

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE MEETING

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WEDNESDAY
JANUARY 27, 2016

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The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:15 a.m., Harold Pincus, Chair, and Foster Gesten, Acting Co-Chair, presiding.

PRESENT:

HAROLD PINCUS, MD, Co-Chair

FOSTER GESTEN, MD, FACP, Acting Co-Chair

RHONDA ANDERSON, RN, DNSc, FAAN, American
Hospital Association

DAVID W. BAKER, MD, MPH, FACP, The Joint
Commission

MARY BARTON, MD, MPP, National Committee for
Quality Assurance

STEVEN BROTMAN, MD, JD, AdvaMed*

JAYNE CHAMBERS, Federation of American Hospitals

MISSY DANFORTH, The Leapfrog Group*

CHRISTOPHER DEZII, RN, MBA, CPHQ, Pharmaceutical
Research and Manufacturers of America
(PhRMA)*

LYNDA FLOWERS, JD, MSN, RN, AARP

DAVID GIFFORD, MD, MPH, American HealthCare
Association

RICHARD GUNDLING, FHFMA, CMA, Healthcare
Financial Management Association*

GAIL HUNT, National Alliance for Caregiving

CHIP N. KAHN, III, MPH, Federation of American
Hospitals*

WILLIAM E. KRAMER, MBA, Pacific Business Group
on Health
SAM LIN, MD, PhD, MBA, American Medical Group
Association*
LISA MCGIFFERT, Consumers Union
ELIZABETH MITCHELL, Network for Regional
Healthcare Improvement*
R. BARRETT NOONE, MD, FACS, American Board of
Medical Specialties
FRANK G. OPELKA, MD, FACS, American College of
Surgeons
AMIR QASEEM, MD, PhD, MHA, American College of
Physicians
CAROL SAKALA, PhD, MSPH, National Partnership
for Women and Families
MARISSA SCHLAIFER, RPh, MS, Academy of Managed
Care Pharmacy
CARL SIRIO, MD, American Medical Association*
MARLA J. WESTON, PhD, RN, American Nurses
Association
STEVE WOJCIK, National Business Group on Health*

INDIVIDUAL SUBJECT MATTER EXPERTS PRESENT

RICHARD ANTONELLI, MD, MS*
MARSHALL CHIN, MD, MPH, FACP

FEDERAL GOVERNMENT LIAISONS PRESENT

KEVIN LARSEN, MD, FACP, Office of the National
Coordinator for Health Information
Technology (ONC)
CHESLEY RICHARDS, MD, MH, FACP, Centers for
Disease Control and Prevention (CDC)
NANCY WILSON, MD, MPH, Agency for Healthcare
Research and Quality (AHRQ)*
PIERRE YONG, MD, MPH, Centers for Medicare
and Medicaid Services (CMS)

WORKGROUP CO-CHAIRS PRESENT

RONALD WALTERS, Hospital Workgroup*

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

ELISA MUNTHALI, Vice President, Quality
Measurement

MARCIA WILSON, Senior Vice President, Quality
Management

TAROON AMIN, NQF Consultant

WUNMI ISIJOLA, Administrative Director

MELISSA MARINELARENA, Senior Director

DEBJANI MUKHERJEE, Senior Director*

ERIN O'ROURKE, Senior Director

SARAH SAMPSEL, Senior Director*

AMBER STERLING, Project Manager

JEAN-LUC TILLY, Project Analyst

ALSO PRESENT:

JOEL ANDRESS, Centers for Medicare and
Medicaid Services (CMS)*

SHAWNN BITTORIE, CommPartners*

HEIDI BOSSLEY, American Medical Association

KARIN FELDMAN, American Society of Clinical
Oncology

NANCY FOSTER, American Hospital Association

THOMAS GRANATIR, American Board of Medical
Specialties

THOMAS JAMES, III, MD, Baptist Health Plan*

DARSHAK SANGHAVI, MD, University of
Massachusetts; Centers for Medicare and
Medicaid Services (CMS)

* present by teleconference

A-G-E-N-D-A

Day 1 Recap.	5
Foster Gesten	
Harold Pincus	
Opportunity for Public Comment12
Pre-Rulemaking Recommendations for Hospital Programs26
Committee Discussion48
Opportunity for Public Comment	193
MAP at 5 Years: Evolution and Vision for the Future	196
Wunmi Isijola, Harold Pincus, Taroon Amin, Erin O'Rourke	
Opportunity for Public Comment	276
Closing Remarks.	280

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

2 9:18 a.m.

3 CO-CHAIR PINCUS: Okay, so why don't
4 we get started. We have actually substantially
5 more people here in person, and I guess we still
6 have a number of people who are on the phone.
7 And I hope to take a tally on that in a couple of
8 minutes.

9 So, let's talk a little bit about just
10 to think about the experience yesterday. I think
11 it really was an extraordinarily productive day
12 despite all the problems with the weather and
13 people getting here.

14 And I think very usefully at the
15 outset, we were able to clarify several important
16 points that were potentially points of confusion.

17 Number one is we were able to clarify
18 the sort of distinctions in the measures under
19 development category, I think, in terms of
20 distinguishing among the three categories of
21 recommending continued development, not
22 recommending continued development, and having

1 insufficient information, where the insufficient
2 information really refers to people who feel they
3 don't have enough information to decide between
4 the two other categories.

5 But more importantly, we got clarity
6 from CMS that they're very willing to and intend
7 to come back to us and give us feedback about
8 measures that we recommend for continuing
9 consideration, but are not ready for primetime.

10 So we're going to be developing a
11 feedback loop about that.

12 And even more importantly, they
13 emphasized the fact that what they're really
14 looking for is less the specific recommendation
15 and more comments that would help them to refine
16 the specific measures.

17 And so the kind of commentary that we
18 had around the table and over the airwaves really
19 is incredibly important. And I think they were
20 very grateful for that kind of in-depth expert
21 advice that we were able to give them.

22 And that's all been sort of written

1 down and captured so that that can be fed back.

2 We also plan over the coming weeks to
3 develop a more specific format for how we can get
4 this feedback in an ongoing way about the
5 performance of measures, the experience that
6 people have had with the measures and what's been
7 done about them.

8 So that we'll be able to have a fuller
9 picture of both the further process of measure
10 development and also what has been the impact of
11 the measures. So I think those are all very
12 positive kinds of things going forward.

13 Foster, do you want to add some more?

14 ACTING CO-CHAIR GESTEN: Sure. Well,
15 first I'd be remiss if we didn't acknowledge the
16 great job of the staff in being able to not only
17 put this meeting together but to deal with the
18 weather issues and folks on the phone. So I want
19 to really shout out to everybody. NQF does an
20 incredible job of organizing this.

21 I heard, in addition to what Harold
22 mentioned, some recurrent themes that are not new

1 to this group and the conversations.

2 And they include I think a desire to
3 have a clear sense of what alignment means, and
4 also clarify where alignment is a good thing, and
5 where alignment creates at least a reality of
6 perception of this sort of double jeopardy of
7 measures counting more than once.

8 I also heard I think from a lot of the
9 comments from the workgroups a continuing
10 struggle of trying to figure out and land on
11 measures that were truly meaningful to patients
12 and patient-centered.

13 And it includes, but it's not limited
14 to, outcomes, like functional outcomes and
15 others.

16 And then clearly payment reform is
17 challenging and pushing on this issue of measures
18 as they relate to shared accountability and
19 trying to figure out what the right way of
20 thinking about that is.

21 And it certainly, if for nothing else,
22 raises lots of issues around risk adjustment and

1 appropriate risk adjustment, whether it's for
2 quality measures, or we'll probably take up that
3 conversation around payment and efficiency as
4 well.

5 So, I thought it was a great, robust
6 conversation yesterday. I look forward to today.

7 CO-CHAIR PINCUS: So, to kick things
8 off I think there's a few new people that need to
9 have the disclosure process. So, Wunmi, do you
10 want to --

11 DR. BURSTIN: We went through a
12 process yesterday of introductions and
13 disclosures. So if anybody is new, if you're an
14 organizational member, all I require is that you
15 disclose if you have more than \$10,000 in
16 anything that might be associated with the work
17 before this committee.

18 I think probably the new people are
19 all organizational members.

20 And then if you're a subject matter
21 expert, just give us a brief overview of what
22 you're engaged in, in terms of work before this

1 committee, contracts, grants, speaker
2 relationships, et cetera.

3 So, why don't we go to who's new at
4 the table. I know we've got Jayne here today.

5 MS. CHAMBERS: My name's Jayne
6 Chambers and I have nothing to disclose. I'm
7 pressing the button.

8 MS. FELDMAN: Karin Feldman from the
9 AFL-CIO. Nothing to disclose.

10 DR. BURSTIN: We've got Lynda Flowers
11 in person today, but she disclosed on the phone
12 yesterday.

13 Anybody new on the telephone?

14 DR. WILSON: Nancy Wilson, nothing to
15 disclose. AHRQ.

16 DR. BURSTIN: Great. And Pierre, do
17 you want to introduce yourself?

18 DR. YONG: Hi. So for folks who know
19 Kate, I'm not Kate, obviously. So, I'm sitting
20 in for Kate today, but I'm representing CMS, and
21 nothing to disclose.

22 CO-CHAIR PINCUS: So, as people -- oh,

1 Lisa?

2 MEMBER MCGIFFERT: Can I have a
3 question on voting? We go back and click to our
4 original link for voting?

5 CO-CHAIR PINCUS: No, there's new
6 links.

7 MEMBER MCGIFFERT: New link. Okay,
8 I'll look for it.

9 MEMBER ANDERSON: I tried to open the
10 new link, and I couldn't get it open. I don't
11 know if everybody else can, but mine wouldn't
12 open.

13 DR. BURSTIN: Have people been able to
14 open the new voting link that you received today?

15 CO-CHAIR PINCUS: Mine worked.

16 DR. WILSON: Yes, mine worked too.

17 DR. BURSTIN: Okay. Shawnn, could you
18 resend one to Rhonda Anderson, please?

19 MS. BITTORIE: Absolutely. And you
20 should see that in a few minutes. And you may
21 want to try a fresh browser when you receive
22 that.

1 DR. BURSTIN: Great. Thank you.

2 CO-CHAIR PINCUS: So, as people
3 recall, we are now doing the public comment
4 periods before we have the discussion of
5 measures.

6 So, I would like to open up the public
7 comment period initially in the room for the
8 hospital measures.

9 DR. SANGHAVI: Hi, I appreciate being
10 here speaking to the group today. I'm just going
11 to introduce myself.

12 My name is Darshak Sanghavi. My
13 background is I'm a pediatric cardiologist at the
14 University of Massachusetts Medical School. And
15 I'm also the director of prevention and
16 population health at the Innovation Center at
17 CMS. So I'm here in my capacity also as a CMS
18 representative.

19 And I just wanted to give a little bit
20 of background to one of the hospital measures
21 that the group is going to be discussing today.

22 I'm giving this as an introduction

1 during the public comment period just to spend a
2 few minutes with background. I will also be here
3 to offer technical guidance on the measure if
4 they come up during the group discussion.

5 But just by way of introduction, the
6 measure that our group has proposed is the
7 smoking prevalence measure at the county level
8 for inclusion in the Hospital Inpatient Quality
9 Reporting System.

10 I also want to emphasize that I'm here
11 in person, and I was here yesterday as well,
12 unfortunately we didn't get to it, just to
13 emphasize the critical importance of this measure
14 and the strategy broadly at CMS and HHS. I want
15 to telegraph that in person.

16 This measure has been a strategic
17 priority both of Patrick Conway, the Deputy
18 Administrator of CMS and former head of CCSQ, as
19 well as Tom Frieden, the head of the Centers for
20 Disease Control.

21 We have developed this concept in
22 consultation with them, and they both strongly

1 have advocated for this.

2 I mention this by way of background
3 because as you're no doubt aware, the use of
4 tobacco is the leading preventable cause of
5 misery among patients today.

6 We believe that with a problem this
7 severe, it would also require interventions that
8 are more innovative than those that have been
9 used in the past in the hopes that they can
10 substantially impact positively the health of
11 Americans.

12 In other words, it is a big problem,
13 and a big problem requires potentially innovative
14 and new strategies to address it.

15 I also want to emphasize that the use
16 of tobacco at the population level does introduce
17 several complexities. But we believe this falls
18 into a broader, strategic series of priorities at
19 CMS.

20 As you are no doubt aware, we are
21 moving from volume-based to value-based
22 reimbursement very broadly, ultimately mirrored

1 in our payments systems that go from fee-for-
2 service to accountable care to bundle payment to
3 potentially in population-based payments.

4 Our payments are going in this
5 direction, and we hope also that our quality
6 metrics will as well.

7 In terms of tobacco specifically at
8 the state level, we are currently negotiating
9 with major large states for tracking tobacco at
10 the state level as an adjustor in the Medicaid
11 program broadly.

12 This falls into a broader series of
13 priorities. Even in the Medicare Shared Savings
14 Program and others, we've considered strategies
15 as well to sort of expand the denominator.

16 We believe that is population health.
17 It is caring for a broad population. And we
18 believe this fits into our broader strategic
19 priority of using an outcome measure.

20 Let me just briefly talk about why the
21 hospital IQR and why at the county level.

22 First of all, we believe that in

1 counties, there are not currently measures that
2 encourage cooperation and coordination.

3 So it is true that all hospitals in a
4 county, by the way, most Americans live in a
5 county that's served by an acute care hospital,
6 do not currently have any incentive to work
7 together, or at least even to recognize a measure
8 that they all share in common, such as community-
9 based smoking prevalence.

10 We believe that working together in
11 some way would be incentivized by having a
12 measure that they all have.

13 In addition, this is a measure that's
14 collected by the Centers for Disease Control
15 directly. So it can be given to hospitals and
16 requires essentially no reporting burden on the
17 part of hospitals. It is essentially no work at
18 all.

19 Having said that again, a cooperative
20 measure, yes, you can work together. Why again
21 at the hospital level?

22 I just wanted to take a minute to say

1 we believe that there is a substantial and
2 emerging body of literature and academic and
3 scientific consensus that improved work even by
4 hospitals can substantially and positively impact
5 the smoking prevalence rate at the county level.

6 For example, according to Centers for
7 Disease Control data, a substantial number of
8 high-risk patients are, in fact, seen at
9 hospitals on an annual basis. And over several
10 years, we see a majority of patients that may be
11 seen in a hospital.

12 We also currently know based on,
13 again, CMS's broad-based strategy when looking at
14 how we think about hospital care, we no longer
15 just think about what happens at that encounter
16 in the emergency department or in the four walls
17 of the hospital.

18 Thirty-day readmission measures, even
19 30-day mortality after MI, all of those things
20 depend on continuing coordination of care.

21 And there's increasing data that only
22 when you actually touch patients after they leave

1 the hospital can you actually substantially
2 reduce smoking rates.

3 The British Medical Journal in 2014
4 editorialized that the prevalence of smoking at
5 the county level can be -- or geographic level
6 can be substantially impacted by improved
7 hospital care.

8 We also believe that hospitals have a
9 variety of strategies at their disposal.

10 For example, the Cleveland Clinic in
11 Cuyahoga County, when they actually went to a
12 smoke-free requirement for employees actually
13 substantially reduced their community county-
14 based smoking rates, while other areas around the
15 Cleveland Clinic did not, other counties.

16 Again, this goes into a clearly
17 established strategy. For example, we also in
18 the IQR have a flu vaccination measure of
19 hospital employees.

20 So, this sort of -- there is a zone of
21 expanding abilities that we have for hospitals to
22 now impact tobacco prevalence rates.

1 And finally, hospitals serve their
2 communities. Many, many hospitals as part of
3 their mission statements clearly recognize that
4 they do not just treat patients that show up at
5 the door, but have a responsibility for their
6 broader community.

7 In fact, many of their fund-raising
8 efforts specifically call out their community
9 involvement as an important part of the reason we
10 should fund these hospitals.

11 Therefore we believe, again, there are
12 substantial areas of leverage for hospitals to
13 impact smoking rates.

14 I'll just conclude by saying finally
15 that what we are proposing now is reporting only.

16 I think that when we propose these
17 types of changes or these sorts of innovative
18 strategies, it is important to do it in a
19 deliberate fashion.

20 The CDC at the state level has
21 endorsed the NQF measure, but not at the county
22 level.

1 Working with CDC very carefully, we
2 believe that the county level measure is quite
3 robust, but that is why it is being -- you're
4 seeing it today as a measure under development,
5 just to explain that.

6 However, we will continue to work with
7 CDC to do that.

8 But I'd like to then just finally just
9 close with the fact that if we don't hold
10 hospitals -- there is no payment against
11 reporting only.

12 It is surprising and shocking in our
13 review how often hospitals, the clinicians that
14 work at the hospitals really have no idea of the
15 population-based burden.

16 And when you don't know what you're
17 dealing with, you can't really address it.

18 This substantially impacts minority
19 and other populations as well. We believe that
20 bringing this to hospitals' attention is
21 critical.

22 And hopefully also we recognize that

1 this will vary. There is going to be differences
2 across the country in what the baseline rate is.

3 Again, we are just looking at a
4 prevalence rate. It puts that on your radar
5 screen and then wherever you start at, you can
6 start to lower that by whatever means you feel is
7 helpful.

8 Again, we are not holding anybody
9 accountable for the baseline population that
10 currently exists. That is what we are looking to
11 understand.

12 So finally, I'd respectfully submit as
13 you can tell, we are quite interested in this
14 measure.

15 We believe that this is the future of
16 how we will be thinking about measurement in many
17 ways with population health.

18 We would respectfully request that the
19 committee here endorse the hospital MAP group's
20 recommendation and continue development on the
21 measure. Thank you.

22 MS. FOSTER: Hi, Nancy Foster from the

1 American Hospital Association.

2 This may come as something of, I don't
3 know, a head-turning reaction after that last
4 comment. But I wanted to get up here to
5 emphasize to you that our member hospitals are
6 keenly aware of the importance of working to
7 improve not only the health of the patients that
8 they touch every day in their hospitals but also
9 of their communities.

10 However, they're struggling. They're
11 struggling not only with the hospital measures
12 that are already on the plate right now in the
13 five programs that we currently have for
14 hospitals, but also because hospitals today are
15 more than just a building with inpatient and
16 outpatient care. So when I said five, there's
17 more than that programs.

18 We are also working with our
19 clinicians who will be collecting, and we'll be
20 helping them to collect, their data for MIPS or
21 for the alternative payment models.

22 We are working with post-acute care.

1 In fact, we have many post-acute care settings.
2 There are lots of things we're doing.

3 And part of the problem for our member
4 hospitals is that right now, it doesn't make
5 sense. There's not really this overarching
6 strategic vision of how do we improve health in
7 this nation. How do we improve healthcare? What
8 role do hospitals and their clinicians and the
9 post-acute care settings they're working with
10 play in moving that forward?

11 And this deluge of measurement, to the
12 point you all have made over the last day, the
13 deluge of measurement causes some confusion
14 rather than helping people see how we really move
15 that quality performance forward in a way that
16 truly makes a difference for patients.

17 That has led our members to ask us to
18 ask you to focus attention on some high-priority
19 opportunities to really make a difference in the
20 health of people and to tell us explicitly what
21 can we do as hospitals, not as public health
22 agencies, but as hospitals to engage on that.

1 What can we do from our perspective as
2 running some post-acute care settings? How do we
3 move this ball down the road? How is that all
4 coordinated and aligned to the word you just
5 used?

6 And the discord comes when we are
7 handed measures that seem an overreach, that seem
8 to be not things that we truly have an effective
9 ability to make a difference in on our own.

10 The smoking prevalence in the
11 community would be one of those examples where we
12 may have an opportunity to affect some, but we're
13 not the major actors there.

14 We are happy to step up and play our
15 role, but it has to be done in coordination and
16 collaboration with all of the other players,
17 including and perhaps most significantly, public
18 health agencies, insurance, organizations that
19 have an ability to affect it through insurance
20 rates, and other players at the table.

21 And so how do you as the MAP try to
22 think about the strategic choice of measures to

1 really drive healthcare forward in this country?

2 I know at this point in your
3 deliberations when you're confronted with
4 recommendations from the workgroups it's really
5 hard to think about how you take that and get to
6 a more strategic viewpoint.

7 But I hope that over the course of the
8 next few months as the MAP prepares for the
9 receipt of the next group of measures from CMS
10 that you think carefully about how to get to that
11 strategic vision and provide some requests, some
12 guidance to CMS about what you'd like to see, and
13 how it can be more effective in driving the
14 entire care system towards a common, strategic
15 point of view. Thank you.

16 CO-CHAIR PINCUS: Any other comments
17 in the room? Public comments on the phone? Can
18 we open that up?

19 OPERATOR: At this time if you would
20 like to make a comment please press * then the
21 number 1. There are no public comments at this
22 time.

1 CO-CHAIR PINCUS: Thank you. So, it
2 looks like we're going to have an interesting
3 morning.

4 So, Erin, are we ready to proceed?

5 MS. O'ROURKE: Yes, I can kick it off
6 on hospital.

7 CO-CHAIR PINCUS: Yes, well, the
8 slides are there for clinician programs.

9 MS. O'ROURKE: I don't know that we
10 want to revisit that.

11 CO-CHAIR PINCUS: No, we don't. Let
12 me just remind folks on the phone in terms of
13 getting in queue for comments to use the Raise
14 Hand function. And welcome, all the folks we
15 have on the phone. We very much want to have you
16 participate. So Raise Hand or if that's not
17 working you can interrupt, but raising hand and
18 then you can get into the queue for questions and
19 comments.

20 MS. O'ROURKE: So, we can skip to the
21 next slide. I think you saw this a number of
22 times yesterday.

1 So, I'm Erin O'Rourke, as you may
2 remember. I'm joined by Melissa Marinelarena,
3 another senior director here at NQF supporting
4 the hospital workgroup.

5 And we are fortunate enough to have
6 our co-chair Dr. Ron Walters on the phone. Ron,
7 if you wanted to introduce yourself?

8 WORKGROUP CO-CHAIR WALTERS: Hi, I'm
9 Ron Walters.

10 MS. O'ROURKE: Fair enough. So, to
11 give you a scope of what the hospital workgroup
12 looks at, it's quickly becoming a bit of a
13 misnomer.

14 We looked at 44 measures for 8
15 setting-specific payment or reporting programs,
16 including the IQR program, the hospital value-
17 based purchasing program, the outpatient quality
18 reporting program, the ambulatory surgery center
19 quality reporting program, the inpatient
20 psychiatric facility reporting program, the PPS-
21 exempt cancer hospital quality reporting program,
22 the HAC reduction program, and the end-stage

1 renal disease quality incentive program. Next
2 slide.

3 So, across the conversations about the
4 measures for all of those various programs, a few
5 overarching themes emerged.

6 First, the group felt the performance
7 measures need to foster better coordination
8 across the care continuum. They stressed there's
9 a need for integrated measures.

10 There needs to be better coordination
11 between hospital and post-acute and long-term
12 care as well as better EHR integration and more
13 readily shared information to ensure that as
14 patients go between community hospital and post-
15 acute settings their information goes with them,
16 and the clinicians treating them have the
17 information they need to ensure they're giving
18 the best possible care.

19 There's a need to carefully evaluate
20 SDS adjustments to ensure that performance is
21 captured accurately as well as there's a need to
22 encourage holistic care from all providers,

1 including setting or treatment-specific settings.

2 The group is really focused on the
3 need to engage patients and families as full
4 partners in their care.

5 They noted a need to measure
6 commitment to and documentation of patients'
7 treatment goals and care preferences.

8 The hospital workgroup supported a
9 balanced approach to patient accountability and
10 to encourage relationships with patients and
11 families and their communities.

12 And they stressed that measures should
13 address outcomes that matter the most to
14 patients.

15 And some examples they gave were
16 cognitive or functional outcomes, safety, patient
17 activation, and the patients being educated, and
18 engaged, and able to participate fully in their
19 care as well, as more measures that address
20 quality of life. Next slide.

21 Finally, the group stressed that
22 there's a need to drive improvement for all

1 patients.

2 Currently the measures in the program
3 are very Medicare-focused as obviously these are
4 Medicare programs. But the group really would
5 like to see the populations covered to be
6 expanded, to expand the services that are
7 covered.

8 In particular, they'd like to see more
9 measures addressing perinatal and pediatric care.

10 They would like to see a global
11 measure of harm that goes beyond the HACs that
12 are currently addressed by the different measures
13 in the program.

14 And finally, they would really like to
15 see measures assessing access to care. They
16 noted that that's a real challenge for a number
17 of patients and would like to see measurement
18 drive to reduce access gaps.

19 So with that, Melissa is going to take
20 you through some of the program-specific
21 considerations.

22 MS. MARINELARENA: Thanks, Erin. So,

1 for IQR, we had 15 measures. And I think it was
2 the most amount of measures.

3 So, one of the issues that we talked
4 about was resource use versus appropriateness of
5 care.

6 And the workgroup agreed that resource
7 use was important to measure, but it is not
8 indicative of quality of care, and it doesn't
9 provide clear information on the appropriateness
10 of care.

11 There was also a long conversation
12 about the support. They supported the community-
13 based measures like the smoking prevalence
14 measure that we just heard about and I'm sure
15 we're going to have a long conversation about.

16 But the workgroup had a robust
17 conversation on the roles that hospitals played
18 within their communities to influence health,
19 wellness, and readmissions as well.

20 And, like Erin just said, the group
21 identified gaps like perinatal and pediatric
22 measures and obstetrics.

1 They also identified cost of drugs,
2 particularly specialty drugs.

3 And they also discussed the need for
4 the all-harm or global harm electronic measure.
5 They felt that this type of measure would provide
6 the public with more useful information about
7 overall hospital care.

8 And it would also provide hospitals
9 with more readily accessible data on their
10 performance, rather than waiting for data from
11 claims-based measures.

12 So, just quickly about the comments
13 that we received. Again, because this was the
14 most amount of measures that we had for all of
15 our programs, we received quite a bit of
16 comments.

17 But the majority of the comments
18 agreed -- and I'll just go over the smoking
19 prevalence.

20 So, the majority of the comments
21 agreed with the MAP's recommendations for the
22 smoking prevalence measure.

1 Although the commenters agreed that
2 smoking is an ongoing public health issue and
3 that hospitals may play a role in reducing
4 smoking prevalence in their communities, but they
5 raised several concerns.

6 And some of these concerns included
7 the impact of SDS factors, attribution and
8 factors beyond the hospital's control such as
9 taxes, public smoking laws, access to smoking
10 cessation medications and counseling.

11 There was also concerns about the
12 development of new measures that only addresses -
13 - this measure only addresses smoking rather than
14 tobacco cessation, which includes smokeless
15 products as well.

16 There was also concern with accurately
17 collecting and recording EHR data for some of the
18 measures. And some of those are the stroke
19 measures.

20 There is an antimicrobial use measure
21 that was conditionally supported.

22 This -- some of the commenters did not

1 support the inclusion of the measure in the
2 program because it is intended for surveillance
3 and internal quality improvement efforts.

4 Commenters also stated that this
5 measure is not appropriate for accountability
6 purposes at this time due to the limited
7 experience with the measure.

8 The formerly PSI-90 received several
9 comments as well. And this is in several
10 different programs.

11 And commenters were happy to see that
12 CMS is working to improve this measure, but they
13 also stated that little is known about the
14 performance of the measure after the improvements
15 of the measure.

16 And another commenter urged CMS to
17 remove the measure from the programs altogether.

18 Erin just mentioned measures that are
19 more meaningful to patients. We had several
20 mortality measures. And the workgroup discussed
21 that mortality was not necessarily the most
22 meaningful outcome for patients, and a lot of the

1 commenters agreed with that as well.

2 Sometimes it's functional status for
3 a stroke patient, assessing cognitive and
4 functional outcomes, and the commenters agreed
5 with them.

6 We can move on. Okay, so now Erin
7 will cover hospital value-based purchasing.

8 MS. O'ROURKE: Sure. So, for the
9 value-based purchasing program, the hospital
10 workgroup continued to stress a parsimonious
11 approach to this program to reduce the burden and
12 increase interpretability.

13 However, they would like to see this
14 program expand beyond the current safety measures
15 that are included. It currently includes PSI-90
16 and a number of the NSHN PAC measures.

17 The group stressed if the new CABG
18 mortality measure that was on the MUC list is
19 implemented, there'd be a need to monitor that
20 closely for any potential unintended
21 consequences, particularly around reduced
22 referrals for hospice care if that care is

1 warranted.

2 The public comments we received,
3 commenters supported MAP's parsimonious approach,
4 in particular around the cost measures that were
5 under consideration.

6 As Melissa noted, we did receive some
7 comments expressing concerns with the new patient
8 safety and adverse events composite, the revised
9 PSI-90. As Melissa noted, particularly that not
10 much is known about its performance in the real
11 world.

12 And finally, commenters echoed MAP's
13 concern about potential unintended consequences
14 of the CABG mortality measure and would like to
15 ensure that if that is implemented that it's
16 closely monitored so that patients can access
17 care that they desire if they choose hospice over
18 continued treatment.

19 MEMBER MCGIFFERT: What were the
20 unintended consequences of the mortality measure?

21 MS. O'ROURKE: They were concerned
22 basically that physicians may hold off referring

1 patients to hospice if that's what the patient
2 desires to avoid receiving a poor score on the
3 measure.

4 So perhaps that there should be some
5 exclusions around if the patient chooses hospice
6 care over continued treatment. Next slide.

7 So, for the HAC reduction program, we
8 had two measures under consideration. Both were
9 updates to measures that are currently in the
10 program.

11 The workgroup felt that the updated
12 measures were significant improvements to the
13 current version. However, these updates need to
14 be clearly communicated to both providers and to
15 members of the public who might be using these
16 measures.

17 Again, commenters expressed similar
18 concerns about the revised patient safety and
19 adverse event composite, formerly PSI-90, and
20 that more is needed to be known before it's used
21 in a payment program.

22 And then the hospital outpatient

1 quality reporting program. The new measures, the
2 possible admissions would fill some gaps in the
3 program, but there's a need to consider potential
4 need for SDS adjustment as well as risk
5 adjustment generally, and that these needs need
6 to be closely monitored.

7 The group would also like to see
8 additional measures addressing some high-volume
9 outpatient services.

10 Comments generally supported MAP's
11 recommendation. However, some cautioned that
12 admission measures might affect treatment
13 decisions, particularly for cancer patients.

14 And commenters concurred with MAP's
15 recommendation that risk adjustment strategies be
16 carefully considered prior to implementation.

17 So I think Melissa is going to take
18 you through the rest of the programs.

19 MS. MARINELARENA: Sure. So, for
20 ambulatory surgical center quality reporting
21 program, MAP reviewed one measure.

22 And this new measure addresses

1 surgical quality, but the group discussed that
2 gaps still persist across other surgery types.

3 The comments that we received did
4 support MAP's recommendation, noting that the
5 measure does align with recently published
6 professional guidelines and the potential to
7 better understand the prevalence of TAS, or toxic
8 anterior syndrome.

9 But again, there are still gaps that
10 exist across other surgical types.

11 For the cancer hospital quality
12 program, MAP discussed that there was a need for
13 better symmetry between the cancer program and
14 the IQR program.

15 And again, gaps still continue in the
16 quality of life measures.

17 Some commenters indicated that they
18 had concerns that there were a lack of detailed
19 measure specifications on the admissions and
20 emergency department visits for patients
21 receiving outpatient chemotherapy measure.

22 And they also expressed that there was

1 a potential for unintended consequences if the
2 measure is implemented without proper testing and
3 validation, and encouraged MAP not to support the
4 measure.

5 For inpatient psych, MAP supported the
6 new substance abuse measures and the readmission
7 measures.

8 And there was a discussion about
9 measures needing to assess a connection between
10 psychiatric care and primary care.

11 And again, most of the comments that
12 we received did support MAP's conclusions. And
13 they noted that the readmissions measure should
14 be considered for the impact of SDS factors. And
15 this was a theme throughout the conversation with
16 our workgroup.

17 For the end-stage renal disease
18 quality incentive program, one of the
19 conversations that we had when we discussed gaps
20 was that the program should consider measures
21 from the ESRD Seamless Care Organization.

22 And when I took a look at these

1 measures they are -- I can't remember how many
2 there are, maybe 15 or so.

3 They're very holistic. They take a
4 look at the entire patient. So that was a
5 recommendation.

6 And they also talked about not
7 supporting measures that are topped out, or when
8 there are better competing measures. And that
9 was how some of the decisions were made as well.

10 So again, some of the comments that we
11 received disagreed with the recommendation to
12 conditionally support the readmission ratio for
13 dialysis facilities measure.

14 And another set of comments expressed
15 their concern with the quality of the studies
16 that informed a couple of the measures, which
17 included the measurement of phosphorus
18 concentration measure and the avoidance of
19 utilization of high ultrafiltration measure.

20 Now, I think --

21 WORKGROUP CO-CHAIR WALTERS: Can I say
22 a couple of words?

1 MS. MARINELARENA: Oh, yes Ron, go
2 ahead.

3 WORKGROUP CO-CHAIR WALTERS: Okay,
4 sorry. As you can tell when you have excellent
5 staff it makes the job of the co-chairs much
6 easier.

7 So, the first thing I wanted to do was
8 to say hi to Harold and the Coordinating
9 Committee especially from Cristie Travis, co-
10 chair, with me on the hospital workgroup who
11 could not be there this morning. She's on a
12 plane to San Diego, but she really wanted to be
13 here.

14 This is an experienced committee.
15 Many of the committee members have been involved
16 since the inception.

17 I think we have a very collaborative
18 environment. Everybody feels comfortable to say
19 exactly what's on their mind, and that's very
20 much encouraged in any committee.

21 A couple of enhancements I wanted to
22 highlight from the last couple of years that we

1 found extremely valuable. You utilize them also.

2 One is the consent calendar. And even
3 subgroupings within the consent calendar.

4 You experienced that yesterday with
5 things like the drug regimens and so on, where it
6 really helped to consolidate talking about the
7 principles and leaving room for individual
8 measures when required.

9 The other thing, as I alluded to, is
10 co-chairs. As you all have experienced the
11 workload can get quite intense, especially when
12 it's 8 programs and 44 measures, and responding
13 to requests for further discussion and/or pulling
14 off the consent calendar.

15 It really is a good idea. This
16 morning, because Cristie had to leave, really
17 exemplifies how valuable it is to have co-chairs
18 that can work very well together.

19 I want to just emphasize a couple of
20 things that you -- I'm not going to repeat
21 yesterday's conversation about the programs or
22 the strategic direction.

1 I think you handled almost all the
2 issues there very well yesterday, and it's
3 something that we also wrestle with.

4 I did want to emphasize the interplay
5 in the inpatient hospital world of the measures
6 in transition. You spent some time talking about
7 that.

8 And how they interact with the
9 requirements programs, the transition from IQR
10 and value-based purchasing, what do you do with
11 revised measures in any continuum of tweaks,
12 timing, more than tweaks, brand new measure
13 that's changed significantly, how that interplays
14 with what CMS has to do, that came out yesterday
15 with quite a few of the measures.

16 And then I would say as a general
17 rule, and you saw that in kind of our
18 recommendations. We really do give a lot of
19 credence to the standing committees and the
20 endorsement process. That obviously is an
21 important part in our considerations and
22 influenced a lot of our decisions.

1 There are some issues that you've
2 heard talked about that we still have a lot of
3 work to do.

4 As we'll talk about, anything
5 involving the words resource utilization and
6 cost, episode-based payments, end of life, the
7 whole handoff business, still leave an awful lot
8 of room for continued development.

9 So, thank you again for taking the
10 time to listen to eight programs and your
11 thoughtful consideration of which ones you wanted
12 to both discuss further and maybe even consider a
13 change in the recommendation as given by the MAP
14 workgroup.

15 So thank you again, and I'm available
16 for any questions about any measure.

17 CO-CHAIR PINCUS: So, thank you very
18 much Ron and Melissa and Erin for going through
19 the sort of broader overview.

20 We have a few more things to discuss
21 in terms of the impact of the Dual Eligibles
22 Beneficiaries Workgroup and their input.

1 Melissa, are you going to --

2 MS. MARINELARENA: No, that's Debjani.

3 MS. MUKHERJEE: Hi, this is Debjani.

4 I'm the senior director for the Duals Workgroup.

5 So, what I will do on this slide is
6 quickly go over the Dual Workgroup's perspective
7 on hospital recommendations.

8 We would like to share that promoting
9 shared accountability for communication and
10 transitions in care is something very important
11 for our workgroup and the duals population.

12 And by that what we mean is not only
13 having a transition plan, but follow-through,
14 appropriate communication, transmission of
15 information in a timely manner.

16 We would also like to support the
17 alignment of measures across programs and
18 settings as well as encourage the prioritization
19 of measures within and across hospital settings,
20 and thereby getting to parsimony, alignment, and
21 applicability of measures within the hospital
22 setting as well as across programs.

1 And that's the only slide we have for
2 this. Thank you.

3 And any questions, please let me know.

4 CO-CHAIR PINCUS: Anything further
5 from the committee?

6 (No response)

7 CO-CHAIR PINCUS: So, now we're going
8 to go through the measures that have been pulled
9 off for discussion or for voting.

10 And as we did yesterday I'm going to
11 be asking the individuals who pulled the measures
12 whether they intend for it to be for voting or
13 for discussion, bearing in mind the strong
14 encouragement from CMS to get the discussion and
15 advice on the table to help inform them has been
16 the primary priority that they have.

17 But if people feel that they want to
18 re-vote, we're perfectly happy to vote on the
19 measures as well.

20 But first, are there any other members
21 of the committee that want to pull any other
22 measures off for discussion?

1 (No response)

2 CO-CHAIR PINCUS: Okay, so let's
3 proceed.

4 The first one is --

5 MEMBER DANFORTH: Oh, I'm sorry. Hi.
6 This is Missy from Leapfrog. I've had my hand
7 raised on the phone. Sorry. Can I just take one
8 minute to just do a couple of comments?

9 CO-CHAIR PINCUS: Sure.

10 MEMBER DANFORTH: Okay. So, first --
11 because I think I heard Pierre say he was in the
12 room -- I want to congratulate the committee.
13 Their workload has just grown tremendously over
14 the years and I think they did a very
15 comprehensive and efficient job in reviewing
16 measures for these programs.

17 But I will say in general CMS has
18 expressed the desire over the past several years
19 to more closely align, particularly around these
20 hospital programs with private purchasers.

21 And we were a little bit discouraged
22 to see the list of measures this year. In past

1 years, I think the measures have more accurately
2 reflected the express needs of private
3 purchasers, particularly in areas of patient
4 safety.

5 But also I think I was just a little
6 disappointed to see the lack of measures in areas
7 that private purchasers have really been pushing
8 on for the past several years, in areas like
9 overuse and medication safety, misdiagnosis,
10 patient-reported outcomes, consumer/purchaser
11 alliance.

12 They've been incredibly vocal on these
13 areas, MAP workgroups and at the Coordinating
14 Committee level, expressing the need for these
15 kinds of measures.

16 And to see a MUC list that doesn't
17 have any of these kinds of measures was a little
18 discouraging.

19 And I hope that CMS can find ways to
20 encourage innovation among measure developers
21 that really address some of these high-priority
22 things.

1 Just going back to what Nancy said, I
2 think it's important that we send hospitals a
3 really clear message both from the public and the
4 private sector on what we want them to work on,
5 what we think is incredibly important.

6 And I'm not sure that this particular
7 set of measures gets at a lot of those things.

8 The other thing just really quickly is
9 that we all know so much care is moving out of
10 the hospital and into outpatient and ambulatory
11 settings.

12 And it's just incredibly important for
13 people accessing that care because it's at a
14 lower price to have more visibility to the
15 quality and safety of that care.

16 And I think that if there's any way to
17 accelerate the addition of measures into those
18 two programs, the outpatient and the ambulatory,
19 it would be fantastic. So, thank you.

20 CO-CHAIR PINCUS: Thank you, Missy.
21 And I just want to mention that Missy and David
22 Baker are going to be the initial respondents to

1 the discussion on the pulled measures.

2 So, why don't we start off with
3 Measure 151136, Measurement of Phosphorus
4 Concentration, pulled by Lisa.

5 So, Lisa, can you say: is this for
6 voting or for discussion?

7 MEMBER MCGIFFERT: Just for
8 discussion. This is another process measure.
9 Basically, it just measures whether something was
10 measured from what I can tell, and not
11 necessarily connected to improvement of care.

12 There were some comments that
13 questioned whether this measure would lead to any
14 kind of improvement.

15 And there was another comment that was
16 concerned about the quality of the studies that
17 inform the measure.

18 It's important for us to measure
19 what's going on in these dialysis centers, and
20 I'm not sure if there are some other measures
21 that are more outcome-based that would be more
22 meaningful.

1 But that's what we need. We need more
2 of that and less of this kind of measure.

3 Thanks.

4 CO-CHAIR PINCUS: Missy or David, do
5 you want to respond initially?

6 MEMBER BAKER: I'll just take what
7 Lisa said and go a step further.

8 I think this is a really bad process
9 measure. What we care about is really phosphorus
10 control.

11 And what we've learned from -- if
12 you're thinking about hemoglobin Alc, you know,
13 checking Alc, checking blood pressure, checking
14 cholesterol levels.

15 We know those are bad measures.
16 They've all been retired because they're not
17 associated with control.

18 So this is a measure that, again, says
19 did you check it. It doesn't say that you did
20 the fairly complex things that you need to do
21 patient education, medication, dietary
22 improvements, really to get control. So, I think

1 it's a bad process measure.

2 CO-CHAIR PINCUS: Missy, do you have
3 any comments?

4 MEMBER DANFORTH: No.

5 CO-CHAIR PINCUS: Others in the room
6 have any comments on this measure?

7 So, Lisa, you brought this up for
8 discussion.

9 MEMBER MCGIFFERT: Maybe we should
10 vote on it.

11 CO-CHAIR PINCUS: But I don't hear
12 anybody speaking in support of it. And the vote
13 of the committee was for support.

14 WORKGROUP CO-CHAIR WALTERS: So, this
15 is Ron again. I guess that's my role.

16 So, as I mentioned earlier, all the
17 things that have been said are true. And I use
18 the same analogy of hemoglobin A1c. Eventually
19 we have to get to is it under control, and then
20 eventually what's the outcome associated with
21 that.

22 This was just reviewed in 2015, having

1 been originally endorsed in 2007. The committee
2 members expressed exactly a lot of the similar
3 points, but were strongly in favor of keeping
4 this around for now. And we took that strongly
5 into consideration.

6 CO-CHAIR PINCUS: David Gifford?

7 MEMBER GIFFORD: I guess my question
8 is: what are the other measures in the ESRD
9 Quality Incentive Program?

10 Is there an NQF phosphorus target
11 measure? This is the only measure that's
12 available around phosphorus.

13 And where does it fit with the other
14 measures in the portfolio of the ESRD program?
15 The link's not working when I click through to
16 pull up the list.

17 WORKGROUP CO-CHAIR WALTERS: Calcium
18 is the other obvious one.

19 MEMBER GIFFORD: Is it calcium
20 testing, or is it calcium bubble?

21 WORKGROUP CO-CHAIR WALTERS: Remind me
22 about that.

1 MEMBER MCGIFFERT: Let me look it up.

2 MEMBER GIFFORD: So it's a level.

3 WORKGROUP CO-CHAIR WALTERS: Yes, I
4 thought so.

5 MS. O'ROURKE: And that measure is
6 topped out.

7 MEMBER GIFFORD: I think, you know,
8 we're voting on whether this -- to support this
9 for the inclusion in the ESRD program as labeled
10 here, which is an incentive payment program.

11 And I'm reading sort of the program,
12 it's silent on whether it's process or outcome
13 measures, but clearly it's leaning towards
14 outcome measures in the statute, in the other
15 links.

16 I think I would agree with the
17 comments here that I would vote not to support,
18 or support it with conditions that it be quickly
19 switched or paired to an outcome measure.

20 I mean, I can see why you want to
21 progressively get there. But if you're going to
22 pay on this, whether they're testing or not, and

1 it has no management, and there's no other
2 outcome I think that that's not ready for a
3 measure to go into rulemaking for payment.

4 I mean, clearly it's an NQF-endorsed
5 measure. It's good for quality improvement and
6 everything else.

7 But I think we're trying to give
8 feedback and vote on whether the measures are
9 ready to go into a rulemaking for a payment
10 program for ESRD.

11 CO-CHAIR PINCUS: So, I want to step
12 out of the chair role for a moment.

13 I'm inclined to agree with you, but it
14 would be helpful to have two other pieces of
15 information.

16 Number one is to what extent is this
17 measure close to being topped out.

18 And number two, is there anything in
19 the sort of NQF consensus development process
20 pipeline to actually replace this measure with a
21 level measure?

22 DR. BURSTIN: I thought this was in

1 reserve status from endorsement which means,
2 generally reserve status is a designation we have
3 made on the endorsement side for measures that
4 are otherwise very good measures, but are topped
5 out.

6 And we generally don't recommend those
7 get used in programs.

8 MEMBER MCGIFFERT: Okay, so I'll
9 change my proposal to have a vote on this.

10 DR. BURSTIN: Ron was trying to say
11 something.

12 CO-CHAIR PINCUS: Ron, did you want to
13 make a comment?

14 WORKGROUP CO-CHAIR WALTERS: The
15 committee agreed to vote -- voted to recommend
16 the measure for endorsement with reserve status.

17 CO-CHAIR PINCUS: So, what does that
18 mean?

19 WORKGROUP CO-CHAIR WALTERS: What
20 Helen just said.

21 DR. BURSTIN: It's a special status of
22 endorsement for measures that are topped out, but

1 that may still be used for ongoing surveillance
2 or something along those lines, but not
3 necessarily the measures of first choice for
4 programs.

5 CO-CHAIR PINCUS: So, Pierre, can you
6 give a bit of a comment from the perspective of
7 CMS?

8 DR. YONG: Sure. And I believe there
9 was a robust discussion when it was under
10 consideration for endorsement and ultimately was
11 recommended for -- as a top-down measure.

12 Because I think the data did show it
13 was topped up at the bottom end. There was still
14 a not insignificant proportion of facilities
15 which were not performing at the topped-out
16 level, which is why I think it was ultimately
17 recommended for the reserve status.

18 We certainly agree with a lot of the
19 comments offered by the committee members, in
20 that bone mineral disease is an important issue
21 for ESRD patients.

22 Unfortunately, there is not a big pool

1 of other measures in this area. We have convened
2 several TEPs in the past several years to look at
3 this particular issue, and based on the
4 literature, have not been able to identify a
5 really promising concept for development in this
6 area, though we are continuing to look into it.

7 So, I think at this point -- since we
8 believe that the topic and the issue is of
9 importance to this particular patient population
10 and is important for care of these patients,
11 given that it is a current NQF-endorsed measure
12 though it is in reserve status -- that's why we
13 believe it's appropriate for the program at this
14 point.

15 CO-CHAIR PINCUS: I'm just curious.
16 There's no effort around thinking of developing a
17 control measure?

18 DR. YONG: I think we have looked at
19 this issue in the past. I think our last TEP was
20 probably a year or two ago, so we can revisit
21 that.

22 But right now we don't have a current

1 control measure addressing this particular area
2 because no concept surfaced that was promising at
3 that point.

4 CO-CHAIR PINCUS: David and Marshall.

5 MEMBER GIFFORD: A couple of things.
6 If the TEP couldn't figure out a reserve measure
7 and struggled with it, why would we measure a
8 process measure about whether they're getting the
9 testing or not?

10 Because it doesn't sound like there's
11 agreement on what the levels should be or
12 anything.

13 And then as far as, you know, we're
14 not supposed to bypass the NQF voting or anything
15 so the reserve status or not it's an NQF-endorsed
16 measure.

17 I would disagree with the comment that
18 just because it's topped out doesn't mean it
19 shouldn't be in a payment program because there
20 are still some that are not there. And if it's a
21 really important outcome and you want something
22 there, you may want to still have it in a payment

1 program.

2 So, I mean I can understand why you
3 may not for quality improvement -- and I think
4 it's good that NQF has a topped-out status.

5 But again, we're voting on whether to
6 recommend this goes into rulemaking for an
7 incentive program for ESRD.

8 And I would argue it's not appropriate
9 for rulemaking given the comments that people
10 just said. It's a process measure with no one
11 knowing what the outcome should be, so why would
12 we want people to do testing, especially if
13 they're already topped out, what that value is to
14 doing it.

15 I mean, if someone said oh, we really
16 know the phosphorus level and there's some things
17 coming along I think we could put it support with
18 conditions to move that level. But it just
19 doesn't make sense to me.

20 CO-CHAIR PINCUS: Marshall, and then
21 David, and then Frank.

22 DR. CHIN: I was just actually

1 surprised clinically that a measure was unable to
2 be come up with for bone marrow metabolism. So I
3 may want a message back to the TEP, or back to
4 the clinical committees, you know, take another
5 look.

6 I mean, the clear process measure does
7 seem to be fairly distal, and I can't think
8 clinically why they can't come up with an outcome
9 measure that would be closer to the mark. So, I
10 think it's worth a re-look.

11 MEMBER BAKER: I just wanted to ask
12 whether there were also concerns that this could
13 drive over-utilization.

14 Because the measure is that the
15 phosphorus level is checked every month, and the
16 KDOQI guidelines actually say that it should be
17 checked every one to three months. So, that was
18 another concern.

19 Is that something that was discussed?

20 WORKGROUP CO-CHAIR WALTERS: Yes, it
21 was.

22 CO-CHAIR PINCUS: And what was the

1 conclusion? Or I guess the conclusion was that
2 the measure would support it.

3 WORKGROUP CO-CHAIR WALTERS: That is
4 true.

5 So yes, that was discussed, and yes,
6 despite that it was supported.

7 CO-CHAIR PINCUS: Frank?

8 MEMBER OPELKA: So, this is actually
9 a question to NQF staff and probably particularly
10 to Helen.

11 My understanding of the current
12 reserve status is it is not NQF-endorsed. And
13 that there's endorsement and then there's reserve
14 status, but there's not endorsed reserve status.

15 DR. BURSTIN: No, actually, it's a
16 subcategory of endorsed. It remains endorsed,
17 but it's specifically labeled "with reserve
18 status" so that everybody knows that it's topped
19 out.

20 And specifically, although to Giff's
21 point you could certainly use it in payment
22 programs, there is an assumption that that would

1 be sort of a measure not of first choice for
2 those programs, but more for regular surveillance
3 to make sure you kind of take your eyes off the
4 measure. It doesn't drop in performance, but not
5 for regular routine assessment when it's topped
6 out.

7 MEMBER OPELKA: But I don't think
8 that's -- again, I don't know all the facts
9 around this, but having served in these
10 committees and roles in the past when you go in
11 reserve you're no longer maintained. That
12 measure falls off.

13 It's not that a reserve measure gets
14 updated, maintained, et cetera. It goes in
15 reserve and it doesn't come back for endorsement
16 use until it gets updated.

17 So, I beg to differ. I do not think
18 a measure in reserve is considered an endorsed
19 measure.

20 DR. BURSTIN: I'm told by the smart
21 people in the room that it does not come back for
22 maintenance, but it is still a subcategory at

1 least for what we consider endorsement.

2 CO-CHAIR PINCUS: Heidi?

3 MS. BOSSLEY: I guess it's a question
4 again to NQF staff.

5 When I go on QPS, it doesn't say
6 reserve. So, I question either there's something
7 in the database that's wrong, or -- I think we
8 need to clarify. Because it looks like --

9 DR. BURSTIN: We've gone all through
10 this. It is clearly at a very high rate of
11 performance, even if you look to the endorsement
12 summary.

13 But it says at the end of the
14 endorsement summary that the committee voted 22-0
15 to put it in reserve status. So, the labeling of
16 QPS we've already noted as an issue.

17 MS. MARINELARENA: So, can I tell you
18 what I have in the report? So this is what we
19 wrote.

20 MAP agreed not to support proportion
21 of patients with hypercalcemia, which was the
22 other measure, because this measure was recently

1 reviewed by the NQF Renal Standing Committee and
2 was recommended for reserve status because the
3 measure has topped out.

4 MAP also determined that measuring
5 hypercalcemia in this population for a pay-for-
6 performance and public reporting program may not
7 be as meaningful to patients because almost all
8 dialysis patients have calcium levels before the
9 target level.

10 Instead, MAP supported the inclusion
11 of measurement of phosphorus concentration
12 because a minimum performance rate for this
13 measure is zero percent with a mean performance
14 of 87 percent, suggesting that some facilities
15 are not following the process at all. That was
16 the reasoning.

17 MEMBER BAKER: I just want to point
18 out that those ones that are not in compliance on
19 this measure may be still following the current
20 practice guidelines to measure it every one to
21 three months. And they would be assigned a
22 failing score on that. So, I just point that out

1 as another concern.

2 CO-CHAIR PINCUS: But we don't know
3 that. So, Lisa, and then we should probably
4 proceed to a vote.

5 MEMBER MCGIFFERT: Okay. Just to
6 clarify what you just said, David, the current
7 guidelines, if someone was following the current
8 guidelines they would not be performing -- they
9 would not meet this measure performance. Is that
10 what you just said?

11 MEMBER BAKER: So, there may be
12 patients -- I mean, if an organization is really
13 conservative and they're checking the phosphorus
14 based on the past rates, and somebody's always
15 been in control, and they say well, we're going
16 to back off from this to every two or three
17 months that patient would fail the measure.

18 CO-CHAIR PINCUS: Is there a comment
19 by somebody on the phone?

20 So, it sounds like there's differences
21 of opinion on this. So we've moved this from
22 discussion to voting.

1 And the options are to support,
2 conditional support, or do not support.

3 MEMBER GIFFORD: Clarifying on the
4 vote, I heard us talk about support or do not
5 support.

6 If it's conditional support, what are
7 the conditions? And since we have three choices,
8 if someone votes for conditional support, I want
9 to know what the conditions are for them to vote
10 for that.

11 CO-CHAIR PINC US: Right, so that's a
12 good question. So Lisa, you pulled it. Do you
13 have any suggestions around conditions?

14 MEMBER MCGIFFERT: Yes. Someone
15 suggested the conditional support would be that
16 it move towards a -- let's see, support with
17 conditions that it quickly switch to an outcome
18 measure that tells us more about --

19 MEMBER GIFFORD: That's a different
20 measure.

21 CO-CHAIR PINCUS: It will be a
22 different measure.

1 MEMBER MCGIFFERT: Yes, it would be a
2 different measure. So we don't --

3 ACTING CO-CHAIR GESTEN: Well,
4 technically a phosphorus level is not an outcome
5 measure, it's still a process measure.

6 CO-CHAIR PINCUS: Right. I mean, I'm
7 trying to see if there is a potential
8 recommendation or condition.

9 DR. RICHARDS: Well, I think at a
10 minimum being in compliance --

11 CO-CHAIR PINCUS: So, it's either
12 support or do not support.

13 MEMBER MCGIFFERT: So, let's just take
14 a vote. And I recommend that we do not support
15 this. So, how about that? Let's vote on it.

16 CO-CHAIR PINCUS: Okay. So, let's
17 just take the -- before we vote make sure that
18 folks have logged into their -- Coordinating
19 Committee voting members are logged in through
20 their personal ID which they got in an email this
21 morning.

22 And if there's anyone who is not,

1 either on the phone or in the room, now is the
2 time to speak up.

3 ACTING CO-CHAIR GESTEN: This is
4 Foster. Can we have a test, a slide about the
5 snow or something similar today? Because I've
6 been having some significant technical issues
7 this morning.

8 I do have the slide up, but I just
9 don't know whether I have the voting capacity
10 link yet.

11 MS. BITTORIE: We are going to put a
12 test question on the screen right now.

13 DR. BURSTIN: And Shawnn, some people
14 are getting in the room something saying the
15 meeting has ended on their webinar screen.

16 ACTING CO-CHAIR GESTEN: That's what's
17 called wishful thinking.

18 MS. BITTORIE: So, certainly we do
19 want to make sure that if you are clicking on
20 today's link that you have cleared your browser
21 from yesterday. It could be holding onto
22 yesterday's meeting.

1 CO-CHAIR PINCUS: While this is going
2 on, I think both Pierre and Barry had a comment.

3 MEMBER NOONE: I just had a question
4 about getting on. I have yesterday's email but
5 not today's.

6 Today's email didn't -- you sent me
7 yesterday's again.

8 DR. BURSTIN: Shawnn, can you just one
9 more time send today's email to all the members?

10 MS. BITTORIE: Absolutely. Doing that
11 right now.

12 DR. BURSTIN: Thank you.

13 CO-CHAIR PINCUS: Okay. Pierre?
14 Pierre had a comment.

15 DR. YONG: Sorry. One of my staff
16 members is on the phone, Joel Andress, who heads
17 up this measure. So he just wanted to offer a
18 clarifying comment, if that's okay.

19 CO-CHAIR PINCUS: Okay.

20 DR. YONG: Joel, are you on the line?

21 MR. ANDRESS: I am. Can you hear me?

22 DR. YONG: Yes.

1 MR. ANDRESS: Okay. Thank you. So,
2 just one thing to point out. I apologize for
3 being late to the discussion, but I think one
4 thing that bears mention is the fact that this
5 program for which this measure is being
6 considered has an explicit reporting component to
7 it.

8 Whereas other value-based purchasing
9 programs are distinct from reporting programs,
10 the QIP requires both a set of reporting measures
11 and clinical performance measures as part of
12 making the payment determination.

13 So, I think the question that I would
14 ask the committee to consider is, if we are
15 arguing that a reporting measure is of no value,
16 what does that mean for a program that explicitly
17 has a reporting component versus a clinical
18 performance component?

19 I think the other issue is that there
20 has, you know, that reporting measures of this
21 kind of have certainly been --

22 CO-CHAIR PINCUS: Could you just --

1 let me just interrupt you for a moment. Could
2 you explain what you mean by a reporting
3 component as compared to a clinical performance
4 component?

5 MR. ANDRESS: Sure. So, there are two
6 types of measures that go into the QIP.

7 There is a clinical measure on which a
8 facility is assessed based on performance on that
9 measure. So, for readmissions as I'm sure you're
10 familiar with the readmission measures, your
11 performance relative to your peers is assessed,
12 and your score is based upon that relative
13 performance or improvement.

14 For the reporting measure there is a
15 requirement within the QIP that reporting
16 measures define data that must be reported to
17 CMS, and performance or points toward the payment
18 determination are assigned based on whether or
19 not you meet those reporting requirements.

20 So, for instance, for a phosphorus
21 reporting measure you would be assessed on
22 whether or not you reported whether or not a

1 patient had received phosphorus, but not on the
2 percentage of patients who hadn't received
3 phosphorus, if that is at all clear.

4 MEMBER MCGIFFERT: Let me ask if I
5 understand what you're saying.

6 There is a payment you get, an annual
7 update if you report the certain measures that
8 you're required to report by CMS. That's what
9 you're distinguishing as reporting.

10 And then there's another piece to that
11 that's quality that you're paid for.

12 And my understanding is this measure
13 is being considered today for the quality
14 measure, not for the reporting measure.

15 MR. ANDRESS: No, I think --

16 MEMBER MCGIFFERT: Is that wrong?

17 MR. ANDRESS: Well, when measures are
18 submitted for the QIP, they have not been split
19 up in those two camps.

20 In terms of looking at this as a
21 measure, we are simply considering this measure -
22 - which, you are right, is a reporting measure --

1 as a potential for use in the QIP which means it
2 could be used potentially for either purpose.

3 The program itself feeds both
4 categories into the same payment determination.
5 There aren't two separate determinations that are
6 made.

7 As an example, I think for the last
8 payment I think 90 percent of your score is based
9 upon your clinical performance and 10 percent is
10 based on your meeting the reporting requirements.

11 CO-CHAIR PINCUS: So, what you're
12 saying is that it has less value in terms of the
13 overall score that you get.

14 So, just two quick comments from David
15 and from Jayne.

16 MEMBER GIFFORD: I guess I just want
17 to clarify because I'm reading it was submitted
18 under the heading, and just I'm clarifying, under
19 the CMS ESRD program which, going to the link, is
20 a program that uses measures in performance that
21 are tied to payment.

22 And if you don't submit the data you

1 also may have a financial penalty for not
2 submitting the data.

3 And so what Joel is saying -- is Joel
4 saying that you are proposing to use it only for
5 submitting and not tying it to payment? Or it's
6 going to be part of the program so it could be in
7 the rulemaking tied to payment later on, rather
8 than just a penalty for not reporting?

9 What is the vote they're asking for
10 rulemaking on here? Are you asking to include
11 this in rulemaking for just submitting the data,
12 or are you asking for submitting the data as part
13 of the QIP program?

14 DR. YONG: So both components make up
15 your QIP score.

16 MEMBER GIFFORD: So you're asking for
17 the whole QIP program, both penalty and also --

18 DR. YONG: Right. But you would only
19 use it for one. You would not use it for both.
20 Right. You wouldn't have the same measure in
21 both the score calculation for the reporting as
22 well as the performance.

1 CO-CHAIR PINCUS: So, it's part of the
2 program but they're differentially scored.

3 DR. YONG: Right.

4 CO-CHAIR PINCUS: Okay? So I think
5 that's the issue.

6 MEMBER MCGIFFERT: Wait a minute. I
7 may be misunderstanding, but there are a lot of
8 measures that hospitals have to report that are
9 not in the quality incentive payment programs.

10 CO-CHAIR PINCUS: And this,
11 apparently, the issue for us is that it is part
12 of the program, it's scored differently.
13 Different measures are scored differently in the
14 ultimate payment model. And that's I think the
15 key issue.

16 So, just to -- because I think we need
17 to move ahead. And so I think we've belabored
18 this.

19 So, is it okay to try the fake
20 question?

21 MS. O'ROURKE: Yes, so if everyone
22 could go and cast your vote. Is it sunny where

1 you are? Please let us know if you aren't seeing
2 this screen or if you're having any voting
3 issues.

4 WORKGROUP CO-CHAIR WALTERS: Are you
5 able to tell if all of the eligible voters have
6 voted?

7 MS. STERLING: Yes. And just to be
8 sure, federal liaisons, you are not going to be
9 voting so please exclude yourself from that.

10 CO-CHAIR PINCUS: Okay, what's the
11 right number? There should be 27. We have 27.
12 So why don't we move on. No, we have 28. It
13 should be 28?

14 Okay, so let's move on to the real
15 vote. Okay, can we move on to the real vote?

16 MS. STERLING: Yes. Just a second.

17 CO-CHAIR PINCUS: So we can vote now?

18 MS. STERLING: Yes. So you're voting
19 on MUC 151136, Measurement of Phosphorus
20 Concentration for the End-Stage Renal Disease
21 Quality Incentive Program.

22 Your options are support, conditional

1 support, and do not support. And voting is open.

2 CO-CHAIR PINCUS: So, it looks like
3 three people have not voted.

4 Okay, so it looks like the voting is
5 more than 60 percent to do not support.

6 MS. STERLING: Right. So it's 11
7 percent support and 88 percent do not support.
8 So, the workgroup recommendation does not stand
9 and this moves to do not support.

10 CO-CHAIR PINCUS: And the important
11 point here is that the commentary back to CMS is
12 concern about this being purely a reporting
13 measure that may not capture the full
14 recommendations from the guidelines.

15 And the recommendation is strongly
16 toward develop one that would actually measure
17 control or performance in concert with the
18 appropriate guidelines.

19 MEMBER GIFFORD: And I think, Harold,
20 move to an outcome measure, too.

21 CO-CHAIR PINCUS: Right.

22 MEMBER BAKER: I would just add that

1 the workgroup raised all of these issues. So I
2 mean, the justifications for this is all there.
3 They just came to a different conclusion.

4 CO-CHAIR PINCUS: Okay. So let's move
5 on.

6 Now, I understand there's some
7 confusion about what's on the list that have been
8 pulled.

9 MS. O'ROURKE: So, we had a late-
10 breaking pull. So we'll be moving on to the
11 influenza measure for ESRD vaccination. You'll
12 see it on the discussion guide here, MUC 761.

13 And the workgroup's recommendation was
14 do not support for this. And Pierre had pulled
15 this.

16 CO-CHAIR PINCUS: Okay, so Pierre,
17 could you give us some of your rationale?

18 DR. YONG: Sure. We just wanted to
19 make sure, and to share some additional
20 information --

21 CO-CHAIR PINCUS: And is this for re-
22 voting?

1 DR. YONG: Yes. And so, and Ron was
2 very familiar with the conversation. There was a
3 pretty robust conversation at the workgroup on
4 this particular measure.

5 I think the particular issues that
6 were raised at the workgroup discussion were that
7 there was another similar measure that is a
8 claims-based measure, and that is in use in many
9 facilities.

10 The addition that the committee
11 thought might be a better alternative to this
12 which is the data source of this is CROWNWeb.
13 So, the facilities need to input the data into
14 the ESRD data collection system.

15 The particular information we wanted
16 to share with folks is that upon further
17 examination of the claims-based measure, which is
18 not the measure in front of you now, it
19 systematically excludes patients who -- from the
20 numerator who did not receive a flu vaccine
21 during the flu season and passed away.

22 And so we think that's a pretty major

1 flaw to that measure, and that is not -- and that
2 exclusion is not present in this particular
3 measure that is in front of you.

4 So we thought that was one of the
5 reasons we thought this was a stronger measure.

6 The other reason we thought this was a
7 stronger measure potentially was because the data
8 source for the other measure is claims. And so
9 if we do not have access to the claims or a
10 particular flu vaccine was not filed for that
11 patient we won't have access to that information
12 to calculate the rate for that, or account for
13 that patient and the flu vaccine for the measure
14 calculation for that facility.

15 CO-CHAIR PINCUS: Missy, David, do you
16 want to respond?

17 MEMBER BAKER: I don't have any
18 comments.

19 MEMBER DANFORTH: This is Missy. I
20 was actually just comparing the two measures so I
21 definitely understand what you're saying, Pierre,
22 about not counting folks that died who didn't get

1 the vaccine.

2 But also some comments about there
3 being no exclusions. And one of the things about
4 the endorsed measure is that it does exclude
5 patients who declined just based on patient
6 choice.

7 So I notice that's in the workgroup's
8 comments and seems fairly important. Do you have
9 any comment on that?

10 DR. YONG: Sure. Thanks, Missy. If
11 the facility were to -- if we were to use this
12 measure the facility when they input the data
13 into CROWNWeb which is our data collection
14 system, they would be able to indicate in that,
15 in the record whether they were offered the
16 vaccine but declined.

17 CO-CHAIR PINCUS: Ron, do you want to
18 make a comment?

19 WORKGROUP CO-CHAIR WALTERS: Well,
20 Pierre summarized things pretty well.

21 So we have on the one hand a measure
22 that is NQF-endorsed, claims-based, tested, fully

1 aligned, et cetera, et cetera.

2 And we have a materially different
3 measure which is registry-based basically. It's
4 an NHSN database, CROWNWeb.

5 And pertinent to Nancy's point
6 earlier, this is not tested yet. There are
7 workload issues.

8 And the committee also, in additional
9 points raised -- discussed what is the plan for
10 integrating those things, or are we really going
11 to report the two measures on a going-forward
12 basis.

13 And so having not heard a good, long-
14 term solution to that decided to support the
15 measure that exists, 226, and to not support this
16 one.

17 MEMBER DANFORTH: I'm sorry, this is
18 Missy. So, because this isn't a fully tested
19 measure, and it sounds like the exclusion for the
20 denominator and/or numerator aren't defined for
21 the ones Pierre just mentioned in the measure
22 sets, should this have gone to the other category

1 of voting which was, like, support direction?

2 I don't know, I think support
3 continued development or whatever the long
4 discussion was we had yesterday?

5 It seems like this got the type of
6 votes that a fully specified and tested measure
7 received. And I know we had a long conversation
8 about this yesterday.

9 CO-CHAIR PINCUS: Is this on the
10 agenda under the standing committee process?

11 MS. SAMPSEL: Hi Harold, this is Sarah
12 Sampsel. I'm the senior director for the Renal
13 Project. And we have not seen this measure on
14 the list to be submitted for the next Renal
15 Project.

16 DR. BURSTIN: And the KCQA measure I
17 think they were discussing I'm told is not
18 claims-based, at least from the developer. I'm
19 just throwing that out there.

20 CO-CHAIR PINCUS: So, actually that
21 raises a good question. Is there a reason why
22 this wasn't sort of under the measures under

1 development rather than?

2 MR. AMIN: There must have been
3 information -- I look to the staff on this and
4 also CMS -- that this measure was tested.

5 Just because it's not NQF-endorsed
6 wouldn't put it in the fully developed pathway.
7 But CMS claims that this measure was tested which
8 is why it went in the fully developed pathway, I
9 assume.

10 CO-CHAIR PINCUS: But apparently
11 according to some of the workgroup discussion,
12 there are certain key elements and details that -
13 -

14 MR. AMIN: Missing, yes.

15 CO-CHAIR PINCUS: -- that are missing.

16 MR. AMIN: So, clarification from both
17 staff and CMS.

18 MS. O'ROURKE: So, I think the key
19 information that you see missing is why the group
20 initially did not support this measure and
21 instead looked to the NQF-endorsed version. So,
22 I'd ask -- I'd turn to Pierre to clarify.

1 DR. YONG: Sure. Actually, I'm going
2 to ask Joel. Can you clarify, please, for the
3 committee?

4 MR. ANDRESS: I'm sorry, can you
5 restate the question?

6 CO-CHAIR PINCUS: So, the question is,
7 number one, has this measure been tested, has it
8 been fully specified. Because the workgroup's
9 comments included concerns about the lack of full
10 specification.

11 MR. ANDRESS: So, to clarify, the
12 measure has been specified. It has not been
13 tested as of yet.

14 CO-CHAIR PINCUS: So, just should this
15 have been under the measures under development
16 category rather than for implementation? And
17 therefore should we be voting on sort of a
18 different set of conditions?

19 MS. O'ROURKE: From what Joel is
20 saying, it sounds like this should have gone
21 through the under development pathway.

22 CO-CHAIR PINCUS: Can we shift it over

1 to that pathway now?

2 MS. O'ROURKE: Yes, we can put that
3 on.

4 MEMBER DANFORTH: Right. And it seems
5 like it potentially would have gotten a more
6 favorable vote. So instead of a firm do not
7 support, it seems like there was a potential to
8 get support continued development just based on
9 the conversation.

10 CO-CHAIR PINCUS: Does CMS have an
11 objection to doing that? Okay.

12 David or Jayne, do you still have
13 comments?

14 MEMBER GIFFORD: Jayne and I probably
15 can just alternate words.

16 CO-CHAIR PINCUS: Okay.

17 MEMBER GIFFORD: With what we're
18 probably about to say, I suspect.

19 MS. CHAMBERS: Yes, I actually --
20 okay, so here it is.

21 I'm actually a little troubled by the
22 process as a whole. And I respect CMS's opinion

1 and their explanation for why they wanted this
2 measure to come forward.

3 They're advisory at this table. It's
4 the MAP's role to determine whether we think
5 these measures are ready for use in a payment
6 program right now, or not ready for use in a
7 payment program.

8 We are providing advice to the agency
9 about which measures we think are ready for
10 primetime to be used in the next rulemaking cycle
11 in their proposed payment rules.

12 The discussion I'm hearing around the
13 table right now is that this isn't ready. So, I
14 would instead of support or not support, I think
15 you could do conditional support, guidance with
16 further development, and re-specification, and
17 clearer, you know, what's going on, and NQF
18 endorsement.

19 But it's our role to make that
20 decision as to what we want that recommendation
21 to be.

22 CO-CHAIR PINCUS: David?

1 MEMBER GIFFORD: I would completely
2 concur. I would say in reading the statutory
3 requirements for this program it says that
4 measures should be NQF-endorsed save -- where due
5 consideration is given to endorsed measures of
6 the same specified area or medical topic.

7 The workgroup gave due consideration
8 and identified that there is an NQF-endorsed
9 measure in this area and this measure is not
10 under development.

11 And I would completely agree with
12 Jayne. Our role -- I think switching it doesn't
13 give the correct message which is we don't
14 support this. Well, I guess unless we change the
15 vote. But we don't support this measure as
16 currently constructed for rulemaking.

17 It may be a better measure, but we
18 don't know, and it needs to go through further
19 development and come back to the process.

20 But I think the message, regardless
21 what the vote should be, is it's not ready for
22 rulemaking, and you have an NQF-endorsed measure

1 that we do think is ready for rulemaking, and
2 that should be the message to CMS regardless of
3 whatever label we slap on it with the voting.

4 And I think this measuring under
5 development is -- sends the wrong message to CMS
6 and doesn't capture I think, Harold, the way you
7 summarized it yesterday, that yes, they're under
8 development, we want you to come back, which
9 means -- because our role, just as Jayne said, is
10 to advise them whether it's ready for rulemaking.

11 So, I would say almost any measure
12 under development is not probably ready for
13 rulemaking. That would be our message back to
14 CMS.

15 So, if we want to switch it to under
16 rulemaking, I'd want to make sure that labeled on
17 there is it's not ready for rulemaking, that's
18 why there needs to be continued development.

19 CO-CHAIR PINCUS: Amir?

20 MEMBER QASEEM: So, I absolutely agree
21 with Jayne and David, what they just said. I'm
22 not going to repeat what they said, but I haven't

1 heard any argument -- because the committee, the
2 hospital workgroup came up with do not support.

3 And I think we need to have a
4 convincing enough argument to overturn that to
5 even conditional support.

6 And influenza vaccination is one of
7 those issues. We have been talking about
8 harmonization of the measures.

9 At one point in time we had 167 NQF-
10 endorsed measures. I mean, it's craziness to
11 have another measure.

12 And I understand the argument that's
13 being presented, but I think it's just not enough
14 and I think we need to go back to just what's
15 already there. And if it's not serving the
16 purpose and you need to come up with some testing
17 data before we can overturn what the hospital
18 workgroup has already proposed.

19 Because they already had that option,
20 right? They could have given the conditions.

21 CO-CHAIR PINCUS: So, there are two
22 perspectives.

1 One is that we should vote on the
2 measure as it's been through the process, and
3 whether we want to continue to support what the
4 workgroup said or not.

5 Or the alternative approach is to say
6 let's move it into this other category and vote
7 on it that way.

8 So, the question is: could we take
9 just a quick hand vote about which approach
10 people would prefer to take?

11 MR. AMIN: Harold, can I just add one
12 thing? The decision around the testing is on the
13 MUC list that we received from CMS.

14 And in that forum, we got that it was
15 fully tested and specified, which is why I
16 brought it in this category.

17 We heard different information today,
18 so if we follow the consistent rules that we have
19 followed up to this point, we should use the
20 information that was on the official MUC list,
21 and therefore it should stay sort of in the
22 current structure that it's in.

1 CO-CHAIR PINCUS: Okay, so that's --

2 MR. AMIN: So, we should just, you

3 know --

4 MEMBER DANFORTH: That's helpful.

5 MR. AMIN: Unless there's a compelling

6 reason for it to change the vote on the series of

7 decisions that are available to you on this

8 pathway we should keep it consistent.

9 Because this is a procedural matter.

10 I mean, we've raised this a number of times now.

11 But that is the decision rules that we came up

12 with in September. That's what we've

13 implemented.

14 CO-CHAIR PINCUS: My worry is that

15 some of these other measures that have been

16 recently pulled, we may wind up in a similar

17 situation.

18 So, the intent is to be consistent

19 with the original MUC list and how it was

20 presented. Even though there may have been some

21 errors in it.

22 Amir?

1 MEMBER QASEEM: One quick question was
2 we can't really send this measure back to the
3 hospital group and ask them to re-review or
4 something along those lines. It doesn't work
5 that way. Some process, right?

6 CO-CHAIR PINCUS: No.

7 MR. AMIN: We don't have the time for
8 it?

9 DR. BURSTIN: And as Kate pointed out
10 yesterday, the comments are more important. And
11 there's plenty of comments. We should probably -
12 -

13 CO-CHAIR PINCUS: We've got lots of
14 comments. So, let's move on.

15 So, the rule going forward is that we
16 treat this as presented on the original MUC list.
17 And so if we really think that it's, you know,
18 that we disagree with the hospital workgroup's
19 recommendations we would have to overturn that by
20 60 percent. Okay?

21 So, let's vote on -- yes, we never
22 voted.

1 MS. STERLING: Okay. So, we are
2 voting on MUC 15761, the full season influenza
3 vaccination measure. And it's recommended for
4 the End-Stage Renal Disease Quality Incentive
5 Program.

6 And voting is now open. Your options
7 are 1 - support, 2 - conditional support, or 3 -
8 do not support.

9 CO-CHAIR PINCUS: Okay, so it looks
10 like there is continued support for the do not
11 support.

12 MR. TILLY: And the final tally is
13 zero percent support, 7 percent conditional
14 support, 93 percent do not support. So the
15 recommendation is do not support.

16 CO-CHAIR PINCUS: So, now we're going
17 to move towards -- and some people may have it on
18 their discussion guide in different places.

19 MEMBER GIFFORD: Harold, sorry. I
20 just wanted to -- I'd like it in the comments,
21 even though I voted do not support, that you
22 know, to give some hope to the family of the

1 person on life support that that's not a measure
2 they should just throw the measure out.

3 They should keep working on it. And
4 they should come back. And if it's really
5 superior then they should come back through the
6 process and do that.

7 Because I think it may be a superior
8 measure, and it may be a better measure to
9 capture other things. Because they have some
10 concerns with the claims measure, and we might
11 have some similar concerns.

12 So, I'd like the message also to be
13 that they should continue working on these
14 measures. It doesn't mean throw --

15 CO-CHAIR PINCUS: I think that was the
16 message that people got.

17 MEMBER GIFFORD: I just wanted to make
18 sure that that's on the record.

19 CO-CHAIR PINCUS: Okay. So, we're
20 going to be talking next about measure 1013,
21 Adult Local Current Smoking Prevalence.

22 ACTING CO-CHAIR GESTEN: The workgroup

1 recommendation was encourage continued
2 development. And I think this was pulled by CMS.

3 Rhonda, Amir, and Jayne.

4 CO-CHAIR PINCUS: Okay, Rhonda and
5 Jayne.

6 MEMBER ANDERSON: So, I would like to
7 just speak. This is not for a vote. This is for
8 discussion and information.

9 As I think about what was said earlier
10 from the public comment and also what all of us
11 do in the community I want to be sure that we are
12 not attributing things to one organization, and
13 that they don't have a lot of control over.

14 And I also think that we should not be
15 functioning in silos. And what I mean by that is
16 hospitals already do the community health needs
17 assessment.

18 In many of their communities this is
19 one of the findings and one of their action
20 plans.

21 So, I think it's important to be sure
22 that the approach and that the measures are

1 meaningful to everybody that will be using them.

2 As we go back to some of the other
3 comments that were made, if the public at large
4 uses some of this information for their decision-
5 making what are these unintended consequences
6 also for the public at large. Because what will
7 they really understand about this measurement.

8 So, I would like to make sure that we
9 as it goes forward with the current
10 recommendation of encourage continued development
11 that they do take into consideration what is
12 happening already with the community needs health
13 assessment, how that affects hospitals and their
14 individual communities because smoking prevalence
15 is larger in one area than in another area, and I
16 think all of that has to be taken into
17 consideration.

18 ACTING CO-CHAIR GESTEN: So, let me
19 just clarify, Jayne. Did you pull this measure?

20 MS. CHAMBERS: I supported AHA's
21 pulling the measure. We share their comments.
22 We share their concerns.

1 I think that there's -- we're not
2 quite sure how to handle it or how to do it, how
3 to put all the pieces in place.

4 And there are a number of other things
5 on hospital's plates right now and they're
6 learning how to work on population health within
7 the various communities.

8 Each community has different resources
9 available to it. And we're concerned that before
10 something of this nature gets put into a payment
11 program that we have a much better understanding
12 about how it all works.

13 And at this point we don't really know
14 how to make this measure work. Good goal, great
15 concept, we're glad to work on it, but we're not
16 sure how to make it work yet in a really, truly
17 robust way.

18 CO-CHAIR PINCUS: So, Gail and then
19 David.

20 ACTING CO-CHAIR GESTEN: Well, let me
21 just sort of -- do you want to vote? Are we
22 going to be voting on this because that's helpful

1 to know.

2 MS. CHAMBERS: On the list right now
3 is conditional support. Is that right?

4 ACTING CO-CHAIR GESTEN: Encourage
5 continued support.

6 MS. CHAMBERS: Encourage continued
7 development is fine with me. I don't know we
8 need to vote on it.

9 CO-CHAIR PINCUS: Okay, great. Gail?

10 MEMBER HUNT: I just wanted to know
11 what unintended consequences you were thinking of
12 when you mentioned that.

13 MEMBER ANDERSON: It has to do with
14 the prevalence in each area. There may be a
15 higher prevalence in one area, lower in another
16 region, et cetera, community.

17 And as this is applied generically
18 across the board I don't believe that each of
19 those communities have the same level of need.

20 And so that's why I think it's
21 important to understand the community need and
22 not just have a measure that is attributable at

1 that hospital.

2 MEMBER HUNT: I thought it
3 specifically addresses community-based, county-
4 based -- it's a county-based measure so it's
5 dealing with this is what happens in our county
6 versus this is what happens in the next county
7 which may be different. So that's why I don't
8 understand unintended consequences.

9 MEMBER ANDERSON: I maybe
10 misunderstood then what I read, but I thought it
11 was being applied across the board in terms of
12 the reporting aspect of it.

13 CO-CHAIR PINCUS: David?

14 MEMBER GIFFORD: As a former public
15 health official I may get kicked out of the
16 alumni association with my comments, but I
17 haven't heard anything that talks about why the
18 measure needs to be further developed per se.
19 And it's going through the review process.

20 I understand why it falls in the
21 category for that, but I think the comment that
22 I'd like to underscore is this is an important

1 measure, an important public health measure.

2 You can't do these without alignment
3 across the board. And so if CMS is just trying
4 to put this in the hospital program and in the
5 EHR program for physicians you need to align all
6 the other physician groups out there,
7 particularly when you look at the smoking rates
8 in this country. They're in other groups that
9 have to be there.

10 So, if CMS is going to go forward with
11 this the comment I would like to make sure to get
12 back to them is when they do it they need to do
13 it with everyone else aligned.

14 You need to do the FHQCs. You need
15 home health. You need everyone on this measure
16 and everyone having accountability because if not
17 then you are hanging the hospitals out on a limb
18 to what's going on. And I think that's unfair.

19 CO-CHAIR PINCUS: I actually, to step
20 out of the chair's role, I would add another
21 issue for CMS to consider in this.

22 While obviously it's being measured

1 based upon the baseline rate of smoking in a
2 particular county, it doesn't take into account
3 the capacity for change in a county that may have
4 to do with sort of the prevalence of different
5 media exposure, the prevalence of different
6 access to media or to other public health
7 interventions. And that's something to consider.

8 The fact that it's adjusted based on
9 baseline may not be sufficient in terms of the
10 different types of levers and mechanisms that
11 even collaborating hospitals or healthcare
12 institutions can utilize.

13 So again, that's something to think
14 about as one moves forward with further
15 development.

16 Kevin and Lisa.

17 DR. LI: So, I'm going to take my
18 government hat off for just a second and wear the
19 hat that I was on the Vital Signs Committee for
20 the IOM.

21 And for those of you not aware of that
22 committee we were asked to kind of come up with a

1 set of core measures for the country.

2 This is really in --

3 CO-CHAIR PINCUS: And we're going to
4 be talking about that later.

5 DR. LI: Yes. This is really in line
6 with the kinds of discussions we had there. And
7 we were really looking and hoping for measures
8 that blended the kind of care delivery,
9 population focus and encouraged joint
10 accountability.

11 And so, of course I can't speak for
12 that committee, but I can tell you that during
13 our deliberations and in our report we were
14 really hoping for measures like this that would
15 help to close that gap between what has
16 historically been a measure of sort of single
17 accountability to a single program or a single
18 organization and share that accountability across
19 all of us who support healthcare.

20 CO-CHAIR PINCUS: Lisa?

21 MEMBER MCGIFFERT: I was just wanting
22 to be clear. I understand that there's concern

1 that this will be used further.

2 But this is basically in the general
3 reporting that hospitals are required to report
4 certain measures in order to get the annual
5 upgrade in the payments. Am I correct? Or is it
6 specifically in the quality reporting?

7 And the other comment I guess that's
8 kind of been said, but it seems to me that this
9 is trying to get at the hospitals to help assess
10 an issue that the public health community has
11 been unable to assess because they have the
12 patients there.

13 And that seems to be the purpose here
14 is to get them to help assess how many people are
15 smoking. But those are my questions.

16 CO-CHAIR PINCUS: Melissa, you want to
17 respond?

18 MS. MARINELARENA: Sure. So, I can
19 offer additional clarification around this
20 measure.

21 So there is a currently endorsed
22 measure just like this, but it's at the state and

1 national level. It's collected by the CDC using
2 BRFSS, I believe.

3 This is the only measure in the
4 hospital program that is under development. All
5 other measures are fully developed, been tested.

6 So this one was under development.
7 That's why the recommendation was to encourage
8 further development because it is being
9 respecified at the county or city level, I think.

10 And so it will also be collected by
11 the CDC. So the hospitals wouldn't be required
12 to collect the data and it would be by using
13 BRFSS as well. So hospitals won't have to report
14 this data. The burden won't lay on them.

15 It would be CDC collecting. It's a
16 population-based survey. They call people on the
17 telephone. That may change as the measure is
18 developed further, but it'll be CDC doing the
19 work.

20 CO-CHAIR PINCUS: So, I think we have
21 Missy on the phone, and Jayne, and David.

22 MEMBER DANFORTH: Thanks so much. I

1 just want to go back to some of my earlier
2 comments today about the measures that were put
3 forward for these programs in general.

4 So, my understanding is that any
5 measure that goes into the hospital IQR gets
6 publicly reported on Hospital Compare.

7 I had some concerns about how
8 consumers, patients and patient families are
9 supposed to use information that's on a website
10 where information is publicly reported by a
11 hospital for a measure that's reported out I
12 guess by county, or by city. So that's my first
13 concern.

14 My second concern is, again,
15 information -- measures that are part of the
16 hospital IQR are supposed to go onto Hospital
17 Compare which is supposed to be used by patients
18 and patient families.

19 And as I discussed earlier this
20 morning there's so much information that's
21 missing from there, and there's so much education
22 that consumer groups are trying to do to educate

1 consumers about what are those things that are
2 really important when you're choosing a hospital.

3 And so I'm having just a really hard
4 time philosophically seeing how this measure
5 would fit into the IQR. Not that it's not an
6 important measure, but specifically how it fits
7 into the hospital IQR.

8 CO-CHAIR PINCUS: Thank you. Jayne,
9 and then David.

10 MS. CHAMBERS: Missy, thank you for
11 your comments. I'm right with you on that.

12 I mean, the IQR program is part of the
13 entire quality metric of the five hospital
14 payment programs where we report quality measures
15 and we get paid on those measures.

16 It is important that the information
17 that's reported on Hospital Compare be usable by
18 the end user.

19 It's also important that the hospitals
20 can use it to improve care for the patients that
21 they're treating in their hospitals.

22 I think we need to look at this. If

1 this is a population-based measure then every
2 healthcare entity that is involved in delivery of
3 healthcare for patients in their community should
4 be required to report the same measure.

5 Then you could get some synergy behind
6 it and everyone would be working together to try
7 to improve the population health. I think we're
8 not there yet with this measure.

9 And I think that it's expensive to
10 implement measures. No matter what you do
11 there's always an infrastructure that goes with
12 that measure to get it up and running, to review
13 the reports, to be sure the data you're
14 submitting is accurate. There's a cost to that.

15 If we're putting a measure in that's
16 not ready for primetime there's a cost that's a
17 wasted cost that we could be using in better ways
18 to help patients.

19 CO-CHAIR PINCUS: David, and then
20 Marshall.

21 MEMBER BAKER: So, I'll just say that
22 really all the concerns that I've had have been

1 expressed, but I wanted to emphasize one that I
2 think is particularly important that Rhonda
3 started off with.

4 It's we want to be able to have
5 measures that hospitals actually have the ability
6 to control.

7 And if you think about the importance,
8 the most important thing is the taxes on
9 cigarettes.

10 Next thing probably laws against
11 smoking in public places. And then availability
12 of quit lines.

13 And there are so many things that are
14 beyond the hospital's control that are just
15 critical drivers.

16 So, to engage hospitals in some way to
17 help them support all those efforts I think is
18 great. And there have been some good examples,
19 Cleveland Clinic being one of them, that really
20 was engaged with the community trying to get
21 change.

22 But I don't think that the measure is

1 really going to help organizations.

2 And I'll just think about Cook County
3 as well where I think there are 37 hospitals.
4 And imagine 10 do a great job and the others
5 don't. And everybody gets dinged.

6 So, I'm just -- I don't think this is
7 the right way to go. I don't think hospitals
8 have enough control.

9 CO-CHAIR PINCUS: Marshall?

10 DR. CHIN: This is a question maybe
11 for Helen, but I'm wondering like the NQF
12 population health group. I mean, these issues
13 must have come up. I'm just wondering what has
14 been learned from those discussions that are
15 relevant for what we're talking about now.

16 DR. BURSTIN: So, this measure was
17 actually -- and Elisa Munthali, our VP for
18 measurement, is on the side there. She leads
19 this.

20 This measure was endorsed as part of
21 the Population Health Committee, but at the
22 county level.

1 So, I think the reason in our
2 discussions with CMS this could only be an
3 encourage continued development because there's a
4 lot of work to do to think about how you really
5 consider how that measure is then attributable to
6 a hospital.

7 So, the committee has not discussed
8 it, but it certainly could be something that the
9 Population Health Committee can discuss going
10 forward.

11 But there are lots of issues we've
12 heard about risk adjustment and many of the
13 issues that have already been raised.

14 But endorsed at the county level. The
15 applicability to using it in a hospital program
16 is I think where there's a thought there needs
17 more work which is why I think the hospital
18 workgroup landed on the idea of saying encourage
19 continued development. Important priority area,
20 but not necessarily ready.

21 CO-CHAIR PINCUS: So, just a reminder,
22 this is for discussion, not for a vote in terms

1 of the people who pulled it. So, David, and then
2 we should try to move on.

3 MEMBER GIFFORD: I guess I disagree a
4 little with Jayne. This is BRFSS data. The cost
5 is borne by the state public health agencies with
6 funding from CDC. There is no data collection
7 burden on any provider here.

8 That said, I would completely agree
9 with Jayne and other comments, and reiterate my
10 point, and to Dave's point, I still think you
11 want hospitals and everything lined up.

12 Because while I agree the taxes and
13 the other things are the most powerful, still,
14 having your healthcare provider tell you to quit
15 and reinforce it is also a really powerful
16 message. And you need alignment.

17 But I agree with Missy too. Putting
18 this on the hospital with not anywhere else, and
19 putting it in clustered together with all the
20 other measures for consumer choice is misleading
21 information too.

22 So, I think CMS has to figure out how

1 to use this measure across the healthcare system,
2 and how to use it in public reporting.

3 Because it's shifting in a different
4 way, and it's trying to shift us and I would
5 agree with that movement. But you can't use the
6 existing vehicles necessarily to get there. And
7 I think they really need to give some thought to
8 that.

9 Because just to throw it out there
10 actually will -- the unintended consequence is it
11 just ticks off everyone, and no one does it, or
12 they just do checkboxes. And then we don't
13 really get the meaningful improvement in lowering
14 cigarette smoking that we need to.

15 CO-CHAIR PINCUS: So, I think we've
16 given the ample feedback and why don't we move
17 on.

18 The next measure that's been pulled is
19 measure 531, the NHSN antimicrobial use measure.
20 And Rhonda, Amir, and Jayne have pulled it. So,
21 Rhonda, do you want to comment?

22 MEMBER ANDERSON: Sure. This is for

1 discussion also.

2 CO-CHAIR PINCUS: It's for discussion,
3 you said?

4 MEMBER ANDERSON: For discussion, from
5 my perspective, yes.

6 So, as I look at this measure I think
7 there are two things that I have concerns about.

8 One, it isn't a measure for
9 appropriate use. And I think that is a focus
10 that we've had. Going back to many of the
11 comments over the last day and a half about
12 outcome measures and appropriate use, et cetera,
13 versus checking a box, and how many in this case
14 antibiotics do you give.

15 I think also from an unintended
16 consequence perspective particularly in hospitals
17 that are tertiary in nature, and patients are
18 with these illnesses and infections are
19 transferred to from some of the smaller
20 hospitals, et cetera.

21 The large number of antibiotics that
22 they may be giving because of those transfers

1 will be in that database.

2 And that may be leading the public to
3 think that they overuse, but they aren't
4 overusing, they are actually treating patients
5 that have been transferred to them.

6 And then it's my understanding that
7 when the CDC brought this forward and NQF looked
8 at and endorsed the measure that they said it
9 wasn't well suited for public reporting.

10 And I wanted to be clear that
11 everybody, I believe, is working toward
12 appropriate use of antibiotics.

13 But what it would do potentially with
14 public reporting when it is about amount used
15 versus appropriate use is a real dilemma that I
16 have as I read this.

17 CO-CHAIR PINCUS: Jayne?

18 MS. CHAMBERS: Since I've talked
19 enough this morning I'll just say hear hear. I
20 agree with what Rhonda said.

21 But we are working very much towards
22 appropriate use of antibiotics and would welcome

1 a measure of appropriate use.

2 Quantifying the exact number of
3 antibiotics is not necessarily telling us whether
4 or not we're using the right antibiotics in the
5 right setting and right amount.

6 CO-CHAIR PINCUS: Amir?

7 MEMBER QASEEM: Something very
8 similar. I think that these antimicrobial
9 stewardship programs haven't been in place for
10 long enough at this point.

11 I think it's difficult to come up with
12 some sort of a national benchmark, and I think we
13 need some experience.

14 So, the issue is the accountability.
15 I think this measure is not ready for
16 accountability still. And we need some more
17 testing data on it.

18 So that's why I think the conditional
19 support makes sense.

20 CO-CHAIR PINCUS: Missy, David, do you
21 want to respond?

22 MEMBER BAKER: So, I'll say I think

1 this is potentially a really good measure for the
2 hospitals to be able to use as part of their
3 antibiotic stewardship programs for quality
4 improvement.

5 But I have real concerns about the
6 risk adjustment methodology. Again, as what
7 Rhonda said, penalizing tertiary care facilities,
8 it just will be very difficult to accurately risk
9 adjust. So, I have concerns.

10 CO-CHAIR PINCUS: Missy?

11 MEMBER DANFORTH: And this is Missy.
12 I actually am just really supportive of the
13 workgroup's recommendation which is conditional
14 support pending the CDC's recommendation that the
15 measure is ready.

16 I mean, I think the CDC has a lot of
17 experience with hospital-based infection measures
18 and how they're publicly reported, and has been
19 really responsible and really takes seriously the
20 feedback they get from hospitals.

21 So, just to reiterate for the original
22 workgroup's recommendation.

1 CO-CHAIR PINCUS: Lisa and Kevin.

2 MEMBER MCGIFFERT: I also support what
3 the workgroup recommended, conditional support.

4 I'm not crazy about this measure
5 either, but I know that it's -- and I think it's
6 sort of experimental at this point.

7 I was on the patient safety committee
8 and I know that the agency, CDC, is --
9 acknowledges that they're trying to collect
10 information. They don't have the information
11 they need now to establish baselines. And they
12 need more information.

13 They have, I don't know, a hundred,
14 maybe a couple hundred hospitals now that are
15 voluntarily reporting this information, but
16 that's not really enough to get a sense of what's
17 happening out there.

18 There's some evidence that as much as
19 50 percent of the antibiotic prescriptions in
20 hospitals are inappropriately given.

21 And I do think that this is a real key
22 part of an accountable antibiotic stewardship

1 program.

2 A lot of hospitals say they have a
3 stewardship program, but they're kind of all over
4 the map. And we believe that measuring their
5 antibiotic use is a real important first step.

6 So, I believe that antibiotic
7 resistance is probably the most important issue
8 in healthcare today.

9 If we don't start getting a handle on
10 it we will have a really different experience in
11 the future for minor surgeries, and any other
12 number of things that are going to kill people
13 that don't kill them today.

14 So, I think it obviously needs more
15 work, and I think the conditional support is an
16 appropriate recommendation from the committee.

17 CO-CHAIR PINCUS: Kevin, and then
18 Frank.

19 DR. LI: I just want to highlight that
20 I think this is a really terrific step towards
21 the Learning Health System.

22 This measure asks for electronic

1 realtime data to be sent to CDC around some key
2 activities like medication use and antimicrobial
3 resistance.

4 And much like registries have shown
5 that when that information is readily available
6 and easily benchmarked across institutions
7 there's a lot of learning that happens, and
8 there's a lot of natural improvement that can
9 happen if that information is actionable, and
10 live, and able to be shared.

11 So, I think that -- I won't comment on
12 the merits of the measure as a measure, but the
13 infrastructure that it is helping to create, and
14 the sharing made possible by this I think is
15 really fantastic, and want to make sure that
16 people are aware that this new way of measurement
17 is a sort of key new direction.

18 CO-CHAIR PINCUS: Frank, and then
19 Chesley.

20 MEMBER OPELKA: So, I'm building a
21 little bit I think on where Kevin's going, but
22 I've kind of wavered between conditional support

1 and do not support.

2 And the reason I say that is that this
3 is a very important issue, but it's solved very
4 simply with efforts to create digital workflow
5 solutions that are baked into the EHRs.

6 Rather than chipping data -- do
7 another data mark to have it just report upon
8 doesn't really put the solution right in the
9 hands of the clinician at the point of care in
10 realtime.

11 And if that's the intermediate step we
12 have to go through, so be it, and therefore I
13 conditionally support it.

14 But if I were the government and I
15 really wanted to invest in this I would be
16 investing in creating workflow solutions that
17 exist in the EHR that apply antimicrobial
18 appropriateness at the point of care in realtime,
19 rather than something that's after the fact and
20 being reported subsequently.

21 I think it's going to slow us down to
22 do that, but if that's the only way to get there,

1 so bet it. We'll be slow in getting there.

2 CO-CHAIR PINCUS: Chesley?

3 DR. RICHARDS: So, I wanted to hear
4 the other comments before I weighed in from CDC.

5 And I wanted to echo a comment that
6 was said before. We do take very seriously both
7 what the MAP says and what hospitals' concerns
8 are.

9 CO-CHAIR PINCUS: A little close to
10 the mike.

11 DR. RICHARDS: So, about this measure,
12 I don't think anybody at CDC feels like it's
13 ready as currently constituted for public
14 reporting, for two reasons.

15 One, there's not enough experience
16 with it.

17 The second, and it highlights some of
18 the concerns expressed previously by Rhonda. It
19 may need to evolve as a measure from what its
20 current sort of form is.

21 The context, and I think many of you
22 are aware of this, is that antimicrobial

1 resistance, particularly in hospitalized patients
2 and in healthcare is a pressing public health
3 urgency.

4 The President convened a meeting at
5 the White House to talk about this issue and
6 there's a large initiative within the government,
7 at CDC, with CMS, with other agencies to address
8 the problem.

9 So, to your concerns, Frank, it's not
10 just the measurement in isolation. It's part of
11 an entire program that's being put together that
12 includes clinicians, EHR vendors, and state
13 health departments.

14 I think in talking with the staff back
15 and forth this morning this measure probably is
16 two to three years, with all that said is
17 probably two to three years to have enough
18 experience with it to know whether it's
19 appropriate for public reporting.

20 And as I said, the likelihood is that
21 it evolves to a better measure as we learn from
22 that.

1 So, if that's helpful in terms of the
2 vote needs to be taken, I wanted to provide that
3 context.

4 CO-CHAIR PINCUS: Thank you. So, I
5 think we've given, again, sort of a full and
6 comprehensive set of comments back to CMS and we
7 can move on.

8 We have nine more measures to go
9 through that have been pulled. I just want to
10 remind people.

11 So, the next one is excess days in
12 acute care after hospitalization for pneumonia.
13 It's the number 391. And that was pulled by
14 Amir.

15 MEMBER QASEEM: Yes, and I think it's
16 at conditional support so I'm okay to leave it at
17 that.

18 But the point that I just want to make
19 over here is most of the data that this measure
20 is based on is old data.

21 And there's a lot of new studies that
22 have been published that have shown that actually

1 the ICU admission of patients actually improves
2 survival. Actually there is no significant
3 difference in cost. So I think we need to start
4 looking at some of the newer data on this one.

5 They did all recent publications over
6 the past two or three years and there is enough
7 over there that I think that we need to really
8 look into this measure again.

9 CO-CHAIR PINCUS: And this also among
10 the comments was also to consider risk adjustment
11 by sociodemographic factors as well.

12 David, Missy, do you have any comments
13 on this?

14 MEMBER BAKER: I would just add you
15 were talking about the risk adjustment for
16 sociodemographic factors, but I have broader
17 concerns about the risk adjustment methodology.

18 As you expand this out and you're
19 looking at emergency department visits and other
20 things, then that just means that all the
21 comorbidities that the patient has are also
22 contributing.

1 You know, the ratio of what proportion
2 of all of those visits are in any way related to
3 the patient's pneumonia decreases and decreases.

4 So, I think it really has to look very
5 closely at the risk adjustment methodology for
6 this.

7 CO-CHAIR PINCUS: Missy? Any
8 comments?

9 MEMBER DANFORTH: Okay. I don't have
10 any additional comments. I supported the
11 workgroup's original recommendation.

12 CO-CHAIR PINCUS: Okay. David?

13 MEMBER GIFFORD: I would just say that
14 as admissions to hospitals are dropping, and care
15 for pneumonia is being more done in the
16 outpatient or in PAC or assisted living settings
17 the number actually may go up on the hospital
18 side because the acuity of the people who are
19 going there are changing.

20 And I just encourage CMS to think
21 about and look at that. We've seen that in
22 several areas for hospitals.

1 CO-CHAIR PINCUS: Other comments?

2 Okay, so that's, again, we don't need to change
3 the voting on that.

4 The next measure is vaginal birth
5 after cesarean delivery rates. And that's number
6 22. And that was, Lisa, you pulled it?

7 MEMBER MCGIFFERT: I did. I'll try to
8 make this quick.

9 This got a do not support from the
10 workgroup recommendation. And I would like to
11 ask for a vote on this.

12 I think this is a really important
13 measure. I understand the reason that the
14 committee voted to do not support because this is
15 applying only to Medicare population.

16 I have no idea how many people deliver
17 babies on Medicare, but I'm sure it's very small.

18 But the importance of this measure is
19 to get it in the pipeline. And what we would
20 like to see in the future is for this to become
21 an all-payer measure like it is in I think 20
22 states. And I think Carol can talk to that.

1 But it seems to me that we have to --
2 I mean, we were kind of curious about why CMS
3 proposed this for the Medicare population, but we
4 also see this as a precursor to a real measure
5 that would include all payers.

6 And that's why we pulled it. And so I
7 would like to vote and recommend that it be
8 either supported or conditionally supported to
9 expand it. But I think we can't do that because
10 of your new rule, Harold.

11 So, I'll let some of my other
12 colleagues --

13 CO-CHAIR PINCUS: It's all my fault.

14 MEMBER MCGIFFERT: -- talk about this.

15 CO-CHAIR PINCUS: So, David, Missy, do
16 you want to respond initially?

17 MEMBER DANFORTH: I do have comments
18 on this. David, do you as well? I can't see
19 you, so.

20 MEMBER BAKER: Okay. I'll make some
21 comments.

22 My biggest concern about VBAC as a

1 measure is I think this is something that really
2 is a decision that patients need to make.

3 I mean, there are very significant
4 risks involved with VBAC in terms of vaginal
5 lacerations and uterine rupture.

6 There's a lot of clinical situations
7 that vary depending upon how the original
8 cesarean section was done. The risk can vary
9 very substantially.

10 So we don't know what the right rate
11 is. So that's my biggest concern about just
12 trying to have a measure and say, you know, we
13 need to drive down the rate of VBAC. Well, we
14 don't know what the right rate is.

15 So I agree with the committee to do
16 not support.

17 CO-CHAIR PINCUS: Missy?

18 MEMBER DANFORTH: Yes, thanks. So, I
19 actually disagreed with the committee's
20 recommendation on this for a couple of reasons.

21 One is I read through the public
22 comments and there were a lot of public comments

1 about oh, well, we don't know what the right rate
2 is.

3 But as a reminder, when CMS has
4 adopted other maternity care measures into the
5 Inpatient Quality Reporting program and published
6 those results, for example, early elective
7 delivery rate on Hospital Compare they actually
8 don't compare it to a target which was a big
9 disappointment to us, but the decision they made.

10 And so, I think that there's ample
11 opportunity to include a measure in the IQR,
12 publicly report it, let other people, including
13 other organizations use that data in different
14 ways, but also the public use it without
15 necessarily having to decide, well, what's the
16 right rate, is it 10 percent, 15 percent, 20
17 percent.

18 There's maternity care measures now,
19 again, that are published on Hospital Compare
20 that aren't compared to a rate. I don't think
21 that should necessarily stop us.

22 The other thing is I would really,

1 really, really encourage CMS -- and I know Pierre
2 is in the room -- to really think about other
3 ways to get this data for the all-payer
4 population.

5 It looks like the Joint Commission has
6 done a really fantastic job in certifying vendors
7 who are able to get maternity care data on entire
8 populations within a hospital and calculate
9 accurate rates based on measure specifications.

10 My understanding is you proposed this
11 for Medicare fee-for-service only because it's an
12 AHRQ measure and that's how you're calculating
13 the other AHRQ measures.

14 But I would really strongly encourage
15 you to think more broadly, creatively,
16 innovatively about opportunities to get this data
17 from hospitals who for the most part are already
18 using vendors who have a lot of experience in
19 abstracting this kind of data and doing sampling
20 potentially, and not just stop at the workgroup's
21 recommendation and not think about even
22 introducing that as a Medicare fee-for-service

1 only measure. Thanks.

2 CO-CHAIR PINCUS: Thank you. Carol,
3 and then Barry.

4 MEMBER SAKALA: Yes. So, first of
5 all, I'd like to thank CMS for using the MAP
6 process to look at a population that typically is
7 not cared for, a big Medicare population, and
8 extending the possible benefits of this process,
9 and also to congratulate you for really
10 identifying a prime area in my view for quality
11 improvement.

12 In 2010 there was an NIH consensus
13 conference followed by updated guidelines from
14 ACOG and AAFP the gist of which was nearly all
15 women with history of cesarean would be eligible
16 for planning a VBAC. They should be counseled
17 and offered VBAC.

18 And if you cannot provide this, or
19 your hospital cannot provide it they should be
20 informed of where they could get this service.

21 Unfortunately, however, since then and
22 in fact going back more than a decade about 9 in

1 10 women with a previous cesarean are having a
2 repeat cesarean.

3 And I think that part of the reason
4 for the NIH meeting was to balance the salience
5 of catastrophic rupture which is one in thousands
6 to actually have a rupture and have it be
7 catastrophic against our increasing understanding
8 of a lot of shorter- and longer-term harms of
9 cesarean for mothers and babies.

10 And I would just quickly reference --
11 I'm happy to talk about this, but quickly
12 reference a whole series of systematic reviews
13 that now show increased chronic childhood disease
14 in cesarean-born babies, and also the very
15 serious placental problems in future cesareans
16 and future births with prior scarring and
17 adhesions.

18 So, I was really happy to see that
19 ACOG weighed in as supporting this measure in the
20 first open comment period.

21 And I think it's a prime -- it's a way
22 that we can give a nudge here by making this

1 information available.

2 It is an all-payer measure reported by
3 20 states including many of the larger states in
4 the Why Not the Best interface.

5 But I have to tell you how many very
6 savvy people can't make their way through that
7 interface. So I think it's -- even for those 20
8 states it's a challenge.

9 For consumers who need a signal about
10 where there is the capability to provide this
11 service and where there is the support for it as
12 well.

13 And just to get back, I just want to
14 share a little bit. On our last National
15 Listening to Mothers survey we did adapt
16 validated questions from the Informed Medical
17 Decisions Foundation for this very issue.

18 And we saw that women were
19 systematically kind of steered in the direction
20 based on how much information they got about
21 different options, based on the recommendation
22 that their care provider gave, and based on the

1 kind of outcome care that they got.

2 So, we really feel that this is ripe
3 for public reporting.

4 CO-CHAIR PINCUS: Barry?

5 MEMBER NOONE: I assume that the
6 workgroup committee recommended no support
7 because they didn't have sufficient data because
8 of the CMS data.

9 My question is did that data also
10 include Medicaid patients as well as Medicare
11 patients. And was that volume high enough to be
12 able to say no.

13 MS. CHAMBERS: It's a Medicare-only
14 payment program.

15 MEMBER NOONE: Only Medicare? Because
16 there might be enough data out there if you
17 include Medicaid also. Thank you. Then I can't
18 support it.

19 CO-CHAIR PINCUS: Other issues, other
20 speakers want to speak about this?

21 Actually, Pierre, can you say
22 something about why it's just Medicare? What's

1 the implications of focusing on that population?

2 DR. YONG: So, that's a great
3 question. So, I think we appreciate all the
4 comments that indicate that this is an important
5 area because I think that's why we particularly
6 focused on this area.

7 As a claims-based measure the only
8 claims that we currently have are Medicare
9 claims. I certainly, and I think we do have
10 several all-payer measures in the IQR program.

11 The consideration we also need to make
12 when implementing new all-payer measures is that
13 those are usually chart-based measures.
14 Obviously in the future hopefully we'll move to
15 electronic clinical quality measures, so
16 hopefully there will be less burden.

17 But there is an incredible burden
18 placed on hospitals also when we implement new
19 chart-based measures. So, that was also part of
20 the consideration about why use a claims-based
21 measure at this point.

22 But that's why it's -- since it's

1 claims-based only, that's the only things we have
2 are Medicare claims.

3 CO-CHAIR PINCUS: It seems to me the
4 implications of this is that it will be largely
5 the disabled population that would be.

6 DR. YONG: Right. Because we looked
7 at the numbers in the Medicare population. Not
8 surprisingly it's exceedingly small in terms of
9 the denominator eligible for this population. So
10 it would be mostly a non-Medicare population of
11 the measure.

12 CO-CHAIR PINCUS: Foster?

13 ACTING CO-CHAIR GESTEN: When you say
14 you only have Medicare claims what are you doing
15 with all the Medicaid claims that CMS has access
16 to from states that we've been sending for years?

17 I mean, I understand that part of CMS
18 doesn't have them, but it's not as if there's not
19 access to Medicaid claims data from states. Or
20 am I missing something?

21 DR. YONG: That's right. There's
22 tremendous variability in the Medicaid claims and

1 there's a huge effort which I am not an expert on
2 in terms of trying to standardize some of the way
3 we can draw information out of the Medicaid
4 claims.

5 So, I'm not an expert on it so I can't
6 comment on it fully, but I know there is movement
7 away from MSIS and there's efforts on T-MSIS
8 which is the new system for trying to collate all
9 the Medicaid claims and make them more similar to
10 each other.

11 CO-CHAIR PINCUS: Bill?

12 MEMBER KRAMER: As a related question,
13 what would be the pathway to turn this into an
14 all-payer measure? Or at least a Medicaid plus
15 Medicare measure.

16 And where I'm going with this is would
17 it be appropriate then to conditionally support
18 this under the condition that it be turned into
19 an all-payer measure in some way.

20 But I don't know what the pathway
21 would be and whether that's feasible, and how
22 explicit, how quickly we could do that and how

1 explicit we have to be in those conditions.

2 CO-CHAIR PINCUS: Pierre, any
3 thoughts?

4 DR. YONG: I think we'd need to do
5 some testing of it using Medicaid claims data to
6 make sure that we can get reliable rates using
7 the Medicaid claims.

8 It would not obviously get to then
9 all-payer using just claims data because we don't
10 have access to all-payer claims data.

11 CO-CHAIR PINCUS: Rhonda? Carol, are
12 you still up there?

13 MEMBER SAKALA: I just wanted to say
14 that I reached out to Elliott Main who is the
15 medical director of the California Maternal
16 Quality Care Collaborative.

17 And he said they report it in
18 California. It's very straightforward to collect
19 from discharge diagnosis files.

20 And another important point is that
21 it's limited to low-risk women. So I think
22 that's a real plus for a readily and easily

1 collectable measure.

2 CO-CHAIR PINCUS: Rhonda, then Rich
3 Antonelli, then Jayne.

4 MEMBER ANDERSON: I think I'm hearing
5 that everybody agrees that this is important, but
6 it's about where we are today.

7 And to reiterate is it going to give
8 us what we need from a Medicare claims
9 perspective. And I believe that's why the group
10 said no.

11 But that there's the opportunity maybe
12 to do that testing not with conditional, but just
13 move forward, do the testing and come back at a
14 later date with a true recommendation of what
15 should go forward for all-payer.

16 CO-CHAIR PINCUS: Rich, and then
17 Jayne.

18 DR. ANTONELLI: Yes, thank you,
19 Harold. I'm really struggling because of the
20 Medicare limitations.

21 So, dual eligibles are in this
22 population, is that correct, Pierre?

1 DR. YONG: Yes, I believe they are.
2 Because Medicare is the primary payer in Part A.

3 DR. ANTONELLI: Okay. So, I guess,
4 you know, I think the spirit of this is very
5 attractive to me.

6 But the fact that it's so
7 circumscribed to this particular at-risk
8 population, I'm concerned about the message that
9 it may wind up sending.

10 So in other words, I don't think the
11 intent of this measure is let's focus in on a
12 high-risk population, say dual eligible pregnant
13 women and look at VBAC. I think the intention
14 here is to try to look at VBAC as a quality
15 measure.

16 So, I am really struggling with that.
17 I think Foster's point is well taken about if we
18 could align this with Medicaid and put that
19 together that would be attractive.

20 But I guess, unless I'm
21 misrepresenting it, is this measure in the
22 Medicare space because we can actually get the

1 data? Or were people actually thinking about the
2 highly vulnerable dual eligible population as the
3 genesis for the measure?

4 CO-CHAIR PINCUS: Jayne?

5 MS. CHAMBERS: Thank you. It strikes
6 me that this would be a better all-payer measure,
7 that we need to understand better what it is
8 we're doing. But it could easily lend itself to
9 be an ECQM kind of measure.

10 We should not be using a chart-
11 abstracted measure done manually, or using claims
12 for this. But if we could create it as an ECQM
13 measure and bring it back at a later point in
14 time that that would be a much better way to go
15 and would move us much further down the road.

16 CO-CHAIR PINCUS: Bill, and then let's
17 move to voting.

18 MEMBER KRAMER: Just briefly. In
19 thinking about this, maybe this is one where it's
20 very appropriate for us to consider voting for
21 further development, encourage further
22 development.

1 Because I'm concerned that the
2 workgroup's recommendation do not support sounds
3 like we don't support the idea of VBAC.

4 But I hear around the room that people
5 think VBACs are important, but we need to develop
6 the measure further by turning it into an all-
7 payer measure.

8 CO-CHAIR PINCUS: I think what we
9 agreed earlier on was that the way it came in is
10 the way that we need to vote, rather --

11 MS. MARINELARENA: This is a fully
12 developed measure. It's used by --

13 (Simultaneous speaking)

14 CO-CHAIR PINCUS: But also I think
15 we've made clear through our comments what our
16 intent is. Okay? So why don't we move to vote.

17 MS. STERLING: Great. So we are
18 voting on the IQI 22 Vaginal Birth After Cesarean
19 Delivery Rate Uncomplicated. And this is MUC
20 151093. It's recommended for the hospital
21 inpatient quality reporting program.

22 Your options are 1 - support, 2 -

1 conditional support, or 3 - do not support. And
2 voting is now open.

3 CO-CHAIR PINCUS: Bill, do you want to
4 restate what you suggested as conditions?

5 MEMBER KRAMER: Well, I don't quite
6 understand why we don't have an option for
7 encourage further development.

8 DR. BURSTIN: The measure is fully
9 developed and tested for all-payer. It's the
10 application of the measure.

11 CO-CHAIR PINCUS: Yes, the condition,
12 yes. Really, conditional support doesn't really
13 work here because --

14 MEMBER KRAMER: I agree conditional
15 support doesn't work. But why not encourage
16 further development?

17 DR. BURSTIN: Encourage further
18 development can only be for a measure that's in
19 development. This measure is fully developed.
20 It's an AHRQ measure, fully developed, fully
21 tested on all-payer data. So there's nothing
22 further to develop.

1 I think what people are discussing I
2 think is the application of this measure in a
3 Medicare-only IQR program.

4 Again, we have an open perinatal
5 project with measures to be submitted. There are
6 opportunities to bring this measure in for
7 evaluation and endorsement. I don't believe it's
8 ever been submitted.

9 So, there are further opportunities
10 here. I just don't know what is left to do.

11 CO-CHAIR PINCUS: The way to think
12 about it is that it hasn't come in, been proposed
13 before us as a measure to be developed. It's
14 been proposed as a measure to be applied. And so
15 we're voting on it as a measure to be applied.

16 But our comments already make clear
17 that what we're really saying is come back with a
18 measure to be developed.

19 MEMBER KRAMER: Okay.

20 WORKGROUP CO-CHAIR WALTERS: And
21 Harold, this is Ron again. Sorry.

22 This has been a very good discussion

1 and it mirrors a lot. I don't have anything to
2 add to the discussion.

3 But this is the dilemma we found
4 ourselves in. And it really could have gone a
5 lot of different ways.

6 But the box that appeared the most
7 appropriate to us given all that is the one
8 that's in front of you.

9 So, I mean, I can't add anything to
10 that other than that was our choice.

11 CO-CHAIR PINCUS: Okay, so let's
12 continue voting.

13 MEMBER GIFFORD: While we're voting
14 can I just throw out that can we make sure we
15 have time in our next meeting, a significant
16 chunk of time to address this issue of clear
17 confusion of what we're voting on and what the
18 messaging, the voting sends to CMS around
19 rulemaking and everything else.

20 Because I think Bill raises a very
21 good point and I've reiterated a number of times.
22 We want CMS to continue developing stuff. But we

1 also don't think these are ready for rulemaking.

2 And the current voting and labeling
3 does not adequately convey that. And I think we
4 need to have a better way of doing that. And --

5 CO-CHAIR PINCUS: Well, I think part
6 of it is --

7 (Simultaneous speaking)

8 MEMBER GIFFORD: -- discussion, to
9 have that discussion.

10 CO-CHAIR PINCUS: Part of it is being
11 clear about, you know, that CMS makes the choice
12 about which route it's going to come under.

13 MEMBER GIFFORD: But you know what?
14 There has to be a clear definition of what the
15 meaning of that route is.

16 CO-CHAIR PINCUS: Right.

17 MEMBER GIFFORD: That if you're coming
18 in under the encourage development you're not
19 considering it for rulemaking because you're just
20 asking us for feedback.

21 But that's not what they're doing.
22 They're coming in with measures under development

1 that they are considering for rulemaking.

2 So when we vote for encourage further
3 development without conditions or anything else
4 going forward then that's sort of -- they can go
5 out and put it out in the rulemaking.

6 And I think the concern -- and I was
7 reflecting on why Bill and I were arguing the
8 other night about whether it should be
9 insufficient information on one of the measures
10 AMA wanted to put forward is because we want to
11 send a message on insufficient information.

12 We want to use that to say to CMS it's
13 not ready for rulemaking. Whereas encourage
14 development doesn't send a strong enough message.

15 And within encourage development there
16 are some measures that are ready for rulemaking
17 to go forward, and there are some that are not.

18 And so I think that it doesn't capture
19 that well enough.

20 CO-CHAIR PINCUS: We'll come back to
21 that. So, is the full voting done?

22 MS. STERLING: Actually we're still

1 looking for two votes.

2 CO-CHAIR PINCUS: Do we have it?

3 MR. TILLY: We do. The results are 24
4 percent support, 10 percent conditional support,
5 66 percent do not support.

6 CO-CHAIR PINCUS: So the
7 recommendation of the workgroup is not
8 overturned.

9 MS. O'ROURKE: And we can make sure we
10 strengthen the comments that go along with this,
11 that both the workgroup and the Coordinating
12 Committee strongly support the idea of a VBAC
13 rate. We recognize this measure has data
14 limitations. So we will pass along all of the
15 rich discussion.

16 MEMBER MCGIFFERT: Can we clearly say
17 for either the Medicaid population or all-payer
18 database? Thanks.

19 CO-CHAIR PINCUS: So, the next is INR
20 monitoring for individuals on warfarin after
21 hospital discharge.

22 And Amir, is this for discussion or

1 for voting?

2 MEMBER QASEEM: Can I start talking
3 and then we'll go decide?

4 So, this is a measure that I wasn't
5 really sure. I think the workgroup has it as,
6 what, conditional support or something like that,
7 right? Yes.

8 So, I'll just start off by saying I
9 think the basic issue with this measure was that
10 it's just saying that INR was done within 14 days
11 of discharge. Or I'm not really sure that's
12 going to lead to improvement of care, outcomes,
13 what the intent might have been.

14 And then the more looking at this
15 measure, it's a hospital accountability measure.
16 But then I wasn't really clear on how it's going
17 to be implemented.

18 So, the inpatient is going to ensure
19 the discharge summary is sent to the primary care
20 physician. There's a follow-up appointment
21 that's being put in place within 14 days in all.

22 But then the patient population who

1 may not have been to their primary care for a
2 while, or do not have a well-established
3 relationship, how is that all going to work out?

4 So eventually how is this
5 accountability going to translate into a
6 physician level?

7 So, the more I start thinking about it
8 I wasn't really clear if all this has been
9 discussed. Because I look at the notes from the
10 hospital workgroup and I didn't see that any of
11 this was addressed there. So that's why I wasn't
12 sure.

13 So let's see if it has been discussed
14 and what were the responses, and then we can
15 decide whether we're going to re-vote or not.
16 That's the concern from my end.

17 CO-CHAIR PINCUS: Okay. So David,
18 Missy, do you want to comment?

19 MEMBER BAKER: I'll sum up my comments
20 in one word - phosphorus.

21 MEMBER QASEEM: Yes, it's the same
22 issue.

1 (Laughter)

2 MEMBER BAKER: We need a measure of
3 the proportion of patients who had therapeutic
4 control of their INR within a given time period,
5 and this is not going to help us.

6 Helen you just endorsed one.

7 CO-CHAIR PINCUS: Missy? Ron? Do you
8 have comments?

9 MEMBER DANFORTH: No. I was on the
10 patient safety committee along with Lisa who is
11 in the room that reviewed the measure for
12 endorsement. And we had a lot of these same
13 conversations at that workgroup committee.

14 WORKGROUP CO-CHAIR WALTERS: Yes, we
15 did, at the hospital workgroup level.

16 And that's why we put that please
17 consider when perfect world arrives. This would
18 be a great one for EHRs to subsequently report.

19 But right now the same discussion
20 about what can the hospital really do about this.
21 It's conditional support.

22 CO-CHAIR PINCUS: So this, I mean this

1 sounds almost like you're saying that you were
2 grudgingly supportive of it, but you don't think
3 it's ready for primetime.

4 But just to be clear, the condition
5 that you put on this is more about sort of
6 implementation through EHRs, not about some of
7 the concerns that were voiced.

8 WORKGROUP CO-CHAIR WALTERS: Yes, we
9 thought it would be more suited to a different
10 program.

11 And you're right, this is kind of like
12 the theme of the discussion we've had. Had we
13 said do not support, which we did on the one
14 right before this, it would have sent a wrong
15 message about how important the safety issue is.

16 So, the condition was kind of figure
17 out how to get this data in a meaningful way that
18 the hospitals and the subsequent care pathways
19 are supported. I know.

20 CO-CHAIR PINCUS: So, Frank, and then
21 David.

22 MEMBER OPELKA: So, I'm going to go

1 back to David's comment. And I think that's
2 really the gist of the message that we want here.

3 This is, to me it's far worse than
4 phosphorus because this happens regularly and
5 it's exceedingly dangerous that people leave the
6 hospital and there's a missed handoff. And the
7 next thing you know they're back with a major
8 complication related to this medication.

9 So, I think David said it, said it
10 well, what's needed. I don't think conditional
11 support is the answer here.

12 To me an ECQM pathway will not solve
13 this. To me this is do not support and it needs
14 exactly what David had stated.

15 CO-CHAIR PINCUS: So, just to be
16 clear, so what is being proposed is a re-vote,
17 not just discussion.

18 And David, do you have more to say?

19 MEMBER BAKER: I just wanted to
20 emphasize one point. Is there a really good care
21 model about how to do this? And we've all, many
22 of you have seen Coumadin clinics.

1 And what we need to be able to think
2 about is how can we have a measure that will
3 encourage that best practice or measure that best
4 practice, right?

5 Because patients really, they should
6 be seen three days after discharge by an expert
7 who's going to go through all the dietary
8 counseling and the monitoring.

9 To say, you know, at two weeks they
10 had the blood level measured, that's not going to
11 encourage those best care pathways.

12 CO-CHAIR PINCUS: Helen?

13 DR. BURSTIN: Just one brief comment
14 again since you raised the phosphorus issue. At
15 least I remember this discussion. It was a long
16 discussion of the safety committee as Lisa and
17 Missy know.

18 And I think one of the issues was the
19 fact that although not ideal, current performance
20 is only at 50 percent even for a did you do it,
21 not what the actual INR was. So I think that was
22 part.

1 I don't know if Missy or Lisa want to
2 reflect on that, but I think there was a sense
3 that there's a gap there, unlike I think what you
4 heard earlier. So I just want to make that
5 clarification.

6 CO-CHAIR PINCUS: Other comments
7 before we vote? Jayne?

8 MS. CHAMBERS: So, I guess I'm
9 curious. I mean, why is this a hospital measure?
10 Why isn't it at least a hospital and a clinician
11 measure together?

12 It seems to me that this -- I like the
13 analogy to the phosphorus issue. I mean, I think
14 we need to know what we're doing.

15 But there are multiple entities
16 involved here. So I agree with the workgroup's
17 recommendation. This isn't ready for primetime.

18 CO-CHAIR PINCUS: Well, when you say
19 agree with the recommendation, actually what
20 Frank has proposed is to actually change it to do
21 not support.

22 MS. CHAMBERS: I agree with my

1 esteemed colleague.

2 CO-CHAIR PINCUS: So, Melissa?

3 MS. MARINELARENA: Sure. So, let me
4 clarify the measure. It is not a physician-
5 level. It is a hospital measure.

6 So patients that are discharged with a
7 certain level INR, it's not therapeutic. They
8 have to get an INR within the two weeks.

9 The INR is captured by the claims.
10 And so then they match the discharge with the
11 claims. So, it's not held back to a physician.

12 Ideally you would think that that
13 patient is discharged and then goes and sees a
14 physician, but that physician is not held
15 accountable.

16 So, it's the hospital that sends, you
17 know, it's that discharge attached to the claims.
18 It's not physician-level.

19 And then the ECQM part of it came
20 because it's an e-measure. So, the conversation
21 was that many hospitals, the vendors probably are
22 not capable of supporting it at this time so this

1 was an option. So making it the optional ECQM
2 pathway and not requiring it at this time because
3 many vendors aren't able to support it.

4 CO-CHAIR PINCUS: Other comments?

5 WORKGROUP CO-CHAIR WALTERS: This is
6 Ron. I would just say, and as we frequently
7 return to, this is another one that the Shared
8 Savings Program might be an ideal place to park
9 this because it would be much more of an
10 integrated unit usually with an integrated EHR.

11 So, I mean, that was kind of the
12 flavor of the discussion. It's just not --
13 there's nothing wrong with the concept. It's a
14 very good measure. But where does it land.

15 CO-CHAIR PINCUS: Pierre, do you want
16 to comment on sort of in relationship to the
17 thinking of CMS?

18 DR. YONG: Sure. Again, appreciate
19 the sort of discussion and the point that this is
20 a big gap area, an important sort of safety
21 concern.

22 The thinking we had was that in this

1 case a patient was either started or was
2 continuing anticoagulation within the hospital,
3 and that as part of a discharge plan that there
4 is responsibilities of the hospital and the
5 providers within the hospital to make sure
6 there's adequate follow-up.

7 And so that's why we thought it would
8 be appropriate. And it was developed as a
9 hospital specified measure.

10 MEMBER FLOWERS: So, I have a question
11 about whether or not there would be a care
12 transition -- a hospital measure that gets at
13 transitions that would support this.

14 Because otherwise I don't see how the
15 hospital could -- I mean, unless there's a
16 measure that you could align it with that related
17 to transitions of care so that there would be
18 some community-based follow-up to get people into
19 primary care for that measure.

20 CO-CHAIR PINCUS: Pierre?

21 DR. YONG: So, Tara, are you on the
22 line?

1 So, I believe there -- so, there are
2 several sort of hospital discharge measures.

3 We have several measures in the
4 program that talk about, or are addressing care
5 transitions. For example, like our readmissions
6 measures. For example, our sort of concept
7 behind that is care transitions and coordination
8 of care. Is that what you're?

9 MEMBER FLOWERS: I'm sort of looking
10 at a community-based transition where you have
11 the care manager following the person out into
12 the community.

13 Is there any type of measure that
14 would support that? Because I see those two as
15 related. If there's nothing to connect the
16 hospital to the person in the primary care
17 setting or in the community-based setting I don't
18 see how this works.

19 DR. YONG: Right. So thank you for
20 clarifying. Yes, so we think that's obviously an
21 important concept.

22 I don't think we have any measure

1 specifically addressing like a community care
2 coordinator.

3 CO-CHAIR PINCUS: So, we're going to
4 vote on this. The committee's recommendation was
5 conditional support based upon it being developed
6 as an electronic measure.

7 There's been a number of comments
8 raised about this both in terms of the phosphorus
9 issue, in terms of whether it's simply measuring
10 whether something occurred, not whether something
11 is under control.

12 Concern about the sort of appropriate
13 accountability of the hospital as compared to
14 more of a networked kind of accountability.

15 So, and I think we've had a lot of
16 discussion about this. Now it's time to vote.

17 Oh, Melissa, did you want to say
18 something?

19 MS. MARINELARENA: Lynda, just so you
20 know, there's a measure, the timely transmission
21 of a transition record. And this is for
22 discharges from an inpatient facility to home, or

1 self-care, or any site of care.

2 And this is you -- it's patients for
3 whom a transition record was transmitted to the
4 facility, or primary physician, or other
5 healthcare professional designated for follow-up
6 care within 24 hours of discharge.

7 And then the INR measure, it's only
8 for patients discharged to home. So, this would
9 be able to catch those patients.

10 CO-CHAIR PINCUS: Okay. So, again,
11 the three options are support, conditional
12 support, or do not support.

13 The existing on the table measure is
14 conditional support. And it requires 60 percent
15 other than that to change it.

16 MS. STERLING: Right. So we are now
17 voting on MUC 151015. That's INR monitoring for
18 individuals on warfarin after hospital discharge.

19 This is recommended for the hospital
20 inpatient quality reporting program. And again,
21 it is 1 - support, 2 - conditional support, and 3
22 - do not support. And you are able to vote.

1 MEMBER FLOWERS: So, Harold, before we
2 vote could I just say that I could see it being
3 conditionally supported if it were used in
4 conjunction with the transitional care measure
5 that was just mentioned.

6 CO-CHAIR PINCUS: Okay, thank you.
7 So, I think we're ready to vote. Are all the
8 votes in?

9 MR. TILLY: Okay. So, we had 29
10 votes. Seven percent support, 34 percent
11 conditional support, 59 percent do not support.

12 CO-CHAIR PINCUS: So, it is just short
13 of overturning the workgroup's recommendation.

14 But we have given a considerable
15 amount of feedback and we have confidence that
16 they will take that under consideration.

17 MEMBER BAKER: Can I just make one
18 comment that this is such an important area. We
19 talk about gaps and this is one of the most
20 dangerous medicines that we use. Major cause if
21 you look at emergency department visits for
22 adverse drug reactions.

1 So, I just hope this is a -- if this
2 measure goes forward it's just a step towards
3 others. We really need to get these better
4 measures in place.

5 And Helen was looking up the measure.
6 There is one going through the pipeline, but I
7 really support the idea of trying to get better
8 measures for this.

9 MEMBER GIFFORD: And the SNF community
10 would encourage us having a measure on INR use in
11 the SNF area. I know they've been excluded out
12 of this measure. It is the leading problem in
13 the OIG report on adverse events.

14 CO-CHAIR PINCUS: So, this is
15 something that we place a high priority on sort
16 of trying to fix this so that it actually works
17 well for potentially a number of programs.

18 So the next four have all been pulled
19 by CMS. And there may be some similarities among
20 them. So, Pierre, can you give us an overview of
21 what the idea is here?

22 DR. YONG: Yes. So, these are all the

1 resource use measures, correct?

2 So, we wanted to bring this forward to
3 the committee and get some additional feedback
4 because there was a robust discussion about this
5 that Ron, you might be able to supplement at the
6 workgroup meeting.

7 I think there was discussion and
8 recognition that resource use was an important
9 concept. However, that resource use in isolation
10 of other information such as quality information
11 is limited.

12 And so, but it ultimately was not
13 supported by the workgroup.

14 And so we wanted to get some
15 additional feedback particularly in the setting
16 of IQR which is a public reporting program.

17 I think there were additional concerns
18 about the use of the measure in a payment
19 incentive program like hospital value-based
20 purchasing.

21 But in an IQR setting where we are
22 publicly reporting the information the use of

1 similar type resource use measures.

2 Because we have heard in prior rules
3 as well as in conversations with stakeholders
4 that they want additional resource use
5 information.

6 These are clinically oriented
7 episodes. We have a few resource use measures
8 currently in IQR, but this would potentially
9 expand that set and provide additional
10 information.

11 Currently on Hospital Compare we do
12 display the -- several resource use measures in
13 conjunction with other related quality measures
14 such as mortality rates so that it is paired with
15 additional information to supplement the pure
16 sort of payment information.

17 CO-CHAIR PINCUS: And to be clear,
18 you're pulling this for further discussion, not
19 for re-voting.

20 DR. YONG: We would like -- well, for
21 vote, please.

22 CO-CHAIR PINCUS: Okay. So this would

1 require voting on each one of these.

2 So, why don't we discuss the whole
3 issue of before we get into individual measures,
4 the whole sort of concept of these episode-based
5 payment measures.

6 And let's hear first from David and
7 Missy and Ron.

8 WORKGROUP CO-CHAIR WALTERS: David?
9 Missy? Pierre summarized everything.

10 CO-CHAIR PINCUS: Yes, if you could
11 summarize what --

12 WORKGROUP CO-CHAIR WALTERS: Risk
13 adjustment in the data. Making sure that the
14 data is accurate. These are the kinds of things
15 that came up.

16 I think there's issues beneath those,
17 but that's the terms that they're usually couched
18 in.

19 MEMBER DANFORTH: Ron, this is --

20 CO-CHAIR PINCUS: Missy?

21 MEMBER DANFORTH: Yes, sorry. Ron, I
22 just had a couple of questions about that.

1 So, when you say about the accuracy of
2 the data is there concerns that the claims are
3 inaccurate since these are claims-extracted
4 measures?

5 WORKGROUP CO-CHAIR WALTERS: That's a
6 piece of it.

7 MEMBER DANFORTH: Okay. So, private
8 purchasers have been a group of folks that have
9 been pushing for these resource use type
10 measures.

11 I will say that it is a concern when
12 you see a resource use measure that isn't paired
13 with a quality measure.

14 And at least I think for spinal
15 fusion, cholecystectomy, and prostate resection
16 there aren't paired quality measures. Pierre,
17 can you confirm that?

18 DR. YONG: That's correct.

19 CO-CHAIR PINCUS: Melissa? Oh.
20 Missy, did you have other comments?

21 MEMBER DANFORTH: No, I'm sorry. I
22 don't remember seeing these on the original list

1 and so I'm just --

2 CO-CHAIR PINCUS: These were just
3 recently pulled.

4 MEMBER DANFORTH: Okay.

5 CO-CHAIR PINCUS: So, you have to go
6 to the most recent discussion guide from Wunmi
7 which came out I think on --

8 MS. ISIJOLA: At the top it says
9 version 3.6. So you're looking for 3.6.

10 MS. O'ROURKE: If they're not showing
11 in your discussion guide, if you hit Refresh it
12 should pull up a version that has these measures
13 included.

14 We apologize. These were last-minute
15 additions to the discussion items.

16 MEMBER DANFORTH: No, no, I see them,
17 they just weren't on the list that David and I
18 had prepared for. So, I think he might be in the
19 same position I am which is just quickly looking
20 at them now.

21 CO-CHAIR PINCUS: Okay. So, Melissa,
22 did you have a comment on this?

1 MS. MARINELARENA: No. The other
2 thing I wanted to say is that data wasn't
3 provided on variation of these procedures, so
4 there was also a question why these particular
5 procedures were chosen. We didn't have that
6 information.

7 CO-CHAIR PINCUS: Okay. So, I see
8 Mary, Rhonda, and David.

9 MEMBER BARTON: Thanks. I would just
10 say that when you start with a procedure for an
11 efficiency measure you don't know -- part of the
12 issue is who's referred for that procedure.

13 So, I think it's a little, you know,
14 an organization that takes too many people for
15 spinal fusions, for example, outside of
16 guidelines.

17 They're going to have maybe great
18 outcomes for efficiency and outcomes because they
19 were unselective in choosing who came to this
20 procedure.

21 And so that's kind of a problem in my
22 mind with these particular kind of episode-

1 focused things that start with a procedure.

2 Because really a very efficient system
3 will of course only refer people who are clearly
4 indicated for a procedure.

5 CO-CHAIR PINCUS: Rhonda.

6 MEMBER ANDERSON: I'd like just a
7 little bit more understanding of why CMS pulled
8 this. It's a little confusing to me when a group
9 of MUC measures go forward and then a workgroup
10 asks either for more data, or needs some more
11 information, or makes a recommendation.

12 I just don't understand the gap there
13 in CMS's comments.

14 DR. YONG: I think we just wanted to
15 get additional feedback. And so that's why we
16 pulled these for discussion.

17 CO-CHAIR PINCUS: So, I mean, again,
18 just thinking of the process.

19 If all you want is additional feedback
20 do you really require re-voting on this?

21 DR. YONG: I mean, so I think as Kate
22 said yesterday, I think the most important thing

1 is the feedback. So I think that's what we are
2 most interested in.

3 CO-CHAIR PINCUS: Okay. So, Frank,
4 and then -- excuse me, David, then Frank, then
5 Jayne. David Gifford.

6 MEMBER GIFFORD: I thought you were
7 going the other way. Sorry. I was looking at
8 Frank. Frank is really thoughtfully thinking
9 about his comments there.

10 I would support continuing with the do
11 not support on these. I think the feedback then
12 to CMS would be, first off, these aren't
13 efficiency measures. These are resource
14 measures. And I think they shouldn't be labeled
15 as such.

16 Even just looking at the reports from
17 NQF you have to pair them with outcomes.

18 And so I think it's really important
19 if they want to talk about these as efficiency
20 measures what are the outcomes they're going to
21 match them with, and how they're going to pair
22 them with them would be very helpful.

1 I also think that when these measures
2 measure the cost for 30 days after discharge from
3 the hospital the post-acute setting and the
4 variability in the post-acute setting is probably
5 one of the larger drivers.

6 And so the risk adjustment on
7 functional status and support at home becomes an
8 enormous piece of it.

9 What we've seen in the BPCI and others
10 is just bypassing PAC care altogether when
11 there's a cost measure.

12 And we're even starting to hear from
13 some of the MA plans and other stuff that they're
14 seeing adverse events from that. Higher episodes
15 out there of worse care because of the way the
16 measure is structured.

17 And so I think that that just
18 reiterates the need to pair it with an outcome
19 measure when they do it.

20 And they should be pairing it right up
21 front because of that potential unintended
22 consequence of that.

1 And then I'd say the functional
2 measure, you know, Jayne, don't kill me, or
3 Nancy, but I think we have to start getting
4 functional measures from the hospital data.
5 Whether it's the CARE tool or something else,
6 there needs to be some measure of functional
7 status because it's just such an important driver
8 of resource utilization and clinical decision-
9 making and everything else out there.

10 And we now have it in almost every
11 setting but the hospitals.

12 CO-CHAIR PINCUS: Frank?

13 MEMBER OPELKA: Some of what I was
14 going to say was just stated and much more
15 eloquently than I can state it, so.

16 I think this whole set of measures is
17 a very important focused research area that we
18 don't know a lot about. And the potential
19 consequences to care could be significant.

20 I also agree that these are not
21 necessarily efficiency measures, but they are
22 resource measures. And getting beyond Parts A

1 and B into the other components that are built
2 into this, it would be very important to
3 understand how those all build up and stack up.

4 The risk adjustment piece of this and
5 how you actually deal with that is very, very
6 important. Otherwise the unintended consequence
7 is that people shy away from the patients who
8 really need it and look at use on the low end on
9 those who've got very low or limited costs.

10 And so you can get cherry-picking of
11 patients as a potential consequence here.

12 So there's a lot in these measures
13 that are very important. We do support them in
14 the long run, but we think they need to be part
15 of a bigger research project to sort through how
16 we actually end up applying these because of
17 their impact.

18 CO-CHAIR PINCUS: Could I just ask,
19 Helen, where are these on the consensus process
20 line for the standing committees?

21 DR. BURSTIN: Not been submitted.

22 CO-CHAIR PINCUS: Not yet been

1 submitted. Okay. Tested but not submitted.

2 Other issues? Anything else that
3 people want to bring up? David Baker.

4 MEMBER BAKER: I just wanted to talk
5 about how difficult it is to really develop
6 efficiency measures.

7 Because if we're talking about cost
8 per quality, now think about for these procedures
9 your outcomes can vary from death to a whole
10 variety of other complications.

11 So, if you think about how you're
12 going to weight that and do that it's a real
13 challenge.

14 I think our biggest opportunity is to
15 be able to think about bundled payment programs
16 where you know what your resources are. You know
17 what is being paid, although Frank brought up the
18 issue for risk adjustment and that's challenging.

19 But then you can really compare apples
20 to apples because you can look at differences in
21 the complication rates across providers given the
22 same fixed set of resources.

1 We still need to get into the area of
2 appropriateness though as people have brought up.
3 So I think that that's an area that we should be
4 thinking more about.

5 DR. BURSTIN: Just one brief point,
6 Harold. So, we have endorsed other resource use
7 measures which we have labeled as building blocks
8 of measures to get to efficiency.

9 These are clearly labeled as payment
10 measures. They're not called efficiency. If we
11 label them as such it really is --

12 CO-CHAIR PINCUS: But they are.

13 DR. BURSTIN: Right. But the actual
14 title is payment measures.

15 I just want to be fair here. We may
16 have labeled them as efficiency, but in fact they
17 are a building block towards efficiency.

18 So I think we have brought other
19 measures like this in and endorsed them in the
20 past. And we would look forward to seeing these
21 come forward in the future so we can better
22 understand the issues raised by MAP.

1 CO-CHAIR PINCUS: So, Pierre, is that
2 okay in terms of additional feedback?

3 Okay, so we have two more measures
4 hopefully that we can get to before we break for
5 lunch.

6 So, this 30-day all-cause unplanned
7 readmission following psychiatric
8 hospitalization. And that was pulled by Amir.
9 Will this be discussion?

10 MEMBER QASEEM: It's conditional
11 support right now. I can probably live with
12 that.

13 And the couple of issues that I just
14 want to bring up is that -- I mean, there is
15 definitely -- this is an important measure.
16 There is -- my concern was that the clinical
17 outcomes might not get better, although the
18 readmissions might reduce.

19 And I wasn't really clear on this
20 whole, the term the psychiatric admission. It's
21 such a broad term. Because I was discussing it
22 with other colleagues as well. It can vary from

1 acute psychiatric episodes to someone who may
2 have had a suicide attempt.

3 So, and then of course this measure
4 did not account for any sociodemographic
5 variables to my understanding and I was quickly
6 looking through this measure.

7 And it hasn't really been reviewed by
8 NQF which I'm actually very strongly supportive
9 of any measure that we move forward NQF
10 endorsement at least should have been reviewed so
11 we know where the details, what's their view on
12 this.

13 So, if it's a conditional support,
14 again, as I said, I'm okay with it. But some of
15 these comments were not listed in there. So I
16 just want to communicate these comments, that
17 they just get added.

18 CO-CHAIR PINCUS: Are there comments
19 by David, or by Ron, or by Missy?

20 MEMBER DANFORTH: I don't have any
21 additional comments.

22 WORKGROUP CO-CHAIR WALTERS: Agree.

1 MEMBER BAKER: I agree with the issues
2 that were raised. This is just such an important
3 measure. I mean, we know about all the problems
4 with re-hospitalization. This is another one
5 that we know that we can actually move the needle
6 and reduce re-hospitalization.

7 So I think really the challenge is the
8 details around the risk adjustment methodology,
9 SDS, et cetera.

10 CO-CHAIR PINCUS: Just to step out
11 into my other role. I mean, as co-chair of the
12 standing committee on behavioral health I look
13 forward to reviewing this measure.

14 This is something that we've time and
15 time again talked about trying to figure out ways
16 to better measure the interface between
17 behavioral health general healthcare.

18 In fact, for people with severe mental
19 illness they have very high rates of comorbidity
20 for general medical conditions. People with
21 psychosis die 10 to 20 years earlier than the
22 average person, typically not from things related

1 to their mental illness.

2 So, this is something that really is
3 right at that interface. So I look forward to
4 reviewing that with the other hat.

5 Other comments? Okay, let's move on
6 to the next one which is substance use core
7 measure set for alcohol and other drug use
8 provided or offered at discharge.

9 It was pulled by Lisa and Amir.

10 MEMBER MCGIFFERT: I pulled it for
11 discussion purposes and mainly because it's a
12 process measure. It seemed like some of the
13 discussion from the committee was wishing for
14 more of an outcome measure.

15 And then I guess a lot of the issues
16 around population screening would apply. Some of
17 the commenters brought that up. So that was
18 really my concern about it.

19 CO-CHAIR PINCUS: Amir?

20 MEMBER QASEEM: So, can I just make
21 comments first and then let's see if there are
22 any responses?

1 CO-CHAIR PINCUS: Sure.

2 MEMBER QASEEM: The issue with this
3 measure is that -- so if a patient who's admitted
4 for pneumonia, essentially you're going to be
5 doing alcohol counseling, or substance abuse
6 counseling in this patient.

7 I'm not really sure or aware of any
8 evidence that says that these two better or
9 improve outcomes.

10 And that's why I'm just starting out
11 with discussion because maybe it's lack of
12 knowledge.

13 And I was looking at you since it's a
14 Joint Commission measure, of course. And maybe
15 you can answer some of these questions.

16 Then of course the exclusions are
17 extensive. But if we start looking at just
18 exclusions some of them are incredibly
19 complicated.

20 So, there is one exclusion. If you
21 look at it it says patient ranking at unhealthy
22 levels who does not meet the criteria for an

1 alcohol use disorder.

2 So, I'm not really sure what does
3 unhealthy levels, how are they defining it? Some
4 of these details are just not there.

5 And then finally I think the comment
6 is that addictions treatment, many times they're
7 not covered by individual insurances, or they
8 might be very incredibly expensive.

9 And then there's the issue of
10 accessibility. That comes up a lot. I mean, not
11 everyone is sitting in D.C. and Philadelphia.
12 Pretty much a lot of places in this country
13 doesn't have access to some of these resources.

14 So, again, that's why I'm not -- I
15 just want to hear from maybe even the workgroup
16 if these items have been discussed.

17 Because they have this as supported
18 and I was a little bit surprised that it's not a
19 conditional support.

20 CO-CHAIR PINCUS: David?

21 MEMBER BAKER: So, as Amir alluded to,
22 this is -- the Joint Commission is the steward

1 for this and I said that I thought I would recuse
2 myself from the discussion.

3 But I will say that there is good
4 evidence that brief physician counseling does
5 affect particularly for alcohol use. Most of
6 those studies are in the outpatient setting. I
7 don't know if anything has been done in the
8 hospital setting. But there is a solid evidence
9 base if you think that you can generalize to the
10 hospital setting.

11 CO-CHAIR PINCUS: And this is
12 something that came before the standing
13 committee. And it was, in fact, endorsed.

14 And there actually is a relatively
15 reasonable evidence base also in terms of
16 inpatient interventions which is included
17 actually in what the Joint Commission submitted.

18 There's also clearly a gap -- oh,
19 there's a relatively strong database in support
20 of inpatient as well as outpatient. Not as
21 strong on the outpatient side in primary care
22 largely because that's where most of the studies

1 have been done.

2 But there is some data around
3 inpatient interventions making a difference as
4 well.

5 And this is part of a set of measures
6 that include sort of screening, and brief
7 counseling, and referral for treatment, and just
8 sort of initiating treatment if appropriate on
9 the inpatient setting.

10 One of the big gaps is, especially for
11 substance abuse is the use of medication-assisted
12 treatment. And that's something where there's a
13 big gap in terms of the adoption of that.

14 And there's also some evidence about
15 that being initiated in the hospital actually as
16 being much more likely that people will engage in
17 it afterwards.

18 So, for those reasons it was in fact
19 endorsed by the standing committee. Bill?

20 WORKGROUP CO-CHAIR WALTERS: This is
21 Ron.

22 CO-CHAIR PINCUS: Oh, Ron.

1 WORKGROUP CO-CHAIR WALTERS: And I
2 agree. So again, we took the opportunity to say
3 how there could be a better measure in the
4 future, how there could be other things brought
5 in in the future.

6 But as a stand-alone measure this has
7 been all the way through the endorsement process
8 and that's why we supported it.

9 So, everything everybody said is are
10 there opportunities to even improve this measure.
11 Absolutely. But the measure by itself has been
12 vetted pretty well.

13 CO-CHAIR PINCUS: And if I recall
14 correctly, and David may correct me, there was an
15 additional element to this measure about
16 following up at 30 days.

17 And the discussion in the standing
18 committee was that while that would be
19 appropriate for like a Medicare Shared Savings
20 kind of program, or an ACO type program, it was
21 probably a bridge too far for hospital
22 accountability in terms of following up for

1 treatment after, 30 days after, but it's
2 something that should be thought about for some
3 of these other programs.

4 MEMBER BAKER: I'll just add in,
5 again, there are really good models. I've seen a
6 few hospitals that have actually set up partners
7 with substance use programs and electronic
8 exchange of information.

9 So we clearly need to be able to move
10 towards being able to assess the proportion of
11 patients who actually are entering treatment.

12 CO-CHAIR PINCUS: And it becomes --

13 MEMBER BAKER: But that's a ways off.

14 CO-CHAIR PINCUS: And it also becomes
15 highly relevant given in the parity components of
16 the ACA which provide for parity of insurance
17 benefits for both mental health and substance
18 abuse. Bill?

19 MEMBER KRAMER: I'll just make a --
20 use this particular measure to make a general
21 comment.

22 Earlier in some of the public input

1 there was discussion about the need for parsimony
2 in all these measure sets.

3 And I think the general concern I have
4 about these kind of process measures is that they
5 tend to crowd out other, more important, useful
6 measures, outcome measures basically.

7 And the fact that this particular
8 measure has been NQF-endorsed is great. But
9 we're supposed to make sure we're recommending
10 things that will be useful for public reporting
11 and payment programs.

12 And I would just want to make sure
13 that in the report to CMS that we have a strong
14 statement not that something could be developed
15 that's better, but something should be developed
16 that's better and more useful to clinicians and
17 to patients.

18 CO-CHAIR PINCUS: Kevin.

19 DR. LI: Just to point out that this,
20 or a similar measure has been required for level
21 1 trauma centers for quite a while as part of
22 level 1 trauma center certification. And so it

1 has experience in a number of large hospital
2 systems. And it has for quite a while through
3 that certification program.

4 CO-CHAIR PINCUS: So, I think we are
5 done. Yesterday I was making fun of Foster
6 saying we got through the -- you know, when I was
7 chairing the PAC stuff it went much more quickly
8 than the clinician one. So I have to sort of
9 take that back.

10 But anyway, so I think we went through
11 a lot of stuff. I think that we provided a lot
12 of very useful feedback to CMS. And hopefully we
13 have also sort of advanced the cause of further
14 development of measures that can be more helpful,
15 more relevant, and filling some of the gaps that
16 we've been most concerned about.

17 So let's move on to lunch. And then
18 after lunch we will take up some of the longer-
19 term crosscutting issues.

20 How long for lunch?

21 MR. AMIN: So, we still have three
22 sessions to go. But they will be relatively, you

1 know, I think they're much more forward-thinking.
2 And hopefully this will be a different type of
3 brain power.

4 So, if we could try to come back at a
5 quarter to and do this again as a working lunch.
6 I apologize that we've been working everybody
7 with no breaks and working lunch for the last two
8 days.

9 But you know, this will be sort of a
10 more discussion-oriented forward-thinking time.
11 So if we can get back in the room at 12:45 we can
12 move on from there. Thanks.

13 CO-CHAIR PINCUS: Thank you.

14 WORKGROUP CO-CHAIR WALTERS: Thank you
15 again for all your input and thoughtful feedback.

16 (Whereupon, the above-entitled matter
17 went off the record at 12:21 p.m. and resumed at
18 12:41 p.m.)

19 ACTING CO-CHAIR GESTEN: So thanks
20 everyone for the rich discussion this morning.
21 We're going to, as we talked about, have a
22 somewhat abbreviated and focused conversation in

1 the afternoon, picking up on some of the themes
2 and questions and issues that we talked about
3 this morning.

4 But we want to start the afternoon,
5 before we get going, with public comment. Are we
6 ready? Are folks ready on the phone?

7 MR. AMIN: Yes. Operator, do we have
8 any public comments on the phone?

9 OPERATOR: If you'd like to make a
10 public comment press star, one. Apparently no
11 public comments.

12 ACTING CO-CHAIR GESTEN: And in the
13 room? Any public comment in the room? Okay, I'm
14 going to turn things over to Taroon.

15 MR. AMIN: Thank you. So just to
16 quickly review a little bit of the agenda for
17 this afternoon, we're going to quickly run
18 through a number of sort of key findings that are
19 reflective of what we've done in the last five
20 years.

21 It's sort of a milestone birthday for
22 the MAP. We are at our five year point. So we

1 thought it would be helpful to look back a bit
2 into the evolution of the measures and the
3 programs that we've evaluated over the last five
4 years.

5 And then quickly just introduce this
6 idea -- reintroduce the idea that we discussed
7 during the September meeting around core
8 concepts, which was an exercise that we were
9 trying to sort of iron down, like actually
10 define, during today's meeting. But we'll
11 unfortunately have to wait for a future date.

12 But we will welcome some initial
13 discussions or thinking about the conversation.
14 And then we'll also move -- then we'll sort of
15 move to the bulk of this afternoon.

16 We're interested in sort of
17 reflections on sort of the role of the
18 coordinating committee as we look across the MAP
19 process. And then maybe do a deep dive on this
20 issue around the voting and the voting categories
21 and the measures under development pathway.

22 I just want to sort of emphasize that,

1 you know, we only have about an hour and a half
2 and we want to obviously be respectful of
3 everyone's time with travel. And so the way
4 we'll sort of do this is present all this
5 information out to you, and then maybe we can
6 just an overall discussion period, all together,
7 as a way to sort of consolidate the discussion.

8 And then also just reflect on the fact
9 that staff will be taking all of the input that
10 we receive during this conversation, and come
11 back with some proposals for a path forward.

12 So the goal of today's discussion is
13 not necessarily to come up with definitive
14 decisions, necessarily. Given the time
15 constraint, we don't want to force that as the
16 ultimate outcome of today's discussion -- today's
17 afternoon session. But more or less a reflection
18 on what the key issues are. And if we can, come
19 up with some general principles on a path
20 forward. Staff will work various proposals to
21 bring back to the coordinating committee.

22 At the latest, that's September. Or

1 potentially during an interim web meeting of this
2 group sometime in the early summer probably.

3 So with that being said, I'll turn it
4 over to my colleague, Wunmi, to run through some
5 discussion -- or just some reflective slides here
6 on MAP at five.

7 MS. ISIJOLA: Thanks, Taroon. So
8 happy birthday MAP. We actually have cake in the
9 back for everyone, just celebrating all of your
10 leadership and your hard work over the past five
11 years.

12 Many of you have been here for quite
13 some time. Many of you have been around for the
14 journey. But we appreciate all of your efforts.

15 One of the things that we've really
16 noticed is really the stride to strengthening the
17 measure sets within the federal programs. To
18 date we've seen well over 1500 measure being
19 considered for use in 20 different programs. And
20 that's really attributed to all of your work in
21 providing those recommendations to CMS.

22 Half of those have been process

1 measures. But we're really seeing a stride to
2 really looking at more outcome-based measures. I
3 think this year alone we've seen a substantial
4 increase in outcome measures that are being
5 presented to the MAP. So I think our voice
6 speaks volumes.

7 So just a quick snapshot of what the
8 percentage of measures that we've been seeing
9 across the five years.

10 Many of the measures have bucketed
11 within the clinician setting, and that may
12 attribute to the broad spectrum of clinical and
13 topical areas. But we also see measures within
14 the hospital in PAC acute settings.

15 So as you know, we've talked about
16 this for the past two days. But really providing
17 upstream guidance to CMS on, not only measures
18 that are fully developed, but also measures that
19 are still under development.

20 This upstream guidance helps them to
21 determine where their priority areas are, and
22 where their investments should lay within

1 measurement testing.

2 We're seeing more than ever that many
3 of the measures that are being considered are
4 still not fully tested. And I know Kate talked
5 about it extensively yesterday, of collaborative
6 efforts. First to look about that feedback loop
7 of bringing measures back once they have been
8 tested and getting your feedback. Less and less
9 of these measures, similarly, less than 30
10 percent of those are still in stage of
11 development. So we still have some work.

12 I think one of the things that we're
13 trying to do also is really integrate our work.
14 So our MAP and CDP processes, so really looking
15 at endorsement and how that ties into selection,
16 and bringing that information to both committees.

17 This is also another representation of
18 where we've been. A lot of the work is tied to
19 the National Quality Strategy priority in looking
20 at where many of the measures lie. Are we
21 establishing alignment across the programs.

22 Since 2011, we've seen an increase in

1 communication and care coordination, which is a
2 hot topic, but also making care affordable. So
3 we see some changes and shifts there.

4 So changes in the quality programs.
5 We're seeing the strategic shift to really
6 looking at the nature of quality initiative
7 programs. As you know, we're pushing more
8 towards value-based purchasing. We're really
9 looking at paid performance initiatives,
10 particularly in the hospital settings.

11 As you know as of last year, there has
12 been a goal of really tying traditional Medicare
13 payments to value, by 2018. So your voices are
14 being heard. We're really pushing the needle
15 forward, so that's great.

16 Also, MACRA legislation demonstrating
17 a change as we repealed the SGR in attempting to
18 really tie payment to value as opposed to just --
19 value, as opposed to just value. But also
20 consolidating the clinician quality initiative
21 programs into the anticipated MIPS program.

22 We talked extensively about the IMPACT

1 Act. Really establishing standardization across
2 post-acute care providers. But also ensuring
3 that we have consistency across the different
4 settings.

5 Next slide. And then this is just
6 another representation of kind of where we're
7 moving. We're seeing that we're really focusing
8 in on payment. In the past we've really seen an
9 increase in reporting, but we're seeing that
10 inversely shift.

11 So I gave a little bit of historical
12 context, but ultimately I wanted us to also dive
13 into the impact and success, and, Taroon, do you
14 want to take it away and really lead us in that?

15 MR. AMIN: Sure. Yes, I would just
16 quickly summarize in terms of the two main sort
17 of takeaways in terms of the measures and the
18 programs, and the evolution over the last five
19 years.

20 There has been a clear change in the
21 types of measures that we've been seeing over the
22 last five years, an increase in the number of

1 proposed measures that look at outcomes. There's
2 also an increase in the number of measures that
3 are, quote unquote, under development, which has
4 been a major topic of discussion over the course
5 of the last two days, and somewhere we will want
6 to focus our discussion a little bit later in
7 this conversation.

8 The second thing is that there's been
9 a change in the programs themselves. So the
10 evolution of these program measures for, in their
11 intended uses, changed considerably. And I think
12 Wunmi sort of covered those.

13 And so just moving on, in terms of
14 some of the impact and successes, with the
15 introduction of readmission measures, we've seen
16 a reduction in the readmission rates. And MAP
17 has supported, again, these measures, using the
18 current in those programs.

19 We've also seen, in the PAC reduction,
20 we've seen some significant reduction in rates on
21 the next slide, a decline of 17 percent in the
22 rates of HACs from 2011 to 2014. And

1 additionally, you know, the translation of these
2 reduction HACs actually reduces significant
3 spending in the healthcare system.

4 So just moving on to some of the other
5 strategic changes here, there continues to be a
6 lot of work related to the MAP and the consensus
7 development process alignments to ensure that
8 there is integration and communication between
9 these two different processes.

10 Moving to the next slide. And so what
11 you'll see here is, you know, continued effort
12 that this group has sort of indicated and also
13 the work that we've been undertaking with our
14 consensus, the CSAC, the Consensus Standards
15 Approval Committee, around how to further
16 integrate the communication and information
17 between the endorsement process and the measure
18 selection process.

19 Some of the elements, looking forward
20 to the next slide, that we've been working on
21 with the NQF Board, is further consideration of
22 how to identify measures that are at the highest

1 standard, meaning that meet the highest level of
2 evidence and testing.

3 On the next slide. And, you know,
4 we've -- the Board has sort of designated this as
5 sort of an NQF plus designation which identifies
6 measures that meet the highest level of evidence
7 in testing. And there may be some significant
8 influence of how this new intended use effort,
9 within the consensus development process, may be
10 used in the selection of measures.

11 So in summary, there are a lot of
12 major activities that are happening across NQF
13 that will influences the MAP process related to
14 our intended use activities, and as it relates to
15 further integration of the CDP and MAP process.

16 So the last thing we wanted to cover
17 today, as it relates to sort of forward-looking
18 efforts that are being undertaken, during our
19 September meeting -- so moving on two or three
20 slides actually.

21 So during our September meeting we
22 discussed quite a bit the importance of a more

1 strategic and standard approach in which we think
2 about gaps and alignments. And one of the
3 elements that came out of the September meeting
4 was encouraging us to think about the development
5 of core concepts that is, that spanned within --
6 across programs, within a workgroup, and then
7 also spanned across workgroups, so that there
8 could be a much more aerial and strategic view in
9 which the MAP identifies strategic areas of
10 measurement.

11 And so one of the things that we
12 worked on that we wanted to continue to work on
13 today, was to look across these. The National
14 Quality Strategy is obviously one of our guiding
15 principles, and then looking across all of the
16 different National Quality Strategy goals and
17 identifying key areas in which we wanted to see
18 progress.

19 We believe that the development -- we
20 collectively, during the September meeting, felt
21 that the development of the MAP core concepts
22 would be able to identify sort of key areas we

1 would want to make advances.

2 So I'm going to actually kind of move,
3 it's slide -- if you can move forward a little
4 bit. We're trying to skip through some of our
5 contents given that we don't actually have a lot
6 of time to cover this. If you could just stop
7 there.

8 One of the areas that we sort of
9 wanted to discuss was that, if you're looking at
10 this as an example around the NQF's priority of
11 strengthening person and family engagements,
12 there is several CMS objectives that sort of
13 address this strategic priority.

14 For instance, promoting patient self-
15 management. The question is, how do we want to
16 really be able to promote patient self-
17 management?

18 And so there were some example areas
19 of focus that came in through the survey that we
20 sent out, related to, for example, care match
21 with the patient goals or the establishment of
22 patient, family, caregiver goals or advanced care

1 planning.

2 So these elements represent sort of
3 areas of focus that we might be able to continue
4 to advance within the workgroups and then across
5 workgroups. Clearly we won't be able to really
6 get into the development of the core concepts
7 during today's meeting, but this will be an
8 activity that we will undertake during a little
9 bit of the off-cycle work, likely in the summer.

10 And so with that, one of the things
11 that we sort of -- we want to transition into, is
12 a discussion around forward-looking areas of
13 improvement for the MAP process. And so there
14 appeared to be at least two different areas that
15 emerged during our discussions over the last two
16 days. This is not actually in the slides at all.
17 Given that these are sort of areas of discussion
18 that emerged from our discussion.

19 The first is a revisiting of the
20 question. And this is where we really want to
21 focus the bulk of our conversation today. The
22 first is, again, this discussion around the role

1 of the coordinating committee. You know, one of
2 the things that we've identified over the last
3 five years, and one of the key areas of input
4 that we got from the coordinating committee last
5 year, was around the fact that we really did not
6 want to have the discussion as just, you know,
7 going through consent calendars after consent
8 calendars and revisiting all of the workgroup
9 deliberations.

10 And so one of the questions sort of
11 posed to the group is, the role of the
12 coordinating committee in reviewing the workgroup
13 recommendations and how to get the coordinating
14 committee, and specifically in what way do we
15 want to get the coordinating committee to have a
16 much more strategic view in the rulemaking
17 process?

18 And then the second is to get some
19 input from the coordinating committee members
20 around this issue of the various different -- the
21 measure under development pathway and then also
22 the decision categories within the fully

1 developed measures and the measures under
2 development pathway.

3 And so focusing our discussion for the
4 last hour that we're together here before we move
5 to public comment, we would welcome discussions
6 across the workgroup members on key areas where
7 the MAP can focus on improvement over the next
8 year of pre-rulemaking.

9 And then second -- and thirdly, this
10 issue around the role of the coordinating
11 committee, and then lastly, the decision
12 categories.

13 Again, we don't anticipate that this
14 discussion will result in sort of defined
15 decisions, but more or less key parameters for us
16 to consider and to bring back to you during a
17 future meeting.

18 So with that said, I'll turn it back
19 to -- if there's any other comments from the
20 staff, and if there isn't, I will turn it over to
21 the Co-Chairs.

22 ACTING CO-CHAIR GESTEN: So in other

1 words, you want this for discussion not for vote?

2 (Laughter.)

3 MS. ISIJOLA: Yes.

4 MR. AMIN: Yes.

5 ACTING CO-CHAIR GESTEN: So in this
6 case, feedback back to NQF and to ourselves about
7 improving the process. So you put a couple
8 different things on the table, clearly picking up
9 on the last day and a half's discussion and some
10 of the things that we struggled with. Why don't
11 we just open it up for comments, and let me just
12 remind folks on the phone that if you use the
13 raise hand function then we can call on you and
14 get your input and we'd love to have your input.

15 DR. WILSON: Foster, this is Nancy.
16 My apologies, I don't have my raised hand
17 function. But if you could put me in the queue,
18 that would be great. I'm all set.

19 ACTING CO-CHAIR GESTEN: You can go
20 first, Nancy. Go ahead.

21 DR. WILSON: Thank you. Thank you so
22 much for the reference to the National Quality

1 Strategy and the priorities.

2 And one of the things that I've been
3 thinking about, since the Affordable Care Act was
4 passed and that we're in our -- kind of like our
5 five year anniversary, is that the --- at the
6 time, the National Priorities Partnership, now
7 the National Quality Partnership, identified
8 long-term goals for each of those priorities, and
9 I wonder if it's time to revisit the goals,
10 reaffirm the goals, and then really think about,
11 okay, what we're measuring is really what we
12 think is the best thing we can measure to get to
13 these long-term goals.

14 So I just want to put that kind of
15 flag in there for -- it's not just about coming
16 up with a strategy with names and priorities,
17 it's about thinking about what are the -- sort of
18 the long-term goals.

19 And NQF did terrific work in
20 identifying what those goals should be. So maybe
21 we ought to revisit or reaffirm them.

22 ACTING CO-CHAIR GESTEN: Okay. Nancy,

1 let me just make sure that I'm understanding your
2 comment to be that, in line with, I think, what
3 Taroon teed up, that this is something that you
4 think would be an important way of framing
5 conversations going forward for the coordinating
6 committee?

7 DR. WILSON: Yes.

8 ACTING CO-CHAIR GESTEN: Okay. Kevin?

9 DR. WILSON: Exactly.

10 ACTING CO-CHAIR GESTEN: Thanks.

11 Kevin?

12 DR. LARSEN: To the earlier discussion
13 we had, I think mostly yesterday, but it kind of
14 came up today as well, we've articulated as the
15 coordinating committee that we want more
16 crosscutting measures, more integration, more
17 kind of shared accountability. And so I think a
18 thoughtful look at how our processes and
19 subcommittees work -- there has been a lot of
20 terrific work there with care coordination groups
21 and the dual eligibles group. I think that as I
22 see the landscape of delivery system reform

1 happening, there's a lot of shift in payment and
2 accountability, that people want measures to
3 support that.

4 And typically, the historical way for
5 things to have worked, is that a new payment
6 model exists. And then data systems start
7 sending data out of that payment system. And
8 then a few years downstream, we actually use that
9 data to create measures about the new payment
10 model.

11 And we're wanting to actually have
12 those measures as part of the new payment models
13 now, and that's part of the tension we've been
14 talking through back and forth here today. So
15 thinking how MAP and its set of subcommittees and
16 the coordinating committee redo our process or
17 continually evolve our process to keep our eyes
18 on what's happening with these new
19 accountabilities and this new shared cross-
20 setting, cross-environment, cross-payment model
21 measurement, I think would be worth some time.

22 ACTING CO-CHAIR GESTEN: Thanks.

1 David?

2 MEMBER GIFFORD: I think that in this
3 evolution of time, as Taroon nicely outlined,
4 there's a dual function in that CMS seems to want
5 from us and I don't think we've set up for it.

6 One is they want early feedback on
7 measures under development as they go forward.
8 And then there's the -- us deciding whether a
9 measure is appropriate for rulemaking. Those are
10 different functions. And I think not only are
11 those different functions, we're trying to do
12 both of them at the same time and it's causing a
13 lot of confusion. And CMS is trying to sometimes
14 do both of them at the same time because of
15 things outside of their control as well.

16 But I think looking at the how the
17 process is set up to meet those two goals,
18 because if all CMS wants is feedback on some of
19 the measures, is the MAP the right vehicle for
20 that or is our workgroups and other stuff, or
21 not?

22 So I think that's the -- and is the

1 feedback about the measures or is the feedback
2 about how it's going to be used in rulemaking to
3 go out?

4 I also don't think, as this has
5 evolved over time and as these measures evolved
6 over time, we've not done a historical look back
7 on how these measures have been done. You know,
8 do they come back? What -- you know, after all
9 of this, what happens?

10 You know, Kate and I were joking about
11 what we're going to see in the PPS rule that
12 comes out in the spring. But what's going on and
13 how do these measures actually get used? And as
14 they evolve over time, what's the role in giving
15 some guidance for that?

16 And I would completely agree with
17 these cross-setting measures, but dealing with
18 the guidance for it. Because even -- while we're
19 looking for that siloing, but still the way CMS
20 and the programs are, they're siloed. And so how
21 do you think about, in that siloed structure,
22 which isn't going to change right away, how do

1 you use cross-setting measures? And I don't
2 think we've had that sort of discussion and
3 process.

4 And then I'd reiterate I think, just
5 reflecting our own process, I don't think our
6 workgroups really understand the guidance and
7 role with it in sitting in and listening to a lot
8 of the workgroups. Some do, and others, it
9 depends on the chair and it depends on a lot of
10 different factors.

11 I think we did our role well today, in
12 many ways that we, and this MAP has said over
13 time and NQF said, and we want to move to
14 outcomes, not process. And so we did say that
15 over time. But I think that there is some value
16 in looking at how we do that and try to move away
17 from voting. I still think we're talking about
18 individual measures and doing work that really
19 should be done elsewhere before it gets here.

20 I just don't think it's being done
21 elsewhere and so that we're having to do that.
22 And I think we need to shift it better over

1 there. Those are my general comments.

2 MR. AMIN: Foster, can I ask some
3 questions as we go?

4 ACTING CO-CHAIR GESTEN: Yes.

5 MR. AMIN: So that we can get some --

6 ACTING CO-CHAIR GESTEN: Absolutely.

7 MR. AMIN: -- a little bit of detail.

8 I think one of the questions, David, that you're
9 raising, that you've raised over the course of
10 the two days that I would like to get broad input
11 on, is this question around whether the measure
12 under development pathway, which was intended to
13 solve the problem of getting early input to CMS
14 on measures before they're fully developed, and
15 the goal of making a decision about a measure,
16 whether it's appropriate for rulemaking, whether
17 those are distinctly separate goals and whether
18 they should be handled in a separate process,
19 quite honestly.

20 I mean one of the major things that
21 we've talked about last year was we can only put
22 so much in this three month period, especially

1 when we're dealing with snowstorms and vacations
2 and all sorts of other activities. It's hard to
3 imagine any more in here.

4 So are they sufficiently different
5 that just creating a separate category is not
6 actually achieving or -- you know, a separate
7 categorization system, is not sufficiently
8 addressing the problem? Or the new issue that we
9 sort of -- that has emerged over this year's pre-
10 rule making.

11 And I'd also welcome feedback from CMS
12 as we go through this, if you have any thoughts
13 as we go through it.

14 MEMBER GIFFORD: I do think it's a
15 good point in that CMS is also going to have to
16 put measures that are not fully developed and
17 specified, that they're going to have to put in
18 rulemaking. I mean, CMS has to specify our cost
19 per beneficiary measure by October 16th. It's
20 going to be in our rule. It has to be in our
21 rule, otherwise they're in violation of statute.

22 Now, they are certainly in violation

1 of statute all the time but I think Burwell has
2 made it pretty clear, they don't want to violate
3 the statutes moving forward. And it's never good
4 on the executive branch to violate statute and
5 just get you called up before Congress and stuff.
6 So I think I can understand that bind that
7 they're in. And they're going to move forward on
8 it.

9 So you're right. It's not that if you
10 skip a step or thing, it still doesn't need it.
11 Because they are asking for input on measures
12 that they are having to go really fast on. I
13 just don't think our process has figured out how
14 to adapt that.

15 ACTING CO-CHAIR GESTEN: Well let me -
16 - I know a couple people want to -- I'm not sure
17 what's in people's heads about whether they want
18 to comment on this or not. Because we -- what's
19 that?

20 (Off-microphone comment.)

21 ACTING CO-CHAIR GESTEN: And I know
22 Harold does and you do. So why don't -- Harold,

1 you had a specific comment around this topic?

2 CO-CHAIR PINCUS: Well, in some ways,
3 you know, what we have -- and I'm not sure we
4 need two different processes, but I think we need
5 two different sets of criteria.

6 And in some ways, we need to sort of
7 go back to the initial criteria. When we first,
8 you know, put together the MAP, we went through
9 and developed criteria that were not necessary
10 measure-specific, but that were also sort of
11 measure set-specific.

12 And we need to go back, I think, and I
13 look at that, and to think about, do we need a
14 separate set of criteria for the MUC process and
15 a separate set of criteria for the MUD process.
16 You know, sort of take ourselves out of the MUC
17 and the MUD.

18 Because I do think that there are
19 different criteria where we're asking like a
20 different question, as David said. The question
21 for the MUC is, you know, are these things ready
22 to be put forth in rulemaking? And for the MUD

1 one it's the question, is it worth making an
2 investment and is that investment likely to be
3 realized, given the current state of information,
4 evidence and practicality?

5 And so I think that they're -- so that
6 I think we need to sort of take a step back and
7 clarify those two distinctions.

8 ACTING CO-CHAIR GESTEN: So, Peter, do
9 you want to respond to that before I get to David
10 and others who might want to --

11 DR. YONG: Yes, thanks, Foster. So I
12 actually want to address two issues that were
13 brought up, but --- so on this first issue about
14 sort of the MUD versus the fully developed.

15 So yes, I think there's a tension that
16 David sort of identified, right, that oftentimes
17 while we would, particularly with statutory
18 mandated measures, we want to bring it to the MAP
19 as fully developed, with all the specs, so you
20 can have a chance to review it and have an
21 understanding of what the measure is addressing.

22 But sometimes, because of statutory

1 deadlines, we are forced, in some ways to,
2 because of the timing of the MUC and the rule, to
3 bring things forward probably before we would
4 normally otherwise would. And so sometimes those
5 constraints are in place.

6 And sometimes we -- but we also put,
7 sometimes, measures on the MUC list because we
8 want feedback. I mean an example I think this
9 year was the tobacco measure, and because it
10 wasn't specified at that -- but it was a fully
11 specified measure otherwise. But it's a novel
12 measure concept for this particular program and
13 we wanted to bring that forward, and thought it
14 would be appropriate and important to get public
15 feedback about that kind of measure because it's
16 such a different sort of way to think about
17 measures in the IQR program.

18 David also raised another issue, which
19 I thought was also really important, and actually
20 Gail and I were just talking about this. But
21 sort of, you know, we talked a little bit about
22 care transitions and the importance of sort of

1 cross-cutting measures. I think the way CMS
2 programs are currently structured, they primarily
3 focus on sort of settings or providers, right?
4 We have inpatient quality reporting, we have
5 outpatient quality reporting. We have, you know,
6 the PAC.

7 So we have all these programs, but yet
8 we recognize that cross-cutting measures are
9 really important. And certainly we've done a lot
10 of thinking and work to try and align measures
11 across programs to the extent possible. I think
12 there's still work to be done there.

13 But thinking forward to the future, I
14 think it would be great to get some feedback
15 about how we should be thinking about sort of
16 alignment in terms of these cross-cutting
17 measures. Because sometimes there are
18 constraints, right? Because sometimes you need
19 multiple providers working together to address
20 care transition, but then what's the appropriate
21 program to put that in given the current
22 structure of our programs?

1 ACTING CO-CHAIR GESTEN: Thank you.

2 So, David, did you want to speak to this point

3 directly? If not, I'll go back to my order.

4 Yes? Okay.

5 MEMBER BAKER: I think one of the
6 challenges that we've had through this meeting,
7 is we've got these different types of measures
8 and they're all intermingled. And we're really
9 doing very different tasks.

10 So one thing that we might think of is
11 imagine if we said, well, first we're going to
12 deal with the straightforward MUCs. Then maybe
13 we're going to deal with any of the statutorily
14 mandated measures, because our feedback on those,
15 we know they're going to go forward. As David
16 said, they have to go forward. And the feedback
17 on that should really be around, how can we
18 improve that, or how can CMS improve that.

19 And then there are others that are
20 under development. Because again, they're very
21 different mental tasks. And I'll use the analogy
22 for National Institute of Health, when we're

1 reviewing grants we divide up the big grants from
2 the small grants from the faculty development
3 grants. Right? Because you're doing totally
4 different tasks. You're viewing them with a
5 different light. So that might be helpful for
6 us.

7 ACTING CO-CHAIR GESTEN: So, let me
8 make sure I understand. You're posing sort of
9 three categories with the first being, you know,
10 ones that are on the MUC list that would be
11 evaluated in support, non-support conditions.

12 The second would be ones that you know
13 are going to go forward. And so the opportunity
14 here is to make this -- try to make it better,
15 knowing that there's some inevitability about it.

16 And then the third is truly things
17 that are under development, meaning they're on a
18 longer course, potentially, with no mandate, and
19 that those may be the buckets of response and/or
20 the process or the prioritization may be
21 different for those three.

22 Is that -- okay. Marla.

1 MEMBER WESTON: I think my comments
2 really mirror this whole conversation about the
3 need for cross-cutting measures and alignment and
4 coordination. I mean when I think about what our
5 responsibility is, it is as the coordinating
6 committee.

7 And so one of the things that we need
8 to think about how to do in the future is to look
9 across the workgroups. And I think part of what
10 is happening is because we look at the measures
11 sort of structured the way they came to us, by
12 workgroup, it causes us to drill down deeply.

13 And when I reflect on why many of the
14 measures were pulled off for discussion or for
15 vote, what was important was not that they were
16 pulled off, but why? And the discussion about
17 why was often around, we need to have cross-
18 cutting measures, we need to expand the settings
19 in which we have this measure.

20 So one of the things I would suggest,
21 in terms of process, is that when things are
22 being put off, that we capture the why ahead of

1 time, and that we look for patterns of how that
2 aggregate and then give us an opportunity to have
3 that discussion, because that's the coordination
4 part of our work.

5 ACTING CO-CHAIR GESTEN: Rich? Okay,
6 Rich Antonelli.

7 DR. ANTONELLI: Yes. Actually, there
8 was a prescient of you to put me in that order.
9 So, Marla, I agree.

10 What I would like to do is to maybe
11 try to capture this notion of, we'll call it the
12 phosphorous measure indicator. And to the degree
13 that measure -- that there are significant
14 measures in the pipeline that are reflective of
15 that, that aren't really going to add value, et
16 cetera, I think that the MAP, especially at the
17 coordinating committee level, and then within the
18 -- even within the standing groups, we should be
19 able to be as proactive as possible to let folks
20 know the kinds of measures that we're looking
21 for.

22 One of the things, and I note Helen

1 has been extremely supportive within the standing
2 committee and care coordination, to enable us to
3 be a little bit more proactive with defining
4 gaps, so one of the --- in addition to looking at
5 measures that find their way for consideration,
6 that encourage alignment and really get us to
7 value, I think we should have a process in place
8 by which we're tracking what we can do to
9 identify gaps and then following, over time, is
10 there activity that's now bringing measures
11 forward in to satisfy those gaps? That would
12 make a really cool dashboard indicator, for
13 example, at the level of the MAP.

14 And then finally I think what I'd like
15 to do is, there are some areas, like the standing
16 committee on care coordination, but then there
17 are care coordination measures that are being
18 considered in the pediatrics standing group and
19 sometimes those activities are really hard to
20 align.

21 So I'd like to encourage more clarity
22 about where those domains actually cross. Not

1 that they would be artificially separated, but in
2 fact to encourage the opportunity for cross-
3 collaboration and to possibly overuse or
4 overemphasize the word coordinate across those
5 various groups, especially as we start getting
6 into the area of identifying meaningful gaps.

7 MR. AMIN: Rich, can I just --

8 ACTING CO-CHAIR GESTEN: Yes. Go
9 ahead, Taroon.

10 MR. AMIN: Just to jump in here just
11 to keep this interactive. I think the --- just
12 to go back to the idea of core concepts that
13 emerged from our discussion in September, from
14 our perspective, the idea in the development of
15 the core concepts is a vehicle from which to be
16 able to identify the key gaps and the key areas
17 of alignment that we want to see both within the
18 workgroups across programs, but also across
19 programs.

20 And so a step toward development of
21 such a tool, an analytic tool by the coordinating
22 committee, will help us to advance some of the

1 objectives that were just discussed.

2 ACTING CO-CHAIR GESTEN: Great.

3 Heidi?

4 MS. BOSSLEY: Just to address a little
5 bit more some of the angst I think that we've had
6 over the last few days, and I've seen workgroups
7 do this as well, looking at those measures under
8 development. And also I think the other
9 category, and I don't know where they fall, are
10 the measures that are being updated in their
11 significant changes.

12 But I think until we can get to a
13 process where those measures, people know that
14 they will either go through NQF endorsement and
15 then the coordinating committee and the
16 workgroups can look at it again and know that
17 it's been evaluated, or that information is
18 provided on how it's performing. Do you have any
19 data on use, do you have data on reliability and
20 validity for that program?

21 Until we have that, I think you will
22 continue to see angst. Because it is, has

1 historically been, one and done. You see it
2 once, we give you an idea of what we think are
3 the issues, and then we're not sure what happens
4 to it again.

5 So I think that piece, if it's a
6 request or a new category, I don't know what it
7 is, asking that the information come back to the
8 coordinating committee, when it's past that
9 development phase, and now ready for rulemaking.

10 ACTING CO-CHAIR GESTEN: Jayne?

11 MS. CHAMBERS: So it's sort of fun to
12 sit here on the fifth anniversary and to think
13 about where this came from, concept, and how it
14 got put into the ACA and then has evolved to
15 where it is now.

16 And the number of programs for which
17 measures are now required, has probably -- I
18 didn't do the exact count, but it's probably
19 quadrupled since this started. So we have many,
20 many more quality programs that are requiring
21 measures with very different focus for what those
22 are.

1 I like the idea -- and the statute
2 actually requires this group to look at measures
3 that are going to be used in rulemaking in the
4 next year, in the upcoming year. So I think it
5 would be fairly easy to do a separate process
6 where you have the measures under development,
7 where we need feedback and discussion and want
8 input from a multistakeholder group that may have
9 various perspectives on this, and to separate
10 those measures from the measures that are ready
11 for prime time and for use in a rulemaking
12 process, and to think about how that might work.

13 It may come down to funding for CMS.
14 And that's, you know, probably an issue that
15 needs to be work through. But it strikes me that
16 we can separate those two without having to have
17 them in the same three month crunch time period.
18 Frankly we wish the statute were written
19 differently so you could get chunks of measures
20 throughout the year, but that's not how it came
21 out.

22 I do think the issue of measure

1 alignment and how we use cost measures or
2 efficiency measures, you know, what all of that
3 means, I think we need to look at that. And I
4 think we need to focus, as the coordinating
5 committee, on really understanding what each of
6 the payment programs is supposed to be doing.
7 And have a real good understanding of the effects
8 those programs have on the entities that are
9 being measured.

10 And so that may take some work for all
11 of us around the table to really delve into
12 programs that are not in our normal bailiwick, so
13 that we really understand the effects of those
14 programs, because there's a lot of interaction
15 among them. And for entities that are measured
16 under two or three different programs, which
17 measures are in which program really makes a
18 difference. So it just -- it's more complex, I
19 think, then sometimes we give ourselves credit
20 for looking at.

21 ACTING CO-CHAIR GESTEN: Thank you.

22 DR. BURSTIN: Just a --

1 ACTING CO-CHAIR GESTEN: Go ahead.

2 DR. BURSTIN: I just have a quick
3 question or a comment. Jayne, that's really
4 helpful and I know you know this stature very
5 well, so thank you for that too.

6 It requires us to look at measures
7 that will be used in rulemaking in the next year
8 but oftentimes the rulemaking is prospective,
9 three years ahead. So it may be the rule for
10 2018.

11 So it would be helpful to understand
12 how much of what we're seeing of measures that
13 are not yet quite ready are in rulemaking, but
14 they're not going to be used for three years
15 hence. So it would help to talk about it.

16 MS. CHAMBERS: I agree. Having, you
17 know, having more information about how we think
18 those measures are going to be used and when we
19 think they're going to be used, would be helpful.
20 And to the extent that it doesn't have to fall in
21 this three month period of time, where you can do
22 it on a more perspective period, if you're

1 thinking further out, you know, I think that
2 would be helpful, too.

3 DR. BURSTIN: That's actually really
4 helpful. Because we just get them lumped by the,
5 it's the upcoming rule. But it could be three
6 years' way. So that should cover that as well.

7 And I was really encouraged by Kate's
8 comments yesterday about the idea of thinking
9 about weaving the feedback loops in. So I think
10 that's a really opportunity for us.

11 And I'm glad Kevin's here, too. That
12 we need to really think about leaning out this
13 process and figuring out how to get that done.

14 Because everybody wants feedback from
15 the field. Many have offered it. We'd love to
16 be able to really bring that all together and
17 just make sense of it.

18 Because it's hard to do this work
19 without knowing the performance of the measures
20 in the field. It just continues to be the black
21 hole for us in endorsement and that.

22 ACTING CO-CHAIR GESTEN: Marshall.

1 DR. CHIN: So I'm going to try to tie
2 together some of the comments in a slightly
3 different take, a slightly different
4 complimentary angle.

5 And I think it's, for me, striking. I
6 think the past couple of times I've been on MAP
7 meetings, how the discussion, really the
8 discussion has been very, very micro.

9 I mean we're talking about like
10 individual measures and a great discussion of
11 issues. Sometimes we talked about an issue
12 raised at the top of this health one. Which
13 sometimes was very successful on the issue. And
14 very thoughtful.

15 But in some ways, where we don't, we
16 haven't had much of the holistic look. So even
17 like the setup to these slides, it's talking
18 about like identifying gaps. Gaps in what we do.
19 So micro gaps.

20 As opposed to thinking about, well,
21 holistically the measure sets we use, are they
22 selected to do what they're intended to do in

1 terms of bringing outcomes and quality of care
2 and providing value.

3 I mean if you look, I think, at the
4 public or the end users or, you know, the front
5 line people in the healthcare, in some ways we're
6 not directly addressing some of the concerns. So
7 for example, we referred, like some of the health
8 organizations today, some of the concerns
9 involved, like feasibility and burdens. That's
10 part of it.

11 But the fine line folks, there's a lot
12 of providers that burnout is a huge issue. The
13 concern. And the fear about like the EHR taking
14 over patient tier as opposed to you treat it, the
15 medical record, as opposed to the patient.

16 And the data collection, is it really
17 improving value. And when we see, for example,
18 like the op-ed, like Bob Wachter's from a couple
19 weeks ago, in terms of like the performance
20 measurement, is it really doing its job or is,
21 you know, the analogy, the education, no child
22 left behind, is really a measurement for

1 measurement sake.

2 So it's something, what Jayne just
3 said about, thinking about, well, what are the
4 outcomes, what we're doing? I mean are these
5 measures, for given programs, truly leading to
6 the improvement in quality and all that we're
7 aiming for or not?

8 Or is it the same thing like, you
9 know, the light and where we drop the keys. You
10 know, are we really sort of improving quality of
11 care in the things that matter to the patients or
12 not?

13 And so I'm glad we're having this
14 discussion. And I'm wondering, to what extend we
15 can build into the working committee or some of
16 this more holistic in other things. You know,
17 really clearly important work.

18 Because otherwise we, there's endless
19 work to do in terms of the rabbit hole of all
20 these micro decisions, micro measures to look at.
21 And we may just be missing the boat in terms of
22 some of the front line people, you know, that

1 were saying, well, you know, what are you doing
2 to address like overall quality of care and
3 making sure that the work that we do, on the
4 front lines, is meaningful.

5 ACTING CO-CHAIR GESTEN: So, while you
6 used different words, I think this may be
7 connected to the comment that Nancy made starting
8 out. Which is --

9 DR. WILSON: Yes.

10 ACTING CO-CHAIR GESTEN: -- from her
11 point of view, looking at what are we trying to
12 achieve. What's our objectives. And to what
13 degree are the measures and these initiatives
14 really getting us to where we want to go.

15 Of course, all of that layered in that
16 there actually is, that congress has spoken and
17 there's certain things that need to be in place -
18 -- whether they necessarily line up in the way
19 that, which we think they should, relative to
20 objectives.

21 DR. LARSEN: And can I just to comment
22 about this particular item?

1 ACTING CO-CHAIR GESTEN: Yes.

2 DR. LARSEN: So I think there's an
3 opportunity, there's another thing that's called
4 out by the Affordable Care Act called the
5 National Impact Assessment of the CMS Quality
6 Measure Reports.

7 I happen to serve on the federal
8 committee that builds the plan to analyze the
9 impact of quality reporting for CMS. And so that
10 is a every three year report; one just came out
11 in 2015. We're now in the process of building
12 what the assessment will look like for the next
13 report, which will be in 2018.

14 But it strikes me that we don't have a
15 lot of back and forth conversation between the
16 MAP and this impact analysis and impact report
17 that this work group does. So that I think might
18 be an opportunity here to link those two
19 Affordable Care Act required activities and
20 figure out where there is some cross pollination.

21 Where this committee can maybe review
22 and see what that impact assessment looks like,

1 but maybe even give some input into how the next
2 analysis in the report is structured.

3 DR. WILSON: This is Nancy. I think
4 that is really important. And I think that what
5 part of the cross pollination was because George
6 Isham was part of the group. I don't know even
7 know if that was, at some point.

8 But we had people in the, you know, in
9 the measurement world who were cross pollinating.
10 But we need to think about that more seriously.
11 And I think that's an incredible group for
12 figuring out what's the impact of what we've been
13 doing.

14 ACTING CO-CHAIR GESTEN: Thanks.
15 Lynda?

16 MEMBER FLOWERS: So, I'd like to go up
17 about another 1,000 aerial feet and go out way in
18 the future and suggest an answer to one of the
19 questions that was raised today, which was: what
20 are we trying to accomplish?

21 And when that question got raised the
22 first thing I thought about was the culture of

1 health. And how our healthcare system is slowly
2 but surely moving in that direction.

3 In the sense that its all of the
4 piece. And that there are many things that
5 impact health. Including your environment and
6 all of the mediating systems that are out there,
7 including housing, safety, access to food, et
8 cetera. Affordable food, healthy foods.

9 And then, so more and more the health
10 system is being pushed to engage in those
11 systems. So we now have the new CMMI Accountable
12 Health Communities Initiative. Which is saying
13 to hospitals and other providers, here is some
14 extra money for you to improve people's health,
15 not only in your setting, but apart from your
16 setting.

17 We now have the RWJ Initiative.
18 Culture of Health dollars going out. For people
19 to integrate health more broadly to address
20 disparities and other issues.

21 So I'm wondering if, futuristically,
22 there are opportunities for us to challenge the

1 work groups to think about the quality of these
2 other relationships in which they engage. With
3 CBOs, with social service agencies.

4 So that when we had that discussion
5 about anticoagulation therapy, you know, so if
6 you want the hospital to be responsible, they
7 have to know that they're handing off to a high
8 quality entity that can really provide, and has a
9 track record of providing.

10 So I think as we think about
11 integrating systems working across silos, there
12 are these intermediaries that are going to be
13 more and more brought into the picture, that are
14 going to have an impact on the success of this
15 payment system. And I think we should be
16 thinking about that futuristically. Thank you.

17 ACTING CO-CHAIR GESTEN: Thanks.

18 Rhonda?

19 MEMBER ANDERSON: A couple of things.
20 I would like to support what was just identified.
21 That was actually part of what I was going to
22 request.

1 But then I'd like to go back to what
2 David and Jayne and others have said about how we
3 can separate these. And a thought came to me,
4 when CMS removed, for discussion or brought for
5 discussion, some of the MUC measures.

6 And I'm wondering if there isn't
7 another category that would be part of that
8 differentiation. Where if CMS has some
9 questions, that they do what Marla was saying.
10 Where the questions are listed out there and the
11 why.

12 So that we understand their removal
13 for discussion. And what they're really trying
14 to get at.

15 Because as they bring forward all the
16 MUCs, you know, we're all responding to those.
17 The teams are, they work groups are, et cetera.
18 But then at this meeting it's a little confusing
19 unless we understand the why.

20 ACTING CO-CHAIR GESTEN: Thank you.
21 Harold?

22 CO-CHAIR PINCUS: So I have a couple

1 of semi-random thoughts about what we've been
2 discussing.

3 One, going back to something David
4 mentioned in terms of making a sort of
5 metaphorical kind of connection to reviewing NIH
6 grants.

7 That one of the things that, you know,
8 I've been involved with some aspects of, some
9 evaluating, sort of NIH processes. And one of
10 the thoughts that we've had on this is that
11 whenever you fund a grant, you're essentially
12 establishing a hypothesis that something will
13 happen as a result of that grant.

14 Yet NIH, for example, never actually
15 makes that hypothesis explicit. And if they did
16 make it explicit, it would be much easier to
17 evaluate their grant making process.

18 I think the same applies to the
19 measures as well. That whenever you implement
20 the measure, you're making some kind of
21 hypothesis that something's going to happen as a
22 result of that measure.

1 And it would be useful to be more
2 explicit about that, in terms of what the
3 expectation is. And that as a way to then follow
4 back.

5 And this comes back to some of the
6 discussions we had yesterday about what kind of
7 feedback process we want to have. To be explicit
8 about that. And then see whether or not in fact,
9 you know, two, three years later, that hypothesis
10 was in fact endorsed, or whether it wasn't.

11 And, you know, one can look at that
12 both qualitatively, and to some extent,
13 quantitatively. Here's the part of the random
14 thinking about that.

15 Is that, you know, it's kind of, I was
16 just thinking about sort of the, it also goes
17 back something that we talked about earlier, that
18 David brought up, about the phosphorous measure.

19 That, you know, when looking backwards
20 and looking at what measures have worked and
21 which ones haven't, you know, and I'm thinking
22 about this in the point of view of like we're

1 kind of in Academy Award season. And my family
2 actually has an annual sort of Academy Award
3 nominations pool that we do.

4 That, you know, which measures,
5 looking back on, do we think made the biggest
6 difference? And are there ways to emulate those
7 kinds of measures?

8 Like I was thinking about the
9 discussion we had earlier about, you know, the
10 hemoglobin A1c, its evolution in how, you know,
11 it's made a really transformative difference in
12 terms of, you know, how we sort of address
13 diabetes. But, you know, the phosphorus measure
14 doesn't do it.

15 And so just to think about, are there
16 certain measures that would get that kind of,
17 sort of Academy Award. And is there some ways,
18 what can we learn from that. So that thing about
19 the qualitative component of it.

20 Third point is, we should really give
21 serious thought to the, really the opportunity
22 that Kate made yesterday, about actually

1 systematizing and formulating a feedback process.

2 That we can have at, you know, the
3 most opportune, and to figure out at the most
4 opportune time to get that information. But also
5 what might be the template for how the
6 information might be presented to us.

7 So that it's not like a make work
8 thing that has to be produced, but it actually
9 is, really gets to the actual point of decision
10 making that helps us.

11 And I think some of these things are,
12 you know, some of the things people measure for
13 us. Some of it is sort of looking prospectively
14 at, you know, what is the plan for what measures
15 need to get out there and when, you know, Jayne,
16 I think you mentioned that sort of the three
17 years out kind of thing and the, you know, and
18 what sort of, what are the expectations going
19 forward, and how would that actually be
20 implemented over time?

21 But then also looking backwards at
22 the, you know, the impact of the measures and

1 trying to identify, you know, sort of what worked
2 and what didn't work.

3 ACTING CO-CHAIR GESTEN: Okay, thank
4 you. Pierre, were you in line was that the
5 leftover? David?

6 MEMBER GIFFORD: So I actually want to
7 go back to Lynda's point. I really liked it.

8 And sort of, as thinking as a
9 geriatrician with a huge group of baby boomers
10 coming along, we need to have a better dialogue
11 and a measurement around quality of life and
12 function and sort of what they want out there.

13 Most of the measures, when you step
14 back and look at that them, are really
15 medicalizing a lot of things and continue to have
16 a very medical, a very strong medical flavor to
17 them.

18 And I think that -- and we've heard
19 that from other various voices within NQF over
20 years about how do we get more of the patient's
21 voice and how do we get more satisfaction or
22 quality of life measures in there. But I just,

1 despite asking for it we don't see it. It's
2 still very medical.

3 Now some of it's because it's driven
4 by congress and payment in some of the issues
5 coming forward. But I think having that, the
6 important aspect.

7 And being, making sure that this
8 doesn't always go, well yes, we really want that.
9 But it's the payment measures we have in front of
10 us, it's Congress, either way, how do we use the
11 power of this entity to drive that?

12 Then a completely unrelated one is, I
13 think there's clearly -- and we saw some of it in
14 the measures -- a growing sense of composite
15 measures. And composite measures, from
16 individual composite measures, almost sort of
17 scale measures, to combining a series of process
18 measures, to even combining a series of outcome
19 measures, to now you have CMS doing a lot of
20 Five-Star ratings.

21 You know, we were one of the early
22 settings that had it, but now a lot of settings

1 have Five-Star. Well the Five-Star setting
2 itself is a composite measure of how they do
3 that.

4 And there's a methodology, an input
5 and waiting and idea for that. And it's really
6 in its infancy.

7 And I don't -- I think there's the
8 potential role. And I don't know whether it's in
9 the MAP or NQF, to look at how these star rating
10 systems, or composite measures that are not sort
11 of scaled within one particular clinical
12 situation, are being constructed and done. I
13 think some guidance would be helpful there.

14 And then I'll go down, back down to
15 completely at sea level. To Dave's earlier
16 comment.

17 I don't think we want parallel systems
18 of this MUD/MUC type of discussion. It's almost
19 you want to have two votes.

20 You want to have a vote, is it ready
21 for rulemaking now? What sort of conditions or
22 tweaks would we like to see if it goes into

1 rulemaking?

2 And then you almost want to vote a
3 second time. And this is, sort of Bill, I think,
4 has opened my eyes to it is, do we think this
5 measure needs more development? Yes. We like
6 this measure, just develop it more. Go with it.

7 It needs lots more development. You
8 almost want to have two votes. Every measure,
9 have two different sort of votes on it.

10 Because otherwise I think, and
11 watching the discussion by different committees,
12 even including the reviews that have happened in
13 CMS about measures that come through for
14 endorsement, there's a lot of concern that if
15 they don't approve something, that means it's
16 going to stop in its track. And everyone thinks
17 the measure is really important.

18 So is there a way to sort of say, not
19 stop it so in its track that it keeps going. And
20 I'm afraid if you have two different paths, you
21 still don't address that situation.

22 ACTING CO-CHAIR GESTEN: Taroon, did

1 you want to make a comment? Or ask a question.

2 MR. AMIN: Yes. This sort of, I
3 think, related to that last train of thought.
4 And also related to the question of the overall
5 role of the coordinating committee.

6 Just reflecting on the past two years,
7 what are the key sort of pieces of feedback that
8 we've heard from the coordinating committee?

9 Particularly between last year and
10 this year, was that procedurally to make sure
11 that the discussion -- and this is to Marla's
12 point as well -- around not setting up the
13 coordinating committee process so that it's just
14 an adjudication group that looks at all the
15 different work group deliberations and makes a
16 final recommendation that stamps the
17 recommendations of the work groups.

18 And so it's sort of a question as it
19 relates to, what do folks believe the role of the
20 coordinating committee is as it relates to
21 individual measure discussions?

22 To a certain extent, a lot of what

1 we've discussed in the past 45 minutes is the
2 role of the coordinating committee that folks
3 would want to see, which is related to
4 coordination.

5 And obviously there was comments
6 around potential improvements that could happen,
7 even in the work group structure. Meaning that
8 they're structured around settings. And that
9 could potentially be an area that we also look
10 at.

11 But even starting from where we are
12 right now, which is an introspective look at
13 ourselves, as you all, as the coordinating
14 committee, what really is the role of the
15 coordinating committee, vis-a-vis, individual
16 measure discussions?

17 And clearly we've funneled the amount
18 of discussions from significant to manageable, I
19 think, this year. Given the snow storm issue
20 aside, it was a manageable set.

21 But still, if you look at how many
22 were actually overturned, I mean one question we

1 could debate is, was the bar too high to
2 overturn? I mean we can revisit that question.
3 We certainly debated that quite a bit last year.

4 But to a certain extent, we didn't
5 overturn a significant number. And it's only to
6 say that it's, again, we've provided a
7 significant amount of feedback back to CMS in the
8 discussions. So there is value there.

9 So it's a question I guess I would
10 also pose to the coordinating committee around
11 its own role, vis-a-vis, individual measures.
12 And again, I would welcome comments from CMS as
13 well on that.

14 ACTING CO-CHAIR GESTEN: Yes, I would
15 just say, I don't know. I don't think the
16 committee knows whether the feedback we provided
17 was qualitatively or quantitatively different
18 then what might have been squeezed out of the
19 work group. Because we don't have access to all
20 of those comments.

21 So I think it was a productive
22 conversation, but I have no way of knowing if

1 it's the same issues that were raised in the work
2 group. And that would be, I think, important to
3 understand. In terms of the question about
4 what's the added value of having a repeat of a
5 conversation.

6 Because what I heard, a lot, from the
7 work group chairs was, yes, we talked about. We
8 mentioned that. We raised that as an issue.

9 So anyhow, Missy, you had a comment.

10 MEMBER DANFORTH: Yes. I just, I
11 tried to get in earlier to go back on this idea
12 around a MUD versus a MUC.

13 And one thing I'm wondering, if it
14 would be possible, because it was raised as an
15 issue yesterday and again today is, you know,
16 there's a number of measures over the past two
17 years about conditional support from the work
18 group. And the coordinating committee and the
19 conditional as NQF endorsement or NQF endorsement
20 plus a look at the respecer adjustment.

21 And there was acknowledgment that, you
22 know, nothing was ever done, you know, with

1 those. I'm wondering if like starting now we can
2 actually go back maybe at least for the past two
3 years, or even one year, and actually bring back
4 those measures that have gotten that NQF
5 endorsement. And have some way too so it will
6 automatically get back on the next MUC list or
7 some ad-hoc review of them by the committees or
8 this committee.

9 But it just seems like such a waste
10 when the developer goes through the work of
11 putting the measures together, putting them on
12 the MUC list, they're told that the only thing
13 that's stopping them from being put in their
14 program is NQF endorsement. They go through the
15 NQF endorsement process, and they never get back
16 on the MUC list.

17 I just think that that could be like
18 really discouraging to developers. A huge waste
19 of resources for the work groups and this
20 committee.

21 So if there's a way to bring, do a
22 retrospective look, get those measures back with

1 a status update, then a way to efficiently review
2 them, I just think that would be incredibly
3 important. And make that an ongoing process as
4 part of this work.

5 CO-CHAIR PINCUS: Helen, do we know
6 how often that is likely to happen or happens?

7 DR. BURSTIN: Yes. No, it's an
8 interesting comment, Missy, and we do need to do
9 a better job of understanding what happens to the
10 decisions each year and, you know, having more of
11 a retrospective view on it.

12 But I think part of what we're seeing
13 is, measures are going into programs before
14 they've hit the adjustment process. It's not as
15 if they're stopped in their tracks because of not
16 yet being endorsed. They're flowing in.

17 I think part of what we heard from
18 Kate yesterday was also this idea of that
19 feedback of what's happening, you know, post-hoc.
20 The measure have then been endorsed, they've been
21 in use, what do we know about its experience in
22 the field.

1 So I think it's just a lot more to
2 understand broadly about this issue of feedback.
3 And I would also just love to go back to the
4 question, you know, Kate specifically posed for
5 yesterday of, what information do you think would
6 be most useful to come back to the MAP?

7 So I think we should queue that up
8 potentially as a discussion to follow up, perhaps
9 on our webinar, in terms of, again, I think
10 there's lots of opportunities.

11 And, you know, explicitly said to work
12 with NQF staff to develop a feedback loop
13 process. So I think that, to me, is one of the
14 biggest opportunities to think about how we
15 change this process going forward.

16 CO-CHAIR PINCUS: Helen, would it be
17 useful to put together maybe a subcommittee to
18 work with staff to develop that?

19 DR. BURSTIN: That would be fabulous.

20 CO-CHAIR PINCUS: Okay. So that's
21 something, I think, is sort of a homework kind of
22 process.

1 DR. BURSTIN: Sure.

2 CO-CHAIR PINCUS: So Kevin and then
3 Heidi I think.

4 ACTING CO-CHAIR GESTEN: Jayne.

5 CO-CHAIR PINCUS: Or Jayne. No. No.
6 And then Lynda and Bill.

7 MEMBER FLOWERS: Okay, so maybe you
8 said it and I didn't hear it. But what keeps the
9 -- why when you send it back out for endorsement,
10 and it's endorsed, it doesn't get back onto the
11 MUC list? What keeps it from getting back on?
12 Which is what Missy just said.

13 MS. CHAMBERS: It doesn't need to be
14 on the MUC list.

15 DR. BURSTIN: Yes.

16 MEMBER FLOWERS: Oh.

17 MS. CHAMBERS: I mean once it's come
18 through and we've made a comment that it's, you
19 know, conditionally supported --

20 MEMBER FLOWERS: Oh.

21 MS. CHAMBERS: -- after it's gone
22 through NQF endorsement. CMS knows what our

1 perspective is. They can do with it what they
2 want. And it doesn't ever need to come back.

3 DR. BURSTIN: So measures under
4 consideration means they're still considering if
5 they're in. Once they're in, they don't
6 necessarily come back.

7 But I think that was part of the
8 discussion yesterday, what would you want know
9 about the experience of those measures, once
10 they've hit the real world.

11 CO-CHAIR PINCUS: Yes. And also that
12 whole, the whole sort of market basket of
13 measures for each of the programs sort of has
14 various subtle shifts that we don't necessarily
15 see --- is also part of the feedback loop.

16 DR. LARSEN: So I want to follow up on
17 Taroon's comment. In part about the, how do we
18 become more than just the adjudication of issues
19 that the work groups didn't handle.

20 And I think partly that's a process
21 question. If we mostly just meet at the very end
22 of this process, we're likely going to mostly

1 focus on those things because we're so sort of
2 distal in the process that we don't have time and
3 energy and analysis to do that work but, you
4 know, to upstream.

5 So some of this is to think about, if
6 we want to do coordination that's more than
7 adjudication, we need to think about what
8 upstream process that we continue to focus on as
9 the coordinating committee.

10 We've done a number of those things,
11 and so I'm not saying we don't. But I think it's
12 important to think about that in this.

13 And a couple of suggestions for areas
14 I think that have already come up in this
15 meeting. One is a consistent approach to risk
16 adjustment. We've talked and talked about this.

17 But we don't necessarily have guidance
18 on what the consistent approach, that the MAP
19 coordinating committee is going to kind of be
20 evaluating and looking at risk adjustment as it
21 comes through.

22 Another is this shared accountability

1 and attribution. So we really want it, we say we
2 really want it, and then every time it comes to
3 us we say, ugh, we don't want it like that
4 though.

5 And so I think there's an opportunity
6 for us to be proactive in this and say, yes, we
7 really want it. And this is an example or these
8 are the principles and criteria for how we really
9 want that shared accountability and attribution.

10 CO-CHAIR PINCUS: Just a comment on
11 that. I think part of the issue around the
12 shared accountability and attribution sort of
13 comes up in the context of sort of cross setting
14 kinds of measures. And also measures that our,
15 you know, particular program, that's not a cross
16 setting measure, but it should be for a cross
17 setting measure.

18 You know, so that's part of matching.
19 You know, and so I think that's part of the whole
20 picture.

21 So, Jayne?

22 MS. CHAMBERS: Yes, sort of building

1 on that. I guess one of the things I've been
2 struggling with is that my vision, or what I
3 thought the coordinating committee was supposed
4 to do, was be wearing a very broad lens and
5 looking at where the conflicts might be between
6 the measures that are coming forward from the
7 various work groups. Where those things could be
8 setting up unintended consequences as you go
9 through quality measurement and have a national
10 quality measurement program from a variety of
11 levels.

12 I don't think we should be looking at,
13 you know, did we overturn our measuring, did we
14 overturn our work groups recommendation. I think
15 it's using the various expertise around this
16 table to take a bigger picture look at, what does
17 this set of measures look like for use in this
18 program and how that might affect or relate to
19 other programs where they have quality measures.

20 And it's a hard lens to wear. But I
21 think that's part of what this group is supposed
22 to do.

1 CO-CHAIR PINCUS: But also, and I just
2 want to say, and, Pierre, I don't know if you
3 want to comment on this, sort of on the side
4 conversation we had during lunch, that your
5 perspective that you perceive at least a
6 different perspective from the work groups as
7 compared to the coordinating committee.

8 DR. YONG: Yes. So thanks, Harold. I
9 mean we were just having a conversation earlier.
10 Because I am the CMS rep to the hospital work
11 group. I typically have not come to, I listen to
12 bits and pieces of prior coordinating committee
13 conversations, but not in its entirety. Because
14 usually Kate has been the representative or
15 Patrick in the past.

16 It's been interesting for me to be
17 here today, particularly because having sat
18 through the hospital work group conversations, a
19 lot of the same issues around these measures were
20 surfacing. I think you've heard and you've
21 observed.

22 But at the same time, we do get a

1 much, I think, a slightly different and broader
2 sort of perspective here. Because folks that are
3 on the hospital world group committee were chosen
4 specifically because of their sort of interest
5 and expertise in the hospital world as opposed to
6 here.

7 You know, I was just commenting like
8 it was great to have a mirror here and here.
9 Have, you know, the AMA perspective here because
10 that's not represented in the hospital work
11 group. Yet clearly there are interests in the
12 web measures, in those, in the IQR program, the
13 hospital program. So that was my comment to
14 Harold earlier.

15 CO-CHAIR PINCUS: Bill?

16 MEMBER KRAMER: Just building on a few
17 of the earlier comments and adding a couple
18 others.

19 Looking back over the five years, one
20 thing I think we should, maybe is not recognized,
21 we should note, is that we were initially formed
22 as a multi-stakeholder group. And I think with

1 recognition that some cases there was conflict
2 between the perspectives and the goals and what
3 we wanted to do.

4 And I've been struck over -- and
5 that's how it was in the early days; there was
6 quite a bit of disagreement, let's say.

7 But I've been impressed this cycle
8 and, you know, in the years leading up to this,
9 about the high degree of consensus on at least
10 some of the core principles and our approaches.
11 It wouldn't bother there's still some differences
12 about methodological issues and so on.

13 It strikes me that there's been
14 significant progress, at least at this table and
15 a number of other tables you sit at, you know,
16 about things like the, while there's a role for
17 process measures, we try to emphasize outcome
18 measures; the desirability of composite measures.

19 Things like that that have sometimes
20 gotten us -- and also issues of accountability
21 outside the walls of the hospital or outside the
22 walls of, you know, what's under control of a

1 particular provider.

2 And I think that's a real
3 accomplishment. That's hard to articulate and
4 hard to describe, but I think most people who
5 have been involved would agree that there's been
6 a progress in that arena.

7 So I think functioning as a healthy
8 multi-stakeholder consensus group is a real
9 accomplishment.

10 This cycle, I think it's worth noting
11 that the work groups I thought were very
12 effective. And that hasn't always been the case
13 in the past.

14 And I think, at least the ones that my
15 team participated in, particularly the hospital
16 and clinician work groups, had strong leadership
17 and strong participation. And I think we saw
18 that in the materials that came to us. We ought
19 to give them a special shout out for the good
20 work that they did.

21 And finally, in terms of our role, I
22 agree with what Jayne just said about our role

1 being, looking at things in a big picture. And
2 that's more than just coordinating, which is the
3 title. Maybe we should rethink our title.

4 But we ought to be taking a look
5 across all of the measures to make sure we've got
6 a -- that it all makes sense.

7 We ought to be thinking forward about
8 what role we play and how we can be effective in
9 helping to drive the whole measure development
10 and consideration and recommendation loop
11 feedback. And that whole process is very
12 important.

13 So I would encourage us to look for us
14 to live that role in this coming year. And not
15 wait until next January to get together again.

16 CO-CHAIR PINCUS: Bill, thank you very
17 much. And I completely agree. It's really been
18 quite amazing to see the evolution of the culture
19 here.

20 And I think a lot of that is
21 attributable to the, you know, the really
22 extraordinary competence of the NQF staff. I

1 think to the way in which I think Beth and George
2 really sort of established a kind of a way -- a
3 process by which people can feel comfortable in
4 stating their opinion.

5 But, you know, really getting to the
6 point in being able to sort of withstand, sort of
7 questioning, but, you know, never really getting
8 out of hand with that. And really striving to
9 achieve what the real goals of this are, which is
10 really to improve the quality of the healthcare
11 for the country.

12 And so I think that that's really been
13 a, you know, a remarkable evolution. And I think
14 we're really at a good point.

15 I think there are things that we can
16 do to improve things in terms of being clearer
17 about sort of objectives, goals, definitions.

18 I think that putting forth a process
19 that will be able to get us systematic
20 information about the results of what we've
21 recommended and what's been implemented will be
22 enormously helpful. Because obviously we want to

1 drive our decision making as much on data as
2 possible.

3 And I think that -- and I totally
4 agree with your point about moving more quickly
5 to do that. And I think, you know, putting
6 together a small committee to think that through
7 with the staff would be very helpful. And also
8 involving CMS in that as well.

9 So I guess, Rhonda, last word. And
10 then we would move to public comment.

11 MEMBER ANDERSON: So just the last
12 piece, that I think we mentioned yesterday and
13 I'd like to not forget, because I haven't heard
14 it mentioned in this little round table, and that
15 is that, yes, we know the goal, improving health,
16 et cetera, et cetera.

17 But I think it was mentioned yesterday
18 that there still might be some core concepts.
19 And I know we didn't want -- we put that a little
20 bit to the side. But that there are some core
21 concepts or core principles in health improvement
22 that cut across everything.

1 And I haven't -- I think it's been
2 raised a few different times, not just this
3 meeting but in previous meetings, and I haven't
4 heard that there really is a response to that.
5 That there is either some cycle that will be put
6 in place where outside of the legal
7 responsibilities that we have, that we really
8 bring forward, what are those precious few
9 outcome measures that really will make a
10 difference to the health of the population at
11 large?

12 So I just don't want to forget that.
13 Because I do believe that that comment has come
14 up many times, and we haven't really addressed it
15 as a whole.

16 CO-CHAIR PINCUS: Thank you, Rhonda.
17 So Taroon, did we cover what you wanted to cover?

18 MR. AMIN: Absolutely. And if I could
19 just sort of highlight a few of the key themes.
20 And there was one additional question that came
21 up here, but I'm just going to cover it as we
22 talk.

1 You know, I think one of the key
2 themes that emerged from our conversation were
3 really identifying the key priorities and the
4 long-term goals. And clearly the topic that
5 Rhonda just mentioned as well.

6 There's this idea around the voting
7 and the measure categorization that David brought
8 up. And the way that needs to be handled, which
9 David also brought up, too --- that both David's
10 talked about.

11 And then third was this idea around
12 the feedback and the process development that
13 needs to occur in terms of a small group, of this
14 group, that advises.

15 And the need to bring in analytics in
16 a way that can measure our performance. Both in
17 terms of the recommendations and how they're
18 received by CMS. And then essentially how the
19 programs are currently structured.

20 So we will take all of this feedback
21 in terms of improvements, and we will sort of
22 work on bringing back to this group, at a later

1 date, some recommendations on a path forward.

2 So with that, I would say thank you
3 very much to the group. Thank you very much to
4 Harold and Foster for your leadership over these
5 two days.

6 And for all of you, for especially
7 those of you that traveled and had to travel or
8 were trying to travel and couldn't get here with
9 all the weather challenges, we sincerely
10 appreciate all the time to review the volume of
11 information that was in front of you, which is
12 not insignificant.

13 So with that, I'll turn it over to
14 Helen, if you have other comments for the rest of
15 the staff.

16 CO-CHAIR PINCUS: And then public
17 comment.

18 MR. AMIN: Then public comment.

19 DR. BURSTIN: I just want to say thank
20 you. I think it's been an extraordinary meeting.

21 And thank you for, Bill, for pointing
22 that out. Because it was definitely palatable.

1 This level of cooperation and willingness to hear
2 different points of view. It's truly changed
3 over time.

4 So I think that's a great
5 accomplishment. And that's what the NQF table is
6 all about. So I'm glad that's happening.

7 I just want to also say how
8 extraordinary this last hour or so has been. So
9 many of the issues that have surfaced are
10 actually the ones we've been grappling with as
11 part of our strategic planning effort that we're
12 doing right now.

13 And you have raised almost every
14 single issue, that we are prioritizing as we
15 speak, of the strategic planning for NQF. So
16 very prescient, thank you.

17 Incredibly informative and we're
18 really looking forward to thinking about working
19 with CMS, working with all of you. Not waiting a
20 year, to Bill's point as well, but really seeing
21 if we could gather some momentum and start
22 working with CMS to think about how we can make

1 this process much more fruitful going forward.

2 And also -- again, hammering this one
3 more time --- we can't effectively, as a nation,
4 do out work without feedback. We've got to be
5 able to build that into our system. So I'm so
6 delighted that became a major theme of this work.

7 And special thanks to Harold and our
8 Chair who was, you know, didn't have to serve but
9 did. So thank you to Foster as well. And we
10 hope Beth's family situation is improving.

11 ACTING CO-CHAIR GESTEN: And also Beth
12 who's been, you know, involved in these
13 strategies.

14 DR. BURSTIN: She's been so much work,
15 but had a family situation and couldn't come. So
16 we wish her well.

17 And thanks so much to all of you. And
18 thanks to the staff who did an extraordinary
19 amount of work, including two snow days when they
20 were technically off. So thanks to all of them.

21 CO-CHAIR PINCUS: So let's open for
22 public comment. From in the room, any public

1 comment?

2 Can we open up the line for public
3 comment by telephone?

4 OPERATOR: At the tone, if you'd like
5 to make comment, please press * then the Number
6 1.

7 CO-CHAIR PINCUS: Okay.

8 OPERATOR: Okay, one moment for your
9 comment.

10 MS. ISIJOLA: Tom James, did you have
11 a comment? Operator, can you open his line
12 please?

13 OPERATOR: Yes, one moment please.
14 Okay, his line is open.

15 MS. ISIJOLA: Tom?

16 DR. JAMES: Yes. Good afternoon, this
17 is Tom James with Baptist Health Plan in
18 Kentucky.

19 The question that I wanted to raise,
20 relative to improving the MAP process, has to do
21 with whether the kinds of measures we should be
22 looking at also include ones involving heuristic

1 decision making.

2 That is, having less information that
3 people tend to make good clinical judgments, both
4 physicians and patients, and whether that might
5 be some novel ways for future measure
6 development. Thank you.

7 CO-CHAIR PINCUS: Can you say a little
8 bit more about what you mean by that?

9 DR. JAMES: Yes.

10 CO-CHAIR PINCUS: Maybe an example.

11 DR. JAMES: Yes, there's, and I put
12 into the chat box some references. But there is,
13 I've been looking at the literature on how
14 clinical decisions are being made in an internet
15 era where people gather little bits of
16 information. And from that they form, from their
17 own experience, a view as to what is the correct
18 answer. And they come up with that correct
19 answer more often than one would suspect them, if
20 they were given lots of information.

21 This becomes problematic for us as
22 we've got 700 plus measures within NQF. It

1 becomes such a volume. And I certainly hear it,
2 now that I'm in the Heartland of the burden of
3 measurement.

4 And yet if we can come up with ways
5 where we use fewer measures, but have people use
6 their own cognitive capabilities, they may be
7 able to make the right decisions. Which is what
8 we want in the first place.

9 CO-CHAIR PINCUS: Well, thank you.
10 You said you sent along some references so we can
11 distribute that to the committee?

12 DR. JAMES: Yes.

13 CO-CHAIR PINCUS: Okay. Well, thank
14 you. Other comments?

15 OPERATOR: There are no other comments
16 at this time.

17 CO-CHAIR PINCUS: Thank you.

18 (Off record comment.)

19 MR. GRANATIR: This is Tom Granatir
20 with the American Board of Medical Specialties.
21 And I'm glad to have been here to have heard the
22 discussion.

1 I also have tremendous admiration for
2 the NQF staff and the work that the subgroups did
3 this time. Which is really terrific.

4 And in some ways made me really, I was
5 very grateful for this last conversation.

6 Because I had felt for a while that the
7 coordinating committee isn't doing enough
8 strategic thinking about how measures are to be
9 used and what programs they ought to be used for.

10 And if they were going to be voting
11 about anything, it ought to be about whether
12 these are measures -- and I would say a measure
13 set. Because I think seeing the measures in
14 isolation doesn't do justice to what you're
15 actually asked to vote on.

16 So is this what we want to hold people
17 and organizations accountable for through our
18 transparency initiatives, or is that what we want
19 to reward or not?

20 And I think that's what MAP was set up
21 to do, in addition to make recommendations about
22 measures.

1 But also to make recommendations about
2 how to achieve what we want to achieve. And I
3 think in a way that was what Dr. Sanghavi was
4 trying to say with his defense of the smoking
5 measure.

6 So I would very much like to see this
7 group really sort of rise to a different level of
8 conversation about the way -- not only the way
9 the measures are used, but also what the whole
10 basket of measures looks like that we're holding
11 people accountable for and trying to create
12 examples for it.

13 And we haven't had that kind of
14 conversation around this table. I think we need
15 to. Thank you.

16 CO-CHAIR PINCUS: Thanks. Well,
17 seeing no further comments, I think, again,
18 thanks to the NQF staff, thanks to all of you.
19 Thanks to all the work groups; thanks to CMS.
20 And look forward to getting together again soon.

21 (Whereupon, the above-entitled matter
22 went off the record at 2:05 p.m.)

A			
\$10,000 9:15	accuracy 170:1	168:15 173:15,19	186:5 263:18
A-G-E-N-D-A 4:1	accurate 110:14 133:9	180:2 181:21 188:15	affordable 199:2 210:3
a.m 1:9 5:2	169:14	271:20	239:4,19 241:8
A1c 52:12,13 53:18	accurately 28:21 33:16	additionally 202:1	AFL-CIO 10:9
246:10	49:1 119:8	additions 171:15	afraid 251:20
AAFP 134:14	achieve 238:12 269:9	address 14:14 20:17	afternoon 193:1,4,17
AARP 1:18	280:2,2	29:13,19 49:21 125:7	194:15 195:17 276:16
abbreviated 192:22	achieving 217:6	148:16 205:13 220:12	agencies 23:22 24:18
abilities 18:21	acknowledge 7:15	222:19 229:4 238:2	114:5 125:7 242:3
ability 24:9,19 111:5	acknowledges 120:9	241:19 246:12 251:21	agency 2:18 89:8 120:8
able 5:15,17 6:21 7:8,16	acknowledgment	addressed 30:12	agenda 85:10 193:16
11:13 29:18 59:4 78:5	255:21	153:11 271:14	aggregate 226:2
83:14 111:4 119:2	ACO 188:20	addresses 33:12,13	ago 59:20 236:19
122:10 133:7 137:12	ACOG 134:14 135:19	38:22 102:3	agree 55:16 56:13
157:1 160:3 164:9,22	Act 200:1 210:3 239:4	addressing 30:9 38:8	58:18 90:11 91:20
167:5 178:15 189:9	239:19	60:1 162:4 163:1	114:8,12,17 115:5
189:10 204:22 205:16	Acting 1:10,12 7:14	217:8 220:21 236:6	117:20 131:15 146:14
206:3,5 226:19	69:3 70:3,16 97:22	adequate 161:6	158:16,19,22 176:20
228:16 234:16 269:6	99:18 100:20 101:4	adequately 149:3	181:22 182:1 188:2
269:19 275:5 278:7	139:13 192:19 193:12	adhesions 135:17	214:16 226:9 233:16
above-entitled 192:16	208:22 209:5,19	adjudication 252:14	267:5,22 268:17
280:21	210:22 211:8,10	260:18 261:7	270:4
absolutely 11:19 71:10	212:22 216:4,6	adjust 119:9	agreed 31:6 32:18,21
91:20 188:11 216:6	218:15,21 220:8	adjusted 104:8	33:1 35:1,4 57:15
271:18	223:1 224:7 226:5	adjustment 8:22 9:1	65:20 145:9
abstracted 144:11	228:8 229:2 230:10	38:4,5,15 113:12	agreement 60:11
abstracting 133:19	232:21 233:1 234:22	119:6 127:10,15,17	agrees 142:5
abuse 40:6 184:5	238:5,10 239:1	128:5 169:13 175:6	AHA's 99:20
187:11 189:18	240:14 242:17 243:20	177:4 178:18 182:8	ahead 42:2 77:17
ACA 189:16 230:14	248:3 251:22 254:14	255:20 257:14 261:16	209:20 225:22 228:9
academic 17:2	259:4 275:11	261:20	233:1,9
Academy 2:8 246:1,2	action 98:19	adjustments 28:20	AHRQ 2:18 10:15
246:17	actionable 122:9	adjustor 15:10	133:12,13 146:20
accelerate 50:17	activation 29:17	Administrative 3:4	aiming 237:7
access 30:15,18 33:9	activities 122:2 203:12	Administrator 13:18	airwaves 6:18
36:16 82:9,11 104:6	203:14 217:2 227:19	admiration 279:1	alcohol 183:7 184:5
139:15,19 141:10	239:19	admission 38:12 127:1	185:1 186:5
185:13 241:7 254:19	activity 206:8 227:10	180:20	align 39:5 48:19 103:5
accessibility 185:10	actors 24:13	admissions 38:2 39:19	143:18 161:16 222:10
accessible 32:9	actual 157:21 179:13	128:14	227:20
accessing 50:13	247:9	admitted 184:3	aligned 24:4 84:1
accomplish 240:20	acuity 128:18	adopted 132:4	103:13
accomplishment 267:3	acute 16:5 28:15	adoption 187:13	alignment 8:3,4,5 46:17
267:9 274:5	126:12 181:1 197:14	Adult 97:21	46:20 103:2 114:16
account 82:12 104:2	ad-hoc 256:7	AdvaMed 1:15	198:21 222:16 225:3
181:4	adapt 136:15 218:14	advance 206:4 228:22	227:6 228:17 232:1
accountabilities 212:19	add 7:13 79:22 93:11	advanced 191:13	alignments 202:7 204:2
accountability 8:18	103:20 127:14 148:2	205:22	all-cause 180:6
29:9 34:5 46:9 103:16	148:9 189:4 226:15	advances 205:1	all-harm 32:4
105:10,17,18 118:14	added 181:17 255:4	adverse 36:8 37:19	all-payer 129:21 133:3
118:16 152:15 153:5	addictions 185:6	165:22 166:13 175:14	136:2 138:10,12
163:13,14 188:22	adding 265:17	advice 6:21 47:15 89:8	140:14,19 141:9,10
211:17 212:2 261:22	addition 7:21 16:13	advise 91:10	142:15 144:6 146:9
262:9,12 266:20	50:17 81:10 227:4	advises 272:14	146:21 151:17
accountable 15:2 21:9	279:21	advisory 89:3	alliance 1:21 49:11
120:22 159:15 241:11	additional 38:8 80:19	advocated 14:1	alluded 43:9 185:21
279:17 280:11	84:8 106:19 128:10	aerial 204:8 240:17	alternate 88:15
	167:3,15,17 168:4,9	affect 24:12,19 38:12	alternative 22:21 81:11

93:5
altogether 34:17
 175:10
alumni 102:16
AMA 150:10 265:9
amazing 268:18
AMBER 3:7
ambulatory 27:18
 38:20 50:10,18
America 1:17
American 1:12,16,19
 1:21 2:2,4,5,6,9,10
 3:11,11,12,13 22:1
 278:20
Americans 14:11 16:4
Amin 3:4 4:14 86:2,14
 86:16 93:11 94:2,5
 95:7 191:21 193:7,15
 200:15 209:4 216:2,5
 216:7 228:7,10 252:2
 271:18 273:18
Amir 2:6 91:19 94:22
 98:3 115:20 118:6
 126:14 151:22 180:8
 183:9,19 185:21
amount 31:2 32:14
 117:14 118:5 165:15
 253:17 254:7 275:19
ample 115:16 132:10
analogy 53:18 158:13
 223:21 236:21
analysis 239:16 240:2
 261:3
Analyst 3:7
analytic 228:21
analytics 272:15
analyze 239:8
and/or 43:13 84:20
 224:19
Anderson 1:12 11:9,18
 98:6 101:13 102:9
 115:22 116:4 142:4
 173:6 242:19 270:11
Andress 3:9 71:16,21
 72:1 73:5 74:15,17
 87:4,11
angle 235:4
angst 229:5,22
anniversary 210:5
 230:12
annual 17:9 74:6 106:4
 246:2
answer 156:11 184:15
 240:18 277:18,19
anterior 39:8
antibiotic 119:3 120:19
 120:22 121:5,6
antibiotics 116:14,21

117:12,22 118:3,4
anticipate 208:13
anticipated 199:21
anticoagulation 161:2
 242:5
antimicrobial 33:20
 115:19 118:8 122:2
 123:17 124:22
Antonelli 2:13 142:3,18
 143:3 226:6,7
anybody 9:13 10:13
 21:8 53:12 124:12
anyway 191:10
apart 241:15
apologies 209:16
apologize 72:2 171:14
 192:6
apparently 77:11 86:10
 193:10
appeared 148:6 206:14
apples 178:19,20
applicability 46:21
 113:15
application 146:10
 147:2
APPLICATIONS 1:3
applied 101:17 102:11
 147:14,15
applies 244:18
apply 123:17 183:16
applying 129:15 177:16
appointment 152:20
appreciate 12:9 138:3
 160:18 196:14 273:10
approach 29:9 35:11
 36:3 93:5,9 98:22
 204:1 261:15,18
approaches 266:10
appropriate 9:1 34:5
 46:14 59:13 61:8
 79:18 116:9,12
 117:12,15,22 118:1
 121:16 125:19 140:17
 144:20 148:7 161:8
 163:12 187:8 188:19
 213:9 216:16 221:14
 222:20
appropriateness 31:4,9
 123:18 179:2
Approval 202:15
approve 251:15
area 59:1,6 60:1 90:6,9
 99:15,15 101:14,15
 113:19 134:10 138:5
 138:6 160:20 165:18
 166:11 176:17 179:1
 179:3 228:6 253:9
areas 18:14 19:12 49:3

49:6,8,13 128:22
 197:13,21 204:9,17
 204:22 205:8,18
 206:3,12,14,17 207:3
 208:6 227:15 228:16
 261:13
arena 267:6
argue 61:8
arguing 72:15 150:7
argument 92:1,4,12
arrives 154:17
articulate 267:3
articulated 211:14
artificially 228:1
aside 253:20
asked 104:22 279:15
asking 47:11 76:9,10
 76:12,16 149:20
 218:11 219:19 230:7
 249:1
asks 121:22 173:10
aspect 102:12 249:6
aspects 244:8
assess 40:9 106:9,11
 106:14 189:10
assessed 73:8,11,21
assessing 30:15 35:3
assessment 64:5 98:17
 99:13 239:5,12,22
assigned 66:21 73:18
assisted 128:16
associated 9:16 52:17
 53:20
association 1:13,19,20
 2:2,9,10 3:11,12 22:1
 102:16
assume 86:9 137:5
assumption 63:22
Assurance 1:15
at-risk 143:7
attached 159:17
attempt 181:2
attempting 199:17
attention 20:20 23:18
attractive 143:5,19
attributable 101:22
 113:5 268:21
attribute 197:12
attributed 196:20
attributing 98:12
attribution 33:7 262:1,9
 262:12
automatically 256:6
availability 111:11
available 45:15 54:12
 94:7 100:9 122:5
 136:1
average 182:22

avoid 37:2
avoidance 41:18
Award 246:1,2,17
aware 14:3,20 22:6
 104:21 122:16 124:22
 184:7
awful 45:7

B

B 177:1
babies 129:17 135:9,14
baby 248:9
back 6:7 7:1 11:3 50:1
 62:3,3 64:15,21 67:16
 79:11 90:19 91:8,13
 92:14 95:2 97:4,5
 99:2 103:12 108:1
 116:10 125:14 126:6
 134:22 136:13 142:13
 144:13 147:17 150:20
 156:1,7 159:11 191:9
 192:4,11 194:1
 195:11,21 196:9
 198:7 208:16,18
 209:6 212:14 214:6,8
 219:7,12 220:6 223:3
 228:12 230:7 239:15
 243:1 244:3 245:4,5
 245:17 246:5 248:7
 248:14 250:14 254:7
 255:11 256:2,3,6,15
 256:22 258:3,6 259:9
 259:10,11 260:2,6
 265:19 272:22
background 12:13,20
 13:2 14:2
backwards 245:19
 247:21
bad 52:8,15 53:1
bailiwick 232:12
baked 123:5
Baker 1:13 50:22 52:6
 62:11 66:17 67:11
 79:22 82:17 110:21
 118:22 127:14 130:20
 153:19 154:2 156:19
 165:17 178:3,4 182:1
 185:21 189:4,13
 223:5
balance 135:4
balanced 29:9
ball 24:3
Baptist 3:14 276:17
bar 254:1
BARRETT 2:4
Barry 71:2 134:3 137:4
BARTON 1:14 172:9
base 186:9,15

based 16:9 17:12 18:14
27:17 31:13 59:3
67:14 73:8,12,18 75:8
75:10 83:5 88:8 102:4
104:1,8 126:20 133:9
136:20,21,22 163:5
baseline 21:2,9 104:1,9
baselines 120:11
basic 152:9
basically 36:22 51:9
84:3 106:2 190:6
basis 17:9 84:12
basket 260:12 280:10
bearing 47:13
bears 72:4
becoming 27:12
beg 64:17
behavioral 182:12,17
belabored 77:17
believe 14:6,17 15:16
15:18,22 16:10 17:1
18:8 19:11 20:2,19
21:15 58:8 59:8,13
101:18 107:2 117:11
121:4,6 142:9 143:1
147:7 162:1 204:19
252:19 271:13
benchmark 118:12
benchmarking 122:6
beneath 169:16
Beneficiaries 45:22
beneficiary 217:19
benefits 134:8 189:17
best 28:18 136:4 157:3
157:3,11 210:12
bet 124:1
Beth 269:1 275:11
Beth's 275:10
better 28:7,10,12 39:7
39:13 41:8 81:11
90:17 97:8 100:11
110:17 125:21 144:6
144:7,14 149:4 166:3
166:7 179:21 180:17
182:16 184:8 188:3
190:15,16 215:22
224:14 248:10 257:9
beyond 30:11 33:8
35:14 111:14 176:22
big 14:12,13 58:22
132:8 134:7 160:20
187:10,13 224:1
268:1
bigger 177:15 263:16
biggest 130:22 131:11
178:14 246:5 258:14
Bill 140:11 144:16
146:3 148:20 150:7

187:19 189:18 251:3
259:6 265:15 268:16
273:21
Bill's 274:20
bind 218:6
birth 129:4 145:18
birthday 193:21 196:8
births 135:16
bit 5:9 12:19 27:12
32:15 48:21 58:6
122:21 136:14 173:7
185:18 193:16 194:1
200:11 201:6 203:22
205:4 206:9 216:7
221:21 227:3 229:5
254:3 266:6 270:20
277:8
bits 264:12 277:15
BITTORIE 3:10 11:19
70:11,18 71:10
black 234:20
blended 105:8
block 179:17
blocks 179:7
blood 52:13 157:10
board 2:4 3:13 101:18
102:11 103:3 202:21
203:4 278:20
boat 237:21
Bob 236:18
body 17:2
bone 58:20 62:2
boomers 248:9
borne 114:5
BOSSLEY 3:11 65:3
229:4
bother 266:11
bottom 58:13
box 116:13 148:6
277:12
BPCI 175:9
brain 192:3
branch 218:4
brand 44:12
break 180:4
breaking 80:10
breaks 192:7
BRFSS 107:2,13 114:4
bridge 188:21
brief 9:21 157:13 179:5
186:4 187:6
briefly 15:20 144:18
bring 144:13 147:6
167:2 178:3 180:14
195:21 208:16 220:18
221:3,13 234:16
243:15 256:3,21
271:8 272:15

bringing 20:20 198:7
198:16 227:10 236:1
272:22
British 18:3
broad 15:17 180:21
197:12 216:10 263:4
broad-based 17:13
broader 14:18 15:12,18
19:6 45:19 127:16
265:1
broadly 13:14 14:22
15:11 133:15 241:19
258:2
BROTMAN 1:15
brought 53:7 93:16
117:7 178:17 179:2
179:18 183:17 188:4
220:13 242:13 243:4
245:18 272:7,9
browser 11:21 70:20
bubble 54:20
bucketed 197:10
buckets 224:19
build 177:3 237:15
275:5
building 22:15 122:20
179:7,17 239:11
262:22 265:16
builds 239:8
built 177:1
bulk 194:15 206:21
bundle 15:2
bundled 178:15
burden 16:16 20:15
35:11 107:14 114:7
138:16,17 278:2
burdens 236:9
burnout 236:12
BURSTIN 3:1 9:11
10:10,16 11:13,17
12:1 56:22 57:10,21
63:15 64:20 65:9
70:13 71:8,12 85:16
95:9 112:16 146:8,17
157:13 177:21 179:5
179:13 232:22 233:2
234:3 257:7 258:19
259:1,15 260:3
273:19 275:14
Burwell 218:1
business 2:1,11 45:7
button 10:7
bypass 60:14
bypassing 175:10

C

CABG 35:17 36:14
cake 196:8

calcium 54:17,19,20
66:8
calculate 82:12 133:8
calculating 133:12
calculation 76:21 82:14
calendar 43:2,3,14
calendars 207:7,8
California 141:15,18
call 19:8 107:16 209:13
226:11
called 70:17 179:10
218:5 239:3,4
camps 74:19
cancer 27:21 38:13
39:11,13
capabilities 278:6
capability 136:10
capable 159:22
capacity 12:17 70:9
104:3
capture 79:13 91:6 97:9
150:18 225:22 226:11
captured 7:1 28:21
159:9
cardiologist 12:13
care 2:9 15:2 16:5
17:14,20 18:7 22:16
22:22 23:1,9 24:2
25:14 28:8,12,18,22
29:4,7,19 30:9,15
31:5,8,10 32:7 35:22
35:22 36:17 37:6
40:10,10,21 46:10
50:9,13,15 51:11 52:9
59:10 105:8 109:20
119:7 123:9,18
126:12 128:14 132:4
132:18 133:7 136:22
137:1 141:16 152:12
152:19 153:1 155:18
156:20 157:11 161:11
161:17,19 162:4,7,8
162:11,16 163:1
164:1,6 165:4 175:10
175:15 176:5,19
186:21 199:1,2 200:2
205:20,22 210:3
211:20 221:22 222:20
227:2,16,17 236:1
237:11 238:2 239:4
239:19
cared 134:7
carefully 20:1 25:10
28:19 38:16
caregiver 205:22
Caregiving 1:21
caring 15:17
CARL 2:9

Carol 2:7 129:22 134:2 141:11
case 116:13 161:1 209:6 267:12
cases 266:1
cast 77:22
catastrophic 135:5,7
catch 164:9
categories 5:20 6:4 75:4 194:20 207:22 208:12 224:9
categorization 217:7 272:7
category 5:19 84:22 87:16 93:6,16 102:21 217:5 229:9 230:6 243:7
cause 14:4 165:20 191:13
causes 23:13 225:12
causing 213:12
cautioned 38:11
CBOs 242:3
CCSQ 13:18
CDC 2:17 19:20 20:1,7 107:1,11,15,18 114:6 117:7 119:16 120:8 122:1 124:4,12 125:7
CDC's 119:14
CDP 198:14 203:15
celebrating 196:9
center 12:16 27:18 38:20 190:22
centers 2:17,19 3:9,15 13:19 16:14 17:6 51:19 190:21
certain 74:7 86:12 106:4 159:7 238:17 246:16 252:22 254:4
certainly 8:21 58:18 63:21 70:18 72:21 113:8 138:9 217:22 222:9 254:3 278:1
certification 190:22 191:3
certifying 133:6
cesarean 129:5 131:8 134:15 135:1,2,9 145:18
cesarean-born 135:14
cesareans 135:15
cessation 33:10,14
cetera 10:2 64:14 84:1 84:1 101:16 116:12 116:20 182:9 226:16 241:8 243:17 270:16 270:16
chair 1:9 42:10 56:12

215:9 275:8
chair's 103:20
chairing 191:7
chairs 255:7
challenge 30:16 136:8 178:13 182:7 241:22
challenges 223:6 273:9
challenging 8:17 178:18
Chambers 1:16 10:5,6 88:19 99:20 101:2,6 109:10 117:18 137:13 144:5 158:8,22 230:11 233:16 259:13 259:17,21 262:22
chance 220:20
change 45:13 57:9 90:14 94:6 104:3 107:17 111:21 129:2 158:20 164:15 199:17 200:20 201:9 214:22 258:15
changed 44:13 201:11 274:2
changes 19:17 199:3,4 202:5 229:11
changing 128:19
chart 144:10
chart-based 138:13,19
chat 277:12
check 52:19
checkboxes 115:12
checked 62:15,17
checking 52:13,13,13 67:13 116:13
chemotherapy 39:21
cherry-picking 177:10
Chesley 2:17 122:19 124:2
Chief 3:1
child 236:21
childhood 135:13
CHIN 2:13 61:22 112:10 235:1
CHIP 1:21
chipping 123:6
choice 24:22 58:3 64:1 83:6 114:20 148:10 149:11
choices 68:7
cholecystectomy 170:15
cholesterol 52:14
choose 36:17
chooses 37:5
choosing 109:2 172:19
chosen 172:5 265:3
CHRISTOPHER 1:17

chronic 135:13
chunk 148:16
chunks 231:19
cigarette 115:14
cigarettes 111:9
circumscribed 143:7
city 107:9 108:12
claims 82:8,9 86:7 97:10 138:8,9 139:2 139:14,15,19,22 140:4,9 141:5,7,9,10 142:8 144:11 159:9 159:11,17 170:2
claims-based 32:11 81:8,17 83:22 85:18 138:7,20 139:1
claims-extracted 170:3
clarification 86:16 106:19 158:5
clarify 5:15,17 8:4 65:8 67:6 75:17 86:22 87:2 87:11 99:19 159:4 220:7
clarifying 68:3 71:18 75:18 162:20
clarity 6:5 227:21
clear 8:3 31:9 50:3 62:6 74:3 105:22 117:10 145:15 147:16 148:16 149:11,14 152:16 153:8 155:4 156:16 168:17 180:19 200:20 218:2
cleared 70:20
clearer 89:17 269:16
clearly 8:16 18:16 19:3 37:14 55:13 56:4 65:10 151:16 173:3 179:9 186:18 189:9 206:5 209:8 237:17 249:13 253:17 265:11 272:4
Cleveland 18:10,15 111:19
click 11:3 54:15
clicking 70:19
Clinic 18:10,15 111:19
clinical 3:11 62:4 72:11 72:17 73:3,7 75:9 131:6 138:15 176:8 180:16 197:12 250:11 277:3,14
clinically 62:1,8 168:6
clinician 26:8 123:9 158:10 191:8 197:11 199:20 267:16
clinicians 20:13 22:19 23:8 28:16 125:12

190:16
clinics 156:22
close 20:9 56:17 105:15 124:9
closely 35:20 36:16 38:6 48:19 128:5
closer 62:9
Closing 4:19
clustered 114:19
CMA 1:20
CMMI 241:11
CMS 2:19 3:10,15 6:6 10:20 12:17,17 13:14 13:18 14:19 25:9,12 34:12,16 44:14 47:14 48:17 49:19 58:7 73:17 74:8 75:19 79:11 86:4,7,17 88:10 91:2,5,14 93:13 98:2 103:3,10,21 113:2 114:22 125:7 126:6 128:20 130:2 132:3 133:1 134:5 137:8 139:15,17 148:18,22 149:11 150:12 160:17 166:19 173:7 174:12 190:13 191:12 196:21 197:17 205:12 213:4 213:13,18 214:19 216:13 217:11,15,18 222:1 223:18 231:13 239:5,9 243:4,8 249:19 251:13 254:7 254:12 259:22 264:10 270:8 272:18 274:19 274:22 280:19
CMS's 17:13 88:22 173:13
co-chair 1:10,11,12 5:3 7:14 9:7 10:22 11:5 11:15 12:2 25:16 26:1 26:7,11 27:6,8 41:21 42:3 45:17 47:4,7 48:2,9 50:20 52:4 53:2,5,11,14 54:6,17 54:21 55:3 56:11 57:12,14,17,19 58:5 59:15 60:4 61:20 62:20,22 63:3,7 65:2 67:2,18 68:11,21 69:3 69:6,11,16 70:3,16 71:1,13,19 72:22 75:11 77:1,4,10 78:4 78:10,17 79:2,10,21 80:4,16,21 82:15 83:17,19 85:9,20 86:10,15 87:6,14,22 88:10,16 89:22 91:19

92:21 94:1,14 95:6,13 96:9,16 97:15,19,22 98:4 99:18 100:18,20 101:4,9 102:13 103:19 105:3,20 106:16 107:20 109:8 110:19 112:9 113:21 115:15 116:2 117:17 118:6,20 119:10 120:1 121:17 122:18 124:2,9 126:4 127:9 128:7,12 129:1 130:13,15 131:17 134:2 137:4,19 139:3 139:12,13 140:11 141:2,11 142:2,16 144:4,16 145:8,14 146:3,11 147:11,20 148:11 149:5,10,16 150:20 151:2,6,19 153:17 154:7,14,22 155:8,20 156:15 157:12 158:6,18 159:2 160:4,5,15 161:20 163:3 164:10 165:6,12 166:14 168:17,22 169:8,10 169:12,20 170:5,19 171:2,5,21 172:7 173:5,17 174:3 176:12 177:18,22 179:12 180:1 181:18 181:22 182:10,11 183:19 184:1 185:20 186:11 187:20,22 188:1,13 189:12,14 190:18 191:4 192:13 192:14,19 193:12 208:22 209:5,19 210:22 211:8,10 212:22 216:4,6 218:15,21 219:2 220:8 223:1 224:7 226:5 228:8 229:2 230:10 232:21 233:1 234:22 238:5,10 239:1 240:14 242:17 243:20,22 248:3 251:22 254:14 257:5 258:16,20 259:2,4,5 260:11 262:10 264:1 265:15 268:16 271:16 273:16 275:11,21 276:7 277:7,10 278:9 278:13,17 280:16 co-chairs 2:21 42:5 43:10,17 208:21 cognitive 29:16 35:3	278:6 collaborating 104:11 collaboration 24:16 228:3 collaborative 42:17 141:16 198:5 collate 140:8 colleague 159:1 196:4 colleagues 130:12 180:22 collect 22:20 107:12 120:9 141:18 collectable 142:1 collected 16:14 107:1 107:10 collecting 22:19 33:17 107:15 collection 81:14 83:13 114:6 236:16 collectively 204:20 College 2:5,6 combining 249:17,18 come 6:7 13:4 22:2 62:2,8 64:15,21 89:2 90:19 91:8 92:16 97:4 97:5 104:22 112:13 118:11 142:13 147:12 147:17 149:12 150:20 179:21 192:4 195:10 195:13,18 214:8 230:7 231:13 251:13 258:6 259:17 260:2,6 261:14 264:11 271:13 275:15 277:18 278:4 comes 24:6 185:10 214:12 245:5 261:21 262:2,13 comfortable 42:18 269:3 coming 7:2 61:17 149:17,22 210:15 248:10 249:5 263:6 268:14 comment 4:4,9,17 12:3 12:7 13:1 22:4 25:20 51:15 57:13 58:6 60:17 67:18 71:2,14 71:18 83:9,18 98:10 102:21 103:11 106:7 115:21 122:11 124:5 135:20 140:6 153:18 156:1 157:13 160:16 165:18 171:22 185:5 189:21 193:5,10,13 208:5 211:2 218:18 218:20 219:1 233:3 238:7,21 250:16 252:1 255:9 257:8	259:18 260:17 262:10 264:3 265:13 270:10 271:13 273:17,18 275:22 276:1,3,5,9,11 278:18 commentary 6:17 79:11 commenter 34:16 commenters 33:1,22 34:4,11 35:1,4 36:3 36:12 37:17 38:14 39:17 183:17 commenting 265:7 comments 6:15 8:9 25:16,17,21 26:13,19 32:12,16,17,20 34:9 36:2,7 38:10 39:3 40:11 41:10,14 48:8 51:12 53:3,6 55:17 58:19 61:9 75:14 82:18 83:2,8 87:9 88:13 95:10,11,14 96:20 99:3,21 102:16 108:2 109:11 114:9 116:11 124:4 126:6 127:10,12 128:8,10 129:1 130:17,21 131:22,22 138:4 145:15 147:16 151:10 153:19 154:8 158:6 160:4 163:7 170:20 173:13 174:9 181:15 181:16,18,21 183:5 183:21 193:8,11 208:19 209:11 216:1 225:1 234:8 235:2 253:5 254:12,20 265:17 273:14 278:14 278:15 280:17 Commission 1:14 133:5 184:14 185:22 186:17 commitment 29:6 committee 1:3,8,14 4:7 9:17 10:1 21:19 42:9 42:14,15,20 47:5,21 48:12 49:14 53:13 54:1 57:15 58:19 65:14 66:1 69:19 72:14 81:10 84:8 85:10 87:3 92:1 104:19,22 105:12 112:21 113:7,9 120:7 121:16 129:14 131:15 137:6 151:12 154:10 154:13 157:16 167:3 182:12 183:13 186:13 187:19 188:18 194:18	195:21 202:15 207:1 207:4,12,14,15,19 208:11 211:6,15 212:16 225:6 226:17 227:2,16 228:22 229:15 230:8 232:5 237:15 239:8,21 252:5,8,13,20 253:2 253:14,15 254:10,16 255:18 256:8,20 261:9,19 263:3 264:7 264:12 265:3 270:6 278:11 279:7 committee's 131:19 163:4 committees 44:19 62:4 64:10 177:20 198:16 251:11 256:7 common 16:8 25:14 CommPartners 3:10 communicate 181:16 communicated 37:14 communication 46:9 46:14 199:1 202:8,16 communities 19:2 22:9 29:11 31:18 33:4 98:18 99:14 100:7 101:19 241:12 community 16:8 18:13 19:6,8 24:11 28:14 31:12 98:11,16 99:12 100:8 101:16,21 106:10 110:3 111:20 162:12 163:1 166:9 community-based 102:3 161:18 162:10 162:17 comorbidities 127:21 comorbidity 182:19 compare 108:6,17 109:17 132:7,8,19 168:11 178:19 compared 73:3 132:20 163:13 264:7 comparing 82:20 compelling 94:5 competence 268:22 competing 41:8 completely 90:1,11 114:8 214:16 249:12 250:15 268:17 complex 52:20 232:18 complexities 14:17 compliance 66:18 69:10 complicated 184:19 complication 156:8 178:21
---	--	---	---

complications 178:10
complimentary 235:4
component 72:6,17,18
 73:3,4 246:19
components 76:14
 177:1 189:15
composite 36:8 37:19
 249:14,15,16 250:2
 250:10 266:18
comprehensive 48:15
 126:6
concentration 41:18
 51:4 66:11 78:20
concept 13:21 59:5
 60:2 100:15 160:13
 162:6,21 167:9 169:4
 221:12 230:13
concepts 194:8 204:5
 204:21 206:6 228:12
 228:15 270:18,21
concern 33:16 36:13
 41:15 62:18 67:1
 79:12 105:22 108:13
 108:14 130:22 131:11
 150:6 153:16 160:21
 163:12 170:11 180:16
 183:18 190:3 236:13
 251:14
concerned 36:21 51:16
 100:9 143:8 145:1
 191:16
concerns 33:5,6,11
 36:7 37:18 39:18
 62:12 87:9 97:10,11
 99:22 108:7 110:22
 116:7 119:5,9 124:7
 124:18 125:9 127:17
 155:7 167:17 170:2
 236:6,8
concert 79:17
conclude 19:14
conclusion 63:1,1 80:3
conclusions 40:12
concur 90:2
concurred 38:14
condition 69:8 140:18
 146:11 155:4,16
conditional 68:2,6,8,15
 78:22 89:15 92:5 96:7
 96:13 101:3 118:18
 119:13 120:3 121:15
 122:22 126:16 142:12
 146:1,12,14 151:4
 152:6 154:21 156:10
 163:5 164:11,14,21
 165:11 180:10 181:13
 185:19 255:17,19
conditionally 33:21

41:12 123:13 130:8
 140:17 165:3 259:19
conditions 55:18 61:18
 68:7,9,13,17 87:18
 92:20 141:1 146:4
 150:3 182:20 224:11
 250:21
conference 1:8 134:13
confidence 165:15
confirm 170:17
conflict 266:1
conflicts 263:5
confronted 25:3
confusing 173:8 243:18
confusion 5:16 23:13
 80:7 148:17 213:13
congratulate 48:12
 134:9
congress 218:5 238:16
 249:4,10
conjunction 165:4
 168:13
connect 162:15
connected 51:11 238:7
connection 40:9 244:5
consensus 17:3 56:19
 134:12 177:19 202:6
 202:14,14 203:9
 266:9 267:8
consent 43:2,3,14
 207:7,7
consequence 115:10
 116:16 175:22 177:6
 177:11
consequences 35:21
 36:13,20 40:1 99:5
 101:11 102:8 176:19
 263:8
conservative 67:13
consider 38:3 40:20
 45:12 65:1 72:14
 103:21 104:7 113:5
 127:10 144:20 154:17
 208:16
considerable 165:14
considerably 201:11
consideration 6:9 36:5
 37:8 45:11 54:5 58:10
 90:5,7 99:11,17
 138:11,20 165:16
 202:21 227:5 260:4
 268:10
considerations 30:21
 44:21
considered 15:14 38:16
 40:14 64:18 72:6
 74:13 196:19 198:3
 227:18

considering 74:21
 149:19 150:1 260:4
consistency 200:3
consistent 93:18 94:8
 94:18 261:15,18
consolidate 43:6 195:7
consolidating 199:20
constituted 124:13
constraint 195:15
constraints 221:5
 222:18
constructed 90:16
 250:12
Consultant 3:4
consultation 13:22
consumer 108:22
 114:20
consumer/purchaser
 49:10
consumers 2:3 108:8
 109:1 136:9
contents 205:5
context 124:21 126:3
 200:12 262:13
continually 212:17
continue 20:6 21:20
 39:15 93:3 97:13
 148:12,22 204:12
 206:3 229:22 248:15
 261:8
continued 5:21,22
 35:10 36:18 37:6 45:8
 85:3 88:8 91:18 96:10
 98:1 99:10 101:5,6
 113:3,19 202:11
continues 202:5 234:20
continuing 6:8 8:9
 17:20 59:6 161:2
 174:10
continuum 28:8 44:11
contracts 10:1
contributing 127:22
control 2:17 13:20
 16:14 17:7 33:8 52:10
 52:17,22 53:19 59:17
 60:1 67:15 79:17
 98:13 111:6,14 112:8
 154:4 163:11 213:15
 266:22
convened 59:1 125:4
conversation 9:3,6
 31:11,15,17 40:15
 43:21 81:2,3 85:7
 88:9 159:20 192:22
 194:13 195:10 201:7
 206:21 225:2 239:15
 254:22 255:5 264:4,9
 272:2 279:5 280:8,14

conversations 8:1 28:3
 40:19 154:13 168:3
 211:5 264:13,18
convey 149:3
convincing 92:4
Conway 13:17
Cook 112:2
cool 227:12
cooperation 16:2 274:1
cooperative 16:19
coordinate 228:4
coordinated 24:4
coordinating 1:3,8 42:8
 49:13 69:18 151:11
 194:18 195:21 207:1
 207:4,12,13,15,19
 208:10 211:5,15
 212:16 225:5 226:17
 228:21 229:15 230:8
 232:4 252:5,8,13,20
 253:2,13,15 254:10
 255:18 261:9,19
 263:3 264:7,12 268:2
 279:7
coordination 16:2
 17:20 24:15 28:7,10
 162:7 199:1 211:20
 225:4 226:3 227:2,16
 227:17 253:4 261:6
coordinator 2:16 163:2
core 105:1 183:6 194:7
 204:5,21 206:6
 228:12,15 266:10
 270:18,20,21
correct 90:13 106:5
 142:22 167:1 170:18
 188:14 277:17,18
correctly 188:14
cost 32:1 36:4 45:6
 110:14,16,17 114:4
 127:3 175:2,11 178:7
 217:18 232:1
costs 177:9
couched 169:17
Coumadin 156:22
counseled 134:16
counseling 33:10 157:8
 184:5,6 186:4 187:7
count 230:18
counties 16:1 18:15
counting 8:7 82:22
country 21:2 25:1 103:8
 105:1 185:12 269:11
county 13:7 15:21 16:4
 16:5 17:5 18:5,11,13
 19:21 20:2 102:3,5,6
 104:2,3 107:9 108:12
 112:2,22 113:14

county-based 102:4
couple 5:7 41:16,22
 42:21,22 43:19 48:8
 60:5 120:14 131:20
 169:22 180:13 209:7
 218:16 235:6 236:18
 242:19 243:22 261:13
 265:17
course 25:7 105:11
 173:3 181:3 184:14
 184:16 201:4 216:9
 224:18 238:15
cover 35:7 203:16
 205:6 234:6 271:17
 271:17,21
covered 30:5,7 185:7
 201:12
CPHQ 1:17
craziness 92:10
crazy 120:4
create 122:13 123:4
 144:12 212:9 280:11
creates 8:5
creating 123:16 217:5
creatively 133:15
credence 44:19
credit 232:19
Cristie 42:9 43:16
criteria 184:22 219:5,7
 219:9,14,15,19 262:8
critical 13:13 20:21
 111:15
cross 212:19 225:17
 227:22 228:2 239:20
 240:5,9 262:13,15,16
cross-cutting 222:1,8
 222:16 225:3
cross-environment
 212:20
cross-payment 212:20
cross-setting 214:17
 215:1
crosscutting 191:19
 211:16
crowd 190:5
CROWNWeb 81:12
 83:13 84:4
crunch 231:17
CSAC 202:14
culture 240:22 241:18
 268:18
curious 59:15 130:2
 158:9
current 35:14 37:13
 59:11,22 63:11 66:19
 67:6,7 93:22 97:21
 99:9 124:20 149:2
 157:19 201:18 220:3

222:21
currently 15:8 16:1,6
 17:12 21:10 22:13
 30:2,12 35:15 37:9
 90:16 106:21 124:13
 138:8 168:8,11 222:2
 272:19
cut 270:22
cutting 225:18
Cuyahoga 18:11
cycle 89:10 266:7
 267:10 271:5

D

D.C 1:9 185:11
DANFORTH 1:16 48:5
 48:10 53:4 82:19
 84:17 88:4 94:4
 107:22 119:11 128:9
 130:17 131:18 154:9
 169:19,21 170:7,21
 171:4,16 181:20
 255:10
dangerous 156:5
 165:20
Darshak 3:14 12:12
dashboard 227:12
data 17:7,21 22:20 32:9
 32:10 33:17 58:12
 73:16 75:22 76:2,11
 76:12 81:12,13,14
 82:7 83:12,13 92:17
 107:12,14 110:13
 114:4,6 118:17 122:1
 123:6,7 126:19,20
 127:4 132:13 133:3,7
 133:16,19 137:7,8,9
 137:16 139:19 141:5
 141:9,10 144:1
 146:21 151:13 155:17
 169:13,14 170:2
 172:2 173:10 176:4
 187:2 212:6,7,9
 229:19,19 236:16
 270:1
database 65:7 84:4
 117:1 151:18 186:19
date 142:14 194:11
 196:18 273:1
Dave's 114:10 250:15
David 1:13,19 50:21
 52:4 54:6 60:4 61:21
 67:6 75:14 82:15
 88:12 89:22 91:21
 100:19 102:13 107:21
 109:9 110:19 114:1
 118:20 127:12 128:12
 130:15,18 153:17

155:21 156:9,14,18
 169:6,8 171:17 172:8
 174:4,5 178:3 181:19
 185:20 188:14 213:1
 216:8 219:20 220:9
 220:16 221:18 223:2
 223:15 243:2 244:3
 245:18 248:5 272:7,9
David's 156:1 272:9
day 4:2 5:11 22:8 23:12
 116:11 209:9
days 126:11 152:10,21
 157:6 175:2 188:16
 189:1 192:8 197:16
 201:5 206:16 216:10
 229:6 266:5 273:5
 275:19
deadlines 221:1
deal 7:17 177:5 223:12
 223:13
dealing 20:17 102:5
 214:17 217:1
death 178:9
debate 254:1
debated 254:3
Debjani 3:5 46:2,3
decade 134:22
decide 6:3 132:15
 152:3 153:15
decided 84:14
deciding 213:8
decision 89:20 93:12
 94:11 99:4 131:2
 132:9 176:8 207:22
 208:11 216:15 247:9
 270:1 277:1
decisions 38:13 41:9
 44:22 94:7 136:17
 195:14 208:15 237:20
 257:10 277:14 278:7
decline 201:21
declined 83:5,16
decreases 128:3,3
deep 194:19
deeply 225:12
defense 280:4
define 73:16 194:10
defined 84:20 208:14
defining 185:3 227:3
definitely 82:21 180:15
 273:22
definition 149:14
definitions 269:17
definitive 195:13
degree 226:12 238:13
 266:9
deliberate 19:19
deliberations 25:3

105:13 207:9 252:15
delighted 275:6
deliver 129:16
delivery 105:8 110:2
 129:5 132:7 145:19
 211:22
deluge 23:11,13
delve 232:11
demonstrating 199:16
denominator 15:15
 84:20 139:9
department 17:16
 39:20 127:19 165:21
departments 125:13
depend 17:20
depending 131:7
depends 215:9,9
Deputy 13:17
describe 267:4
designated 164:5 203:4
designation 57:2 203:5
desirability 266:18
desire 8:2 36:17 48:18
desires 37:2
despite 5:12 63:6 249:1
detail 216:7
detailed 39:18
details 86:12 181:11
 182:8 185:4
determination 72:12
 73:18 75:4
determinations 75:5
determine 89:4 197:21
determined 66:4
develop 7:3 79:16
 145:5 146:22 178:5
 251:6 258:12,18
developed 13:21 86:6,8
 102:18 107:5,18
 145:12 146:9,19,20
 147:13,18 161:8
 163:5 190:14,15
 197:18 208:1 216:14
 217:16 219:9 220:14
 220:19
developer 85:18 256:10
developers 49:20
 256:18
developing 6:10 59:16
 148:22
development 5:19,21
 5:22 7:10 20:4 21:20
 33:12 45:8 56:19 59:5
 85:3 86:1 87:15,21
 88:8 89:16 90:10,19
 91:5,8,12,18 98:2
 99:10 101:7 104:15
 107:4,6,8 113:3,19

144:21,22 146:7,16 146:18,19 149:18,22 150:3,14,15 191:14 194:21 197:19 198:11 201:3 202:7 203:9 204:4,19,21 206:6 207:21 208:2 213:7 216:12 223:20 224:2 224:17 228:14,20 229:8 230:9 231:6 251:5,7 268:9 272:12 277:6 DEZII 1:17 diabetes 246:13 diagnosis 141:19 dialogue 248:10 dialysis 41:13 51:19 66:8 die 182:21 died 82:22 Diego 42:12 dietary 52:21 157:7 differ 64:17 difference 23:16,19 24:9 127:3 187:3 232:18 246:6,11 271:10 differences 21:1 67:20 178:20 266:11 different 30:12 34:10 68:19,22 69:2 77:13 80:3 84:2 87:18 93:17 96:18 100:8 102:7 104:4,5,10 115:3 121:10 132:13 136:21 148:5 155:9 192:2 196:19 200:3 202:9 204:16 206:14 207:20 209:8 213:10,11 215:10 217:4 219:4,5 219:19,20 221:16 223:7,9,21 224:4,5,21 230:21 232:16 235:3 235:3 238:6 251:9,11 251:20 252:15 254:17 264:6 265:1 271:2 274:2 280:7 differentially 77:2 differentiation 243:8 differently 77:12,13 231:19 difficult 118:11 119:8 178:5 digital 123:4 dilemma 117:15 148:3 dinged 112:5 direction 15:5 43:22 85:1 122:17 136:19	241:2 directly 16:15 223:3 236:6 director 3:4,5,5,6,6 12:15 27:3 46:4 85:12 141:15 disabled 139:5 disagree 60:17 95:18 114:3 disagreed 41:11 131:19 disagreement 266:6 disappointed 49:6 disappointment 132:9 discharge 141:19 151:21 152:11,19 157:6 159:10,17 161:3 162:2 164:6,18 175:2 183:8 discharged 159:6,13 164:8 discharges 163:22 disclose 9:15 10:6,9,15 10:21 disclosed 10:11 disclosure 9:9 disclosures 9:13 discord 24:6 discouraged 48:21 discouraging 49:18 256:18 discuss 45:12,20 113:9 169:2 205:9 discussed 32:3 34:20 39:1,12 40:19 62:19 63:5 84:9 108:19 113:7 153:9,13 185:16 194:6 203:22 229:1 253:1 discussing 12:21 85:17 147:1 180:21 244:2 discussion 4:7 12:4 13:4 40:8 43:13 47:9 47:13,14,22 51:1,6,8 53:8 58:9 67:22 72:3 80:12 81:6 85:4 86:11 89:12 96:18 98:8 113:22 116:1,2,4 147:22 148:2 149:8,9 151:15,22 154:19 155:12 156:17 157:15 157:16 160:12,19 163:16 167:4,7 168:18 171:6,11,15 173:16 180:9 183:11 183:13 184:11 186:2 188:17 190:1 192:20 195:6,7,12,16 196:5 201:4,6 206:12,17,18	206:22 207:6 208:3 208:14 209:1,9 211:12 215:2 225:14 225:16 226:3 228:13 231:7 235:7,8,10 237:14 242:4 243:4,5 243:13 246:9 250:18 251:11 252:11 258:8 260:8 278:22 discussion-oriented 192:10 discussions 105:6 112:14 113:2 194:13 206:15 208:5 245:6 252:21 253:16,18 254:8 disease 2:17 13:20 16:14 17:7 28:1 40:17 58:20 78:20 96:4 135:13 disorder 185:1 disparities 241:20 display 168:12 disposal 18:9 distal 62:7 261:2 distinct 72:9 distinctions 5:18 220:7 distinctly 216:17 distinguishing 5:20 74:9 distribute 278:11 dive 194:19 200:12 divide 224:1 DNSc 1:12 documentation 29:6 doing 12:3 23:2 61:14 71:10 88:11 107:18 133:19 139:14 144:8 149:4,21 158:14 184:5 215:18 223:9 224:3 232:6 236:20 237:4 238:1 240:13 249:19 274:12 279:7 dollars 241:18 domains 227:22 door 19:5 double 8:6 doubt 14:3,20 downstream 212:8 Dr 9:11 10:10,14,16,18 11:13,16,17 12:1,9 27:6 56:22 57:10,21 58:8 59:18 61:22 63:15 64:20 65:9 69:9 70:13 71:8,12,15,20 71:22 76:14,18 77:3 80:18 81:1 83:10 85:16 87:1 95:9	104:17 105:5 112:10 112:16 121:19 124:3 124:11 138:2 139:6 139:21 141:4 142:18 143:1,3 146:8,17 157:13 160:18 161:21 162:19 166:22 168:20 170:18 173:14,21 177:21 179:5,13 190:19 209:15,21 211:7,9,12 220:11 226:7 232:22 233:2 234:3 235:1 238:9,21 239:2 240:3 257:7 258:19 259:1,15 260:3,16 264:8 273:19 275:14 276:16 277:9,11 278:12 280:3 draw 140:3 drill 225:12 drive 25:1 29:22 30:18 62:13 131:13 249:11 268:9 270:1 driven 249:3 driver 176:7 drivers 111:15 175:5 driving 25:13 drop 64:4 237:9 dropping 128:14 drug 43:5 165:22 183:7 drugs 32:1,2 dual 45:21 46:6 142:21 143:12 144:2 211:21 213:4 duals 46:4,11 due 34:6 90:4,7
E			
E 2:1			
e-measure 159:20			
earlier 53:16 84:6 98:9 108:1,19 145:9 158:4 182:21 189:22 211:12 245:17 246:9 250:15 255:11 264:9 265:14 265:17			
early 132:6 196:2 213:6 216:13 249:21 266:5			
easier 42:6 244:16			
easily 122:6 141:22 144:8			
easy 231:5			
echo 124:5			
echoed 36:12			
ECQM 144:9,12 156:12 159:19 160:1			
editorialized 18:4			

educate 108:22
educated 29:17
education 52:21 108:21
 236:21
effective 24:8 25:13
 267:12 268:8
effectively 275:3
effects 232:7,13
efficiency 9:3 172:11
 172:18 174:13,19
 176:21 178:6 179:8
 179:10,16,17 232:2
efficient 48:15 173:2
efficiently 257:1
effort 59:16 140:1
 202:11 203:8 274:11
efforts 19:8 34:3 111:17
 123:4 140:7 196:14
 198:6 203:18
EHR 28:12 33:17 103:5
 123:17 125:12 160:10
 236:13
EHRs 123:5 154:18
 155:6
eight 45:10
either 65:6 69:11 70:1
 75:2 120:5 130:8
 151:17 161:1 173:10
 229:14 249:10 271:5
elective 132:6
electronic 32:4 121:22
 138:15 163:6 189:7
element 188:15
elements 86:12 202:19
 204:3 206:2
eligible 78:5 134:15
 139:9 143:12 144:2
eligibles 45:21 142:21
 211:21
Elisa 3:2 112:17
ELIZABETH 2:3
Elliott 141:14
eloquently 176:15
email 69:20 71:4,6,9
emerged 28:5 206:15
 206:18 217:9 228:13
 272:2
emergency 17:16 39:20
 127:19 165:21
emerging 17:2
emphasize 13:10,13
 14:15 22:5 43:19 44:4
 111:1 156:20 194:22
 266:17
emphasized 6:13
employees 18:12,19
emulate 246:6
enable 227:2

encounter 17:15
encourage 16:2 28:22
 29:10 46:18 49:20
 98:1 99:10 101:4,6
 107:7 113:3,18
 128:20 133:1,14
 144:21 146:7,15,17
 149:18 150:2,13,15
 157:3,11 166:10
 227:6,21 228:2
 268:13
encouraged 40:3 42:20
 105:9 234:7
encouragement 47:14
encouraging 204:4
end-stage 27:22 40:17
 78:20 96:4
ended 70:15
endless 237:18
endorse 21:19
endorsed 19:21 54:1
 63:14,16,16 64:18
 83:4 90:5 92:10
 106:21 112:20 113:14
 117:8 154:6 179:6,19
 186:13 187:19 245:10
 257:16,20 259:10
endorsement 44:20
 57:1,3,16,22 58:10
 63:13 64:15 65:1,11
 65:14 89:18 147:7
 154:12 181:10 188:7
 198:15 202:17 229:14
 234:21 251:14 255:19
 255:19 256:5,14,15
 259:9,22
energy 261:3
engage 23:22 29:3
 111:16 187:16 241:10
 242:2
engaged 9:22 29:18
 111:20
engagements 205:11
enhancements 42:21
enormous 175:8
enormously 269:22
ensure 28:13,17,20
 36:15 152:18 202:7
ensuring 200:2
entering 189:11
entire 25:14 41:4
 109:13 125:11 133:7
entirety 264:13
entities 158:15 232:8
 232:15
entity 110:2 242:8
 249:11
environment 42:18

241:5
episode 172:22
episode-based 45:6
 169:4
episodes 168:7 175:14
 181:1
era 277:15
Erin 3:6 4:15 26:4 27:1
 30:22 31:20 34:18
 35:6 45:18
errors 94:21
especially 42:9 43:11
 61:12 187:10 216:22
 226:16 228:5 273:6
ESRD 40:21 54:8,14
 55:9 56:10 58:21 61:7
 75:19 80:11 81:14
essentially 16:16,17
 184:4 244:11 272:18
establish 120:11
established 18:17
 269:2
establishing 198:21
 200:1 244:12
establishment 205:21
esteemed 159:1
et 10:2 64:14 84:1,1
 101:16 116:12,20
 182:9 226:15 241:7
 243:17 270:16,16
evaluate 28:19 244:17
evaluated 194:3 224:11
 229:17
evaluating 244:9
 261:20
evaluation 147:7
event 37:19
events 36:8 166:13
 175:14
eventually 53:18,20
 153:4
everybody 7:19 11:11
 42:18 63:18 99:1
 112:5 117:11 142:5
 188:9 192:6 234:14
everyone's 195:3
evidence 120:18 184:8
 186:4,8,15 187:14
 203:2,6 220:4
evolution 4:12 194:2
 200:18 201:10 213:3
 246:10 268:18 269:13
evolve 124:19 212:17
 214:14
evolved 214:5,5 230:14
evolves 125:21
exact 118:2 230:18
exactly 42:19 54:2

156:14 211:9
examination 81:17
example 17:6 18:10,17
 75:7 132:6 162:5,6
 172:15 205:10,18,20
 221:8 227:13 236:7
 236:17 244:14 262:7
 277:10
examples 24:11 29:15
 111:18 280:12
exceedingly 139:8
 156:5
excellent 42:4
excess 126:11
exchange 189:8
exclude 78:9 83:4
excluded 166:11
excludes 81:19
exclusion 82:2 84:19
 184:20
exclusions 37:5 83:3
 184:16,18
excuse 174:4
executive 218:4
exemplifies 43:17
exempt 27:21
exercise 194:8
exist 39:10 123:17
existing 115:6 164:13
exists 21:10 84:15
 212:6
expand 15:15 30:6
 35:14 127:18 130:9
 168:9 225:18
expanded 30:6
expanding 18:21
expectation 245:3
expectations 247:18
expensive 110:9 185:8
experience 5:10 7:5
 34:7 118:13 119:17
 121:10 124:15 125:18
 133:18 191:1 257:21
 260:9 277:17
experienced 42:14 43:4
 43:10
experimental 120:6
expert 6:20 9:21 140:1
 140:5 157:6
expertise 263:15 265:5
EXPERTS 2:12
explain 20:5 73:2
explanation 89:1
explicit 72:6 140:22
 141:1 244:15,16
 245:2,7
explicitly 23:20 72:16
 258:11

exposure 104:5
express 49:2
expressed 37:17 39:22
 41:14 48:18 54:2
 111:1 124:18
expressing 36:7 49:14
extend 237:14
extending 134:8
extensive 184:17
extensively 198:5
 199:22
extent 56:16 222:11
 233:20 245:12 252:22
 254:4
extra 241:14
extraordinarily 5:11
extraordinary 268:22
 273:20 274:8 275:18
extremely 43:1 227:1
eyes 64:3 212:17 251:4

F

FAAN 1:12
fabulous 258:19
facilities 41:13 58:14
 66:14 81:9,13 119:7
facility 27:20 73:8
 82:14 83:11,12
 163:22 164:4
FACP 1:12,13 2:13,15
 2:17
FACS 2:4,5
fact 6:13 17:8 19:7 20:9
 23:1 72:4 104:8
 123:19 134:22 143:6
 157:19 179:16 182:18
 186:13 187:18 190:7
 195:8 207:5 228:2
 245:8,10
factors 33:7,8 40:14
 127:11,16 215:10
facts 64:8
faculty 224:2
fail 67:17
failing 66:22
fair 27:10 179:15
fairly 52:20 62:7 83:8
 231:5
fake 77:19
fall 229:9 233:20
falls 14:17 15:12 64:12
 102:20
familiar 73:10 81:2
families 2:8 29:3,11
 108:8,18
family 96:22 205:11,22
 246:1 275:10,15
fantastic 50:19 122:15

133:6
far 60:13 156:3 188:21
fashion 19:19
fast 218:12
fault 130:13
favor 54:3
favorable 88:6
fear 236:13
feasibility 236:9
feasible 140:21
fed 7:1
federal 2:15 78:8
 196:17 239:7
Federation 1:16,21
fee-for 15:1
fee-for-service 133:11
 133:22
feedback 6:7,11 7:4
 56:8 115:16 119:20
 149:20 165:15 167:3
 167:15 173:15,19
 174:1,11 180:2
 191:12 192:15 198:6
 198:8 209:6 213:6,18
 214:1,1 217:11 221:8
 221:15 222:14 223:14
 223:16 231:7 234:9
 234:14 245:7 247:1
 252:7 254:7,16
 257:19 258:2,12
 260:15 268:11 272:12
 272:20 275:4
feeds 75:3
feel 6:2 21:6 47:17
 137:2 269:3
feels 42:18 124:12
feet 240:17
Feldman 3:11 10:8,8
felt 28:6 32:5 37:11
 204:20 279:6
fewer 278:5
FHFMA 1:20
FHQCs 103:14
field 234:15,20 257:22
fifth 230:12
figure 8:10,19 60:6
 114:22 155:16 182:15
 239:20 247:3
figured 218:13
figuring 234:13 240:12
filed 82:10
files 141:19
fill 38:2
filling 191:15
final 96:12 252:16
finally 19:1,14 20:8
 21:12 29:21 30:14
 36:12 185:5 227:14

267:21
financial 1:20 76:1
find 49:19 227:5
findings 98:19 193:18
fine 101:7 236:11
firm 88:6
first 7:15 15:22 28:6
 42:7 47:20 48:4,10
 58:3 64:1 108:12
 121:5 134:4 135:20
 169:6 174:12 183:21
 198:6 206:19,22
 209:20 219:7 220:13
 223:11 224:9 240:22
 278:8
fit 54:13 109:5
fits 15:18 109:6
five 22:13,16 109:13
 193:19,22 194:3
 196:6,10 197:9
 200:18,22 207:3
 210:5 265:19
Five-Star 249:20 250:1
 250:1
fix 166:16
fixed 178:22
flag 210:15
flavor 160:12 248:16
flaw 82:1
Floor 1:8
Flowers 1:18 10:10
 161:10 162:9 165:1
 240:16 259:7,16,20
flowing 257:16
flu 18:18 81:20,21
 82:10,13
focus 23:18 105:9
 116:9 143:11 201:6
 205:19 206:3,21
 208:7 222:3 230:21
 232:4 261:1,8
focused 29:2 138:6
 173:1 176:17 192:22
focusing 138:1 200:7
 208:3
folks 7:18 10:18 26:12
 26:14 69:18 81:16
 82:22 170:8 193:6
 209:12 226:19 236:11
 252:19 253:2 265:2
follow 93:18 245:3
 258:8 260:16
follow-through 46:13
follow-up 152:20 161:6
 161:18 164:5
followed 93:19 134:13
following 66:15,19 67:7
 162:11 180:7 188:16

188:22 227:9
food 241:7,8
foods 241:8
force 195:15
forced 221:1
forget 270:13 271:12
form 124:20 277:16
format 7:3
formed 265:21
former 13:18 102:14
formerly 34:8 37:19
formulating 247:1
forth 125:15 212:14
 219:22 239:15 269:18
fortunate 27:5
forum 1:1,8 93:14
forward 7:12 9:6 23:10
 23:15 25:1 89:2 95:15
 99:9 103:10 104:14
 108:3 113:10 117:7
 142:13,15 150:4,10
 150:17 166:2 167:2
 173:9 179:20,21
 181:9 182:13 183:3
 195:11,20 199:15
 202:19 205:3 211:5
 213:7 218:3,7 221:3
 221:13 222:13 223:15
 223:16 224:13 227:11
 243:15 247:19 249:5
 258:15 263:6 268:7
 271:8 273:1 274:18
 275:1 280:20
forward-looking 203:17
 206:12
forward-thinking 192:1
 192:10
foster 1:9,12 3:12 4:3
 7:13 21:22,22 28:7
 70:4 139:12 191:5
 209:15 216:2 220:11
 273:4 275:9
Foster's 143:17
found 43:1 148:3
Foundation 136:17
four 17:16 166:18
framing 211:4
Frank 2:5 61:21 63:7
 121:18 122:18 125:9
 155:20 158:20 174:3
 174:4,8,8 176:12
 178:17
Frankly 231:18
frequently 160:6
fresh 11:21
Frieden 13:19
front 81:18 82:3 148:8
 175:21 236:4 237:22

238:4 249:9 273:11
fruitful 275:1
full 29:3 79:13 87:9
 96:2 126:5 150:21
fuller 7:8
fully 29:18 83:22 84:18
 85:6 86:6,8 87:8
 93:15 107:5 140:6
 145:11 146:8,19,20
 146:20 197:18 198:4
 207:22 216:14 217:16
 220:14,19 221:10
fun 191:5 230:11
function 26:14 209:13
 209:17 213:4 248:12
functional 8:14 29:16
 35:2,4 175:7 176:1,4
 176:6
functioning 98:15
 267:7
functions 213:10,11
fund 19:10 244:11
fund-raising 19:7
funding 114:6 231:13
funneled 253:17
further 7:9 43:13 45:12
 47:4 52:7 81:16 89:16
 90:18 102:18 104:14
 106:1 107:8,18
 144:15,21,21 145:6
 146:7,16,17,22 147:9
 150:2 168:18 191:13
 202:15,21 203:15
 234:1 280:17
fusion 170:15
fusions 172:15
future 4:13 21:15
 121:11 129:20 135:15
 135:16 138:14 179:21
 188:4,5 194:11
 208:17 222:13 225:8
 240:18 277:5
futuristically 241:21
 242:16

G

G 2:5
Gail 1:21 100:18 101:9
 221:20
gap 105:15 158:3
 160:20 173:12 186:18
 187:13
gaps 30:18 31:21 38:2
 39:2,9,15 40:19
 165:19 187:10 191:15
 204:2 227:4,9,11
 228:6,16 235:18,18
 235:19

gather 274:21 277:15
general 44:16 48:17
 106:2 108:3 182:17
 182:20 189:20 190:3
 195:19 216:1
generalize 186:9
generally 38:5,10 57:2
 57:6
generically 101:17
genesis 144:3
geographic 18:5
George 240:5 269:1
geriatrician 248:9
Gesten 1:10,12 4:3 7:14
 69:3 70:3,16 97:22
 99:18 100:20 101:4
 139:13 192:19 193:12
 208:22 209:5,19
 210:22 211:8,10
 212:22 216:4,6
 218:15,21 220:8
 223:1 224:7 226:5
 228:8 229:2 230:10
 232:21 233:1 234:22
 238:5,10 239:1
 240:14 242:17 243:20
 248:3 251:22 254:14
 259:4 275:11
getting 5:13 26:13
 46:20 60:8 70:14 71:4
 121:9 124:1 176:3,22
 198:8 216:13 228:5
 238:14 259:11 269:5
 269:7 280:20
Giff's 63:20
Gifford 1:19 54:6,7,19
 55:2,7 60:5 68:3,19
 75:16 76:16 79:19
 88:14,17 90:1 96:19
 97:17 102:14 114:3
 128:13 148:13 149:8
 149:13,17 166:9
 174:5,6 213:2 217:14
 248:6
gist 134:14 156:2
give 6:7,21 9:21 12:19
 27:11 44:18 56:7 58:6
 80:17 90:13 96:22
 115:7 116:14 135:22
 142:7 166:20 226:2
 230:2 232:19 240:1
 246:20 267:19
given 16:15 45:13
 59:11 61:9 90:5 92:20
 115:16 120:20 126:5
 148:7 154:4 165:14
 178:21 189:15 195:14
 205:5 206:17 220:3

222:21 237:5 253:19
 277:20
giving 12:22 28:17
 116:22 214:14
glad 100:15 234:11
 237:13 274:6 278:21
global 30:10 32:4
go 10:3 11:3 15:1 28:14
 32:18 42:1 46:6 47:8
 52:7 56:3,9 64:10
 65:5 73:6 77:22 90:18
 92:14 99:2 103:10
 108:1,16 112:7
 123:12 126:8 128:17
 142:15 144:14 150:4
 150:17 151:10 152:3
 155:22 157:7 171:5
 173:9 191:22 209:19
 209:20 213:7 214:3
 216:3 217:12,13
 218:12 219:7,12
 223:3,15,16 224:13
 228:8,12 229:14
 233:1 238:14 240:16
 240:17 243:1 248:7
 249:8 250:14 251:6
 255:11 256:2,14
 258:3 263:8
goal 100:14 195:12
 199:12 216:15 270:15
goals 29:7 204:16
 205:21,22 210:8,9,10
 210:13,18,20 213:17
 216:17 266:2 269:9
 269:17 272:4
goes 18:16 28:15 30:11
 61:6 64:14 99:9 108:5
 110:11 159:13 166:2
 245:16 250:22 256:10
going 6:10 7:12 12:10
 12:21 15:4 21:1 26:2
 30:19 31:15 38:17
 43:20 45:18 46:1 47:7
 47:10 50:1,22 51:19
 55:21 67:15 70:11
 71:1 75:19 76:6 78:8
 84:10 87:1 89:17
 91:22 95:15 96:16
 97:20 100:22 102:19
 103:10,18 104:17
 105:3 112:1 113:9
 116:10 121:12 122:21
 123:21 128:19 134:22
 140:16 142:7 149:12
 150:4 152:12,16,18
 153:3,5,15 154:5
 155:22 157:7,10
 163:3 166:6 172:17

174:7,20,21 176:14
 178:12 184:4 192:21
 193:5,14,17 205:2
 207:7 211:5 214:2,11
 214:12,22 217:15,17
 217:20 218:7 223:11
 223:13,15 224:13
 226:15 231:3 233:14
 233:18,19 235:1
 241:18 242:12,14,21
 244:3,21 247:18
 251:16,19 257:13
 258:15 260:22 261:19
 271:21 275:1 279:10
going-forward 84:11
good 8:4 43:15 56:5
 57:4 61:4 68:12 84:13
 85:21 100:14 111:18
 119:1 147:22 148:21
 156:20 160:14 186:3
 189:5 217:15 218:3
 232:7 267:19 269:14
 276:16 277:3
gotten 88:5 256:4
 266:20
government 2:15
 104:18 123:14 125:6
Granatir 3:13 278:19,19
grant 244:11,13,17
grants 10:1 224:1,1,2,3
 244:6
grappling 274:10
grateful 6:20 279:5
great 7:16 9:5 10:16
 12:1 100:14 101:9
 111:18 112:4 138:2
 145:17 154:18 172:17
 190:8 199:15 209:18
 222:14 229:2 235:10
 265:8 274:4
group 1:16 2:1,2,11 8:1
 12:10,21 13:4,6 25:9
 28:6 29:2,21 30:4
 31:20 35:17 38:7 39:1
 86:19 95:3 112:12
 142:9 170:8 173:8
 196:2 202:12 207:11
 211:21 227:18 231:2
 231:8 239:17 240:6
 240:11 248:9 252:14
 252:15 253:7 254:19
 255:2,7,18 263:21
 264:11,18 265:3,11
 265:22 267:8 272:13
 272:14,22 273:3
 280:7
group's 21:19
groups 103:6,8 108:22

211:20 226:18 228:5
 242:1 243:17 252:17
 256:19 260:19 263:7
 263:14 264:6 267:11
 267:16 280:19
growing 249:14
grown 48:13
grudgingly 155:2
guess 5:5 53:15 54:7
 63:1 65:3 75:16 90:14
 106:7 108:12 114:3
 143:3,20 158:8
 183:15 254:9 263:1
 270:9
guidance 13:3 25:12
 89:15 197:17,20
 214:15,18 215:6
 250:13 261:17
guide 80:12 96:18
 171:6,11
guidelines 39:6 62:16
 66:20 67:7,8 79:14,18
 134:13 172:16
guiding 204:14
GUNDLING 1:20

H

HAC 27:22 37:7
HACs 30:11 201:22
 202:2
half 116:11 195:1
 196:22
half's 209:9
hammering 275:2
hand 26:14,16,17 48:6
 83:21 93:9 209:13,16
 269:8
handed 24:7
handing 242:7
handle 100:2 121:9
 260:19
handled 44:1 216:18
 272:8
handoff 45:7 156:6
hands 123:9
hanging 103:17
happen 122:9 239:7
 244:13,21 253:6
 257:6
happened 251:12
happening 99:12
 120:17 203:12 212:1
 212:18 225:10 257:19
 274:6
happens 17:15 102:5,6
 122:7 156:4 214:9
 230:3 257:6,9
happy 24:14 34:11

47:18 135:11,18
 196:8
hard 25:5 109:3 196:10
 217:2 227:19 234:18
 263:20 267:3,4
harm 30:11 32:4
harmonization 92:8
harms 135:8
Harold 1:9,11 4:3,14
 7:21 42:8 79:19 85:11
 91:6 93:11 96:19
 130:10 142:19 147:21
 165:1 179:6 218:22
 218:22 243:21 264:8
 265:14 273:4 275:7
hat 104:18,19 183:4
head 13:18,19
head-turning 22:3
heading 75:18
heads 71:16 218:17
health 2:1,11,16 3:14
 12:16 14:10 15:16
 21:17 22:7 23:6,20,21
 24:18 31:18 33:2
 98:16 99:12 100:6
 102:15 103:1,15
 104:6 106:10 110:7
 112:12,21 113:9
 114:5 121:21 125:2
 125:13 182:12,17
 189:17 223:22 235:12
 236:7 241:1,5,9,12,14
 241:18,19 270:15,21
 271:10 276:17
healthcare 1:19,20 2:4
 2:18 23:7 25:1 104:11
 105:19 110:2,3
 114:14 115:1 121:8
 125:2 164:5 182:17
 202:3 236:5 241:1
 269:10
healthy 241:8 267:7
hear 53:11 71:21
 117:19,19 124:3
 145:4 169:6 175:12
 185:15 259:8 274:1
 278:1
heard 7:21 8:8 31:14
 45:2 48:11 68:4 84:13
 92:1 93:17 102:17
 113:12 158:4 168:2
 199:14 248:18 252:8
 255:6 257:17 264:20
 270:13 271:4 278:21
hearing 89:12 142:4
Heartland 278:2
Heidi 3:11 65:2 229:3
 259:3

held 159:11,14
Helen 3:1 57:20 63:10
 112:11 154:6 157:12
 166:5 177:19 226:22
 257:5 258:16 273:14
help 6:15 47:15 105:15
 106:9,14 110:18
 111:17 112:1 154:5
 228:22 233:15
helped 43:6
helpful 21:7 56:14 94:4
 100:22 126:1 174:22
 191:14 194:1 224:5
 233:4,11,19 234:2,4
 250:13 269:22 270:7
helping 22:20 23:14
 122:13 268:9
helps 197:20 247:10
hemoglobin 52:12
 53:18 246:10
heuristic 276:22
HHS 13:14
hi 10:18 12:9 21:22 27:8
 42:8 46:3 48:5 85:11
high 41:19 65:10
 137:11 166:15 182:19
 242:7 254:1 266:9
high-priority 23:18
 49:21
high-risk 17:8 143:12
high-volume 38:8
higher 101:15 175:14
highest 202:22 203:1,6
highlight 42:22 121:19
 271:19
highlights 124:17
highly 144:2 189:15
historical 200:11 212:4
 214:6
historically 105:16
 230:1
history 134:15
hit 171:11 257:14
 260:10
hold 20:9 36:22 279:16
holding 21:8 70:21
 280:10
hole 234:21 237:19
holistic 28:22 41:3
 235:16 237:16
holistically 235:21
home 103:15 163:22
 164:8 175:7
homework 258:21
honestly 216:19
hope 5:7 15:5 25:7
 49:19 96:22 166:1
 275:10

hopefully 20:22 138:14
 138:16 180:4 191:12
 192:2
hopes 14:9
hoping 105:7,14
hospice 35:22 36:17
 37:1,5
hospital 1:13 2:21 3:12
 4:5 12:8,20 13:8
 15:21 16:5,21 17:11
 17:14,17 18:1,7,19
 21:19 22:1,11 26:6
 27:4,11,16,21 28:11
 28:14 29:8 32:7 35:7
 35:9 37:22 39:11
 42:10 44:5 46:7,19,21
 48:20 50:10 92:2,17
 95:3,18 102:1 103:4
 107:4 108:5,6,11,16
 108:16 109:2,7,13,17
 113:6,15,17 114:18
 128:17 132:7,19
 133:8 134:19 145:20
 151:21 152:15 153:10
 154:15,20 156:6
 158:9,10 159:5,16
 161:2,4,5,9,12,15
 162:2,16 163:13
 164:18,19 167:19
 168:11 175:3 176:4
 186:8,10 187:15
 188:21 191:1 197:14
 199:10 242:6 264:10
 264:18 265:3,5,10,13
 266:21 267:15
hospital's 33:8 100:5
 111:14
hospital-based 119:17
hospitalization 126:12
 180:8
hospitalized 125:1
hospitals 1:16,22 16:3
 16:15,17 17:4,9 18:8
 18:21 19:1,2,10,12
 20:10,13,14,20 22:5,8
 22:14,14 23:4,8,21,22
 31:17 32:8 33:3 50:2
 77:8 98:16 99:13
 103:17 104:11 106:3
 106:9 107:11,13
 109:19,21 111:5,16
 112:3,7 114:11
 116:16,20 119:2,20
 120:14,20 121:2
 124:7 128:14,22
 133:17 138:18 155:18
 159:21 176:11 189:6
 241:13

hot 199:2
hour 195:1 208:4 274:8
hours 164:6
House 125:5
housing 241:7
huge 140:1 236:12
 248:9 256:18
hundred 120:13,14
HUNT 1:21 101:10
 102:2
hypercalcemia 65:21
 66:5
hypothesis 244:12,15
 244:21 245:9

I

ICU 127:1
ID 69:20
idea 20:14 43:15 113:18
 129:16 145:3 151:12
 166:7,21 194:6,6
 228:12,14 230:2
 231:1 234:8 250:5
 255:11 257:18 272:6
 272:11
ideal 157:19 160:8
Ideally 159:12
identified 31:21 32:1
 90:8 207:2 210:7
 220:16 242:20
identifies 203:5 204:9
identify 59:4 202:22
 204:22 227:9 228:16
 248:1
identifying 134:10
 204:17 210:20 228:6
 235:18 272:3
Ill 1:21 3:14
illness 182:19 183:1
illnesses 116:18
imagine 112:4 217:3
 223:11
impact 7:10 14:10 17:4
 18:22 19:13 33:7
 40:14 45:21 177:17
 199:22 200:13 201:14
 239:5,9,16,16,22
 240:12 241:5 242:14
 247:22
impacted 18:6
impacts 20:18
implement 110:10
 138:18 244:19
implementation 38:16
 87:16 155:6
implemented 35:19
 36:15 40:2 94:13
 152:17 247:20 269:21

implementing 138:12
implications 138:1
 139:4
importance 13:13 22:6
 59:9 111:7 129:18
 203:22 221:22
important 5:15 6:19
 19:9,18 31:7 44:21
 46:10 50:2,5,12 51:18
 58:20 59:10 60:21
 79:10 83:8 95:10
 98:21 101:21 102:22
 103:1 109:2,6,16,19
 111:2,8 113:19 121:5
 121:7 123:3 129:12
 138:4 141:20 142:5
 145:5 155:15 160:20
 162:21 165:18 167:8
 173:22 174:18 176:7
 176:17 177:2,6,13
 180:15 182:2 190:5
 211:4 221:14,19
 222:9 225:15 237:17
 240:4 249:6 251:17
 255:2 257:3 261:12
 268:12
importantly 6:5,12
impressed 266:7
improve 22:7 23:6,7
 34:12 109:20 110:7
 184:9 188:10 223:18
 223:18 241:14 269:10
 269:16
improved 17:3 18:6
improvement 2:4 29:22
 34:3 51:11,14 56:5
 61:3 73:13 115:13
 119:4 122:8 134:11
 152:12 206:13 208:7
 237:6 270:21
improvements 34:14
 37:12 52:22 253:6
 272:21
improves 127:1
improving 209:7
 236:17 237:10 270:15
 275:10 276:20
in-depth 6:20
inaccurate 170:3
inappropriately 120:20
incentive 16:6 28:1
 40:18 54:9 55:10 61:7
 77:9 78:21 96:4
 167:19
incentivized 16:11
inception 42:16
inclined 56:13
include 8:2 76:10 130:5

132:11 137:10,17
 187:6 276:22
included 33:6 35:15
 41:17 87:9 171:13
 186:16
includes 8:13 33:14
 35:15 125:12
including 24:17 27:16
 29:1 132:12 136:3
 241:5,7 251:12
 275:19
inclusion 13:8 34:1
 55:9 66:10
increase 35:12 197:4
 198:22 200:9,22
 201:2
increased 135:13
increasing 17:21 135:7
incredible 7:20 138:17
 240:11
incredibly 6:19 49:12
 50:5,12 184:18 185:8
 257:2 274:17
indicate 83:14 138:4
indicated 39:17 173:4
 202:12
indicative 31:8
indicator 226:12 227:12
individual 2:12 43:7
 99:14 169:3 185:7
 215:18 235:10 249:16
 252:21 253:15 254:11
individuals 47:11
 151:20 164:18
inevitability 224:15
infancy 250:6
infection 119:17
infections 116:18
influence 31:18 203:8
influenced 44:22
influenzas 203:13
influenza 80:11 92:6
 96:2
inform 47:15 51:17
information 2:16 6:1,2
 6:3 28:13,15,17 31:9
 32:6 46:15 56:15
 80:20 81:15 82:11
 86:3,19 93:17,20 98:8
 99:4 108:9,10,15,20
 109:16 114:21 120:10
 120:10,12,15 122:5,9
 136:1,20 140:3 150:9
 150:11 167:10,10,22
 168:5,10,15,16 172:6
 173:11 189:8 195:5
 198:16 202:16 220:3
 229:17 230:7 233:17

247:4,6 258:5 269:20
 273:11 277:2,16,20
informative 274:17
informed 41:16 134:20
 136:16
infrastructure 110:11
 122:13
initial 50:22 194:12
 219:7
initially 12:7 52:5 86:20
 130:16 265:21
initiated 187:15
initiating 187:8
initiative 125:6 199:6
 199:20 241:12,17
initiatives 199:9 238:13
 279:18
innovation 12:16 49:20
innovative 14:8,13
 19:17
innovatively 133:16
inpatient 13:8 22:15
 27:19 40:5 44:5 132:5
 145:21 152:18 163:22
 164:20 186:16,20
 187:3,9 222:4
input 45:22 81:13 83:12
 189:22 192:15 195:9
 207:3,19 209:14,14
 216:10,13 218:11
 231:8 240:1 250:4
INR 151:19 152:10
 154:4 157:21 159:7,8
 159:9 164:7,17
 166:10
insignificant 58:14
 273:12
instance 73:20 205:14
Institute 223:22
institutions 104:12
 122:6
insufficient 6:1,1 150:9
 150:11
insurance 24:18,19
 189:16
insurances 185:7
integrate 198:13 202:16
 241:19
integrated 28:9 160:10
 160:10
integrating 84:10
 242:11
integration 28:12 202:8
 203:15 211:16
intend 6:6 47:12
intended 34:2 201:11
 203:8,14 216:12
 235:22

intense 43:11
intent 94:18 143:11
 145:16 152:13
intention 143:13
interact 44:8
interaction 232:14
interactive 228:11
interest 265:4
interested 21:13 174:2
 194:16
interesting 26:2 257:8
 264:16
interests 265:11
interface 136:4,7
 182:16 183:3
interim 196:1
intermediaries 242:12
intermediate 123:11
intermingled 223:8
internal 34:3
internet 277:14
interplay 44:4
interplays 44:13
interpretability 35:12
interrupt 26:17 73:1
interventions 14:7
 104:7 186:16 187:3
introduce 10:17 12:11
 14:16 27:7 194:5
introducing 133:22
introduction 12:22 13:5
 201:15
introductions 9:12
introspective 253:12
inversely 200:10
invest 123:15
investing 123:16
investment 220:2,2
investments 197:22
involved 42:15 110:2
 131:4 158:16 236:9
 244:8 267:5 275:12
involvement 19:9
involving 45:5 270:8
 276:22
IOM 104:20
IQI 145:18
IQR 15:21 18:18 27:16
 31:1 39:14 44:9 108:5
 108:16 109:5,7,12
 132:11 138:10 147:3
 167:16,21 168:8
 221:17 265:12
iron 194:9
Isham 240:6
Isijola 3:4 4:14 171:8
 196:7 209:3 276:10
 276:15

isolation 125:10 167:9
 279:14
issue 8:17 33:2 58:20
 59:3,8,19 65:16 72:19
 77:5,11,15 103:21
 106:10 118:14 121:7
 123:3 125:5 136:17
 148:16 152:9 153:22
 155:15 157:14 158:13
 163:9 169:3 172:12
 178:18 184:2 185:9
 194:20 207:20 208:10
 217:8 220:13 221:18
 231:14,22 235:11,13
 236:12 253:19 255:8
 255:15 258:2 262:11
 274:14
issues 7:18 8:22 31:3
 44:2 45:1 70:6 78:3
 80:1 81:5 84:7 92:7
 112:12 113:11,13
 137:19 157:18 169:16
 178:2 179:22 180:13
 182:1 183:15 191:19
 193:2 195:18 220:12
 230:3 235:11 241:20
 249:4 255:1 260:18
 264:19 266:12,20
 274:9
it'll 107:18
item 238:22
items 171:15 185:16

J

J 2:10
James 3:14 276:10,16
 276:17 277:9,11
 278:12
January 1:6 268:15
Jayne 1:16 10:4,5 75:15
 88:12,14 90:12 91:9
 91:21 98:3,5 99:19
 107:21 109:8 114:4,9
 115:20 117:17 142:3
 142:17 144:4 158:7
 174:5 176:2 230:10
 233:3 237:2 243:2
 247:15 259:4,5
 262:21 267:22
JD 1:15,18
JEAN-LUC 3:7
jeopardy 8:6
job 7:16,20 42:5 48:15
 112:4 133:6 236:20
 257:9
Joel 3:9 71:16,20 76:3,3
 87:2,19
joined 27:2

joint 1:13 105:9 133:5
 184:14 185:22 186:17
joking 214:10
Journal 18:3
journey 196:14
judgments 277:3
jump 228:10
justice 279:14
justifications 80:2

K

KAHN 1:21
Karin 3:11 10:8
Kate 10:19,19,20 95:9
 173:21 198:4 214:10
 246:22 257:18 258:4
 264:14
Kate's 234:7
KCQA 85:16
KDOQI 62:16
keenly 22:6
keep 94:8 97:3 212:17
 228:11
keeping 54:3
keeps 251:19 259:8,11
Kentucky 276:18
Kevin 2:15 104:16
 120:1 121:17 190:18
 211:8,11 259:2
Kevin's 122:21 234:11
key 77:15 86:12,18
 120:21 122:1,17
 193:18 195:18 204:17
 204:22 207:3 208:6
 208:15 228:16,16
 252:7 271:19 272:1,3
keys 237:9
kick 9:7 26:5
kicked 102:15
kill 121:12,13 176:2
kind 6:17,20 44:17
 51:14 52:2 64:3 72:21
 104:22 105:8 106:8
 121:3 122:22 130:2
 133:19 136:19 137:1
 144:9 155:11,16
 160:11 163:14 172:21
 172:22 188:20 190:4
 200:6 205:2 210:4,14
 211:13,17 221:15
 244:5,20 245:6,15
 246:1,16 247:17
 258:21 261:19 269:2
 280:13
kinds 7:12 49:15,17
 105:6 169:14 226:20
 246:7 262:14 276:21
know 10:4,18 11:11
 17:12 20:16 22:3 25:2
 26:9 47:3 50:9 52:12
 52:15 55:7 60:13
 61:16 62:4 64:8 67:2
 68:9 70:9 72:20 78:1
 85:2,7 89:17 90:18
 94:3 95:17 96:22
 100:13 101:1,7,10
 120:5,8,13 125:18
 128:1 131:10,12,14
 132:1 133:1 140:6,20
 143:4 147:10 149:11
 149:13 155:19 156:7
 157:9,17 158:1,14
 159:17 163:20 166:11
 172:11,13 176:2,18
 178:16,16 181:11
 182:3,5 186:7 191:6
 192:1,9 195:1 197:15
 198:4 199:7,11 202:1
 202:11 203:3 207:1,6
 214:7,8,10 217:6
 218:16,21 219:3,8,16
 219:21 221:21 222:5
 223:15 224:9,12
 226:20 229:9,13,16
 230:6 231:14 232:2
 233:4,4,17 234:1
 236:4,21 237:9,10,16
 237:22 238:1 240:6,7
 240:8 242:5,7 243:16
 244:7 245:9,11,15,19
 245:21 246:4,9,10,12
 246:13 247:2,12,14
 247:15,17,22 248:1
 249:21 250:8 254:15
 255:15,22,22 257:5
 257:10,19,21 258:4
 258:11 259:19 260:8
 261:4 262:15,18,19
 263:13 264:2 265:7,9
 266:8,15,22 268:21
 269:5,7,13 270:5,15
 270:19 272:1 275:8
 275:12
knowing 61:11 224:15
 234:19 254:22
knowledge 184:12
known 34:13 36:10
 37:20
knows 63:18 254:16
 259:22
KRAMER 2:1 140:12
 144:18 146:5,14
 147:19 189:19 265:16

L

label 91:3 179:11

labeled 55:9 63:17
91:16 174:14 179:7,9
179:16
labeling 65:15 149:2
lacerations 131:5
lack 39:18 49:6 87:9
184:11
land 8:10 160:14
landed 113:18
landscape 211:22
large 15:9 99:3,6
116:21 125:6 191:1
271:11
largely 139:4 186:22
larger 99:15 136:3
175:5
LARSEN 2:15 211:12
238:21 239:2 260:16
last-minute 171:14
lastly 208:11
late 72:3 80:9
latest 195:22
Laughter 154:1 209:2
laws 33:9 111:10
lay 107:14 197:22
layered 238:15
lead 51:13 152:12
200:14
leadership 196:10
267:16 273:4
leading 14:4 117:2
166:12 237:5 266:8
leads 112:18
leaning 55:13 234:12
Leapfrog 1:16 48:6
learn 125:21 246:18
learned 52:11 112:14
learning 100:6 121:21
122:7
leave 17:22 43:16 45:7
126:16 156:5
leaving 43:7
led 23:17
left 147:10 236:22
leftover 248:5
legal 271:6
legislation 199:16
lend 144:8
lens 263:4,20
let's 5:9 48:2 68:16
69:13,15,16 78:14
80:4 93:6 95:14,21
143:11 144:16 148:11
153:13 169:6 183:5
183:21 191:17 266:6
275:21
level 13:7 14:16 15:8,10
15:21 16:21 17:5 18:5

18:5 19:20,22 20:2
49:14 55:2 56:21
58:16 61:16,18 62:15
66:9 69:4 101:19
107:1,9 112:22
113:14 153:6 154:15
157:10 159:5,7
190:20,22 203:1,6
226:17 227:13 250:15
274:1 280:7
levels 52:14 60:11 66:8
184:22 185:3 263:11
leverage 19:12
levers 104:10
LI 104:17 105:5 121:19
190:19
liaisons 2:15 78:8
lie 198:20
life 29:20 39:16 45:6
97:1 248:11,22
light 224:5 237:9
liked 248:7
likelihood 125:20
limb 103:17
limitations 142:20
151:14
limited 8:13 34:6
141:21 167:11 177:9
LIN 2:2
line 71:20 105:5 161:22
177:20 211:2 236:5
236:11 237:22 238:18
248:4 276:2,11,14
lined 114:11
lines 58:2 95:4 111:12
238:4
link 11:4,7,10,14 70:10
70:20 75:19 239:18
link's 54:15
links 11:6 55:15
Lisa 2:3 11:1 51:4,5
52:7 53:7 67:3 68:12
104:16 105:20 120:1
129:6 154:10 157:16
158:1 183:9
list 35:18 48:22 49:16
54:16 80:7 85:14
93:13,20 94:19 95:16
101:2 170:22 171:17
221:7 224:10 256:6
256:12,16 259:11,14
listed 181:15 243:10
listen 45:10 264:11
listening 136:15 215:7
literature 17:2 59:4
277:13
little 5:9 12:19 34:13
48:21 49:5,17 88:21

114:4 122:21 124:9
136:14 172:13 173:7
173:8 185:18 193:16
200:11 201:6 205:3
206:8 216:7 221:21
227:3 229:4 243:18
270:14,19 277:7,15
live 16:4 122:10 180:11
268:14
living 128:16
Local 97:21
logged 69:18,19
long 31:11,15 84:13
85:3,7 118:10 157:15
177:14 191:20
long-term 28:11 210:8
210:13,18 272:4
longer 17:14 64:11
191:18 224:18
longer-term 135:8
look 9:6 11:8 40:22
41:4 55:1 59:2,6 62:5
65:11 86:3 103:7
109:22 116:6 127:8
128:4,21 134:6
143:13,14 153:9
165:21 177:8 178:20
179:20 182:12 183:3
184:21 194:1,18
198:6 201:1 204:13
211:18 214:6 219:13
225:8,10 226:1
229:16 231:2 232:3
233:6 235:16 236:3
237:20 239:12 245:11
248:14 250:9 253:9
253:12,21 255:20
256:22 263:16,17
268:4,13 280:20
looked 27:14 59:18
86:21 117:7 139:6
looking 6:14 17:13 21:3
21:10 74:20 105:7
127:4,19 151:1
152:14 162:9 166:5
171:9,19 174:7,16
181:6 184:13,17
197:2 198:14,19
199:6,9 202:19
204:15 205:9 213:16
214:19 215:16 226:20
227:4 229:7 232:20
238:11 245:19,20
246:5 247:13,21
261:20 263:5,12
265:19 268:1 274:18
276:22 277:13
looks 26:2 27:12 65:8

79:2,4 96:9 133:5
239:22 252:14 280:10
loop 6:11 198:6 258:12
260:15 268:10
loops 234:9
lot 8:8 34:22 44:18,22
45:2,7 50:7 54:2
58:18 77:7 98:13
113:4 119:16 121:2
122:7,8 126:21 131:6
131:22 133:18 135:8
148:1,5 154:12
163:15 176:18 177:12
183:15 185:10,12
191:11,11 198:18
202:6 203:11 205:5
211:19 212:1 213:13
215:7,9 222:9 232:14
236:11 239:15 248:15
249:19,22 251:14
252:22 255:6 258:1
264:19 268:20
lots 8:22 23:2 95:13
113:11 251:7 258:10
277:20
love 209:14 234:15
258:3
low 177:8,9
low-risk 141:21
lower 21:6 50:14
101:15
lowering 115:13
lumped 234:4
lunch 180:5 191:17,18
191:20 192:5,7 264:4
Lynda 1:18 10:10
163:19 240:15 259:6
Lynda's 248:7

M

MA 175:13
MACRA 199:16
main 141:14 200:16
maintained 64:11,14
maintenance 64:22
major 15:9 24:13 81:22
156:7 165:20 201:4
203:12 216:20 275:6
majority 17:10 32:17,20
making 72:12 99:5
135:22 160:1 169:13
176:9 187:3 191:5
199:2 216:15 217:10
220:1 238:3 244:4,17
244:20 247:10 249:7
270:1 277:1
manageable 253:18,20
Managed 2:8

management 1:20 3:3
56:1 205:15,17
manager 3:7 162:11
mandate 224:18
mandated 220:18
223:14
manner 46:15
manually 144:11
Manufacturers 1:17
map 4:12 21:19 24:21
25:8 38:21 39:12 40:3
40:5 45:13 49:13
65:20 66:4,10 121:4
124:7 134:5 179:22
193:22 194:18 196:6
196:8 197:5 198:14
201:16 202:6 203:13
203:15 204:9,21
206:13 208:7 212:15
213:19 215:12 219:8
220:18 226:16 227:13
235:6 239:16 250:9
258:6 261:18 276:20
279:20
MAP's 32:21 36:3,12
38:10,14 39:4 40:12
89:4
MARCIA 3:3
Marinelarena 3:5 27:2
30:22 38:19 42:1 46:2
65:17 106:18 145:11
159:3 163:19 172:1
MARISSA 2:8
mark 62:9 123:7
market 260:12
Marla 2:10 224:22
226:9 243:9
Marla's 252:11
marrow 62:2
Marshall 2:13 60:4
61:20 110:20 112:9
234:22
Mary 1:14 172:8
Massachusetts 3:15
12:14
match 159:10 174:21
205:20
matching 262:18
materially 84:2
materials 267:18
Maternal 141:15
maternity 132:4,18
133:7
matter 2:12 9:20 29:13
94:9 110:10 192:16
237:11 280:21
MBA 1:17 2:1,2
MCGIFFERT 2:3 11:2,7

36:19 51:7 53:9 55:1
57:8 67:5 68:14 69:1
69:13 74:4,16 77:6
105:21 120:2 129:7
130:14 151:16 183:10
MD 1:11,12,13,14,15,19
2:2,4,5,6,9,13,13,15
2:17,18,19 3:1,14,14
mean 46:12 55:20 56:4
57:18 60:18 61:2,15
62:6 66:13 67:12 69:6
72:16 73:2 80:2 92:10
94:10 97:14 98:15
109:12 112:12 119:16
130:2 131:3 139:17
148:9 154:22 158:9
158:13 160:11 161:15
173:17,21 180:14
182:3,11 185:10
216:20 217:18 221:8
225:4 235:9 236:3
237:4 253:22 254:2
259:17 264:9 277:8
meaning 149:15 203:1
224:17 253:7
meaningful 8:11 34:19
34:22 51:22 66:7 99:1
115:13 155:17 228:6
238:4
means 8:3 21:6 57:1
75:1 91:9 127:20
232:3 251:15 260:4
measure 1:3 7:9 13:3,6
13:7,13,16 15:19 16:7
16:12,13,20 18:18
19:21 20:2,4 21:14,21
29:5 30:11 31:7,14
32:4,5,22 33:13,20
34:1,5,7,12,14,15,17
35:18 36:14,20 37:3
38:21,22 39:5,19,21
40:2,4,13 41:13,18,19
44:12 45:16 49:20
51:3,8,13,17,18 52:2
52:9,18 53:1,6 54:11
54:11 55:5,19 56:3,5
56:17,20,21 57:16
58:11 59:11,17 60:1,6
60:7,8,16 61:10 62:1
62:6,9,14 63:2 64:1,4
64:12,13,18,19 65:22
65:22 66:3,13,19,20
67:9,17 68:18,20,22
69:2,5,5 71:17 72:5
72:15 73:7,9,14,21
74:12,14,14,21,21,22
76:20 79:13,16,20
80:11 81:4,7,8,17,18

82:1,3,5,7,8,13 83:4
83:12,21 84:3,15,19
84:21 85:6,13,16 86:4
86:7,20 87:7,12 89:2
90:9,9,15,17,22 91:11
92:11 93:2 95:2 96:3
97:1,2,8,8,10,20
99:19,21 100:14
101:22 102:4,18
103:1,1,15 105:16
106:20,22 107:3,17
108:5,11 109:4,6
110:1,4,8,12,15
111:22 112:16,20
113:5 115:1,18,19,19
116:6,8 117:8 118:1
118:15 119:1,15
120:4 121:22 122:12
122:12 124:11,19
125:15,21 126:19
127:8 129:4,13,18,21
130:4 131:1,12
132:11 133:9,12
134:1 135:19 136:2
138:7,21 139:11
140:14,15,19 142:1
143:11,15,21 144:3,6
144:9,11,13 145:6,7
145:12 146:8,10,18
146:19,20 147:2,6,13
147:14,15,18 151:13
152:4,9,15,15 154:2
154:11 157:2,3 158:9
158:11 159:4,5
160:14 161:9,12,16
161:19 162:13,22
163:6,20 164:7,13
165:4 166:2,5,10,12
167:18 170:12,13
172:11 175:2,11,16
175:19 176:2,6
180:15 181:3,6,9
182:3,13,16 183:7,12
183:14 184:3,14
188:3,6,10,11,15
189:20 190:2,8,20
196:17,18 202:17
207:21 210:12 213:9
216:11,15 217:19
219:11 220:21 221:9
221:11,12,15 225:19
226:12,13 231:22
235:21 239:6 244:20
244:22 245:18 246:13
247:12 250:2 251:5,6
251:8,17 252:21
253:16 257:20 262:16
262:17 268:9 272:7

272:16 277:5 279:12
280:5
measure-specific
219:10
measured 51:10 103:22
157:10 232:9,15
measurement 3:2
21:16 23:11,13 30:17
41:17 51:3 66:11
78:19 99:7 112:18
122:16 125:10 198:1
204:10 212:21 236:20
236:22 237:1 240:9
248:11 263:9,10
278:3
measures 5:18 6:8,16
7:5,6,11 8:7,11,17 9:2
12:5,8,20 16:1 17:18
22:11 24:7,22 25:9
27:14 28:4,7,9 29:12
29:19 30:2,9,12,15
31:1,2,13,22 32:11,14
33:12,18,19 34:18,20
35:14,16 36:4 37:8,9
37:12,16 38:1,8,12
39:16 40:6,7,9,20
41:1,7,8,16 43:8,12
44:5,11,15 46:17,19
46:21 47:8,11,19,22
48:16,22 49:1,6,15,17
50:7,17 51:1,9,20
52:15 54:8,14 55:13
55:14 56:8 57:3,4,22
58:3 59:1 72:10,11,20
73:6,10,16 74:7,17
75:20 77:8,13 82:20
84:11 85:22 87:15
89:5,9 90:4,5 92:8,10
94:15 97:14 98:22
105:1,7,14 106:4
107:5 108:2,15
109:14,15 110:10
111:5 114:20 116:12
119:17 126:8 132:4
132:18 133:13 138:10
138:12,13,15,19
147:5 149:22 150:9
150:16 162:2,3,6
166:4,8 167:1 168:1,7
168:12,13 169:3,5
170:4,10,16 171:12
173:9 174:13,14,20
175:1 176:4,16,21,22
177:12 178:6 179:7,8
179:10,14,19 180:3
187:5 190:4,6,6
191:14 194:2,21
197:1,2,4,8,10,13,17

197:18 198:3,7,9,20
 200:17,21 201:1,2,10
 201:15,17 202:22
 203:6,10 208:1,1
 211:16 212:2,9,12
 213:7,19 214:1,5,7,13
 214:17 215:1,18
 216:14 217:16 218:11
 220:18 221:7,17
 222:1,8,10,17 223:7
 223:14 225:3,10,14
 225:18 226:14,20
 227:5,10,17 229:7,10
 229:13 230:17,21
 231:2,6,10,10,19
 232:1,2,17 233:6,12
 233:18 234:19 235:10
 237:5,20 238:13
 243:5 244:19 245:20
 246:4,7,16 247:14,22
 248:13,22 249:9,14
 249:15,15,16,17,18
 249:19 250:10 251:13
 254:11 255:16 256:4
 256:11,22 257:13
 260:3,9,13 262:14,14
 263:6,17,19 264:19
 265:12 266:17,18,18
 268:5 271:9 276:21
 277:22 278:5 279:8
 279:12,13,22 280:9
 280:10
measuring 66:4 91:4
 121:4 163:9 210:11
 263:13
mechanisms 104:10
media 104:5,6
mediating 241:6
Medicaid 2:19 3:10,15
 15:10 137:10,17
 139:15,19,22 140:3,9
 140:14 141:5,7
 143:18 151:17
medical 2:2,5,9 3:11,13
 12:14 18:3 90:6
 136:16 141:15 182:20
 236:15 248:16,16
 249:2 278:20
medicalizing 248:15
Medicare 2:19 3:9,15
 15:13 30:4 129:15,17
 130:3 133:11,22
 134:7 137:10,15,22
 138:8 139:2,7,14
 140:15 142:8,20
 143:2,22 188:19
 199:12
Medicare-focused 30:3

Medicare-only 137:13
 147:3
medication 49:9 52:21
 122:2 156:8
medication-assisted
 187:11
medications 33:10
medicines 165:20
meet 67:9 73:19 184:22
 203:1,6 213:17
 260:21
meeting 1:3 7:17 70:15
 70:22 75:10 125:4
 135:4 148:15 167:6
 194:7,10 196:1
 203:19,21 204:3,20
 206:7 208:17 223:6
 243:18 261:15 271:3
 273:20
meetings 235:7 271:3
Melissa 3:5 27:2 30:19
 36:6,9 38:17 45:18
 46:1 106:16 159:2
 163:17 170:19 171:21
member 9:14 11:2,7,9
 22:5 23:3 36:19 48:5
 48:10 51:7 52:6 53:4
 53:9 54:7,19 55:1,2,7
 57:8 60:5 62:11 63:8
 64:7 66:17 67:5,11
 68:3,14,19 69:1,13
 71:3 74:4,16 75:16
 76:16 77:6 79:19,22
 82:17,19 84:17 88:4
 88:14,17 90:1 91:20
 94:4 95:1 96:19 97:17
 98:6 101:10,13 102:2
 102:9,14 105:21
 107:22 110:21 114:3
 115:22 116:4 118:7
 118:22 119:11 120:2
 122:20 126:15 127:14
 128:9,13 129:7
 130:14,17,20 131:18
 134:4 137:5,15
 140:12 141:13 142:4
 144:18 146:5,14
 147:19 148:13 149:8
 149:13,17 151:16
 152:2 153:19,21
 154:2,9 155:22
 156:19 161:10 162:9
 165:1,17 166:9
 169:19,21 170:7,21
 171:4,16 172:9 173:6
 174:6 176:13 178:4
 180:10 181:20 182:1
 183:10,20 184:2

185:21 189:4,13,19
 213:2 217:14 223:5
 225:1 240:16 242:19
 248:6 255:10 259:7
 259:16,20 265:16
 270:11
members 9:19 23:17
 37:15 42:15 47:20
 54:2 58:19 69:19 71:9
 71:16 207:19 208:6
mental 182:18 183:1
 189:17 223:21
mention 14:2 50:21
 72:4
mentioned 7:22 34:18
 53:16 84:21 101:12
 165:5 244:4 247:16
 255:8 270:12,14,17
 272:5
merits 122:12
message 50:3 62:3
 90:13,20 91:2,5,13
 97:12,16 114:16
 143:8 150:11,14
 155:15 156:2
messaging 148:18
met 1:8
metabolism 62:2
metaphorical 244:5
methodological 266:12
methodology 119:6
 127:17 128:5 182:8
 250:4
metric 109:13
metrics 15:6
MH 2:17
MHA 2:6
MI 17:19
micro 235:8,19 237:20
 237:20
mike 124:10
milestone 193:21
mind 42:19 47:13
 172:22
mine 11:11,15,16
mineral 58:20
minimum 66:12 69:10
minor 121:11
minority 20:18
minute 16:22 48:8 77:6
minutes 5:8 11:20 13:2
 253:1
MIPS 22:20 199:21
mirror 225:2 265:8
mirrored 14:22
mirrors 148:1
misdiagnosis 49:9
misery 14:5

misleading 114:20
misnomer 27:13
misrepresenting
 143:21
missed 156:6
missing 86:14,15,19
 108:21 139:20 237:21
mission 19:3
Missy 1:16 48:6 50:20
 50:21 52:4 53:2 82:15
 82:19 83:10 84:18
 107:21 109:10 114:17
 118:20 119:10,11
 127:12 128:7 130:15
 131:17 153:18 154:7
 157:17 158:1 169:7,9
 169:20 170:20 181:19
 255:9 257:8 259:12
misunderstanding 77:7
misunderstood 102:10
MITCHELL 2:3
model 77:14 156:21
 212:6,10,20
models 22:21 189:5
 212:12
moment 56:12 73:1
 276:8,13
momentum 274:21
money 241:14
monitor 35:19
monitored 36:16 38:6
monitoring 151:20
 157:8 164:17
month 62:15 216:22
 231:17 233:21
months 25:8 62:17
 66:21 67:17
morning 26:3 42:11
 43:16 69:21 70:7
 108:20 117:19 125:15
 192:20 193:3
mortality 17:19 34:20
 34:21 35:18 36:14,20
 168:14
mothers 135:9 136:15
move 23:14 24:3 35:6
 61:18 68:16 77:17
 78:12,14,15 79:20
 80:4 93:6 95:14 96:17
 114:2 115:16 126:7
 138:14 142:13 144:15
 144:17 145:16 181:9
 182:5 183:5 189:9
 191:17 192:12 194:14
 194:15 205:2,3 208:4
 215:13,16 218:7
 270:10
moved 67:21

movement 115:5 140:6
moves 79:9 104:14
moving 14:21 23:10
 50:9 80:10 200:7
 201:13 202:4,10
 203:19 218:3 241:2
 270:4
MPH 1:13,19,21 2:13,18
 2:19 3:1
MPP 1:14
MSIS 140:7
MSN 1:18
MSPH 2:7
MUC 35:18 49:16 78:19
 80:12 93:13,20 94:19
 95:16 96:2 145:19
 164:17 173:9 219:14
 219:16,21 221:2,7
 224:10 243:5 255:12
 256:6,12,16 259:11
 259:14
MUCs 223:12 243:16
MUD 219:15,17,22
 220:14 255:12
MUD/MUC 250:18
MUKHERJEE 3:5 46:3
multi-stakeholder
 265:22 267:8
multiple 158:15 222:19
multistakeholder 231:8
Munthali 3:2 112:17

N

N 1:21
N.W 1:9
name 12:12
name's 10:5
names 210:16
Nancy 2:18 3:12 10:14
 21:22 50:1 176:3
 209:15,20 210:22
 238:7 240:3
Nancy's 84:5
nation 23:7 275:3
national 1:1,8,14,21 2:7
 2:11,15 107:1 118:12
 136:14 198:19 204:13
 204:16 209:22 210:6
 210:7 223:22 239:5
 263:9
natural 122:8
nature 100:10 116:17
 199:6
nearly 134:14
necessarily 34:21
 51:11 58:3 113:20
 115:6 118:3 132:15
 132:21 176:21 195:13

195:14 238:18 260:6
 260:14 261:17
necessary 219:9
need 9:8 28:7,9,17,19
 28:21 29:3,5,22 32:3
 35:19 37:13 38:3,4,5
 39:12 49:14 52:1,1,20
 65:8 77:16 81:13 92:3
 92:14,16 101:8,19,21
 103:5,12,14,14,15
 109:22 114:16 115:7
 115:14 118:13,16
 120:11,12 124:19
 127:3,7 129:2 131:2
 131:13 136:9 138:11
 141:4 142:8 144:7
 145:5,10 149:4 154:2
 157:1 158:14 166:3
 175:18 177:8,14
 179:1 189:9 190:1
 215:22 218:10 219:4
 219:4,6,12,13 220:6
 222:18 225:3,7,17,18
 231:7 232:3,4 234:12
 238:17 240:10 247:15
 248:10 257:8 259:13
 260:2 261:7 272:15
 280:14
needed 37:20 156:10
needing 40:9
needle 182:5 199:14
needs 28:10 38:5 49:2
 90:18 91:18 98:16
 99:12 102:18 113:16
 121:14 126:2 156:13
 173:10 176:6 231:15
 251:5,7 272:8,13
negotiating 15:8
Network 2:3
networked 163:14
never 95:21 218:3
 244:14 256:15 269:7
new 7:22 9:8,13,18 10:3
 10:13 11:5,7,10,14
 14:14 33:12 35:17
 36:7 38:1,22 40:6
 44:12 122:16,17
 126:21 130:10 138:12
 138:18 140:8 203:8
 212:5,9,12,18,19
 217:8 230:6 241:11
newer 127:4
NHSN 84:4 115:19
nicely 213:3
night 150:8
NIH 134:12 135:4 244:5
 244:9,14
nine 126:8

nominations 246:3
non-Medicare 139:10
non-support 224:11
normal 232:12
normally 221:4
note 226:22 265:21
noted 29:5 30:16 36:6,9
 40:13 65:16
notes 153:9
notice 83:7
noticed 196:16
noting 39:4 267:10
notion 226:11
novel 221:11 277:5
NQF 3:1,4 7:19 19:21
 27:3 54:10 56:19
 60:14 61:4 63:9 65:4
 66:1 89:17 92:9
 112:11 117:7 174:17
 181:8,9 202:21 203:5
 203:12 209:6 210:19
 215:13 229:14 248:19
 250:9 255:19,19
 256:4,14,15 258:12
 259:22 268:22 274:5
 274:15 277:22 279:2
 280:18
NQF's 205:10
NQF-endorsed 56:4
 59:11 60:15 63:12
 83:22 86:5,21 90:4,8
 90:22 190:8
NSHN 35:16
nudge 135:22
number 5:6,17 17:7
 25:21 26:21 30:16
 35:16 56:16,18 78:11
 87:7 94:10 100:4
 116:21 118:2 121:12
 126:13 128:17 129:5
 148:21 163:7 166:17
 191:1 193:18 200:22
 201:2 230:16 254:5
 255:16 261:10 266:15
 276:5
numbers 139:7
numerator 81:20 84:20
Nurses 2:10

O

O'Rourke 3:6 4:15 26:5
 26:9,20 27:1,10 35:8
 36:21 55:5 77:21 80:9
 86:18 87:19 88:2
 151:9 171:10
objection 88:11
objectives 205:12
 229:1 238:12,20

269:17
observed 264:21
obstetrics 31:22
obvious 54:18
obviously 10:19 30:3
 44:20 103:22 121:14
 138:14 141:8 162:20
 195:2 204:14 253:5
 269:22
occur 272:13
occurred 163:10
October 217:19
off-cycle 206:9
Off-microphone 218:20
offer 13:3 71:17 106:19
offered 58:19 83:15
 134:17 183:8 234:15
Office 2:15
Officer 3:1
official 93:20 102:15
oftentimes 220:16
 233:8
oh 10:22 42:1 48:5
 61:15 132:1 163:17
 170:19 186:18 187:22
 259:16,20
OIG 166:13
okay 5:3 11:7,17 35:6
 42:3 48:2,10 57:8
 67:5 69:16 71:13,18
 71:19 72:1 77:4,19
 78:10,14,15 79:4 80:4
 80:16 88:11,16,20
 94:1 95:20 96:1,9
 97:19 98:4 101:9
 126:16 128:9,12
 129:2 130:20 143:3
 145:16 147:19 148:11
 153:17 164:10 165:6
 165:9 168:22 170:7
 171:4,21 172:7 174:3
 178:1 180:2,3 181:14
 183:5 193:13 210:11
 210:22 211:8 223:4
 224:22 226:5 248:3
 258:20 259:7 276:7,8
 276:14 278:13
old 126:20
ONC 2:16
once 8:7 198:7 230:2
 259:17 260:5,9
Oncology 3:12
ones 45:11 66:18 84:21
 224:10,12 245:21
 267:14 274:10 276:22
ongoing 7:4 33:2 58:1
 257:3
op-ed 236:18

OPELKA 2:5 63:8 64:7
122:20 155:22 176:13
open 11:9,10,12,14
12:6 25:18 79:1 96:6
135:20 146:2 147:4
209:11 275:21 276:2
276:11,14
opened 251:4
Operator 25:19 193:7,9
276:4,8,11,13 278:15
opinion 67:21 88:22
269:4
opportune 247:3,4
opportunities 23:19
133:16 147:6,9
188:10 241:22 258:10
258:14
opportunity 4:4,9,17
24:12 132:11 142:11
178:14 188:2 224:13
226:2 228:2 234:10
239:3,18 246:21
262:5
opposed 199:18,19
235:20 236:14,15
265:5
option 92:19 146:6
160:1
optional 160:1
options 68:1 78:22 96:6
136:21 145:22 164:11
order 106:4 223:3 226:8
organization 40:21
67:12 98:12 105:18
172:14
organizational 9:14,19
organizations 24:18
112:1 132:13 236:8
279:17
organizing 7:20
oriented 168:6
original 11:4 94:19
95:16 119:21 128:11
131:7 170:22
originally 54:1
ought 210:21 267:18
268:4,7 279:9,11
outcome 15:19 34:22
53:20 55:12,14,19
56:2 60:21 61:11 62:8
68:17 69:4 79:20
116:12 137:1 175:18
183:14 190:6 195:16
197:4 249:18 266:17
271:9
outcome-based 51:21
197:2
outcomes 8:14,14

29:13,16 35:4 49:10
152:12 172:18,18
174:17,20 178:9
180:17 184:9 201:1
215:14 236:1 237:4
outlined 213:3
outpatient 22:16 27:17
37:22 38:9 39:21
50:10,18 128:16
186:6,20,21 222:5
outset 5:15
outside 172:15 213:15
266:21,21 271:6
over-utilization 62:13
overall 32:7 75:13
195:6 238:2 252:4
overarching 23:5 28:5
overemphasize 228:4
overreach 24:7
overturn 92:4,17 95:19
254:2,5 263:13,14
overturned 151:8
253:22
overturning 165:13
overuse 49:9 117:3
228:3
overusing 117:4
overview 9:21 45:19
166:20

P

P-R-O-C-E-E-D-I-N-G-S
5:1
p.m 192:17,18 280:22
PAC 35:16 128:16
175:10 191:7 197:14
201:19 222:6
Pacific 2:1
paid 74:11 109:15
178:17 199:9
pair 174:17,21 175:18
paired 55:19 168:14
170:12,16
pairing 175:20
palatable 273:22
parallel 250:17
parameters 208:15
parity 189:15,16
park 160:8
parsimonious 35:10
36:3
parsimony 46:20 190:1
part 16:17 19:2,9 23:3
44:21 72:11 76:6,12
77:1,11 108:15
109:12 112:20 119:2
120:22 125:10 133:17
135:3 138:19 139:17

143:2 149:5,10
157:22 159:19 161:3
172:11 177:14 187:5
190:21 212:12,13
225:9 226:4 236:10
240:5,6 242:21 243:7
245:13 257:4,12,17
260:7,15,17 262:11
262:18,19 263:21
274:11
participate 26:16 29:18
participated 267:15
participation 267:17
particular 30:8 36:4
50:6 59:3,9 60:1 81:4
81:5,15 82:2,10 104:2
143:7 172:4,22
189:20 190:7 221:12
238:22 250:11 262:15
267:1
particularly 32:2 35:21
36:9 38:13 48:19 49:3
63:9 103:7 111:2
116:16 125:1 138:5
167:15 186:5 199:10
220:17 252:9 264:17
267:15
partly 260:20
partners 29:4 189:6
Partnership 1:3 2:7
210:6,7
Parts 176:22
pass 151:14
passed 81:21 210:4
path 195:11,19 273:1
paths 251:20
pathway 86:6,8 87:21
88:1 94:8 140:13,20
156:12 160:2 194:21
207:21 208:2 216:12
pathways 155:18
157:11
patient 29:9,16 35:3
36:7 37:1,5,18 41:4
49:3 52:21 59:9 67:17
74:1 82:11,13 83:5
108:8,18 120:7
127:21 152:22 154:10
159:13 161:1 184:3,6
184:21 205:14,16,21
205:22 236:14,15
patient's 128:3 248:20
patient-centered 8:12
patient-reported 49:10
patients 8:11 14:5 17:8
17:10,22 19:4 22:7
23:16 28:14 29:3,6,10
29:14,17 30:1,17

34:19,22 36:16 37:1
38:13 39:20 58:21
59:10 65:21 66:7,8
67:12 74:2 81:19 83:5
106:12 108:8,17
109:20 110:3,18
116:17 117:4 125:1
127:1 131:2 137:10
137:11 154:3 157:5
159:6 164:2,8,9 177:7
177:11 189:11 190:17
237:11 277:4
Patrick 13:17 264:15
patterns 226:1
pay 55:22
pay-for 66:5
payer 143:2 145:7
payers 130:5
payment 8:16 9:3 15:2
20:10 22:21 27:15
37:21 55:10 56:3,9
60:19,22 63:21 72:12
73:17 74:6 75:4,8,21
76:5,7 77:9,14 89:5,7
89:11 100:10 109:14
137:14 167:18 168:16
169:5 178:15 179:9
179:14 190:11 199:18
200:8 212:1,5,7,9,12
232:6 242:15 249:4,9
payments 15:1,3,4 45:6
106:5 199:13
pediatric 12:13 30:9
31:21
pediatrics 227:18
peers 73:11
penalizing 119:7
penalty 76:1,8,17
pending 119:14
people 5:5,6,13 6:2 7:6
9:8,18 10:22 11:13
12:2 23:14,20 47:17
50:13 61:9,12 64:21
70:13 79:3 93:10
96:17 97:16 106:14
107:16 114:1 121:12
122:16 126:10 128:18
129:16 132:12 136:6
144:1 145:4 147:1
156:5 161:18 172:14
173:3 177:7 178:3
179:2 182:18,20
187:16 212:2 218:16
229:13 236:5 237:22
240:8 241:18 247:12
267:4 269:3 277:3,15
278:5 279:16 280:11
people's 218:17 241:14

perceive 264:5
percent 66:13,14 75:8,9
 79:5,7,7 95:20 96:13
 96:13,14 120:19
 132:16,16,17 151:4,4
 151:5 157:20 164:14
 165:10,10,11 198:10
 201:21
percentage 74:2 197:8
perception 8:6
perfect 154:17
perfectly 47:18
performance 7:5 23:15
 28:6,20 32:10 34:14
 36:10 64:4 65:11 66:6
 66:12,13 67:9 72:11
 72:18 73:3,8,11,13,17
 75:9,20 76:22 79:17
 157:19 199:9 234:19
 236:19 272:16
performing 58:15 67:8
 229:18
perinatal 30:9 31:21
 147:4
period 12:7 13:1 135:20
 154:4 195:6 216:22
 231:17 233:21,22
periods 12:4
persist 39:2
person 5:5 10:11 13:11
 13:15 97:1 162:11,16
 182:22 205:11
personal 69:20
perspective 24:1 46:6
 58:6 116:5,16 142:9
 228:14 233:22 260:1
 264:5,6 265:2,9
perspectives 92:22
 231:9 266:2
pertinent 84:5
Peter 220:8
Pharmaceutical 1:17
Pharmacy 2:9
phase 230:9
PhD 2:2,6,7,10
Philadelphia 185:11
philosophically 109:4
phone 5:6 7:18 10:11
 25:17 26:12,15 27:6
 48:7 67:19 70:1 71:16
 107:21 193:6,8
 209:12
phosphorous 226:12
 245:18
phosphorus 41:17 51:3
 52:9 54:10,12 61:16
 62:15 66:11 67:13
 69:4 73:20 74:1,3

78:19 153:20 156:4
 157:14 158:13 163:8
 246:13
PhRMA 1:18
physician 103:6 152:20
 153:6 159:4,11,14,14
 164:4 186:4
physician-level 159:18
physicians 2:7 36:22
 103:5 277:4
picking 193:1 209:8
picture 7:9 242:13
 262:20 263:16 268:1
piece 74:10 170:6 175:8
 177:4 230:5 241:4
 270:12
pieces 56:14 100:3
 252:7 264:12
Pierre 2:19 10:16 48:11
 58:5 71:2,13,14 80:14
 80:16 82:21 83:20
 84:21 86:22 133:1
 137:21 141:2 142:22
 160:15 161:20 166:20
 169:9 170:16 180:1
 248:4 264:2
PINC 68:11
Pincus 1:9,11 4:3,14
 5:3 9:7 10:22 11:5,15
 12:2 25:16 26:1,7,11
 45:17 47:4,7 48:2,9
 50:20 52:4 53:2,5,11
 54:6 56:11 57:12,17
 58:5 59:15 60:4 61:20
 62:22 63:7 65:2 67:2
 67:18 68:21 69:6,11
 69:16 71:1,13,19
 72:22 75:11 77:1,4,10
 78:10,17 79:2,10,21
 80:4,16,21 82:15
 83:17 85:9,20 86:10
 86:15 87:6,14,22
 88:10,16 89:22 91:19
 92:21 94:1,14 95:6,13
 96:9,16 97:15,19 98:4
 100:18 101:9 102:13
 103:19 105:3,20
 106:16 107:20 109:8
 110:19 112:9 113:21
 115:15 116:2 117:17
 118:6,20 119:10
 120:1 121:17 122:18
 124:2,9 126:4 127:9
 128:7,12 129:1
 130:13,15 131:17
 134:2 137:4,19 139:3
 139:12 140:11 141:2
 141:11 142:2,16

144:4,16 145:8,14
 146:3,11 147:11
 148:11 149:5,10,16
 150:20 151:2,6,19
 153:17 154:7,22
 155:20 156:15 157:12
 158:6,18 159:2 160:4
 160:15 161:20 163:3
 164:10 165:6,12
 166:14 168:17,22
 169:10,20 170:19
 171:2,5,21 172:7
 173:5,17 174:3
 176:12 177:18,22
 179:12 180:1 181:18
 182:10 183:19 184:1
 185:20 186:11 187:22
 188:13 189:12,14
 190:18 191:4 192:13
 219:2 243:22 257:5
 258:16,20 259:2,5
 260:11 262:10 264:1
 265:15 268:16 271:16
 273:16 275:21 276:7
 277:7,10 278:9,13,17
 280:16
pipeline 56:20 129:19
 166:6 226:14
place 100:3 118:9
 152:21 160:8 166:4
 166:15 221:5 227:7
 238:17 271:6 278:8
placed 138:18
placental 135:15
places 96:18 111:11
 185:12
plan 3:14 7:2 46:13
 84:9 161:3 239:8
 247:14 276:17
plane 42:12
planning 134:16 206:1
 274:11,15
plans 98:20 175:13
plate 22:12
plates 100:5
play 23:10 24:14 33:3
 268:8
played 31:17
players 24:16,20
please 11:18 25:20 47:3
 78:1,9 87:2 154:16
 168:21 276:5,12,13
plenty 95:11
plus 140:14 141:22
 203:5 255:20 277:22
pneumonia 126:12
 128:3,15 184:4
point 23:12 25:2,15

59:7,14 60:3 63:21
 66:17,22 72:2 79:11
 84:5 92:9 93:19
 100:13 114:10,10
 118:10 120:6 123:9
 123:18 126:18 138:21
 141:20 143:17 144:13
 148:21 156:20 160:19
 179:5 190:19 193:22
 217:15 223:2 238:11
 240:7 245:22 246:20
 247:9 248:7 252:12
 269:6,14 270:4
 274:20
pointed 95:9
pointing 273:21
points 5:16,16 54:3
 73:17 84:9 274:2
pollinating 240:9
pollination 239:20
 240:5
pool 58:22 246:3
poor 37:2
population 12:16 14:16
 15:16,17 21:9,17
 46:11 59:9 66:5 100:6
 105:9 110:7 112:12
 112:21 113:9 129:15
 130:3 133:4 134:6,7
 138:1 139:5,7,9,10
 142:22 143:8,12
 144:2 151:17 152:22
 183:16 271:10
population-based 15:3
 20:15 107:16 110:1
populations 20:19 30:5
 133:8
portfolio 54:14
pose 254:10
posed 207:11 258:4
posing 224:8
position 171:19
positive 7:12
positively 14:10 17:4
possible 28:18 38:2
 122:14 134:8 222:11
 226:19 255:14 270:2
possibly 228:3
post 28:14
post-acute 22:22 23:1,9
 24:2 28:11 175:3,4
 200:2
post-hoc 257:19
potential 35:20 36:13
 38:3 39:6 40:1 69:7
 75:1 88:7 175:21
 176:18 177:11 250:8
 253:6

potentially 5:16 14:13
 15:3 75:2 82:7 88:5
 117:13 119:1 133:20
 166:17 168:8 196:1
 224:18 253:9 258:8
power 192:3 249:11
powerful 114:13,15
PPS 27:20 214:11
practicality 220:4
practice 66:20 157:3,4
pre 217:9
pre-rulemaking 4:5
 208:8
precious 271:8
precursor 130:4
prefer 93:10
preferences 29:7
pregnant 143:12
prepared 171:18
prepares 25:8
prescient 226:8 274:16
prescriptions 120:19
present 1:11 2:12,15,21
 3:9,18 82:2 195:4
presented 92:13 94:20
 95:16 197:5 247:6
President 3:2,3 125:4
presiding 1:10
press 25:20 193:10
 276:5
pressing 10:7 125:2
pressure 52:13
pretty 81:3,22 83:20
 185:12 188:12 218:2
prevalence 13:7 16:9
 17:5 18:4,22 21:4
 24:10 31:13 32:19,22
 33:4 39:7 97:21 99:14
 101:14,15 104:4,5
preventable 14:4
prevention 2:17 12:15
previous 135:1 271:3
previously 124:18
price 50:14
primarily 222:2
primary 40:10 47:16
 143:2 152:19 153:1
 161:19 162:16 164:4
 186:21
prime 134:10 135:21
 231:11
primetime 6:9 89:10
 110:16 155:3 158:17
principles 43:7 195:19
 204:15 262:8 266:10
 270:21
prior 38:16 135:16
 168:2 264:12

priorities 14:18 15:13
 210:1,6,8,16 272:3
prioritization 46:18
 224:20
prioritizing 274:14
priority 13:17 15:19
 47:16 113:19 166:15
 197:21 198:19 205:10
 205:13
private 48:20 49:2,7
 50:4 170:7
proactive 226:19 227:3
 262:6
probably 9:2,18 59:20
 63:9 67:3 88:14,18
 91:12 95:11 111:10
 121:7 125:15,17
 159:21 175:4 180:11
 188:21 196:2 221:3
 230:17,18 231:14
problem 14:6,12,13
 23:3 125:8 166:12
 172:21 216:13 217:8
problematic 277:21
problems 5:12 135:15
 182:3
procedural 94:9
procedurally 252:10
procedure 172:10,12
 172:20 173:1,4
procedures 172:3,5
 178:8
proceed 26:4 48:3 67:4
process 7:9 9:9,12
 44:20 51:8 52:8 53:1
 55:12 56:19 60:8
 61:10 62:6 66:15 69:5
 85:10 88:22 90:19
 93:2 95:5 97:6 102:19
 134:6,8 173:18
 177:19 183:12 188:7
 190:4 194:19 196:22
 202:7,17,18 203:9,13
 203:15 206:13 207:17
 209:7 212:16,17
 213:17 215:3,5,14
 216:18 218:13 219:14
 219:15 224:20 225:21
 227:7 229:13 231:5
 231:12 234:13 239:11
 244:17 245:7 247:1
 249:17 252:13 256:15
 257:3,14 258:13,15
 258:22 260:20,22
 261:2,8 266:17
 268:11 269:3,18
 272:12 275:1 276:20
processes 198:14

202:9 211:18 219:4
 244:9
produced 247:8
productive 5:11 254:21
products 33:15
professional 39:6
 164:5
program 15:11,14
 27:16,17,18,19,20,21
 27:22 28:1 30:2,13
 34:2 35:9,11,14 37:7
 37:10,21 38:1,3,21
 39:12,13,14 40:18,20
 54:9,14 55:9,10,11
 56:10 59:13 60:19
 61:1,7 66:6 72:5,16
 75:3,19,20 76:6,13,17
 77:2,12 78:21 89:6,7
 90:3 96:5 100:11
 103:4,5 105:17 107:4
 109:12 113:15 121:1
 121:3 125:11 132:5
 137:14 138:10 145:21
 147:3 155:10 160:8
 162:4 164:20 167:16
 167:19 188:20,20
 191:3 199:21 201:10
 221:12,17 222:21
 229:20 232:17 256:14
 262:15 263:10,18
 265:12,13
program-specific 30:20
programs 4:6 22:13,17
 26:8 27:15 28:4 30:4
 32:15 34:10,17 38:18
 43:12,21 44:9 45:10
 46:17,22 48:16,20
 50:18 57:7 58:4 63:22
 64:2 72:9,9 77:9
 108:3 109:14 118:9
 119:3 166:17 178:15
 189:3,7 190:11 194:3
 196:17,19 198:21
 199:4,7,21 200:18
 201:9,18 204:6
 214:20 222:2,7,11,22
 228:18,19 230:16,20
 232:6,8,12,14,16
 237:5 257:13 260:13
 263:19 272:19 279:9
progress 204:18
 266:14 267:6
progressively 55:21
project 3:7,7 85:13,15
 147:5 177:15
promising 59:5 60:2
promote 205:16
promoting 46:8 205:14

proper 40:2
proportion 58:14 65:20
 128:1 154:3 189:10
proposal 57:9
proposals 195:11,20
propose 19:16
proposed 13:6 89:11
 92:18 130:3 133:10
 147:12,14 156:16
 158:20 201:1
proposing 19:15 76:4
prospective 233:8
prospectively 247:13
prostate 170:15
provide 25:11 31:9 32:5
 32:8 126:2 134:18,19
 136:10 168:9 189:16
 242:8
provided 172:3 183:8
 191:11 229:18 254:6
 254:16
provider 114:7,14
 136:22 267:1
providers 28:22 37:14
 161:5 178:21 200:2
 222:3,19 236:12
 241:13
providing 89:8 196:21
 197:16 236:2 242:9
PSI-90 34:8 35:15 36:9
 37:19
psych 40:5
psychiatric 27:20 40:10
 180:7,20 181:1
psychosis 182:21
public 4:4,9,17 12:3,6
 13:1 23:21 24:17
 25:17,21 32:6 33:2,9
 36:2 37:15 50:3 66:6
 98:10 99:3,6 102:14
 103:1 104:6 106:10
 111:11 114:5 115:2
 117:2,9,14 124:13
 125:2,19 131:21,22
 132:14 137:3 167:16
 189:22 190:10 193:5
 193:8,10,11,13 208:5
 221:14 236:4 270:10
 273:16,18 275:22,22
 276:2
publications 127:5
publicly 108:6,10
 119:18 132:12 167:22
published 39:5 126:22
 132:5,19
pull 47:21 54:16 80:10
 99:19 171:12
pulled 47:8,11 51:1,4

68:12 80:8,14 94:16
 98:2 114:1 115:18,20
 126:9,13 129:6 130:6
 166:18 171:3 173:7
 173:16 180:8 183:9
 183:10 225:14,16
pulling 43:13 99:21
 168:18
purchasers 48:20 49:3
 49:7 170:8
purchasing 27:17 35:7
 35:9 44:10 72:8
 167:20 199:8
pure 168:15
purely 79:12
purpose 75:2 92:16
 106:13
purposes 34:6 183:11
pushed 241:10
pushing 8:17 49:7
 170:9 199:7,14
put 7:17 61:17 65:15
 70:11 86:6 88:2 100:3
 100:10 103:4 108:2
 123:8 125:11 143:18
 150:5,10 152:21
 154:16 155:5 209:7
 209:17 210:14 216:21
 217:16,17 219:8,22
 221:6 222:21 225:22
 226:8 230:14 256:13
 258:17 270:19 271:5
 277:11
puts 21:4
putting 110:15 114:17
 114:19 256:11,11
 269:18 270:5

Q

QASEEM 2:6 91:20
 95:1 118:7 126:15
 152:2 153:21 180:10
 183:20 184:2
QIP 72:10 73:6,15 74:18
 75:1 76:13,15,17
QPS 65:5,16
quadrupled 230:19
qualitative 246:19
qualitatively 245:12
 254:17
quality 1:1,8,15 2:18
 3:2,3 9:2 13:8 15:5
 23:15 27:17,19,21
 28:1 29:20 31:8 34:3
 38:1,20 39:1,11,16
 40:18 41:15 50:15
 51:16 54:9 56:5 61:3
 74:11,13 77:9 78:21

96:4 106:6 109:13,14
 119:3 132:5 134:10
 138:15 141:16 143:14
 145:21 164:20 167:10
 168:13 170:13,16
 178:8 198:19 199:4,6
 199:20 204:14,16
 209:22 210:7 222:4,5
 230:20 236:1 237:6
 237:10 238:2 239:5,9
 242:1,8 248:11,22
 263:9,10,19 269:10
Quantifying 118:2
quantitatively 245:13
 254:17
quarter 192:5
question 11:3 54:7 63:9
 65:3,6 68:12 70:12
 71:3 72:13 77:20
 85:21 87:5,6 93:8
 95:1 112:10 137:9
 138:3 140:12 161:10
 172:4 205:15 206:20
 216:11 219:20,20
 220:1 233:3 240:21
 252:1,4,18 253:22
 254:2,9 255:3 258:4
 260:21 271:20 276:19
questioned 51:13
questioning 269:7
questions 26:18 45:16
 47:3 106:15 136:16
 169:22 184:15 193:2
 207:10 216:3,8
 240:19 243:9,10
queue 26:13,18 209:17
 258:7
quick 75:14 93:9 95:1
 129:8 197:7 233:2
quickly 27:12 32:12
 46:6 50:8 55:18 68:17
 135:10,11 140:22
 171:19 181:5 191:7
 193:16,17 194:5
 200:16 270:4
quit 111:12 114:14
quite 20:2 21:13 32:15
 43:11 44:15 100:2
 146:5 190:21 191:2
 196:12 203:22 216:19
 233:13 254:3 266:6
 268:18
quote 201:3

R

R 2:4
rabbit 237:19
radar 21:4

raise 26:13,16 209:13
 276:19
raised 33:5 48:7 80:1
 81:6 84:9 94:10
 113:13 157:14 163:8
 179:22 182:2 209:16
 216:9 221:18 235:12
 240:19,21 255:1,8,14
 271:2 274:13
raises 8:22 85:21
 148:20
raising 26:17 216:9
random 245:13
ranking 184:21
rate 17:5 21:2,4 65:10
 66:12 82:12 104:1
 131:10,13,14 132:1,7
 132:16,20 145:19
 151:13
rates 18:2,14,22 19:13
 24:20 67:14 103:7
 129:5 133:9 141:6
 168:14 178:21 182:19
 201:16,20,22
rating 250:9
ratings 249:20
ratio 41:12 128:1
rationale 80:17
re-hospitalization
 182:4,6
re-look 62:10
re-review 95:3
re-specification 89:16
re-vote 47:18 153:15
 156:16
re-voting 168:19
 173:20
reached 141:14
reaction 22:3
reactions 165:22
read 102:10 117:16
 131:21
readily 28:13 32:9
 122:5 141:22
reading 55:11 75:17
 90:2
readmission 17:18 40:6
 41:12 73:10 180:7
 201:15,16
readmissions 31:19
 40:13 73:9 162:5
 180:18
ready 6:9 26:4 56:2,9
 89:5,6,9,13 90:21
 91:1,10,12,17 110:16
 113:20 118:15 119:15
 124:13 149:1 150:13
 150:16 155:3 158:17

165:7 193:6,6 219:21
 230:9 231:10 233:13
 250:20
reaffirm 210:10,21
real 30:16 36:10 78:14
 78:15 117:15 119:5
 120:21 121:5 130:4
 141:22 178:12 232:7
 260:10 267:2,8 269:9
reality 8:5
realized 220:3
really 5:11 6:2,13,18
 7:19 20:14,17 23:5,14
 23:19 25:1,4 29:2
 30:4,14 42:12 43:6,15
 43:16 44:18 49:7,21
 50:3,8 52:8,9,22 59:5
 60:21 61:15 67:12
 84:10 95:2,17 97:4
 99:7 100:13,16 105:2
 105:5,7,14 109:2,3
 110:22 111:19 112:1
 113:4 114:15 115:7
 115:13 119:1,12,19
 119:19 120:16 121:10
 121:20 122:15 123:8
 123:15 127:7 128:4
 129:12 131:1 132:22
 133:1,1,2,6,14 134:9
 135:18 137:2 142:19
 143:16 146:12,12
 147:17 148:4 152:5
 152:11,16 153:8
 154:20 156:2,20
 157:5 166:3,7 173:2
 173:20 174:8,18
 177:8 178:5,19
 179:11 180:19 181:7
 182:7 183:2,18 184:7
 185:2 189:5 196:15
 196:16,20 197:1,2,16
 198:13,14 199:5,8,12
 199:14,18 200:1,7,8
 200:14 205:16 206:5
 206:20 207:5 210:10
 210:11 215:6,18
 218:12 221:19 222:9
 223:8,17 225:2
 226:15 227:6,12,19
 232:5,11,13,17 233:3
 234:3,7,10,12,16
 235:7 236:16,20,22
 237:10,17 238:14
 240:4 242:8 243:13
 246:11,20,21 247:9
 248:7,14 249:8 250:5
 251:17 253:14 256:18
 262:1,2,7,8 268:17,21

269:2,5,7,8,10,12,14 271:4,7,9,14 272:3 274:18,20 279:3,4 280:7 realtime 122:1 123:10 123:18 reason 19:9 82:6 85:21 94:6 113:1 123:2 129:13 135:3 reasonable 186:15 reasoning 66:16 reasons 82:5 124:14 131:20 187:18 recall 12:3 188:13 Recap 4:2 receipt 25:9 receive 11:21 36:6 81:20 195:10 received 11:14 32:13 32:15 34:8 36:2 39:3 40:12 41:11 74:1,2 85:7 93:13 272:18 receiving 37:2 39:21 recognition 167:8 266:1 recognize 16:7 19:3 20:22 151:13 222:8 recognized 265:20 recommend 6:8 57:6 57:15 61:6 69:14 130:7 recommendation 6:14 21:20 38:11,15 39:4 41:5,11 45:13 69:8 79:8,15 80:13 89:20 96:15 98:1 99:10 107:7 119:13,14,22 121:16 128:11 129:10 131:20 133:21 136:21 142:14 145:2 151:7 158:17,19 163:4 165:13 173:11 252:16 263:14 268:10 recommendations 4:5 25:4 32:21 44:18 46:7 79:14 95:19 196:21 207:13 252:17 272:17 273:1 279:21 280:1 recommended 58:11 58:17 66:2 96:3 120:3 137:6 145:20 164:19 269:21 recommending 5:21,22 190:9 record 83:15 97:18 163:21 164:3 192:17 236:15 242:9 278:18 280:22	recording 33:17 recurrent 7:22 recuse 186:1 redo 212:16 reduce 18:2 30:18 35:11 180:18 182:6 reduced 18:13 35:21 reduces 202:2 reducing 33:3 reduction 27:22 37:7 201:16,19,20 202:2 refer 173:3 reference 135:10,12 209:22 references 277:12 278:10 referral 187:7 referrals 35:22 referred 172:12 236:7 referring 36:22 refers 6:2 refine 6:15 reflect 158:2 195:8 225:13 reflected 49:2 reflecting 150:7 215:5 252:6 reflection 195:17 reflections 194:17 reflective 193:19 196:5 226:14 reform 8:16 211:22 Refresh 171:11 regardless 90:20 91:2 regimens 43:5 region 101:16 Regional 2:3 registries 122:4 registry-based 84:3 regular 64:2,5 regularly 156:4 reimbursement 14:22 reinforce 114:15 reintroduce 194:6 reiterate 114:9 119:21 142:7 215:4 reiterated 148:21 reiterates 175:18 relate 8:18 263:18 related 128:2 140:12 156:8 161:16 162:15 168:13 182:22 202:6 203:13 205:20 252:3 252:4 253:3 relates 203:14,17 252:19,20 relationship 153:3 160:16	relationships 10:2 29:10 242:2 relative 73:11,12 238:19 276:20 relatively 186:14,19 191:22 relevant 112:15 189:15 191:15 reliability 229:19 reliable 141:6 remains 63:16 remarkable 269:13 Remarks 4:19 remember 27:2 41:1 157:15 170:22 remind 26:12 54:21 126:10 209:12 reminder 113:21 132:3 remiss 7:15 removal 243:12 remove 34:17 removed 243:4 renal 28:1 40:17 66:1 78:20 85:12,14 96:4 rep 264:10 repealed 199:17 repeat 43:20 91:22 135:2 255:4 replace 56:20 report 65:18 74:7,8 77:8 84:11 105:13 106:3 107:13 109:14 110:4 123:7 132:12 141:17 154:18 166:13 190:13 239:10,13,16 240:2 reported 73:16,22 108:6,10,11 109:17 119:18 123:20 136:2 reporting 13:9 16:16 19:15 20:11 27:15,18 27:19,20,21 38:1,20 66:6 72:6,9,10,15,17 72:20 73:2,14,15,19 73:21 74:9,14,22 75:10 76:8,21 79:12 102:12 106:3,6 115:2 117:9,14 120:15 124:14 125:19 132:5 137:3 145:21 164:20 167:16,22 190:10 200:9 222:4,5 239:9 reports 110:13 174:16 239:6 represent 206:2 representation 198:17 200:6 representative 12:18	264:14 represented 265:10 representing 10:20 request 21:18 230:6 242:22 requests 25:11 43:13 require 9:14 14:7 169:1 173:20 required 43:8 74:8 106:3 107:11 110:4 190:20 230:17 239:19 requirement 18:12 73:15 requirements 44:9 73:19 75:10 90:3 requires 14:13 16:16 72:10 164:14 231:2 233:6 requiring 160:2 230:20 research 1:17 2:18 176:17 177:15 resection 170:15 resend 11:18 reserve 57:1,2,16 58:17 59:12 60:6,15 63:12 63:13,14,17 64:11,13 64:15,18 65:6,15 66:2 resistance 121:7 122:3 125:1 resource 31:4,6 45:5 167:1,8,9 168:1,4,7 168:12 170:9,12 174:13 176:8,22 179:6 resources 100:8 178:16 178:22 185:13 256:19 respecified 107:9 respect 88:22 respector 255:20 respectful 195:2 respectfully 21:12,18 respond 52:5 82:16 106:17 118:21 130:16 220:9 respondents 50:22 responding 43:12 243:16 response 47:6 48:1 224:19 271:4 responses 153:14 183:22 responsibilities 161:4 271:7 responsibility 19:5 225:5 responsible 119:19 242:6 rest 38:18 273:14
---	---	--	--

restate 87:5 146:4
result 208:14 244:13,22
results 132:6 151:3
 269:20
resumed 192:17
rethink 268:3
retired 52:16
retrospective 256:22
 257:11
return 160:7
review 20:13 102:19
 110:12 193:16 220:20
 239:21 256:7 257:1
 273:10
reviewed 38:21 53:22
 66:1 154:11 181:7,10
reviewing 48:15 182:13
 183:4 207:12 224:1
 244:5
reviews 135:12 251:12
revised 36:8 37:18
 44:11
revisit 26:10 59:20
 210:9,21 254:2
revisiting 206:19 207:8
reward 279:19
Rhonda 1:12 11:18
 98:3,4 111:2 115:20
 115:21 117:20 119:7
 124:18 141:11 142:2
 172:8 173:5 242:18
 270:9 271:16 272:5
rich 142:2,16 151:15
 192:20 226:5,6 228:7
RICHARD 1:20 2:13
RICHARDS 2:17 69:9
 124:3,11
right 8:19 22:12 23:4
 59:22 68:11 69:6
 70:12 71:11 74:22
 76:18,20 77:3 78:11
 79:6,21 88:4 89:6,13
 92:20 95:5 100:5
 101:2,3 109:11 112:7
 118:4,5,5 123:8
 131:10,14 132:1,16
 139:6,21 149:16
 152:7 154:19 155:11
 155:14 157:4 162:19
 164:16 175:20 179:13
 180:11 183:3 213:19
 214:22 218:9 220:16
 222:3,18 224:3
 253:12 274:12 278:7
ripe 137:2
rise 280:7
risk 8:22 9:1 38:4,15
 113:12 119:6,8

127:10,15,17 128:5
 131:8 169:12 175:6
 177:4 178:18 182:8
 261:15,20
risks 131:4
RN 1:12,17,18 2:10
road 24:3 144:15
robust 9:5 20:3 31:16
 58:9 81:3 100:17
 167:4
role 23:8 24:15 33:3
 53:15 56:12 89:4,19
 90:12 91:9 103:20
 182:11 194:17 206:22
 207:11 208:10 214:14
 215:7,11 250:8 252:5
 252:19 253:2,14
 254:11 266:16 267:21
 267:22 268:8,14
roles 31:17 64:10
Ron 27:6,6,9 42:1 45:18
 53:15 57:10,12 81:1
 83:17 147:21 154:7
 160:6 167:5 169:7,19
 169:21 181:19 187:21
 187:22
RONALD 2:21
room 1:9 12:7 25:17
 43:7 45:8 48:12 53:5
 64:21 70:1,14 133:2
 145:4 154:11 192:11
 193:13,13 275:22
round 270:14
route 149:12,15
routine 64:5
RPh 2:8
rule 44:17 95:15 130:10
 214:11 217:10,20,21
 221:2 233:9 234:5
rulemaking 56:3,9 61:6
 61:9 76:7,10,11 89:10
 90:16,22 91:1,10,13
 91:16,17 148:19
 149:1,19 150:1,5,13
 150:16 207:16 213:9
 214:2 216:16 217:18
 219:22 230:9 231:3
 231:11 233:7,8,13
 250:21 251:1
rules 89:11 93:18 94:11
 168:2
run 177:14 193:17
 196:4
running 24:2 110:12
rupture 131:5 135:5,6
RWJ 241:17

S

safety 29:16 35:14 36:8
 37:18 49:4,9 50:15
 120:7 154:10 155:15
 157:16 160:20 241:7
SAKALA 2:7 134:4
 141:13
sake 237:1
salience 135:4
SAM 2:2
sampling 133:19
Sampsel 3:6 85:11,12
San 42:12
Sanghavi 3:14 12:9,12
 280:3
Sarah 3:6 85:11
sat 264:17
satisfaction 248:21
satisfy 227:11
save 90:4
Savings 15:13 160:8
 188:19
savvy 136:6
saw 26:21 44:17 136:18
 249:13 267:17
saying 19:14 70:14
 74:5 75:12 76:3,4
 82:21 87:20 113:18
 147:17 152:8,10
 155:1 191:6 238:1
 241:12 243:9 261:11
says 52:18 65:13 90:3
 124:7 171:8 184:8,21
scale 249:17
scaled 250:11
scarring 135:16
SCHLAIFER 2:8
School 12:14
scientific 3:1 17:3
scope 27:11
score 37:2 66:22 73:12
 75:8,13 76:15,21
scored 77:2,12,13
screen 21:5 70:12,15
 78:2
screening 183:16 187:6
SDS 28:20 33:7 38:4
 40:14 182:9
se 102:18
sea 250:15
Seamless 40:21
season 81:21 96:2
 246:1
second 78:16 104:18
 108:14 124:17 201:8
 207:18 208:9 224:12
 251:3
section 131:8
sector 50:4

see 11:20 17:10 23:14
 25:12 30:5,8,10,15,17
 34:11 35:13 38:7
 48:22 49:6,16 55:20
 68:16 69:7 80:12
 86:19 129:20 130:4
 130:18 135:18 153:10
 153:13 161:14 162:14
 162:18 165:2 170:12
 171:16 172:7 183:21
 197:13 199:3 202:11
 204:17 211:22 214:11
 228:17 229:22 230:1
 236:17 239:22 245:8
 249:1 250:22 253:3
 260:15 268:18 280:6
seeing 20:4 78:1 109:4
 170:22 175:14 179:20
 197:1,8 198:2 199:5
 200:7,9,21 233:12
 257:12 274:20 279:13
 280:17
seen 17:8,11 85:13
 128:21 156:22 157:6
 175:9 189:5 196:18
 197:3 198:22 200:8
 201:15,19,20 229:6
sees 159:13
selected 235:22
selection 198:15
 202:18 203:10
self 205:14,16
self-care 164:1
semi-random 244:1
send 50:2 71:9 95:2
 150:11,14 259:9
sending 139:16 143:9
 212:7
sends 91:5 148:18
 159:16
senior 3:3,5,5,6,6 27:3
 46:4 85:12
sense 8:3 23:5 61:19
 118:19 120:16 158:2
 234:17 241:3 249:14
 268:6
sent 71:6 122:1 152:19
 155:14 205:20 278:10
separate 75:5 216:17
 216:18 217:5,6
 219:14,15 231:5,9,16
 243:3
separated 228:1
September 94:12 194:7
 195:22 203:19,21
 204:3,20 228:13
series 14:18 15:12 94:6
 135:12 249:17,18

serious 135:15 246:21
seriously 119:19 124:6
 240:10
serve 19:1 239:7 275:8
served 16:5 64:9
service 15:2 134:20
 136:11 242:3
services 2:19 3:10,15
 30:6 38:9
serving 92:15
session 195:17
sessions 191:22
set 41:14 50:7 72:10
 87:18 105:1 126:6
 168:9 176:16 178:22
 183:7 187:5 189:6
 209:18 212:15 213:5
 213:17 219:14,15
 253:20 263:17 279:13
 279:20
set-specific 219:11
sets 84:22 190:2 196:17
 219:5 235:21
setting 29:1 46:22
 118:5 162:17,17
 167:15,21 175:3,4
 176:11 186:6,8,10
 187:9 197:11 212:20
 241:15,16 250:1
 252:12 262:13,16,17
 263:8
setting-specific 27:15
settings 23:1,9 24:2
 28:15 29:1 46:18,19
 50:11 128:16 197:14
 199:10 200:4 222:3
 225:18 249:22,22
 253:8
setup 235:17
Seven 165:10
severe 14:7 182:18
SGR 199:17
share 16:8 46:8 80:19
 81:16 99:21,22
 105:18 136:14
shared 8:18 15:13
 28:13 46:9 122:10
 160:7 188:19 211:17
 212:19 261:22 262:9
 262:12
sharing 122:14
Shawnn 3:10 11:17
 70:13 71:8
shift 87:22 115:4 199:5
 200:10 212:1 215:22
shifting 115:3
shifts 199:3 260:14
shocking 20:12

short 165:12
shorter 135:8
shout 7:19 267:19
show 19:4 58:12 135:13
showing 171:10
shown 122:4 126:22
shy 177:7
side 57:3 112:18 128:18
 186:21 264:3 270:20
signal 136:9
significant 37:12 70:6
 127:2 131:3 148:15
 176:19 201:20 202:2
 203:7 226:13 229:11
 253:18 254:5,7
 266:14
significantly 24:17
 44:13
Signs 104:19
silent 55:12
siloed 214:20,21
siloing 214:19
silos 98:15 242:11
similar 37:17 54:2 70:5
 81:7 94:16 97:11
 118:8 140:9 168:1
 190:20
similarities 166:19
similarly 198:9
simply 74:21 123:4
 163:9
Simultaneous 145:13
 149:7
sincerely 273:9
single 105:16,17,17
 274:14
SIRIO 2:9
sit 230:12 266:15
site 164:1
sitting 10:19 185:11
 215:7
situation 94:17 250:12
 251:21 275:10,15
situations 131:6
skip 26:20 205:4 218:10
slap 91:3
slide 26:21 28:2 29:20
 37:6 46:5 47:1 70:4,8
 200:5 201:21 202:10
 202:20 203:3 205:3
slides 26:8 196:5
 203:20 206:16 235:17
slightly 235:2,3 265:1
slow 123:21 124:1
slowly 241:1
small 129:17 139:8
 224:2 270:6 272:13
smaller 116:19

smart 64:20
smoke-free 18:12
smokeless 33:14
smoking 13:7 16:9 17:5
 18:2,4,14 19:13 24:10
 31:13 32:18,22 33:2,4
 33:9,9,13 97:21 99:14
 103:7 104:1 106:15
 111:11 115:14 280:4
snapshot 197:7
SNF 166:9,11
snow 70:5 253:19
 275:19
snowstorms 217:1
social 242:3
Society 3:11
sociodemographic
 127:11,16 181:4
solid 186:8
solution 84:14 123:8
solutions 123:5,16
solve 156:12 216:13
solved 123:3
somebody 67:19
somebody's 67:14
something's 244:21
somewhat 192:22
soon 280:20
sorry 42:4 48:5,7 71:15
 84:17 87:4 96:19
 147:21 169:21 170:21
 174:7
sort 5:18 6:22 8:6 15:15
 18:20 45:19 55:11
 56:19 64:1 85:22
 87:17 93:21 100:21
 104:4 105:16 118:12
 120:6 122:17 124:20
 126:5 150:4 155:5
 160:16,19,20 162:2,6
 162:9 163:12 166:15
 168:16 169:4 177:15
 187:6,8 191:8,13
 192:9 193:18,21
 194:9,14,16,17,22
 195:4,7 200:16
 201:12 202:12 203:4
 203:5,17 204:22
 205:8,12 206:2,11,17
 207:10 208:14 210:17
 215:2 217:9 219:6,10
 219:16 220:6,14,16
 221:16,21,22 222:3
 222:15 224:8 225:11
 230:11 237:10 244:4
 244:9 245:16 246:2
 246:12,17 247:13,16
 247:18 248:1,8,12

249:16 250:10,21
 251:3,9,18 252:2,7,18
 258:21 260:12,13
 261:1 262:12,13,22
 264:3 265:2,4 269:2,6
 269:6,17 271:19
 272:21 280:7
sorts 19:17 217:2
sound 60:10
sounds 67:20 84:19
 87:20 145:2 155:1
source 81:12 82:8
space 143:22
spanned 204:5,7
speak 70:2 98:7 105:11
 137:20 223:2 274:15
speaker 10:1
speakers 137:20
speaking 12:10 53:12
 145:13 149:7
speaks 197:6
special 57:21 267:19
 275:7
Specialties 2:5 3:13
 278:20
specialty 32:2
specific 6:14,16 7:3
 219:1
specifically 15:7 19:8
 63:17,20 102:3 106:6
 109:6 163:1 207:14
 258:4 265:4
specification 87:10
specifications 39:19
 133:9
specified 85:6 87:8,12
 90:6 93:15 161:9
 217:17 221:10,11
specify 217:18
specs 220:19
spectrum 197:12
spend 13:1
spending 202:3
spent 44:6
spinal 170:14 172:15
spirit 143:4
split 74:18
spoken 238:16
spring 214:12
squeezed 254:18
stack 177:3
staff 3:1 7:16 42:5 63:9
 65:4 71:15 86:3,17
 125:14 195:9,20
 208:20 258:12,18
 268:22 270:7 273:15
 275:18 279:2 280:18
stage 198:10

stakeholders 168:3	119:3 120:22 121:3	subcommittees 211:19	96:13,14,14,15,21
stamps 252:16	stop 132:21 133:20	212:15	97:1 101:3,5 105:19
stand 79:8	205:6 251:16,19	subgroupings 43:3	111:17 118:19 119:14
stand-alone 188:6	stopped 257:15	subgroups 279:2	120:2,3 121:15
standard 203:1 204:1	stopping 256:13	subject 2:12 9:20	122:22 123:1,13
standardization 200:1	storm 253:19	submit 21:12 75:22	126:16 129:9,14
standardize 140:2	straightforward 141:18	submitted 74:18 75:17	131:16 136:11 137:6
Standards 202:14	223:12	85:14 147:5,8 177:21	137:18 140:17 145:2
standing 44:19 66:1	strategic 13:16 14:18	178:1,1 186:17	145:3,22 146:1,1,12
85:10 177:20 182:12	15:18 23:6 24:22 25:6	submitting 76:2,5,11	146:15 151:4,4,5,12
186:12 187:19 188:17	25:11,14 43:22 199:5	76:12 110:14	152:6 154:21 155:13
226:18 227:1,15,18	202:5 204:1,8,9	subsequent 155:18	156:11,13 158:21
star 193:10 250:9	205:13 207:16 274:11	subsequently 123:20	160:3 161:13 162:14
start 21:5,6 51:2 121:9	274:15 279:8	154:18	163:5 164:11,12,12
127:3 152:2,8 153:7	strategies 14:14 15:14	substance 40:6 183:6	164:14,21,21,22
172:10 173:1 176:3	18:9 19:18 38:15	184:5 187:11 189:7	165:10,11,11 166:7
184:17 193:4 212:6	275:13	189:17	174:10,11 175:7
228:5 274:21	strategy 13:14 17:13	substantial 17:1,7	177:13 180:11 181:13
started 5:4 111:3 161:1	18:17 198:19 204:14	19:12 197:3	185:19 186:19 212:3
230:19	204:16 210:1,16	substantially 5:4 14:10	224:11 242:20 255:17
starting 175:12 184:10	Street 1:9	17:4 18:1,6,13 20:18	supported 29:8 31:12
238:7 253:11 256:1	strengthen 151:10	131:9	33:21 36:3 38:10 40:5
state 15:8,10 19:20	strengthening 196:16	subtle 260:14	63:6 66:10 99:20
106:22 114:5 125:12	205:11	success 200:13 242:14	128:10 130:8,8
176:15 220:3	stress 35:10	successes 201:14	155:19 165:3 167:13
stated 34:4,13 156:14	stressed 28:8 29:12,21	successful 235:13	185:17 188:8 201:17
176:14	35:17	sufficient 104:9 137:7	259:19
statement 190:14	stride 196:16 197:1	sufficiently 217:4,7	supporting 27:3 41:7
statements 19:3	strikes 144:5 231:15	suggest 225:20 240:18	135:19 159:22
states 15:9 129:22	239:14 266:13	suggested 68:15 146:4	supportive 119:12
136:3,3,8 139:16,19	striking 235:5	suggesting 66:14	155:2 181:8 227:1
stating 269:4	striving 269:8	suggestions 68:13	supposed 60:14 108:9
stature 233:4	stroke 33:18 35:3	261:13	108:16,17 190:9
status 35:2 57:1,2,16	strong 47:13 150:14	suicide 181:2	232:6 263:3,21
57:21 58:17 59:12	186:19,21 190:13	suited 117:9 155:9	sure 7:14 31:14 35:8
60:15 61:4 63:12,14	248:16 267:16,17	sum 153:19	38:19 48:9 50:6 51:20
63:14,18 65:15 66:2	stronger 82:5,7	summarize 169:11	58:8 64:3 69:17 70:19
175:7 176:7 257:1	strongly 13:22 54:3,4	200:16	73:5,9 78:8 80:18,19
statute 55:14 217:21	79:15 133:14 151:12	summarized 83:20 91:7	83:10 87:1 91:16
218:1,4 231:1,18	181:8	169:9	97:18 98:11,21 99:8
statutes 218:3	struck 266:4	summary 65:12,14	100:2,16 103:11
statutorily 223:13	structure 93:22 214:21	152:19 203:11	106:18 110:13 115:22
statutory 90:2 220:17	222:22 253:7	summer 196:2 206:9	122:15 129:17 141:6
220:22	structured 175:16	sunny 77:22	148:14 151:9 152:5
stay 93:21	222:2 225:11 240:2	superior 97:5,7	152:11 153:12 159:3
steered 136:19	253:8 272:19	supplement 167:5	160:18 161:5 169:13
step 24:14 52:7 56:11	struggle 8:10	168:15	184:1,7 185:2 190:9
103:19 121:5,20	struggled 60:7 209:10	support 31:12 34:1	190:12 200:15 211:1
123:11 166:2 182:10	struggling 22:10,11	39:4 40:3,12 41:12	218:16 219:3 224:8
218:10 220:6 228:20	142:19 143:16 263:2	46:16 53:12,13 55:8	230:3 238:3 249:7
248:13	studies 41:15 51:16	55:17,18 61:17 63:2	252:10 259:1 268:5
STERLING 3:7 78:7,16	126:21 186:6,22	65:20 68:1,2,2,4,5,6,8	surely 241:2
78:18 79:6 96:1	stuff 148:22 175:13	68:15,16 69:12,12,14	surfaced 60:2 274:9
145:17 150:22 164:16	191:7,11 213:20	78:22 79:1,1,5,7,7,9	surfacing 264:20
STEVE 2:11	218:5	80:14 84:14,15 85:1,2	Surgeons 2:6
STEVEN 1:15	subcategory 63:16	86:20 88:7,8 89:14,14	surgeries 121:11
steward 185:22	64:22	89:15 90:14,15 92:2,5	surgery 27:18 39:2
stewardship 118:9	subcommittee 258:17	93:3 96:7,7,8,10,11	surgical 38:20 39:1,10

surprised 62:1 185:18
surprising 20:12
surprisingly 139:8
surveillance 34:2 58:1
 64:2
survey 107:16 136:15
 205:19
survival 127:2
suspect 88:18 277:19
switch 68:17 91:15
switched 55:19
switching 90:12
symmetry 39:13
syndrome 39:8
synergy 110:5
system 13:9 25:14
 81:14 83:14 115:1
 121:21 140:8 173:2
 202:3 211:22 212:7
 217:7 241:1,10
 242:15 275:5
systematic 135:12
 269:19
systematically 81:19
 136:19
systematizing 247:1
systems 15:1 191:2
 212:6 241:6,11
 242:11 250:10,17

T

T-MSIS 140:7
table 6:18 10:4 24:20
 47:15 89:3,13 164:13
 209:8 232:11 263:16
 266:14 270:14 274:5
 280:14
tables 266:15
take 5:7 9:2 16:22 25:5
 30:19 38:17 41:3 48:7
 52:6 62:4 64:3 69:13
 69:17 93:8,10 99:11
 104:2,17 124:6
 165:16 191:9,18
 200:14 219:16 220:6
 232:10 235:3 263:16
 272:20
takeaways 200:17
taken 99:16 126:2
 143:17
takes 119:19 172:14
talk 5:9 15:20 45:4 68:4
 125:5 129:22 130:14
 135:11 162:4 165:19
 174:19 178:4 233:15
 271:22
talked 31:3 41:6 45:2
 117:18 182:15 192:21

193:2 197:15 198:4
 199:22 216:21 221:21
 235:11 245:17 255:7
 261:16,16 272:10
talking 43:6 44:6 92:7
 97:20 105:4 112:15
 125:14 127:15 152:2
 178:7 212:14 215:17
 221:20 235:9,17
talks 102:17
tally 5:7 96:12
Tara 161:21
target 54:10 66:9 132:8
Taroon 3:4 4:14 193:14
 196:7 200:13 211:3
 213:3 228:9 251:22
 271:17
Taroon's 260:17
TAS 39:7
tasks 223:9,21 224:4
taxes 33:9 111:8 114:12
team 267:15
teams 243:17
technical 13:3 70:6
technically 69:4 275:20
Technology 2:16
teed 211:3
teleconference 3:18
telegraph 13:15
telephone 10:13 107:17
 276:3
tell 21:13 23:20 42:4
 51:10 65:17 78:5
 105:12 114:14 136:5
telling 118:3
tells 68:18
template 247:5
tend 190:5 277:3
tension 212:13 220:15
TEP 59:19 60:6 62:3
TEPs 59:2
term 84:14 180:20,21
 191:19
terms 5:19 9:22 15:7
 26:12 45:21 74:20
 75:12 102:11 104:9
 113:22 126:1 131:4
 139:8 140:2 163:8,9
 169:17 180:2 186:15
 187:13 188:22 200:16
 200:17 201:13 222:16
 225:21 236:1,19
 237:19,21 244:4
 245:2 246:12 255:3
 258:9 267:21 269:16
 272:13,17,21
terrific 121:20 210:19
 211:20 279:3

tertiary 116:17 119:7
test 70:4,12
tested 83:22 84:6,18
 85:6 86:4,7 87:7,13
 93:15 107:5 146:9,21
 178:1 198:4,8
testing 40:2 54:20
 55:22 60:9 61:12
 92:16 93:12 118:17
 141:5 142:12,13
 198:1 203:2,7
thank 12:1 21:21 25:15
 26:1 45:9,15,17 47:2
 50:19,20 71:12 72:1
 109:8,10 126:4 134:2
 134:5 137:17 142:18
 144:5 162:19 165:6
 192:13,14 193:15
 209:21,21 223:1
 232:21 233:5 242:16
 243:20 248:3 268:16
 271:16 273:2,3,19,21
 274:16 275:9 277:6
 278:9,13,17 280:15
thanks 30:22 52:3
 83:10 107:22 131:18
 134:1 151:18 172:9
 192:12,19 196:7
 211:10 212:22 220:11
 240:14 242:17 264:8
 275:7,17,18,20
 280:16,18,18,19,19
theme 40:15 155:12
 275:6
themes 7:22 28:5 193:1
 271:19 272:2
therapeutic 154:3
 159:7
therapy 242:5
they'd 30:8
thing 8:4 42:7 43:9 50:8
 72:2,4 93:12 111:8,10
 132:22 156:7 172:2
 173:22 201:8 203:16
 210:12 218:10 223:10
 237:8 239:3 240:22
 246:18 247:8,17
 255:13 256:12 265:20
things 7:12 9:7 17:19
 23:2 24:8 43:5,20
 45:20 49:22 50:7
 52:20 53:17 60:5
 61:16 83:3,20 84:10
 97:9 98:12 100:4
 109:1 111:13 114:13
 116:7 121:12 127:20
 139:1 169:14 173:1
 182:22 188:4 190:10

193:14 196:15 198:12
 204:11 206:10 207:2
 209:8,10 210:2 212:5
 213:15 216:20 219:21
 221:3 224:16 225:7
 225:20,21 226:22
 237:11,16 238:17
 241:4 242:19 244:7
 247:11,12 248:15
 261:1,10 263:1,7
 266:16,19 268:1
 269:15,16
think 5:10,10,14,19
 6:19 7:11 8:2,8 9:8,18
 17:14,15 19:16 24:22
 25:5,10 26:21 31:1
 38:17 41:20 42:17
 44:1 48:11,14 49:1,5
 50:2,5,16 52:8,22
 55:7,16 56:2,7 58:12
 58:16 59:7,18,19 61:3
 61:17 62:7,10 64:7,17
 65:7 69:9 71:2 72:3
 72:13,19 74:15 75:7,8
 77:4,14,16,17 79:19
 81:5,22 85:2,17 86:18
 89:4,9,14 90:12,20
 91:1,4,6 92:3,13,14
 95:17 97:7,15 98:2,9
 98:14,21 99:16 100:1
 101:20 102:21 103:18
 104:13 107:9,20
 109:22 110:7,9 111:2
 111:7,17,22 112:2,3,6
 112:7 113:1,4,16,17
 114:10,22 115:7,15
 116:6,9,15 117:3
 118:8,11,12,15,18,22
 119:16 120:5,21
 121:14,15,20 122:11
 122:14,21 123:21
 124:12,21 125:14
 126:5,15 127:3,7
 128:4,20 129:12,21
 129:22 130:9 131:1
 132:10,20 133:2,15
 133:21 135:3,21
 136:7 138:3,5,9 141:4
 141:21 142:4 143:4
 143:10,13,17 145:5,8
 145:14 147:1,2,11
 148:20 149:1,3,5
 150:6,18 152:5,9
 155:2 156:1,9,10
 157:1,18,21 158:2,3
 158:13 159:12 162:20
 162:22 163:15 165:7
 167:7,17 169:16

170:14 171:7,18	thinks 251:16	timing 44:12 221:2	treat 19:4 95:16 236:14
172:13 173:14,21,22	third 224:16 246:20	title 179:14 268:3,3	treating 28:16 109:21
174:1,11,14,18 175:1	272:11	tobacco 14:4,16 15:7,9	117:4
175:17 176:3,16	thirdly 208:9	18:22 33:14 221:9	treatment 29:7 36:18
177:14 178:8,11,14	Thirty-day 17:18	today 9:6 10:4,11,20	37:6 38:12 185:6
178:15 179:3,18	THOMAS 3:13,14	11:14 12:10,21 14:5	187:7,8,12 189:1,11
182:7 185:5 186:9	thought 9:5 55:4 56:22	20:4 22:14 70:5 74:13	treatment-specific 29:1
190:3 191:4,10,11	81:11 82:4,5,6 102:2	93:17 108:2 121:8,13	tremendous 139:22
192:1 197:3,5 198:12	102:10 113:16 115:7	142:6 203:17 204:13	279:1
201:11 204:1,4	155:9 161:7 174:6	206:21 211:14 212:14	tremendously 48:13
210:10,12 211:2,4,13	186:1 189:2 194:1	215:11 236:8 240:19	tried 11:9 255:11
211:17,21 212:21	221:13,19 240:22	255:15 264:17	troubled 88:21
213:2,5,10,16,22	243:3 246:21 252:3	today's 70:20 71:5,6,9	true 16:3 53:17 63:4
214:4,21 215:2,4,5,11	263:3 267:11	194:10 195:12,16,16	142:14
215:15,17,20,22	thoughtful 45:11	206:7	truly 8:11 23:16 24:8
216:8 217:14 218:1,6	192:15 211:18 235:14	told 64:20 85:17 256:12	100:16 224:16 237:5
218:13 219:4,12,13	thoughtfully 174:8	Tom 13:19 276:10,15	274:2
219:18 220:5,6,15	thoughts 141:3 217:12	276:17 278:19	try 11:21 24:21 77:19
221:8,16 222:1,11,14	244:1,10	tone 276:4	110:6 114:2 129:7
223:5,10 225:1,4,8,9	thousands 135:5	tool 176:5 228:21,21	143:14 192:4 215:16
226:16 227:7,14	three 5:20 62:17 66:21	top 171:8 235:12	222:10 224:14 226:11
228:11 229:5,8,12,21	67:16 68:7 79:3	top-down 58:11	235:1 266:17
230:2,5,12 231:4,12	125:16,17 127:6	topic 59:8 90:6 199:2	trying 8:10,19 56:7
231:22 232:3,4,19	157:6 164:11 191:21	201:4 219:1 272:4	57:10 69:7 103:3
233:17,19 234:1,9,12	203:19 216:22 224:9	topical 197:13	106:9 108:22 111:20
235:5,6 236:3 238:6	224:21 231:17 232:16	topped 41:7 55:6 56:17	115:4 120:9 131:12
238:19 239:2,17	233:9,14,21 234:5	57:4,22 58:13 60:18	140:2,8 166:7,16
240:3,4,10,11 242:1	239:10 245:9 247:16	61:13 63:18 64:5 66:3	182:15 194:9 198:13
242:10,10,15 244:18	throw 97:2,14 115:9	topped-out 58:15 61:4	205:4 213:11,13
246:5,15 247:11,16	148:14	totally 224:3 270:3	238:11 240:20 243:13
248:18 249:5,13	throwing 85:19	touch 17:22 22:8	248:1 273:8 280:4,11
250:7,13,17 251:3,4	ticks 115:11	toxic 39:7	turn 86:22 140:13
251:10 252:3 253:19	tie 199:18 235:1	track 242:9 251:16,19	193:14 196:3 208:18
254:15,21 255:2	tied 75:21 76:7 198:18	tracking 15:9 227:8	208:20 273:13
256:17 257:2,12,17	tier 236:14	tracks 257:15	turned 140:18
258:1,5,7,9,13,14,21	ties 198:15	traditional 199:12	turning 145:6
259:3 260:7,20 261:5	TILLY 3:7 96:12 151:3	train 252:3	tweaks 44:11,12 250:22
261:7,11,12,14 262:5	165:9	transferred 116:19	two 6:4 37:8 50:18
262:11,19 263:12,14	time 25:19,22 34:6 44:6	117:5	56:14,18 59:20 67:16
263:21 264:20 265:1	45:10 70:2 71:9 92:9	transfers 116:22	73:5 74:19 75:5,14
265:20,22 267:2,4,7	95:7 109:4 144:14	transformative 246:11	82:20 84:11 92:21
267:10,14,17 268:20	148:15,16 154:4	transition 44:6,9 46:13	116:7 124:14 125:16
269:1,1,12,13,15,18	159:22 160:2 163:16	161:12 162:10 163:21	125:17 127:6 151:1
270:3,5,6,12,17 271:1	182:14,15 192:10	164:3 206:11 222:20	157:9 159:8 162:14
272:1 273:20 274:4	195:3,14 196:13	transitional 165:4	180:3 184:8 192:7
274:22 279:13,20	205:6 210:6,9 212:21	transitions 46:10	197:16 200:16 201:5
280:3,14,17	213:3,12,14 214:5,6	161:13,17 162:5,7	202:9 203:19 206:14
thinking 8:20 21:16	214:14 215:13,15	221:22	206:15 213:17 216:10
52:12 59:16 70:17	218:1 226:1 227:9	translate 153:5	219:4,5 220:7,12
101:11 144:1,19	231:11,17 233:21	translation 202:1	231:16 232:16 239:18
153:7 160:17,22	247:4,20 251:3 261:2	transmission 46:14	245:9 250:19 251:8,9
173:18 174:8 179:4	262:2 264:22 273:10	163:20	251:20 252:6 255:16
194:13 210:3,17	274:3 275:3 278:16	transmitted 164:3	256:2 273:5 275:19
212:15 222:10,13,15	279:3	transparency 279:18	tying 76:5 199:12
234:1,8 235:20 237:3	timely 46:15 163:20	trauma 190:21,22	type 32:5 85:5 162:13
242:16 245:14,16,21	times 26:22 94:10	travel 195:3 273:7,8	168:1 170:9 188:20
246:8 248:8 268:7	148:21 185:6 235:6	traveled 273:7	192:2 250:18
274:18 279:8	271:2,14	Travis 42:9	types 19:17 39:2,10

73:6 104:10 200:21
223:7
typically 134:6 182:22
212:4 264:11

U

ugh 262:3
ultimate 77:14 195:16
ultimately 14:22 58:10
58:16 167:12 200:12
ultrafiltration 41:19
unable 62:1 106:11
Uncomplicated 145:19
underscore 102:22
understand 21:11 39:7
61:2 74:5 80:6 82:21
92:12 99:7 101:21
102:8,20 105:22
129:13 139:17 144:7
146:6 173:12 177:3
179:22 215:6 218:6
224:8 232:13 233:11
243:12,19 255:3
258:2
understanding 63:11
74:12 100:11 108:4
117:6 133:10 135:7
173:7 181:5 211:1
220:21 232:5,7 257:9
undertake 206:8
undertaken 203:18
undertaking 202:13
unfair 103:18
unfortunately 13:12
58:22 134:21 194:11
unhealthy 184:21 185:3
unintended 35:20
36:13,20 40:1 99:5
101:11 102:8 115:10
116:15 175:21 177:6
263:8
Union 2:3
unit 160:10
University 3:14 12:14
unplanned 180:6
unquote 201:3
unrelated 249:12
unselective 172:19
upcoming 231:4 234:5
update 74:7 257:1
updated 37:11 64:14,16
134:13 229:10
updates 37:9,13
upgrade 106:5
upstream 197:17,20
261:4,8
urged 34:16
urgency 125:3

usable 109:17
use 14:3,15 26:13 31:4
31:7 33:20 53:17
63:21 64:16 75:1 76:4
76:19,19 81:8 83:11
89:5,6 93:19 108:9
109:20 115:1,2,5,19
116:9,12 117:12,15
117:22 118:1 119:2
121:5 122:2 132:13
132:14 138:20 150:12
165:20 166:10 167:1
167:8,9,18,22 168:1,4
168:7,12 170:9,12
177:8 179:6 183:6,7
185:1 186:5 187:11
189:7,20 196:19
203:8,14 209:12
212:8 215:1 223:21
229:19 231:11 232:1
235:21 249:10 257:21
263:17 278:5,5
useful 32:6 190:5,10,16
191:12 245:1 258:6
258:17
usefully 5:14
user 109:18
users 236:4
uses 75:20 99:4 201:11
usually 138:13 160:10
169:17 264:14
uterine 131:5
utilization 41:19 45:5
176:8
utilize 43:1 104:12

V

vacations 217:1
vaccination 18:18
80:11 92:6 96:3
vaccine 81:20 82:10,13
83:1,16
vaginal 129:4 131:4
145:18
validated 136:16
validation 40:3
validity 229:20
valuable 43:1,17
value 27:16 61:13 72:15
75:12 199:13,18,19
199:19 215:15 226:15
227:7 236:2,17 254:8
255:4
value-based 14:21 35:7
35:9 44:10 72:8
167:19 199:8
variability 139:22 175:4
variables 181:5

variation 172:3
variety 18:9 178:10
263:10
various 28:4 100:7
195:20 207:20 228:5
231:9 248:19 260:14
263:7,15
vary 21:1 131:7,8 178:9
180:22
VBAC 130:22 131:4,13
134:16,17 143:13,14
145:3 151:12
VBACs 145:5
vehicle 213:19 228:15
vehicles 115:6
vendors 125:12 133:6
133:18 159:21 160:3
version 37:13 86:21
171:9,12
versus 31:4 72:17
102:6 116:13 117:15
220:14 255:12
vetted 188:12
Vice 3:2,3
view 25:15 134:10
181:11 204:8 207:16
238:11 245:22 257:11
274:2 277:17
viewing 224:4
viewpoint 25:6
violate 218:2,4
violation 217:21,22
vis-a-vis 253:15 254:11
visibility 50:14
vision 4:12 23:6 25:11
263:2
visits 39:20 127:19
128:2 165:21
Vital 104:19
vocal 49:12
voice 197:5 248:21
voiced 155:7
voices 199:13 248:19
volume 137:11 273:10
278:1
volume-based 14:21
volumes 197:6
voluntarily 120:15
vote 47:18 53:10,12
55:17 56:8 57:9,15
67:4 68:4,9 69:14,15
69:17 76:9 77:22
78:15,15,17 88:6
90:15,21 93:1,6,9
94:6 95:21 98:7
100:21 101:8 113:22
126:2 129:11 130:7
145:10,16 150:2

158:7 163:4,16
164:22 165:2,7
168:21 209:1 225:15
250:20 251:2 279:15
voted 57:15 65:14 78:6
79:3 95:22 96:21
129:14
voters 78:5
votes 68:8 85:6 151:1
165:8,10 250:19
251:8,9
voting 11:3,4,14 47:9
47:12 51:6 55:8 60:14
61:5 67:22 69:19 70:9
78:2,9,18 79:1,4
80:22 85:1 87:17 91:3
96:2,6 100:22 129:3
144:17,20 145:18
146:2 147:15 148:12
148:13,17,18 149:2
150:21 152:1 164:17
169:1 194:20,20
215:17 272:6 279:10
VP 112:17
vulnerable 144:2

W

W 1:13
Wachter's 236:18
wait 77:6 194:11 268:15
waiting 32:10 250:5
274:19
walls 17:16 266:21,22
Walters 2:21 27:6,8,9
41:21 42:3 53:14
54:17,21 55:3 57:14
57:19 62:20 63:3 78:4
83:19 147:20 154:14
155:8 160:5 169:8,12
170:5 181:22 187:20
188:1 192:14
want 7:13,18 9:10 10:17
11:21 13:10,14 14:15
26:10,15 43:19 44:4
47:17,21 48:12 50:4
50:21 52:5 55:20
56:11 57:12 60:21,22
61:12 62:3 66:17 68:8
70:19 75:16 82:16
83:17 89:20 91:8,15
91:16 93:3 98:11
100:21 106:16 108:1
111:4 114:11 115:21
118:21 121:19 122:15
126:9,18 130:16
136:13 137:20 146:3
148:22 150:10,12
153:18 156:2 158:1,4

160:15 163:17 168:4	211:4 212:4 214:19	215:2 216:21 222:9	16:20 17:3 20:6,14
173:19 174:19 178:3	221:16 222:1 225:11	223:6,7 229:5 240:12	43:18 45:3 50:4 95:4
179:15 180:14 181:16	227:5 234:6 238:18	244:1,10 248:18	100:6,14,15,16
185:15 190:12 193:4	240:17 245:3 249:10	252:8 253:1,17 254:6	107:19 113:4,17
194:22 195:2,15	251:18 254:22 256:5	259:18 261:10,16	121:15 146:13,15
200:14 201:5 205:1	256:21 257:1 269:1,2	268:5 269:20 274:10	153:3 195:20 196:10
205:15 206:11,20	272:8,16 280:3,8,8	275:4 277:22	196:20 198:11,13,18
207:6,15 209:1	ways 21:17 49:19	wear 104:18 263:20	202:6,13 204:12
210:14 211:15 212:2	110:17 132:14 133:3	wearing 263:4	206:9 210:19 211:19
213:4,6 215:13 218:2	148:5 182:15 189:13	weather 5:12 7:18	211:20 215:18 222:10
218:16,17 220:9,10	215:12 219:2,6 221:1	273:9	222:12 226:4 231:12
220:12,18 221:8	235:15 236:5 246:6	weaving 234:9	231:15 232:10 234:18
223:2 228:17 231:7	246:17 277:5 278:4	web 196:1 265:12	237:17,19 238:3
238:14 242:6 245:7	279:4	webinar 70:15 258:9	239:17 242:1 243:17
248:6,12 249:8	we'll 7:8 9:2 22:19 45:4	website 108:9	247:7 248:2 252:15
250:17,19,20 251:2,8	80:10 124:1 138:14	WEDNESDAY 1:5	252:17 253:7 254:19
252:1 253:3 260:2,8	150:20 152:3 194:10	weeks 7:2 157:9 159:8	255:1,7,17 256:10,19
260:16 261:6 262:1,2	194:14,14 195:4	236:19	257:4 258:11,18
262:3,7,9 264:2,3	226:11	weighed 124:4 135:19	260:19 261:3 263:7
269:22 270:19 271:12	we're 6:10 23:2 24:12	weight 178:12	263:14 264:6,10,18
273:19 274:7 278:8	26:2 31:15 47:7,18	welcome 26:14 117:22	265:10 267:11,16,20
279:16,18 280:2	55:8 56:7 60:13 61:5	194:12 208:5 217:11	272:22 275:4,6,14,19
wanted 12:19 16:22	67:15 88:17 96:16	254:12	279:2 280:19
22:4 27:7 42:7,12,21	97:19 100:1,9,15,15	well-established 153:2	worked 11:15,16
45:11 62:11 71:17	105:3 110:7,15	wellness 31:19	204:12 212:5 245:20
80:18 81:15 89:1	112:15 118:4 144:8	went 9:11 18:11 86:8	248:1
96:20 97:17 101:10	147:15,17 148:13,17	191:7,10 192:17	workflow 123:4,16
111:1 117:10 123:15	150:22 153:15 158:14	219:8 280:22	workgroup 2:21,21
124:3,5 126:2 141:13	163:3 165:7 175:12	weren't 171:17	27:4,8,11 29:8 31:6
150:10 156:19 167:2	178:7 190:9,9 192:21	WESTON 2:10 225:1	31:16 34:20 35:10
167:14 172:2 173:14	193:17 194:16 197:1	White 125:5	37:11 40:16 41:21
178:4 200:12 203:16	198:2,12 199:5,7,8,14	who've 177:9	42:3,10 45:14,22 46:4
204:12,17 205:9	200:6,7,7,9 205:4	WILLIAM 2:1	46:11 53:14 54:17,21
221:13 266:3 271:17	208:4 210:4,11	willing 6:6	55:3 57:14,19 62:20
276:19	212:11 213:11 214:11	willingness 274:1	63:3 78:4 79:8 80:1
wanting 105:21 212:11	214:18 215:17,21	Wilson 2:18 3:3 10:14	81:3,6 83:19 86:11
wants 213:18 234:14	217:1 219:19 223:8	10:14 11:16 209:15	90:7 92:2,18 93:4
warfarin 151:20 164:18	223:11,13,22 226:20	209:21 211:7,9 238:9	97:22 113:18 120:3
warranted 36:1	227:8 230:3 233:12	240:3	129:10 137:6 147:20
Washington 1:9	235:9 236:5 237:4,6	wind 94:16 143:9	151:7,11 152:5
wasn't 85:22 117:9	237:13 239:11 243:16	wish 231:18 275:16	153:10 154:13,14,15
152:4,16 153:8,11	245:22 257:12 260:22	wishful 70:17	155:8 160:5 167:6,13
172:2 180:19 221:10	261:1 269:14 274:11	wishing 183:13	169:8,12 170:5 173:9
245:10	274:17 280:10	withstand 269:6	181:22 185:15 187:20
waste 256:9,18	we've 10:4,10 15:14	WOJCIK 2:11	188:1 192:14 204:6
wasted 110:17	52:11 65:9,16 67:21	women 2:8 134:15	207:8,12 208:6
watching 251:11	77:17 94:10,12 95:13	135:1 136:18 141:21	225:12
wavered 122:22	113:11 115:15 116:10	143:13	workgroup's 46:6
way 7:4 8:19 13:5 14:2	126:5 128:21 139:16	wonder 210:9	80:13 83:7 87:8 95:18
16:4,11 23:15 50:16	145:15 155:12 156:21	wondering 112:11,13	119:13,22 128:11
91:6 93:7 95:5 100:17	163:15 175:9 182:14	237:14 241:21 243:6	133:20 145:2 158:16
111:16 112:7 115:4	191:16 192:6 193:19	255:13 256:1	165:13
122:16 123:22 128:2	194:3 196:15,18	word 24:4 153:20 228:4	workgroups 8:9 25:4
135:21 136:6 140:2	197:3,8,15 198:18,22	270:9	49:13 204:7 206:4,5
140:19 144:14 145:9	200:8,21 201:15,19	words 14:12 41:22 45:5	213:20 215:6,8 225:9
145:10 147:11 149:4	201:20 202:13,20	88:15 143:10 209:1	228:18 229:6,16
155:17 174:7 175:15	203:4 207:2 211:14	238:6	working 16:10 20:1
188:7 195:3,7 207:14	212:13 213:5 214:6	work 9:16,22 16:6,17	22:6,18,22 23:9 26:17

34:12 54:15 97:3,13
 110:6 117:11,21
 192:5,6,7 202:20
 222:19 237:15 242:11
 274:18,19,22
workload 43:11 48:13
 84:7
works 100:12 162:18
 166:16
world 36:11 44:5
 154:17 240:9 260:10
 265:3,5
worry 94:14
worse 156:3 175:15
worth 62:10 212:21
 220:1 267:10
wouldn't 11:11 76:20
 86:6 107:11 266:11
wrestle 44:3
written 6:22 231:18
wrong 65:7 74:16 91:5
 155:14 160:13
wrote 65:19
Wunmi 3:4 4:14 9:9
 171:6 196:4 201:12

X

Y

year 48:22 59:20
 193:22 197:3 199:11
 207:5 208:8 210:5
 216:21 221:9 231:4,4
 231:20 233:7 239:10
 252:9,10 253:19
 254:3 256:3 257:10
 268:14 274:20
year's 217:9
years 4:12 17:10 42:22
 48:14,18 49:1,8 59:2
 125:16,17 127:6
 139:16 182:21 193:20
 194:4 196:11 197:9
 200:19,22 207:3
 212:8 233:9,14 234:6
 245:9 247:17 248:20
 252:6 255:17 256:3
 265:19 266:8
yesterday 5:10 9:6,12
 10:12 13:11 26:22
 43:4 44:2,14 47:10
 70:21 85:4,8 91:7
 95:10 173:22 191:5
 198:5 211:13 234:8
 245:6 246:22 255:15
 257:18 258:5 260:8
 270:12,17
yesterday's 43:21

70:22 71:4,7
YONG 2:19 10:18 58:8
 59:18 71:15,20,22
 76:14,18 77:3 80:18
 81:1 83:10 87:1 138:2
 139:6,21 141:4 143:1
 160:18 161:21 162:19
 166:22 168:20 170:18
 173:14,21 220:11
 264:8

Z

zero 66:13 96:13
zone 18:20

0

1

1 4:2 25:21 96:7 145:22
 164:21 190:21,22
 276:6
1,000 240:17
10 75:9 112:4 132:16
 135:1 151:4 182:21
1013 97:20
1030 1:9
11 79:6
12 4:4
12:21 192:17
12:41 192:18
12:45 192:11
14 152:10,21
15 31:1 41:2 132:16
1500 196:18
151015 164:17
151093 145:20
151136 51:3 78:19
15761 96:2
15th 1:9
167 92:9
16th 217:19
17 201:21
193 4:9
196 4:13

2

2 96:7 145:22 164:21
2:05 280:22
20 129:21 132:16 136:3
 136:7 182:21 196:19
2007 54:1
2010 134:12
2011 198:22 201:22
2014 18:3 201:22
2015 53:22 239:11
2016 1:6
2018 199:13 233:10
 239:13

22 129:6 145:18
22-0 65:14
226 84:15
24 151:3 164:6
26 4:6
27 1:6 78:11,11
276 4:17
28 78:12,13
280 4:19
29 165:9

3

3 96:7 146:1 164:21
3.6 171:9,9
30 175:2 188:16 189:1
 198:9
30-day 17:19 180:6
34 165:10
37 112:3
391 126:13

4

44 27:14 43:12
45 253:1
48 4:7

5

5 4:2,12
50 120:19 157:20
531 115:19
59 165:11

6

60 79:5 95:20 164:14
66 151:5

7

7 96:13
700 277:22
761 80:12

8

8 27:14 43:12
87 66:14
88 79:7

9

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Coordinating Committee Meeting

Before: NQF

Date: 01-27-16

Place: Washington, DC

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