is going to be helpful. The
3 question is how do we do it?

4 CO-CHAIR MERENSTEIN: I think the
5 question is where do we do it too though. I mean
6 with the dental exam, the primary care doctor is
7 not doing that. So I think as Rich said, maybe
8 it should be -- the recommendation should be that
9 they see an eye doctor before they're five years
10 old.

11 DR. WINKLER: I would just like to
12 circle back to Todd's comment was, you know, the
13 question is are the specifications that they
14 presented to us consistent with the evidence that
15 was discussed, and just be sure that that vote
16 represents a response to that question. If you'd
17 like to rethink it, we could certainly redo.

18 MEMBER STEIN: Well, we're not voting
19 on reliability and validity and things like that.
20 So I think a bunch of these issues and nuances
21 and how it's actually are going to happen, at
22 least for me. I'm using this as my means of

1 conveying my opinions about that.

2 DR. WINKLER: So do you feel like
3 maybe we want to, you know, revisit, focus --
4 yes. I mean Todd was obviously right. The
5 question is are the specifications consistent
6 with the evidence you discussed?

7 MEMBER SCHACHAT: Does this vote, if
8 it stays this way, stop it? Well, I don't think
9 it should be stopped, because it's a good thing.
10 I just think that what -- the details aren't
11 there yet, to know that it's going to work right.
12 But if pilot things don't have to work right,
13 then I'm happy to change my vote. I just think
14 what we have right now isn't going to work, but
15 they should go ahead and do something.

16 DR. WINKLER: Well, I mean that's
17 essentially -- you know, what we're trying to do
18 is evaluate whether the measure is measuring
19 something important, that basically is evidence-
20 based in the way it's constructed, and certainly
21 we expect them to learn more when they do the
22 formal testing for reliability and validity in

1 terms of the results.

2 MEMBER STEIN: So I think it's great
3 that we're doing this pilot thing and giving you
4 guys feedback, and I agree with Andy, that if
5 this is going to stop discussing rest of it, so
6 you don't get more feedback, it kind of defeats
7 the purpose. So if we have to vote a certain way
8 just to be able to get through more questions.
9 See, it seems like a Catch-22, right?

10 DR. WINKLER: Yes.

11 MEMBER STEIN: Like why not give them
12 feedback on usability, because it's a pilot
13 thing, just because of how we voted on this?

14 DR. WINKLER: Right. Well, it's a
15 little bit more than just providing feedback,
16 because you're ultimately going to determine
17 where NQF should approve it for trial use. You
18 will be making a recommendation. So these are
19 the things that are feeding into it, and these
20 are your evaluation of it. So again, that's why
21 I think Todd's question is spot on, and does your
22 vote represent your sense of whether the

1 specifications are consistent with the evidence.

2 MEMBER SCHACHAT: So how quickly can
3 they -- if we say we don't like this, but show us
4 something else, how quickly can that process go
5 and let them do something, and I don't know if
6 they have funding to do that.

7 MR. ROMAN: It depends on the request.

8 MEMBER SCHACHAT: Right. You know, is
9 there a way to have this -- something further by
10 the next, or that conference call two months from
11 now?

12 MR. ROMAN: It would really depend on
13 what the request is. I mean if it's changing
14 some wording or adding coding, or you know, just
15 changes to the spec itself I think are possible.
16 But adding in stuff that would require testing,
17 that probably is out of the scope of what we'd be
18 able to do.

19 MEMBER SCHACHAT: It's just that for
20 me the biggest -- I think measuring vision by
21 pediatricians is probably a good thing, and so
22 I'm happy to approve that. For me, I'm more

1 focused on what Josh was talking about, and that
2 is what about all the stuff that's going on in
3 schools, and how is that brought in here, and is
4 there a way to put it all together.

5 Do we want one screening system going
6 and just let the schools do it, or do we want
7 two, or is this -- it is clear that -- well maybe
8 you can just tell us. I don't know how many
9 states have rules, and of those, how many require
10 anything in the preschool age, and support this
11 here, this is in the preschool age. Then the
12 evidence I'd like to know is is it more important
13 to do it in the preschool age, in which case
14 maybe states should all change their laws and not
15 do it in schools? I mean I can go on and on, and
16 I apologize.

17 MR. ROMAN: With regard to states, I
18 mean, not all the states have a policy about it.
19 There are a handful that have no policy at all.
20 Most do have some policy. Again, they vary on
21 whether or not they're actually a policy or a
22 guideline.

1 Not all of them recommend it in
2 preschool age. Some are like second grade and
3 ninth grade. Others are pre-K and earlier, so as
4 soon as they're in school or as soon as they're
5 in any type of preschool-type activity. But it's
6 not uniform, unfortunately, and that's why this
7 measure is focused on the preschool age, because
8 that is what the recommendation is, is that doing
9 it at that age is really kind of the sweet spot
10 to find the issues early, before they get more
11 developed, because by the time they're in school,
12 it's getting dangerous or problematic.

13 CO-CHAIR MERENSTEIN: Josh, then Todd,
14 and then maybe we consider re-voting this.

15 MEMBER STEIN: I was just going to
16 say that I'm willing to reconsider my position
17 until we can give them more feedback.

18 MEMBER RAMBASEK: It sounds like the
19 major concern is coordination between the state
20 screening programs and what the pediatricians are
21 doing. But I think I heard in the discussion it
22 said that the pediatrician should just be able to

1 check a box that says "school screening was
2 done."

3 So, and then the only hurdle they have
4 to jump through to get this measure positive
5 would be to make the referral. I don't see why
6 the pediatrician can't just -- or the family
7 practitioner or nurse practitioner or primary
8 provider -- can't just say "mom, dad, bring me in
9 the school result," or just call the principal
10 and say, "fax all 500 over," and just do
11 referrals that are appropriate, and then that
12 would be even easier for them.

13 Then they'd have 500, a stack of 500
14 tests sitting on their desk, and they could just
15 look at the abnormal ones and have the nurse
16 contact them. I'm not sure that's a big -- it
17 doesn't seem like a big deal.

18 CO-CHAIR MERENSTEIN: Any comments?
19 Do you want us to re-vote?

20 MR. ROMAN: I agree. I don't think
21 it's a big deal. I think, really, more though
22 it's how you -- what you're going to incorporate

1 into the spec, because I think just seeing that
2 it was done from the provider perspective isn't
3 really sufficient for a measure.

4 You want to see that it was done and
5 what are the results. So you need to have some -
6 - I think the way we have to work it in is that
7 the physician at least acknowledge that the
8 results are normal or they're abnormal or there
9 are referrals needed. Just seeing that a
10 screening is done is kind of a low bar measure.

11 So that's the only thing. I think, in
12 implementing it and putting it in the spec, we'd
13 have to figure out how we would incorporate that
14 the physician has to acknowledge what the result
15 was. Because just seeing that it was done, it
16 wouldn't really be sufficient.

17 MEMBER PATEL: This is Vaishali on the
18 phone. I probably should have asked this
19 earlier. Can somebody clarify are the current
20 school screenings just for amblyopia, or do they
21 screen for all kinds of vision problems? And who
22 is the screening done by?

1 MR. ROMAN: As we stated, you can't
2 screen for amblyopia. You can screen for
3 decreased vision. And then, again, the most
4 common cause of decreased vision is going to be
5 refractive error, myopia more commonly, and
6 hyperopia secondarily. So you can't screen for
7 amblyopia. And then who does the screening, I
8 can't speak for that.

9 MEMBER PATEL: Is it eye care
10 professionals or is it primary care providers or
11 is it some other professional?

12 MEMBER MADONNA: It could be just
13 about anybody, including mom, who's the head of
14 the PTA. It could be just about anybody
15 screening, providing the vision screening at a
16 school.

17 MEMBER PATEL: Okay. Thank you.
18 Thank you for the clarification.

19 MR. ROMAN: The requirements by the
20 states vary. You're exactly right. It really
21 varies by state.

22 MEMBER PATEL: Okay. Thank you for

1 the clarification. And also as a -- not so much
2 as an eye care professional, because I'm not one,
3 but as a mom, I would say I like the idea of, you
4 know, proper vision screening, either in a
5 primary care professional office or in an eye
6 care professional office.

7 CO-CHAIR MERENSTEIN: I think we
8 should re-vote this to give us more feedback.

9 MS. ROBINSON-ECTOR: Okay. So voting
10 is now open for performance step with the trial
11 use e-Measure 2721 for measure specifications.
12 And for those on the call, Option 1 is high, 2 is
13 moderate, 3 is low and 4 is insufficient.

14 All the votes are in. Thirteen
15 percent voted high, 67 percent voted moderate, 13
16 percent voted low, and 7 percent voted
17 insufficient. So, for measure specifications for
18 the trial use e-Measure 2721, the measure passes.

19 CO-CHAIR MERENSTEIN: We're going to
20 go to feasibility. Andrew, is there anything to
21 add about feasibility? Turn on your mic.

22 MEMBER SCHACHAT: We've been told that

1 some preliminary evaluations have been done.
2 Obviously, it's feasible to score if
3 pediatricians do something. Is there a code
4 created for it that says I did it?

5 MR. ROMAN: Yes.

6 MEMBER SCHACHAT: Yeah. And there
7 could be a code -- there's a code saying that I
8 referred also?

9 MR. ROMAN: Yes, there's a way that
10 referrals are represented in the EHR.

11 MEMBER SCHACHAT: So it's quite
12 feasible.

13 CO-CHAIR MERENSTEIN: Anything to add?

14 MEMBER FRIEDMAN: No. Just given the
15 caveats that we're previously described about
16 duplication of screening, I think it's very
17 feasible.

18 CO-CHAIR MERENSTEIN: Any comments?
19 Josh.

20 MEMBER STEIN: One more piece of
21 feedback, since this is going to be an e-measure.
22 You should be able to capture that a referral was

1 made, assuming the referring doc is in the
2 system. That's why I think this would be a
3 better plan measure. But for docs, you know,
4 where if a pediatrician has a working
5 relationship with an ophthalmologist and sends a
6 patient, there's some way of capturing that in
7 the electronic health record.

8 Then that would be, to me, more
9 powerful than just saying "I referred a patient,"
10 to see that the referral was made, or that an
11 action was done.

12 MR. ROMAN: So, the way that you
13 measure specification works, that particular data
14 element is looking to see that a referral was
15 made. I think that the way it gets implemented,
16 it varies per EHR. But that is the intent of
17 that data element in this measure, is that, if
18 there's a problem found, that the child is
19 referred.

20 It's not just saying that a referral
21 is needed. It's saying a referral was made. The
22 part that we were not able to incorporate is that

1 any follow-up from the eye care specialist
2 happened, in this version of the measure.

3 MEMBER FRIEDMAN: Again, it gets into
4 semantics. So, a referral is necessary. So, you
5 could say that. A referral is made, you schedule
6 the patient. You don't know if the patient
7 actually showed up. And then the patient showed
8 up, was a referral necessary, was there feedback,
9 was there something done? You know, there's all
10 these other issues that go on.

11 CO-CHAIR MERENSTEIN: Let's vote on
12 feasibility.

13 MS. ROBINSON-ECTOR: Voting for
14 feasibility for trial use e-Measure 2721 is now
15 open. And for those on the call, Option 1 is
16 high, 2 is moderate, 3 is low and 4 is
17 insufficient.

18 Okay. All the votes are in. Twenty
19 percent voted high, 67 percent voted moderate, 7
20 percent voted low and 7 percent voted
21 insufficient. So, for feasibility for the trial
22 use e-Measure 2721, the measure passes.

1 CO-CHAIR MERENSTEIN: Okay, usability.
2 We've been talking about that. Steve?

3 MEMBER STRODE: Do you know how CMS
4 plans to use this? If it's put into the
5 meaningful use basket, and it does turn out that
6 the pediatricians, family docs, and others have
7 really low scores, reflecting, as we would
8 suspect, poor coordination of care in this
9 sphere, then that would be valuable information
10 that the pilot would show.

11 On the other hand, if it's going to be
12 implemented and then it's going to tie in to
13 reimbursement for those providers, in the face of
14 what we suspect is really poor coordination of
15 care, then that bothers me. Do you know what the
16 intent is when this rolled out?

17 MS. AMBROSE: Our understanding is
18 that the measure is planned to be implemented as
19 part Medicaid CHIP programs, state programs also.
20 Again, I don't know what the applicability would
21 be in the EHR incentive program because of the
22 age range. But I think the intent was really to

1 encourage kids in Medicaid CHIP populations to
2 get screened, because there was a gap in
3 screening for those children.

4 MEMBER STRODE: And recognizing that
5 SCHIP can vary from state to state, but is your
6 impression that a check saying, "screening was
7 done by me," or momma said screening was done
8 somewhere, would be sufficient for payment?

9 DR. WINKLER: Steve, let me just jump
10 in. Remember that this is simply an approval for
11 trial use. And NQF's approval specifically says
12 this measure is not yet ready for accountability
13 purposes. So it's to learn to use it, find out
14 what it can do. It needs to come back with all
15 of that information for consideration for a full
16 endorsement. So that's part of the fact that it's
17 trial use, and that's an element of it.

18 CO-CHAIR MERENSTEIN: Josh.

19 MEMBER STEIN: I just want to follow
20 up on Steve's point. I actually see this
21 potentially as an excellent opportunity, because
22 you've got 50 states that are doing things in

1 very different ways, and we know that a lot of
2 kids are falling through the cracks and not
3 getting screened, by either a Lions Club or the
4 school or the pediatrician or someone and they
5 show up at age seven with amblyopia that was
6 undetected, and there's nothing we can do about
7 it at that point.

8 So the challenge for you guys is, how
9 you can you get all the states on board to do
10 this the right way, where you don't have 50
11 different ways of doing it, but one way that CMS
12 endorses that will convince the states to buy
13 into to do it the right way?

14 MEMBER MADONNA: So, earlier today we
15 talked about diabetics, who are a vulnerable
16 population, and we talked about measures to
17 improve the care of diabetics.

18 Now we're talking about a vulnerable
19 population, kids, and yet we didn't talk about
20 screening diabetics. We're examining diabetics.
21 Why aren't we examining kids? Why are we just
22 screening them and having all of these different

1 types of screeners? As Josh just said, this
2 could bring -- this could kind of pull it
3 together.

4 If the screening's done by a thousand
5 different types of people, many of whom have
6 really no clue what they're doing, and then
7 they've got to send that information to the
8 pediatrician, who may or may not go through the
9 forms that they're given, that may or may not
10 check off a box, and then the pediatrician must
11 then take the next step and send for an eye
12 examination.

13 It just seems to me, again, I'll go
14 back to what I said before, that it would be a
15 lot simpler to promote eye examinations. And my
16 fear is that having a screening in place may
17 reduce the number of children who are adequately
18 examined.

19 MEMBER SCHACHAT: So I think the
20 reason is that we don't have the data yet that
21 doing exams on all kids has reasonable
22 sensitivity and specificity and cost

1 effectiveness. If the vision's normal, if we
2 knew the vision's normal, the other things we're
3 looking for are not common enough that it makes
4 doing an exam on everybody --

5 MEMBER MADONNA: And we may or may not
6 know that.

7 MEMBER SCHACHAT: As long as these
8 visions are reliable visions. I think there's
9 evidence in favor of measuring vision but maybe
10 not do a whole exam. Anyway, it's a different
11 issue, because it's not part of this measure.

12 MEMBER PATEL: So, this is Vaishali on
13 the phone again. So, you know, I completely
14 agree with actually doing this, again, as a
15 mother, doing it in the eye care professional's
16 office. And if we don't have the data to say,
17 you know, how many kids are going to actually get
18 diagnosed if we have the requirement of directly
19 sending all kids between the age of three to five
20 to eye care professional's office.

21 So if you screen 100 kids, how many --
22 or a thousand kids -- how many are you going to

1 identify with vision problems, how many are you
2 going to identify with amblyopia screening? We
3 can do that testing.

4 I mean, it costs time and money, but
5 it can be done. And I would recommend it, as
6 opposed to doing that same screening of, you
7 know, another thousand kids in the primary care
8 provider's office and, you know, then referring
9 patients and seeing how many actually make it to
10 an eye care professional office and get
11 identified with some kind of problem.

12 You know, you can do that, too. So,
13 that can be done, and I would encourage doing
14 that as part of the testing. But my gut feeling
15 tells me that without doing that kind of
16 screening, that if you send kids directly to an
17 eye care professional's office, you are more
18 likely to have more people go and get screened
19 and get, you know, diagnosed, even without doing
20 the testing.

21 CO-CHAIR MERENSTEIN: Todd.

22 MEMBER RAMBASEK: I just want to make

1 a cultural point that we, as a society, spend
2 about twice as much per capita on health care as
3 patients, people in Japan, and they live longer
4 than we do. And it reflects a cultural problem
5 with how we value and allot health care dollars.

6 And if somebody who's published 200
7 articles has said there's not data to say that
8 that's cost effective, then we probably shouldn't
9 recommend it.

10 MEMBER PATEL: So, again, as a health
11 services researcher, I completely see your point.
12 But we are talking about vision problems in kids.
13 So, yeah, I see the point that, yes, we should do
14 the testing before we make decisions, and I'm all
15 in favor of doing that. So, then if we're
16 considering two different options, there should
17 be testing done.

18 CO-CHAIR MERENSTEIN: So I think
19 they're taking notes of this, but that's not
20 really what's at the table right now. I mean, at
21 the table is vision screening in the primary care
22 office and the usability of that.

1 Comments before we vote? I think
2 we've had a lot of comments, but, okay, one more
3 comment.

4 MEMBER RAMBASEK: Just a quick
5 question. So, is the pediatrician allowed to
6 check off what the school did according to this
7 measure?

8 MR. ROMAN: It's not in the spec right
9 now, no.

10 MEMBER RAMBASEK: It's not specified
11 or they're not allowed to?

12 MR. ROMAN: It's not specified, and as
13 far as whether or not they're allowed to, that's
14 a question that we would have to look at through
15 more research and probably with discussions with
16 some of CMS and others, because, you know, for
17 the purposes of the measure that we are talking
18 about, it's what a provider did or an eligible
19 professional did in their office.

20 Whether or not they can say that they
21 passed the measure because the school did
22 something, I'm not sure and I can't answer that

1 question. Right now, the measure does not
2 include it.

3 MS. AMBROSE: Yeah, it becomes a
4 question of attribution to that particular
5 provider, I think. But if there's an opportunity
6 to expand the measure, I think, from a
7 specification perspective, it would be doable to
8 add a data element to capture that.

9 CO-CHAIR MERENSTEIN: So, that's a
10 recommendation, but the vote is not -- that's not
11 a possibility for the vote. So let's --

12 MEMBER LYNCH: This is Judith. I need
13 a clarification. Are we voting on screening for
14 vision testing or screening for amblyopia?

15 CO-CHAIR MERENSTEIN: Vision testing.

16 MEMBER LYNCH: Okay, thank you.

17 MS. ROBINSON-ECTOR: Voting is now
18 open for usability and use for the trial use e-
19 Measure 2721. And for those on the phone, option
20 1 is high, 2 is moderate, 3 is low and 4 is
21 insufficient information.

22 MS. GORHAM: We're just waiting on

1 Judith.

2 MS. ROBINSON-ECTOR: Okay. All the
3 votes are in. Thirteen percent voted high, 40
4 percent voted moderate, 27 percent voted low, and
5 20 percent voted insufficient information. So
6 this would fall in the gray zone, but it's not a
7 must pass.

8 CO-CHAIR MERENSTEIN: So we're voting
9 on use? I mean, recommendation for endorsement.

10 (Pause.)

11 MS. ROBINSON-ECTOR: Voting for
12 overall suitability for approval for trial use
13 for e-Measure 2721 is now open. And for those on
14 the call, option one is yes and option two is no.

15 All the votes are in. Sixty-seven
16 percent voted yes and 33 percent voted no. So,
17 for recommendation for trial use for e-Measure
18 2721, the measure passes.

19 MR. ROMAN: Thank you.

20 DR. WINKLER: We're going to switch
21 gears and bring out our last set of measure
22 developers. And we're going to talk about

1 hearing screening.

2 (Pause.)

3 CO-CHAIR MERENSTEIN: Kathy was
4 supposed to do all the ophthalmology, but I
5 agreed to switch for that last one. I don't know
6 why. It looked like it was going to be easy.

7 So we're going to do Hearing Screening
8 Prior to Hospital Discharge. If you can just
9 introduce yourselves and give us some background.

10 MR. EICHWALD: I'm John Eichwald. I'm
11 with the Center for Disease Control's National
12 Center on Birth Defects and Developmental
13 Disabilities.

14 MR. GAFFNEY: Hello. My name's Marcus
15 Gaffney. I'm also with the CDC National Center
16 on Birth Defects and Developmental Disabilities.

17 CO-CHAIR MERENSTEIN: Do you want to
18 introduce the measure, or all the measures?
19 Either way. You can just do the first one or all
20 of them.

21 MR. GAFFNEY: Okay. I believe we have
22 three measures that are going to be discussed

1 today. The first is 1354, Hearing Screening
2 Prior to Hospital Discharge. And then I believe
3 after lunch we're also going to be discussing
4 Measure Number 1360, Audiological Evaluation No
5 Later Than Three Months of Age, and Measure
6 Number 1361, Intervention No Later Than Six
7 Months of Age.

8 DR. WINKLER: If they're happy with
9 that, that's fine.

10 CO-CHAIR MERENSTEIN: All right.
11 We'll go on. So we're going to go to evidence.
12 It's myself and Tammy. The evidence, I think, is
13 pretty straightforward. There's three randomized
14 controlled trials, one observational trial, a few
15 recommendations from NIH panels and AAP panels,
16 and then the United States Preventative Services
17 Task Force Grade B evidence is the evidence
18 behind screening. Do you have anything to add
19 about that, Tammy?

20 MEMBER BRADHAM: Just one comment
21 about the U.S. Preventative Task Force is that
22 they did inactivate this particular measure for

1 hearing screening because there had been no new
2 evidence published since the last time they had
3 done their statement. And so that was done in
4 2008.

5 CO-CHAIR MERENSTEIN: Any questions or
6 comments about that? So we'll vote on the
7 evidence.

8 MS. ROBINSON-ECTOR: Okay. So voting
9 for evidence for Measure 1354 is now open. And
10 for those on the call, option one is high, two is
11 moderate, three is low and four is insufficient
12 evidence.

13 All the votes are in. Sixty percent
14 voted high, 33 percent voted moderate, 7 percent
15 voted low, and zero voted insufficient evidence.
16 So for Measure 1354, the measure passes on
17 evidence.

18 CO-CHAIR MERENSTEIN: Opportunities
19 for improvement. So, on this one, there's not
20 really that much. The CDC says that 97 percent
21 of newborns in the United States were screened,
22 and of those that were screened, 1.8 percent did

1 not pass the final or more recent hearing.

2 There is some disparities. The only
3 people that aren't screened are the births that
4 are occurring in small and rural facilities or
5 outside the hospital. So, we talked a lot about
6 this yesterday. My bias is that there's not much
7 room for improvement, but they've done such a
8 good job that I'm not interested in voting
9 against it. But that's obviously open for
10 debate. Tammy.

11 MEMBER BRADHAM: We are at a ceiling
12 effect with this particular measure because it's
13 hearing screening within one month. Something to
14 consider would be maybe hearing screening prior
15 to hospital discharge. That may add some
16 opportunities there to look at.

17 But we are running into issues, as
18 mentioned in here, regarding disparities, where
19 we have families that live in border states, so
20 they may be born in another state, and so that
21 information doesn't cross over to the state that
22 they reside in. Or the other opportunity here is

1 to capture babies that are born through midwives.

2 CO-CHAIR MERENSTEIN: So, just to
3 clarify, I think this is just before discharge.
4 So it is before discharge. Because the only
5 exclusion for this one is death in the hospital.
6 So I don't know if there's -- yeah, questions
7 about it?

8 MEMBER RAMBASEK: Well, this is going
9 to come up in same discussion as yesterday, which
10 is do you need to keep a rule in place or will
11 there be slideback?

12 CO-CHAIR MERENSTEIN: And again, I'm
13 open to listen to others. Just my view is that
14 it's a little different than yesterday, in the
15 sense that the physicians themselves have stopped
16 using steroids. This is, I think, sort of the
17 hospitals have changed in practice, and I think
18 they changed because this has been looked at.

19 But you're right. There's not much
20 room for improvement. The question is if they
21 stop checking it, will there be slideback?

22 MEMBER STEWART: Yeah, I would say

1 this one is different, because this is now -- in
2 most states it's a regulation. It's actually
3 gone around the world now. And quite frankly
4 this is in many ways an unfunded mandate, that
5 this must be done, but there's no resources to do
6 it.

7 So if you don't measure it, then
8 hospitals are going to find ways to not do it, or
9 they're going to find ways to, you know, ensure
10 that the patient has the availability for follow
11 up, but they're not going to actually do the
12 screening.

13 So I think that this is one where if
14 you don't measure this, it will definitely fall
15 off. It will be a problem.

16 MEMBER YOUDE: I agree with Mickey.

17 MEMBER LYNCH: This is Judith. I
18 agree as well.

19 CO-CHAIR MERENSTEIN: Any other
20 thoughts about this one?

21 MEMBER FRIEDMAN: Okay. For all of
22 us lame ophthalmologists, what are the current

1 guidelines for screening right now? What are the
2 requirements?

3 MEMBER BRADHAM: So, the screening in
4 the hospital, they either have to have an
5 otoacoustic emission or an automated ABR, which
6 are tests that are routinely done either by the
7 nurses, or they maybe have an audiologist that
8 does it, or they may have volunteers that do it.
9 But they have to be signed off by the physician.

10 So they are regulated. They have to
11 be trained to be able to do this procedure.
12 There is good sensitivity and specificity for
13 these measures. We do run into some risk of, if
14 the hospital does otoacoustic emission, that we
15 may miss auditory neuropathy spectrum disorder
16 children.

17 MEMBER FRIEDMAN: Okay. So,
18 basically, screening is required right now. Why
19 are we -- what will this measure do to enhance
20 that? If the measure doesn't get passed,
21 screening is still required. Is that correct?

22 MEMBER BRADHAM: At this current time,

1 it is still required, but families can opt out to
2 not have it done, and we're starting to see a
3 slight trend with this pattern because of the
4 cost. And so they may have to -- because the
5 programs that are coming into the hospital to
6 provide the screenings, they may be out of
7 network for the family, and so then they get
8 passed the charge or they can just elect not to
9 have it done.

10 CO-CHAIR MERENSTEIN: But if you have
11 a quality measure, they can still opt out of it,
12 presumably. I think John has to answer that.

13 MR. EICHWALD: One of the issues is
14 this is state regulation, and there's only 44
15 states that actually passed legislation. So
16 we've got six states and some territories that
17 have no legislation in place.

18 Also that legislation varies
19 considerably by jurisdiction. Some only
20 recommend. Some of them basically say, "We'll
21 only keep screening if you maintain such and such
22 level." So there's no real one standard of

1 regulatory, of having it done.

2 MEMBER FRIEDMAN: So, again, this
3 dovetails to the discussion that we had on the
4 last measure. There's some state input. The
5 states are variable. The question is, do you
6 attack that by creating a quality measure, or do
7 you have legislation done at the federal level,
8 or do you go to these individual states and say,
9 "We need to have a uniform state requirement"?
10 And then all 50 states have requirements and
11 they're all the same, and then you're done.

12 MR. ROMAN: There is no federal
13 regulation. So this is just state-based.

14 CO-CHAIR MERENSTEIN: Todd.

15 MEMBER RAMBASEK: Forty-four states
16 have laws saying you have to do this. So, 12
17 percent of states have laws that you don't. So
18 there's only three percent are not getting
19 screened. So apparently, even in the states
20 where there's no law, there's still a lot of this
21 happening?

22 MR. EICHWALD: Yeah, the screening

1 still continues even without state regulation.

2 CO-CHAIR MERENSTEIN: Tammy.

3 MEMBER BRADHAM: So, all states have
4 an EHDI program, or Early Hearing Detection and
5 Intervention program. And so there is somebody
6 hired at the state level that coordinates these
7 efforts, and they collect, maybe by fax, maybe by
8 email, maybe by whatever mechanism, information
9 from the hospitals as well, as we'll learn later,
10 audiologists and early intervention providers.

11 They collect that information and then
12 they send it on to CDC for reporting. This
13 information's really important, though, for the
14 reauthorization for the fundings that the states
15 get for the reauthorization for these programs.

16 CO-CHAIR MERENSTEIN: Josh.

17 MEMBER STEIN: I think one of the
18 fundamental differences between this and the last
19 one, though, is here most patients are getting it
20 appropriately, and we're up in the 90s and we
21 want to maintain that.

22 With the vision screening, it's not

1 clear how -- it's certainly not up in the 90s,
2 and one needs to develop a system to try to get
3 good vision screening. So I think that they're
4 different, even though the states are supposedly
5 involved.

6 CO-CHAIR MERENSTEIN: Any other
7 comments or questions about this? Yeah, sorry.
8 Todd.

9 MEMBER RAMBASEK: Yeah. If we did
10 pull back, what's the -- we just watch it and
11 then reinitiate it when it falls below -- you
12 know? How does that -- how would that process
13 work should anybody move in that direction?

14 MR. EICHWALD: Well, we would still --
15 we would probably still collect the data.
16 Endorsement by NQF obviously creates a quality
17 measure here that people respect and basically
18 would continue to follow.

19 So, I mean, endorsement, I think, is
20 what really helped this, and it also helped this
21 get accepted by CMS as one of the meaningful use
22 measure. So we look forward to maintaining NQF

1 endorsement.

2 DR. WINKLER: This is actually an e-
3 measure, and I think that the registry version of
4 the measure is a reflection of the EDHI program.
5 The e-measure is at a facility level. We don't
6 have a lot of hospital level data. Some states
7 were able to provide it, but in general, it's
8 collected within the state. And so there's this
9 aggregate population level, less so the actual
10 provider level, that looks that perhaps the e-
11 measure version may provide an opportunity to
12 see, to get more granular down at the hospital
13 level, where we may begin to see differences,
14 particularly regionally or wherever those
15 hospitals might be.

16 CO-CHAIR MERENSTEIN: Rich.

17 MEMBER MADONNA: Just a quick
18 question. Help me answer that question that's up
19 there right now. I know the measure is -- we
20 have a ceiling effect right now. But are there
21 disparities right now? Is it just the state by
22 state disparity or rural/urban disparity? Okay.

1 MEMBER BRADHAM: There are disparities
2 because of -- depending on -- not all children
3 get born in a hospital, so trying to capture the
4 midwives births, the rural settings, the border
5 pregnancies. So there are some opportunities
6 there.

7 MEMBER STEIN: Will this address the
8 kids born outside the hospital?

9 MEMBER BRADHAM: This measure is for
10 hearing screenings within one month. So it
11 doesn't --

12 CO-CHAIR MERENSTEIN: This is before
13 discharge. So it will not address the ones born
14 outside the hospital.

15 MR. EICHWALD: Yeah, the measure is
16 screening before hospital discharge. There are
17 hospitals that do go below a percentage, often --
18 I'll bring as an example military hospitals.
19 When you have a change in command, oftentimes
20 hospitals will not start reporting that data back
21 to us. Once again, it's nice to have that
22 national standard that we can look at and make

1 sure that every hospital within a jurisdiction is
2 is meeting the national standards.

3 CO-CHAIR MERENSTEIN: So I think we
4 should vote. I mean, I think people -- the
5 points are clear.

6 MS. ROBINSON-ECTOR: Voting is now
7 open for the performance gap for Measure 1354.
8 And for those in the call, option one is high,
9 two is moderate, three is low and four is
10 insufficient.

11 All the votes are in. Seven percent
12 voted high, 60 percent voted moderate, 27 percent
13 voted low, and 7 percent voted insufficient. So,
14 for performance gap for Measure 1354, the measure
15 passes.

16 CO-CHAIR MERENSTEIN: So, reliability.
17 So, it's pretty straightforward. It's all live
18 births during the measurement period that are
19 screened for hearing loss. The
20 numerator/denominator is all live births that are
21 discharged from the hospital. I don't think
22 there's any coding issues.

1 The way it's reported is by states.
2 So the states report it to -- the hospitals
3 report it to the state and then you collect it
4 from the states. And again, the only exclusion
5 is neonatal death. I don't know if Tammy has
6 anything to add about that.

7 MEMBER BRADHAM: I would just
8 encourage looking at are there feasibility
9 studies and looking at claim-based data, kind of
10 starting to look in that direction.

11 DR. WINKLER: Just to reiterate, we
12 have two versions of the measure. We're talking
13 now about the registry measure that's part of the
14 EDHI program. Again, tends to be focused more at
15 a higher population level. We will talk about
16 the e-measure next.

17 CO-CHAIR MERENSTEIN: Comments or
18 questions about the reliability? I guess we'll
19 vote on that.

20 MS. ROBINSON-ECTOR: Voting is now
21 open for reliability for the registry version of
22 Measure 1354. And for those on the call, option

1 one is high, two is moderate, three is low and
2 four is insufficient.

3 All the votes are in. Sixty percent
4 voted high, 40 percent voted moderate, zero voted
5 low and zero voted insufficient. So for
6 reliability for the registry version of Measure
7 1354, the measure passes.

8 CO-CHAIR MERENSTEIN: So, for
9 validity, you're not going to be surprised
10 because we talked about it. There's room for
11 improvement and they did two state checks. On
12 Vermont they checked, and they found 3.3 percent
13 errors in the charts when they did the medical
14 record check. In Tennessee, 0.2 percent. In New
15 Jersey, the lowest hospital score is 96 percent,
16 the highest, and 33 hospitals actually reported
17 100 percent compliance with hearing, and there's
18 no risk adjustments. Do you have anything to
19 add?

20 MEMBER BRADHAM: And just to point
21 out, New Jersey the -- yeah, New Jersey -- was it
22 New Jersey is the state that does not have

1 mandated -- or it was Vermont that does not have
2 mandated newborn hearing screening, and they
3 still had a really good reporting.

4 CO-CHAIR MERENSTEIN: Questions about
5 that? Then we'll vote on that.

6 MS. ROBINSON-ECTOR: Voting is now
7 open for validity for the registry version of
8 Measure 1354. And for those on the call, option
9 one is high, two is moderate, three is low and
10 four is insufficient.

11 All the votes are in. Eighty-seven
12 percent voted high, thirteen percent voted
13 moderate, zero voted low and zero voted
14 insufficient. So for validity for the registry
15 version of Measure 1354, the measure passes.

16 CO-CHAIR MERENSTEIN: So, feasibility.
17 I might need some help from the developers,
18 because is one part that's a little confusing.
19 It sounds like the states fax them the answers.
20 And we're not talking e-measures, so that was a
21 little strange to me. And we haven't talked
22 about the e-measure, and maybe that will correct

1 some of the problems. But is that how it's
2 actually done?

3 MR. GAFFNEY: Are you meaning
4 reporting from hospitals to the state, or the
5 state to us?

6 CO-CHAIR MERENSTEIN: Yeah, yeah, no.

7 MR. GAFFNEY: From hospitals to the
8 state? There's various ways. A lot of reporting
9 is done electronically now, either through web-
10 based systems or a weekly, maybe even a monthly
11 upload directly to the state, depending on how
12 that data system's set up.

13 We do see in some of the smaller
14 facilities, there may be faxing of the results,
15 or maybe even mailing. There is predominantly
16 more reported in an electronic format. To us, we
17 have a web-based survey we conduct once a year.
18 So the states report using that web-based survey.

19 CO-CHAIR MERENSTEIN: Anything to add?
20 Yeah, Josh.

21 MEMBER STEIN: This came up with the
22 last measure. Do you guys plan on looking at --

1 not necessarily with this measure, but are you
2 planning on looking at the kids who fail the
3 screening, getting seen by the ENT doc? Is that
4 --

5 MEMBER BRADHAM: That's the next
6 measure. There's another measure.

7 CO-CHAIR MERENSTEIN: The next two
8 measures.

9 MEMBER STEIN: Okay.

10 CO-CHAIR MERENSTEIN: Any other
11 questions? So we'll vote on this.

12 MS. ROBINSON-ECTOR: Voting is now
13 open for feasibility for the registry version of
14 Measure 1354. And for those on the call, option
15 one is high, two is moderate, three is low and
16 four is insufficient.

17 All the votes are in. Eighty percent
18 voted high, 20 percent voted moderate, zero voted
19 low and zero voted insufficient. So for
20 feasibility for the registry version of Measure
21 1354, the measure passes.

22 CO-CHAIR MERENSTEIN: Then usability.

1 Not that much. I can't think of many unintended
2 consequences for this test. It's pretty easily
3 used and it's tied to meaningful use. So that's
4 probably why you see the rates so high. And it's
5 publicly available, right? Yeah, it's publicly
6 available. Tammy.

7 MEMBER BRADHAM: Agree.

8 CO-CHAIR MERENSTEIN: Any comments?

9 I guess we'll vote on it.

10 MS. ROBINSON-ECTOR: Voting is now
11 open for usability and use for the registry
12 version of Measure 1354. And for those on the
13 call, option one is high, two is moderate, three
14 is low and four is insufficient information.

15 Great. All the votes are in. Ninety-
16 three percent voted high, 7 percent voted
17 moderate, zero voted low and zero voted
18 insufficient information. So for usability and
19 use for the registry version of Measure 1354, the
20 measure passes.

21 CO-CHAIR MERENSTEIN: Any further
22 comments before we vote? We'll vote.

1 MS. ROBINSON-ECTOR: Voting for a
2 recommendation for overall suitability for
3 endorsement for the registry version of Measure
4 1354. And for those on the call, option one is
5 yes and option two is no.

6 All the votes are in. Ninety-three
7 percent voted yes and 7 percent voted no. So for
8 a recommendation for overall suitability for
9 endorsement for the registry version of Measure
10 1354, the measure passes.

11 CO-CHAIR MERENSTEIN: Let's see. So,
12 do you want to do the e-measures, Reva?

13 DR. WINKLER: Yeah. This measure also
14 has an e-measure version that has just been
15 included in meaningful use for hospitals for next
16 year, I think it is? Yes. And this measure
17 hasn't been formally tested. So we have the same
18 issue we have with the ones we talked about
19 yesterday, with the eye care measures. And the
20 developers have agreed to do the simulated data
21 set testing and provide the results back to us in
22 our call in August.

1 So that would be the condition by
2 which you could approve or pass the criterion for
3 this measure. Does anybody have any questions
4 about specifications for the e-measure? Or,
5 John, did you want to talk about anything about
6 the e-measure? I know you've been working on it
7 for a while.

8 MR. EICHWALD: Yeah, we've been
9 developing this for several years. Actually,
10 this measure was started out -- our original
11 intent was this to be an e-measure and it's just
12 taken us a while to get there. Once NQF endorsed
13 it, CMS did pick it up. It was actually CMS' --
14 we're now on Version 4 of it. It's been a little
15 bit of a moving target.

16 We've also tried to harmonize it with
17 the other newborn e-measures, and so our
18 denominator is essentially the same in that. And
19 that would be the three measures NQF -- let me
20 get my glasses on -- about breast feeding, NQF
21 Measure 488, which is -- the measure steward is
22 the Joint Commission. There's another measure on

1 newborn hearing screening, which is 1354, the one
2 you're reviewing now. And then healthy newborns,
3 NQF 716, which CMS is the measure steward.

4 So whenever there's been any kind of
5 discussion of changing what the data measure is,
6 we're trying to make sure that we're harmonizing
7 this so, again, reducing the burden on hospitals
8 to report this kind of measure.

9 DR. WINKLER: Any other comments or
10 questions about the e-measure version of this, in
11 terms of scientific acceptability?

12 MS. ROBINSON-ECTOR: Voting is now
13 open for reliability and validity for the e-
14 Measure 1354. And for those on the call, option
15 one is yes with conditions and option two is no.

16 All the votes are in. Ninety-three
17 percent voted yes with conditions and 7 percent
18 voted no. So for reliability and validity for
19 the e-Measure 1354, the measure passes.

20 DR. WINKLER: In terms of feasibility
21 of the e-measure, John, do you have any comment
22 on the use of the data elements in the usual

1 players in the EHR vendor space?

2 MR. EICHWALD: Well, we've actually
3 been working with some vendors. We're working
4 with an organization called Integrating the
5 Healthcare Enterprise. And we've actually just
6 published a document that's out for public
7 comments, and this basically takes the measure
8 that is defined here and it's sort of the how-to.
9 How do we create the content using a quality
10 reporting document architecture, QRD-8
11 architecture, and then being able to take the
12 individual quality report, the quality report at
13 the individual level, combine that, aggregate
14 that into a quality measure at the population
15 level.

16 So, that profile is out right now for
17 public comment. We specifically built it so that
18 it worked for EDHI, but we're really trying to
19 make sure that it will work for other quality
20 measures as well.

21 DR. WINKLER: Any questions or
22 comments about the feasibility of an e-measure

1 version of this measure? Okay.

2 MS. ROBINSON-ECTOR: Voting is now
3 open for feasibility for e-Measure 1354. And for
4 those on the call, option one is high, two is
5 moderate, three is low and four is insufficient.

6 All the votes are in. Ninety-three
7 percent voted high, 7 percent voted moderate,
8 zero voted low and zero voted insufficient. So,
9 for feasibility for e-Measure 1354, the measure
10 passes.

11 DR. WINKLER: Is there anything about
12 the usability and use that was going to be
13 different on the e-measure compared to the
14 registry measure?

15 MEMBER YOUDE: I am a huge fan of
16 this, because there's a significant amount of
17 time processing paperwork with the registry
18 version, and this will ease the usability
19 considerably.

20 DR. WINKLER: Let's vote on usability.

21 MS. ROBINSON-ECTOR: Voting is now
22 open for usability and use for e-Measure 1354.

1 Option one is high, two is moderate, three is low
2 and four is insufficient information.

3 All the votes are in. Ninety-three
4 percent voted high, 7 percent voted moderate,
5 zero voted low and zero voted insufficient. So
6 for usability and use for e-Measure 1354, the
7 measure passes.

8 DR. WINKLER: Anything overall about
9 the e-measure before we vote? No. Sorry, okay.

10 MS. ROBINSON-ECTOR: So recommendation
11 for overall suitability for endorsement for e-
12 Measure 1354 is now open. Option one is yes with
13 conditions and option two is no.

14 DR. WINKLER: Just as a reminder, the
15 conditions are that they bring back the results
16 of the testing in the simulated data set.

17 MS. LUONG: Vaishali, if you can email
18 me your votes, thanks.

19 MEMBER PATEL: Yes, Vy.

20 MS. ROBINSON-ECTOR: All the votes are
21 in. One hundred percent voted yes with
22 conditions and zero voted no. So for

1 recommendation for overall suitability for
2 endorsement for e-Measure 1354, the measure
3 passes.

4 MS. LUONG: Operator, at this time
5 we'd like to open up the line for public
6 comments.

7 OPERATOR: Okay. At this time, if
8 you'd like to make a comment, please press star
9 then the number one.

10 (No response.)

11 OPERATOR: There are no public
12 comments at this time.

13 MS. LUONG: Thank you.

14 DR. WINKLER: Okay. Lunch is here.
15 A little fuel for the brain cells, a little
16 break. We're scheduled to reconvene at 12:30.

17 MS. LUONG: Yes. So for those on the
18 phone, we're scheduled to reconvene at 12:30.
19 And, Vaishali, I've got your email, so thank you
20 for participating for the past two days, and when
21 you come back, we won't be discussing measures
22 anymore.

1 MEMBER PATEL: Great, thank you.

2 MS. LUONG: Thanks, bye.

3 (Whereupon, the above-entitled matter
4 went off the record at 12:01 p.m. and resumed at
5 12:30 p.m.)

6 MS. LUONG: So before we start the
7 conversation on the Measures discussion, just for
8 logistical purposes, I know a lot of people are
9 traveling to either Dulles or Reagan for their
10 flight. And if you can, I think it will be a
11 good idea to maybe take the cab together since
12 you guys are at the same hotel, so just
13 coordinate amongst each other because I know some
14 of you are flying out around 5:00 or 6:00, which
15 is around the same time as most people. Thanks.

16 CO-CHAIR YAREMCHUK: So, the other
17 question is expense reports. Can you also just
18 let people know in terms, are they going to be
19 sent electronically to everybody?

20 MS. LUONG: So for reimbursement, but
21 I'm sure our meetings department will be sending
22 out an email to everyone here within the next few

1 days by the committee members with directions on
2 reimbursement. And for the people that were at
3 last night's dinner, if you can just make a note
4 in there that Kathleen was the person that
5 handled the check. Thanks.

6 CO-CHAIR YAREMCHUK: Okay. So the
7 Measure that we're going to now, 1360
8 Audiological Evaluation no later than 3 months of
9 age.

10 CO-CHAIR MERENSTEIN: Developers want
11 to say anything about that?

12 CO-CHAIR YAREMCHUK: They're not
13 listening.

14 MR. GAFFNEY: I don't think at this
15 point. Just the measure is about audiological
16 evaluation before 3 months of age. Happy to
17 address any questions.

18 CO-CHAIR MERENSTEIN: So Tammy, I guess
19 you're by yourself on this one.

20 MEMBER BRADHAM: So the evidence for
21 this is basically is follow-up to once a baby's
22 been seen in the hospital and they get a refer,

1 then they are supposed to be referred to an
2 audiologist no later than 3 months of age for
3 audiologic testing. And during that time, the
4 audiologist is expected to make a diagnosis at
5 that point.

6 And so there are reliable measures out
7 there to be able to test a baby's hearing
8 sensitivity by 3 months of age and Joint
9 Commission of Infant Hearing Position Statement,
10 which is made up of multiple organizations have
11 endorsed this practice.

12 CO-CHAIR MERENSTEIN: Any questions
13 about the evidence? I guess we'll vote.

14 MS. ROBINSON-ECTOR: Voting for
15 Evidence for Measure 1360 is now open. And for
16 those on the call, Option 1 is High, 2 is
17 Moderate, 3 is Low, and 4 is Insufficient
18 Evidence.

19 So all the votes are in. So 11 voted
20 High, 2 voted Moderate, 0 voted Low, and 0 voted
21 Insufficient. So for Evidence for Measure 1360,
22 the Measure passes.

1 CO-CHAIR MERENSTEIN: Opportunity for
2 Improvement?

3 MEMBER BRADHAM: So the opportunity
4 improvement in looking at the national data.
5 When they first started, what they're reporting
6 is that back in 2007 at or around 66 percent and
7 the national data is showing in 2012 we're at 69
8 percent of audiologists completing the
9 audiological evaluation by 3 months of age. As
10 far as disparity data, there isn't much disparity
11 between whites, blacks, and Hispanics in getting
12 the audiological evaluation by 3 months of age.

13 CO-CHAIR MERENSTEIN: This is great
14 data, it says it's 54 percent for whites, 51
15 percent for blacks, 52 for Hispanics. But
16 overall, it's 71 percent.

17 MR. GAFFNEY: I just want to clarify.
18 You're saying 71 percent overall for --

19 CO-CHAIR MERENSTEIN: That's what it
20 says, again, is that -- are you looking at that
21 Tammy? It says the performance gaps is 70.8
22 percent in 2011.

1 MEMBER BRADHAM: I do not see that. I
2 just see whites, blacks, and Hispanics, 54.8
3 percent for white, 51 percent for black, and 52.2
4 ---

5 MR. GAFFNEY: How's the group 70?

6 CO-CHAIR MERENSTEIN: But then the
7 average should be close to, like, 54 percent, 53
8 percent.

9 (Off mic comment)

10 CO-CHAIR MERENSTEIN: Any questions or
11 anything about the Performance Gap? There hasn't
12 been much change in the last five years.

13 DR. WINKLER: Yes. I mean, in all
14 honesty, what I did is they had given us the
15 links to the various data and I had tried to
16 abstract it. And it's possible that when I did
17 that I may have not quite caught on. We can see.
18 It could have been my abstraction error.

19 CO-CHAIR MERENSTEIN: Any other
20 comments? So we vote on Performance Gap.

21 MEMBER BRADHAM: I guess the only other
22 comment that I'll make about this is that most

1 states don't require an audiologist to report
2 their results to the state and so there are
3 opportunities there to continue to monitor this
4 to see that reporting improve.

5 MEMBER STEIN: Can you clarify can
6 these kids be seen by someone other than --
7 appropriately seen by someone other than an
8 audiologist? Like, if they went to an ENT doc?

9 MEMBER BRADHAM: They really need to
10 see an audiologist for the hearing testing and
11 then they go to the otolaryngologist if hearing
12 loss is identified for the medical work-up. But
13 it requires the audiometric testing.

14 There may be some ENTs that do the
15 actual hearing test or may have some techs, but
16 typically for pediatrics, they usually have an
17 audiologist do the testing. And also this does
18 require use of electrophysiology testing at this
19 age, at 3 months, and so the audiologist has to
20 interpret those test results.

21 MEMBER STEIN: So what's your
22 explanation for the performance gap? It sounds

1 like it's around 50 percent. Is it the parents
2 just aren't taking the kids in?

3 MEMBER BRADHAM: That is part of it.
4 Part of it is also some of those babies haven't
5 even been released yet from the hospital. So
6 they may have failed the newborn hearing
7 screening, but they're still in the PICU or
8 something like that and so there are other
9 reasons for that.

10 MEMBER STEIN: Do you think those kids
11 should be excluded from the denominator?

12 MEMBER BRADHAM: We actually asked this
13 question about maturation because if we're
14 looking at prematurity, we do adjust for that
15 during testing and that is not something at this
16 point that they're adjusting for.

17 MR. ROMAN: If I can point out one or
18 two things. Sort of the data as it stands right
19 now is about 69 percent of kids are get evaluated
20 before 3 months. That's based on documented
21 data, so it is likely it's even higher than that.
22 But this is just based on what the states can

1 actually document in their systems.

2 We have recently made a update to the
3 survey, it doesn't yet reflect in the data that's
4 being shared here, where states can account for
5 those children that were in a NICU for greater
6 than 30 days. So that's kind of setting us up to
7 get a start to address some of that issue there.
8 And that is just a recent change that's just been
9 implemented.

10 MEMBER BRADHAM: One of the other
11 issues is that hospitals didn't know where to
12 refer babies and so in 2013 in the spring, they
13 released EHDI-PALS, which is a website where they
14 can go to, to find audiologists for the testing.
15 And so I'm hoping that as data becomes more
16 available, we might actually see some improvement
17 there as well. And that's a national registry of
18 facilities and what type of equipment they have,
19 et cetera.

20 CO-CHAIR MERENSTEIN: Any other
21 comments? So let's vote on the Performance Gap.

22 MS. ROBINSON-ECTOR: Voting is now open

1 for Performance Gap for Measure 1360. And for
2 those on the call, Option 1 is High, 2 is
3 Moderate, 3 is Low, and 4 is Insufficient.

4 All the votes are in, 79 percent voted
5 High, 21 percent voted Moderate, 0 voted Low, and
6 0 voted Insufficient. So for Performance Gap for
7 Measure 1360, the Measure passes.

8 CO-CHAIR MERENSTEIN: Tammy,
9 Reliability.

10 MEMBER BRADHAM: Next one is looking at
11 reliability. The states report this data to, we
12 mentioned this earlier, the states report this
13 data to CDC. The states are getting reports from
14 the audiologists or the facilities where they
15 work. A lot of time this is faxed information.
16 It could be an upload of their equipment to the
17 state. But the actual testing procedure that's
18 done, ADRs are -- that whole diagnostic process
19 has very high sensitivity and specificity for
20 detecting mild and greater hearing losses.

21 CO-CHAIR MERENSTEIN: Comments? All
22 right. We'll vote on Reliability.

1 MS. ROBINSON-ECTOR: Voting for
2 Reliability for Measure 1360 is now open. And
3 for those on the call, Option 1 is High, 2 is
4 Moderate, 3 is Low, and 4 is Insufficient.

5 Okay. Votes are in, 50 percent voted
6 High and 50 percent voted Moderate. So this
7 would fall into the grey zone.

8 CO-CHAIR MERENSTEIN: No, it passes.

9 MS. ROBINSON-ECTOR: Oh, sorry. It
10 passes. Oops, sorry. So the Measure passes for
11 Reliability.

12 CO-CHAIR MERENSTEIN: Validity?

13 MEMBER BRADHAM: I was, like, what?
14 Okay. So validity, they did testing, they looked
15 at Tennessee State Early Hearing Detection
16 Information System of 24 audiology facilities and
17 found that 97 of the 3,892 records, which was 2.5
18 percent, were found to have errors, including
19 inconsistent values among diagnosis, diagnostic
20 code, and/or missing values. They did exclude
21 infant death in this measure. There's no
22 information on missing data.

1 CO-CHAIR MERENSTEIN: That's pretty
2 good. Any questions about that? Let's vote on
3 Validity?

4 MS. ROBINSON-ECTOR: Voting on Validity
5 for Measure 1360 is now open. And for those on
6 the call, Option 1 is High, 2 is Moderate, 3 is
7 Low, and 4 is Insufficient.

8 All the votes are in, 57 percent voted
9 High, 43 percent voted Moderate, 0 voted Low, and
10 0 voted Insufficient. So for Validity for
11 Measure 1360, the Measure passes.

12 CO-CHAIR MERENSTEIN: Feasibility?

13 MEMBER BRADHAM: So the feasibility is
14 that the data is collected through the EHDI
15 program. All the data elements are available for
16 the audiologist to report based on the testing
17 that they do. The one comment that I think is
18 worth mentioning here is that all states require
19 that if you've identified a child with hearing
20 loss through Child Prime that they have to report
21 it. So if they do identify hearing loss, it has
22 to be reported at that point. So it's there.

1 They have a mechanism to provide that
2 information.

3 MEMBER STRODE: Who's that reported to?

4 MEMBER BRADHAM: It varies by state.
5 But most states either report it to their
6 Department of Health or their Department of
7 Education. Usually it's in the Department of
8 Education though.

9 CO-CHAIR MERENSTEIN: Any other
10 comments or questions about Feasibility? I guess
11 we'll vote on it.

12 MS. ROBINSON-ECTOR: Voting for
13 Feasibility is now open for Measure 1360. And
14 for those on the call, Option 1 is High, 2 is
15 Moderate, 3 is Low, and 4 is Insufficient.

16 71 percent voted High, 29 percent
17 voted Moderate, 0 voted Low, and 0 voted
18 Insufficient. So for Feasibility, Measure 1360
19 passes.

20 CO-CHAIR MERENSTEIN: Usability?

21 MEMBER BRADHAM: Usability and use,
22 these are publically reported on a lot of the

1 EHDI state websites. The information is
2 available.

3 CO-CHAIR MERENSTEIN: Any comments,
4 questions? We'll vote on this one.

5 MS. ROBINSON-ECTOR: Voting is open for
6 Usability and Use for Measure 1360. Option 1 is
7 High, 2 is Moderate, 3 is Low, and 4 is
8 Insufficient Information.

9 Votes are in, 93 percent voted High,
10 7 percent voted Moderate, 0 voted Low, and 0
11 voted Insufficient Information. So for Usability
12 and Use, Measure 1360 passes.

13 And voting for Recommendation for
14 Overall Suitability for Endorsement for Measure
15 1360 is now open. Option 1 is Yes and Option 2
16 is No.

17 Okay. Looks like we're missing one
18 vote in the room. Thank you. It's still not
19 coming up. I should have 14. It's 13 now? Oh,
20 so we should have 14 votes, yes. So we're
21 missing someone inside the room. There we go.
22 Thank you. Okay, 100 percent voted Yes and 0

1 voted No. So for Recommendation for Overall
2 Suitability for Endorsement for Measure 1360, the
3 Measure passes.

4 CO-CHAIR MERENSTEIN: Okay. Our last
5 intervention. Intervention no later than 6
6 months of age. Developers have anything to add
7 before we start?

8 MR. GAFFNEY: Just that this is the
9 first step in the process is what this is
10 reflecting for those kids that have been
11 identified with a permanent hearing loss, how
12 many are actually getting intervention before 6
13 months, which is the recommended benchmark.

14 CO-CHAIR MERENSTEIN: Okay. Judith,
15 you can start.

16 MEMBER LYNCH: Okay. This is an
17 outgrowth of the past two Measures under
18 consideration. And this will set the proportion
19 of infants with permanent hearing loss who have
20 been enrolled in intervention services no later
21 than 6 months.

22 The evidence is pretty much the same

1 as it was in the previous Measure, the Joint
2 Commission on Infant Hearing Position Statement
3 and a systemic review of the literature on early
4 intervention that looked at 168 studies of
5 various types. The evidence seems to be pretty
6 strong at a Level III. But the big problem that
7 our call had on this was the definition of
8 intervention.

9 CO-CHAIR MERENSTEIN: Yes. I guess
10 we'll get to that more further along. But what
11 about the evidence behind it, you said it's a
12 Level III, you thought?

13 MEMBER LYNCH: Yes. At Level III.

14 CO-CHAIR MERENSTEIN: Jackie, you have
15 anything to add about that?

16 MEMBER YOUDE: No. Nothing to add.

17 CO-CHAIR MERENSTEIN: Any questions or
18 comments about the evidence? So we'll vote on
19 the -- oh sorry, my fault. Tammy?

20 MEMBER BRADHAM: So just a comment on
21 the evidence. A lot of this is based off of
22 Christine Yoshinaga-Itano's research back in the

1 late '90s, early 2000 in which babies that were
2 identified with hearing loss by 6 months of age
3 and started getting intervention were basically
4 on target when they started school for language
5 skills. Whether it was sign language or oral or
6 whatever.

7 So the evidence is there. Mary Pat
8 Moeller also has published on this topic. These
9 have been sample sizes of around 100 children,
10 but it has been replicated in cochlear implant
11 research that once they do get appropriate
12 intervention that these children do make marked
13 improvements in their linguistic and
14 communicative abilities.

15 CO-CHAIR MERENSTEIN: Okay. We're
16 going to vote on the Evidence.

17 MS. ROBINSON-ECTOR: Voting for
18 Evidence for Measure 1361 is now open. Option 1
19 is High, 2 is Moderate, 3 is Low, and 4 is
20 Insufficient Evidence.

21 MEMBER LYNCH: Okay. Oh, I'm sorry.

22 CO-CHAIR MERENSTEIN: Just one second,

1 okay?

2 MS. ROBINSON-ECTOR: Okay. All the
3 votes are in, 57 percent voted High, 43 percent
4 voted Moderate, 0 voted Low, and 0 voted
5 Insufficient. So for Evidence, Measure 1361
6 passes.

7 CO-CHAIR MERENSTEIN: So Judith, on
8 Opportunities for Improvement?

9 MEMBER LYNCH: Yes. This is not so
10 dissimilar from the previous Measure in that the
11 CDC data from 2006 to '12 shows between 66.4
12 percent and 69.1 percent. So it seems as if
13 there is a real need for improvement in this
14 area. As far as disparity data, whites 54.8
15 percent, blacks 51 percent, and Hispanics 52.2
16 percent.

17 MEMBER YOUDE: I'd also like to --

18 CO-CHAIR MERENSTEIN: Jackie?

19 MEMBER YOUDE: -- add to Judith's
20 comments about the average performance being 67
21 percent across the nation that the range is
22 actually 100 percent. So there's incredible

1 variability.

2 MEMBER LYNCH: Absolutely. Thank you.

3 CO-CHAIR MERENSTEIN: Is this
4 variability where there might not be providers to
5 do this? I mean, we think there's rural places
6 where there's no providers to provide this.

7 MR. GAFFNEY: I think some of that
8 variability may be access to services. I think
9 some of it is also, probably a large part,
10 reporting requirements. Privacy regulations can
11 make it difficult for state EHDI programs to
12 confirm from the Part C EI programs and for the
13 Department of Education to confirm if those
14 children referred actually are receiving
15 services.

16 So I think this goes to back to this
17 documented issue again. Data that's being
18 presented here reflects these kids are actually
19 documented to get these services. There's
20 probably a lot more kids getting services due to
21 privacy laws and other things.

22 MR. EICHWALD: And just also, this is

1 again based on state rules and regulations.
2 Eligibility changes by state and so that's
3 probably where we're seeing a lot of the
4 variability.

5 CO-CHAIR MERENSTEIN: Tammy, anything?

6 MEMBER BRADHAM: It does vary by state.
7 Some states if you have a unilateral hearing loss
8 or a mild hearing loss, then you don't qualify
9 for services. And so we're missing those kids
10 and it is very clear in the Joint Commission
11 Statement that these children need to be included
12 in early intervention and so this is definitely
13 an opportunity for improvement.

14 CO-CHAIR MERENSTEIN: Any other
15 questions about -- sorry, Steve?

16 MEMBER STRODE: Do you know why the
17 U.S. Preventative Services Task Force said we're
18 not going to review evidence for this Measure
19 anymore?

20 MEMBER LYNCH: Yes. They considered it
21 outdated.

22 MEMBER STRODE: And didn't have new

1 evidence to review?

2 MEMBER LYNCH: Right.

3 MEMBER BRADHAM: There's just no new,
4 I mean -- babies are being screened. We know
5 that there are consequences if they don't get
6 early identification. There really isn't a lot
7 of new evidence right now.

8 MR. GAFFNEY: If I can just mention one
9 thing. We are currently supporting ongoing
10 research. The findings haven't been published
11 yet, but that is something that's being worked
12 on, being funded.

13 CO-CHAIR MERENSTEIN: Any other
14 questions or comments about Opportunities for
15 Improvement? So we'll vote on that.

16 MS. ROBINSON-ECTOR: Voting is now open
17 for Performance Gap for Measure 1361. For those
18 on the line, Option 1 is High, 2 is Moderate, 3
19 is Low, and 4 is Insufficient.

20 All the votes are in, 79 percent voted
21 High, 21 percent voted Moderate, 0 voted Low, and
22 0 voted Insufficient. So for Performance Gap for

1 Measure 1361, the Measure passes.

2 CO-CHAIR MERENSTEIN: Judith, we're
3 going to talk about Reliability.

4 MEMBER LYNCH: Okay. This is our
5 clinical database registry. And the data is
6 available in Early Hearing Detection and
7 Intervention Information Systems in the states.
8 However, only one state data set was used for
9 validity and that was from January to December
10 2014.

11 CO-CHAIR MERENSTEIN: We're doing
12 Reliability, but yes. Jackie, you have something
13 to add about Reliability?

14 MEMBER YOUDE: Yes. So if we're
15 looking at the numerator and denominator
16 statements, the numerator statement, I have a
17 couple of questions on. Stated as is, "Numerator
18 contains the number of infants born during the
19 time window that have been diagnosed with
20 permanent hearing loss whose age is less than 6
21 months at the time of enrollment into
22 intervention services."

1 I have three questions. One, how are
2 we defining age? Is it chronological age or
3 corrected age? Two, we're saying the time of
4 enrollment. Can we clarify what that means? And
5 three, given that we're looking at the time of
6 enrollment, but the Measure is called
7 "Intervention no later than 6 months of age," can
8 we discuss that slightly?

9 MEMBER LYNCH: You know, I keep coming
10 back to the fact that we don't know what the
11 intervention is.

12 MEMBER BRADHAM: And I would also like
13 to comment on the fact that, what population are
14 you really looking at? Just the Medicaid
15 population?

16 CO-CHAIR MERENSTEIN: So lots of
17 questions for the developers, yes. Maybe one at
18 a time.

19 MR. GAFFNEY: Okay. I'll try to
20 address your question first once again. I
21 believe there was a first for age. Most likely
22 chronological age is what's being addressed at

1 the moment. For enrollment, the definition now,
2 what we consider enrollment is assigned IFSP plan
3 as reported by the state. So that's what we're
4 using as our marker for enrollment. And I
5 believe the third point was, exactly what
6 intervention --

7 MEMBER YOUDE: Yes. So why are we
8 looking at enrollment when the Measure is called
9 "Intervention no later than 6 months of age?"

10 MR. GAFFNEY: To be honest, that's just
11 the way our data collection is set up at the
12 moment, to what the states can report. And using
13 enrollment as, I guess, would imply the beginning
14 of intervention services. And that's what the
15 benchmarks are for ensuring intervention starts
16 by 6 months. So that's why it's set up the way
17 it is at the moment.

18 MEMBER YOUDE: Two more questions
19 following up on that. One, is there any data to
20 tell us the length of time between enrollment
21 status and actual intervention? Two, is there
22 any data to tell us the percent of enrollees that

1 receive intervention?

2 MEMBER LYNCH: I would add to that who
3 is doing the enrollment and how is it collected?

4 MR. GAFFNEY: I'm going to answer this
5 second question first. Enrollment is being
6 reported usually by the intervention program.
7 That's the program that has the IFSP date, so
8 that's usually typically who's reporting back to
9 an EHDI program saying, yes this child is
10 enrolled. So that's who's reporting that back.
11 Does that address the question on the phone?

12 MEMBER LYNCH: Yes.

13 MR. GAFFNEY: Okay. And then --

14 MEMBER LYNCH: But I'm still worried
15 about what the intervention is and nobody is
16 answering that.

17 MR. GAFFNEY: And, I mean, that's a
18 great question. There is variation in what can
19 be considered intervention. Part of the
20 variation is going to be driven by what the
21 parents decide is best, what are they going to go
22 with. And a lot of times that comes down to the

1 parents' decision. Also recommendations from the
2 providers.

3 Also availability of services. I
4 mean, there are definitely difference probably
5 between if you're in a rural area what you have
6 access to, to if you're in a large metropolitan
7 area what services you're going to be able to
8 have. And we are not collecting that specific
9 data right now. But the enrollment in EI is
10 probably the first step towards getting the
11 outcomes on these children. Enrollment, that's
12 the first step in this process.

13 MEMBER YOUDE: So it sounds like we're
14 using the enrollment as a proxy for intervention
15 and I'm still curious if there's any data to tell
16 us the length of time between enrollment status
17 and intervention? Whatever that intervention may
18 be considering that it has to be with the child
19 and not with the parent.

20 MR. GAFFNEY: Right. There's no data
21 that we currently have about the average age
22 between when the IFSP starts and when it's signed

1 and when services begin. Nothing anywhere large
2 scale that we have to report other than --

3 CO-CHAIR MERENSTEIN: Who are you
4 measuring? You're measuring the primary care
5 doctor if they've signed them up for enrollment?
6 Or how do you --

7 MR. GAFFNEY: No. It's the Part C
8 intervention program, they administer the IFSP.
9 So they work with the families and the families
10 actually have to sign the IFSP from how I
11 understand it with the Part C EI programs. It
12 doesn't usually involve the PCP or the medical
13 home at the IFSP stage.

14 MEMBER YOUDE: One other thing that I
15 do have, just speaking on strictly field
16 experience, so if you have data to contradict
17 this, I welcome it because I want to be
18 contradicted. So I have seen families sign an
19 IFSP, I've heard about this IFSP, I've been there
20 for it, but signing it and getting to
21 intervention, I have seen anywhere from days to
22 months to up to a year in terms of actually being

1 enrolled and receiving intervention.

2 And so when I'm looking at the title
3 of this Measure, which is called "Intervention no
4 later than 6 months of age" and we're using a
5 proxy for enrollment by 6 months, but we have no
6 data to tell us the average length of time or any
7 length of time at all between enrollment and
8 intervention, I have a lot of trepidation about
9 that.

10 MR. EICHWALD: The point I'd just like
11 to make is that Part C is available under
12 Department of Education in every state. So
13 that's why we chose this. There are parents that
14 choose to go private, but that's very difficult
15 to capture. And that's not necessarily available
16 in every state.

17 And then the second part of that,
18 since we're using children that are enrolled in a
19 program that is run by the Department of
20 Education, we have different privacy rules than
21 we do in healthcare and that's the FERPA, Family
22 Educational Rights and Privacy Act. And then on

1 top of that, the Part C has their own privacy
2 rules.

3 And so that's part of the reason it's
4 difficult to try to get to that data where you're
5 saying, we've got a signed IFSP, when did that
6 child actually receive the service, what kind of
7 services. And it gets sort of to the duration,
8 length of time.

9 MEMBER YOUDE: Yes. And I know it's
10 difficult to collect. There's a lot of people
11 involved in early intervention. There's a lot of
12 coordination of care going on.

13 And so what I'm wondering then, taking
14 it the next step, that if we can only look at
15 enrollment, but really what the evidence is
16 suggesting is that we need to look at the time of
17 intervention and it needs to be before 6 months
18 of age, chronological or corrected, why not look
19 at claims data and define intervention across the
20 field? So in audiology, it could be time of
21 first fit for cochlear implant or hearing aid.
22 For SLP, it could be time of first therapy

1 appointment. So on and so forth.

2 MR. GAFFNEY: And I'm going to preface
3 my answer by, this may not be a complete answer.
4 What I know on the claims data, we have been
5 working a little bit with claims data, market
6 scan database. Again, I'm not an expert on it.

7 I'm not sure, data may be in there
8 for, like, kids that have been fitted with a
9 cochlear implant, maybe it'll pull billing codes
10 on that, maybe even hearing aid fittings. But
11 for things like speech language therapy, other
12 services like that and the non-medical devices,
13 I'm not sure that's going to show up in the
14 billing codes. It may, but I'm not sure if it
15 will.

16 So that's -- while looking at the
17 billing codes may help with part of this, I'm not
18 sure it would give us a complete picture of how
19 many kids are receiving EI. And especially
20 because some of these services are things a lot
21 of states that are directly provided from the
22 state Part C programs. Again, I'm not sure how

1 that shows up in billing codes when a state
2 Department of Education is providing the
3 services. I'm just not sure how that shows up.
4 So --

5 CO-CHAIR MERENSTEIN: Tammy?

6 MR. GAFFNEY: -- a partial answer.

7 MEMBER BRADHAM: Yes.

8 CO-CHAIR MERENSTEIN: All right. Tammy
9 has a question.

10 MEMBER BRADHAM: So just a -- and I
11 guess this is my professional hat. Do you have
12 any data on disparity or socioeconomic of the
13 children in Part C that are getting those
14 services? Because we do know that a lot of
15 families are electing to go private or they may
16 get a cochlear implant and so they're going to
17 get their intervention services through that
18 program and won't sign up with the Part C
19 program.

20 Or the other thing to keep in mind is
21 that the Joint Commission says that they need to
22 be provided with early intervention services by a

1 qualified provider. Well, Part C, the program,
2 the way it's designed is to be able to help the
3 parent navigate the systems to help the parent
4 understand maybe how to use a hearing aid or to
5 start learning basic sign with the parent. And
6 so it's not necessarily direct intervention per
7 se with the child.

8 Plus some of those early
9 interventionists are people with high school
10 degrees and don't have that expertise in dealing
11 with linguistic and communicative competencies.
12 And so I guess we're kind of pushing back a
13 little bit because the Measure is calling for
14 intervention, but really what we're measuring is
15 just that they've signed the form.

16 MEMBER YOUDE: When I'm looking at --
17 and Tammy, I entirely agree with what you said.
18 When I'm looking at the current state of this
19 Measure, I think it reliably measures the date of
20 enrollment for the Part C population for those
21 who qualify for early intervention.

22 I don't think that it reliably looks

1 at the bigger population and the time of
2 intervention. It doesn't tell us what's going on
3 outside of Part C and it doesn't tell us what the
4 actual time of intervention is and I just have a
5 lot of trepidation around that.

6 MR. EICHWALD: I'd just like to make
7 the point that, I mean, that making legitimate
8 statements here. What we really want to get to
9 is outcome. This is just a process Measure. We
10 recognize that. But it is a standardized process
11 Measure that we can measure in every state.

12 We do want to start looking at the
13 outcomes of these children that have gotten and
14 that's really the direction we want to go. It's
15 just we don't have a measure for that yet. How
16 we define what is intervention? The dosage of
17 the intervention.

18 I've been struggling with that and
19 trying to figure out what -- and I use that word
20 dosage a little, I mean, what's the duration?
21 Who's the provider? How often does it occur?
22 How soon? I mean, so it's something we're still

1 struggling with to try to get to outcomes. We
2 look at this as a process measure.

3 MEMBER YOUDE: And it is and I
4 appreciate all of the thought that has gone into
5 this and I entirely agree with the intent of
6 measuring intervention before 6 months. I
7 entirely agree with wanting to measure outcomes.
8 This may be the first step in getting there. I
9 just don't know that because we're looking at
10 such a specific subset of patients. That said,
11 it's important and if that's what we have data to
12 work with right now, that's really where we're
13 at.

14 MR. GAFFNEY: And if I may just add one
15 thing to that. As John said, I mean, we
16 acknowledge this as a process Measure and there
17 are things that could be done. I do think it
18 represents the place it makes the most sense to
19 start with this. I think it's the best way to
20 start measuring this at the moment based on
21 what's available actually from states. And I
22 could comment, I wish I had the information I

1 could pull off because they are very, very valid
2 questions. And we do have some efforts on the
3 way too that will hopefully help advance that.

4 I will say for the population, while
5 Part C does not properly serve everybody, I think
6 it does serve a large portion of the kids that do
7 have permanent hearing loss. I mean, we've got a
8 pretty captive population there and we look at
9 our data, like, number of kids, if we back out
10 from just number of kids that have a permanent
11 hearing loss and number of kids getting
12 intervention, I mean, it's a lot of kids states
13 are able to document, yes they're getting some
14 type of intervention. So I think it speaks to
15 we're at least getting a lot of the group. And
16 so I would put that out there.

17 CO-CHAIR MERENSTEIN: Josh, you have a
18 question?

19 MEMBER STEIN: For those of us who are
20 not in this field, it sounds like both of you,
21 Jackie and Tammy, have an issue with what the
22 title is and what's being measured are two

1 different things. So I guess the question for
2 you guys is, is what's being measured important?
3 Like, is capturing enrollment or whatever's being
4 measured, is that something useful? If someone's
5 being enrolled, is that important for having
6 intervention?

7 MEMBER STEWART: I mean, I know you're
8 asking them the question. I think that you have
9 to get referred before you can get the
10 intervention, so, I mean, this is one of these
11 stepwise processes. That's a very good point
12 that in fact what we're measuring is referral for
13 intervention, not the actual intervention. But
14 the referral's a necessary step.

15 MEMBER YOUDE: Right. And you have to
16 be enrolled before you can get intervention.
17 That's just part of it. And I would be fine
18 using enrollment as a proxy for intervention if I
19 knew how long it takes from enrollment to first
20 treatment. And that date is not available at
21 this point in time. And based on experience, so
22 this is anecdotal, I have seen it vary from days

1 to months to over a year. And I just -- that
2 really just kind of makes me hesitate.

3 MEMBER STEIN: So would you guys feel
4 comfortable with this Measure if the title was
5 just changed to reflect what's actually being
6 captured?

7 MEMBER YOUDE: I think that we would
8 need to go and change the month as well to kind
9 of accommodate for that lag time or the lead time
10 to actually getting intervention. So if we were
11 to change it to "Enrollment no later than 4
12 months of age," I'd feel pretty good about that.

13 Because then I have a two month buffer
14 and in my professional opinion, if we've
15 identified the hearing loss at age 3 months, the
16 enrollment form should be sent at that point in
17 time, during that appointment. So technically,
18 we should have a three month period of time for
19 that intervention to start, but given that life
20 happens, I would be fine having "Enrollment
21 status no later than 4 months of age."

22 MEMBER BRADHAM: I'm going to push back

1 a little bit there though, Jackie. Because Mary
2 Pat Moeller's research shows by 11 months of age
3 that they were enrolled in early intervention and
4 Yoshinaga-Itano's research shows that they were
5 identified by 6 months.

6 So even if it could be considered that
7 "Enrolled in intervention no later than 6 months
8 of age," I would be fine with that. I think the
9 enroll intervention would be key there. If we're
10 going to measure intervention, then I think we
11 need to look at numerator and denominator.

12 MEMBER YOUDE: And I appreciate the
13 push back, because I really love spirited
14 conversation. That said, those two studies I'm
15 sure were accounted for in the systematic review
16 that was presented in this evidence which was
17 rated as High and passed.

18 And so given that the evidence
19 presented up front suggests that intervention no
20 later 6 months of age is the best practice or is
21 necessary to have the best outcomes, I appreciate
22 those two studies, but I'm going to put them in

1 the bigger context of the evidence presented.

2 CO-CHAIR MERENSTEIN: Any other
3 questions or comments?

4 MEMBER FRIEDMAN: Again from a
5 layperson, the Measure's not perfect, but at
6 least it's a start. And based on what I've
7 heard, I think it's a reasonable thing to do.
8 Obviously, if they're not referred, it's a moot
9 point. Now, you can go -- the intervention may
10 be inappropriate too and we're not commenting on
11 that.

12 So just because they're getting
13 intervention doesn't mean that you're actually
14 ultimately helping the patient as well. But it's
15 a start and based limited what their capability
16 of doing, this is what they're trying to measure
17 and I think it's a good starting point.

18 MEMBER YOUDE: I agree with you. It's
19 a great starting point. It's not perfect, but it
20 is what we're working with. At the same time, to
21 be consistent with the evidence and we have had
22 that conversation about intervention, I just get

1 nervous that we're looking at a form.

2 We're measuring has the form been
3 filled out? Has the form been filled out by 6
4 months of age? If the form was filled out, what
5 happened after that? And we don't know. So to
6 me, this looks like we're measuring a form or
7 administration.

8 MEMBER FRIEDMAN: So, we've been saying
9 that for the last two days. We've been saying
10 that for the last two days constantly. Well,
11 does it make a difference? I have no idea.
12 Referral, does it make a difference? I have no
13 idea. We don't know. But at least it's a start.
14 I mean, if you don't even do that step, you know
15 they're not going to get better, in theory. But
16 we have to start at some point.

17 CO-CHAIR MERENSTEIN: Josh and then
18 Tammy.

19 MEMBER BRADHAM: This is Tammy and I
20 just want to add one piece to it and then I'll be
21 quiet, I promise. Is that the issue is the
22 consumer perspective, the parent perspective, the

1 conversations that I've had with them.

2 Because they're talking about
3 intervention no later than 6 months of age and
4 they're just now getting that phone call from the
5 Part C provider so they can get that form signed,
6 but then they find out it's going to take them
7 six months before they can get their hearing aid.
8 And then it's going to take another three months
9 to start their intervention because they don't
10 like to start speech therapy until they're 12
11 months of age.

12 And so that's where the issue is, is
13 when I'm based with that family and they're going
14 with the state program and that's how the state
15 program works. And so this metric needs to
16 reflect intervention by 6 months of age so I can
17 make sure that, that child gets their hearing aid
18 or gets with the speech pathologist or that deaf
19 mentor or enrolled in a sign language class by 6
20 months of age. That's why this is such a hot
21 thing.

22 MEMBER YOUDE: I agree with Tammy.

1 MEMBER FRIEDMAN: So basically what
2 you've told us is that based on the way it's
3 written here, they're not doing that? And so
4 that's pretty obvious, we vote it down. Because
5 they're not doing what they're saying they're
6 doing. They're just referring within six months,
7 but they may not get intervention at all. And
8 they're not capturing the data. Is that correct?

9 CO-CHAIR MERENSTEIN: Josh?

10 MEMBER STEIN: I just wanted to, I
11 guess, follow up on that. I mean, I think it
12 sounds like from -- as we're pretty much lay in
13 this, that the issue is with the wording and that
14 it may be misleading to consumers and to other
15 groups that an intervention was performed. So
16 certainly the title and probably some of the
17 content needs to be modified to better reflect
18 what's actually going on.

19 MEMBER STEWART: And I think we're --
20 with all the passion and argument about how this
21 is not happening, we're in danger of losing this
22 quality Measure, because of all this discussion.

1 I mean, is that really what we want to do here?

2 MEMBER STEIN: This came up earlier, I
3 think there's a post discussion period where they
4 could make some changes very quickly and get it
5 in the right format and then probably approved.

6 CO-CHAIR MERENSTEIN: It seems like to
7 me that if we changed the title, we would be okay
8 with it. I mean, because I sort of agree that
9 it's not fair for a state to say they're doing
10 this if they're not really giving interventions
11 till a year. But if they are enrolling, they
12 should get credit for that. And so it seems like
13 to me it's a title issue more than a --

14 MEMBER YOUDE: I think there's --

15 CO-CHAIR MERENSTEIN: -- a general --

16 MEMBER YOUDE: I think there's a couple
17 of issues. One, you're spot on. There's really
18 solid methodology behind measuring the enrollment
19 for this population. We can measure the
20 enrollment.

21 I think the issue that Tammy brought
22 up earlier though is that the evidence is

1 pointing towards intervention. And kind of going
2 back to what Micky was saying, we have to start
3 somewhere. We know this is important. Is it
4 perfect? No, not in my opinion.

5 But I also don't want to lose what is
6 possible because if we're not going to measure it
7 and we can look into the validity here in just a
8 little bit. But we don't want to lose those
9 patients. We don't want people being like, oh
10 no, I don't have to fill out a form in time,
11 nobody's going to hold me accountable, so I'm not
12 going to do it until I have the time to do it and
13 nobody ever has time. And so I don't want to
14 lose what we've got. But I also know that
15 there's some caveats here, in that we're not
16 really measuring intervention.

17 MEMBER GOLDBERG: It seems that we
18 really have a separate performance Measure that
19 needs to be developed and that is time from
20 enrollment to time from the intervention. And
21 so, I mean, we're looking at enrollment and
22 calling it intervention. So maybe the title

1 should be changed.

2 MEMBER YOUDE: If we could --

3 CO-CHAIR MERENSTEIN: Before --

4 MEMBER YOUDE: -- change the title and
5 then start measuring time of enrollment to time
6 of first intervention, whatever that intervention
7 may actually be as long as it's with the child
8 and not with the parent, that would be two very
9 interesting ways to do it.

10 CO-CHAIR MERENSTEIN: Yes. Although I
11 don't think we can vote on that. I mean, they
12 don't know how to measure the intervention yet.
13 But they know how to measure the enrollment so
14 they could change the title. Anybody else have
15 anything to say before we vote?

16 MEMBER LYNCH: So we're going to vote
17 on the Reliability as it is now, not what the
18 outcome should be in the future, correct?

19 CO-CHAIR MERENSTEIN: I think we have
20 to, yes.

21 MEMBER LYNCH: Okay.

22 MEMBER STEIN: So just to clarify, if

1 the developers are comfortable changing the
2 title, we still have to vote it down so they can
3 change the title to bring it back up? Or can
4 they say that now and then we can --

5 DR. WINKLER: No. If --

6 MEMBER STEIN: -- vote on it?

7 DR. WINKLER: -- they're willing to
8 entertain that, that's a suggestion that they
9 could follow up with.

10 MR. GAFFNEY: And just to clarify,
11 we're definitely willing to entertain that.

12 CO-CHAIR MERENSTEIN: Let's vote on it,
13 on the Reliability.

14 MEMBER YOUDE: Just to make sure I'm
15 clear. So the developers have said they're
16 willing to entertain changing the title. So we
17 are voting on the Reliability with a possible
18 suggested title change?

19 DR. WINKLER: Keep in mind the title
20 does not reflect your specifications. The
21 Reliability is about how the Measure's
22 implemented with those specifications. So the

1 title is important in terms of messaging and
2 communication, but it does not drive the
3 specifications of the Measure. So keep those two
4 things separate.

5 CO-CHAIR MERENSTEIN: All right. We're
6 going to vote the Reliability of the Measure,
7 enrollment.

8 MS. LUONG: I think Judith has a
9 question.

10 CO-CHAIR MERENSTEIN: Judith?

11 MEMBER LYNCH: No. I'm still confused
12 about what the voting will mean. So if we vote
13 down Reliability, does that mean that we have to
14 throw it out or is this not a specific one that
15 has to be passed?

16 CO-CHAIR MERENSTEIN: No. It would be
17 thrown out then. The Measure would be thrown
18 out. Micky?

19 MEMBER STEWART: And just to clarify
20 further, it actually says in the Measure,
21 "enrolled in intervention." So we're just
22 suggesting that the title should reflect what it

1 says in the Measure.

2 MEMBER LYNCH: Right, okay.

3 MS. ROBINSON-ECTOR: Voting is now open
4 for Reliability for Measure 1361. Option 1 is
5 High, Option 2 is Moderate, 3 is Low, and 4 is
6 Insufficient.

7 Okay. All the votes are in, 7 percent
8 voted High, 79 percent voted Moderate, 14 percent
9 voted Low, and 0 voted Insufficient. So for
10 Reliability for Measure 1361, the Measure passes.

11 CO-CHAIR MERENSTEIN: Judith, we're
12 going to talk about Validity.

13 MEMBER LYNCH: Okay. The Measure was
14 tested on our clinical database registry. As I
15 said before, one state EHDI dataset from January
16 '14 to December '14 was done and data from the
17 2012 TDCJ Screening Hearing and Follow-up Survey
18 was done to test the ability to identify
19 different. In 2014, 25 out of 74 records or 33.8
20 were found to have inconsistencies between the
21 diagnosis code and the enrollment status.

22 In other words, the diagnosis code

1 indicated the patient does not have hearing loss,
2 but the enrollment status is "Yes." In addition,
3 19 records had inconsistencies or missing
4 information was found by comparing information
5 between the state EHDI with the other system,
6 which is the Tennessee Patient Tracking Billing
7 Management Information System. So it looks like
8 there may be some issues with validity. And I
9 think, Jackie, was this where you had some
10 problems with all the coding?

11 MEMBER YOUDE: You know, when we were
12 first on the call, we did have some problems with
13 coding. But the developers have since updated it
14 and there's no problems with the codes anymore.

15 MEMBER LYNCH: Good.

16 MEMBER YOUDE: Also, adding to that, I
17 know we say there are some problems with validity
18 and I think it is worth noting that those 25 of
19 the 74 or the 34 percent of the records that had
20 some inconsistencies between diagnosis codes and
21 enrollment status make sense. Because kids can
22 be referred for EI and still have normal hearing

1 for any other diagnosis code.

2 That said, of the 49 records of those
3 who actually do in fact have hearing loss, there
4 was 19 records or 26 records that had
5 inconsistencies, leaving 30 records that were
6 valid, or 61 percent of those 49 records with
7 permanent hearing loss. So when I looked at
8 that, I said, okay well that's 2014 and I'm not
9 really sure how many kids in 2014 were diagnosed
10 with permanent hearing loss.

11 What I do see is going against the
12 records referred for EI, but I don't see it into
13 the bigger context of the picture for the state
14 of Tennessee and I was wondering, do you guys
15 have any information on that?

16 MR. GAFFNEY: You mean, overall
17 identified in Tennessee?

18 MEMBER YOUDE: With permanent hearing
19 loss in Tennessee in 2014.

20 MR. GAFFNEY: No. We have 2013, we do
21 not have 2014 yet. We run about two years behind
22 in our usual collection.

1 MEMBER YOUDE: So because we saw that
2 the 25 of the 74 had inconsistencies between
3 diagnosis code, meaning that they were referred
4 but they had normal hearing because they had some
5 other diagnosis going on, is there any mechanism
6 in place to make sure that the work between EHDI
7 and EI is solid so that we aren't having any of
8 those variables accounted for in the process
9 metric?

10 MR. GAFFNEY: On a state by state
11 level, I mean, there are different procedures in
12 place. And I'll say, I think some states do a
13 better job than others with their linkage with EI
14 and the type of working relationship they have.
15 Some have data sharing agreements in place that
16 make it a lot easier to check the completeness
17 and the accuracy of the data, but there is some
18 variation.

19 MEMBER YOUDE: Thank you.

20 CO-CHAIR MERENSTEIN: So just can you
21 -- I mean, it seems like to me there's a lot of
22 errors in the data. Am I missing something here?

1 Any other questions about Validity?

2 CO-CHAIR YAREMCHUK: I guess this is a
3 question about a two year lag and my question is
4 why does it take two years?

5 MR. GAFFNEY: It takes two years based
6 on the way we collect the data. Main reason is,
7 take for example a child born in December of
8 2014, end of the calendar year. We want to give
9 them a year to get through the EHDI process,
10 screening, diagnostic, and intervention. To get
11 through the process before the state reports that
12 data to us.

13 So in 2016, we're going to go back --
14 January 2016, we'll go back and collect 2014 data
15 because that will give all those kids born in
16 December of that end of the year, at least a year
17 to work through the EHDI process. So it's very
18 deliberate on our part because we want to try to
19 get the most complete data and make sure kids
20 have had time to go through the process.

21 CO-CHAIR YAREMCHUK: Is this a rolling
22 year or do you do it by calendar year?

1 MR. GAFFNEY: By calendar year.

2 CO-CHAIR YAREMCHUK: And I guess that's
3 a question in and of itself, why you would do
4 that as opposed to a rolling.

5 MR. GAFFNEY: To be honest, we found
6 the calendar year has worked best for us for ease
7 of reporting for the states, for reporting the
8 data out for comparison sakes. States are able
9 to do an update mid-year to the day-to-day
10 reported if for some reason they come with some
11 corrections. But that is the process we've been
12 using since we started collecting data several
13 years ago.

14 MR. EICHWALD: I'd just like to point
15 out that, so the child born in December will be 1
16 year of age. It's that child that was born in
17 January of that year, will be 2 years of age.
18 And so we have to have that two year delay.

19 CO-CHAIR MERENSTEIN: Any other
20 comments, questions on Validity before we vote?
21 We're going to vote.

22 MS. ROBINSON-ECTOR: Voting is now open

1 for Validity for Measure 1361. Option 1 is High,
2 2 is Moderate, 3 is Low, and 4 is Insufficient.

3 All the votes are in, 0 voted High, 79
4 voted Moderate, 21 voted Low, and 0 voted
5 Insufficient. So for Validity for Measure 1361,
6 the Measure passes.

7 CO-CHAIR MERENSTEIN: Judith,
8 Feasibility please?

9 MEMBER LYNCH: Feasibility. Hospitals
10 and practices provide data to the state who in
11 turn upload the data. Many states still use
12 faxes and then these are turned into electronic
13 forms. This other data system may lead to errors
14 in reporting as well as manual data entry and
15 inconsistencies on measures collected.

16 CO-CHAIR MERENSTEIN: Jackie?

17 MEMBER YOUDE: I have nothing to add.
18 She did a great job.

19 CO-CHAIR MERENSTEIN: Okay. Any
20 questions about Feasibility? Comments? We'll
21 vote on that.

22 MS. ROBINSON-ECTOR: Voting for

1 Feasibility is now open for Measure 1361. Option
2 1 is High, 2 is Moderate, 3 is Low, and 4 is
3 Insufficient.

4 All the votes are in, 21 percent voted
5 High, 71 percent voted Moderate, 7 percent voted
6 Low, and 0 voted Insufficient. So for
7 Feasibility for Measure 1361, the Measure passes.

8 MEMBER LYNCH: Okay. And finally,
9 Usability and Use. This is electronic data which
10 is reported by the CDC, so I don't think there's
11 probably very much of a problem with usability.

12 CO-CHAIR MERENSTEIN: Jackie?

13 MEMBER YOUDE: Nothing to add, Tammy?

14 CO-CHAIR MERENSTEIN: Reva?

15 DR. WINKLER: Yes. I just have one
16 question. This Measure takes us out of the realm
17 of very clearly who's being measured. So it's
18 clear that we measure this at the state, but who
19 else, level of analysis, who else is really being
20 measured by this Measure?

21 Are there specific providers that get
22 a percent performance? Facilities? Health

1 plans? Who actually is being measured? Or is it
2 really something that is done at the state level?
3 Which is fine, it's a population health measure
4 and that's acceptable, but I think it's important
5 to know who actually is being measured by this
6 Measure.

7 MEMBER BRADHAM: We are measuring the
8 Part C service coordinator.

9 MEMBER LYNCH: Right.

10 MR. GAFFNEY: Which we think, it is the
11 state level, that's what's being measured. The
12 state.

13 DR. WINKLER: So it's state.

14 CO-CHAIR MERENSTEIN: Any other
15 comments, questions about that? All right.
16 We're going to vote on that then.

17 MS. ROBINSON-ECTOR: Voting is now open
18 for Usability and Use for Measure 1361. Option 1
19 is High, 2 is Moderate, 3 is Low, and 4 is
20 Insufficient Information.

21 All the votes are in, 50 percent voted
22 High, 50 percent voted Moderate, 0 voted Low, and

1 0 voted Insufficient Information. So for
2 Usability and Use for Measure 1361, the Measure
3 passes.

4 And we are now opening voting for
5 Recommendation for Overall Suitability for
6 Endorsement for Measure 1361. Option 1 is Yes
7 and Option 2 is No.

8 MS. LUONG: Judith, can you resend me
9 a vote? It's a blank in the email. Thanks.

10 MEMBER LYNCH: Oh, I'm sorry.

11 MS. LUONG: It's okay. Thank you.

12 MEMBER LYNCH: You got it?

13 MS. LUONG: Yes.

14 MEMBER LYNCH: Okay.

15 MS. ROBINSON-ECTOR: All the votes are
16 in, 93 percent voted Yes and 7 percent voted No.
17 So for Recommendation for Overall Suitability for
18 Endorsement for Measure 1361, the Measure passes.

19 CO-CHAIR MERENSTEIN: Just to clarify,
20 will they come back to us at the next call or
21 something with the change in the title or how is
22 that going to work?

1 DR. WINKLER: You can let us know if
2 you want to retitle it.

3 MR. EICHWALD: I'd like to actually
4 work with the some of the members of the panel to
5 make sure that we've got consensus here. I was
6 just thinking that perhaps we change to something
7 that -- and we'll work on this, "Proportion of
8 infants with permanent hearing loss who have a
9 signed IFSP no later than 6 months of age." At
10 least that would be a cleaner title. But I'd
11 rather just get consensus from those involved.

12 DR. WINKLER: I think we can work with
13 them to work with the involved, passionate
14 members of the Committee.

15 MR. EICHWALD: That's one thing that
16 I've learned, is that we have passionate people
17 involved. I mean, that makes life much more
18 enjoyable.

19 DR. WINKLER: Okay. Thank you all very
20 much. Well, that's the end of the measures that
21 we have to evaluate.

22 We've got a little bit more time

1 before we're due to close. And an important
2 thing that I'd ask you to do is to reflect on the
3 measures we've looked at that are in this
4 portfolio. And I know we've got two very
5 distinct areas, in eye care and ENT, but from
6 sort of a close-in perspective right now, we'd
7 love your input and feedback on where you see
8 opportunities within the topic area for, you
9 know, newer measures.

10 Where is the next wave of measures?
11 Are there topic areas that haven't been
12 considered or measured? Are there types of
13 measures? You know, we may have a lot of process
14 measures. Are there opportunities for outcome
15 measures or patient-reported outcome measures?

16 So, in eye care measures, I think, you
17 know, we saw in four different conditions as well
18 as screening for children. As you were thinking
19 about the measures, for the eye care folks, are
20 there any real gaps in the work you do where
21 quality problems are a problem that you think,
22 you know, might be fruitful areas for new

1 measures? Todd?

2 MEMBER RAMBASEK: I asked this question
3 at dinner last night and someone suggested I
4 bring it up here, but antibiotics for viral upper
5 respiratory infections. Meaning, not
6 prescribing. I don't know if that's in a primary
7 care portfolio already.

8 DR. WINKLER: It is. We do have the
9 appropriate use, or inappropriate use of
10 antibiotics in kids with upper respiratory
11 infection. I'd have to go see if it's kids or
12 adults.

13 MEMBER RAMBASEK: And adults?

14 DR. WINKLER: Yeah, I have to go see
15 that. That's a good question.

16 CO-CHAIR MERENSTEIN: For the eye one,
17 I think we talked about that maybe someone needs
18 to look if there's evidence -- maybe unless you
19 know there's not -- that there should be an eye
20 exam by a professional in ophthalmology or
21 optometry before age 5.

22 They have that in dentistry now,

1 that's a recommendation, and I think probably the
2 evidence is as good probably for the eye doctors.
3 So, some group needs to look into that and make
4 it a measure, I think. Unless the evidence is
5 not there, I don't know.

6 MEMBER YOUDE: Tammy and I had a pretty
7 good discussion about this yesterday as well. Do
8 you want to share your thoughts on what we can
9 with adult hearing aid or adult amplification
10 quality measures?

11 MEMBER BRADHAM: I was actually
12 thinking pediatrics or adults, reliability of the
13 hearing aid fittings. There are some metrics
14 that are out there that can be used. Some
15 research that's coming out of a multi-center
16 study has shown that children with mild to severe
17 hearing loss, a lot of them are being actually
18 underfit with amplification. And so having some
19 type of an outcome measure that children are
20 being appropriately fit would be good.

21 I know that our association has talked
22 about vestibular metrics that they want to have

1 some discussions about. And then I'm also
2 curious about the ANOM system that ASTRA has
3 developed, is that something for an opportunity
4 for NQF to review?

5 MEMBER STEIN: So, would the IRIS
6 registry now becoming available that's capturing
7 care by most ophthalmologists, I think that in
8 the near future we will have opportunities to
9 look at outcome measures in ophthalmology a lot
10 more easily. Information that's captured a lot
11 better than in claims.

12 So, also, with the new staging systems
13 for glaucoma severity, one can look at levels of
14 eye pressure for patients with different
15 severities of glaucoma. Yesterday, someone asked
16 about visual field. That would be a process
17 measure, but that's an important measure of
18 assessing the status of someone's glaucoma. So I
19 think there are a number of different measures
20 that can be done in ophthalmology's sphere.

21 CO-CHAIR MERENSTEIN: Steve?

22 MEMBER STRODE: We've talked in a

1 number of these measures about referral, did the
2 evaluation actually take place as an appropriate
3 intervention? And I think it would be a next
4 step in process measures, given that our health
5 care system is not becoming any more simple for
6 the consumer. And that we're also moving to
7 health systems, then I would expect that that
8 data might help drive those systems to the idea
9 of the patient navigator who could help somebody
10 get through all the confusion, to ultimately get
11 what's needed for the good outcome.

12 MEMBER STEIN: One thing that I noticed
13 in us going through all these measures, it looks
14 like the folks who are writing the guidelines for
15 ENT have developed guidelines capturing, you
16 know, flagging inappropriate use. I mean, almost
17 all the guidelines that are in the portfolio.
18 Whereas, in ophthalmology, it's trying to capture
19 appropriate or quality use. So I think that
20 there may be opportunities for some of the eye
21 guidelines to capture inappropriate use and for
22 the ENT to capture quality or appropriate use.

1 CO-CHAIR MERENSTEIN: Scott?

2 MEMBER FRIEDMAN: So, just to embellish
3 on that, the Academy, I've been on a couple of
4 meetings and groups where we did talk about
5 overuse, which is a big deal with the NQF, as you
6 know. For example, inappropriate use of glaucoma
7 drops for people that don't have glaucoma, is one
8 example. So I think that is something that we
9 will look at in the future.

10 Also, composite measures for
11 ophthalmology, for example. So, we do a
12 referral. Well, did the referral actually take
13 place? Did the referring doctor receive the
14 referral? Did he change the treatment and did
15 it affect the outcome? That could be something
16 that we can look at.

17 Also, you have on this list cost and
18 resource use measures. So, we're gathering data
19 for treating a disease. We can treat it with a
20 Drug A, which is very cheap, or Drug B, which is
21 very expensive. And when you look at efficiency
22 measures, are we getting our bang for our buck?

1 If we give them a more expensive drug, is the
2 outcome much better? Is it significantly better
3 to justify the cost? Those are things that we
4 can also start looking at as well.

5 MEMBER BRADHAM: And I wanted to
6 suggest maybe a late talker for speech. Because
7 that can be indicative of a progressive hearing
8 loss or multiple things.

9 DR. WINKLER: I wanted to ask some of
10 the otolaryngologists, the measures for adults --
11 and there really isn't even many for adults --
12 it's really limited to ear infections. I mean,
13 what are the other big topics you guys take care
14 of that might be fruitful areas?

15 CO-CHAIR YAREMCHUK: I mean, one is
16 also sinus. And that kind of crosses lots of
17 different specialties. And I think it also goes
18 to appropriate and inappropriate use,
19 overutilization, underutilization. It has
20 imaging. It has antibiotics. And I think that
21 that would get to some of the things that you
22 talked about.

1 And then I think there's another thing
2 that came up, and I can't remember if it was -- I
3 think it was New England Journal of Medicine
4 about the Choosing Wisely Campaign, which a lot
5 of specialties have paid attention to. But what
6 they dinged ENTs specifically about, and I'm
7 going to say orthopedics as well, is surgical
8 procedures, and I think you mentioned it, on
9 cataracts. You know, are you doing cataracts too
10 early? And are there guidelines in terms of
11 appropriateness for certain procedures? That
12 kind of thing. And so I think that that's
13 something that I think would have some value to
14 look at.

15 MEMBER STEWART: Yeah, I complete
16 agree, sinusitis is one that's not represented
17 well. One of the big problems with sinusitis is
18 that there's not any FDA -- all antibiotics we
19 use for sinusitis are off-label for chronic
20 sinusitis because the FDA cannot agree on what is
21 the definition of chronic sinusitis.

22 So we have a definitional diagnosis

1 problem in these conditions. Is it inflammatory?
2 Is it infectious? How do you prove it? For how
3 long? Et cetera.

4 So, one of the problems I think we
5 have in sinusitis, and one of the reasons it has
6 not leant itself well to guidelines, is because
7 we don't have an absolute measure of who has it
8 and who doesn't. But clearly it's a prevalent
9 problem where there is controversy, overuse,
10 unnecessary surgery, overuse of antibiotics, et
11 cetera.

12 CO-CHAIR YAREMCHUK: I think it's also
13 the issue of imaging. And so I think acute
14 sinusitis and the issue of viral versus bacterial
15 in the guidelines is addressed. Chronic
16 sinusitis and the appropriate diagnosis of
17 chronic sinusitis and treatment is, I'm going to
18 say, a separate issue. But acute sinusitis, I
19 think there's some good information about that.

20 And then there's a recent tonsillitis
21 guideline as well. And I think if we take to
22 heart the article, I think was New England

1 Journal of Medicine, regarding appropriateness of
2 surgical procedures, the tonsillectomy guideline
3 kind of gets to that. And that would be an
4 appropriate one to look at in terms of
5 overutilization.

6 CO-CHAIR MERENSTEIN: When you're
7 talking about acute sinusitis, though, there's
8 new ENT guidelines. They recommend it's about
9 two to ten percent bacterial, and if you look at
10 the data, over 90 percent of the time antibiotics
11 are prescribed. So acute sinusitis is a really
12 big issue.

13 MEMBER STEWART: Acute would be easier
14 to do, there's no doubt about it. And you're
15 right, we have a guideline on that.

16 CO-CHAIR YAREMCHUK: And that one just
17 came out and that was recently updated. So there
18 have been a guideline, and I think it was four
19 years ago, it was recently updated. Clearly,
20 acute sinusitis there's more agreement, more
21 studies, more information about that versus
22 chronic sinusitis.

1 MEMBER RAMBASEK: I hear what you're
2 saying about chronic sinusitis, and that there
3 are no drugs of any kind, especially antibiotics,
4 approved for it. But I don't see how that makes
5 it difficult to lend it to a guideline. It just
6 seems that "antibiotics should not be used for
7 chronic sinusitis" would be an easy and helpful
8 guideline. Is that --

9 MEMBER STEWART: You'd have to define
10 what chronic sinusitis is. Is that the presence
11 of symptoms for three months? Is it a CT scan?
12 Is it endoscopy? I mean, if you're going to have
13 a guideline, you've got to have entry criteria,
14 that's the problem.

15 MEMBER RAMBASEK: Either one.

16 MEMBER STEWART: Yeah.

17 CO-CHAIR YAREMCHUK: But, I mean, I
18 think the current guideline does say symptom more
19 than 12 weeks. And so they have defined the
20 diagnosis of what falls into that bucket of
21 chronic sinusitis going forward. So I think
22 those are all opportunities.

1 And I think also the issue of imaging
2 is a problem, mostly because there's more and
3 more evidence coming out about over-radiation and
4 experience over a lifetime experiencing it. And
5 I didn't realize this, but there's something
6 going on with, quote-unquote, the epidemic of
7 thyroid surgery. And the question is, there is
8 some evidence that relates that to CT scans. And
9 we always think, "Oh, it's only one CT scan," but
10 over a lifetime, the dental, the CT and the
11 others start to add up and that may be
12 contributing to thyroid cancer.

13 MEMBER RAMBASEK: I have seen overuse
14 of it as well, especially in children.

15 CO-CHAIR MERENSTEIN: The one other
16 thing I would add is the ENT people seemed upset
17 that we did not vote for their steroids for
18 serous otitis, but if you look into viral
19 pharyngitis, I think it's probably a much higher
20 rate of steroid use than on serous otitis.

21 MEMBER STRODE: Is there a problem
22 with inappropriate prescribing of hearing aids

1 for adults? And if somebody's paying out-of-
2 pocket, that's their privilege. But if your
3 health plan or the feds are paying for it, then
4 it becomes a different issue. Is that an issue
5 or not?

6 CO-CHAIR YAREMCHUK: I mean, I'm only
7 going to say hearing aids aren't a covered
8 benefit for Medicare. So they don't pay for
9 hearing aids. I don't think they pay for glasses
10 either, do they?

11 MEMBER YOUDE: I like where you're
12 going with the hearing aid discussion. There is
13 a big difference in care between those who -- or
14 not difference in care, sorry -- a difference
15 between those insurances that pay for hearing
16 aids and those who pay out-of-pocket on the rates
17 of people getting hearing aids.

18 So, people with insurance typically
19 get the hearing aid, it's paid for, no big deal.
20 But when you are out-of-pocket, it becomes a is
21 this absolutely a necessity to do? If it's not a
22 necessity, it could be perceived as a luxury

1 because these are not inexpensive devices.

2 And I would actually take a different
3 angle on it, saying let's look at the care being
4 -- or not the care, but the fit of the hearing
5 aid rather than the prevalence, if you will,
6 between the two different populations, where some
7 audiologists do real ear measures on a fitting,
8 others will be just like, "Hey, do you think this
9 sounds good? Are you hearing better?"

10 And so there's a huge difference where
11 best practice indicates that you should always be
12 doing real ear at first fit. And so it goes
13 along with what Tammy was saying where let's
14 perhaps put in a process metric where we're
15 saying -- a very simple one, best practice
16 indicates real ear should be done at all first
17 fits for all adults unless there's some sort of
18 pathology going on where you can't actually get
19 the hearing aid in the ear, in which case you'd
20 be doing a BAHA or something else.

21 But is real ear being done or not?
22 And then we can start there and then we can build

1 off of that saying, "Okay, is it to target? If
2 it's not to target, why?" And start building off
3 that, much like we're building off of the IFSP
4 enrollment status.

5 MEMBER STRODE: So do I understand that
6 as doing some audiological testing at that
7 fitting and not just, "Gee, you're better now
8 that you've got that stuck in your ear?"

9 MEMBER YOUDE: It's not necessarily
10 audiologic testing. When I hear audiologic
11 testing, I think of like a hearing test, you
12 know, "Raise your hand," that type of thing.
13 When I'm thinking of real ear testing, what we're
14 actually doing is putting a probe mic in the ear
15 and we're fitting the hearing aid to
16 prescription, if you will. And so we're
17 inputting the hearing test and then we're
18 measuring the output of the hearing aid to make
19 sure the output matches the appropriate
20 amplification for that hearing loss.

21 CO-CHAIR MERENSTEIN: Judith, do you
22 have a comment?

1 MEMBER LYNCH: No.

2 CO-CHAIR MERENSTEIN: All right. Josh?

3 MEMBER STEIN: For the ENT folks in
4 the audience, are there any surgical procedures
5 that might lend itself well to quality measures?
6 Or any reason why there aren't any that are
7 either being proposed or under consideration?

8 MEMBER GOLDBERG: Stapedectomy has
9 been held up as one. Once upon a time, most
10 otolaryngologists were trained to do ear surgery,
11 including stapedectomy, and now it appears that
12 only otolaryngologists who have done otology
13 fellowships should be doing them. And the
14 outcomes from those cases could be measured.

15 CO-CHAIR YAREMCHUK: I mean, I think
16 tonsillelectomy would be one. And I think tubes
17 would be the other one that could be measured.
18 And I think we'd get a large number of providers
19 within ENT that do that.

20 MEMBER STEWART: And sinus surgery.
21 Getting beyond the indications with
22 complications, appropriateness.

1 MEMBER GOLDBERG: Especially
2 appropriateness.

3 CO-CHAIR MERENSTEIN: Andrew, any
4 comment?

5 MEMBER SCHACHAT: I was going to ask
6 if there are crisp, agreed-to outcome measures
7 for those surgeries?

8 CO-CHAIR YAREMCHUK: I think it's more
9 based on indications in terms of tubes and for
10 tonsils. When Micky's talking about sinus
11 surgery, I think it's return to operating room,
12 30 days. And the one thing we didn't talk about
13 it, and we've kind of, but is the issue of
14 patient satisfaction or shared decisionmaking or
15 that kind of thing.

16 How many people that have sinus
17 surgery are happy afterward? Because there's a
18 whole lot of it going around, and I don't know if
19 you see, but I see patients back that go, "I
20 didn't get any better. I don't feel any
21 different." And so I think there's two parts.
22 Are you operating on the X-ray? Are you

1 operating on the patient? And does the patient
2 feel better afterward?

3 MEMBER GOLDBERG: And patient-reported
4 outcomes are very important.

5 DR. WINKLER: I have pages, so, thank
6 you. We should be able to write something very
7 nice about it. So, we do appreciate it. And we
8 do look forward.

9 So, the other ask I have of you is,
10 wherever you're out there in your home, think
11 about how your practice may be being measured.
12 Are there measures being used in your realm that
13 potentially is something that could be a measure
14 that could be more broadly applicable and rise up
15 to a national level that could augment this
16 portfolio?

17 As I say, one of your roles on the
18 Committee is to oversee this portfolio. And so
19 it's not just what's in it, but also help us
20 solicit and drive the things that should be in
21 it. And so those sorts of feedback and input is
22 very valuable. And your discussions with your

1 colleagues and what's going on in your world can
2 help kind of drive this thing as well. And so we
3 do kind of ask that of you as you leave this
4 little room and go back to your practices.

5 CO-CHAIR YAREMCHUK: I guess the only
6 other thing I wanted to say was we talk about
7 this in terms of PQRS, we talk about this for
8 public reporting, but I'm going to say, as a
9 specialty, one of the other things, one is
10 maintenance of certification. You have to
11 practice improvement module. So some of these
12 measures could be used for that.

13 The other part of it is, if you are in
14 a hospital, there's FPPE and OPPE, which are
15 Joint Commission requirements. Focused Practice
16 Performance Evaluations and Ongoing Practice
17 Performance Evaluations. And the idea being that
18 you just don't rely on your credentialing cycle,
19 but that there's an ongoing measurement of each
20 provider in terms of the procedures they're doing
21 and what they're doing.

22 And I don't know, Micky, if you have

1 anything to say for your department or your
2 institution in terms of doing this, but as ENT,
3 I'm struggling with coming up with measures for
4 people that are on staff at University of
5 Michigan, anybody else that's on staff somewhere,
6 on how they're dealing with those requirements.

7 Josh, you're nodding your head, are
8 you --

9 MEMBER STEIN: I just had a follow-up
10 question. How expensive is it for someone to
11 bring a measure to you guys for approval? I know
12 there's obviously a lot of paperwork involved.

13 DR. WINKLER: That's variable. It
14 depends. I mean, there are organizations, such
15 as NCQA, Joint Commission, PCPI, that's their
16 business. So there are the costs of just having
17 people around doing business. The expertise
18 required to develop a measure is somewhat
19 specific. The type of specifying a measure,
20 understanding data elements and calculation
21 algorithms, understanding evaluation of
22 reliability and validity for measurement, you

1 know, doing some basic testing in the field for
2 feasibility.

3 So, those costs are going to be highly
4 variable. Bringing it to NQF costs you nothing.
5 We do open calls for measures, you fill out the
6 form, you're there. But the actual getting the
7 information, taking a concept, fully specifying
8 so you have good, crisp, coded data elements,
9 there are people who are skilled at this. And
10 you don't do it over lunch on the back of a
11 napkin. So there is some element there.

12 But in many large systems and big
13 institutions, you've got people kind of doing
14 that. So it really depends on where that might
15 be coming from. And we see measures developed
16 from within universities. Not a huge number of
17 them, but we do see that. As well as the more
18 traditional professional societies are becoming
19 big in that. But also the traditional measure
20 developers.

21 But often some of the big, big
22 systems, and that's not here -- I'm an old Kaiser

1 doc, so I know that they've got their own system.
2 Some of the bigger systems -- how about Michigan,
3 you got measures you're doing internally? Yeah,
4 I mean, so the question of whether you could
5 respond to the questions to meet the criteria,
6 we'd welcome it.

7 All right. I think we may have
8 exhausted that, but we're supposed to do public
9 comment one more time.

10 MS. LUONG: Operator?

11 DR. WINKLER: Just check and see if
12 any of us --

13 MS. LUONG: Hi, Operator. Can you
14 open up the lines for public comments?

15 OPERATOR: Okay. At this time, if you
16 would to make a comment, please press star and
17 then the number one. There are no public
18 comments at this time.

19 MS. LUONG: Thank you.

20 DR. WINKLER: So, anyway, thank you
21 all very, very much. It's been enjoyable meeting
22 all of you. We will be in touch and we will have

1 follow-ups and we'll let you know. And so Vy's
2 going to tell you what comes next.

3 MS. LUONG: Okay. Great. I know I
4 said this earlier and I'll be brief. Thank you
5 again so much. We really appreciate the
6 thoughtful discussions for the past two days. As
7 a reminder, in two weeks we will be convening on
8 June 22nd for the post-meeting call. Following
9 that is the draft report for commenting. That
10 will be posted on the ENT project page from July
11 10 to August 10. So feel free to share this
12 within your network.

13 There will be another call in August
14 to review the comments from the commenting
15 period. We then will have an updated draft
16 report with redlines based on the comment call,
17 and that will be posted for membership voting in
18 September.

19 After membership voting, we will go to
20 CSAC in October. Following CSAC, we will go to
21 the Board for measure ratification of the
22 measures in this project, and that's in November.

1 And then the project will wrap up with appeals
2 from November to December of this year. And we
3 expect to have the final report published on the
4 NQF website early next year.

5 So thank you again, everyone, and we
6 look forward to speaking with you in a few weeks.

7 DR. WINKLER: Thanks, everybody.

8 (Whereupon, the meeting in the above-
9 entitled matter was concluded at 1:55 p.m.)

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A			
\$12 6:22	217:16	administrative 32:20	73:2 78:7 87:6 136:15
\$15.00 41:17	Act 47:21 211:22	33:4,15	aid 212:21 213:10 215:4
\$2 6:22	action 146:11	adopted 17:11	224:7,17 244:9,13
\$20.00 41:17 46:5	actionable 120:16,18	adopters 27:9	254:12,19 255:5,19
a.m 1:9 4:2 92:5,6	active 100:2,4 104:7	adoption 5:12 6:18 17:7	256:15,18
A1C 29:6 73:12 74:13	activity 140:5	ADRs 193:18	aids 253:22 254:7,9,16
74:14 81:15	actual 9:18 103:10	adult 244:9,9	254:17
AA 65:11	169:9 190:15 193:17	adults 7:13 243:12,13	algorithm 96:17 99:15
AAP 96:8,10,13 110:21	207:21 216:4 219:13	244:12 248:10,11	algorithms 261:21
112:2 159:15	262:6	254:1 255:17	aligns 115:11
abilities 200:14	acuity 3:12 95:16 96:16	advance 56:22 218:3	Allergan 1:18
ability 28:6 78:4 93:9	96:19 97:4 99:7 101:7	advanced 40:22 42:14	Allergy 1:18
231:18	103:16 104:18 106:5	58:7,8 129:14	allot 154:5
able 5:18 15:1 29:12	107:2 109:13,16,18	advantageous 9:1	allowed 155:5,11,13
36:10 62:22 81:19	109:19 110:11 113:10	advertisements 46:3	allows 93:2,5
82:19 104:12 105:1	113:14,18 114:3,3,13	Aetna 1:15	alluded 14:4
111:15 130:9 137:8	115:5,9,13 119:15	affect 247:15	alternative 11:4
138:18 140:22 145:22	133:16	afterward 258:17 259:2	AMA-PCPI 3:9,11
146:22 164:11 169:7	acute 250:13,18 251:7	age 3:17,18 40:2 41:8	amazing 56:22 57:8
181:11 187:7 209:7	251:11,13,20	52:3,3 58:15 103:11	amblyopia 96:4,11 97:5
215:2 218:13 236:8	add 9:8,13 15:8 20:3	103:21 113:10 120:5	97:14,16 98:4,20 99:9
259:6	34:17 37:16 38:16	122:17 139:10,11,13	99:16 100:2,19 101:2
abnormal 7:21 107:9	41:4 48:16 52:10 53:6	140:2,7,9 148:22	113:6,9,12 114:2,11
123:14,19 124:5	54:2 61:18 65:11,12	150:5 152:19 159:5,7	114:16,19,20 115:2
141:15 142:8	66:18 68:8 78:20 84:6	186:9,16 187:2,8	128:9 133:16,20
above-entitled 92:4	85:12 86:22 88:19	188:9,12 190:19	134:1,2,5,8 135:1
185:3	99:20 100:9,12,14	198:6 200:2 205:20	142:20 143:2,7 150:5
ABR 164:5	116:19 117:1,3	206:2,2,3,7,21,22	153:2 156:14
absence 3:8 8:8 55:7	131:21 144:21 145:13	207:9 209:21 211:4	AMBROSE 2:9 96:3
56:12	156:8 159:18 161:15	212:18 220:12,15,21	101:20 102:7 106:8
absolute 250:7	172:6 173:19 175:19	221:2,8,20 223:4	111:13 123:5 125:8
absolutely 81:10 96:1	198:6 199:15,16	224:3,11,16,20	126:6,13 148:17
107:18 117:11 202:2	201:19 205:13 208:2	236:16,17 241:9	156:3
254:21	217:14 223:20 237:17	243:21	AMD 3:6 11:8 15:8,10
abstract 189:16	238:13 253:11,16	age-related 3:4,6 4:20	15:19 28:12 31:8,13
abstraction 189:18	added 12:2 31:4 124:6	5:5 7:9,10 39:15	40:2,5,8,9,15,22
abstractor 50:8	adding 106:12 138:14	40:18 41:10	41:18 44:8 45:13
Academy 3:5,7 91:21	138:16 232:16	agents 6:22	46:15 50:6 58:12 61:2
247:3	addition 102:4 129:13	ages 103:15,22 113:15	American 1:16 3:5,7
accept 59:5 90:6 120:1	232:2	113:18,19	Americans 58:15
acceptability 89:22	additional 3:19 100:15	aggregate 169:9 181:13	ammunition 81:9
180:11	100:17 101:3,5,8	ago 77:13 78:6 236:13	amount 14:18 41:18
acceptable 75:4 110:1	109:22 113:16 131:18	251:19	116:16 182:16
239:4	additionally 15:9	agree 20:19 28:3 85:8	ample 80:20 116:15
accepted 74:16 168:21	address 7:4 93:16	101:5 133:14,22	amplification 244:9,18
access 117:7 202:8	125:9 170:7,13	134:22 137:4 141:20	256:20
209:6	186:17 192:7 206:20	152:14 163:16,18	AMSLER 49:13
accommodate 220:9	208:11	177:7 215:17 217:5,7	analysis 238:19
account 192:4	addressed 206:22	222:18 224:22 226:8	ancillary 8:18
accountability 94:12	250:15	249:16,20	and/or 8:9 40:4 194:20
149:12	adequate 31:3,4 129:9	agreed 52:7 66:6 99:5	Andrew 1:19 10:20
accountable 227:11	adequately 22:15 93:14	158:5 178:20	56:15 58:22 97:12
accounted 221:15	151:17	agreed-to 258:6	116:14 144:20 258:3
234:8	Adjourn 3:22	agreement 48:10,11,14	Andy 50:16 76:16 95:16
accuracy 234:17	adjust 36:18 191:14	48:21 66:9 251:20	100:6 114:6 137:4
achieve 29:7	adjusting 191:16	agreements 234:15	anecdotal 219:22
acknowledge 142:7,14	adjustments 173:18	ahead 9:10 21:1 27:12	angle 36:11 255:3
	administer 210:8	32:17 34:16 35:3 41:6	ANN 2:3
	administration 223:7	42:8 58:21 61:20 71:1	annual 59:16,19

ANOM 245:2	area 76:10 108:17 117:11 201:14 209:5 209:7 242:8	available 25:5 32:7 35:11 46:2 53:3 104:16 105:8 177:5,6 192:16 195:15 197:2 205:6 211:11,15 217:21 219:20 245:6	becoming 78:13 245:6 246:5 262:18
answer 32:4 112:6 120:3 134:9 155:22 165:12 169:18 208:4 213:3,3 214:6	areas 93:17 242:5,11,22 248:14	average 64:16 189:7 201:20 209:21 211:6	bedside 16:1
answering 208:16	AREDs 9:14 15:21 35:13,14 40:4,19,19 41:7 43:2 49:13 50:3 52:2	avoid 106:21	beginning 17:14 132:4 207:13
answers 10:21 174:19	argument 225:20	avoidable 57:9	begins 44:2
anterior 27:1	article 5:12 250:22	aware 31:22	behalf 91:21
anti-VEGF 6:22 14:5	articles 154:7	awesome 13:16	believe 49:6 65:8 104:22 158:21 159:2 206:21 207:5
antibiotics 243:4,10 248:20 249:18 250:10 251:10 252:3,6	asked 32:19 35:20 58:1 58:2 99:2 104:14 112:5 142:18 191:12 243:2 245:15	B	benchmark 198:13
Antioxidant 3:6 39:16	asking 112:7 219:8	B 34:21 111:1,7 112:12 112:18 133:8 159:17 247:20	benchmarks 207:15
antioxidants 6:18 10:6 15:12,16 40:20 41:14 43:15	assess 56:18	babies 162:1 191:4 192:12 200:1 204:4	beneficial 42:7 57:22 97:21 134:2,21
anybody 143:13,14 168:13 179:3 228:14 261:5	assessed 52:4	baby's 186:21 187:7	benefit 12:2 44:9,11 58:5 254:8
anymore 184:22 203:19 232:14	assessing 23:9 245:18	back 8:3,6,14,22 10:2 14:7 36:15 58:8,9 64:13 72:11 91:19 112:17,20 128:14 129:21 130:10 135:12 149:14 151:14 168:10 170:20 178:21 183:15 184:21 188:6 199:22 202:16 206:10 208:8 208:10 215:12 218:9 220:22 221:13 227:2 229:3 235:13,14 240:20 258:19 260:4 262:10	benefits 40:4 44:12
anyway 110:8 115:12 152:10 263:20	assessment 52:5 94:10	background 158:9	best 208:21 217:19 221:20,21 236:6 255:11,15
apologize 139:16	assigned 17:3 207:2	bacterial 250:14 251:9	Beth 5:12
apparently 166:19	assistants 129:14	bad 135:2	better 5:9 11:14 14:11 23:4 24:1 25:12,17 27:5,11 29:8 30:16 31:15,16 35:1,18 73:13,22 74:1 78:5 81:7 105:18 128:9 134:10,19 146:3 223:15 225:17 234:13 245:11 248:2,2 255:9 256:7 258:20 259:2
appeals 265:1	associated 75:3	BAHA 255:20	beyond 30:13 257:21
appears 28:6 53:20 257:11	association 1:16 244:21	bang 247:22	bias 161:6
applicability 148:20	assuming 107:6 146:1	bar 80:15 142:10	big 77:17 117:12 141:16,17,21 199:6 247:5 248:13 249:17 251:12 254:13,19 262:12,19,21,21
applicable 259:14	ASTRA 245:2	based 35:11,15 40:17 57:12 66:12 67:12 96:12 100:20 112:16 136:20 175:10 191:20 191:22 195:16 199:21 203:1 217:20 219:21 222:6,15 224:13 225:2 235:5 258:9 264:16	bigger 216:1 222:1 233:13 263:2
applies 60:19 93:15	asymptomatic 10:10 11:12 57:21 97:19	basic 29:4 62:5 115:13 215:5 262:1	biggest 83:4 118:4 138:20
appointment 213:1 220:17	attack 166:6	basically 7:14 8:5 73:15 136:19 164:18 165:20 168:17 181:7 186:21 200:3 225:1	Bill 4:22 14:4 56:22
appreciate 31:10 33:9 217:4 221:12,21 259:7 264:5	attention 92:1 129:9 249:5	basis 50:13 130:21	Bill's 56:16
appreciated 77:8	attribution 156:4	basket 148:5	billing 213:9,14,17 214:1 232:6
appropriate 6:18 29:14 52:3 55:22 56:17 57:5 96:16 107:8 141:11 200:11 243:9 246:2 246:19,22 248:18 250:16 251:4 256:19	attuned 96:18	Beckman 35:13	billion 6:22
appropriately 15:11 30:8 44:7 124:7,14,17 124:17 167:20 190:7 244:20	AuD 2:1		billions 14:4
appropriateness 249:11 251:1 257:22 258:2	audience 257:4		binocular 114:8
approval 92:15 93:2,10 93:12 94:18 116:6 149:10,11 157:12 261:11	audiologic 187:3 256:10,10		Birth 158:12,16
approve 137:17 138:22 179:2	audiological 3:16 159:4 186:8,15 188:9,12 256:6		birthdays 119:17
approved 226:5 252:4	audiologist 109:10 164:7 187:2,4 190:1,8 190:10,17,19 195:16		births 161:3 170:4 171:18,20
AR 1:22	audiologists 167:10 188:8 192:14 193:14 255:7		bit 10:12 76:8 97:3 129:10 134:11 137:15 179:15 213:5 215:13 221:1 227:8 241:22
architecture 181:10,11	audiology 194:16 212:20		black 189:3
	audiometric 190:13		blacks 188:11,15 189:2
	auditory 164:15		
	augment 14:20 77:20 259:15		
	August 178:22 264:11 264:13		
	automated 76:19 164:5		
	availability 82:20 163:10 209:3		

201:15
blank 240:9
bleeding 10:12,19
blind 56:5,7
blindness 5:4 6:2,8
7:12 41:22 55:18 56:1
56:4 57:3,6,9,14,14
58:13,14 81:18 100:3
100:18
blood 7:21 29:8 31:19
107:11
blow 81:13
blurry 123:21 124:16
board 64:19 150:9
264:21
bolstered 5:16
BONNIE 69:20
border 161:19 170:4
born 161:20 162:1
170:3,8,13 205:18
235:7,15 236:15,16
bothers 148:15
box 125:1 141:1 151:10
BRADHAM 1:13 32:18
41:7 43:20 108:10
109:7 122:5 128:2,11
159:20 161:11 164:3
164:22 167:3 170:1,9
172:7 173:20 176:5
177:7 186:20 188:3
189:1,21 190:9 191:3
191:12 192:10 193:10
194:13 195:13 196:4
196:21 199:20 203:6
204:3 206:12 214:7
214:10 220:22 223:19
239:7 244:11 248:5
brain 184:15
break 91:18,19 184:16
breast 179:20
brief 55:9 264:4
briefly 7:12
bring 72:11 95:11 110:8
141:8 151:2 157:21
170:18 183:15 229:3
243:4 261:11
bringing 24:17 262:4
broadly 259:14
brought 21:13 139:3
226:21
buck 247:22
bucket 252:20
buffer 220:13
build 255:22
building 256:2,3
built 130:19 181:17
bump 63:5
bunch 135:20
burden 180:7

business 261:16,17
buy 150:12
bye 185:2

C

C 3:1 202:12 210:7,11
211:11 212:1 213:22
214:13,18 215:1,20
216:3 218:5 224:5
239:8
cab 185:11
calculation 261:20
calendar 235:8,22
236:1,6
call 12:10 18:12 44:17
47:2 51:14 52:16
53:12 54:8,22 60:7
64:1 65:18 67:3,17
68:15 69:9 70:12
71:14 72:11,15 74:10
76:7,17 79:14 83:12
84:10 86:6 88:7 89:1
89:12 90:5,12 91:10
133:17 138:10 141:9
144:12 147:15 157:14
160:10 171:8 172:22
174:8 176:14 177:13
178:4,22 180:14
182:4 187:16 193:2
194:3 195:6 196:14
199:7 224:4 232:12
240:20 264:8,13,16
called 181:4 206:6
207:8 211:3
calling 215:13 227:22
calls 262:5
Campaign 249:4
cancer 5:19 253:12
Candidate 3:3,15
capability 222:15
capita 154:2
captive 218:8
capturable 71:10
capture 11:21 26:10
30:16 34:18 106:16
108:3 111:15 125:15
145:22 156:8 162:1
170:3 211:15 246:18
246:21,22
captured 119:10 126:12
126:14 220:6 245:10
capturing 22:14 30:11
109:18 146:6 219:3
225:8 245:6 246:15
care 1:3 3:11 6:10 16:10
27:1 40:3 42:20 52:8
53:22 55:11,12,22
59:17 66:7 73:5,9,17
75:15,18,19 76:2,11

76:19 77:21 78:14,17
80:11 81:4,7 85:9
87:12,14,20 88:1 92:9
97:10 98:13,14 99:13
101:21 104:7,9
110:14 111:16 114:16
115:14,14,17 117:8
117:15,21 126:15
128:21 129:1,15
131:1,11,16,16
134:15 135:6 143:9
143:10 144:2,5,6
147:1 148:8,15
150:17 152:15,20
153:7,10,17 154:2,5
154:21 178:19 210:4
212:12 242:5,16,19
243:7 245:7 246:5
248:13 254:13,14
255:3,4
CARNAHAN 1:14 9:11
11:16 35:4,15 42:9
87:4,8 107:22
carry 72:4 77:22 91:4
130:9
case 110:15 139:13
255:19
cases 6:17 257:14
cataract 41:11 66:16
cataracts 249:9,9
catch 12:3 58:9
Catch-22 137:9
catching 11:18
categories 61:14
category 92:9
caught 189:17
cause 6:7 7:11,12 58:12
58:14 143:4
causes 5:4 57:14
caveats 145:15 227:15
CCC-A 1:13 2:1
CDC 3:13,17,18 158:15
160:20 167:12 193:13
201:11 238:10
ceiling 161:11 169:20
cells 184:15
Center 1:13 158:11,12
158:15
certain 41:18 113:3
137:7 249:11
certainly 14:12 50:9
74:5,8 81:2 129:4
132:18 134:3 135:17
136:20 168:1 225:16
certification 260:10
cetera 192:19 250:3,11
Chairman 7:5
challenge 98:15 150:8
challenging 76:11

change 10:11 16:11
73:22 82:20 115:10
136:13 139:14 170:19
189:12 192:8 220:8
220:11 228:4,14
229:3,18 240:21
241:6 247:14
changed 81:22 82:3
117:16 162:17,18
220:5 226:7 228:1
changes 7:19 14:9 18:5
138:15 203:2 226:4
changing 138:13 180:5
229:1,16
charge 165:8
chart 19:19 48:9,12
49:5,15 78:11
charts 49:6 109:16
173:13
cheap 247:20
check 29:12 75:5
119:22 125:1 141:1
149:6 151:10 155:6
173:14 186:5 234:16
263:11
checked 173:12
checking 28:21 129:5
129:22 162:21
checks 173:11
child 97:8,9 101:1
102:1 103:15 104:5
108:20 115:8 131:15
146:18 195:19,20
208:9 209:18 212:6
215:7 224:17 228:7
235:7 236:15,16
child's 121:4
children 3:12 46:15
95:16 96:5 103:19
107:3,5,18 108:6
110:12,13 117:10
118:6 119:15 120:4
120:10,11,12 122:6,9
122:17 123:8 133:8
149:3 151:17 164:16
170:2 192:5 200:9,12
202:14 203:11 209:11
211:18 214:13 216:13
242:18 244:16,19
253:14
CHIP 148:19 149:1
choose 211:14
choosing 30:14 249:4
chose 211:13
Christine 199:22
chronic 249:19,21
250:15,17 251:22
252:2,7,10,21
chronological 206:2,22

212:18
circle 135:12
cite 57:2
claim 49:4 85:20
claim-based 172:9
claims 22:1,6 24:5,7,21
 25:3,18 32:21 33:4,15
 37:11 48:8 60:18 62:1
 64:12,15 65:17 66:2
 67:2,9,15,22 68:13,22
 69:7,13 83:21 84:1,14
 84:19 85:2,6,10,16,19
 86:4,11,19 88:5,12,21
 89:8,11,17 105:7
 212:19 213:4,5
 245:11
clarification 143:18
 144:1 156:13
clarify 9:11 48:21 75:21
 101:19 142:19 162:3
 188:17 190:5 206:4
 228:22 229:10 230:19
 240:19
class 224:19
classification 35:13
cleaner 241:10
clear 42:6,9 57:21 97:18
 97:19,20 106:19
 107:18 120:13,17
 124:19 139:7 168:1
 171:5 203:10 229:15
 238:18
clearly 26:14 76:4 122:1
 122:2 238:17 250:8
 251:19
Cleveland 1:19 117:11
clickers 13:2 79:17
clinic 1:20 102:13 126:8
clinical 8:13 16:1 32:21
 40:18 42:5 57:10
 205:5 231:14
clinician 17:16 75:14
 75:17
close 25:6 104:9 189:7
 242:1
close-in 242:6
closer 58:6
closes 118:11
closing 106:10,15
 118:3
Club 130:15 150:3
clue 151:6
CMS 3:12 122:11
 129:20,21 130:9,11
 148:3 150:11 155:16
 168:21 179:13,13
 180:3
CMS/EHR 126:20
Co-Chair 1:12,12 4:16

7:6 9:3,9 10:20 12:6
 13:9 18:6,9 19:5 20:2
 20:4,7,16 21:1 25:22
 27:8 30:19 32:16 33:9
 34:15 35:3 36:21 37:8
 37:15,17,19 38:5,15
 38:17,19 39:5,14 41:2
 41:5 42:8 43:13,19
 44:13 45:2,16,18
 46:10,20 47:4,7,16
 48:15,18 49:8 50:19
 51:8,11,21 52:12 53:1
 53:5,7,9,18 54:1,3,5
 54:16 55:5 56:10
 58:17,21 59:21 60:3
 60:21 61:16,19 62:16
 63:19 64:8 65:13,15
 66:4,19,22 67:11 68:2
 68:7,9,11 69:2,15
 70:1,7,22 71:6 73:1
 76:5 78:7,18 79:10
 80:2,22 81:20 82:16
 83:8,19 84:7,21 85:13
 85:15 86:1,13,15 87:1
 87:3,6 88:14 89:19
 95:21 97:12 99:19
 101:10 106:17 110:17
 112:11,22 113:19
 114:18 115:18 116:13
 116:19,22 117:4
 118:12 122:3 124:18
 131:20 133:13 135:4
 140:13 141:18 144:7
 144:19 145:13,18
 147:11 148:1 149:18
 153:21 154:18 156:9
 156:15 157:8 158:3
 158:17 159:10 160:5
 160:18 162:2,12
 163:19 165:10 166:14
 167:2,16 168:6
 169:16 170:12 171:3
 171:16 172:17 173:8
 174:4,16 175:6,19
 176:7,10,22 177:8,21
 178:11 185:16 186:6
 186:10,12,18 187:12
 188:1,13,19 189:6,10
 189:19 192:20 193:8
 193:21 194:8,12
 195:1,12 196:9,20
 197:3 198:4,14 199:9
 199:14,17 200:15,22
 201:7,18 202:3 203:5
 203:14 204:13 205:2
 205:11 206:16 210:3
 214:5,8 218:17 222:2
 223:17 225:9 226:6
 226:15 228:3,10,19

229:12 230:5,10,16
 231:11 234:20 235:2
 235:21 236:2,19
 237:7,16,19 238:12
 238:14 239:14 240:19
 243:16 245:21 247:1
 248:15 250:12 251:6
 251:16 252:17 253:15
 254:6 256:21 257:2
 257:15 258:3,8 260:5
Co-Chairs 1:10 4:15
cochlear 200:10 212:21
 213:9 214:16
code 43:14,16 47:20,21
 49:1 85:19,21 109:14
 109:17 145:3,7,7
 194:20 231:21,22
 233:1 234:3
coded 262:8
codes 65:2,6 67:13
 109:15 213:9,14,17
 214:1 232:14,20
coding 35:7,11,16 36:6
 115:5 129:7 138:14
 171:22 232:10,13
Cole 1:19
collapse 5:11
colleagues 260:1
collect 15:18 43:14
 85:18 167:7,11
 168:15 172:3 212:10
 235:6,14
collected 23:11 169:8
 195:14 208:3 237:15
collecting 209:8 236:12
collection 207:11
 233:22
College 1:17,21
combine 181:13
combined 123:6
come 10:9 22:3 50:18
 58:8,9 92:10 113:3
 126:5 149:14 162:9
 184:21 236:10 240:20
comes 30:2 208:22
 264:2
comfortable 220:4
 229:1
coming 28:16 34:19
 92:19 165:5 197:19
 206:9 244:15 253:3
 261:3 262:15
command 170:19
comment 3:14,20 11:10
 16:20 34:18 55:9
 64:22 65:9 82:4 93:4
 113:21 135:12 155:3
 159:20 180:21 181:17
 184:8 189:9,22

195:17 199:20 206:13
 217:22 256:22 258:4
 263:9,16 264:16
commenting 222:10
 264:9,14
comments 4:11,15 5:1
 14:21 18:7 20:5 21:14
 41:6 48:18 49:9 51:9
 52:12 53:7 54:3 56:17
 60:1 61:17,19 66:19
 70:2 78:19 83:2 85:13
 101:13 106:18 110:8
 113:1 141:18 145:18
 155:1,2 160:6 168:7
 172:17 177:8,22
 180:9 181:7,22 184:6
 184:12 189:20 192:21
 193:21 196:10 197:3
 199:18 201:20 204:14
 222:3 236:20 237:20
 239:15 263:14,18
 264:14
Commission 179:22
 187:9 199:2 203:10
 214:21 260:15 261:15
committee 1:3,8 36:8
 76:20 186:1 241:14
 259:18
common 7:11,12,15,17
 10:4 13:21 99:11
 143:4 152:3
commonly 107:10
 143:5
communicate 73:16,19
communicated 75:5,13
communicating 73:8
 78:22 87:9
communication 3:10
 73:4 75:7,11,14 76:13
 76:16 77:2 230:2
communicative 200:14
 215:11
community 74:18,19
 130:5,14
Company 1:15
compared 91:1 182:13
comparing 232:4
comparison 34:20 49:2
 236:8
competencies 215:11
competitive 16:22
complete 110:13 213:3
 213:18 235:19 249:15
completed 125:19
completely 5:18 152:13
 154:11
completeness 234:16
completing 188:8
completion 57:1

compliance 23:5 173:17	consultation 65:10	77:16	69:19,21 71:9 72:10
complicated 98:19	consumer 223:22 246:6	counseling 3:6 6:11,13	80:5 83:22 84:1,3
complications 257:22	consumers 225:14	6:16 39:16 40:15	85:2,10 86:18 90:2,4
component 97:7 104:3	contact 141:16	43:10,15,17 46:6,12	94:2 98:14,15 102:14
106:12 121:11	contains 205:18	49:1	104:13,20 105:7,10
composite 247:10	content 181:9 225:17	count 44:3 77:9	105:11,13 116:15
Computations 55:20	context 222:1 233:13	counting 22:19,22	120:15,15 125:14
concentrating 34:13	continue 4:5 23:17	couple 13:20 27:20	127:1,2,6 131:14
concept 107:11 262:7	168:18 190:3	74:15 80:16 205:17	146:13,17 151:20
conceptualized 111:14	Continued 3:15	226:16 247:3	152:16 154:7 156:8
concern 97:17 128:1	continues 167:1	course 5:18 6:1 14:18	168:15 169:6 170:20
140:19	contracted 106:7	44:10 77:19	172:9 175:12 178:20
concerned 127:18	129:19	cover 59:14	180:5,22 183:16
129:6	contradict 210:16	covered 29:2 254:7	188:4,7,10,14 189:15
concerns 71:9 132:16	contradicted 210:18	CPT 47:20 49:1	191:18,21 192:3,15
concluded 265:9	contributing 253:12	CPT-2 85:19	193:11,13 194:22
condition 10:6 13:21	control 42:3 55:20	cracks 127:20 150:2	195:14,15 201:11,14
90:7 108:21 134:2	57:10 73:12,13,22	create 181:9	202:17 205:5,8
179:1	74:1 81:16	created 145:4	207:11,19,22 209:9
conditions 1:3 70:12,18	Control's 158:11	creates 168:16	209:15,20 210:16
72:9,16,19 90:13,15	controlled 73:19	creating 166:6	211:6 212:4,19 213:4
91:11,13 119:13	159:14	credentialing 260:18	213:5,7 214:12
180:15,17 183:13,15	controversy 250:9	credit 226:12	217:11 218:9 225:8
183:22 242:17 250:1	convening 264:7	crisp 258:6 262:8	231:16 234:15,17,22
conduct 93:9 175:17	conversation 76:8	criteria 23:8 40:8 63:18	235:6,12,14,19 236:8
conducted 96:22	132:17 185:7 221:14	64:12 90:7 92:20	236:12 237:10,11,13
conference 1:9 138:10	222:22	93:19 102:10 252:13	237:14 238:9 246:8
confirm 202:12,13	conversations 114:1	263:5	247:18 251:10 261:20
conflation 133:4	224:1	criterion 179:2	262:8
confused 230:11	conveying 136:1	cross 161:21	data's 105:16
confusing 174:18	convince 150:12	crosses 248:16	database 205:5 213:6
confusion 33:19 34:9	coordinate 56:19	crucial 105:4	231:14
246:10	185:13	CSAC 264:20,20	dataset 231:15
conjunction 106:14	coordinates 167:6	CT 252:11 253:8,9,10	date 208:7 215:19
consensus 241:5,11	coordinating 56:17	cuff 31:20	219:20
consequences 129:7	coordination 55:11	cultural 154:1,4	day 3:2 4:4,5,8 28:21
177:2 204:5	76:10 128:21,22	curious 76:21 209:15	82:6
consider 102:18 110:11	134:15 140:19 148:8	245:2	day-to-day 236:9
127:9 140:14 161:14	148:14 212:12	current 35:7 36:5 78:10	daycare 128:5,12
207:2	coordinator 239:8	142:19 163:22 164:22	days 95:4 184:20 186:1
considerably 165:19	copy 75:6,16 76:2 77:21	215:18 252:18	192:6 210:21 219:22
182:19	Cornell 1:21	currently 38:8,13 43:22	223:9,10 258:12
consideration 3:3,15	correct 33:10 43:9 49:7	68:4,5 88:16 109:12	264:6
102:16,20 149:15	81:11 164:21 174:22	110:1 204:9 209:21	DCCT 55:19
198:18 257:7	225:8 228:18	cycle 260:18	deaf 224:18
considered 87:15 115:7	corrected 206:3 212:18		deal 5:15 6:11 26:4
203:20 208:19 221:6	corrections 236:11		132:20 141:17,21
242:12	correctly 111:8		247:5 254:19
considering 45:12	cost 7:2 11:19 12:1,3	D	dealing 78:2 215:10
154:16 209:18	14:6 41:17,21 57:16	D.C 1:9	261:6
consistent 133:9	97:21 108:3,18 109:4	dad 141:8	deals 7:9 124:20
135:14 136:5 138:1	109:5 111:11 151:22	danger 225:21	death 162:5 172:5
222:21	154:8 165:4 247:17	dangerous 140:12	194:21
constant 55:21	248:3	Daniel 1:9,12 2:15	debate 161:10
constantly 223:10	costs 153:4 261:16	data 13:12,12 15:6	December 205:9
constructed 136:20	262:3,4	19:12 21:3 23:6,6,10	231:16 235:7,16
consult 74:11	counsel 2:3 15:11 50:2	23:21 24:5 25:8 26:10	236:15 265:2
Consultants 1:15	50:11	33:11 37:10,11,12	decide 208:21
	counseled 40:3 50:20	43:14 45:4,9,19 48:5	decided 105:14 126:1
		53:2 61:6 64:18 69:19	

decision 90:6 209:1	136:10	250:16 252:20	discussants 7:6 41:3
decisionmaking 258:14	detect 96:20 119:16	diagnostic 193:18	95:17
decisions 154:14	134:5	194:19 235:10	discussed 5:7 37:11
decrease 6:20 55:18	detected 117:14	dialysis 56:8	38:8 40:7 49:12,14
81:17	detecting 11:10 15:8	dictated 50:7	73:11 76:12 77:15
decreased 6:7 114:3	128:8 193:20	died 56:7	105:19 135:15 136:6
143:3,4	detection 57:5 59:6	difference 5:17 34:4	158:22
decreasing 6:16 7:1	98:4 167:4 194:15	46:18 209:4 223:11	discussing 129:18
deeper 23:4	205:6	223:12 254:13,14,14	137:5 159:3 184:21
defeats 137:6	determination 1:22	255:10	discussion 3:19 9:6,10
Defects 158:12,16	65:11	differences 22:6 95:3	18:17 37:17 38:17
define 8:7 212:19	determine 94:6 137:16	167:18 169:13	45:17 50:2,5,5 65:13
216:16 252:9	determined 117:13	different 10:13 21:15	66:11,20 68:9 76:6
defined 37:13 65:2 76:4	develop 7:19,21 17:10	23:11,21,22 36:10	77:13 78:21 81:14
181:8 252:19	131:10 168:2 261:18	57:2 62:1 70:4 72:2	87:1 99:4 100:11
defining 206:2	developed 55:16 96:9	76:9 78:2 90:22 95:1	101:15 102:9 115:19
definitely 11:11 100:9	102:20 112:1 140:11	108:17,19 109:1,15	133:5,6,17 140:21
102:16 163:14 203:12	227:19 245:3 246:15	118:6,6 123:16	162:9 166:3 180:5
209:4 229:11	262:15	124:10 150:1,11,22	185:7 225:22 226:3
definition 75:10 199:7	developer 19:6 47:22	151:5 152:10 154:16	244:7 254:12
207:1 249:21	64:15	162:14 163:1 168:4	discussion's 33:7
definitional 249:22	developers 13:11 20:17	182:13 211:20 219:1	discussions 71:8 99:22
degeneration 3:4,6	65:1 75:2 80:4 83:20	231:19 234:11 242:17	155:15 245:1 259:22
4:21 5:6,15 6:7,17	85:2 95:21 96:2 99:5	245:14,19 248:17	264:6
7:10,11 8:1,7,9,12 9:2	157:22 174:17 178:20	254:4 255:2,6 258:21	disease 5:19 6:1 25:14
10:1,4,16 26:5 27:6	186:10 198:6 206:17	differentiate 18:1	40:19 41:9 58:10
36:13 39:16,20 41:10	229:1,15 232:13	differently 49:17	77:19 81:13 158:11
41:12,15 65:7	262:20	difficult 97:15 105:5	247:19
degrees 215:10	developing 106:11	113:8 202:11 211:14	diseases 22:10 41:10
delay 236:18	179:9	212:4,10 252:5	116:16 135:2
deleterious 134:18	development 57:18	dig 23:4	disorder 164:15
deliberate 235:18	92:12,15 94:16	dilate 26:16,19 28:10	disparities 117:7 118:1
demands 22:9	Developmental 158:12	dilated 3:5 4:21 7:10	118:5 161:2,18
denominator 19:14	158:16	27:21,22 28:12,17	169:21 170:1
47:20 48:9 65:2 87:16	devices 213:12 255:1	39:21 44:6 59:3	disparity 169:22,22
119:9 120:4,7 122:6,8	devil 99:17	dilating 21:17	188:10,10 201:14
179:18 191:11 205:15	diabetes 3:11 5:19 6:2	dinged 249:6	214:12
221:11	11:6 56:7 59:12,18	dinner 4:9 186:3 243:3	dissimilar 201:10
denominators 100:1	73:5,12 74:1,12 80:15	direct 31:7 215:6	distinct 242:5
denote 65:3	81:3,7	direction 134:12 168:13	distinction 114:13
dental 135:6 253:10	diabetic 3:8,10 4:19 5:6	172:10 216:14	distinguish 66:7 85:9
dentistry 243:22	6:2,6 7:3 36:13 55:6	directions 186:1	district 130:6
department 185:21	55:20 56:11 57:18	directly 126:5,10	doable 156:7
196:6,6,7 202:13	58:13 59:11 63:16	152:18 153:16 175:11	doc 19:13 73:20 78:9
211:12,19 214:2	65:3,6 73:3,10 74:20	213:21	146:1 176:3 190:8
261:1	75:15,18 91:1	Director 2:6	263:1
depend 126:18 138:12	diabetics 59:14 81:14	Disabilities 158:13,16	docs 19:8 22:7 26:3,4
depending 6:21 14:5	150:15,17,20,20	Disability 1:22	63:13 74:6 84:2
23:10 170:2 175:11	diagnose 8:1,16 10:15	disadvantaged 117:10	123:20 130:3 146:3
depends 108:13 128:11	134:5	disagree 133:18	148:6
138:7 261:14 262:14	diagnosed 101:2	disc 28:20	doctor 30:22 76:2 77:21
described 145:15	152:18 153:19 205:19	discharge 3:13 158:8	78:17 87:20,22 88:1
describes 43:8	233:9	159:2 161:15 162:3,4	129:11 135:6,9 210:5
description 42:17 96:6	diagnosing 9:2,16,17	170:13,16	247:13
designation 93:11	diagnosis 40:2 59:11	discharged 171:21	doctor's 42:11
designed 42:4 215:2	59:12 100:2,5 114:15	discuss 29:7 43:1	doctors 26:14 59:8 61:5
desk 141:14	187:4 194:19 231:21	56:14 74:17 80:3 85:3	61:7,22 62:1,11 127:3
detail 29:9	231:22 232:20 233:1	206:8	129:13 244:2
details 97:2 99:18	234:3,5 249:22	Discussant 73:5	document 8:17 35:15

50:12 51:6 62:20
 77:14 130:19 181:6
 181:10 192:1 218:13
documentation 3:8
 16:3,18 22:21 55:7
 56:11 75:4,12,19
 125:12,18
documented 25:16
 42:21 50:4 191:20
 202:17,19
documenting 8:22 16:8
 17:20 26:22 27:6
 62:18 63:15
documents 49:16
doing 8:20 9:13 11:4
 13:16 14:11 21:19
 22:7 23:7 26:11 27:11
 29:14,19 30:7,7 33:4
 36:12 59:4 62:17
 63:14 78:10 80:8
 82:22 95:3 102:22
 104:3 105:6 106:2
 107:5 112:10 128:13
 130:15 135:7 137:3
 140:8,21 149:22
 150:11 151:6,21
 152:4,14,15 153:6,13
 153:15,19 154:15
 205:11 208:3 222:16
 225:3,5,6 226:9 249:9
 255:12,20 256:6,14
 257:13 260:20,21
 261:2,17 262:1,13
 263:3
dollars 14:5 154:5
dosage 216:16,20
doubt 251:14
dovetails 166:3
Dr 4:3,14 5:2 14:20
 15:17,17 16:20 17:13
 21:2,13 22:18 23:6,8
 24:4,15 25:1,11 27:14
 32:4 33:18 36:4 42:16
 43:9,16 45:22 49:10
 55:9 61:9 62:9,19
 63:6,8,13 64:9 65:8
 69:17 71:3,7 72:1,6
 76:7 77:12 81:10 83:4
 85:17,21 89:21 90:19
 91:17,20 92:7 95:7
 96:1 107:1 117:5
 119:4 132:15 133:12
 135:11 136:2,16
 137:10,14 149:9
 157:20 159:8 169:2
 172:11 178:13 180:9
 180:20 181:21 182:11
 182:20 183:8,14
 184:14 189:13 229:5

229:7,19 238:15
 239:13 241:1,12,19
 243:8,14 248:9 259:5
 261:13 263:11,20
 265:7
draft 264:9,15
dramatic 6:5,9 22:5
 77:18 83:7
dramatically 7:2 15:4
 21:15 78:5
drive 230:2 246:8
 259:20 260:2
driven 208:20
drops 18:3,4 29:13
 247:7
DRS 6:3 55:14
drug 247:20,20 248:1
drugs 252:3
drusen 31:12
dry 7:16 10:3,8 12:1
 15:10 31:12 50:6
due 202:20 242:1
Dulles 185:9
dunk 82:2
duplicates 33:1
duplication 145:16
duration 212:7 216:20

E

e 3:1 66:9 70:4 89:19
 90:10,22 94:10
 118:17 122:14 156:18
 169:2,10 180:13
 183:11
e-measure 24:17 64:10
 64:13 66:10 69:16,21
 70:2 71:8 72:3,8,21
 75:3 85:3,3 86:19
 90:17 91:2,3,9,15
 92:9 94:5 102:19
 104:13 110:1,2 116:1
 116:12 119:2,5
 120:22 121:1,8,18
 122:11 126:18 132:7
 144:11,18 145:21
 147:14,22 157:13,17
 169:5 172:16 174:22
 178:14 179:4,6,11
 180:10,19,21 181:22
 182:3,9,13,22 183:6,9
 184:2
e-measures 72:14 75:9
 85:5 89:22 90:1 92:12
 92:15 93:16 174:20
 178:12 179:17
e-version 70:10,20
 71:13,21 72:14
ear 1:3 248:12 255:7,12
 255:16,19,21 256:8

256:13,14 257:10
earlier 11:14 128:9
 140:3 142:19 150:14
 193:12 226:2,22
 264:4
early 10:15 27:9 40:14
 44:8 45:21 108:21
 113:18 140:10 167:4
 167:10 194:15 199:3
 200:1 203:12 204:6
 205:6 212:11 214:22
 215:8,21 221:3
 249:10 265:4
ease 182:18 236:6
easier 33:17 81:6 82:18
 141:12 234:16 251:13
easily 177:2 245:10
easy 32:10 77:5 104:19
 158:6 252:7
echo 11:11 108:1
edema 3:9 6:6 55:8
 56:12 58:4
EDHI 169:4 172:14
 181:18
EDHR 102:15
educating 25:17
education 5:9 16:13
 25:12 42:12 56:9
 196:7,8 202:13
 211:12,20 214:2
Educational 211:22
EENT 1:3
effect 35:9 82:14
 161:12 169:20
effective 5:22 11:19
 12:1,3 14:6 41:21
 57:16 97:22 108:3
 109:5 154:8
effectiveness 108:19
 109:4 111:11 152:1
effects 15:15
efficacy 6:16
efficiency 107:20
 247:21
efficient 53:22
effort 130:5
efforts 167:7 218:2
EGDI-1a 3:13
EHDI 167:4 195:14
 197:1 202:11 208:9
 231:15 232:5 234:6
 235:9,17
EHDI-1a 3:18
EHDI-3 3:17
EHDI-PALS 192:13
EHR 16:18 19:19 24:11
 25:7 48:12 50:1 53:3
 76:3 102:20 105:1,4
 105:10 106:3 125:15

129:16 130:19 131:15
 145:10 146:16 148:21
 181:1
EHRs 21:6 78:2
EI 202:12 209:9 210:11
 213:19 232:22 233:12
 234:7,13
Eichwald 2:10 158:10
 158:10 165:13 166:22
 168:14 170:15 179:8
 181:2 202:22 211:10
 216:6 236:14 241:3
 241:15
eight 4:6 13:6 39:11
Eighty 176:17
Eighty-seven 174:11
either 31:13 78:16
 97:10 127:22 144:4
 150:3 158:19 164:4,6
 175:9 185:9 196:5
 252:15 254:10 257:7
elderly 5:5
elect 165:8
electing 214:15
electronic 16:3 23:3
 32:21 71:10 77:4
 78:15 82:18 104:14
 130:1 146:7 175:16
 237:12 238:9
electronically 175:9
 185:19
electrophysiology
 190:18
element 19:12 48:5
 69:19,19 90:2 125:14
 146:14,17 149:17
 156:8 262:11
elements 37:12 71:9
 180:22 195:15 261:20
 262:8
elevations 31:10
eligibility 122:16 203:2
eligible 13:17 63:11
 82:8,10,12 87:17
 102:22 126:21 127:2
 155:18
eliminate 77:17
eliminated 43:2
email 12:14 47:10 167:8
 183:17 184:19 185:22
 240:9
embellish 247:2
emission 164:5,14
emphasis 26:12
emphasizing 77:16
encounter 17:15 43:11
encourage 18:4 73:21
 149:1 153:13 172:8
encouraging 130:13

endocrinologist 78:16
81:4
endorsed 24:21 179:12
187:11
endorsement 39:6,9,13
54:18,21 55:4 69:4,7
69:13 72:7,14,21
89:10,17 91:9,15
93:11 149:16 157:9
168:16,19 169:1
178:3,9 183:11 184:2
197:14 198:2 240:6
240:18
endorses 150:12
endoscopy 252:12
ends 76:21
England 249:3 250:22
enhance 164:19
enjoyable 4:10 241:18
263:21
enroll 221:9
enrolled 198:20 208:10
211:1,18 219:5,16
221:3,7 224:19
230:21
enrollees 207:22
enrolling 226:11
enrollment 205:21
206:4,6 207:1,2,4,8
207:13,20 208:3,5
209:9,11,14,16 210:5
211:5,7 212:15
215:20 219:3,18,19
220:11,16,20 226:18
226:20 227:20,21
228:5,13 230:7
231:21 232:2,21
256:4
ensure 163:9
ensuring 207:15
ENT 1:18 176:3 190:8
242:5 246:15,22
251:8 253:16 257:3
257:19 261:2 264:10
entailed 125:20
entered 98:15
Enterprise 181:5
entertain 132:18 229:8
229:11,16
entirely 215:17 217:5,7
entities 130:12
entitled 265:9
entry 237:14 252:13
ENTs 190:14 249:6
epidemic 253:6
equipment 192:18
193:16
error 100:5,7 143:5
189:18

errors 173:13 194:18
234:22 237:13
especially 34:19 213:19
252:3 253:14 258:1
essentially 24:15
101:22 113:9,17
136:17 179:18
establish 122:15
et 192:19 250:3,10
etcetera 97:5
ETDRS 55:14
evaluate 94:22 136:18
241:21
evaluated 191:19
evaluating 104:8
evaluation 3:16 4:6
65:9 119:12 125:5
137:20 159:4 186:8
186:16 188:9,12
246:2 261:21
evaluations 145:1
260:16,17
evening 4:8
events 55:10 64:17
Eventually 134:12
everybody 4:10 50:11
92:7 111:5,9 112:6
152:4 185:19 218:5
265:7
everyone's 34:1
evidence 5:16 6:15
8:21 9:5 11:13 12:9
12:12 13:7,7 40:13,16
41:1 42:6 44:14,16,19
45:1,1 60:6,9,15,15
60:20 73:16 74:3 79:7
79:11,13,16,22 93:21
95:20 96:6 97:1,3
101:13,13 106:18
107:3 111:1,3,7,20
112:5,8,18,21 113:2
113:13,16 115:20
116:1,4,11,11 125:20
131:8 133:5,8,10
135:14 136:6,19
138:1 139:12 152:9
159:11,12,17,17
160:2,7,9,12,15,17
186:20 187:13,15,18
187:21 198:22 199:5
199:11,18,21 200:7
200:16,18,20 201:5
203:18 204:1,7
212:15 221:16,18
222:1,21 226:22
243:18 244:2,4 253:3
253:8
evidence-based 111:11
evolutionary 92:14
evolving 108:17
exactly 17:18 36:9
61:11 98:18 119:9,10
143:20 207:5
exam 7:10 29:1,10 31:4
39:21 44:6 59:3,17,19
59:22 63:16 111:16
114:4 117:20 135:6
152:4,10 243:20
examination 3:5 4:22
27:21 28:1 29:14
77:15 97:11 151:12
examinations 5:17 58:2
118:10 151:15
examine 29:3 31:15,16
examined 20:18 115:16
151:18
examining 17:19,20
150:20,21
example 22:7 26:15
27:2 40:12 87:11
100:1 117:12 170:18
235:7 247:6,8,11
examples 66:17
exams 110:13 151:21
excellent 80:9 149:21
exception 19:22 66:11
exceptions 47:21 66:14
exclude 100:8 194:20
excluded 191:11
exclusion 100:19 162:5
172:4
exclusionary 102:10
exclusions 28:6,8,13
28:15 52:8 100:1,10
100:15
excuse 53:2 61:17
110:6 126:4
exhausted 263:8
existing 18:5
expand 121:10 125:10
126:3 127:9 156:6
expect 75:6 90:3
130:22 136:21 246:7
265:3
expected 81:4 187:4
expecting 69:20
expense 185:17
expensive 247:21
248:1 261:10
experience 78:9 94:19
118:3 210:16 219:21
253:4
experiences 76:9,22
experiencing 253:4
expert 20:19 52:6 66:5
85:7 96:13 110:21
131:9 213:6
expertise 215:10

261:17
experts 121:10
explain 17:4 42:22
133:3
explanation 190:22
exploring 102:13
extend 52:7
extra 12:2 77:5 134:17
extraction 19:19 25:8
37:11 48:13
extractions 23:3
extractors 49:15
extremely 19:11,15,21
20:1
eye 1:3,19 8:4,6,14,17
8:19,22 10:2,12,18
11:3 21:17 28:17,19
28:21 31:1,15,16
40:10,18,22 41:9 46:3
59:17,22 75:19 92:9
97:10,11 99:13 104:7
104:9 109:16 110:13
110:14 111:16 114:4
114:16 115:17 118:9
126:10 129:1 131:11
131:16 135:9 143:9
144:2,5 147:1 151:11
151:15 152:15,20
153:10,17 178:19
242:5,16,19 243:16
243:19 244:2 245:14
246:20
eyes 29:13 73:20 74:9

F

FAAFP 1:22
face 20:18 42:11,11,17
42:17 43:3,3,7,7 52:5
66:8 85:7 148:13
facilities 161:4 175:14
192:18 193:14 194:16
238:22
facility 169:5
fact 74:1 82:22 90:1
149:16 206:10,13
219:12 233:3
factor 103:2
fail 87:10 122:21 176:2
failed 122:6 191:6
failing 110:4
failure 87:15
fair 226:9
fairly 8:21
fall 127:19 132:14 157:6
163:14 194:7
falling 150:2
falls 168:11 252:20
false 108:11

falsely 108:6
families 117:11 161:19
 165:1 210:9,18
 214:15
family 46:14 78:9
 129:11,13 130:2
 141:6 148:6 165:7
 211:21 224:13
fan 182:15
far 11:2,10 28:22 78:9
 105:3 111:20 155:13
 188:10 201:14
fashion 9:18
father 56:7
fault 114:22 199:19
favor 152:9 154:15
fax 78:3 141:10 167:7
 174:19
faxed 193:15
faxes 237:12
faxing 175:14
FDA 249:18,20
fear 151:16
feasibility 37:8,14,21
 38:3 53:1,11,17 67:11
 67:15,22 71:4,8,13,18
 71:21 86:14,16,20
 88:5,13 90:21 91:3
 94:10 104:15 144:20
 144:21 147:12,14,21
 172:8 174:16 176:13
 176:20 180:20 181:22
 182:3,9 195:12,13
 196:10,13,18 237:8,9
 237:20 238:1,7 262:2
feasible 67:13 145:2,12
 145:17
features 31:7
federal 166:7,12
feds 254:3
feed 130:15
feedback 93:4 96:15
 132:22 137:4,6,12,15
 140:17 144:8 145:21
 147:8 242:7 259:21
feeding 137:19 179:20
feel 30:7 72:2 94:16
 97:1 129:12 136:2
 220:3,12 258:20
 259:2 264:11
feeling 153:14
fellowships 257:13
FERPA 211:21
field 210:15 212:20
 218:20 245:16 262:1
figure 33:5 99:1,16
 142:13 216:19
fill 227:10 262:5
filled 223:3,3,4

final 161:1 265:3
finally 5:10 238:8
find 12:5 16:14 22:1
 75:6 79:9 115:15
 134:13 140:10 149:13
 163:8,9 192:14 224:6
finding 21:15
findings 8:17 27:6
 61:15 121:17 204:10
fine 119:19 121:12
 159:9 219:17 220:20
 221:8 239:3
finished 58:18
first 4:17 5:14 7:9 17:9
 19:7 22:3 23:2 27:20
 28:22 76:12 99:8
 101:14 115:14 120:10
 121:1 158:19 159:1
 188:5 198:9 206:20
 206:21 208:5 209:10
 209:12 212:21,22
 217:8 219:19 228:6
 232:12 255:12,16
fit 212:21 244:20 255:4
 255:12
fits 255:17
fitted 213:8
fitting 255:7 256:7,15
fittings 213:10 244:13
five 6:4,17 7:1 55:17
 57:3 66:12 78:5
 103:16,22 113:20
 128:3,4 135:9 152:19
 189:12
flagging 246:16
flight 185:10
Floor 1:9
Flora 2:13 5:1 21:3 61:8
 63:5
Flora's 17:13 36:7
Florida 1:15
flying 185:14
focus 63:7 100:22
 136:3
focused 15:5 103:21
 106:2 139:1 140:7
 172:14 260:15
focusing 79:7
fold 9:21
folks 21:4 30:14 76:20
 242:19 246:14 257:3
follow 15:17 30:22
 39:19 58:6 81:2,5
 98:8 112:2 149:19
 163:10 168:18 225:11
 229:9
follow-on 111:18
follow-up 105:3,15
 106:12 107:9 110:17

117:8 121:11 147:1
 186:21 231:17 261:9
follow-ups 264:1
following 16:15 44:4
 114:22 207:19 264:8
 264:20
force 96:7,8 112:12
 128:16 133:7,15,15
 159:17,21 203:17
form 49:18 69:16 75:7
 75:10 215:15 220:16
 223:1,2,3,4,6 224:5
 227:10 262:6
formal 136:22
formally 178:17
format 175:16 226:5
forms 151:9 237:13
formulation 40:5
forth 213:1
Forty-four 166:15
Forum 1:1,9
forward 26:13 93:7
 94:20 168:22 252:21
 259:8 265:6
found 108:2 117:19
 121:13 146:18 173:12
 194:17,18 231:20
 232:4 236:5
four 12:11 18:13 31:21
 44:18 47:3 51:15
 52:17 53:13 54:9 60:8
 64:2 65:20 67:5,18
 68:16 71:16 79:15
 83:13 84:11 86:7 88:8
 89:2 160:11 171:9
 173:2 174:10 176:16
 177:14 182:5 183:2
 242:17 251:18
FPPE 260:14
frankly 163:3
fraud 22:8 29:17
free 12:4 93:13 97:1
 117:20 264:11
Friedman 1:15 7:8 9:20
 10:21 13:11 19:6
 20:17 26:1 37:9 38:7
 42:1 49:19 51:1 63:8
 73:6,7 75:21 80:4
 83:20 85:1,6 86:14,17
 87:18 88:15 95:5
 99:21 113:2 117:2
 123:10 133:22 145:14
 147:3 163:21 164:17
 166:2 222:4 223:8
 225:1 247:2
front 221:19
fruitful 242:22 248:14
fuel 184:15
fulfill 33:16

fulfills 33:15
full 149:15
fully 22:14 93:1 262:7
function 5:20 79:4,5
 94:20
fundamental 167:18
funded 204:12
funding 138:6
fundings 167:14
fundus 59:3 66:15
further 53:21 97:11
 106:17 138:9 177:21
 199:10 230:20
future 38:14 102:16
 106:21 127:13 129:22
 131:6 132:19 228:18
 245:8 247:9

G

G 43:16
Gaffney 2:11 158:14,15
 158:21 175:3,7
 186:14 188:17 189:5
 198:8 202:7 204:8
 206:19 207:10 208:4
 208:13,17 209:20
 210:7 213:2 214:6
 217:14 229:10 233:16
 233:20 234:10 235:5
 236:1,5 239:10
gain 94:19
gap 18:11 19:3 42:20
 47:1,14 63:22 64:6
 83:11,17 118:17
 119:2 149:2 171:7,14
 189:11,20 190:22
 192:21 193:1,6
 204:17,22
gaps 3:19 6:10 188:21
 242:20
gathering 247:18
gears 157:21
Gee 256:7
general 2:3 26:6 27:4
 27:15 29:3 32:5 59:16
 61:20 78:12 169:7
 226:15
generally 29:1 32:2
 52:7
generating 29:22
generic 50:5
germane 129:17
getting 62:5,7 73:20
 74:9 78:16 93:4 98:13
 102:2 103:19 104:17
 120:19,19 128:10
 130:4 131:3 134:10
 140:12 150:3 166:18
 167:19 176:3 188:11

193:13 198:12 200:3
 202:20 209:10 210:20
 214:13 217:8 218:11
 218:13,15 220:10
 222:12 224:4 247:22
 254:17 257:21 262:6
give 16:8 23:21 35:9,10
 45:10 97:1 117:20
 137:11 140:17 144:8
 158:9 213:18 235:8
 235:15 248:1
given 42:13 101:6
 145:14 151:9 189:14
 206:5 220:19 221:18
 246:4
givers 40:3
gives 24:1
giving 137:3 226:10
glad 15:6
glasses 99:12,14
 117:20 179:20 254:9
glaucoma 36:11 108:2
 108:4,20 245:13,15
 245:18 247:6,7
global 30:3
go 7:18 9:10 21:1 27:12
 32:2,16 34:15 35:3
 41:6 42:8 56:5 58:21
 61:20 64:13 71:1,4
 73:2 78:7,9 79:18
 87:6 91:5 95:10,19
 99:13 115:20 118:14
 134:19 136:15 138:4
 139:15 144:20 147:10
 151:8,13 153:18
 159:11,11 166:8
 170:17 190:11 192:14
 197:21 208:21 211:14
 214:15 216:14 220:8
 222:9 235:13,14,20
 243:11,14 258:19
 260:4 264:19,20
goal 53:22 103:13,18
goes 202:16 248:17
 255:12
going 4:4,18 5:3 6:11
 14:2,6 16:11 18:19
 21:22 22:1,2,5 24:5
 24:10,11 25:2 29:20
 30:6,12,15,16 34:20
 36:9,19 45:22 63:17
 63:18 71:1 72:10 73:2
 76:22 79:4 81:16
 82:13 84:4 90:20 93:7
 93:20,20 94:20,21
 95:1 98:8 100:4,7
 102:5 108:22 115:19
 117:5 118:13 121:21
 123:21 124:5,20

125:1,4,6 127:19,20
 129:2,3 134:8,18
 135:2,21 136:11,14
 137:5,16 139:2,5
 140:15 141:22 143:4
 144:19 145:21 148:11
 148:12 152:17,22
 153:2 157:20,22
 158:6,7,22 159:3,11
 162:8 163:8,9,11
 173:9 182:12 185:18
 186:7 200:16 203:18
 205:3 208:4,20,21
 209:7 212:12 213:2
 213:13 214:16 216:2
 220:22 221:10,22
 223:15 224:6,8,13
 225:18 227:1,6,11,12
 228:16 230:6 231:12
 233:11 234:5 235:13
 236:21 239:16 240:22
 246:13 249:7 250:17
 252:12,21 253:6
 254:7,12 255:18
 258:5,18 260:1,8
 262:3 264:2
gold 19:15,19 48:13
GOLDBERG 1:15
 227:17 257:8 258:1
 259:3
good 4:3,7 5:9 7:8 8:21
 25:6 28:15 34:10
 64:16 85:10 95:13
 96:3 101:15 111:6
 112:6 128:21 129:5
 136:9 138:21 161:8
 164:12 168:3 174:3
 185:11 195:2 219:11
 220:12 222:17 232:15
 243:15 244:2,7,20
 246:11 250:19 255:9
 262:8
goodly 4:9
GORHAM 2:5 156:22
gotten 216:13
grade 36:3 111:1,7
 140:2,3 159:17
grading 31:12
granting 94:18
granular 169:12
granularity 36:5,17
gray 132:14 157:6
great 13:4 16:13 18:21
 22:7 24:4 33:7 55:13
 55:13 77:12 81:8 91:5
 94:17 96:15 137:2
 177:15 185:1 188:13
 208:18 222:19 237:18
 264:3

greater 192:5 193:20
grey 194:7
group 1:14 4:11 27:16
 42:3 65:2 96:13
 113:22 129:12 189:5
 218:15 244:3
groups 46:14 225:15
 247:4
guess 8:17 17:13,16
 23:8 62:4 76:14 81:20
 82:1 85:15 110:19
 132:3 172:18 177:9
 186:18 187:13 189:21
 196:10 199:9 207:13
 214:11 215:12 219:1
 225:11 235:2 236:2
 260:5
guidance 109:22 110:2
guideline 110:22 113:5
 139:22 250:21 251:2
 251:15,18 252:5,8,13
 252:18
guidelines 5:10 16:13
 16:15 17:6,8 55:16
 103:7 164:1 246:14
 246:15,17,21 249:10
 250:6,15 251:8
gut 153:14
guys 13:2 137:4 150:8
 175:22 185:12 219:2
 220:3 233:14 248:13
 261:11

H

halfway 92:16
HAMMERSMITH 2:3
hand 148:11 256:12
handful 139:19
handle 127:16
handled 186:5
HANLEY 2:12 75:8 82:4
 85:18 87:13
happen 78:5 135:21
happened 123:1 147:2
 223:5
happening 77:2 166:21
 225:21
happens 103:1 121:19
 220:20
happy 136:13 138:22
 159:8 186:16 258:17
hard 76:12
harder 61:12
Harmonization 3:19
harmonize 179:16
harmonizing 180:6
harms 97:22
hat 214:11
hate 25:10
head 143:13 261:7
heading 134:11
health 1:17,18 36:8
 53:22 71:10 98:13,14
 104:14 114:9 130:1
 146:7 154:2,5,10
 196:6 238:22 239:3
 246:4,7 254:3
healthcare 2:1 181:5
 211:21
healthy 46:8 180:2
hear 18:17 252:1
 256:10
heard 61:2 111:4
 132:17 140:21 210:19
 222:7
hearing 3:13 23:10
 109:9 158:1,7 159:1
 160:1 161:1,13,14
 167:4 170:10 171:19
 173:17 174:2 180:1
 187:7,9 190:10,11,15
 191:6 193:20 194:15
 195:19,21 198:11,19
 199:2 200:2 203:7,8
 205:6,20 212:21
 213:10 215:4 218:7
 218:11 220:15 224:7
 224:17 231:17 232:1
 232:22 233:3,7,10,18
 234:4 241:8 244:9,13
 244:17 248:7 253:22
 254:7,9,12,15,17,19
 255:4,9,19 256:11,15
 256:17,18,20
heart 81:13 250:22
held 257:9
Hello 158:14
help 33:8 169:18
 174:17 213:17 215:2
 215:3 218:3 246:8,9
 259:19 260:2
helped 107:19 131:9
 168:20,20
helpful 79:1,6,7 135:2
 252:7
helping 222:14
helps 106:20,21
hemoglobin 29:6 73:12
 74:13,14 81:15
hemorrhage 8:10 31:8
 66:16
hesitate 220:2
Hey 255:8
Hi 18:14 263:13
high 12:10 13:5 18:12
 19:1,11,15,21 20:1,12
 29:21 37:4 38:1 39:1

44:17,21 47:2,12
 51:14,17 52:16,19
 53:12,15,22 54:8,12
 57:19 60:7,13 61:3
 64:1,4,18,20 65:19,22
 67:4,6,17,20 68:15,19
 71:15,19 79:14,20
 83:12,15 84:2,3,10,16
 86:6,9 88:7,10 89:1,5
 98:1 112:12 116:2,9
 118:19,22 132:9,12
 144:12,15 147:16,19
 156:20 157:3 160:10
 160:14 171:8,12
 173:1,4 174:9,12
 176:15,18 177:4,13
 177:16 182:4,7 183:1
 183:4 187:16,20
 193:2,5,19 194:3,6
 195:6,9 196:14,16
 197:7,9 200:19 201:3
 204:18,21 215:9
 221:17 231:5,8 237:1
 237:3 238:2,5 239:19
 239:22
higher 73:11 172:15
 191:21 253:19
highest 11:20 173:16
highly 262:3
hired 167:6
Hispanics 188:11,15
 189:2 201:15
history 7:20 57:12
hold 12:18 227:11
home 96:10 210:13
 259:10
honest 207:10 236:5
honesty 189:14
hope 4:8,10 103:18
 123:14,18,20 124:16
 129:20 130:9
hopefully 218:3
hoping 46:17 133:2
 192:15
horrible 131:2
hospital 3:13 158:8
 159:2 161:5,15 162:5
 164:4,14 165:5 169:6
 169:12 170:3,8,14,16
 171:1,21 173:15
 186:22 191:5 260:14
hospitals 162:17 163:8
 167:9 169:15 170:17
 170:18,20 172:2
 173:16 175:4,7
 178:15 180:7 192:11
 237:9
hot 224:20
hotel 185:12

How's 189:5
how-to 181:8
howl 17:2
huge 33:18 45:12 58:15
 108:4,5 117:22
 182:15 255:10 262:16
hundred 183:21
hurdle 141:3
hyperopia 143:6
hypertension 81:16

I

i.e 8:8
ICD-10 35:17 36:18
ICD-9 35:19 36:20 65:2
idea 35:19 58:9 97:16
 99:17 112:7 124:22
 129:4 144:3 185:11
 223:11,13 246:8
 260:17
ideal 31:2 39:19
identification 204:6
identified 97:8 108:6
 153:11 190:12 195:19
 198:11 200:2 220:15
 221:5 233:17
identify 58:3 96:19
 153:1,2 195:21
 231:18
identifying 108:20
 109:2
IFSP 207:2 208:7
 209:22 210:8,10,13
 210:19,19 212:5
 241:9 256:3
III 42:4,5 199:6,12,13
imagine 63:4
imaging 248:20 250:13
 253:1
immediately 118:11
impact 77:19
implant 200:10 212:21
 213:9 214:16
implementation 93:8
 93:14 94:8
implemented 102:18
 126:19,20 127:7
 146:15 148:12,18
 192:9 229:22
implementing 142:12
imply 207:13
importance 92:20
 93:19
important 30:18 34:18
 36:4 39:22 44:6 82:2
 93:17 94:15,17
 114:12 132:1 136:19
 139:12 167:13 217:11
 219:2,5 227:3 230:1
 239:4 242:1 245:17
 259:4
importantly 55:19
impossible 24:7
impression 149:6
improve 63:7 82:21
 150:17 190:4
improvement 5:8 9:19
 13:10 14:15,17 45:3
 60:22 80:3,14,21
 93:18 116:14 118:15
 160:19 161:7 162:20
 173:11 188:2,4
 192:16 201:8,13
 203:13 204:15 260:11
improvements 45:13
 76:15 200:13
inactivate 159:22
inadvertently 75:9
inappropriate 45:19
 222:10 243:9 246:16
 246:21 247:6 248:18
 253:22
inappropriately 42:19
 124:9
inbox 77:7
incentive 102:21
 148:21
include 75:12 101:6
 103:12,21 105:15
 121:11 122:12 125:11
 127:3 131:17 156:2
included 65:4 76:3
 100:19 101:4 125:14
 126:22 178:15 203:11
includes 97:6
including 8:2 86:18
 143:13 194:18 257:11
inconsistencies 231:20
 232:3,20 233:5 234:2
 237:15
inconsistent 194:19
incorporate 131:7,10
 141:22 142:13 146:22
increase 13:22 45:6
increased 82:5,11
increases 82:13
increasing 45:5
increasingly 78:15
incredible 201:22
indicated 232:1
indicates 45:4 255:11
 255:16
indicating 58:4
indication 55:22 115:15
indications 257:21
 258:9
indicative 248:7
individual 105:19 166:8

181:12,13
inexpensive 255:1
infant 187:9 194:21
 199:2
infants 198:19 205:18
 241:8
infection 243:11
infections 243:5 248:12
infectious 250:2
inflammatory 250:1
influence 130:8,11
information 15:18
 22:15 31:11 39:3 40:7
 54:10,13 68:17,21
 75:20 89:3,6 104:17
 126:14 131:4,7 148:9
 149:15 151:7 156:21
 157:5 161:21 167:8
 167:11 177:14,18
 183:2 193:15 194:16
 194:22 196:2 197:1,8
 197:11 205:7 217:22
 232:4,4,7 233:15
 239:20 240:1 245:10
 250:19 251:21 262:7
information's 167:13
informed 59:18
infrastructure 102:6
initial 21:14 23:2 92:19
 96:12 114:1
initially 96:9 111:14
 112:1
input 166:4 242:7
 259:21
inputting 256:17
inside 197:21
instance 125:12 126:8
Institute 1:19
institution 261:2
institutions 262:13
instruments 56:9
insufficient 12:11 13:7
 18:13 19:3 20:13 37:6
 38:3 39:2 44:18,22
 47:3,14 51:15,19
 52:17,21 53:13,16
 54:10,13 60:8,15 64:2
 64:5 65:20 66:1 67:5
 67:8,18,21 68:16,21
 71:16,20 79:15,21
 83:13,16 84:12,18
 86:7,10 88:8,11 89:2
 89:6 116:3,11 118:20
 119:1 132:10,13
 144:13,17 147:17,21
 156:21 157:5 160:11
 160:15 171:10,13
 173:2,5 174:10,14
 176:16,19 177:14,18

182:5,8 183:2,5
 187:17,21 193:3,6
 194:4 195:7,10
 196:15,18 197:8,11
 200:20 201:5 204:19
 204:22 231:6,9 237:2
 237:5 238:3,6 239:20
 240:1
insurance 1:15 254:18
insurances 254:15
Integrating 181:4
intended 94:12,13
 101:18,20
intent 115:11 146:16
 148:16,22 179:11
 217:5
inter 48:5
inter-rater 19:12
interaction 55:21
interested 161:8
interesting 40:6 82:17
 228:9
intermediate 40:9,22
internally 94:5 263:3
interoperability 78:1
interpret 190:20
interpreted 125:22
interpreting 111:8
intervention 3:17 9:14
 11:19 159:6 167:5,10
 198:5,5,12,20 199:4,8
 200:3,12 203:12
 205:7,22 206:7,11
 207:6,9,14,15,21
 208:1,6,15,19 209:14
 209:17,17 210:8,21
 211:1,3,8 212:11,17
 212:19 214:17,22
 215:6,14,21 216:2,4
 216:16,17 217:6
 218:12,14 219:6,10
 219:13,13,16,18
 220:10,19 221:3,7,9
 221:10,19 222:9,13
 222:22 224:3,9,16
 225:7,15 227:1,16,20
 227:22 228:6,6,12
 230:21 235:10 246:3
interventionists 215:9
interventions 226:10
introduce 158:9,18
introduced 33:18 34:8
introduction 32:6
involve 210:12
involved 130:6 168:5
 212:11 241:11,13,17
 261:12
IRIS 15:1 19:9 22:14
 30:13,17 38:12,13

45:10 48:2 61:6 68:6
 80:12 88:18 91:21
 245:5
issue 11:2 14:8,21
 23:20 30:9 65:1 76:13
 101:12 109:6 118:4
 118:13 128:7 152:11
 178:18 192:7 202:17
 218:21 223:21 224:12
 225:13 226:13,21
 250:13,14,18 251:12
 253:1 254:4,4 258:13
issues 21:22 37:13 70:1
 84:5 86:20 92:21 97:4
 117:7 129:16 132:20
 135:20 140:10 147:10
 161:17 165:13 171:22
 192:11 226:17 232:8
it'll 213:9

J

Jackie 199:14 201:18
 205:12 218:21 221:1
 232:9 237:16 238:12
JACQUELYN 2:1
January 205:9 231:15
 235:14 236:17
Japan 154:3
JD 2:3
Jersey 173:15,21,21,22
job 13:16 14:11 25:6,17
 26:11,18,22 27:5,11
 34:10 35:1 80:9 161:8
 234:13 237:18
John 2:10 158:10
 165:12 179:5 180:21
 217:15
joining 4:4
Joint 179:22 187:8
 199:1 203:10 214:21
 260:15 261:15
Josh 34:9,16 81:2
 101:15 124:18 139:1
 140:13 145:19 149:18
 151:1 167:16 175:20
 218:17 223:17 225:9
 257:2 261:7
JOSHUA 1:20
Journal 249:3 251:1
Judith 1:16 12:13 18:18
 47:9 156:12 157:1
 163:17 198:14 201:7
 205:2 230:8,10
 231:11 237:7 240:8
 256:21
Judith's 201:19
July 264:10
jump 83:7 141:4 149:9

June 1:6 264:8
jurisdiction 165:19
 171:1
justify 248:3

K

Kaiser 262:22
KAITLYNN 2:6
Kathleen 1:10,12 186:4
Kathy 158:3
keep 126:1 134:12
 162:10 165:21 206:9
 214:20 229:19 230:3
keeps 111:5
KENDRA 2:12
kept 12:18
key 104:2,4 128:19
 221:9
kid 123:17 124:22 125:5
 129:8
kidney 5:20 79:4
kids 97:4 99:8 100:4,6
 123:13,13 124:3,14
 126:9 127:19 128:2,5
 129:15 149:1 150:2
 150:19,21 151:21
 152:17,19,21,22
 153:7,16 154:12
 170:8 176:2 190:6
 191:2,10,19 198:10
 202:18,20 203:9
 213:8,19 218:6,9,10
 218:11,12 232:21
 233:9 235:15,19
 243:10,11
kind 26:16 31:20 39:18
 61:4 82:17 90:19
 105:7 106:6 107:14
 109:18 111:9 112:17
 114:22 121:6,16,19
 122:16 123:10,22
 124:9,10,12 129:9
 132:21 137:6 140:9
 142:10 151:2 153:11
 153:15 172:9 180:4,8
 192:6 212:6 215:12
 220:2,8 227:1 248:16
 249:12 251:3 252:3
 258:13,15 260:2,3
 262:13
kinds 28:14 66:14
 117:14 142:21
knew 152:2 219:19
know 4:9 12:15 18:14
 23:7,13,21 24:2,2,9
 25:2 28:9 29:6,22
 30:4,11,12 32:8 33:17
 42:2,13 43:5,10 49:13
 49:14,16,17 61:21

63:15 73:10,11 74:7,9
 75:22 76:22 79:1,4
 83:1 87:12,19 92:13
 93:21 94:15 98:19
 100:12 102:13 104:3
 104:6 107:4,13,19
 117:7 119:8 120:2
 131:20 132:2,19
 135:12 136:3,11,17
 138:5,8,14 139:8,12
 144:4 146:3 147:6,9
 148:3,15,20 150:1
 152:6,13,17 153:7,8
 153:12,19 155:16
 158:5 162:6 163:9
 168:12 169:19 172:5
 179:6 185:8,13,18
 192:11 203:16 204:4
 206:9,10 212:9 213:4
 214:14 217:9 219:7
 223:5,13,14 227:3,14
 228:12,13 232:11,17
 239:5 241:1 242:4,9
 242:13,17,22 243:6
 243:19 244:5,21
 246:16 247:6 249:9
 256:12 258:18 260:22
 261:11 262:1 263:1
 264:1,3

known 15:21
knows 88:2

L

laborious 36:14
lack 33:19
lag 220:9 235:3
lame 163:22
language 200:4,5
 213:11 224:19
laptop 13:3
large 14:18 57:11 97:20
 202:9 209:6 210:1
 218:6 257:18 262:12
larger 59:14
largest 46:14
late 200:1 248:6
lately 46:2
latest 16:15,16
law 98:8,9 166:20
laws 98:6 116:18
 139:14 166:16,17
 202:21
lay 225:12
layperson 222:5
lead 15:12 74:2 97:2
 220:9 237:13
leading 5:4 6:7 58:12
 58:14

leads 73:12,13
leant 250:6
learn 136:21 149:13
 167:9
learned 241:16
learning 215:5
leave 124:13 260:3
leaving 233:5
leery 6:13
left 75:9
legal 7:12
legislation 165:15,17
 165:18 166:7
legitimate 216:7
lend 252:5 257:5
length 207:20 209:16
 211:6,7 212:8
lens 95:1
lenses 32:7
let's 115:20 147:11
 156:11 178:11 182:20
 192:21 195:2 229:12
 255:3,13
letter 75:13,16 76:1
 85:22 87:22
letters 77:9
letting 79:1
level 3:9 5:16 6:15 8:7
 9:1 55:8 56:12 57:17
 61:4 73:15 74:3,7,14
 74:20 75:4 84:3 105:6
 105:22 106:4 112:8
 112:11,18 126:2
 133:8 165:22 166:7
 167:6 169:5,6,9,10,13
 172:15 181:13,15
 199:6,12,13 234:11
 238:19 239:2,11
 259:15
levels 32:2 73:11 118:7
 245:13
Libby 101:12
life 98:2 102:11 108:22
 109:1 220:19 241:17
lifetime 253:4,10
lifetime's 134:4
likelihood 11:17 57:19
 82:21
limited 8:3 69:18
 104:12 115:4 131:13
 131:17 222:15 248:12
line 5:8 18:15 184:5
 204:18
lines 56:9 263:14
linguistic 200:13
 215:11
linkage 234:13
linking 110:2
links 189:15

Lions 130:15 150:3
lipid 31:9
lipids 77:18
list 65:5 247:17
listen 81:18 162:13
listening 110:8,9
 186:13
literature 94:1 118:5
 199:3
little 6:13 10:12 26:7
 49:12 63:5 76:8 77:17
 108:19 127:17 129:6
 129:10 134:11 137:15
 162:14 174:18,21
 179:14 184:15,15
 213:5 215:13 216:20
 221:1 227:8 241:22
 260:4
live 108:22 154:3
 161:19 171:17,20
logic 121:1,8,18
logistical 185:8
long 12:19 56:4 152:7
 219:19 228:7 250:3
longer 32:12 42:22
 154:3
look 4:5 5:3,20 8:6,16
 9:21 10:2,7,18 11:2
 15:1,2 21:18,22 22:1
 26:9 29:16,17 30:13
 31:6 32:8,19 33:20,21
 34:1 35:20,21 40:16
 42:18 57:20 63:16
 64:11 66:15 75:18
 77:10 80:12 81:21
 89:21 93:20 95:1,10
 101:8 103:2 112:19
 113:14 119:7 122:1,2
 127:10,14,20 129:8
 131:13,19 141:15
 155:14 161:16 168:22
 170:22 172:10 212:14
 212:16,18 217:2
 218:8 221:11 227:7
 243:18 244:3 245:9
 245:13 247:9,16,21
 249:14 251:4,9
 253:18 255:3 259:8
 265:6
looked 19:11 41:9,13
 77:10 93:3 100:18
 106:11 111:10 115:17
 158:6 162:18 194:14
 199:4 233:7 242:3
looking 4:18 8:3,14,19
 8:22 11:12 12:5 16:2
 16:7,18 21:5,17 23:15
 24:19 33:2,3 41:11
 62:10,10,12 64:17

66:13 73:8 84:1,2
 93:16 95:4 102:11,21
 103:14 105:7 107:3
 107:15 108:1 109:4
 109:13 110:20 115:7
 119:11 120:8,15
 121:2 129:22 146:14
 152:3 172:8,9 175:22
 176:2 188:4,20
 191:14 193:10 205:15
 206:5,14 207:8 211:2
 213:16 215:16,18
 216:12 217:9 223:1
 227:21 248:4
looks 8:6 12:22 37:22
 40:1 60:10 70:14
 79:16 110:21 111:7
 120:13 121:17 169:10
 197:17 215:22 223:6
 232:7 246:13
loop 104:10 106:10,15
 118:3,11
lose 227:5,8,14
losing 41:19 225:21
loss 45:15 106:21 109:3
 123:12,18 135:1
 171:19 190:12 195:20
 195:21 198:11,19
 200:2 203:7,8 205:20
 218:7,11 220:15
 232:1 233:3,7,10,19
 241:8 244:17 248:8
 256:20
losses 193:20
lost 36:1
lot 4:5 16:13,14 22:2,4
 30:7 31:14 34:8 36:19
 49:11 63:13 80:20
 108:7 113:13 115:19
 132:15 150:1 151:15
 155:2 161:5 166:20
 169:6 175:8 185:8
 193:15 196:22 199:21
 202:20 203:3 204:6
 208:22 211:8 212:10
 212:11 213:20 214:14
 216:5 218:12,15
 234:16,21 242:13
 244:17 245:9,10
 249:4 258:18 261:12
lots 78:10 80:14,17
 84:1 206:16 248:16
love 221:13 242:7
low 12:11 13:6 18:13
 19:2 20:13 34:14 37:5
 38:2 39:2 44:18,22
 47:3,13 49:10 51:15
 51:18 52:17,20 53:13
 53:16 54:9,12 60:8,14

64:2,5,20 65:19 66:1
 66:11 67:4,7,18,21
 68:16,20 71:15,20
 79:15,21 83:13,16
 84:11,17 86:7,10 88:8
 88:11 89:2,5 116:3,10
 118:19 119:1 132:9
 132:13 142:10 144:13
 144:16 147:16,20
 148:7 156:20 157:4
 160:11,15 171:9,13
 173:1,5 174:9,13
 176:15,19 177:14,17
 182:5,8 183:1,5
 187:17,20 193:3,5
 194:4 195:7,9 196:15
 196:17 197:7,10
 200:19 201:4 204:19
 204:21 231:5,9 237:2
 237:4 238:2,6 239:19
 239:22
lower 14:13 15:4 61:13
 74:14,20 80:13,20
lowest 173:15
Lum 2:13 5:1 15:17
 22:18 25:11 43:9,16
 61:9 63:6 65:8
lunch 159:3 184:14
 262:10
LUONG 2:5 12:13,20
 18:14,18,21 47:9
 60:17 84:13 85:5
 116:5 183:17 184:4
 184:13,17 185:2,6,20
 230:8 240:8,11,13
 263:10,13,19 264:3
luxury 254:22
LYNCH 1:16 12:15
 18:19 156:12,16
 163:17 198:16 199:13
 200:21 201:9 202:2
 203:20 204:2 205:4
 206:9 208:2,12,14
 228:16,21 230:11
 231:2,13 232:15
 237:9 238:8 239:9
 240:10,12,14 257:1

M

mac 9:22 26:4
macular 3:4,5,6,8 4:21
 4:21 5:5,15 6:6,6,17
 7:9,10,11 8:1,8,9,11
 9:2 10:1,3,16 16:8
 25:15 27:6,21,22
 29:16 32:8 36:13
 39:15,20 41:10,11,15
 44:6 55:7 56:12 58:4
 59:3 65:7

MADONNA 1:17 9:7
 15:7 20:3 27:19 29:11
 29:18 37:16 38:16
 39:18 41:8 44:4 45:4
 47:18 48:22 52:1 53:2
 53:19 110:6 113:21
 118:8 126:4,11
 127:17 128:8 143:12
 150:14 152:5 169:17
mailing 175:15
Main 235:6
maintain 165:21 167:21
maintaining 168:22
maintenance 260:10
major 140:19
making 76:15 114:15
 126:9 129:8 137:18
 216:7
mammography 107:13
management 77:14
 232:7
Manager 2:5,5
managing 3:11 73:5
 75:15,17
mandate 163:4
mandated 174:1,2
Manger 2:6
manifestation 24:13
manual 237:14
mapping 23:2
MARCIA 2:4
Marcus 2:11 158:14
mark 75:5
marked 200:12
marker 207:4
market 213:5
Mary 200:7 221:1
matches 256:19
Matt 9:10 35:3 42:8
 87:7
matter 31:14 43:20 92:4
 112:19 185:3 265:9
MATTHEW 1:14
maturation 191:13
McGlynn's 5:12
MD 1:12,12,14,15,15,18
 1:19,20,21,22 2:6
mean 13:22 14:13,17
 23:17 30:5,18 33:11
 33:12 35:12 45:8
 59:17 62:7 82:16
 105:22 108:7 111:6
 111:13 112:3,9 117:9
 120:14 123:20 124:2
 124:10 125:18 126:6
 129:4 130:12 131:22
 134:22 135:5 136:4
 136:16 138:13 139:15
 139:18 153:4 154:20

157:9 168:19 171:4
 189:13 202:5 204:4
 208:17 209:4 216:7
 216:20,22 217:15
 218:7,12 219:7,10
 222:13 223:14 225:11
 226:1,8 227:21
 228:11 230:12,13
 233:16 234:11,21
 241:17 246:16 248:12
 248:15 252:12,17
 254:6 257:15 261:14
 263:4
meaning 175:3 234:3
 243:5
meaningful 13:13 93:7
 106:9 126:20 148:5
 168:21 177:3 178:15
means 25:20,20 33:12
 48:21 49:14 119:18
 119:20 135:22 206:4
meant 94:14
measure 6:12 7:9 8:5
 9:4,12 12:9,16 13:7
 18:1,11 19:3,8 20:10
 20:14,14,20,22 21:5
 21:12 23:18 24:15,16
 24:22 25:13,13,18,21
 26:15 27:17,20 29:13
 30:1,14 33:1,4 34:12
 36:2 37:2,6,7,9,14,21
 38:3,7,21 39:3,9,13
 39:13,19 40:1,17
 42:16 43:8 44:5,16
 45:1 47:1,15,15,19
 48:1 51:4,13,19 52:7
 52:15,21 53:11,17,19
 54:7,14,14,18,21 55:4
 55:4,6,10 56:21 59:13
 59:20 60:6,16,16,19
 62:22 63:10,12,22
 64:6,6,10 66:3,3,6,10
 67:9,16 68:1,1,14
 69:1,1,3,8,14,14 70:4
 70:5,10,20,20 71:1,14
 71:21,22 72:3,15,22
 73:2,8 75:9 76:12
 79:13,22,22 82:9,9,10
 83:11,17,17 84:5,9,19
 84:20 85:9,18 86:5,12
 86:12,17,21 87:15
 88:6,12,13,15,22 89:7
 89:11,18,18 90:11,11
 90:17,17 91:1,16
 92:10,22 94:3,15,17
 94:20,22 95:6,11,15
 95:15,17 96:4,5,11,17
 96:18,21 97:6,15 98:7
 100:17,21 101:17,18

102:10,19 103:14,21
 105:6,18,19,20,22
 106:4,7,10,11,14,15
 107:2 109:8 110:20
 111:14,17,18,19,22
 112:1 113:7,8 116:12
 118:18 119:3,5
 120:21 121:9 122:15
 123:4 125:6,9 126:2
 127:13,16,19 128:3
 129:18 130:19 131:6
 132:7,16 134:10
 136:18 140:7 141:4
 142:3,10 144:11,17
 144:18 146:3,13,17
 147:2,22 148:18
 149:12 152:11 155:7
 155:17,21 156:1,6,19
 157:18,21 158:18
 159:4,5,22 160:9,16
 160:16 161:12 163:7
 163:14 164:19,20
 165:11 166:4,6
 168:17,22 169:3,4,11
 169:19 170:9,15
 171:7,14,14 172:12
 172:13,22 173:6,7
 174:8,15,15 175:22
 176:1,6,6,14,20,21
 177:12,19,20 178:3,9
 178:10,13,16 179:3
 179:10,21,21,22
 180:3,5,8,14,19 181:7
 181:14 182:1,9,14
 183:7,12 184:2 186:7
 186:15 187:15,21,22
 193:1,7,7 194:2,10,21
 195:5,11,11 196:13
 196:18 197:6,12,14
 198:2,3 199:1 200:18
 201:5,10 203:18
 204:17 205:1,1 206:6
 207:8 211:3 215:13
 215:19 216:9,11,11
 216:15 217:2,7,16
 220:4 221:10 222:16
 225:22 226:19 227:6
 227:18 228:12,13
 230:3,6,17,20 231:1,4
 231:10,10,13 237:1,5
 237:6 238:1,7,7,16,18
 238:20 239:3,6,18
 240:2,2,6,18,18 244:4
 244:19 245:17,17
 250:7 259:13 261:11
 261:18,19 262:19
 264:21
measure's 102:18
 105:14 222:5 229:21

measured 16:10 63:7
 74:13 107:10 119:9
 218:22 219:2,4
 238:17,20 239:1,5,11
 242:12 257:14,17
 259:11
measurement 2:4 5:10
 23:16 35:5 93:17
 100:3 120:5,7 122:10
 171:18 260:19 261:22
measurements 31:21
measures 3:3,15 4:6,17
 5:14 6:14 7:4 14:22
 15:3,5,19 17:15 22:4
 22:21 24:8 27:18 29:7
 29:8 30:2,10 31:17,19
 32:2 34:2 52:9 62:11
 62:13 63:1 82:13
 89:20 90:3 92:8,17,18
 92:22 93:13,15 94:11
 94:11 95:19 106:3,9
 107:7 120:9 150:16
 158:18,22 164:13
 176:8 178:19 179:19
 181:20 184:21 185:7
 187:6 198:17 215:19
 237:15 241:20 242:3
 242:9,10,13,14,15,15
 242:16,19 243:1
 244:10 245:9,19
 246:1,4,13 247:10,18
 247:22 248:10 255:7
 257:5 258:6 259:12
 260:12 261:3 262:5
 262:15 263:3 264:22
measuring 21:9,20 33:6
 33:8 136:18 138:20
 152:9 210:4,4 215:14
 217:6,20 219:12
 223:2,6 226:18
 227:16 228:5 239:7
 256:18
mechanism 167:8
 196:1 234:5
MEd 1:22
Medicaid 130:12
 148:19 149:1 206:14
Medicaid/CHIP 127:7
medical 1:13,14,21
 33:7 75:16 77:4 96:10
 127:3 173:13 190:12
 210:12
Medicare 254:8
medicine 15:22 87:20
 249:3 251:1
medicines 59:16
meet 21:5 25:21 40:8
 63:18 125:5 263:5
meeting 17:6 81:22

171:2 263:21 265:8
meetings 185:21 247:4
Melanie 127:12
Member 3:14,20 7:8 9:7
 9:11,20 10:21 11:1,16
 11:22 12:15 13:11
 15:7 18:2,16,19 19:6
 20:3,17 22:12 26:1
 27:19 28:14 29:11,15
 29:18,21 30:21 31:6
 32:18 34:17 35:4,12
 35:15,17 37:9,16 38:7
 38:16 39:18 41:4,7,8
 41:16 42:1,9 43:20
 44:1,4 45:4 46:13
 47:18 48:16,20,22
 49:19 51:1 52:1,10
 53:2,6,19 54:2 56:16
 58:19 59:1,9,15 61:1
 61:11,18,21 62:3
 64:14 65:12 66:5,18
 67:12 68:4,8 73:7
 75:1,21 77:3 78:8,20
 80:4 81:1 83:20 84:6
 85:1,6,12 86:14,17,22
 87:4,8,18 88:15,19
 95:5 97:13 99:21
 101:16 102:1 104:2
 105:17 106:19 107:17
 107:22 108:10,16
 109:7 110:6,19 112:3
 113:2,21 116:15
 117:2,9 118:2,8
 119:14 120:8 121:20
 122:5 123:10 124:19
 126:4,11 127:17
 128:2,8,11,19 129:11
 133:2,19,22 135:18
 136:7 137:2,11 138:2
 138:8,19 140:15,18
 142:17 143:9,12,17
 143:22 144:22 145:6
 145:11,14,20 147:3
 148:3 149:4,19
 150:14 151:19 152:5
 152:7,12 153:22
 154:10 155:4,10
 156:12,16 159:20
 161:11 162:8,22
 163:16,17,21 164:3
 164:17,22 166:2,15
 167:3,17 168:9
 169:17 170:1,7,9
 172:7 173:20 175:21
 176:5,9 177:7 182:15
 183:19 185:1 186:20
 188:3 189:1,21 190:5
 190:9,21 191:3,10,12
 192:10 193:10 194:13

195:13 196:3,4,21
 198:16 199:13,16,20
 200:21 201:9,17,19
 202:2 203:6,16,20,22
 204:2,3 205:4,14
 206:9,12 207:7,18
 208:2,12,14 209:13
 210:14 212:9 214:7
 214:10 215:16 217:3
 218:19 219:7,15
 220:3,7,22 221:12
 222:4,18 223:8,19
 224:22 225:1,10,19
 226:2,14,16 227:17
 228:2,4,16,21,22
 229:6,14 230:11,19
 231:2,13 232:11,15
 232:16 233:18 234:1
 234:19 237:9,17
 238:8,13 239:7,9
 240:10,12,14 243:2
 243:13 244:6,11
 245:5,22 246:12
 247:2 248:5 249:15
 251:13 252:1,9,15,16
 253:13,21 254:11
 256:5,9 257:1,3,8,20
 258:1,5 259:3 261:9
members 20:19 46:14
 52:6 66:6 85:8 91:22
 186:1 241:4,14
membership 264:17,19
mention 64:9 65:1
 74:10 114:19 204:8
mentioned 39:21 47:18
 62:17 82:17 161:18
 193:12 249:8
mentioning 195:18
mentor 224:19
Merenstein 1:10,12
 45:18 62:16 95:21
 97:12 99:19 101:10
 106:17 110:17 112:11
 112:22 113:19 114:18
 115:18 116:13,19,22
 117:4 118:12 122:3
 124:18 131:20 133:13
 135:4 140:13 141:18
 144:7,19 145:13,18
 147:11 148:1 149:18
 153:21 154:18 156:9
 156:15 157:8 158:3
 158:17 159:10 160:5
 160:18 162:2,12
 163:19 165:10 166:14
 167:2,16 168:6
 169:16 170:12 171:3
 171:16 172:17 173:8
 174:4,16 175:6,19

176:7,10,22 177:8,21
 178:11 186:10,18
 187:12 188:1,13,19
 189:6,10,19 192:20
 193:8,21 194:8,12
 195:1,12 196:9,20
 197:3 198:4,14 199:9
 199:14,17 200:15,22
 201:7,18 202:3 203:5
 203:14 204:13 205:2
 205:11 206:16 210:3
 214:5,8 218:17 222:2
 223:17 225:9 226:6
 226:15 228:3,10,19
 229:12 230:5,10,16
 231:11 234:20 236:19
 237:7,16,19 238:12
 238:14 239:14 240:19
 243:16 245:21 247:1
 251:6 253:15 256:21
 257:2 258:3
mess 130:8
message 129:21
 130:10
messages 77:7,8
messaging 230:1
messy 130:10
met 1:8
method 108:14
methodology 226:18
methods 23:3
metric 120:13 224:15
 234:9 255:14
metrics 244:13,22
metropolitan 209:6
mic 144:21 189:9
 256:14
Michael 1:21 110:18
Michigan 1:20 118:3
 261:5 263:2
Mickey 163:16
Micky 227:2 230:18
 260:22
Micky's 258:10
mid-year 236:9
midlevel 130:3
midwives 162:1 170:4
mild 7:19 193:20 203:8
 244:16
military 170:18
mind 214:20 229:19
minerals 40:21
minute 91:19
misinterpret 21:16
misleading 225:14
missed 32:11 50:7,9
 111:3
missing 60:10 70:14
 79:16 97:22 133:10

194:20,22 197:17,21
 203:9 232:3 234:22
mnemonics 49:13
moderate 10:3 12:11
 13:6 18:13 19:2,17
 20:12 37:4 38:2 39:1
 44:18,21 47:3,13
 51:15,17 52:16,20
 53:13,15 54:9,12 60:8
 60:14 64:2,4,20 65:19
 65:22 66:9 67:4,7,17
 67:20 68:15,20 71:15
 71:19 79:15,20 83:13
 83:15 84:11,17 86:6,9
 88:7,10 89:1,5 116:3
 116:9 118:19,22
 132:9,12 144:13,15
 147:16,19 156:20
 157:4 160:11,14
 171:9,12 173:1,4
 174:9,13 176:15,18
 177:13,17 182:5,7
 183:1,4 187:17,20
 193:3,5 194:4,6 195:6
 195:9 196:15,17
 197:7,10 200:19
 201:4 204:18,21
 231:5,8 237:2,4 238:2
 238:5 239:19,22
modified 100:1 225:17
module 260:11
Moeller 200:8
Moeller's 221:2
mom 119:22 141:8
 143:13 144:3
moment 207:1,12,17
 217:20
momma 149:7
money 14:7 153:4
monitor 190:3
month 41:17 46:5 50:16
 50:18 161:13 170:10
 220:8,13,18
monthly 28:16 175:10
months 3:17,17 40:4
 50:20 51:2 56:6
 138:10 159:5,7 186:8
 186:16 187:2,8 188:9
 188:12 190:19 191:20
 198:6,13,21 200:2
 205:21 206:7 207:9
 207:16 210:22 211:4
 211:5 212:17 217:6
 220:1,12,15,21 221:2
 221:5,7,20 223:4
 224:3,7,8,11,16,20
 225:6 241:9 252:11
moot 222:8
morning 4:3 7:8 96:3

mother 152:15
move 26:12 80:15
 115:21 130:18 168:13
moving 4:17 39:14
 179:15 246:6
MPH 1:21,22 2:5,6,6
MSA 1:12
multi-center 42:4
 244:15
multiple 187:10 248:8
myopia 143:5

N

N 3:1,1
N.W 1:9
NALINI 2:9
name 95:14
name's 158:14
napkin 262:11
nation 201:21
national 1:1,8 57:12
 158:11,15 170:22
 171:2 188:4,7 192:17
 259:15
natural 5:8 6:1 7:19
 57:12 77:19 121:22
navigate 215:3
navigator 246:9
NCQA 261:15
near 245:8
necessarily 119:18
 176:1 211:15 215:6
 256:9
necessary 31:1,3
 120:14 147:4,8
 219:14 221:21
necessity 254:21,22
need 10:18 23:22 25:7
 26:12 27:4 28:12,20
 33:8 42:14 69:15
 99:11 104:8 125:2
 134:5,6 142:5 156:12
 162:10 166:9 174:17
 190:9 201:13 203:11
 212:16 214:21 220:8
 221:11
needed 104:21 115:8
 120:11 121:5,7 123:2
 142:9 146:21 246:11
needs 8:2,16 100:17
 115:16,16 134:10
 149:14 168:2 212:17
 224:15 225:17 227:19
 243:17 244:3
NEI 56:2
neonatal 172:5
nephropathy 81:6
nervous 223:1

network 165:7 264:12
neurologic 79:5
neuropathy 81:5
 164:15
never 92:11
nevertheless 15:16
new 6:17 10:17,19 22:4
 35:6,8 47:21 58:13,14
 77:4 90:22 92:9,10,18
 93:15 101:17 160:1
 173:14,21,21,22
 203:22 204:3,7
 242:22 245:12 249:3
 250:22 251:8
newborn 174:2 179:17
 180:1 191:6
newborns 160:21 180:2
newer 242:9
nice 121:12 170:21
 259:7
NICU 192:5
night 243:3
night's 186:3
NIH 159:15
nine 14:22 24:8 62:13
 63:4 83:6
Ninety 177:15
Ninety-three 178:6
 180:16 182:6 183:3
ninth 140:3
nobody's 227:11
nodding 261:7
non-eye 30:22
non-medical 213:12
non-smoker 44:3
normal 99:8 121:4,7
 122:20 123:2 142:8
 152:1,2 232:22 234:4
NOSE 1:3
note 60:17 84:13 90:7
 186:3
noted 65:8
notes 154:19
noticed 246:12
noting 232:18
notwithstanding 82:22
November 264:22
 265:2
NP 1:16
NQF 2:3 3:14,20 6:13
 94:18 96:14 137:17
 168:16,22 179:12,19
 179:20 180:3 245:4
 247:5 262:4 265:4
NQF's 92:14 149:11
nuances 135:20
number 4:9 6:16 11:13
 13:16,19 15:14 45:5
 45:12 64:16 82:5

151:17 159:4,6 184:9
 205:18 218:9,10,11
 245:19 246:1 257:18
 262:16 263:17
numbers 57:3 64:20
 80:19 82:12
numerator 19:16,20,22
 47:19 48:10,14,22
 59:3 119:11,15 122:7
 205:15,16,17 221:11
numerator/denomina...
 171:20
numerous 57:9
nurse 1:16 141:7,15
nurses 129:15 164:7
nutritional 41:14

O

O 3:1
obliged 129:12
observational 159:14
observations 29:16
obtaining 102:14
obvious 74:6 111:10
 225:4
obviously 107:8 136:4
 145:2 161:9 168:16
 222:8 261:12
occasionally 10:17
occur 103:4,12 109:19
 216:21
occurred 104:18 105:5
 105:12
occurring 161:4
occurs 42:17 43:3
October 264:20
ocular 114:9
OD 1:17
OD's 78:13
odds 9:17
off-label 249:19
office 42:11 48:7 49:3
 74:11 76:18 125:7
 144:5,6 152:16,20
 153:8,10,17 154:22
 155:19
oftentimes 170:19
oh 12:20 47:5,7 61:17
 70:16,16 71:2,18 84:9
 90:11 111:5 117:4
 123:20 194:9 197:19
 199:19 200:21 227:9
 240:10 253:9
okay 9:3,9 12:20 13:4
 18:18,21 20:11 21:13
 32:16 37:3,22 39:10
 39:14 41:5 44:13,20
 45:2 47:11,16 52:18
 54:1 55:5 56:10,13,14

60:10,12,21 63:6
 65:21 67:6 68:18 70:7
 70:14,16,22 71:6,12
 71:17 73:1 75:3 80:2
 85:6 86:1 88:9 89:14
 90:19 91:12 95:9,10
 112:4 117:4 119:14
 120:7,21 143:17,22
 144:9 147:18 148:1
 155:2 156:16 157:2
 158:21 160:8 163:21
 164:17 169:22 176:9
 182:1 183:9 184:7,14
 186:6 194:5,14
 197:17,22 198:4,14
 198:16 200:15,21
 201:1,2 205:4 206:19
 208:13 226:7 228:21
 231:2,7,13 233:8
 237:19 238:8 240:11
 240:14 241:19 256:1
 263:15 264:3
old 35:6 46:4 95:14
 110:15 135:10 262:22
older 40:2 52:4 58:13
 59:10,12
once 12:4 31:22 44:1
 50:16,21 103:17
 121:16 170:21 175:17
 179:12 186:21 200:11
 206:20 257:9
one's 77:18
ones 22:3 24:1 27:10
 34:6 52:2 108:8
 141:15 170:13 178:18
ongoing 3:11 73:5 81:3
 204:9 260:16,19
Oops 194:10
open 12:9 18:11 20:10
 36:10 37:2,21 38:21
 39:8 44:16 47:1 51:13
 52:15 53:11 54:7,20
 60:6 63:22 65:17 67:2
 67:16 68:13 69:8
 70:10 71:13 72:13
 79:13 83:11 84:9 86:4
 88:5,21 89:9 90:10
 91:8 116:1,21 118:17
 132:8 144:10 147:15
 156:18 157:13 160:9
 161:9 162:13 171:7
 172:21 174:7 176:13
 177:11 180:13 182:3
 182:22 183:12 184:5
 187:15 192:22 194:2
 195:5 196:13 197:5
 197:15 200:18 204:16
 231:3 236:22 238:1
 239:17 262:5 263:14

- opening** 240:4
operating 258:11,22
 259:1
Operator 184:4,7,11
 263:10,13,15
ophthalmologist 27:15
 32:5 49:5 97:10 99:1
 104:6 130:2 146:5
ophthalmologist's 48:6
 49:3,6
ophthalmologists
 16:14 26:6 27:5 48:2
 59:5 78:12 98:21
 127:4 133:14 163:22
 245:7
ophthalmology 3:5,7
 29:5 74:19 158:4
 243:20 245:9 246:18
 247:11
ophthalmology's
 245:20
ophthalmoscope 31:7
opinion 8:19 80:21
 110:21 220:14 227:4
opinions 136:1
OPPE 260:14
opportunities 160:18
 161:16 170:5 190:3
 201:8 204:14 242:8
 242:14 245:8 246:20
 252:22
opportunity 13:9 45:3
 60:22 80:3 116:13
 118:14 125:10 126:3
 149:21 156:5 161:22
 169:11 188:1,3
 203:13 245:3
opposed 9:16 35:13
 110:15 153:6 236:4
opt 165:1,11
option 11:8,9 12:10
 18:12 25:4,10 44:17
 47:2 51:14 52:16
 53:12 54:8,22,22 60:7
 64:1 65:18 67:3,17
 68:15 69:9,9 70:12,13
 71:14 72:16,16 79:14
 83:12 84:10 86:6 88:7
 89:1,12,12 90:12,13
 91:10,11 92:16
 109:20 116:2 118:18
 132:8 144:12 147:15
 156:19 157:14,14
 160:10 171:8 172:22
 174:8 176:14 177:13
 178:4,5 180:14,15
 182:4 183:1,12,13
 187:16 193:2 194:3
 195:6 196:14 197:6
 197:15,15 200:18
 204:18 231:4,5 237:1
 238:1 239:18 240:6,7
options 121:16 154:16
optometrist 130:1
optometrists 127:4
optometry 1:17 243:21
oral 200:5
order 7:22 8:15 10:15
 134:4
organ 79:5
organization 112:19
 181:4
organizations 112:14
 187:10 261:14
original 33:14 96:5
 131:9 179:10
originally 97:14 100:20
 121:9
orthopedics 249:7
otitis 253:18,20
otoacoustic 164:5,14
otolaryngologist
 190:11
otolaryngologists
 248:10 257:10,12
otology 257:12
ought 57:6 61:13
out-of 254:1
out-of-pocket 254:16
 254:20
outcome 74:13 107:6
 107:15 216:9 228:18
 242:14,15 244:19
 245:9 246:11 247:15
 248:2 258:6
outcomes 1:17 5:9
 11:15 107:5,16 128:9
 209:11 216:13 217:1
 217:7 221:21 257:14
 259:4
outdated 203:21
outgrowth 198:17
outlined 128:15
output 256:18,19
outside 106:6 125:7
 161:5 170:8,14 216:3
over-radiation 253:3
overall 39:8,12 54:20
 55:3 59:22 69:6,12
 72:13,20 89:10,16
 91:8,8,14 157:12
 178:2,8 183:8,11
 184:1 188:16,18
 197:14 198:1 233:16
 240:5,17
overlaps 124:20
overlooked 116:17
oversee 259:18
overuse 46:9,11,14
 247:5 250:9,10
 253:13
overutilization 248:19
 251:5

P

P-R-O-C-E-E-D-I-N-G-S
 4:1
p.m 185:4,5 265:9
page 3:1 264:10
pages 259:5
paid 62:5,7 130:21
 249:5 254:19
palatable 134:13
panel 20:19 52:6 66:5
 85:8 92:1 241:4
panels 159:15,15
pap 107:12
paper's 74:16
paperwork 182:17
 261:12
parent 128:12 209:19
 215:3,3,5 223:22
 228:8
parents 46:16 129:1
 191:1 208:21 209:1
 211:13
part 24:21 39:21 60:18
 92:14 102:2 119:12
 122:1,2 146:22
 148:19 149:16 152:11
 153:14 172:13 174:18
 191:3,4 202:9,12
 208:19 210:7,11
 211:11,17 212:1,3
 213:17,22 214:13,18
 215:1,20 216:3 218:5
 219:17 224:5 235:18
 239:8 260:13
partial 214:6
participating 184:20
particular 24:17 30:1
 30:10 146:13 156:4
 159:22 161:12
particularly 119:7
 169:14
Partners 2:2
parts 258:21
pass 90:6 122:22 157:7
 161:1 179:2
passed 116:18 155:21
 164:20 165:8,15
 221:17 230:15
passes 13:8 19:4 20:15
 37:7 38:4 39:4,13
 45:1 47:15 51:20
 52:22 53:17 54:15
 55:4 60:16 64:7 66:3
 67:10 68:1 69:1,14
 70:21 71:22 72:22
 80:1 83:18 84:20
 86:12 88:13 89:8,18
 90:18 91:16 116:12
 119:3 122:20 123:1,4
 144:18 147:22 157:18
 160:16 171:15 173:7
 174:15 176:21 177:20
 178:10 180:19 182:10
 183:7 184:3 187:22
 193:7 194:8,10,10
 195:11 196:19 197:12
 198:3 201:6 205:1
 231:10 237:6 238:7
 240:3,18
passing 110:4
passion 225:20
passionate 241:13,16
Pat 200:7 221:2
PATEL 1:17 18:16
 142:17 143:9,17,22
 152:12 154:10 183:19
 185:1
pathologist 224:18
pathology 5:21 255:18
patient 28:10 35:10
 43:12 50:3,15 73:18
 73:21 75:19 77:16,22
 87:9,11 105:12 129:1
 131:11 146:6,9 147:6
 147:6,7 163:10
 222:14 232:1,6 246:9
 258:14 259:1,1
patient's 75:15,17
patient-reported
 242:15 259:3
patients 6:20 11:21
 14:3 17:19 26:16,20
 28:12,16 40:2,7,12,15
 40:21 41:18 42:11
 46:2,15 52:3 58:3,5
 59:10,19 73:9 74:8,12
 75:22 80:18 87:19,21
 107:16 108:5 123:11
 123:18 153:9 154:3
 167:19 217:10 227:9
 245:14 258:19
pattern 16:9 165:3
patterns 29:2
paucity 80:10
Pause 157:10 158:2
pay 62:8 254:8,9,15,16
paying 254:1,3
payment 94:14 149:8
PCP 78:22 79:8 210:12
PCPI 91:21 261:15
pediatric 97:10 98:21
 99:1 104:6

- pediatrician** 119:19,21
128:14,22 133:21
140:22 141:6 146:4
150:4 151:8,10 155:5
- pediatrician's** 125:1,7
- pediatricians** 99:2
101:18,22 102:3
128:17 129:5,13
130:2 138:21 140:20
145:3 148:6
- pediatrics** 190:16
244:12
- people** 7:18 13:15,18
13:19 14:9,10,13
15:15 21:16 22:20
25:17 26:2 30:5 32:10
34:11 35:20 45:20
46:4,6 56:21 58:13
80:8,9,11,14,19 81:7
81:13 82:1 83:1 108:4
129:7 130:3 131:2
132:4 151:5 153:18
154:3 161:3 168:17
171:4 185:8,15,18
186:2 212:10 215:9
227:9 241:16 247:7
253:16 254:17,18
258:16 261:4,17
262:9,13
- people's** 76:9
- perceived** 254:22
- percent** 5:13 6:3,8 13:5
13:5,6,14,17 14:1
16:4 17:2 19:1,1,15
19:16,20 20:1,12,12
21:4,7,8 22:19 26:16
26:19 37:4,4,5 38:1,1
38:2,22 39:1,11,11
42:18,21 44:21,21
45:7,7,9,11 46:1,9
47:12,13 48:9,10,14
48:21 49:10,21 50:1
50:12 51:17,17,18
52:19,19,20 53:15,15
54:11,12 55:1,2,18
56:1,3 57:3,7 60:13
60:13 61:3,4,10 63:3
63:11 64:3,4 65:22,22
66:12,12 67:6,7,7,19
67:20 68:19,19 69:10
70:18 71:18,19 72:19
79:19,20,21 80:6,6
81:17,18 82:7,11
83:14,15 84:16,16
86:8,9 88:10,10 89:4
89:15 90:14,15 91:13
101:5 116:9,9,10,10
118:21,22 119:1
132:11,12,12,13
- 144:15,15,16,16
147:19,19,20,20
157:3,4,4,5,16,16
160:13,14,14,20,22
166:17,18 171:11,12
171:12,13 173:3,4,12
173:14,15,17 174:12
174:12 176:17,18
177:16,16 178:7,7
180:17,17 182:7,7
183:4,4,21 188:6,8,14
188:15,16,18,22
189:3,3,7,8 191:1,19
193:4,5 194:5,6,18
195:8,9 196:16,16
197:9,10,22 201:3,3
201:12,12,15,15,16
201:21,22 204:20,21
207:22 231:7,8,8
232:19 233:6 238:4,5
238:5,22 239:21,22
240:16,16 251:9,10
- percentage** 14:17 40:1
59:10 108:4,5 170:17
- percentages** 29:21
- percentile** 11:21 26:21
- percents** 80:16
- perfect** 108:9 222:5,19
227:4
- perfectly** 46:7
- performance** 2:1 13:13
14:1,13 15:3 16:2,17
17:1,4 18:11 19:3
33:20,21 34:2,3,14
45:8,10,13 47:1,14
62:8,13 63:1,2,22
64:6 82:14 83:11,17
93:17,22 118:17
119:2 144:10 171:7
171:14 188:21 189:11
189:20 190:22 192:21
193:1,6 201:20
204:17,22 227:18
238:22 260:16,17
- performed** 28:1 43:17
43:18 94:11 225:15
- period** 100:3 120:5,7
171:18 220:18 226:3
264:15
- peripheral** 109:3
- permanent** 198:11,19
205:20 218:7,10
233:7,10,18 241:8
- Permanente** 1:14
- person** 11:18 17:3
114:5 186:4
- persons** 15:10 40:14
45:12,14
- perspective** 23:9
- 105:11 111:12 134:9
142:2 156:7 223:22
223:22 242:6
- PharmD** 1:17
- pharyngitis** 253:19
- Phase** 42:4,4
- PhD** 1:13 2:4
- phone** 74:10 76:7 116:2
118:18 132:8 142:18
152:13 156:19 184:18
208:11 224:4
- photographs** 11:5
- photos** 59:7,7
- physically** 24:6 25:9
- physician** 3:10 16:21
16:22 43:11 73:4,9,17
76:3 87:14 103:15
121:3 122:13 123:4,7
126:15 129:14 142:7
142:14 164:9
- physicians** 16:19,22
25:5 82:5 131:1
162:15
- pick** 179:13
- picture** 213:18 233:13
- PICU** 191:7
- piece** 87:17 105:4,4
145:20 223:20
- pilot** 129:16,17 136:12
137:3,12 148:10
- pilot's** 129:17
- place** 108:15 127:22
151:16 162:10 165:17
217:18 234:6,12,15
246:2 247:13
- placebo** 42:3
- places** 31:22 98:12
202:5
- plan** 105:6,18,20,22
106:4 146:3 175:22
207:2 254:3
- planned** 148:18
- planning** 176:2
- plans** 148:4 239:1
- plausible** 14:12
- players** 181:1
- pleasant** 4:8
- pleasantly** 77:6
- please** 70:16 95:12
184:8 237:8 263:16
- plus** 49:13,13 128:14
215:8
- PMP** 2:5
- pocket** 254:2
- point** 13:2 16:9 21:2,21
24:4,12 35:2,22 36:5
59:2 62:8 73:3 78:21
79:17 93:22 110:14
112:17,20 125:8
- 129:10 149:20 150:7
154:1,11,13 173:20
186:15 187:5 191:16
191:17 195:22 207:5
211:10 216:7 219:11
219:21 220:16 222:9
222:17,19 223:16
236:14
- pointed** 111:21 133:3
- pointing** 227:1
- points** 115:19 131:22
132:1 171:5
- policies** 103:5,8
- policy** 36:8 103:10
139:18,19,20,21
- poor** 26:11,22 73:12
98:1 109:1 128:15
148:8,14
- poorer** 117:10,10
- poorly** 73:19
- population** 59:14
119:10 150:16,19
169:9 172:15 181:14
206:13,15 215:20
216:1 218:4,8 226:19
239:3
- populations** 57:12
149:1 255:6
- portfolio** 59:22 242:4
243:7 246:17 259:16
259:18
- portion** 218:6
- posing** 127:22
- position** 140:16 187:9
199:2
- positive** 29:12 97:9
108:11 141:4
- possibilities** 80:10
- possibility** 22:13,13
102:14 126:7 156:11
- possible** 26:2 50:7,8,14
59:6 80:13,18 104:22
105:2 106:3 111:15
138:15 189:16 227:6
229:17
- possibly** 10:13 24:2
73:21
- post** 226:3
- post-comment** 72:11
90:5
- post-meeting** 264:8
- posted** 264:10,17
- potential** 92:21 94:1
105:22
- potentially** 80:17 102:9
106:4 108:21 125:14
134:8 149:21 259:13
- powerful** 146:9
- PQRS** 13:12 19:14 21:7

21:16 22:20,22 26:3
 27:9 29:22 30:4 38:9
 38:9 45:4 48:3,8
 53:20 61:5,22 63:12
 68:5 80:5 81:22 88:16
 260:7
practically 25:2
practice 16:9,12 17:3,3
 24:7 29:2 74:5 75:22
 78:3 81:12 129:14
 162:17 187:11 221:20
 255:11,15 259:11
 260:11,15,16
practiced 56:4
practices 16:4,11
 237:10 260:4
practicing 32:11
practitioner 126:10
 141:7,7
practitioners 1:16 45:6
pre 128:4
pre-K 140:3
pre-meeting 65:9
pre-school 103:13
predicts 57:17
predominantly 175:15
preface 213:2
preferred 29:2
pregnancies 170:5
preliminary 132:21
 145:1
prematurity 191:14
preschool 128:10
 139:10,11,13 140:2,7
preschool-type 140:5
prescribed 43:6 251:11
prescribing 243:6
 253:22
prescription 256:16
presence 3:8 55:7
 56:11 65:3 119:16
 252:10
present 1:11 2:8,20
 10:17 97:17
presented 19:7 47:22
 85:2 96:22 97:14
 111:4 135:14 202:18
 221:16,19 222:1
President 2:4
presiding 1:10
press 184:8 263:16
pressure 31:19 107:12
 245:14
presumably 134:20
 165:12
pretty 6:9 16:22 17:11
 50:6 74:6 77:4 98:2
 98:19 112:12 159:13
 171:17 177:2 195:1

198:22 199:5 218:8
 220:12 225:4,12
 244:6
prevalence 97:20 255:5
prevalent 250:8
prevent 81:18 97:4
 123:12,17
preventable 98:2
Preventative 128:16
 133:6 159:16,21
 203:17
preventing 41:22
prevention 56:3
Preventive 96:7
previous 91:5 199:1
 201:10
previously 10:7 145:15
primarily 26:4
primary 55:12,22 59:17
 73:9,17 74:13 76:2,19
 77:20 78:17 81:4
 87:12,14,19 88:1
 101:21 111:16 115:13
 115:14 126:15 131:1
 135:6 141:7 143:10
 144:5 153:7 154:21
 210:4 243:6
Prime 195:20
principal 141:9
print 74:17
prior 3:13 158:8 159:2
 161:14
privacy 202:10,21
 211:20,22 212:1
private 128:12 211:14
 214:15
privilege 254:2
privy 113:22
probably 6:12 15:22
 18:20 21:8 22:3 23:1
 23:3 26:20 29:19
 30:16 50:4 63:8 99:3
 111:17 138:17,21
 142:18 154:8 155:15
 168:15 177:4 202:9
 202:20 203:3 209:4
 209:10 225:16 226:5
 238:11 244:1,2
 253:19
probe 256:14
problem 17:17 30:3
 58:16 93:22 98:10,11
 115:16 117:19,22
 121:13 130:17 146:18
 153:11 154:4 163:15
 199:6 238:11 242:21
 250:1,9 252:14 253:2
 253:21
problematic 104:10

140:12
problems 96:20 101:6
 108:7 110:9 111:15
 114:8,9 119:17
 142:21 153:1 154:12
 175:1 232:10,12,14
 232:17 242:21 249:17
 250:4
procedure 164:11
 193:17
procedures 234:11
 249:8,11 251:2 257:4
 260:20
process 9:4 31:1 36:14
 40:17 56:21 73:7
 92:14 95:10 107:1
 120:9 121:15 138:4
 168:12 193:18 198:9
 209:12 216:9,10
 217:2,16 234:8 235:9
 235:11,17,20 236:11
 242:13 245:16 246:4
 255:14
processes 123:17
 219:11
processing 182:17
professional 110:14
 114:17 115:17 126:22
 131:12,16 143:11
 144:2,5,6 153:10
 155:19 214:11 220:14
 243:20 262:18
professional's 152:15
 152:20 153:17
professionalism 92:2
professionals 13:17
 82:8,12 102:22 127:3
 143:10
profile 181:16
program 38:9 81:11
 88:16 102:3,21
 117:13,16 122:11,15
 126:21 127:1,6,7
 148:21 167:4,5 169:4
 172:14 195:15 208:6
 208:7,9 210:8 211:19
 214:18,19 215:1
 224:14,15
programs 93:7 103:3
 103:20 140:20 148:19
 148:19 165:5 167:15
 202:11,12 210:11
 213:22
progression 7:18 40:5
 41:15,19 74:2
progressive 248:7
project 2:5,5,6 264:10
 264:22 265:1
proliferative 57:18

58:10
promise 94:17 223:21
promote 93:8 118:9
 151:15
promoting 23:18
proof 8:12 40:13
proper 130:21 144:4
properly 124:4 127:21
 218:5
proportion 198:18
 241:7
proposed 257:7
prove 250:2
provide 23:18 98:7
 165:6 169:7,11
 178:21 196:1 202:6
 237:10
provided 40:15 80:5
 126:14 213:21 214:22
provider 34:20,21
 59:18 81:3 87:10
 99:14 104:5 105:11
 105:19 122:17,22
 123:1 141:8 142:2
 155:18 156:5 169:10
 215:1 216:21 224:5
 260:20
provider's 75:19 153:8
providers 63:11 76:16
 83:2 101:19 127:5
 129:2 130:16,17
 143:10 148:13 167:10
 202:4,6 209:2 238:21
 257:18
provides 23:14 110:2
providing 93:1 137:15
 143:15 214:2
proxy 209:14 211:5
 219:18
PTA 143:14
public 3:14,20 93:4
 94:13 181:6,17 184:5
 184:11 260:8 263:8
 263:14,17
publically 38:9 53:20
 88:17 196:22
publication 6:3
publicly 177:5,5
published 154:6 160:2
 181:6 200:8 204:10
 265:3
pull 151:2 168:10 213:9
 218:1
pulling 32:22 64:18
purpose 105:14 126:18
 132:21 137:7
purposes 127:14
 149:13 155:17 185:8
purview 106:1

push 220:22 221:13
pushing 215:12
put 18:3 50:2 109:21
 139:4 148:4 218:16
 221:22 255:14
putting 18:4 29:13
 61:22 93:3 117:21
 142:12 256:14

Q

QRD-8 181:10
qualified 215:1
qualifies 51:3,5,7
qualify 113:13 203:8
 215:21
quality 1:1,8 2:4 5:8
 17:17 30:16 52:8
 53:22 64:17 66:7 85:9
 93:18,22 165:11
 166:6 168:16 181:9
 181:12,12,14,19
 225:22 242:21 244:10
 246:19,22 257:5
quarter 41:20
question 10:22 21:11
 23:12 27:12 28:4,22
 30:17 32:19 33:14
 35:4 45:19 59:9 64:22
 77:12 81:21 82:1
 85:16 87:5 100:5
 112:5 117:6 133:12
 134:15 135:3,5,13,16
 136:5 137:21 155:5
 155:14 156:1,4
 162:20 166:5 169:18
 169:18 185:17 191:13
 206:20 208:5,11,18
 214:9 218:18 219:1,8
 230:9 235:3,3 236:3
 238:16 243:2,15
 253:7 261:10 263:4
questioned 113:4
questions 4:11 27:20
 70:2 75:2 95:2 101:11
 101:12 102:8 125:17
 126:1 132:5 137:8
 160:5 162:6 168:7
 172:18 174:4 176:11
 179:3 180:10 181:21
 186:17 187:12 189:10
 195:2 196:10 197:4
 199:17 203:15 204:14
 205:17 206:1,17
 207:18 218:2 222:3
 235:1 236:20 237:20
 239:15 263:5
quick 87:4 99:21 155:4
 169:17

quickly 17:11 138:2,4
 226:4
quiet 223:21
quite 67:13 97:3 145:11
 163:3 189:17
quote-unquote 253:6

R

races 118:6
Raise 256:12
raises 36:4
RAMBASEK 1:18 48:20
 61:21 133:2,19
 140:18 153:22 155:4
 155:10 162:8 166:15
 168:9 243:2,13 252:1
 252:15 253:13
randomized 8:13 40:18
 42:4,5 57:10,22
 159:13
range 13:14 148:22
 201:21
ranged 48:4
rare 28:13 134:2
rarely 135:1
rate 5:11 16:2 17:2
 45:10 57:6 61:9 63:2
 82:7,14 108:11
 253:20
rated 41:1 221:17
rater 48:6
rates 19:10 57:4 61:3
 64:21 66:11 177:4
 254:16
ratification 264:21
rationale 98:3
re-vote 141:19 144:8
re-voting 140:14
reach 16:1
read 75:11 121:17
readily 53:3
ready 9:4 12:6 18:9
 20:7 36:21 37:19
 38:19 44:14 46:20
 51:11 53:9 60:3 63:19
 65:15 66:22 70:8
 79:11 83:8 84:7 86:2
 93:14 149:12
Reagan 185:9
real 16:3 44:12 102:11
 130:11 165:22 201:13
 242:20 255:7,12,16
 255:21 256:13
reality 87:20
realize 253:5
really 16:9,14 23:17
 27:1 33:16 36:17 61:1
 76:11,13,15 94:8
 96:17 100:21 105:13
 106:1 107:19 108:2
 108:13 111:10 112:19
 114:1,10,12 115:11
 119:11 126:18 127:5
 129:8 131:21 132:1
 138:12 140:9 141:21
 142:3,16 143:20
 148:7,14,22 151:6
 154:20 160:20 167:13
 168:20 174:3 181:18
 190:9 204:6 206:14
 212:15 215:14 216:8
 216:14 217:12 220:2
 221:13 226:1,10,17
 227:16,18 233:9
 238:19 239:2 248:11
 248:12 251:11 262:14
 264:5
realm 94:9 238:16
 259:12
reason 49:20 87:9,21
 111:22 114:7 116:17
 122:14 123:6 151:20
 212:3 235:6 236:10
 257:6
reasonable 99:7 151:21
 222:7
reasons 28:15 88:3
 191:9 250:5
reauthorization 167:14
 167:15
Recap 3:2
receive 208:1 212:6
 247:13
received 119:15,20
receives 119:19
receiving 202:14 211:1
 213:19
recognize 216:10
recognizing 149:4
recommend 10:5 54:17
 69:3 110:4 140:1
 153:5 154:9 165:20
 251:8
recommendation 9:15
 39:8,12 42:10 54:20
 55:3 69:6,12 72:13,20
 89:9,16 91:8,14 103:9
 110:22 113:6 115:1
 128:17 131:6 135:8
 137:18 140:8 156:10
 157:9,17 178:2,8
 183:10 184:1 197:13
 198:1 240:5,17 244:1
recommendations 29:3
 35:9 36:7 96:12,12
 103:7 106:13 112:15
 112:17 159:15 209:1
recommended 40:21

198:13
recommending 24:20
 113:10
reconcile 125:6
reconciling 102:4
reconsider 140:16
reconvene 184:16,18
record 75:17,20 82:18
 92:5 98:14 101:2
 104:14 130:1 146:7
 173:14 185:4
recorded 85:19 126:16
records 16:3 32:21
 71:10 77:4 194:17
 231:19 232:3,19
 233:2,4,4,5,6,12
redlines 264:16
redo 135:17
reduce 15:14 151:17
reduced 57:15 99:10
 114:7
reduces 41:18
reducing 180:7
reduction 57:8
refer 97:18 186:22
 192:12
referral 3:12 87:22 97:7
 104:19,21 106:10,15
 111:18 115:8 120:12
 121:5,7,14 122:7,22
 123:3,3 126:5,9
 130:21 141:5 145:22
 146:10,14,20,21
 147:4,5,8 219:12
 223:12 246:1 247:12
 247:12,14
referral's 219:14
referrals 127:16 141:11
 142:9 145:10
referred 76:1 97:9
 119:18 120:20 123:14
 123:15,19 124:7,8,14
 124:17 145:8 146:9
 146:19 187:1 202:14
 219:9 222:8 232:22
 233:12 234:3
referring 76:1 123:9
 146:1 153:8 225:6
 247:13
reflect 192:3 220:5
 224:16 225:17 229:20
 230:22 242:2
reflecting 148:7 198:10
reflection 169:4
reflects 154:4 202:18
reform 28:20
refraction 114:5
refractive 100:5,7 143:5
regard 139:17

regarding 83:3 161:18 251:1	187:6	152:18 166:9	203:18 204:1 221:15
regimen 73:22	reliably 57:17 61:7 215:19,22	requirements 143:19 164:2 166:10 202:10	245:4 264:14
regionally 169:14	relies 107:8	260:15 261:6	reviewed 65:10 94:5
registries 5:11	rely 260:18	requires 10:13 190:13	113:16
registry 19:9 21:5 22:4 22:14 24:11,16,19	remarkable 56:8	requiring 116:18	reviewers 96:15
25:18 26:9 30:13	remember 76:11 77:13 149:10 249:2	research 155:15 199:22 200:11 204:10 221:2	reviewing 180:2
32:21 33:3 34:5 37:11	remind 129:12	221:4 244:15	revised 101:17
38:12,13 45:10 48:2	reminder 183:14 264:7	researcher 154:11	revisions 132:19
60:18 61:6 62:10	removed 87:16 114:21	resend 240:8	revisit 136:3
64:12,18 65:17 66:2	renamed 95:15	reside 161:22	revote 70:15
67:2,9,15,22 68:14,22	repeating 128:18	resource 247:18	Rich 2:14 4:22 5:2
69:7,13 70:4 72:3	replaced 59:8	resources 163:5	14:20 15:18 16:20
80:12 83:22 84:3,14	replicate 125:4	respect 168:17	21:13 23:6 24:4 25:1
84:19 85:3,7,10 86:4	replicated 200:10	respectively 66:12	27:14 32:4 33:18 36:4
86:11,19 88:5,12,18	report 14:10,14,21 26:15 27:17 30:4,6,14	respiratory 243:5,10	37:15 38:15 42:16
88:22 89:7,11,17	34:10 45:6 63:4 80:19	respond 263:5	45:22 49:10 55:9 62:9
169:3 172:13,21	83:5,6 172:2,3 175:18	response 4:13 18:8	62:19 63:13 77:12
173:6 174:7,14	180:8 181:12,12	20:6 37:18 38:18	81:10 83:4 85:17,21
176:13,20 177:11,19	190:1 193:11,12	51:10 52:13 53:8 54:4	91:20 113:20 135:7
178:3,9 182:14,17	195:16,20 196:5	60:2 65:14 66:21	169:16
192:17 205:5 231:14	207:12 210:2 264:9	68:10 70:6 71:11 72:5	Richard 1:17 20:2
245:6	264:16 265:3	85:14 87:2 135:16	27:13 39:17
regroup 69:22	reported 24:11 27:17 28:10 38:10 64:15,17	184:10	Richard's 129:10
regulated 164:10	68:5 83:21 88:17	rest 59:1 98:2 108:22	ridiculous 26:17 123:22
regulation 163:2 165:14 166:13 167:1	172:1 173:16 175:16	137:5	124:9
regulations 202:10 203:1	195:22 196:3,22	result 14:1 45:14 141:9	right 4:14 11:1,16,22
regulatory 166:1	207:3 208:6 236:10	142:14	12:21 16:5 27:15
reimbursement 148:13 185:20 186:2	238:10	results 6:5,21 13:13	34:15 51:1 54:16
reinitiate 168:11	reporting 13:15,18,20 14:9,11 21:7 26:3,7	21:11,16 23:11,14,19	56:14 60:3 64:11
reiterate 172:11	26:11 27:10 34:7,12	23:22 24:2 72:11	79:10 83:8 84:21 86:1
Related 41:9	43:17 48:3 61:5,8	74:17 75:12 90:4	86:15 91:17 95:2,9,13
relates 253:8	62:12,14,21 63:9,12	137:1 142:5,8 175:14	98:20 99:3 105:20
relation 35:10	63:14,17 64:15,20	178:21 183:15 190:2	109:21 110:7,12
relationship 107:4,15 122:16 146:5 234:14	66:13 80:8,10 82:5,7	190:20	111:6 114:19 122:8
released 191:5 192:13	82:8,10,13 83:1 94:13	resumed 92:6 185:4	123:5 127:15 133:18
relevant 57:20	105:11 167:12 170:20	retention 77:18	134:12 136:4,11,12
reliability 19:5,8,10,12 19:13,18 20:1,10,14	174:3 175:4,8 181:10	rethink 135:17	136:14 137:9,14
47:4,17 48:1,4,5,6,8	188:5 190:4 202:10	retina 1:15 5:17 26:3,4	138:8 143:20 150:10
48:12 51:13,19 64:8	208:8,10 236:7,7	26:14 27:7 28:2 29:4	150:13 154:20 155:8
64:14,16,19 65:17	237:14 260:8	62:4 63:9 78:12	156:1 159:10 162:19
66:2 70:11,19 83:19	reports 118:5 185:17 193:13 235:11	retinal 63:16 74:18	164:1,18 169:19,20
83:21 84:1,4,5,9,18	represent 21:9 137:22	retinopathy 3:8,9,10	169:21 177:5 181:16
90:10,16 94:9 119:6	representative 57:11	4:19 5:6 9:1 36:3,13	191:18 193:22 204:2
135:19 136:22 171:16	represented 145:10 249:16	55:6,8 56:11,13 57:17	204:7 209:9,20 214:8
172:18,21 173:6	represents 135:16 217:18	57:18 58:7,14 59:11	217:12 219:15 226:5
180:13,18 193:9,11	request 138:7,13	62:2 65:3 73:4,10,13	230:5 231:2 239:9,15
193:22 194:2,11	require 138:16 139:9 190:1,18 195:18	73:14 74:2,7,21 79:2	242:6 251:15 257:2
205:3,12,13 228:17	required 164:18,21 165:1 261:18	79:3 81:17 91:2	263:7
229:13,17,21 230:6	requirement 122:10,14	retirement 25:6	Rights 211:22
230:13 231:4,10		retitle 241:2	rise 259:14
244:12 261:22		return 258:11	risk 36:18 41:19 43:1
reliable 78:4 152:8		Reva 2:6 21:1 33:10	44:11,11 98:22
		178:12 238:14	164:13 173:18
		review 40:17 48:9 49:5	risk-adjusted 52:9
		78:11 90:4,7 92:19	risks 40:4,11
		94:6 96:14 97:1	road 95:5
		112:21 132:22 199:3	ROBINSON-ECTOR 2:6
			12:8,22 18:10,22 20:9
			37:1,20 38:20 39:7

44:15 46:22 47:5,11
 51:12 52:14 53:10
 54:6,19 60:5 63:21
 65:16 67:1,14 68:12
 69:5 70:9 71:12 72:12
 79:12 83:10 84:8,15
 86:3 88:4,20 90:9
 91:7 115:22 116:7,8
 116:20 118:16 132:6
 144:9 147:13 156:17
 157:2,11 160:8 171:6
 172:20 174:6 176:12
 177:10 178:1 180:12
 182:2,21 183:10,20
 187:14 192:22 194:1
 194:9 195:4 196:12
 197:5 200:17 201:2
 204:16 231:3 236:22
 237:22 239:17 240:15
robust 93:9
role 78:10
roles 259:17
rolled 148:16
rolling 235:21 236:4
ROMAN 2:15 100:9
 102:17 104:11 105:21
 108:13 109:12 112:13
 113:5 114:21 120:21
 122:8 126:17 131:5
 138:7,12 139:17
 141:20 143:1,19
 145:5,9 146:12 155:8
 155:12 157:19 166:12
 191:17
room 1:9 13:1 14:14,16
 60:11 70:15 80:14,20
 83:3 133:14 161:7
 162:20 173:10 197:18
 197:21 258:11 260:4
routine 50:13
routinely 164:6
rule 162:10
rules 130:7,13 139:9
 203:1 211:20 212:2
run 164:13 211:19
 233:21
running 161:17
rural 161:4 170:4 202:5
 209:5
rural/urban 169:22

S

S 3:1
safe 41:21
sakes 236:8
sample 200:9
sat 49:12
satisfaction 258:14

save 14:2,4,7 134:3,8
saved 14:18
saves 8:14
saving 7:2 15:9 45:14
 73:17 80:16,17
savings 6:21 15:13
saw 234:1 242:17
saying 9:12 24:20 25:1
 33:10 34:3,11 42:10
 56:2 73:20 75:5 77:21
 104:8 111:5 112:4
 123:20 125:1 145:7
 146:9,20,21 149:6
 166:16 188:18 206:3
 208:9 212:5 223:8,9
 225:5 227:2 252:2
 255:3,13,15 256:1
says 9:22 11:11 21:3
 29:15 33:11 50:20
 81:12 85:21 93:12
 98:8 113:6,19 115:2
 141:1 145:4 149:11
 160:20 188:14,20,21
 214:21 230:20 231:1
scale 15:21 16:6 35:14
 210:2
scales 16:16
scan 213:6 252:11
 253:9
scans 253:8
scare 81:6,19
scarring 28:20
scenarios 26:2
Schachat 1:19 11:1,22
 18:2 28:14 29:15 31:6
 35:12,17 41:16 44:1
 46:13 56:15,16 58:19
 59:1,15 61:1,11 62:3
 64:14 66:5 67:12 68:4
 77:3 97:13 106:19
 107:17 116:15 117:9
 119:14 136:7 138:2,8
 138:19 144:22 145:6
 145:11 151:19 152:7
 258:5
schedule 147:5
scheduled 184:16,18
SCHIP 149:5
school 98:12 102:2,14
 103:1,20,20 119:21
 124:22 125:3,12,19
 126:5,8,15,21 127:16
 127:18 128:3,22
 130:6 131:8 140:4,11
 141:1,9 142:20
 143:16 150:4 155:6
 155:21 200:4 215:9
school-based 102:12
schoolers 128:5

schools 102:5 124:21
 130:4,12,14 134:17
 139:3,6,15
science 5:9 55:14 56:9
scientific 8:12 89:22
 180:11
scope 106:6 138:17
score 17:12 19:8 22:11
 48:1 61:3 145:2
 173:15
scored 61:7
scores 61:13 98:10
 125:21,21 131:2
 148:7
Scott 1:15 7:7 11:11
 15:8 25:22 27:15 34:9
 73:6 86:13 95:17
 99:19 122:4 247:1
Scott's 14:20
screen 81:5 97:16
 98:18,20,22 107:9
 114:2,8,9 122:7,20
 123:13,13 125:2
 134:6 142:21 143:2,2
 143:6 152:21
screened 103:19 108:8
 120:10,12,19 122:18
 122:19 123:19 124:2
 124:4,4,7,15,15,22
 127:21 128:10 130:4
 131:3 149:2 150:3
 153:18 160:21,22
 161:3 166:19 171:19
 204:4
screeners 151:1
screening 3:12,13 11:4
 58:1 59:7 95:16 96:4
 96:9,17,19 97:8,14
 98:3,12,16 99:7 101:3
 101:7 102:2 103:13
 103:17 104:4,7,18
 106:5,20 107:2,5,7,10
 107:11,12,12,13
 108:2,12,14,17 109:9
 109:11,16 110:11
 111:19 113:3,6,9,10
 113:12,14,18 114:2
 114:13 115:2,13
 117:8,12,13,17,17,19
 117:21 119:16,19,20
 119:21 121:2,6,9,12
 122:21 123:1,2,8
 125:3,13,19,20 126:9
 130:20 133:7,16,20
 134:1,7,16,17,20,22
 139:5 140:20 141:1
 142:10,22 143:7,15
 143:15 144:4 145:16
 149:3,6,7 150:20,22

151:16 153:2,6,16
 154:21 156:13,14
 158:1,7 159:1,18
 160:1 161:13,14
 163:12 164:1,3,18,21
 165:21 166:22 167:22
 168:3 170:16 174:2
 176:3 180:1 191:7
 231:17 235:10 242:18
screening's 103:4
 151:4
screenings 102:5
 110:10,16 118:10
 128:13,18 130:14,15
 142:20 165:6 170:10
se 215:7
second 28:5 120:4,11
 121:7,22 140:2
 200:22 208:5 211:17
secondarily 143:6
seconds 77:6
see 5:21 9:18 10:12,18
 11:3,12 15:3 17:1,12
 22:2,5 24:5 30:15
 31:7,8,9,12,17 34:7
 34:13 43:4 46:4,15
 56:20 63:2 65:5 69:20
 83:7 90:20 93:20
 104:8,20 105:5 108:8
 121:2,12 128:17
 130:10,18 135:9
 137:9 141:5 142:4
 146:10,14 149:20
 154:11,13 165:2
 169:12,13 175:13
 177:4 178:11 189:1,2
 189:17 190:4,10
 192:16 233:11,12
 242:7 243:11,14
 252:4 258:19,19
 262:15,17 263:11
seeing 24:13 103:15
 120:9 131:11 132:5
 142:1,9,15 153:9
 203:3
seen 16:18 50:16,17
 92:11 176:3 186:22
 190:6,7 210:18,21
 219:22 253:13
selected 15:2 111:22
self-apparent 53:3
semantics 123:11
 124:12 147:4
send 12:13 77:9 87:22
 98:22 114:4 151:7,11
 153:16 167:12
sending 152:19 185:21
sends 146:5
Senior 2:4,5,6

- sense** 8:15 11:15 28:7
62:15 73:18 74:4
76:14 91:2 98:5
100:14 101:1 110:10
118:9 137:22 162:15
217:18 232:21
sensitivities 107:20
sensitivity 108:11
128:15 134:16,19
151:22 164:12 187:8
193:19
sent 75:20 76:1,2 85:21
185:19 220:16
separate 121:22 227:18
230:4 250:18
Separating 120:17
September 264:18
serous 253:18,20
serve 218:5,6
service 128:16 212:6
239:8
services 1:18,22 96:8
133:7 154:11 159:16
198:20 202:8,15,19
202:20 203:9,17
205:22 207:14 209:3
209:7 210:1 212:7
213:12,20 214:3,14
214:17,22
set 69:21 72:10 90:4
114:14 157:21 175:12
178:21 183:16 198:18
205:8 207:11,16
SETH 1:15
setting 101:21 111:16
115:14 128:12 192:6
settings 102:11,12
128:6 170:4
seven 51:18 52:20 55:2
60:13 67:7 68:19
71:19 78:6 79:20
150:5 171:11
severe 7:16,17 10:3
244:16
severities 245:15
severity 3:9 15:20 16:6
16:16 25:14 36:3 55:8
56:12 245:13
SHACONNA 2:5
share 244:8 264:11
shared 192:4 258:14
sharing 234:15
show 42:2 44:12 138:3
148:10 150:5 213:13
showed 147:7,7
showing 73:16 188:7
shown 11:7 44:9 57:13
244:16
shows 5:12 55:10
201:11 214:1,3 221:2
221:4
side 15:14
sight-threatening
108:21
sign 8:9,11 200:5
210:10,18 214:18
215:5 224:19
signed 164:9 209:22
210:5 212:5 215:15
224:5 241:9
significant 45:14
182:16
significantly 248:2
signing 210:20
similar 69:17 107:14
112:15 118:2
simple 32:18 50:6
126:1 246:5 255:15
simpler 151:15
simplified 35:14
simply 110:21 149:10
simulated 69:21 72:10
90:4 178:20 183:16
single 19:13 48:6 49:2
sinus 248:16 257:20
258:10,16
sinusitis 249:16,17,19
249:20,21 250:5,14
250:16,17,18 251:7
251:11,20,22 252:2,7
252:10,21
sit 18:16 42:21
sites 104:14 105:1
115:6
sitting 141:14
six 104:1 110:15 113:11
120:5 122:9,18 159:6
165:16 224:7 225:6
sixth 119:17
Sixty 160:13 173:3
Sixty-seven 157:15
sizes 200:9
skilled 262:9
skills 200:5
slam 82:2
slide 95:12,14
slideback 162:11,21
slight 165:3
slightly 57:2 206:8
slowing 41:15
SLP 212:22
small 13:19 14:17 45:5
64:22 161:4
smaller 175:13
smear 107:12
smiling 49:20
smoker 43:21
smokers 40:13 43:1
smoking 43:22 44:2
societies 17:10 110:3
262:18
society 154:1
socioeconomic 118:7
214:12
solicit 259:20
solid 226:18 234:7
solve 99:15
solves 117:22
somebody 114:4
142:19 154:6 167:5
246:9
somebody's 254:1
someone's 219:4
245:18
somewhat 82:18 95:1
261:18
soon 88:16 140:4,4
216:22
sooner 58:8
sorry 4:20 47:7,8 48:20
58:21,22 60:20 71:2
71:18 87:7 96:1
106:18 109:10 111:3
113:5 117:1 168:7
183:9 194:9,10
199:19 200:21 203:15
240:10 254:14
sort 29:4 90:20 92:16
92:19 98:21 117:18
126:17 132:20,22
162:16 181:8 191:18
212:7 226:8 242:6
255:17
sorts 259:21
sound 94:7
sounds 111:9 118:8
133:13,17 140:18
174:19 190:22 209:13
218:20 225:12 255:9
source 33:11 34:19
104:13 127:1,2,6
sources 23:21 34:22
37:10 86:18 94:2
space 59:16 97:15 98:5
181:1
speak 95:22 96:2 143:8
speaking 210:15 265:6
speaks 218:14
spec 138:15 142:1,12
155:8
specialist 97:11 104:7
104:9 147:1
specialists 27:7 28:3
62:2,4 63:9 76:21
78:12
specialties 248:17
249:5
specialty 55:11 110:3
112:14 260:9
specific 30:1 103:6,11
109:15 209:8 217:10
230:14 238:21 261:19
specifically 25:14 41:11
41:13 149:11 181:17
249:6
specification 25:13
31:5 50:19 97:2
146:13 156:7
specifications 31:17
47:19 70:3 94:6 96:18
119:8 125:9,11 132:3
132:7 133:9 135:13
136:5 138:1 144:11
144:17 179:4 229:20
229:22 230:3
specificity 32:3 107:20
108:12 128:15 132:2
134:16 151:22 164:12
193:19
specified 37:10 47:20
86:18 96:11 98:17
120:3 127:15 132:17
155:10,12
specifies 36:3
specify 27:21,22 31:20
109:8
specifying 261:19
262:7
spectrum 164:15
speech 213:11 224:10
224:18 248:6
spend 46:5 154:1
spending 46:4
sphere 148:9 245:20
spirited 221:13
spot 117:18 137:21
140:9 226:17
spring 192:12
stable 10:8
stack 141:13
staff 2:3 91:22 261:4,5
stage 5:18,22 10:16
15:10 210:13
staged 36:10
stages 36:10 94:16
staging 9:13 17:21
22:10 35:5,6,8,10
39:20 42:13 44:7
245:12
standard 19:15,19
48:13 49:18 78:14
165:22 170:22
standardized 216:10
standards 171:2
STANDING 1:3
stands 191:18

stapedectomy 257:8,11
star 184:8 263:16
start 95:19 128:3
 170:20 185:6 192:7
 198:7,15 215:5
 216:12 217:19,20
 220:19 222:6,15
 223:13,16 224:9,10
 227:2 228:5 248:4
 253:11 255:22 256:2
started 4:12,17 12:17
 179:10 188:5 200:3,4
 236:12
starting 165:2 172:10
 222:17,19
starts 207:15 209:22
state 25:14 98:6,6
 102:2 130:7 140:19
 143:21 148:19 149:5
 149:5 161:20,21
 165:14 166:4,9 167:1
 167:6 169:8,21,22
 172:3 173:11,22
 175:4,5,8,11 190:2
 193:17 194:15 196:4
 197:1 202:11 203:1,2
 203:6 205:8 207:3
 211:12,16 213:22
 214:1 215:18 216:11
 224:14,14 226:9
 231:15 232:5 233:13
 234:10,10 235:11
 237:10 238:18 239:2
 239:11,12,13
state-based 166:13
stated 143:1 205:17
statement 160:3 187:9
 199:2 203:11 205:16
statements 56:2 205:16
 216:8
states 7:13 24:10 96:7
 98:10 103:3,6,6
 116:17 124:21 130:13
 139:9,14,17,18
 143:20 149:22 150:9
 150:12 159:16 160:21
 161:19 163:2 165:15
 165:16 166:5,8,10,15
 166:17,19 167:3,14
 168:4 169:6 172:1,2,4
 174:19 175:18 190:1
 191:22 192:4 193:11
 193:12,13 195:18
 196:5 203:7 205:7
 207:12 213:21 217:21
 218:12 234:12 236:7
 236:8 237:11
statistical 134:21
status 79:2,2 207:21

209:16 220:21 231:21
 232:2,21 245:18
 256:4
stays 136:8
STEIN 1:20 22:12 29:21
 34:17 78:20 101:16
 102:1 104:2 105:17
 108:16 118:2 124:19
 128:19 135:18 137:2
 137:11 140:15 145:20
 149:19 167:17 170:7
 175:21 176:9 190:5
 190:21 191:10 218:19
 220:3 225:10 226:2
 228:22 229:6 245:5
 246:12 257:3 261:9
step 99:8 121:22 123:9
 124:6 144:10 151:11
 198:9 209:10,12
 212:14 217:8 219:14
 223:14 246:4
steps 29:9 124:11
stepwise 219:11
stereoscopic 29:1
 30:22
stereoscopically 28:4
 29:19 32:9
steroid 253:20
steroids 162:16 253:17
Steve 30:20 32:4 45:16
 48:15 53:5 54:1 58:17
 61:17 68:7 78:7 80:22
 81:10 148:2 149:9
 203:15 245:21
Steve's 149:20
STEVEN 1:22
steward 179:21 180:3
STEWART 1:21 110:19
 112:3 162:22 219:7
 225:19 230:19 249:15
 251:13 252:9,16
 257:20
stop 117:17 136:8
 137:5 162:21
stopped 136:9 162:15
story 55:13 56:8 61:2
 61:12 80:7
strabismus 97:5
straightforward 53:4
 159:13 171:17
strange 174:21
Street 1:9
strictly 210:15
STRODE 1:22 30:21
 41:4 48:16 52:10 53:6
 54:2 59:9 61:18 65:12
 66:18 68:8 75:1 78:8
 81:1 84:6 85:12 86:22
 88:19 129:11 148:3

149:4 196:3 203:16
 203:22 245:22 253:21
 256:5
strong 41:1 199:6
strongly 66:6 85:8
struggling 216:18
 217:1 261:3
stuck 256:8
studies 57:1,4,13
 109:19 111:21 172:9
 199:4 221:14,22
 251:21
study 40:19 41:9 42:2
 52:2 55:14,14 74:11
 109:4,13 115:9
 244:16
stuff 27:1 56:18 62:8
 77:17,17 92:2 117:14
 138:16 139:2
subject 110:10
submission 75:10
submit 33:22
submitted 34:5 36:16
 45:9 48:2 90:2
subset 217:10
subtle 61:15
successful 128:20
 129:2
successfully 68:6
sudden 17:11
sued 109:11
sufficient 142:3,16
 149:8
sugar 29:8
suggest 99:6 248:6
suggested 50:16 99:6
 229:18 243:3
suggesting 11:17
 212:16 230:22
suggestion 131:8 229:8
suggestions 121:10
suggests 221:19
suitability 39:8,12
 54:20 55:3 69:6,12
 72:7,13,21 89:10,16
 91:9,15 157:12 178:2
 178:8 183:11 184:1
 197:14 198:2 240:5
 240:17
suitable 39:6 54:18
 69:3
summarize 83:22
SUNY 1:17
supplement 3:7 9:14
 39:17
supplementation 40:9
 40:14 41:14 44:10
supplements 40:12
 42:15 52:1

supply 15:6
support 16:21 92:14
 99:17 111:1 112:8
 139:10
supporting 204:9
supports 93:6
supposed 53:21 102:3
 103:4 158:4 187:1
 263:8
supposedly 168:4
sure 29:8 42:16 43:7
 65:4 98:16,19 100:13
 103:2 109:3 110:6,7
 124:3 129:3 135:15
 141:16 155:22 171:1
 180:6 181:19 185:21
 213:7,13,14,18,22
 214:3 221:15 224:17
 229:14 233:9 234:6
 235:19 241:5 256:19
surgeries 258:7
surgery 250:10 253:7
 257:10,20 258:11,17
surgical 249:7 251:2
 257:4
surprised 77:6 173:9
surrogate 79:3
survey 175:17,18 192:3
 231:17
surveyor 130:3
suspect 148:8,14
sweet 140:9
switch 157:20 158:5
symptom 252:18
symptoms 10:11,17
 252:11
system 30:11 36:6
 63:12 77:14 98:13
 127:18 139:5 146:2
 168:2 194:16 232:5,7
 237:13 245:2 246:5
 263:1
system's 175:12
systematic 40:17 52:4
 221:15
systemic 199:3
systems 79:6 102:15,15
 175:10 192:1 205:7
 215:3 245:12 246:7,8
 262:12,22 263:2

T

T 3:1,1
table 154:20,21
take 25:10 36:14 46:3
 46:16 117:16 124:5
 129:21 151:11 181:11
 185:11 224:6,8 235:4
 235:7 246:2 247:12

248:13 250:21 255:2
taken 179:12
takes 15:22 181:7
 219:19 235:5 238:16
talk 17:7 84:22 95:8,14
 150:19 157:22 172:15
 179:5 205:3 231:12
 247:4 258:12 260:6,7
talked 16:21 61:21 72:9
 76:8 92:13 125:16
 132:2 134:14 150:15
 150:16 161:5 173:10
 174:21 178:18 243:17
 244:21 245:22 248:22
talker 248:6
talking 12:17 33:19
 46:1 81:8 106:16
 111:2 113:17 119:5
 128:4,5 139:1 148:2
 150:18 154:12 155:17
 172:12 174:20 224:2
 251:7 258:10
talks 115:2
TAMALA 1:13
Tammy 32:17 41:6
 43:19 108:10 109:7
 122:3 159:12,19
 161:10 167:2 172:5
 177:6 186:18 188:21
 193:8 199:19 203:5
 214:5,8 215:17
 218:21 223:18,19
 224:22 226:21 238:13
 244:6 255:13
target 179:15 200:4
 256:1,2
task 96:7,8 112:12
 128:16 133:7,15,15
 159:17,21 203:17
TDCJ 231:17
teaching 29:4
team 96:10 106:13
technical 94:5
technically 94:7 220:17
techs 190:15
teleconference 2:20
tell 46:1 139:8 207:20
 207:22 209:15 211:6
 216:2,3 264:2
telling 56:20
tells 153:15
ten 5:13 16:4 17:2 21:4
 22:19 82:7 91:18
 251:9
tends 172:14
Tennessee 173:14
 194:15 232:6 233:14
 233:17,19
tens 80:17

terminating 100:2
terms 35:5 79:1 81:22
 91:2 119:4 120:14
 137:1 180:11,20
 185:18 210:22 230:1
 249:10 251:4 258:9
 260:7,20 261:2
terrible 17:5
territories 165:16
test 100:16 102:12
 109:16 177:2 187:7
 190:15,20 231:18
 256:11,17
tested 48:5 93:1,15
 100:18 102:11 104:15
 108:18 115:3 178:17
 231:14
testing 8:2 10:13 19:7
 48:1 66:10 69:18,19
 69:20 72:9 83:21
 85:11 90:3,5 93:9
 97:4 99:15 100:17
 101:9 104:11,12
 108:1 113:16 115:4,5
 119:6 127:11 131:6
 131:14,18 136:22
 138:16 153:3,14,20
 154:14,17 156:14,15
 178:21 183:16 187:3
 190:10,13,17,18
 191:15 192:14 193:17
 194:14 195:16 256:6
 256:10,11,13 262:1
tests 8:18 110:5 141:14
 164:6
text 110:1
thank 4:4 5:2 7:5 12:21
 13:3 30:19 48:16
 52:10 54:16 60:11
 70:16 77:8 91:17,19
 91:20,22 92:2,8
 143:17,18,22 156:16
 157:19 184:13,19
 185:1 197:18,22
 202:2 234:19 240:11
 241:19 259:5 263:19
 263:20 264:4 265:5
thanks 12:14 18:21
 47:10 70:17 183:18
 185:2,15 186:5 240:9
 265:7
theory 8:17 223:15
therapy 212:22 213:11
 224:10
they'd 141:13
thickening 8:8 16:8
 25:15
thing 12:4 24:5 25:11
 62:5 74:10 83:5 90:21

98:17 99:22 102:17
 104:4,4 107:14,21
 110:12 128:20 129:6
 134:14 136:9 137:3
 137:13 138:21 142:11
 204:9 210:14 214:20
 217:15 222:7 224:21
 241:15 242:2 246:12
 249:1,12 253:16
 256:12 258:12,15
 260:2,6
things 13:21 22:7 25:19
 30:6 31:18 36:18
 57:20 66:15 82:19
 95:8 107:11 129:7
 131:19 135:19 136:12
 137:19 149:22 152:2
 191:18 202:21 213:11
 213:20 217:17 219:1
 230:4 248:3,8,21
 259:20 260:9
think 4:7 5:2 6:12 9:17
 9:20,21 14:8,10,14
 21:9,19 22:1,7,12
 23:13,22 25:4,11
 27:14,15,16 28:2 29:1
 29:15 30:5,5,9,18
 32:1,2,5 33:6,18 34:8
 34:9,18,22 35:19 36:2
 37:13 38:11 49:16
 50:1 55:10 59:15 61:1
 61:5 62:4,9 63:10
 65:5 74:6 79:6,8,9
 82:20 83:4,6 84:4
 85:17 95:7 100:15
 102:15,17 103:13
 104:15 105:6,16,17
 105:21 106:3 107:6
 108:1,16,18 109:3,6
 109:21 111:13,14,17
 111:21 113:15,20
 114:11 115:18 118:13
 121:21 122:15 124:13
 125:8,10,16,22 126:2
 126:6 127:4,8,12
 128:6,19 129:16
 131:5,18,22 132:15
 132:18 134:9,13,22
 135:4,7,20 136:8,10
 136:13 137:2,21
 138:15,20 140:21
 141:20,21 142:1,6,11
 144:7 145:16 146:2
 146:15 148:22 151:19
 152:8 154:18 155:1
 156:5,6 159:12 162:3
 162:16,17 163:13
 165:12 167:17 168:3
 168:19 169:3 171:3,4

171:21 177:1 178:16
 185:10 186:14 191:10
 195:17 202:5,7,8,16
 215:19,22 217:17,19
 218:5,14 219:8 220:7
 221:8,10 222:7,17
 225:11,19 226:3,14
 226:16,21 228:11,19
 230:8 232:9,18
 234:12 238:10 239:4
 239:10 241:12 242:16
 242:21 243:17 244:1
 244:4 245:7,19 246:3
 246:19 247:8 248:17
 248:20 249:1,3,8,12
 249:13 250:4,12,13
 250:19,21,22 251:18
 252:18,21 253:1,9,19
 254:9 255:8 256:11
 257:15,16,18 258:8
 258:11,21 259:10
 263:7
thinking 82:2 241:6
 242:18 244:12 256:13
thinks 111:9 112:6
thinner 36:19
third 41:20 105:3
 119:17 207:5
thirteen 144:14 157:3
 174:12
thought 76:16 126:7
 199:12 217:4
thoughtful 264:6
thoughts 163:20 244:8
thousand 6:20 14:2
 151:4 152:22 153:7
thousands 80:18
threats 20:21
three 12:11 13:1 14:22
 15:2 17:9 18:13 34:5
 36:15 44:2,18 47:3
 51:15 52:17 53:13
 54:9 60:8 62:11,21
 64:2 65:19 67:4,18
 68:16 71:15 79:15
 83:5,13 84:11 86:6
 88:7 89:2 103:16,22
 110:15 113:20 128:4
 152:19 158:22 159:5
 159:13 160:11 166:18
 171:9 173:1 174:9
 176:15 177:13,16
 179:19 182:5 183:1
 206:1,5 220:18 224:8
 252:11
THROAT 1:3
throw 230:14
thrown 230:17,17
THURSDAY 1:5

thyroid 253:7,12
tie 148:12
tied 177:3
tier 121:7
till 226:11
time 5:8 12:19 14:19
 19:20 41:20 42:18
 43:3,4 46:6 50:12
 51:2 56:9 58:10 73:3
 85:4 91:18 94:1
 103:15 110:7 112:5
 114:10 140:11 153:4
 160:2 164:22 182:17
 184:4,7,12 185:15
 187:3 193:15 205:19
 205:21 206:3,5,18
 207:20 209:16 211:6
 211:7 212:8,16,20,22
 216:1,4 219:21 220:9
 220:9,17,18 222:20
 227:10,12,13,19,20
 228:5,5 235:20
 241:22 251:10 257:9
 263:9,15,18
timely 9:18 57:5,15
times 49:11 50:17,17
 51:4,7 208:22
timing 100:10
title 96:5 211:2 218:22
 220:4 225:16 226:7
 226:13 227:22 228:4
 228:14 229:2,3,16,18
 229:19 230:1,22
 240:21 241:10
today 4:12,18 5:3 96:22
 100:11 125:2 150:14
 159:1
Todd 1:18 48:19 61:20
 133:1 136:4 140:13
 153:21 166:14 168:8
 243:1
Todd's 135:12 137:21
told 58:8 144:22 225:2
tonsillitis 250:20
tonsillectomy 251:2
 257:16
tonsils 258:10
tool 109:9,11
tools 108:18
top 212:1
topic 200:8 242:8,11
topics 3:19 248:13
touch 263:22
tough 92:2 105:13
track 104:20
Tracking 232:6
traditional 76:10
 262:18,19
trained 164:11 257:10

training 81:11
traveling 185:9
treat 58:10 247:19
treatable 7:22 116:16
 134:3
treated 123:15 124:17
treating 9:2 10:6 26:4
 134:1 247:19
treatment 11:14 29:10
 40:20 57:6,15,16,22
 58:3 74:12 97:21
 117:18 219:20 247:14
 250:17
treatments 10:14 97:22
tremendous 116:16
trend 165:3
trepidation 211:8 216:5
trial 6:3 42:5,22 55:19
 55:21 92:16 93:2,10
 93:13 94:18 116:6,12
 118:17 119:2 132:7
 137:17 144:10,18
 147:14,21 149:11,17
 156:18 157:12,17
 159:14
trials 8:13 11:14 16:1
 40:18 57:10,22
 159:14
tried 179:16 189:15
trouble 46:16 98:5
true 22:18
truly 23:20 77:2
try 121:10 168:2 206:19
 212:4 217:1 235:18
trying 11:18 17:16
 24:10 25:5 33:5 74:14
 74:19 93:8 101:16
 136:17 170:3 180:6
 181:18 216:19 222:16
 246:18
tubes 257:16 258:9
turn 103:22 120:5 131:1
 144:21 148:5 237:11
turnaround 17:7
turned 122:9 237:12
tweaked 134:11
Twenty 147:18
twice 31:22 50:18
 134:17 154:2
two 4:4 5:4,14 7:3,14
 9:20 12:10 14:1 18:12
 19:7 40:18 44:2,17
 47:2,6,22 50:21 51:14
 52:16 53:12 54:8,22
 56:6 57:7 60:7 64:1
 65:19 67:4,17 68:15
 69:9 70:13 71:15
 72:16 77:5 79:14
 83:12 84:11 86:6 88:7

89:1,13 90:13 91:11
 95:4 101:4 120:9,17
 122:1 123:4,6 131:18
 138:10 139:7 154:16
 157:14 160:10 171:9
 172:12 173:1,11
 174:9 176:7,15
 177:13 178:5 180:15
 182:4 183:1,13
 184:20 191:18 198:17
 206:3 207:18,21
 218:22 220:13 221:14
 221:22 223:9,10
 228:8 230:3 233:21
 235:3,4,5 236:18
 242:4 251:9 255:6
 258:21 264:6,7
two-thirds 31:11
type 7:15,16,16,17 8:1
 10:5 75:14 109:22
 113:3 140:5 192:18
 218:14 234:14 244:19
 256:12 261:19
types 7:14 10:14 19:7
 47:22 109:16 151:1,5
 199:5 242:12
typical 50:6
typically 7:20 75:22
 190:16 208:8 254:18

U

U.S 128:16 133:6
 159:21 203:17
ultimately 123:17 134:7
 137:16 222:14 246:10
under-use 46:11
underestimate 22:16
 23:2
underfit 244:18
understand 17:17 22:9
 94:19 101:17 129:15
 129:19 210:11 215:4
 256:5
understandable 120:18
understanding 24:1
 33:8 148:17 261:20
 261:21
Understood 29:11
underutilization 248:19
undetected 150:6
unfortunately 49:21
 78:1 87:18 140:6
unfunded 163:4
uniform 140:6 166:9
unilateral 203:7
unintended 129:7
 177:1
United 7:13 24:9 96:7
 159:16 160:21

universities 262:16
University 1:13,20
 261:4
unnecessary 125:4
 250:10
upcoming 94:22
update 192:2 236:9
updated 232:13 251:17
 251:19 264:15
upload 175:11 193:16
 237:11
upper 243:4,10
upset 253:16
uptick 5:13
usability 38:5,21 39:3
 53:18 54:7,14 68:2,13
 68:21 72:1 88:14,21
 89:7 90:21 91:4 92:21
 95:9 118:13 131:22
 133:5 137:12 148:1
 154:22 156:18 176:22
 177:11,18 182:12,18
 182:20,22 183:6
 196:20,21 197:6,11
 238:9,11 239:18
 240:2
use 6:21 14:6 25:12
 31:20 38:6,14,21 39:3
 45:20 54:7,14 68:3,13
 68:22 71:4 72:1 88:21
 89:7 90:21 91:3,3
 92:16,21 93:2,6,7,10
 93:13 94:19 95:6,8
 101:21 102:20 106:9
 110:5 116:6,12
 118:17 119:2 126:20
 132:7 137:17 144:11
 144:18 147:14,22
 148:4,5 149:11,13,17
 156:18,18 157:9,12
 157:17 168:21 177:3
 177:11,19 178:15
 180:22 182:12,22
 183:6 190:18 196:21
 197:6,12 215:4
 216:19 237:11 238:9
 239:18 240:2 243:9,9
 246:16,19,21,22
 247:6,18 248:18
 249:19 253:20
useful 40:14 79:9 219:4
USPSTF 100:20 110:22
 112:17,20 115:1
usual 180:22 233:22
usually 49:12 190:16
 196:7 208:6,8 210:12

V

Vaishali 1:17 18:14
142:17 152:12 183:17
184:19
valid 20:20 23:14,19
24:2 111:17 218:1
233:6
validity 20:16,18,18,21
21:11 23:9 32:20 37:2
37:6 51:22 52:4,5,15
52:21 66:4,8 67:3,10
69:19 70:11,19 84:22
85:7,11 86:5,11 90:2
90:10,16 94:9 119:7
135:19 136:22 173:9
174:7,14 180:13,18
194:12,14 195:3,4,10
205:9 227:7 231:12
232:8,17 235:1
236:20 237:1,5
261:22
valuable 148:9 259:22
value 9:12 154:5 249:13
values 194:19,20
Vanderbilt 1:13
variability 30:15 202:1
202:4,8 203:4
variable 166:5 261:13
262:4
variables 234:8
variation 98:9 208:18
208:20 234:18
variations 34:7
varies 143:21 146:16
165:18 196:4
various 79:5 107:11
175:8 189:15 199:5
vary 103:3,8 139:20
143:20 149:5 203:6
219:22
vendor 181:1
vendors 105:1 181:3
verbally 75:13
verbatim 75:11
verbiage 50:3
Vermont 173:12 174:1
version 24:18,21 60:19
64:10,12 65:18 66:3
67:2,9,15,22 68:14,22
69:7,13 84:14,19 86:4
86:11 88:6,12,22 89:8
89:11,17 90:11,17
147:2 169:3,11
172:21 173:6 174:7
174:15 176:13,20
177:12,19 178:3,9,14
179:14 180:10 182:1
182:18
versions 172:12
versus 19:14,19 34:21

48:8 49:5 72:3 114:15
250:14 251:21
vessels 7:22
vestibular 244:22
vetted 93:5
Vice 2:4
view 162:13
viewpoint 134:21
viral 243:4 250:14
253:18
vision 7:2 8:14 14:2
15:9,12,13 41:19
45:15 73:17 80:17
81:8 96:19,20 98:1
99:9,10 103:13
106:20,21 107:6,16
108:7,9 109:1,3,10,11
111:15 113:3 114:7
119:16 121:4 123:12
123:17,19 124:16
125:13 129:5 133:7
134:4,6,7,8 135:1
138:20 142:21 143:3
143:4,15 144:4 152:9
153:1 154:12,21
156:14,15 167:22
168:3
vision's 123:21 152:1,2
visions 152:8,8
visit 28:17 42:11 43:4
50:14,15 122:12
visits 50:21 55:22
vison 14:18
visual 3:12 95:15 96:9
96:16,19 97:3 99:6
101:6,7 103:16
104:18 106:5 107:2
109:13,18,19 110:11
113:10,14,17 114:3,3
114:13 115:4,9,12
117:8 119:15 133:16
245:16
vitamin 10:5
vitamins 41:16 42:19
46:3,7,17 50:11
vitreous 66:16
Volk 32:7
volunteered 76:17
volunteers 164:8
vote 9:5 12:7,16 18:9
20:8 36:22 37:19
38:19 39:5 44:14
46:21 47:10 51:11
53:9 54:5,17 60:4,11
63:20 65:15 66:22
68:11 69:2,16 70:8,15
72:7 79:11,16 83:9
84:7,16 86:2 87:3
91:5,6 101:14 106:18

112:9 115:20 132:4,5
135:15 136:7,13
137:7,22 147:11
155:1 156:10,11
160:6 171:4 172:19
174:5 176:11 177:9
177:22,22 182:20
183:9 187:13 189:20
192:21 193:22 195:2
196:11 197:4,18
199:18 200:16 204:15
225:4 228:11,15,16
229:2,6,12 230:6,12
236:20,21 237:21
239:16 240:9 253:17
voted 13:5,5,6,6 19:1,1
19:2,2 20:12,12,13,13
37:4,4,5,5 38:1,1,2,2
39:1,1,2,2,11,11
44:21,21,22,22 47:12
47:13,13,14 51:17,17
51:18,18 52:19,19,20
52:21 53:15,15,16,16
54:11,12,12,13 55:2,2
60:13,13,14,14 64:4,4
64:5,5 65:22,22 66:1
66:1 67:6,7,7,8,20,20
67:21,21 68:19,19,20
68:20 69:11,11 70:18
70:19 71:19,19,20,20
72:19,20 79:20,20,21
79:21 83:15,15,16,16
84:16,17,17 86:9,9,10
86:10 88:10,10,11,11
89:5,5,5,6,15,15
90:15,16 91:13,14
116:9,9,10,10 118:22
118:22,22 119:1
132:11,12,12,13
137:13 144:15,15,16
144:16 147:19,19,20
147:20 157:3,4,4,5,16
157:16 160:14,14,15
160:15 171:12,12,13
171:13 173:4,4,4,5
174:12,12,13,13
176:18,18,18,19
177:16,16,17,17
178:7,7 180:17,18
182:7,7,8,8 183:4,4,5
183:5,21,22 187:19
187:20,20,20 193:4,5
193:5,6 194:5,6 195:8
195:9,9,10 196:16,17
196:17,17 197:9,10
197:10,11,22 198:1
201:3,4,4,4 204:20,21
204:21,22 231:8,8,9,9
237:3,4,4,4 238:4,5,5

238:6 239:21,22,22
240:1,16,16
votes 13:1,4 18:22
20:11 37:3,22 38:22
39:10 44:20 47:12,12
51:16,16 52:18,19
53:14,14 54:11 55:1
60:12 64:3 65:21
67:19 68:18 69:10
70:17,17 71:17,18
72:2,18,18 79:19
83:14 84:15 86:8 88:9
89:4,14 90:14 91:12
116:8 118:21 132:11
144:14 147:18 157:3
157:15 160:13 171:11
173:3 174:11 176:17
177:15 178:6 180:16
182:6 183:3,18,20
187:19 193:4 194:5
195:8 197:9,20 201:3
204:20 231:7 237:3
238:4 239:21 240:15
voting 12:8,14 18:10,15
20:9 37:1,20 38:20
39:7 44:15 46:22
51:12 52:14 53:10
54:6,19 60:5 63:21
65:16 67:1,14 68:12
69:5 70:9 71:4,12
72:12 79:12 83:10
84:8 86:3 88:4,20
89:9 90:9 91:7 106:20
106:22 115:22 116:20
132:6 133:9 135:18
144:9 147:13 156:13
156:17 157:8,11
160:8 161:8 171:6
172:20 174:6 176:12
177:10 178:1 180:12
182:2,21 187:14
192:22 194:1 195:4
196:12 197:5,13
200:17 204:16 229:17
230:12 231:3 236:22
237:22 239:17 240:4
264:17,19
voting's 118:16
vulnerable 150:15,18
Vy 2:5 64:9 183:19
Vy's 264:1

W

wait 18:19
waiting 13:1 47:6
156:22
wall 109:16
want 5:20 9:4 17:22
21:2 23:17 28:11,16

31:15 34:17 36:18
 49:22 60:17 72:4 74:7
 74:8 87:21 88:1 94:4
 95:18 100:7,12 101:4
 119:7 123:11,12
 124:3 131:21 132:4
 136:3 139:5,6 141:19
 142:4 149:19 153:22
 158:17 167:21 178:12
 179:5 186:10 188:17
 210:17 216:8,12,14
 223:20 226:1 227:5,8
 227:9,13 235:8,18
 241:2 244:8,22
wanted 81:1 99:5
 100:13 225:10 248:5
 248:9 260:6
wanting 217:7
wants 33:21
Washington 1:9
wasn't 10:19 14:16 42:9
 65:4 105:14 106:1
 108:3 123:7
watch 168:10
wave 242:10
way 17:14 27:3 31:13
 35:7 41:22 66:13
 74:21 76:18 78:4
 98:20 120:22 123:12
 132:16 136:8,20
 137:7 138:9 139:4
 142:6 145:9 146:6,12
 146:15 150:10,11,13
 158:19 172:1 207:11
 207:16 215:2 217:19
 218:3 225:2 235:6
ways 11:4 79:7 113:13
 123:4 150:1,11 163:4
 163:8,9 175:8 228:9
we'll 4:16 7:4 15:5
 64:11,13 71:4 89:21
 93:3 95:19 132:5
 134:13 159:11 160:6
 165:20 167:9 172:18
 174:5 176:11 177:9
 177:22 187:13 193:22
 196:11 197:4 199:10
 199:18 204:15 235:14
 237:20 241:7 264:1
we're 4:18 5:3 6:11 7:2
 9:4,12,13 13:1 15:1
 21:9,15,22 22:2,2,5
 23:9,10,15 24:13,19
 32:19 33:8,20 34:11
 36:9,12 41:11 47:5
 59:4 60:10 62:9,10,12
 69:20 70:14,22 73:1
 76:15 79:16 90:19,20
 93:20,20 94:21 95:4

102:11 103:14 111:2
 119:5 120:16 128:4,5
 129:18,22 131:3,17
 133:8 135:18 136:17
 137:3 144:19 145:15
 150:18,20 152:2
 154:15 156:22 157:8
 157:20,22 158:7
 159:3,11 165:2
 167:20 172:12 174:20
 179:14 180:6,6 181:3
 181:18 184:16,18
 186:7 188:7 191:13
 197:17,20 200:15
 203:3,9,17 205:2,11
 205:14 206:3,5 207:3
 209:13 211:4,18
 215:12,14 216:22
 217:9,12 218:15
 219:12 221:9 222:10
 222:20 223:1,2,6
 225:12,19,21 227:6
 227:15,21 228:16
 229:11 230:5,21
 231:11 235:13 236:21
 239:16 242:1 246:6
 247:18 255:14 256:3
 256:13,15,16,17
 263:8
we've 6:7 15:21 16:17
 16:20 36:16 39:20
 69:18 82:17 90:1 92:7
 95:13,18 108:1 132:2
 144:22 148:2 155:2
 165:16 179:8,16
 181:2,5 212:5 218:7
 220:14 223:8,9
 227:14 236:11 241:5
 241:22 242:3,4
 245:22 258:13
web 175:9
web-based 175:17,18
website 192:13 265:4
websites 197:1
weekly 175:10
weeks 50:22 90:8
 252:19 264:7 265:6
Weill 1:21
welcome 3:2 4:16
 210:17 263:6
went 4:9 92:5 185:4
 190:8
weren't 108:8 113:22
western 6:8
wet 6:17 7:15 8:1,9,11
 9:16,17 10:16 11:10
 11:11,18,21 12:5 15:8
 31:8
wets 12:2

whatever's 219:3
white 189:3
whites 188:11,14 189:2
 201:14
whoever's 130:14
wide 46:2
widely 32:7
wildly 23:11
WILLIAM 2:14
willing 132:18 140:16
 229:7,11,16
WILSON 2:4
window 205:19
WINKLER 2:6 4:3,14
 17:13 21:2 23:8 24:15
 64:9 69:17 71:3,7
 72:1,6 76:7 89:21
 90:19 91:17 92:7 95:7
 96:1 107:1 117:5
 119:4 132:15 133:12
 135:11 136:2,16
 137:10,14 149:9
 157:20 159:8 169:2
 172:11 178:13 180:9
 180:20 181:21 182:11
 182:20 183:8,14
 184:14 189:13 229:5
 229:7,19 238:15
 239:13 241:1,12,19
 243:8,14 248:9 259:5
 261:13 263:11,20
 265:7
Wisely 249:4
wish 217:22
wonderful 16:12
wondering 27:8 212:13
 233:14
word 216:19
wording 113:8 115:1,3
 115:10 138:14 225:13
words 62:20 231:22
work 11:7 97:16 106:2
 117:14 121:19 136:11
 136:12,14 142:6
 168:13 181:19 193:15
 210:9 217:12 234:6
 235:17 240:22 241:4
 241:7,12,13 242:20
work-up 190:12
worked 81:11 99:14
 115:6 181:18 204:11
 236:6
working 22:20 58:15
 98:5 129:20 146:4
 179:6 181:3,3 213:5
 222:20 234:14
works 23:16 121:1
 146:13 224:15
worksheet 110:20

world 6:8 77:1 163:3
 260:1
worried 208:14
worse 7:20 35:1 73:20
 74:9
worth 134:4 195:18
 232:18
wouldn't 87:8 101:3
 122:5 142:16
wrap 265:1
write 35:21 259:6
writing 246:14
written 75:6 78:14
 225:3

X

X-ray 258:22

Y

Yaremchuk 1:10,12
 4:16 7:6 9:3,9 10:20
 12:6 13:9 18:6,9 19:5
 20:2,4,7,16 21:1
 25:22 27:8 30:19
 32:16 33:9 34:15 35:3
 36:21 37:8,15,17,19
 38:5,15,17,19 39:5,14
 41:2,5 42:8 43:13,19
 44:13 45:2,16 46:10
 46:20 47:4,7,16 48:15
 48:18 49:8 50:19 51:8
 51:11,21 52:12 53:1,5
 53:7,9,18 54:1,3,5,16
 55:5 56:10 58:17,21
 59:21 60:3,21 61:16
 61:19 63:19 64:8
 65:13,15 66:4,19,22
 67:11 68:2,7,9,11
 69:2,15 70:1,7,22
 71:6 73:1 76:5 78:7
 78:18 79:10 80:2,22
 81:20 82:16 83:8,19
 84:7,21 85:13,15 86:1
 86:13,15 87:1,3,6
 88:14 89:19 185:16
 186:6,12 235:2,21
 236:2 248:15 250:12
 251:16 252:17 254:6
 257:15 258:8 260:5
yeah 107:1 111:13
 118:14 131:5 145:6
 154:13 156:3 162:6
 162:22 166:22 168:7
 168:9 170:15 173:21
 175:6,6,20 177:5
 178:13 179:8 243:14
 249:15 252:16 263:3
year 22:22 45:9 46:4

51:3 57:3 63:3 122:10
 122:13 175:17 178:16
 210:22 220:1 226:11
 235:3,8,9,16,16,22,22
 236:1,6,16,17,18
 265:2,4
years 5:13 6:4,18 7:1
 15:22 32:6 36:15 44:2
 55:17 59:10 74:15
 77:13 78:6 81:13
 110:15 135:9 179:9
 189:12 233:21 235:4
 235:5 236:13,17
 251:19
yesterday 4:7 5:7 21:14
 21:21 24:13 64:11
 69:18 92:13 105:20
 161:6 162:9,14
 178:19 244:7 245:15
Yoshinaga-Itano's
 199:22 221:4
YOUDE 2:1 120:8
 121:20 163:16 182:15
 199:16 201:17,19
 205:14 207:7,18
 209:13 210:14 212:9
 215:16 217:3 219:15
 220:7 221:12 222:18
 224:22 226:14,16
 228:2,4 229:14
 232:11,16 233:18
 234:1,19 237:17
 238:13 244:6 254:11
 256:9

Z

Zeiss 32:7
zero 13:6 19:2,2 20:13
 20:13 37:5 38:2 39:1
 39:2 44:22,22 47:13
 47:14 51:18 52:20
 53:16,16 54:12,13
 60:14,14 64:4,5 66:1
 66:1 67:8,20,21 68:20
 68:20 69:11 70:18
 71:19,20 72:19 79:21
 83:15,16 84:17,17
 86:9,10 88:11,11 89:5
 89:5,6,15 90:15 91:13
 118:22 160:15 173:4
 173:5 174:13,13
 176:18,19 177:17,17
 182:8,8 183:5,5,22
zone 157:6 194:7

O

O 35:8,14 187:20,20
 193:5,6 195:9,10

196:17,17 197:10,10
 197:22 201:4,4
 204:21,22 231:9
 237:3,4 238:6 239:22
 240:1
0.2 173:14
0.89 19:10
0087 3:4 4:21 12:9 13:8
 18:11 19:4 20:10,14
 37:2,6,21 38:3,21
 39:4,9,13
0088 3:8 55:6 56:10
 60:6,16 63:22 64:6
 65:18 66:3 67:2,9,16
 68:1,14 69:1,8,14
 70:10,20 71:14,21
 72:15,21
0089 3:10 73:3 79:13,22
 83:11,17 84:9,19 86:5
 86:12 88:6,13,22 89:7
 89:11,18 90:11,17
 91:10,16
0566 3:6 44:16 45:1
 47:1,15 51:13,19
 52:15,22 53:11,17
 54:7,14,21 55:4

1

1 3:2 19:11 35:8,14
 116:2 118:18 122:1
 132:9 144:12 147:15
 156:20 187:16 193:2
 194:3 195:6 196:14
 197:6,15 200:18
 204:18 231:4 236:15
 237:1 238:2 239:18
 240:6

1.0 48:4
1.8 160:22
1:55 265:9
10 264:11,11
10:04 92:5
10:20 92:6
100 26:16,19 50:1,12
 69:10 70:18 72:18
 89:4,14 90:14 91:12
 101:4 152:21 173:17
 197:22 200:9 201:22
1030 1:9
10F 87:8
11 187:19 221:2
12 27:16 40:3 50:17,20
 166:16 201:11 224:10
 252:19
12:01 185:4
12:30 184:16,18 185:5
13 116:10 144:15
 197:19

13.9 45:7
1354 3:13 159:1 160:9
 160:16 171:7,14
 172:22 173:7 174:8
 174:15 176:14,21
 177:12,19 178:4,10
 180:1,14,19 182:3,9
 182:22 183:6,12
 184:2
1360 3:16 159:4 186:7
 187:15,21 193:1,7
 194:2 195:5,11
 196:13,18 197:6,12
 197:15 198:2
1361 3:17 159:6 200:18
 201:5 204:17 205:1
 231:4,10 237:1,5
 238:1,7 239:18 240:2
 240:6,18
14 13:17 47:12 70:17
 71:17 197:19,20
 231:8,16,16
15 37:3,5 38:2 51:16
 52:18 53:14 72:18
 79:19
159 3:13
15th 1:9
16 20:19 52:6 63:10
 66:6 85:8
16.5 82:11
168 199:4
17 15:22
18 59:10,11
184 3:14
186 3:17
19 13:17 232:3 233:4
198 3:18
1985 17:10

2

2 9:14 35:8,14 40:19
 43:2 52:2 116:2
 118:19 122:2 132:9
 144:12 147:16 156:20
 187:16,20 193:2
 194:3 195:6 196:14
 197:7,15 200:19
 204:18 231:5 236:17
 237:2 238:2 239:19
 240:7
2.5 194:17
20 42:18 46:1,9 51:16
 53:15 63:10 65:21
 67:20 81:12 84:16
 88:10 116:10 132:13
 157:5 176:18
200 154:6
2000 200:1

2006 201:11
2007 188:6
2008 160:4
2009 13:12 80:5 81:21
 82:6
2010 45:7 82:7
2011 188:22
2012 13:13 45:7 80:5
 81:21 188:7 231:17
2013 82:7,11 192:12
 233:20
2014 16:19 45:10 48:3
 205:10 231:19 233:8
 233:9,19,21 235:8,14
2015 1:6 83:7
2016 235:13,14
21 193:5 204:21 237:4
 238:4
22nd 264:8
23 39:1 51:4,6
24 50:17,21 194:16
241 3:19
25 231:19 232:18 234:2
26 63:11 233:4
263 3:20
265 3:22
27 83:14 118:22 132:12
 157:4 171:12
2721 3:12 95:15 116:1
 116:12 118:18 119:2
 132:8 144:11,18
 147:14,22 156:19
 157:13,18
2722 16:19
29 47:13 196:16
2P 87:9

3

3 3:17 116:3 118:19
 132:9 144:13 147:16
 156:20 186:8,16
 187:2,8,17 188:9,12
 190:19 191:20 193:3
 194:4 195:6 196:15
 197:7 200:19 204:18
 220:15 231:5 237:2
 238:2 239:19
3,892 194:17
3.3 173:12
30 32:6 192:6 233:5
 258:12
300 6:20
31 13:5 19:1
33 52:19 54:12 67:6
 157:16 160:14 173:16
33.8 231:19
34 232:19
35 46:4

36 61:9 63:3**362.07** 65:4**38** 38:1**39** 3:7 48:21 49:10,21**39.2** 48:10

4

4 1:6 3:2 116:3 118:19
132:9 144:13 147:16
156:20 179:14 187:17
193:3 194:4 195:7
196:15 197:7 200:19
204:19 220:11,21
231:5 237:2 238:2
239:19**40** 42:20 44:21 86:8

157:3 173:4

43 195:9 201:3**44** 165:14**45** 19:16 20:1**46** 20:12 38:1 48:4**47** 64:4 79:19,20 132:12**488** 179:21**49** 233:2,6**490** 48:1

5

5 3:5 243:21**5:00** 185:14**50** 5:13 6:3 40:2 52:3

55:17 57:3 87:8

130:13 149:22 150:10

166:10 191:1 194:5,6

239:21,22

500 19:8 141:10,13,13**51** 188:14 189:3 201:15**52** 188:15**52.2** 189:3 201:15**53** 64:3 189:7**54** 20:11 188:14 189:7**54.8** 189:2 201:14**55** 3:9**57** 195:8 201:3

6

6 3:17 198:5,12,21

200:2 205:20 206:7

207:9,16 211:4,5

212:17 217:6 221:5,7

221:20 223:3 224:3

224:16,19 241:9

6:00 185:14**60** 44:20 52:19 67:6

86:9 116:9 171:12

60's 109:2**61** 233:6**62** 13:5**66** 188:6**66.4** 201:11**67** 54:11 118:21 144:15

147:19 201:20

69 19:1 37:4 188:7

191:19

69.1 201:12

7

7 116:9 119:1 132:11

144:16 147:19,20

160:14 171:13 177:16

178:7 180:17 182:7

183:4 197:10 231:7

238:5 240:16

7.8 45:6**70** 32:12 56:1 81:17

189:5

70's 109:2**70.8** 188:21**70s** 56:6**71** 47:12 188:16,18

196:16 238:5

716 180:3**73** 3:11 51:17 83:15**74** 231:19 232:19 234:2**75** 7:13**75.5** 48:14**77** 38:22**79** 193:4 204:20 231:8

237:3

8

8:29 4:2**8:30** 1:9**80** 53:14 65:22 67:19

84:16 88:9

80s 55:15**82** 45:11**85** 55:16

9

90 6:8 56:3 81:17

251:10

90s 167:20 168:1 200:1**92** 39:10 45:8 55:20

80:6

93 55:1 60:12 68:18

71:18 80:6 197:9

240:16

94 13:14**95** 3:12 21:7,8 56:3 61:4**96** 19:15 61:3 173:15**96.1** 13:14 48:9**96th** 26:20**97** 19:20 160:20 194:17**9th** 1:9

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This is to certify that the foregoing transcript

In the matter of: Eye Care, Ear, Nose and Throat
Conditions (EENT) Standing Committee

Before: NQF

Date: 06-04-2015

Place: Washington, D.C.

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