

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
HOSPITAL WORKGROUP

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WEDNESDAY
DECEMBER 16, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Cristie Upshaw Travis and Ronald S. Walters, Co-Chairs, presiding.

PRESENT:

CRISTIE UPSHAW TRAVIS, MSHHA, Co-Chair

RONALD S. WALTERS, MD, MBA, MHA, MS, Co-Chair

ANDREA BENIN, MD, Children's Hospital
Association

DAVID ENGLER, PhD, America's Essential Hospitals

NANCY FOSTER, American Hospital Association

SHELLEY FULD NASSO, National Coalition for
Cancer Survivorship

MARTIN HATLIE, JD, Project Patient Care

JEFF JACOBS, MD, The Society of Thoracic
Surgeons

HEATHER LEWIS, RN, Geisinger Health System

SHEKHAR MEHTA, PharmD, MS, Pharmacy Quality
Alliance

ALLEN NISSENSON, MD, FACP, FASN, FNKF, Kidney
Care Partners

KAREN ROTH, RN, MBA, CPA, St. Louis Area
Business Health Coalition

LESLIE SCHULTZ, PhD, Premier, Inc.

BROCK SLABACH, MPH, FACHE, National Rural Health
Association

DONNA SLOSBURG, BSN, LHRM, CASC, ASC Quality
Collaboration

KELLY TRAUTNER, AFT Nurses and Health
Professionals

WEI YING, MD, MS, MBA, Blue Cross Blue Shield of
Massachusetts

INDIVIDUAL SUBJECT MATTER EXPERTS (Voting):

GREGORY ALEXANDER, PhD, RN, FAAN

ELIZABETH EVANS, DNP

JACK FOWLER, PhD

MITCHELL LEVY, MD, FCCM, FCCP

DOLORES MITCHELL

R. SEAN MORRISON, MD

MICHAEL P. PHELAN, MD, FACEP

ANN MARIE SULLIVAN, MD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

PAMELA OWENS, PhD, Agency for Healthcare
Research and Quality (AHRQ)*

DANIEL POLLOCK, MD, Centers for Disease Control
and Prevention

PIERRE YOUNG, MD, MPH, Centers for Medicare and
Medicaid Services (CMS)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON

PRESENT:

THOMAS LUTZOW, PhD, MBA

NQF STAFF:

HELEN BURSTIN, MD, Chief Scientific Officer

ESLISA MUNTHALI, Vice President, Quality
Measurement

TAROON AMIN, Staff Support

WUNMI ISIJOLA, Senior Project Manager

MELISSA MARINELARENA, Senior Director, Hospital
Group

ERIN O'ROURKE, Senior Project Manager

ZEHRA SHAHAB, Project Manager

JEAN-LUC TILLY, Project Analyst

MARCIA WILSON, Senior Vice President, Quality
Measurement

ALSO PRESENT:

HEIDI BOSSLEY, Federation of American Hospitals*

SUZANNAH BERNHEIM, MD, Centers for Medicare and
Medicaid Services (CMS)*

AKIN DEMEHIN, American Hospital Association

MEGAN HAYDEN, Centers for Medicare and
Medicaid Services (CMS)*

TARA LEMONS, Centers for Medicare and
Medicaid Services (CMS)

KAREN SPALDING BUSH, Centers for Medicare and
Medicaid Services (CMS)*

*participating by telephone

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

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives	6
CMS Opening Remarks.	20
Overview of Pre-Rulemaking Approach.	38
Overview of Hospital Inpatient Quality Reporting (HIQR) Program	73
Opportunity for Public Comment on Measures Under Consideration for HIQR	74
Pre-Rulemaking Input on Hospital Inpatient Quality Reporting Measure Set - Consent Calendar 1	78
Pre-Rulemaking Input on Hospital Inpatient Quality Reporting Measure Set - Consent Calendar 2	173
Pre-Rulemaking Input on Hospital Inpatient Quality Reporting Measure Set - Consent Calendar 3	240
CMS Measure Concepts Presentation	
Overview of Hospital Value-Based Purchasing Program.	287
Opportunity for Public Comment on Measures Under Consideration for HVBP	291
Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 1	296
Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 2	341

Pre-Rulemaking Input on Hospital Value-Based Purchasing Program Measure Set - Consent Calendar 3	345
Overview of the Hospital Acquired Condition Reduction Program (HACRP).	400
Opportunity for Public Comment on Measures Under Consideration for HACRP.	402
Pre-Rulemaking Input on Hospital Acquired Condition Reduction Program Consent Calendar	402
Opportunity for Public Comment	428
Summary of Day	429

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

9:03 a.m.

CO-CHAIR WALTERS: Welcome and thanks for coming to the meeting. Thanks for all your work prior to the meeting. That will pay off later on. Cristie and I are happy to be your chairs and try to put some order into this meeting, try to keep everybody pretty much on time and try to get everybody out sometime tomorrow.

(Laughter)

CO-CHAIR WALTERS: Those of you who are new shouldn't be scared by that last comment.

(Laughter)

CO-CHAIR WALTERS: You should just remember it.

(Laughter)

CO-CHAIR WALTERS: But welcome to those of you that are on the Committee for the first time, also.

So the thing we love is feedback, so please feel free to give feedback to staff or us,

1 or write it in Facebook or Twitter or whatever --

2 (Laughter)

3 CO-CHAIR TRAVIS: -- about any
4 opportunities you see for improvement. We've
5 made a lot of modifications over the years and we
6 think this is now going to be the best version of
7 this. So welcome again. Thanks for coming.

8 CO-CHAIR TRAVIS: Thank you, Ron. I'm
9 pleased to be sitting next to Ron. He had this
10 experience last year, so he's the one that I'm
11 going to look to to be sure that we give everyone
12 an opportunity, but that we do try to keep
13 moving. And that will be our challenge today.
14 But I just echo his thanks to everyone for all
15 the work he's put in to date and over the next
16 two days. Thank you.

17 CO-CHAIR WALTERS: Now, Ann, AKA
18 Helen --

19 DR. BURSTIN: I am ready. Helen
20 Burstin, Chief Scientific Officer here at NQF. I
21 am actually Ann and Chris. So good morning,
22 everybody. I'm serving -- and myself I guess

1 still. Pleasure to be back with MAP again this
2 year. Some people refer to this as the holiday
3 season. At NQF this is MAP season. But
4 hopefully our efforts at continuous quality
5 improvement, which have been pretty significant
6 over the years, have both made it a better and
7 more manageable experience for you as reviewers
8 and members of the table, but also especially
9 important to make it better that our staff do not
10 work across the holidays as best we can.

11 So we look forward to a full and
12 interesting discussion today. We recognize the
13 importance of MAP. Hospital MAP in particular
14 has always been on the cutting edge of discussing
15 a lot of critical issues and we're looking
16 forward to bringing up all those policy issues
17 throughout the day.

18 So I'm also going to go through --
19 just to be efficient, we'll do introductions and
20 disclosures at the same time, just so you guys
21 can get to work since you have a lot on your
22 plate for the next two days.

1 So most of you know you're divided
2 into two different groups. There's the
3 organizational members, as well as those who are
4 individual subject matter experts and the federal
5 liaisons. We'll do the disclosures differently
6 across those different groups.

7 So organizational representatives, not
8 surprisingly, we do expect that you would
9 represent a particular viewpoint and usually
10 represent the interests of those who have invited
11 you to participate as their organizational
12 representative. As part of your disclosure today
13 we only ask that you disclose if you have an
14 interest of \$10,000 or more. In an entity that's
15 related to any of the work before the Committee.
16 Please tell us who you represent and if you have
17 anything to disclose.

18 We'll do organizational members first.
19 We'll see if there's anybody on the phone to do
20 that. Then we'll come back and do the subject
21 matter experts. We've seen your CVs since we got
22 to pick you as part of our Committee process, so

1 if we went through your full CVs, you would never
2 actually get to the IQR today.

3 (Laughter)

4 DR. BURSTIN: So short, brief
5 introductions and any disclosures would be
6 welcomed. So with that, I've got a lovely list
7 here. We're going to begin with the Chairs, so
8 we don't we begin with Cristie?

9 CO-CHAIR TRAVIS: Hi, Cristie Travis.
10 I'm the CEO of the Memphis Business Group on
11 Health and I have no disclosures to make, but I
12 will also say that I'm very involved over on the
13 consensus development process for the NQF, being
14 a member of CSAC as well as the
15 Admissions/Readmissions Standing Committee and
16 some other committees that have been operating on
17 that side. So I think I bring the CDP
18 perspective to the MAP as well. So thank you.

19 CO-CHAIR WALTERS: Ron Walters. My
20 day job is at MD Anderson Cancer Center in
21 Houston, and I have nothing to disclose.

22 DR. BURSTIN: Thank you. I know that

1 Kelly Trautner will be joining us this afternoon
2 from the AFT Nurses and Health Professionals.

3 I'm just going to run down this list
4 just to make it simpler. So, Nancy Foster?

5 MEMBER FOSTER: Thank you, Helen. I'm
6 Nancy Foster. I'm the Vice President for Quality
7 and Patient Safety Policy at the American
8 Hospital Association representing that
9 organization today, and I have nothing to
10 disclose.

11 DR. BURSTIN: David Engler?

12 MEMBER ENGLER: Good morning. I'm
13 David Engler. I'm Senior Vice President of
14 America's Essential Hospitals. It's my third
15 year on MAP and I have nothing to disclose today.
16 Thank you.

17 DR. BURSTIN: Welcome back to those
18 who have returned to do this yet again.

19 Next Donna Slosburg, ASC Quality
20 Collaboration.

21 MEMBER SLOSBURG: Can you hear me?
22 Hi, I'm Donna Slosburg. I'm the Executive

1 Director of the Ambulatory Surgery Center Quality
2 Collaboration. We develop quality measures for
3 ambulatory surgery centers. And this is my third
4 year as well, and the only thing I have to
5 disclose is that I am a measure developer for
6 ambulatory surgery center measures.

7 DR. BURSTIN: Thank you. Wei Ying
8 from Blue Cross?

9 MEMBER YING: I'm Wei Ying. I'm
10 Director of Performance Measurement and
11 Population Health from Blue Cross/Blue Cross
12 Mass. This is the third year I'm on MAPs, and
13 nothing to disclose.

14 DR. BURSTIN: Andrea Benin?

15 MEMBER BENIN: Good morning. I'm
16 Andrea Benin. I'm Senior Vice President for
17 Quality and Patient Safety at Connecticut
18 Children's Medical Center in Hartford. I'm a
19 pediatric infectious disease doctor and I am
20 representing the Children's Hospital Association,
21 and I have nothing to disclose. Thank you.

22 DR. BURSTIN: Thanks, Andrea.

1 Heather Lewis?

2 MEMBER LEWIS: I'm Heather Lewis from
3 Geisinger Health System. I am the Associate Vice
4 President for Quality and Safety for the health
5 system. I'm a nurse by training and I have
6 nothing to disclose.

7 DR. BURSTIN: Thank you. Allen
8 Nissenson?

9 MEMBER NISSENSON: I'm Allen
10 Nissenson. I'm a nephrologist, Emeritus
11 Professor of Medicine and former Associate Dean
12 at UCLA Medical School, and currently Chief
13 Medical Officer for DaVita Health Care Partners.
14 And I'm representing Kidney Care Partners and
15 also co-chair the Kidney Care Quality Alliance
16 which is a measure development group for kidney
17 care. And my disclosures, I am a full-time
18 salaried employee at DaVita Health Care Partners.

19 DR. BURSTIN: Thank you, Allen. And
20 our next organizational member is Mothers Against
21 Medical Error. I know Helen Haskell is not here.
22 Jennifer, are you on the phone?

1 MS. HUFF: I am.

2 DR. BURSTIN: Wonderful. Could you
3 introduce yourself?

4 MS. HUFF: Jennifer Eames Huff. I am
5 an independent consultant and a senior advisor to
6 the Consumer Purchaser Alliance, and I am
7 substituting for Helen for the morning half, and
8 I have nothing to disclose.

9 DR. BURSTIN: Great. Thank you.
10 Shelley?

11 MEMBER FULD NASSO: Hi, I'm Shelley
12 Fuld Nasso. I'm the CEO of the National
13 Coalition for Cancer Survivorship, a patient
14 advocacy group focused on quality of cancer care.
15 This is my third year on the MAP and only my
16 second in person because I did the first by
17 phone, which I do not recommend.

18 (Laughter)

19 MEMBER FULD NASSO: So I'm glad to be
20 here. And I'm also with Cristie and some others
21 a member of the CSAC.

22 DR. BURSTIN: Thank you. Brock?

1 MEMBER SLABACH: Good morning. My
2 name is Brock Slabach and I'm with the National
3 Rural Health Association, former hospital
4 administrator, and I have nothing to disclose.

5 DR. BURSTIN: Shek?

6 MEMBER MEHTA: Good morning. My name
7 is Shek Mehta. I'm the Director of Clinical
8 Guidelines and Quality Improvement at ASHB. I've
9 been on the MAP -- this is going on my fourth
10 year. I had represented ASHB in the past, but
11 now I'm representing the Pharmacy Quality
12 Alliance.

13 DR. BURSTIN: Martin Hatlie?

14 MEMBER HATLIE: Morning. I'm Marty
15 Hatlie. I'm the CEO of Project Patient Care.
16 We're a Chicago-based improvement coalition
17 dedicated to bringing the voice of the patient
18 and his co-partner in improvement and culture
19 transformation work. And I'm a lawyer by
20 training. I do not have anything to declare.

21 DR. BURSTIN: Excellent. Jeff,
22 literally walked in just in time to -- and

1 introduce yourself and if you have any
2 disclosures.

3 MEMBER JACOBS: My name is Jeff
4 Jacobs. I'm a cardiac surgeon at Johns Hopkins
5 All Childrens Heart Institute. I chair the
6 Society of Thoracic Surgeons National Database
7 Workforce. And other than that, I really don't have
8 anything else to disclose except I'm a little bit
9 late.

10 (Laughter)

11 DR. BURSTIN: We saw. Leslie Schultz?

12 MEMBER SCHULTZ: Good morning. Leslie
13 Schultz. I am with Premier and I am employed by
14 Premier. I also have the privilege of sitting on
15 the CPD for Patient Safety Measures, and nothing
16 else to disclose.

17 DR. BURSTIN: Thanks, Leslie. Karen
18 Roth?

19 MEMBER ROTH: Hi, I'm Karen Roth. I'm
20 the Director of Research at the St. Louis Area
21 Business Health Coalition. I represent
22 purchasers and I have nothing to disclose.

1 DR. BURSTIN: Thank you. And Thomas
2 Lutzow?

3 MEMBER LUTZOW: Yes, I'm Tom Lutzow.
4 I'm President of iCare, an HMO in Milwaukee, and
5 I'm a crossover representative from the MAP's
6 Duals Group. Nothing to disclose.

7 DR. BURSTIN: Excellent. Thank you.
8 Next we're going to move on to the
9 subject matter experts. These are a little
10 different. You sit as individuals, and so we do
11 ask you to give a bit more detail on your
12 professional activities, particularly disclosures
13 of any activities that are directly relevant to
14 the work before the Committee today: grants,
15 consulting, speaking arrangements, things of
16 those kinds. But again, only if relevant to the
17 Committee's work. We know your CVs.

18 Again, you sit as an individual. You
19 do not represent the interests of a specific
20 organization or anyone who may have nominated
21 you. And we're just looking forward to hearing
22 from you. And just because you disclose doesn't

1 mean you have a conflict. Obviously we just want
2 to understand what people bring to the table.

3 So with that, let's go to the first
4 person, Greg Alexander.

5 DR. ALEXANDER: Hi, I'm Greg
6 Alexander. It's my first year on the MAP, first
7 meeting here. I'm a registered nurse. I'm a
8 professor at the University of Missouri. My
9 background is I have research grants. I have
10 several active ones right now, too. In
11 particular, one through the Centers for Medicare
12 and Medicaid Innovations Group and on hospital
13 readmissions and long-term care trying to prevent
14 avoidable hospitalizations.

15 And then I have another one through
16 the Agency for Healthcare Research and Quality
17 looking at quality measures related to IT
18 adoption trends over several years. Thank you.

19 DR. BURSTIN: Thanks. Thanks, Greg.
20 Jack Fowler?

21 DR. FOWLER: Hi, I'm Jack Fowler. I'm
22 a part-time advisor these days on the research

1 agenda of the Informed Medical Decisions
2 Foundation in Boston. And the foundation is now
3 part of Healthwise, a non-profit organization
4 that provides health information in a variety of
5 forms to patients who are facing decisions and
6 other medical issues.

7 DR. BURSTIN: Any disclosures? That's
8 it?

9 DR. FOWLER: (No audible response)

10 DR. BURSTIN: Okay. So no other
11 disclosures?

12 MEMBER FOWLER: Do you think --

13 DR. BURSTIN: I think we got it.
14 Sorry.

15 DR. LEVY: Yes, I'm Mitchell Levy.
16 I'm the Director of the Division of Pulmonary
17 Critical Care Medicine at Brown University. I'm
18 the subject matter expert for safety. I've been
19 on the MAP for I think three or four years. My
20 main work is in sepsis. I do a lot of work in
21 quality improvement and performance improvement
22 and knowledge translation. And I have no

1 financial conflicts of interest, although I've
2 worked as one of the lead investigators of the
3 Surviving Sepsis Campaign for about 12 years.
4 And we developed the metrics that now have been
5 taken up by CMS and are mandated nationally.

6 DR. BURSTIN: Thanks. Sean?

7 DR. MORRISON: Sean Morrison. I'm a
8 professor of geriatrics and palliative medicine
9 at the Icahn School of Medicine at Mount Sinai in
10 New York. I direct the Palliative Care Institute
11 there and the National Palliative Care Research
12 Center. I receive funding from the NIH, from
13 PCORI and private sector philanthropy, none of
14 which is industry-related. And no disclosures.

15 DR. BURSTIN: Thank you. Dolores?

16 MS. MITCHELL: I'm Dolores Mitchell.
17 I'm the executive director of the Group Insurance
18 Commission of the Commonwealth of Massachusetts.
19 And although I have informed this august
20 organization three times that all of those
21 initials after my name, which are totally
22 incomprehensible to me; I don't even know what

1 they -- well, RN, I know what an RN is --

2 (Laughter)

3 MS. MITCHELL: -- and I'm not an RN,
4 nor am I a CMM, nor am I an FACHE, nor am I an
5 MSHA. So thank you for the honor, but I'm not
6 entitled to any of them. I'm not sure who
7 decided I was a subject matter expert. All I
8 know about hospitals is what Nancy Foster and
9 Rich Umbdenstock have tried to dis-inform me of
10 my bad opinions.

11 (Laughter)

12 MS. MITCHELL: But I'm happy to be
13 here. This is I think maybe my fourth year on
14 this wonderful group. And I'm saying that
15 without sarcasm, by the way. It's been a
16 pleasure. And I think my only conflict could be
17 construed as a non-financial one, namely that I
18 sit on the board of the NCQA, which does develop
19 measures. And I have nothing -- unfortunately I
20 have nothing financial to disclose.

21 (Laughter)

22 DR. BURSTIN: Thank you, Dolores. It

1 was much cheaper than going to all those schools,
2 wasn't it?

3 (Laughter)

4 DR. BURSTIN: We just pop it on a
5 slide for you and you're good to go.

6 So, Mike, please?

7 DR. PHELAN: Can I have some of those
8 initials, Dolores?

9 (Laughter)

10 DR. PHELAN: I am Mike Phelan. I'm an
11 emergency medicine physician at the Cleveland
12 Clinic. Also at that institution I'm on the
13 quality side. And I work pretty extensively with
14 the American College of Emergency Physicians,
15 ACEP's Quality Patient Safety Committee. I have
16 some small grants and other than that nothing
17 really to disclose. Mostly related to research
18 around quality and emergency medicine.

19 DR. BURSTIN: Thanks, Mike. Ann
20 Marie?

21 DR. SULLIVAN: Hi, I'm Ann Sullivan.
22 I'm the commissioner for the State of New York

1 Office of Mental Health and I'm also on the
2 Medicaid MAP Workgroup. And nothing to disclose.

3 DR. BURSTIN: Thank you. And lastly,
4 our federal representatives. Pierre, want to
5 introduce yourself?

6 DR. YOUNG: Hi, I'm Pierre Young. I'm
7 here representing CMS, and at CMS I work on the
8 quality measures that we put into our program.
9 So happy to be here.

10 DR. BURSTIN: Dan?

11 DR. POLLOCK: I am Dan Pollock. I'm
12 representing Centers for Disease Control and
13 Prevention. At CDC I lead the group that's
14 responsible for the National Healthcare Safety
15 Network, which is a surveillance system used,
16 among other purposes, to measure healthcare-
17 associated infections, antimicrobial use and
18 resistance, and other adverse events and
19 adherence to prevention practices. And a
20 pleasure to be here.

21 DR. BURSTIN: And I know Pam Owens
22 couldn't be here in person today. But Pam are

1 you on the phone?

2 DR. OWENS: I am. Thank you very
3 much. And I am sorry that I'm not able to be
4 there today. My name is Pam Owens. I'm the
5 scientific lead on the AHRQ Quality Indicators
6 and I'm an epidemiologist by training.

7 DR. BURSTIN: Great. Thanks, Pam.

8 So just my last word on this. Oh, I'm
9 sorry. Go ahead.

10 MS. EVANS: Yes, I wasn't on that.
11 I'm Beth Evans. I was also one of the expert --

12 DR. BURSTIN: Okay.

13 MS. EVANS: -- attendees. And I'm not
14 on the list, but I'm here.

15 (Laughter)

16 MS. EVANS: My name is Beth Evans.
17 I'm a nephrology nurse practitioner in
18 Albuquerque, New Mexico. I'm representing
19 American Nephrology Nursing Association and I'm
20 also on the NQF Renal Standing Committee. Thank
21 you.

22 DR. BURSTIN: Yes, you are. And

1 you're on my piece of paper, but you missed the
2 slides. Our apologies. Thank you so much.

3 So lastly, the reason we do
4 disclosures is just so everybody knows what
5 everybody brings to the table as we have these
6 discussions. Again, disclosures don't
7 necessarily mean a conflict, but really
8 importantly at any point during this meeting you
9 have any concerns about somebody's disclosures or
10 about somebody potential biases they're bringing
11 to the table, or anything really at all, please
12 come forward to NQF staff or the Chairs. Always
13 better to deal with those issues in real time
14 rather than finding out about them sort of much,
15 much later when people are concerned that there
16 was not really a robust and open discussion.

17 So with that, I'm just going to ask if
18 you have -- based on everything you've heard, do
19 you have any questions of each other about
20 disclosures or any other issues regarding your
21 introductions?

22 (No audible response)

1 DR. BURSTIN: All right. I think it's
2 time for you guys to get to work.

3 CO-CHAIR WALTERS: -- staff?

4 MS. MARINELARENA: Hi, everyone. My
5 name is Melissa Marinelarena. I'm the Senior
6 Director now in the Hospital Group. This is my
7 first year with MAP. I recently came back to
8 NQF. I was here back in 2008, so it was the pre-
9 MAP area. So I want to thank everybody for all
10 of your hard work, the team, all the support
11 staff that we have here at NQF working on this,
12 and we're looking forward to the next two days.

13 PARTICIPANT: Talk about where you
14 were before.

15 MS. MARINELARENA: Where was I before?
16 I've been a lot of places. Well, I was in the
17 hospital. I worked at Cedar Sinai. I worked
18 with their measures there and did all the measure
19 collection. And so, I went from here, from the
20 policy side to the implementation side. So very
21 familiar with a lot of these measures. And
22 again, welcome.

1 MS. O'ROURKE: Hello, everyone. I'm
2 Erin O'Rourke. I'm the Senior Project Manager
3 supporting the Hospital Workgroup, and this is my
4 I believe fifth year supporting the MAP. I've
5 been here since the beginning and I'm excited to
6 work with you all for another year.

7 MS. SHAHAB: Good morning, everyone.
8 My name is Zehra Shahab. I am the Project
9 Manager supporting this workgroup. I've been at
10 NQF for about two-and-a-half years now and I've
11 supported the readmissions project, care
12 coordination, population health. I've been on a
13 variety of projects, but this is my first time on
14 MAP Hospital and looking forward to a great two
15 days.

16 MR. TILLY: Hi, everyone. My name is
17 Jean-Luc Tilly. I'm a project analyst supporting
18 the MAP Hospital Workgroup. I've been at NQF for
19 about three-and-a-half months. It's been great
20 so far.

21 CO-CHAIR WALTERS: And I'll tell the
22 new people; the people who've been here a while

1 know, we have excellent staff support. So feel
2 free to talk to them about anything you may need.
3 It's excellent.

4 So for the new people also, your job
5 is to speak up, it's to get involved and get a
6 buddy for someone that's been here longer, and if
7 you have any questions, feel free to ask them.
8 Don't be shy. This does not tend to be a shy
9 meeting, by the way.

10 The objectives are very simple. We
11 want to improve patient care and we want to make
12 sure we know how we're measuring to do that. So
13 let's not forget that it's all about measuring
14 the improvement we make in patient care. And as
15 a part of that, it's to deliver report to CMS
16 about the proposed measures, the measures under
17 consideration.

18 So that's the objective of the
19 meeting. And we appreciate everybody's input
20 prior to the meeting.

21 At this time I'm going to turn to over
22 to Pierre, who's going to make some opening

1 remarks from CMS.

2 DR. YOUNG: Thanks, Ron. So it's a
3 pleasure to be here. And just so folks know, we
4 at CMS start thinking about the MUC list that we
5 put together that you will be considering today
6 starting in the spring time. So this is almost a
7 year-long process for us at CMS.

8 And so, we always look forward to the
9 MAP because, one, it's wonderful to see the
10 diversity of perspectives represented on the
11 Committee and the Workgroup, but also because
12 it's a chance to see many returning members, but
13 also to welcome new members. I always look
14 forward to hearing Delores' comments and the
15 perspective she brings to the table. But do want
16 to thank all of you for taking time. I know
17 you're all very busy, so taking two full days to
18 participate and know that you spend many hours in
19 addition outside of the two days at NQF to review
20 the measures and provide your perspective.

21 I remember sitting here last year and
22 somebody was asking a question checking that CMS

1 really does consider the input the MAP provides,
2 and I want to reassure that we do take the MAP
3 input very seriously and we want to make sure
4 that we are here. And you'll see my colleagues
5 coming to join me at the table, because we value
6 your input and the diversity of opinions. So
7 thank you for that.

8 I do want to thank also Ron, and
9 welcome Cristie for chairing this particular
10 workgroup, and also to thank Helen and her staff
11 for all the work they've been putting in. And
12 we've been really lucky to be able to work with
13 them and certainly know that this meeting will
14 proceed really smoothly in large part due to all
15 the work that they've put in. So thank you.

16 CO-CHAIR TRAVIS: So we have just a
17 couple of minutes. Does anybody have any
18 questions they would like to ask Pierre before we
19 get started? Yes, Nancy?

20 MEMBER FOSTER: Pierre, first of all,
21 thanks for being here. It's been incredibly
22 important throughout I think all of the years

1 that we've been doing the MAP to have CMS be a
2 very vital presence at the table and be able to
3 help us understand what's coming and why and so
4 forth.

5 And in that regard I'd like to ask you
6 if you could help us understand the set of
7 measures that have come forward for the hospital
8 programs this year. If one were to just sort of
9 look at this blank slate, it might look like kind
10 of a hodgepodge of measures. So is there a sort
11 of framing thought or series of thoughts that
12 brought these measures forward for this year that
13 you might help us understand?

14 DR. YOUNG: Sure. So when we start
15 thinking about putting together the MUC list, I
16 think the thought, our sort of guiding principles
17 and sort of goals are outlined in the National
18 Quality Strategy. So I think that's the first
19 place where we start. But then we also look at
20 each program individually. And as you notice,
21 each program has its own MUC list. So we look at
22 the measures within each program, look at the

1 goals of those programs and look for particular
2 gaps in the quality measures that are already
3 implemented into those programs.

4 There are other considerations we also
5 consider, so we also consider when putting
6 together that list prior comments from the MAP.
7 So we review prior MAP reports. We look for
8 opportunities for alignment, because there are
9 certainly concerns around burden and sort of
10 misalignment between programs that we know is
11 very real. So we want to be sensitive to that.

12 There are also priorities that we
13 additionally have such as care coordination,
14 improving care outcomes, patient and family
15 caregiver, and improving that outcome space. So
16 I think those are some of the priorities we also
17 think about sort of that overlay some of the
18 other considerations that we've put together.

19 So while the MUC list for each program
20 is only a small subset of measures, you can
21 imagine that those would be potentially
22 implemented into a larger program which has

1 potentially many more measures. And so we think
2 about the measure set as a whole, not just what
3 you see on the MUC list. So hopefully that helps
4 a little bit.

5 CO-CHAIR TRAVIS: Delores?

6 MS. MITCHELL: Well, I wasn't going to
7 say anything right off the bat, but --

8 (Laughter)

9 MS. MITCHELL: -- Pierre's comment in
10 response to Nancy's question made me think that I
11 wanted to give CMS an admonition, if you will,
12 which you can ignore or not as you wish.

13 But I have often been struck in these
14 meetings by what is the appropriate focus on the
15 federal programs. I understand that they're your
16 programs and you pay for them and you want to
17 have the best measures possible for working with
18 them. But I think one of the considerations that
19 I was listening for in your answer that I did not
20 hear is the incredible ripple effect of
21 everything that you decide on the rest of the
22 healthcare world, or the medical world, or the

1 purchaser world, or the payer world, particularly
2 given the increasing size, scope and magnitude of
3 the federal role.

4 It may be a program that my agency,
5 for example, has absolutely nothing to do with,
6 but what you decide and how you run things and
7 what rules you use and what measures you use has
8 an incredible impact on us. And I hope that's
9 always on your list of things you think about,
10 because you should.

11 DR. YOUNG: So thank you, Delores.
12 And I know that's been a topic of discussion, I
13 think, also in discussions in the MAP, I think,
14 at the Coordinating Committee level as well as in
15 the individual workgroups that have been
16 discussed. And so you're absolutely right that
17 there are ramifications for decisions that CMS
18 makes, and certainly CMS, beyond the work and the
19 discussions here, is also involved with private
20 payers, with like the Care Core Measures
21 Consortium and other activities with other
22 private partners in terms of thinking about and

1 sort of making headway towards potentially
2 aligning measure sets, for example, and core
3 measures across program. So certainly that is a
4 consideration, but thank you for bringing that
5 up.

6 CO-CHAIR TRAVIS: Ron?

7 CO-CHAIR WALTERS: Yes, I'd like to
8 say also I'm sure I don't need to tell most of
9 the people, or maybe all the people in this room,
10 but as someone who does read the final rule every
11 year and over years, you do get that very sense
12 of appreciation, because they reference NQF
13 Hospital Workgroup frequently in the final rule
14 as rationales for either decisions they made or
15 decisions they did not make. And it also gives
16 you a very good feel, to the answer to Delores'
17 question, as far as not only historically what's
18 been the thinking process, but you get a pretty
19 good feel for what's coming along in future
20 pipeline and so on.

21 So it's all there. It's in a rather
22 bulky document. But take the opportunity to read

1 it, if you don't.

2 CO-CHAIR TRAVIS: Okay. If you do
3 want to make a comment, please put your tent card
4 up. That'll help me be sure I call on you and
5 can be sure that I get the right person's name.
6 It's a large group.

7 So Marty?

8 MEMBER HATLIE: I just wanted to make
9 a comment kind of building on what we've seen so
10 far, because I have the good fortune to be able
11 to listen to a lot of patients and family
12 members. And I think that even though I find
13 this MUC list every year overwhelming to look at,
14 especially just given the time frame, and I
15 always come here feeling a little insecure about
16 whether I've got command of the material, even
17 though I know I don't, I think there is an
18 alignment that I'm seeing. So it can look like a
19 hodgepodge to me, but there is an alignment that
20 you see over time. And I think consumers
21 increasingly are seeing that from CMS as a whole
22 through the different projects that are being

1 focused on as transformation vehicles for
2 healthcare.

3 So two or three years ago I remember
4 having a conversation with Helen Haskell about
5 how there was just no confidence that CMS was
6 actually aligning with quality and safety going
7 forward. And I think that's really, really
8 changed in the last couple of years. So it makes
9 me excited to be here and I think I want to just
10 give CMS kudos for I think having a strategy to
11 really drive not only improvement, but culture
12 change in healthcare.

13 DR. BURSTIN: Okay. Well, seeing no
14 more cards, I think we'll go on and get started
15 looking at the measures themselves, which is why
16 we're here today.

17 I'm going to turn it over to Erin
18 O'Rourke and Zehra Shahab. And I just want to
19 add my thanks to them. One of the biggest
20 changes that we made in the process this year was
21 to have some preliminary analysis done according
22 to an objective rubric, and the staff took on

1 that responsibility. And I know it was extremely
2 helpful to me in helping me kind of hone my
3 thoughts, and I hope you found the same thing.
4 So I want to thank Erin and her team for taking
5 on that for us.

6 And I'm going to turn it over to them
7 to talk about the pre-rulemaking approach so
8 we'll understand how our work over the next
9 couple of days fits into the bigger picture.

10 MS. SHAHAB: Thanks, Cristie. So good
11 morning. I'm going to be providing an overview
12 of the MAP pre-rulemaking criteria and the
13 approach that we've taken including decision
14 categories and describing the measure selection
15 criteria for everyone as well.

16 So on this slide, first it's a three-
17 step process how we've improved it. We have
18 developed program measure sets like frameworks,
19 which is in Excel, that you can see in the
20 materials. And this is titled, "The MAP Hospital
21 Workgroup Frameworks," and it includes the
22 current measures in the program. And we put it

1 in an Excel so you can filter and look at it
2 according to topic, priorities and the measure
3 type. So also we've also looked at the measures
4 under consideration for how they would affect the
5 current program sets and we've also identified
6 priority measure gaps for each of these programs
7 and settings.

8 And on the next slide we also would
9 like each of the MAP workgroups to reach a
10 decision about each of the measures under
11 consideration. And I will describe each of the
12 decisions categories for the measures. Each
13 decision should be accompanied by a statement or
14 rationale that explains the decision by the
15 workgroup.

16 On the next slide you will see -- so
17 there's two types of pathway. One is for fully
18 developed measures. And for fully developed
19 measures the options are you can either support,
20 conditionally support or do not support. And a
21 few examples of conditions that could be are NQF
22 endorsement, whether they require further

1 experience or further testing.

2 Okay. So the second option is for
3 measures under development you can either
4 encourage development if it addresses a critical
5 program objective and promotes alignment, or you
6 could do not encourage further consideration if
7 it already overlaps with a measure that's in the
8 program and if it doesn't address a critical
9 program objective as well.

10 And the last option is insufficient
11 information, which you can select if the
12 numerator and denominator are not provided.

13 DR. PHELAN: Can you go back a slide?

14 MS. SHAHAB: Sure.

15 DR. PHELAN: You know in the past this
16 conditional support has always kind of been kind
17 of a nebulous category to me. What happens if we
18 give conditional support? Does it automatically
19 -- like for instance, in measures that aren't
20 currently NQF-endorsed but they're in the process
21 of being endorsed at NQF, is there an opportunity
22 for the MAP to revisit that or does conditional

1 support mean once it's NQF-endorsed it rolls
2 through the process?

3 MS. O'ROURKE: So technically MAP only
4 needs to review a measure one time. CMS is not
5 obligated to bring a measure back to us unless
6 it's undergone a substantial change. Pierre can
7 probably illuminate that a little bit more, but
8 conditional support, you would not automatically
9 review that again. It would be up to CMS to put
10 the measure back on the MUC list and bring it
11 back to MAP for review.

12 DR. PHELAN: And the reason I bring
13 that up is because some of these measures are
14 currently undergoing SDS testing and things like
15 that I think it would be very valuable on -- I
16 hate adding another category or something like
17 that, but the idea that we really like the
18 measure and it sounds like a great idea, but we'd
19 really like to see what the final product is.

20 It has always bothered me on a couple
21 of different levels because I'm like, well, we're
22 kind of endorsing something that we really don't

1 know what the final product is yet. So I've
2 always wondered if possible -- and that has given
3 me great consternation because then it comes up
4 with a decision of I really like the measure, but
5 I cannot support it because I'm not going to be
6 able to get another shot to look at it.

7 MS. O'ROURKE: Absolutely. And we
8 recognize that's a grave concern shared by this
9 workgroup and I think all of the MAP workgroups.
10 And I don't know that I have a satisfying answer
11 for you, but I did want to make sure that
12 everyone knows we capture all of your discussions
13 and concerns and put those in the rationale that
14 goes along with each decision of the support,
15 conditional support, do not support. So even if
16 there's not a formal chance to review it again,
17 all of your feedback does go to CMS.

18 DR. POLLOCK: Zehra, I wonder if you
19 could just say what you mean by "fully developed
20 measures." Are you using that concept
21 interchangeably with NQF-endorsed measures, or is
22 it something different?

1 MS. O'ROURKE: Absolutely. So the
2 pathways are really determined by the level of
3 testing. If a measure is specified but has not
4 yet been tested for the setting or level of
5 analysis of the program, that is how it ended up
6 in the measure under development pathway, whereas
7 a measure that's not NQF-endorsed yet but is
8 tested and specified would be considered a fully
9 developed measure.

10 DR. POLLOCK: I'm still a bit confused.
11 If a measure is endorsed by NQF, it's typically
12 endorsed for use in a particular type of
13 healthcare location. So again, what is meant by
14 fully developed measures? Are they measures that
15 are indeed NQF-endorsed or is it some other
16 category?

17 DR. BURSTIN: So typically anything
18 that's endorsed obviously is fully developed. We
19 still do have measures that come forward in which
20 the developer has indicated a desire to continue
21 testing, and I think in a couple of examples we
22 put those in the continued development category.

1 But I think those are just a few examples that we
2 can talk through.

3 DR. POLLOCK: So the essence is a
4 fully developed measure can be one that may or
5 may not be subject to further testing depending
6 on what the developer seeks with respect to that
7 measure?

8 DR. BURSTIN: No, but it may be
9 endorsed and brought in potentially for one level
10 analysis and at another level of analysis we
11 would still consider that needing further
12 testing. So it could be endorsed at one level of
13 analysis or requires further testing for a
14 different level of analysis or issues along those
15 lines.

16 CO-CHAIR WALTERS: If I could add my
17 two cents. If you show that slide and then the
18 next slide, the really tough distinction which is
19 being talked about here is that conditional
20 support. And it can be subject to NQF
21 endorsement, or encourage continued development.
22 I mean, that's kind of the dividing line. And as

1 we go through the process I think everybody in
2 the room is going to have to make a decision
3 about the conditional support versus less than
4 the conditional support. So this is a very
5 pertinent topic and it's going to depend a lot on
6 the measure, where it is in development, where it
7 is in the testing, etcetera, etcetera. I mean,
8 that's probably the best you can do.

9 DR. POLLOCK: And I guess it comes
10 down to then without having another support
11 category in that hat, it probably will fall to a
12 do not support if you don't have enough of the
13 information to make that decision based on
14 socioeconomic factors that are being implemented.
15 And that just has always bothered me because I
16 want to say that we support it. Wait for the
17 next round and the only thing that's really
18 available in that category is do not support,
19 unless you say conditionally support because no
20 matter what comes out at the end of that NQF
21 endorsement process, they're just going to accept
22 it as a good measure, so to speak.

1 CO-CHAIR TRAVIS: Allen?

2 MEMBER NISSENSON: Yes, just to follow
3 up on Michael's point. Do you have any data on
4 what actually happens? What fraction of measures
5 are in the conditional support and then what
6 actually happens? So how many of those end up
7 going forward and additional work is done and
8 then they get adopted? So it would give I think
9 a more realistic picture what it means to vote in
10 that category.

11 MS. MARINELARENA: So most of the
12 measures right now in the hospital are already
13 endorsed. Some of them there may be updates, so
14 it's just an update to the measure. But we also
15 want to assure you, too, that here at NQF we are
16 incorporating the CDP work with the MAP work. So
17 all of the measures that were conditionally
18 supported because they were not NQF-endorsed last
19 year have come to us regarding projects and we
20 reach out to the measure developers.

21 I know for example I'm leading the
22 cancer work and cardiovascular work as well, so

1 even measures that were on the MUC last year and
2 got conditionally supported based on NQF
3 endorsement, we are reaching out to the
4 developers to make sure and ask them if they're
5 going to submit the measures. If it's a CMS
6 measure, it does come to us.

7 CO-CHAIR TRAVIS: Nancy?

8 MEMBER FOSTER: So I know this has
9 been a learning process over the several years
10 that we've all been involved in -- at least some
11 of us have been involved, so I'm just reflecting
12 on my confusion in response to Michael's question
13 earlier and the conversation that's ensued.

14 It seems to me, Ron, that your
15 response is right. That is where the tension is.
16 Do we conditionally support, do we encourage
17 further development or do something else? But if
18 a measure has been classified as, quote, "fully
19 developed," we don't have that choice. So maybe
20 part of our conversation should be around whether
21 we think it actually is fully developed, is
22 appropriately classified in that respect for the

1 program or use for which it is being proposed.

2 Is that a fair conversation to have?

3 CO-CHAIR WALTERS: I think that's one
4 of the factors that go into that decision for
5 sure. And there is a certain element of trust, I
6 would say, in the NQF endorsement process that it
7 will make sure that a measure doesn't get through
8 that isn't less than that. But it's going to be
9 measure-specific.

10 MEMBER FOSTER: Okay. And then in
11 response to Allen's question, I would say I'm in
12 the trust but verify category.

13 CO-CHAIR TRAVIS: Tom?

14 MEMBER LUTZOW: Yes, it seems that
15 throughout the measures one of the values that
16 you kind of hit is meaningful comparison between
17 providers. And I think the next generation is
18 going to look back at this work and feel that
19 that's too narrow.

20 There has to also be to what extent do
21 these measures meet another criteria, and that is
22 meaningful coordination between providers. And

1 one of the measures in this list speaks to that,
2 and that is the smoking cessation. There are
3 others that could be articulated along the lines
4 of meaningful coordination, and that is
5 readmission. But so much of the success in the
6 total healthcare scheme is related to
7 coordination of resources and our measures don't
8 really get to that. Across the board they don't
9 get to that. And what we have in fact is a
10 siloing effect on many of these measures rather
11 than a coordination effect.

12 And so collective impact has to be an
13 important consideration in selecting measures.
14 Smoking cessation can't be taken care of in three
15 days, in a three-patient inpatient stay. There
16 are others, too, especially with chronic
17 conditions that linger beyond that touch period.
18 The entire system, both in the medical side and
19 the social service side, has to be aligned. And
20 wherever Medicaid and Medicare dollars are spent
21 there's an opportunity for coordination.

22 And so that has to be a value I think

1 going forward that needs to be addressed by these
2 measures and the question has to be asked to what
3 extent does this measure or that measure speak to
4 coordination? And in some cases it will be zero,
5 it doesn't speak at all. And in other cases it
6 needs to speak to coordination. And maybe that's
7 some other domain that needs to be spoken to, but
8 I think as a general rule; and I'm glad CMS is
9 here, we're too narrow.

10 CO-CHAIR TRAVIS: Thank you, Tom. And
11 I may give Pierre a chance to kind of respond.

12 One of the aspects that I've seen
13 develop over time in the MAP work is the desire
14 and actually the implementation of measures,
15 similar measures across programs, something like
16 a smoking cessation, because there isn't just one
17 -- it's not one touch in one setting that's going
18 to have that kind of an impact. And so we have
19 begun to see measures that cross all of these
20 programs intentionally. So especially those that
21 hold providers accountable for like readmissions.
22 It's not just one provider that's impacting the

1 readmission.

2 And so we're beginning to see, I
3 think, from an intentional standpoint from CMS
4 that some of these measures do need to go across
5 the programs. And of course care coordination is
6 one of the priorities that CMS has identified.

7 So your point I think is very well
8 taken that we need to begin to look across these
9 programs and see how they're working together,
10 not just independently of each other. And that
11 is certainly something on the consensus
12 development process side that we're beginning to
13 see, because we see the measures, a lot of the
14 measures before they get to the MUC list. And
15 that rationale and that intent is beginning to
16 take place.

17 But I agree with you, Tom, that we
18 need to keep that kind of front and center in our
19 mind. And sometimes it's hard to look across all
20 these measures and programs and see the big
21 picture.

22 But I don't know, Pierre, if you want

1 to kind of give us one final comment before we
2 move on.

3 DR. YOUNG: Sure, Cristie.

4 Absolutely. So we certainly do think about sort
5 of -- care coordination is one of the priorities
6 for us when we're thinking about measures for our
7 programs, and also alignment between programs as
8 we discussed earlier.

9 But I did want to go back for a second
10 just to comment on the sort of fully developed
11 measure and sort of how we think about that.
12 Certainly the measures we put forward on the MUC
13 list we believe are appropriate for the program.
14 And there are particular reasons we may bring
15 forward during discussions. Like for example,
16 we'll talk about the tobacco measure, for
17 example, just a little bit that we specifically
18 want feedback on and we'll provide additional
19 context when we have those discussions.

20 And I don't have a hard statistic, but
21 when it comes to the endorsement process, I mean,
22 the timing unfortunately is not -- there are

1 constraints, because from CMS' perspective in
2 order to implement a measure into a program we
3 have to go through rulemaking, through proposed
4 rule and the final rule, which is a lengthy
5 process. And then the endorsement process is
6 also a lengthy process. So if we were to go
7 sequentially from endorsement first and then
8 bring it to the MAP and then put it through the
9 rule and then add on the measure development
10 time, we're talking like five years. And that's
11 a long time to wait from our perspective to try
12 and really meet our goals of improving healthcare
13 delivered in the nation.

14 So oftentimes we may have what we
15 consider a fully developed measure that has not
16 gone through the NQF process yet simply because
17 an appropriate project hasn't opened up and that
18 may open up in the next few months. And so those
19 measures we still believe are fully developed and
20 we put them on the MUC list for your
21 consideration at that point. But our intention
22 is to submit them to the NQF's consensus

1 endorsement -- development process for
2 consideration for endorsement to sort of when
3 that appropriate project comes up. So I hope
4 that helps.

5 CO-CHAIR TRAVIS: Zehra?

6 MS. SHAHAB: Thanks. Thanks everyone.
7 So we discussed the pathways and I just wanted to
8 give a quick overview of the measure selection
9 criteria. And I won't read each of these, but
10 I'll give kind of a high-level overview. So just
11 keep in mind that these are not absolute rules.
12 They're more of a general guidance on who the
13 decisions should be made.

14 The focus should be to select high-
15 quality measures that while NQF endorsement is
16 not required, it is highly preferred. They also
17 should address the National Quality Strategy
18 three aims. They should respond to the specific
19 program goals and requirements. They should
20 include a mix of measure types. They should fill
21 critical gaps. Also consider health disparities
22 and cultural competency. And also increase

1 alignment.

2 So on this next slide you'll notice
3 that, as Cristie was referring to earlier, the
4 staff has conducted preliminary analysis for each
5 measure under consideration. This is just to
6 help facilitate the consent calendar. And you
7 will find these in the discussion guide. And
8 these are in the materials.

9 So the preliminary analyses are
10 created using an algorithm which asks a series of
11 questions about each of the measures under
12 consideration. And this was developed from the
13 MAP measure selection criteria and approved by
14 the Map Coordinating Committee. So please note,
15 though, that these are just intended to provide a
16 brief profile and to be a starting point for
17 discussions. And you can wholeheartedly agree or
18 disagree with the staff's preliminary
19 recommendations and vote accordingly.

20 And before I turn it over to Erin, I
21 wanted to see if there were any other questions
22 about the decision categories or anything I've

1 reviewed in the slides so far.

2 MS. MITCHELL: A quick process
3 question. Do I assume correctly that the consent
4 designation is used in the same way that it's
5 used in most parliamentary venues, namely that
6 unless somebody wishes to discuss it, it is in
7 fact deemed to have passed? Is that correct?

8 MS. SHAHAB: Yes, that's correct.

9 MS. MITCHELL; Correct? Okay. Thank
10 you. I just wanted to be clear.

11 MS. SHAHAB: Yes. Okay.

12 MEMBER FOSTER: Clarity on what's
13 passed. It is the staff recommendation that's
14 passed? Is that right?

15 MS. SHAHAB: Yes, that's correct.

16 MEMBER FOSTER: Thank you.

17 MS. SHAHAB: Okay. Erin's going to
18 review the voting process and we'll also do a
19 test voting slide after this.

20 MS. O'ROURKE: Thanks, Zehra. So I
21 did want to do a few housekeeping items before we
22 jump into the voting process. Does everyone who

1 is an organizational representative or a subject
2 matter expert have a little blue clicker in front
3 of them? That's what you'll be using to do the
4 vote. If you don't, please raise your hand and
5 Jean-Luc will come assist you.

6 And as Cristie mentioned, if you wish
7 to speak, please put your tent card up
8 vertically. And also to please have your
9 microphone on when you're speaking so the
10 transcriptionist can capture everything you have
11 to say so that we have it all for our report. We
12 don't want to miss anything. And on another note
13 on the microphones, I believe only three can be
14 on at a time. So if you're having an issue
15 turning your microphone on, please make sure
16 others haven't left theirs on accidentally.

17 Moving on to some key principles for
18 our voting procedures. We'll be taking a vote on
19 every measure under consideration either as an
20 individual agenda item or as part of the consent
21 calendar as I just described and Delores and
22 Nancy clarified. So if you don't pull a measure

1 off of the consent calendar, the staff
2 recommendation will pass.

3 We are asking the workgroups this year
4 to reach a decision on every measure under
5 consideration. This is a request from the MAP
6 Coordinating Committee that we no longer pass
7 things up to them without the benefit of a
8 recommendation from the Workgroup. They
9 recognize that the subject matter experts on
10 hospital measurement are the ones around this
11 table and it's difficult for the Coordinating
12 Committee to make a final decision without the
13 benefit of your input. So we'll be pushing to
14 try to get to a decision on every measure. No
15 more split decisions, if you will.

16 However, with that being said, the
17 Coordinating Committee does have the option to
18 continue discussion about a particularly
19 important matter if there's a policy issue or a
20 particular strategic issue they wish to
21 discussion. So the measures still will be
22 discussed with the Coordinating Committee.

1 They'll also have the chance to review the public
2 comments that we received and react to those.

3 Next slide. So just to let you know
4 a little bit of how things are going to flow,
5 we'll have some introductory presentations from
6 NQF staff and the Workgroup chair to give some
7 context about the programmatic discussion. We'll
8 then open the floor for discussion and voting.

9 The electronic discussion guide will
10 be the main tool that we'll be using to go
11 through the meeting, so please let us know if
12 you're unable to get that up. That decision has
13 all the information you'll need about the
14 measure, the specifications that were on the
15 Measure Under Consideration list, what public
16 comments we received, as well as the full details
17 of the staff's preliminary analysis. So please
18 let us know if you're having any Internet issues
19 and can't pull that decision up.

20 The discussion guide is organized as
21 follows: The measure under consideration are
22 divided into a series of related groups for

1 discussion and voting. Each measure under
2 consideration does have a staff preliminary
3 analysis. As Zehra said, that's really just our
4 attempt to pull together what we could find about
5 that measure and give you all a starting point
6 for discussion. It's not binding in any way.

7 The discussion guide notes the results
8 of this preliminary analysis, so a preliminary
9 what staff would think it would be a support, do
10 not support of a conditional support based on
11 past MAP deliberations, research from the field,
12 things like that, and provides the rationale of
13 how we got to that decision.

14 Next slide. So the voting process
15 this year is a little bit different for those of
16 you who've participated in the past. We
17 attempted to eliminate some of the voting that we
18 did last year, so there will be no more voting to
19 vote. And we're also going to attempt to take
20 only one vote per measure. Last year we
21 subjected you to voting if you supported it,
22 voting if you conditionally supported it or

1 voting if you did not support it. So we
2 collapsed it all. There will be one vote per
3 measure with support, conditional support, do not
4 support all at one time. Hopefully that moves us
5 through a little bit faster.

6 So the first step is staff will
7 present each group of measures as a consent
8 calendar reflecting the results of the
9 preliminary analysis that we used using the MAP
10 selection criteria and the objectives of the
11 program.

12 Next slide. The next step, the
13 measures can be pulled from the consent calendar
14 and become a regular agenda item that will be
15 discussed individually. So the Co-Chairs will
16 ask you all to identify any MUCs that you'd like
17 to pull off the consent calendar. Every
18 Workgroup member has the ability to ask that one
19 or more MUCs on the consent calendar be removed
20 for individual discussion.

21 And we did attempt to start this
22 process via email. So we do have all of the ones

1 that you submitted to us ahead of time that you'd
2 like discussed as individual agenda items. So
3 the Chairs have those notes. But if you missed
4 the email, you are still welcome to pull measures
5 at this time. I did want to clarify that. So we
6 have what has already been pulled, but don't feel
7 like you cannot pull additional measures if you
8 wish to discuss them.

9 Once all the measures that the
10 Workgroup would like to discuss are removed from
11 the consent calendar, the Co-Chair will ask if
12 there's any objection to accepting the
13 preliminary analysis and the recommendation of
14 the MUCs remaining on the consent calendar. If
15 there's no objections made, the consent calendar
16 and associated recommendations will be accepted.
17 So we will not be taking a formal vote to accept
18 the consent calendar. So another change from
19 last year and eliminate one more click.

20 Next slide.

21 MS. MITCHELL: Another procedural
22 question?

1 MS. O'ROURKE: Yes.

2 MS. MITCHELL: Are we going to take
3 each of these subject matter areas one at a time
4 and go through this process, or do you expect to
5 go all the way through the entire list for the
6 pulling of measures?

7 MS. O'ROURKE: We're going to go
8 consent calendar by consent calendar.

9 MS. MITCHELL: We're going to do what?

10 MS. O'ROURKE: We'll do one at a time.

11 MS. MITCHELL: Okay.

12 MS. O'ROURKE: So one area at a time.

13 So we'll finish what was on one calendar --

14 MS. MITCHELL: All right.

15 MS. O'ROURKE: -- then move on.

16 MS. MITCHELL: That's just what I was
17 going to ask to do. Thank you.

18 MS. O'ROURKE: We will not expect you
19 to keep track of 40 measures and then come back.

20 So once we are done with what's left
21 on the consent calendar, we'll move on to voting
22 on the individual measures. So if you were the

1 member who pulled that measure for discussion,
2 you are first up to discuss it. We'd ask that
3 you explain why you pulled it and why you
4 disagreed with the staff preliminary analysis.

5 We'll then turn to the lead
6 discussants that have been identified to give
7 their opinion. They are really welcome to say
8 whatever they would like to say about the
9 measure, if they agree with the staff analysis,
10 if they agree with the person who pulled it, or
11 if they have a completely different opinion.

12 DR. LEVY: I have a question. So a
13 number of the measures appear on more than one
14 program. Do you want one discussion on the
15 measure or revisit it for each program?

16 MS. O'ROURKE: So right now we've got
17 it for each program. I think that's maybe
18 something as we get to those measures we can
19 pause and ask the group if they feel a need to
20 re-discuss it, if there's meaningful differences
21 say between IQR and the HAC Reduction Program
22 that they would like to discuss. But similarly

1 to years past we'd like to be as consistent as
2 possible and have one recommendation for the
3 measure across programs, but we understand there
4 might be different issues a Workgroup member
5 would like to discuss for a different program.

6 So once we've heard from the lead
7 discussants, we'll open up the floor for the
8 entire Workgroup and we'll discuss as needed. We
9 ask that in the interest of time you refrain from
10 repeating points that have already been presented
11 by others. We've got an awful lot to get through
12 today. And then after the discussion of each
13 measure under consideration, we'll go to a vote
14 on that measure.

15 For a fully supported measure, which
16 I believe are all but one that we'll be
17 discussing today, your choices are support,
18 support with conditions or do not support.

19 Next slide. So another change from
20 last year is in how we'll be tallying the votes.
21 This is really how we were able to eliminate some
22 of them. If a measure receives greater than or

1 equal to 60 percent for any one condition; so
2 support, conditional support or do not support,
3 that condition passes. Where the change is is
4 this year we'll be summing the results of the
5 support and conditional support to get to a
6 conditional support decision.

7 So if 55 percent of you support it, 5
8 percent would also conditionally support it, it
9 would default to a conditional support and staff
10 will pause afterwards and clarify the conditions.
11 So a little bit of a change from last year that
12 those can be summed to get to a conditional
13 support. If we don't get to conditional support
14 by summing support and conditional support, the
15 recommendation would be a do not support.

16 And finally, abstentions are
17 discouraged, but they will not count in the
18 denominator. We have built in some additional
19 breaks and a little bit of a longer lunch time
20 this year, so we'd ask if at all possible you not
21 step away during the voting. We know life
22 happens, but please try to participate in all of

1 the votes if you can.

2 So next slide. Just a few guidelines
3 for public commenting. We had a public comment
4 period on the measures under consideration. We
5 have incorporated those into your discussion
6 guide. If you see a little number of public
7 comments received, say two for example, if you
8 click that two it will take you so that you can
9 read the full comments that were submitted. We
10 ask that the Workgroup members read these through
11 and consider them in your deliberations.

12 We'll have an opportunity for public
13 comment before the discussion on each program.
14 Commenters are asked to limit their comments to
15 only the measures for that program and to limit
16 their comments to two minutes so that everyone
17 has a chance to speak.

18 We will have a global public comment
19 period at the end of each day. This is a chance
20 for the public to weigh in on everything that has
21 been discussed. And if they want to provide
22 comments on a Workgroup recommendation, that

1 would be the time. We'll also have our usual
2 formal written public comment period that this
3 year will be running from December 23rd through
4 January 12th. And these public comments will be
5 considered by the Coordinating Committee as well
6 as submitted to CMS.

7 I think that is my last slide on
8 voting, so I can take any additional questions.

9 MEMBER BENIN: Erin, were there
10 updates to that discussion guide, or if I
11 downloaded it a few days ago is that okay? Do we
12 need to re-download it?

13 MS. O'ROURKE: We updated it
14 yesterday. So there's a 12/15 version on the
15 SharePoint site. The SharePoint site is
16 public.qualityforum.org. So if you go there,
17 you'll see a version dated 12/15 that has all the
18 latest updates.

19 MR. TILLY: And just to be totally
20 certain, that version we labeled 3.1 in the top
21 left corner.

22 CO-CHAIR TRAVIS: Marty?

1 MEMBER HATLIE: So there's going to be
2 no split voting, I get that, but suppose there's
3 a very strong minority opinion? It doesn't rise
4 to 40 percent, but it's 35 percent. How does
5 that go forward to the Coordinating Committee, if
6 at all?

7 MS. O'ROURKE: So that is really what
8 the rational category is for. And we capture
9 both sides of the discussion there when there are
10 strong opinions on both sides or a substantial
11 minority opinion. Staff will also be bringing
12 issues like that to the Coordinating Committee.
13 So we're trying to avoid any re-votes on the
14 measures, but when there is some strong minority
15 opinions about some key issues, those will be
16 going to the Coordinating Committee for
17 consideration.

18 So if there's no other questions,
19 we're going to do a quick test vote. So on the
20 top of your clicker you'll see the buttons that
21 say 1A, 2B, 3C. Those are the ones that we'll be
22 using today. So if you could all take your

1 clicker. Then our test question is how do you
2 feel about testing our voting system?

3 (Laughter.)

4 MS. O'ROURKE: Do you support this
5 test vote, would you support it with some
6 conditions, or do you not support that we're
7 taking this test vote? And if you'd point your
8 clickers at Jean-Luc over there in the corner --
9 point them at him. I'm told it's not totally
10 necessary, but it seems to work some magic.

11 MS. SHAHAB: I also want to add I'm
12 going to be doing a proxy vote on behalf of
13 Jennifer Eames Huff, who is going to be
14 substituting for Helen Haskell until about 1:00
15 p.m. So I have that clicker and I'll be getting
16 votes from here from chat.

17 (Voting.)

18 CO-CHAIR TRAVIS: Has everybody voted?

19 MS. O'ROURKE: There should be 26. If
20 everyone could keep clicking.

21 And, oh, Jeff is out of the room. So
22 there we go.

1 MR. TILLY: Oh, so that's just --
2 sorry. That little clock on -- that's just the
3 timer on the right.

4 MS. O'ROURKE: Oh.

5 MR. TILLY: We actually have 23
6 responses so far, so I think we need two more.

7 MS. O'ROURKE: Okay. So keep
8 clicking.

9 MR. TILLY: Yes.

10 MS. O'ROURKE: You'll see the red
11 button light up. And your vote will not be
12 counted more than once, so don't be afraid to
13 keep hitting when we have these issues of getting
14 everything tallied.

15 CO-CHAIR TRAVIS: And it will count
16 your last vote if you change your mind, yes.

17 MR. TILLY: Okay. We just hit 25, and
18 that's it.

19 MS. O'ROURKE: So we don't have
20 consensus about testing our voting system. We'd
21 have to sum this.

22 (Laughter.)

1 MS. O'ROURKE: Conditional support.

2 So if there's other procedural
3 questions, I can turn it to Melissa to quick us
4 off for IQR.

5 MS. MARINELARENA: So this is just
6 going to be a very quick overview. We did this
7 overview during the web meeting, so this is just
8 a review for everybody.

9 Again, just as a reminder; and I'm
10 sure everybody here is more than familiar with
11 these programs as we sit around the table, the
12 IQR Program is a pay-for-reporting and public
13 reporting program. The incentive structure is;
14 and we did correct this from the web meeting,
15 that hospitals receive a quarter of the
16 applicable percentage points of the annual market
17 basket, or the AMB payment update. And for those
18 hospitals who choose not to participate in the
19 program, they get the same percentage in
20 reduction in payments.

21 The goal of the program is to provide
22 an incentive for the hospitals to report quality

1 information about their services and to provide
2 consumers information about the hospital quality
3 so that they can make informed choices.

4 Next slide. We are reviewing -- this
5 year IQR and the EHR Incentive Program is
6 together, so we're considering both measures for
7 both programs. Again, this is a pay-for-
8 reporting program. And the difference in this
9 now as of 2015 there will be a reduction of
10 three-quarters of a percentage of the applicable
11 percentage of the annual market basket payment
12 update. So the difference is there's no longer
13 an incentive to participate in meaningful use.
14 Now there is a reduction.

15 And the program goals here are again
16 to provide widespread adoption of certified EHR
17 technology to providers to incentivize the
18 meaningful use of EHRs for hospitals. And of
19 course by doing that we're looking to include
20 quality, safety, efficiency in reducing health
21 disparities and engaging patients and their
22 family, improving care coordination and

1 population and public health, and of course to
2 maintain privacy and security of patient health
3 information.

4 Again this was just a quick overview.
5 And now I will turn it over to Ron and we'll get
6 started. Yes?

7 MEMBER BENIN: So what you're saying
8 then is that if we are voting support for any of
9 these metrics, we're supporting them both for the
10 IQR and for meaningful use?

11 MS. MARINELARENA: Correct. It's just
12 that now CMS is no longer requiring hospitals to
13 submit two separate programs. It's just through
14 one program.

15 CO-CHAIR WALTERS: Okay. Everybody
16 ready? So as mentioned earlier, at the beginning
17 of every program the first thing we're going to
18 do is call for public comments about the
19 measures, and this will be any public comments
20 about any measure in the entire program. We'll
21 do it first for in the room, but you on the phone
22 can start to think about what you'd like to do.

1 Are there any public comments? Thank
2 you very much. Go ahead and identify yourself.

3 MR. DEMIHIN: Morning. My name is
4 Akin Demihin. I'm with the American Hospital
5 Association. Thank you for the opportunity to
6 share a couple of thoughts about the IQR Program.
7 And actually this point was just raised as a part
8 of this discussion about the differences and
9 commonality between the IQR and the Medicare EHR
10 Incentive Program.

11 And I guess my recommendation to the
12 Committee would be to continue to consider those
13 programs as parallel programs and not necessarily
14 as the same program. We've begun to see more
15 commonality between the programs over the past
16 couple of years. There is a voluntary eQCM
17 reporting option for the IQR now. There will be
18 a mandatory eQCM reporting requirement that
19 starts at the end of 2016.

20 Hospitals have expressed an enormous
21 amount of frustration with the current state of
22 eQCM reporting, especially with respect to

1 getting reliable and accurate data out of eQMs,
2 the extent to which different EHR vendors support
3 particularly eQMs. If their vendor doesn't
4 happen to support one, it could leave them
5 without the ability to report data.

6 We also have ongoing questions about
7 the extent to which eQMs have been tested across
8 different EHR platforms and are quite concerned
9 about a mandate that would have hospitals report
10 on all of the same eQMs.

11 And so as you think about how to
12 recommend some of the measures on this list that
13 are in fact eQMs, you may want to make those
14 recommendations conditional on their being used
15 to support this kind of separate track for eQM
16 reporting rather than being something that would
17 be a mandate to all hospitals. Thank you.

18 MS. BOSSLEY: Heidi Bossley. I'm
19 consultant to the Federation of American
20 Hospitals today. I'm just going to speak
21 generally to a few comments.

22 I know all of you have already

1 discussed this, but again from the perspective of
2 the hospitals I wanted to reiterate that it is
3 important to look at the set of measures within a
4 program and make sure that the juice is worth the
5 squeeze, I guess I would say.

6 What we see with some of the measures
7 that are proposed is a concept still, not quite
8 ready for prime time. We're not sure that we
9 actually know how these measures will be used,
10 nor do we have information on reliability and
11 validity, two critical pieces that we need to see
12 before we see it moved into programs.

13 The other thing I would just note is
14 even when we look at, for example, the cost
15 measures, you can get that information from
16 claims. So there is an assumption that it is
17 easy for hospitals because there is little work,
18 but actually when you look at the other side of
19 this, there's still the quality improvement
20 perspective as well as just the tracking that
21 they need to do internally to make sure that this
22 data is correct and that they're capturing

1 everything.

2 So just want to balance that
3 perspective of looking at the claims. Oh, it's
4 easy. It actually isn't. There's a huge lift.
5 So if you can all be judicious as you think
6 through, that would be very helpful.

7 CO-CHAIR WALTERS: Thank you very
8 much. Are there any other comments in the room?

9 (No audible response.)

10 CO-CHAIR WALTERS: Okay. Thank you.
11 Do we have any comments on the phone?

12 OPERATOR: At this time to make a
13 comment, please star then the number one.

14 (Pause.)

15 OPERATOR: There are no public
16 comments at this time.

17 CO-CHAIR WALTERS: Thank you very
18 much.

19 So we will now move onto the consent
20 calendar. As was mentioned earlier, we have
21 grouped these into shorter calendars so that
22 we're not dealing with 20 and 25 measures at one

1 time and flipping a bunch of pages. So the first
2 Calendar 1, you should show has five measures on
3 it. Four of them have been pulled for
4 discussion. We'll get to them in just a second.
5 One measure, Measure 2 out of the calendar, which
6 was the harmonized SSI measure, is still on the
7 consent calendar.

8 Is there anybody in the room that
9 would like to pull that one?

10 MEMBER SCHULTZ: Yes, this is Leslie
11 Schultz. I'd like to ask that that be pulled.

12 CO-CHAIR WALTERS: Okay. Measure 2
13 has not been pulled. That does not leave us a
14 consent calendar anymore.

15 (Laughter.)

16 CO-CHAIR WALTERS: So we will now move
17 to the Item No. 1 on the list, which is the adult
18 local current smoking prevalence. And we have a
19 presentation from CMS about that. Then we'll go
20 with Andrea, who was the one who pulled that
21 measure. Then we will go to the lead
22 discussions, and then we'll open it up for

1 general discussion. Okay? And that's kind of
2 the routine we'll go through for every one of the
3 pulled measures. So first, we're open to the
4 presentation from CMS.

5 DR. SANGHAVI: Thank you. My name is
6 Darshak Sanghavi. I am a pediatric cardiologist
7 and the Director of Prevention in Population
8 Healthcare at the Innovation Center in Medicare.
9 I'll just acknowledge I'm accompanied by several
10 members of my team today.

11 I'll just review this measure summary
12 in concept, which is a project that our group has
13 proposed and it's something that has also been
14 endorsed by our center director Patrick Conway,
15 as well as Tom Frieden, the leader of the Centers
16 for Disease Control.

17 The concept is an adult local current
18 smoking prevalence as measured by the Behavioral
19 Risk Factor Surveillance System, BRFSS,
20 affectionately known as "Birfiss." This is NQF-
21 endorsed at the state level, as you can see by
22 given number 2020, which has also -- that data is

1 also collected at the county level in the
2 identical manner. And this is going to be
3 reported interesting not -- this information is
4 actually collected by the CDC at the county level
5 and reported by the CDC directly. We can talk
6 about that.

7 Why a geographic measure for the IQR?
8 And I'm going to try to limit my comments to two
9 minutes so we can get to the discussion. Happy
10 to discuss any of the research that underlies
11 this if that will be useful to any members of the
12 group.

13 The first question is why a geographic
14 measure for IQR? We believe that smoking
15 prevalence is a critical outcome measure for
16 population health. We at CMS broadly are
17 interested in quality measures that promote
18 coordination and population-based health. Not
19 only measures, but as some of you are aware, we
20 have announced a national strategy that also
21 tries to put our payment strategies behind that
22 as well with gradually increasing circles of

1 population-based accountability for payment.

2 We believe that there is significant
3 evidence demonstrating that the smoking
4 prevalence is substantially impacted by multi-
5 modal interventions that occur at the hospital
6 level and also continue afterwards after those
7 encounters as well. And there's substantial
8 opportunity for improvement there.

9 To take one example, 18 percent of
10 inpatients continue to smoke while they're in
11 hospitals here. Significant community-based
12 measures that can be endorsed by hospitals can
13 have an impact on smoking to the point where last
14 year the BMJ in 2014 reported that, quote, "Their
15 findings by review suggest that delivering
16 smoking cessation as a routine component of
17 hospital-based care can have substantial impacts
18 on prevalence of smoking." We believe this can
19 be substantially also augmented by coordinated
20 efforts across hospitals that are all in a county
21 signaling the possibility of collaboration as
22 well.

1 Next slide, please. Why the county as
2 opposed to some other geographic denominators?
3 Here we believe that county levels are easy to
4 understand. We are striving for some basic
5 concept of simplicity balanced with obviously an
6 important outcome measure. Many other strategies
7 can exist. Hospital referral regions. Those are
8 derived from cardiac and neurosurgical referral
9 patterns. Census tracks others. Each of those
10 have issues. We believe the county-based level
11 is the way to go because CDC has a methodology to
12 collect that information through the BRFSS and
13 reports it on a county level.

14 What about counties served by multiple
15 hospitals? The key here, and I think one of the
16 things we'd like to point out, is that the
17 measure applies to all hospitals within a county.
18 It connects them in some way. Hospitals,
19 according to the CDC, have an enormous impact on
20 the population geographically located around --
21 in which they are. Most Americans are in a
22 county that is served by an acute-care hospital

1 and we believe that there is substantial
2 possibility of coordinated activities. And we
3 have also seen this activity already catalyzed in
4 multiple health centers and also at large
5 geographic centers including statewide in places
6 like Oregon, as well as Maryland, through some of
7 the other coordinated programs we are putting out
8 there.

9 So I think one of the things that's
10 been raised is what is CMS' strategic vision?
11 This is a measure that in many ways starts to
12 push that measurement strategy to go with that
13 strategic vision. We could talk about that as
14 well.

15 Our final slide is next. Some may
16 legitimately ask, well, what do hospitals -- what
17 powers do they have or what ability do they have
18 to significantly impact smoking rates at the
19 county level? We believe that there is
20 substantial data that underlies this. CDC is
21 developing a tool kit to assist with that. We
22 know that inpatient care can be a critical

1 component there.

2 We know that best practices also at
3 employers. One example is at Cuyahoga County,
4 Cleveland Clinic serves, initiated substantial
5 changes in employment practices and that was
6 correlated with a specific potentially
7 attributable reduction in the county-based
8 smoking prevalence at that level.

9 We also believe that there's
10 substantial opportunities for community
11 partnership as well. And as many of you are
12 aware, there is a significant body of evidence
13 that community-based interventions, of which
14 hospitals play a critical part because of the
15 patient population that are served in those
16 hospitals can fulfill -- and some of those are
17 listed there. Tobacco 21. The effects on
18 impacting price of tobacco as well as cessation
19 campaigns more broadly.

20 And finally, we also believe that CDC
21 can assist with developing a tool kit which will
22 be distributed. And I had mentioned that.

1 I'm at time right now. I will stop
2 there, but thank you for the opportunity to bring
3 this to the Committee.

4 CO-CHAIR WALTERS: Thank you very
5 much, Darshak.

6 Hold your cards. Now in this
7 particular circumstance the person who asked that
8 the measure be pulled happened to be one of the
9 lead discussants. So, Andrea?

10 MEMBER BENIN: I think this is a
11 really important area to look at and BRFSS is a
12 really important epidemiological methodology for
13 looking at smoking and how we impact smoking and
14 reduce it as a society. So it's a critically
15 important area. It's an epidemiological piece of
16 work right now and I'm not clear how tying it to
17 an accountability program for hospitals is the
18 right thing as far as really thinking about how
19 this can be moved.

20 There is only a certain amount that
21 hospitals can impact around the people who come
22 to them and are in contact with them, and so this

1 really strikes me as an epidemiological tool more
2 than an accountability metric for a hospital. I
3 think that there are lots of opportunities for
4 CDC and CMS to come together and perform these
5 analyses and be able to present out those
6 analyses in order to begin to drive that
7 conversation a little bit different, but this
8 hasn't been used nationally. It's not been
9 looked at nationally and as far as having people
10 understand how it works and how it performs so
11 that hospitals would know really how they're
12 driving it.

13 So it just seems to me that it's
14 premature for use as an accountability metric in
15 a hospital-based program. It has potential and I
16 think there's a lot of analytics that could be
17 helpful in the future for hospitals to understand
18 this better, but right now this strikes me really
19 as an epidemiological function of BRFSS more than
20 a true quality metric that hospitals are ready to
21 be held accountable for.

22 CO-CHAIR WALTERS: Do you have a

1 recommendation about what that should be
2 classified as?

3 MEMBER BENIN: I would recommend that
4 at a do not support.

5 CO-CHAIR WALTERS: Now, we're going to
6 come back to you for the other measures in a
7 little bit. Leslie, you're the other lead
8 discussant.

9 MEMBER SCHULTZ: Thank you. This is
10 Leslie Schultz. This is the harmonized SSI
11 measure.

12 CO-CHAIR WALTERS: We're still on the
13 local current smoking measure.

14 MEMBER SCHULTZ: Okay. Great. I
15 agree with both CMS and Andrea that this is a
16 population health measure and we do encourage
17 that, however, again the limitations as to a
18 given hospital's ability to directly influence
19 this measure, we think that's beyond their scope.
20 And so I would support Andrea in the do not
21 support.

22 CO-CHAIR WALTERS: Thank you very

1 much. Now get the cards ready. I didn't notice
2 -- Jack, go ahead.

3 DR. FOWLER: Just two quick comments.
4 One, I think we know there are a lot of
5 demographic drivers of smoking and correlates
6 that really trump almost everything else in terms
7 of smoking prevalence. And so, it feels like
8 this would penalize hospitals that happen to be
9 located in the wrong places where the wrong kinds
10 of people live.

11 And second, I do have trouble with the
12 notion that when 15 percent of the population
13 maybe gets hospitalized a year, the whole
14 hospital is responsible for the smoking rate at a
15 population. And this coordination rationale
16 didn't impress me, so I support the against vote.

17 MS. O'ROURKE: I do want to make one
18 procedural clarification before we go too far.
19 This is our one measure that is on the under
20 development pathway, so your choices are actually
21 encourage future development or do not encourage
22 further consideration. So they're on the small

1 screens to the side. It's fully developed at the
2 state level, so this would be an application for
3 the county level and it has not been tested at
4 the county level.

5 DR. BURSTIN: In addition, in our
6 conversations even if it is at the county level,
7 there's probably an additional step to think
8 through testing as it relates to hospital
9 performance as well.

10 CO-CHAIR WALTERS: Ann Marie?

11 DR. SULLIVAN: I'm not sure how the
12 person who developed this considers the big --
13 for example, in New York City, if you up the
14 taxes on smoking or you ban it in certain parts
15 of the city, it has a huge effect on smoking.
16 That has nothing to do with the hospitals. And
17 so it's not just the hospitals will be penalized
18 for not doing it. I mean, you could have a
19 society, a certain area where smoking initiatives
20 are being made which would make the hospitals
21 look very good and have nothing to do with what
22 the hospitals are doing. So I'm not sure how the

1 developer of this tying it to what the -- if
2 there's enough value for what the hospitals could
3 do to impact it when big societal things can
4 impact smoking almost in a much more aggressive
5 way than others.

6 So for example, if you were to have a
7 city that suddenly said you can't smoke any
8 place; and that has cut smoking rates in the
9 city, I'm not sure how that then impacts
10 hospitals. How do you know that the hospital's
11 done anything at all?

12 CO-CHAIR WALTERS: Okay. You can
13 clarify an answer to that. Thank you.

14 DR. SANGHAVI: Sure. So that is
15 correct that there can be impact if a city
16 suddenly substantially increased the tobacco
17 taxes. There are also many things that hospitals
18 can do that also impact the smoking rate, though,
19 however, as well.

20 As I pointed out, there are
21 significant data that show that enhanced
22 inpatient care actually does have substantial

1 impacts on local-based smoking prevalence.
2 There's also substantial impact that in hospital
3 employee hiring and other practices can have
4 substantial impacts. And based on our
5 information, looking at Trinity Health, St.
6 Luke's Center, Kansas City, Partnership for a
7 Healthier Carroll Hospital in Maryland, and
8 numerous others, they have actually created large
9 broad-based campaigns for the express purpose of
10 reducing the smoking prevalence widely in
11 partnership with other hospitals.

12 So this is true that, yes, major
13 changes in -- you know, we passed the Affordable
14 Care Act in 2010. That was something that was
15 significantly outside the control of hospitals;
16 may have improved quality in some places, damaged
17 it in others. These types of things will happen.
18 We believe that this should not impede our
19 efforts to try and actually then realign our work
20 and our payments at the population-based level.

21 CO-CHAIR WALTERS: Thank you. We got
22 Sean, Nancy, Brock, Mike and Jeff. Sean?

1 DR. MORRISON: Yes, I mean, I don't
2 think anybody would argue from a societal
3 perspective that smoking has significant impact
4 on public health, but what strikes me about this
5 is that this -- our quality programs seem to be
6 the only hammer that we have against the nail
7 which tobacco use. And, yes, the data suggests
8 that hospitals can reduce smoking, but the
9 reality is the data suggests that increasing the
10 tax on cigarettes is a much more effective
11 approach to reducing smoking cessation, that
12 public service advertising campaigns are a much
13 more effective way of reducing --

14 And what strikes me about this measure
15 is people are feeling very frustrated about it.
16 This is the only program where we think we can
17 make an impact, but quite honestly, as Jack
18 pointed out, only 15 percent of Americans are
19 hospitalized. Probably about 20 percent, less
20 than that, are actually smokers. And this seems
21 to put a tremendous burden on the wrong
22 institution and the wrong program to address a

1 very important public health crisis. And I would
2 suggest that we don't support this and we move
3 efforts about smoking cessation outside of an
4 accountability program and more into a public
5 health perspective where they really belong.

6 CO-CHAIR WALTERS: Nancy?

7 MEMBER FOSTER: To keep this short I
8 will just associate myself with all of the
9 remarks that have been made by my colleagues on
10 the Committee thus far. Important program -- or
11 important issue, wrong program, wrong target.

12 I would also point out that hospitals
13 have the annoying capacity to not be related to
14 just one community, right? They serve broad-
15 based communities. And you would decide which
16 county to associate with Mayo Clinic or how to --
17 even looking at the hospitals here in the
18 District, they serve Maryland and Virginia as
19 well. It becomes very complicated in a way that
20 just causes you to run down a rabbit hole to
21 chase something that's not worth chasing.

22 CO-CHAIR WALTERS: Brock?

1 MEMBER SLABACH: I have two questions.
2 First is how does the data get accumulated? And
3 I'm concerned about small rural counties in
4 remote areas. How does that data get put into a
5 system that now is going to evaluate the
6 hospital's ability to stop smoking in their
7 community?

8 The second issue is is this in the ACO
9 data set? And wouldn't this be more appropriate
10 for those hospitals that have chosen to
11 participate to be accountable for a community's
12 health rather than affecting all the hospitals
13 that haven't made that strategic choice possibly
14 yet?

15 DR. SANGHAVI: So the answer to the
16 first question is this is done on a county-level
17 basis. There's a minimum number of individuals
18 that have to be in a county for that to survey.
19 There is methodologies used. It's essentially
20 two survey questions. It's a telephone-based
21 survey that are asked. And that's durable over
22 time. It's been done since the early 1980s, and

1 again reported by CDC directly. So the reporting
2 on the hospitals is not there.

3 To answer your second question, why
4 IQR and not other areas? I think again we would
5 say that smoking as the major and most important
6 preventable cause of hospitalizations deserves a
7 multi-modal strategy. We are not simply coming
8 to the MAP Committee as the sole component of our
9 anti-smoking strategy, but believe that this is
10 part of a broader rubric in sort of thinking
11 about the types of interventions that are most
12 effective.

13 We also, for example, don't
14 incentivize strategies that could reduce
15 community-based infection, but we have programs
16 here that certainly look at sepsis, for example.
17 We are downstream to many of these areas, but I
18 think that ultimately we do need to find ways to
19 actually create those programs that have upstream
20 impacts.

21 So I think that with that, having said
22 that multi-modal strategy again, the strategy

1 here we could -- we are coming to IQR. There is
2 also as I said a parallel strategy to use this in
3 our Medicaid statewide redesigned programs as
4 well as potentially in the ACO programs that we
5 do.

6 So again, we would like to create --
7 one of the key things here is that the Committee
8 here has an opportunity to say we would like to
9 work with part of this broader public health
10 effort along with other programs, the direction
11 in which we're going, or the Committee can say
12 that we would choose to sort of hold back and
13 follow the rest of the organization.

14 CO-CHAIR WALTERS: We have Michael,
15 Jeff and Marty. And I would probably ask that
16 each one contribute incremental comments.
17 Michael?

18 DR. PHELAN: I hate to be kind of the
19 disagreeer amongst the rest of the crowd, but I
20 see this opportunity as the movement of where
21 quality measurement needs to go towards the
22 future. Wellness is the reason why we really

1 want to get into the healthcare arena, and to not
2 incentivize in a way like this which brings the
3 multiple partners -- it brings health systems
4 together, it brings public and private
5 cooperation, it would do so much around this
6 arena of health wellness to try to improve the --
7 decrease the rates in communities. And
8 hospitals, health systems and all the things that
9 are associated with those health systems would be
10 incentivized to cooperate, number one, which is
11 one of the big things that we probably don't do a
12 really good job at doing, and really meaningfully
13 impact the lives of patients, not just in a one-
14 on-one setting, but in a much larger broader
15 sense.

16 So I kind of sense this is the
17 direction of where healthcare quality
18 measurements needs to go and the incentives that
19 need to be put around something like a community-
20 based smoking rate or community-based
21 hypertension rate, or whatever rate you want to
22 look at, or whatever metric you want to look at

1 for that. And I think this is an opportunity to
2 do that. They could piecemeal pick every single
3 incentive. Like there's some good data that just
4 briefly discussing with patients in the emergency
5 department has about a 10 percent reduction in
6 smoking rate for that population. But to
7 piecemeal do this instead of wholesale trying to
8 get it from the very far end, which is the
9 outcome.

10 We really want to see the outcome
11 measure be what we're striving for and then let
12 the communities decide however they want to do
13 it, or the hospital decide how they can best
14 impact through whatever programs CDC has or CMS.
15 And the hospitals and hospital systems will go
16 hog wild if there's a measure. And how I
17 envision this is I imagine -- and I don't know
18 how they would incorporate it, but maybe a
19 reduction -- if your community has a higher
20 smoking rate, there may be a reduction in some
21 kind of payment by a percentage or however it
22 goes.

1 But from a wellness perspective and a
2 community perspective we definitely don't do
3 enough to encourage our patients to not smoke.
4 And it is a really heavy lift amongst -- if
5 you're in a busy clinic and you're trying to move
6 things along, but to meaningfully impact the
7 patients' lives. The one and done doesn't do it,
8 but to have a community working behind and
9 rallying behind something like smoking -- and
10 unfortunately the only way to get some of these
11 incentives to this is with either a carrot or a
12 stick.

13 I would much rather see a carrot, an
14 increase in pay for every decrease instead of
15 something to take away, which I think would get a
16 lot more buy-in for the communities that you're
17 trying to impact. Instead of taking it and
18 saying, well, we're going to take some money away
19 from you, well, we're going to encourage you
20 because the up-front investment in this would be
21 tremendous. Because at the back end is where
22 you're going to be saving all the money, the

1 millions in COPD, cancer care and things like
2 that, or billions down the road. And even in my
3 small practice, I mean, I looked at how many
4 people who actually come in and smoke with a
5 significant disease like COPD, if they were ever
6 given, at least in the medical record, any
7 indication not to smoke. And it's almost
8 negligible.

9 So when you review a medical record
10 and you see someone who's been in the ED in the
11 last six months four or five times for COPD and
12 not a single provider actually meaningfully sat
13 down and said have you ever thought about
14 quitting? We have programs here at the clinic we
15 can get you involved in. It's discouraging.

16 So I think I would ask the people in
17 the group to think about this, but also from CMS'
18 perspective the carrot works way better than the
19 stick. So having incentives where it flips it
20 from we're taking money away if your community is
21 higher in smoking, well, we're going to give you
22 money for significant reductions, not just the

1 fact that you have a 15 or 30 percent smoking in
2 your community. If you show a three or four-
3 percent reduction, we're going to incentivize you
4 to get that.

5 So I would actually recommend we; what
6 is it, continued development, but along those
7 lines to incentivize hospitals to do that,
8 because there are a lot of programs out there
9 that can meaningfully impact patients' lives, and
10 this is one where I think the carrot will work
11 better than the stick. And I think it's
12 something that we should be looking at strongly.

13 These health systems have a tremendous
14 impact based on the community they work in. If
15 it's the worker, employer population where you
16 can say we won't hire you if you smoke, or doing
17 things like actually meaningfully interacting
18 with patients in an in-patient setting, in an ED
19 setting or in an outpatient setting. I think it
20 can significantly impact the smoking rates in the
21 communities that these hospitals and health
22 systems serve.

1 CO-CHAIR WALTERS: Thank you very
2 much. I will remind everyone we're trying to get
3 through our first measure.

4 (Laughter.)

5 CO-CHAIR WALTERS: So please keep that
6 in mind as we move through a couple days here.

7 Jeff?

8 MEMBER JACOBS: Thank you. I'll try
9 to be brief. I just wanted to comment, probably
10 say something a little bit different from the
11 majority of what the first speaker said.

12 It seems from what I understand that
13 our options here are to encourage future
14 development or not encourage future development.
15 We don't have to fully endorse this at this point
16 in time. And it seems that this measure is
17 somewhat of a paradigm shift in the types of
18 measures that are usually reviewed by this group;
19 although I'm new to the group, but this is a
20 measure that's putting hospitals responsible for
21 the global health of the community.

22 And that's an interesting idea. It

1 could be debated whether or not that's the right
2 or wrong idea, but I don't think we should shut
3 that idea down today because it's an interesting
4 idea that I think merits further exploration
5 whether we should develop measures that put a
6 hospital or a group of hospitals in a community
7 responsible for the global health of the
8 community.

9 And based on that rationale, I would
10 encourage our group to encourage future
11 development of this measure so that the measure
12 developers can try to address some of the other
13 concerns raised by the earlier discussants and
14 come back to this group with a more polished
15 measure that might address those concerns. This
16 is a new idea and I don't think we should just
17 shut down today.

18 CO-CHAIR WALTERS: Marty?

19 MEMBER HATLIE: I agree with the last
20 two speakers. I think that we've underestimated
21 the role that hospitals can play partnering with
22 other community groups and public health groups

1 in trying to advance wellness. I think it is a
2 paradigm shift. And I think the argument that
3 hospitals shouldn't have accountability, it's
4 unfair because they have a small part of the job,
5 or they can't do it all is just not where we're
6 going. And then the coordination strategy is
7 community responsibility and I think I want to
8 incentivize that.

9 So I'll vote certainly for continued
10 development. Thank you.

11 CO-CHAIR WALTERS: Last comment.
12 Nancy?

13 MEMBER FOSTER: Thanks. Just a very
14 different point, which is that this is proposed
15 for both IQR and EHR meaningful use program. Can
16 we at least agree that since it is not an EHR-
17 derived measure it should not be encouraged for
18 further development for that program and then
19 take a vote on the other?

20 CO-CHAIR WALTERS: Everybody ready to
21 vote?

22 (No audible response.)

1 CO-CHAIR WALTERS: Thank you. So
2 that's how it works, measure by measure by
3 measure. And we'll now open it up for voting.

4 MR. TILLY: Okay. The measure's how
5 open for a vote for the adult local current
6 smoking prevalence. Encourage continued
7 development, do not encourage continued
8 development, and insufficient information are the
9 choices.

10 MS. SHAHAB: Jennifer, can you please
11 send me your vote?

12 (Voting.)

13 MR. TILLY: Okay. So we actually just
14 need one more vote.

15 (Pause.)

16 MR. TILLY: Okay. And the results are
17 60 percent encourage continued development, 40
18 percent do not encourage continued development, 0
19 percent insufficient information.

20 CO-CHAIR WALTERS: So by our
21 guidelines, 60 percent encourage further
22 development.

1 Yes, Mitch?

2 DR. LEVY: I have a question. I'm not
3 sure. So this measure is not fully developed and
4 when -- if it's part of -- and the other three
5 are. So if it's part of a consent agenda and we
6 accept that it's not -- I mean, only --

7 I understand that, but had it been
8 left, which I know this group's going to do with
9 anything, but -- with any of them, but had we
10 left it alone, what would be the voting on all
11 for them? Would we be voting to support them?

12 DR. BURSTIN: Whatever the staff
13 recommendations was remains.

14 DR. LEVY: Ah, I see. I get it.

15 DR. BURSTIN: So support --

16 DR. LEVY: All right.

17 DR. BURSTIN: -- continued development
18 would have been --

19 DR. LEVY: That's great.

20 CO-CHAIR WALTERS: Just for your
21 information, after about 25 minutes of discussion
22 the staff recommendation was encouraged for the

1 development.

2 (Laughter.)

3 CO-CHAIR WALTERS: Let's move on to
4 No. 2, which is the SSI measure that was pulled
5 by Leslie. So you will be discussing why you've
6 asked that to be pulled first.

7 MEMBER BENIN: Ron, is there a place
8 where we're supposed to know what the staff
9 position is? Is that obvious on here somewhere?

10 CO-CHAIR WALTERS: If you go to that
11 previously referenced new discussion guide, that
12 is 3.1 in the upper left corner, and you scroll
13 down to the measures -- so right now we're on
14 Measure No. 2 in the first calendar, that one was
15 listed as encourage further development.

16 MS. SHAHAB: So if it's helpful, I can
17 also note what the staff recommendation is for
18 each measure, because that I have that at hand.
19 So our staff recommendation was encourage further
20 development for this measure. For the next
21 measure, the SSI one, our staff recommendation is
22 conditional support pending NQF update.

1 CO-CHAIR WALTERS: Okay. Leslie?

2 MEMBER SCHULTZ: This is Leslie and
3 thank you for helping me get up to speed with
4 process. I mean, I appreciate Zehra's comments
5 there.

6 In reflection I do support what the
7 staff's recommendation was. I do know that this
8 measure is currently going to be in the process
9 for periodic re-endorsement and review. I want
10 to see the outcome of that first. And then do
11 recommend that it be introduced into IQR, but not
12 into other programs at this time.

13 CO-CHAIR WALTERS: Okay. The other
14 lead discussant was Andrea.

15 MEMBER BENIN: I don't have a lot to
16 add about this. I'm just not understanding at
17 all whether this is the NHSN metric or the NSQIP
18 metric, or whether it's -- because how can it be
19 both because they have different sampling frames.
20 And so I just have struggled to understand this
21 and I assumed the idea was to figure it out and
22 throw it in IQR and see how it worked, but I

1 would love some clarification on that.

2 DR. POLLOCK: So this is a harmonized
3 measure in which ACS, NSQIP and CDC, NHSN agreed
4 on the core measure constructs and the risk
5 adjustment methodology. And the measures been in
6 use in IQR since 2012, so the system for
7 reporting purposes is NHSN. So we continue to
8 enable both individual instances as well as
9 sampling of the entirety of the denominated
10 patient population being reported into NHSN.

11 MEMBER BENIN: Well, I think what
12 you're saying is -- just to let me rephrase --

13 DR. POLLOCK: Sure.

14 MEMBER BENIN: -- make sure I
15 understand, the NHSN metric has been in place for
16 several years in IQR. We all know that. So, but
17 then the idea here is that in lieu of submitting
18 all of your patients, you could just submit the
19 sample that you used for NSQIP.

20 DR. POLLOCK: You can submit a sample.

21 MEMBER BENIN: Okay. So that's what
22 this is asking. Is it okay to update this to

1 be --

2 DR. POLLOCK: No, the staff will in
3 part --

4 (Simultaneous speaking.)

5 MEMBER BENIN: So this is nothing new
6 about this metric?

7 MS. MARINELARENA: The only thing
8 that's new is the name.

9 MEMBER BENIN: The name?

10 MS. MARINELARENA: Yes.

11 MEMBER BENIN: This is a name update?

12 MS. MARINELARENA: Yes.

13 MEMBER BENIN: Okay. That's probably
14 why I was confused.

15 MS. MARINELARENA: So it's already in
16 the program.

17 DR. POLLOCK: I don't think the name
18 is new.

19 MEMBER BENIN: So why are we voting on
20 it?

21 DR. POLLOCK: Everything's the same.

22 MEMBER BENIN: I mean, I could not --

1 DR. POLLOCK: We haven't made any
2 changes --

3 MEMBER BENIN: -- sort this out.

4 (Simultaneous speaking.)

5 DR. POLLOCK: -- since 2012.

6 DR. YOUNG: It's to allow
7 accommodation for calculation of the SIR, the
8 standardized -- or, excuse me, the ARM.

9 MEMBER BENIN: So it's an update to
10 the ARM methodology that we --

11 DR. YOUNG: Correct.

12 MEMBER BENIN: -- voted on last year?
13 There were a couple of other metrics, or
14 whatever. But this is just to get this one up to
15 date? Okay. I have nothing else to add.

16 CO-CHAIR WALTERS: We knew that was
17 going to cause that very discussion. Sean, is
18 your card up?

19 Michael?

20 DR. PHELAN: I'm confused on how this
21 measure -- so there's an NHSN measure that is
22 pulled from Holters? How is the data gathered

1 for that? From CPT codes?

2 DR. POLLOCK: No, it's an active
3 surveillance where staff within hospitals
4 identify instances of SSIs during
5 hospitalizations or in the aftermath of
6 hospitalizations. So it's not a claims-based
7 measure. It's not purely a medical records
8 measure insofar as there can be contact after
9 hospitalizations. There can be information
10 collected outside of the scope of what's in the
11 actual medical record of care in keeping with the
12 other approaches that are used in the NHSN
13 healthcare-associated infection measures.

14 DR. PHELAN: And so this is a
15 harmonized measure between NSQIP and NHSN? And
16 how is it harmonized?

17 Okay. So why is it on the list?

18 DR. BURSTIN: Updated the methodology
19 to the ARM. It's going to reflect the other
20 NHSN-related measures.

21 DR. PHELAN: Okay.

22 DR. BURSTIN: It was a phenomenal

1 amount of work, so thank you to ACS and CDC for
2 in fact doing this.

3 DR. POLLOCK: We'll be resubmitting
4 for maintenance purposes this coming year.

5 CO-CHAIR WALTERS: Any other cards up?
6 Nancy?

7 MEMBER FOSTER: Out of due respect for
8 the NQF process I'm going to suggest that we
9 continue to support the staff recommendation
10 here. I think this is worthwhile doing, updating
11 this measure. It continues to be a familiar and
12 useful measure, but we do want to have NQF take a
13 look at the update just to make sure everything
14 works as planned.

15 CO-CHAIR WALTERS: Jeff?

16 MEMBER JACOBS: This is a very fast
17 question. Does the ultimate results of the
18 measure -- are they identical and use the same
19 definitions whether it's done through NSQIP or
20 through NHSN?

21 DR. POLLOCK: Correct.

22 MEMBER JACOBS: So the definitions are

1 completely harmonizing?

2 DR. POLLOCK: Correct.

3 MEMBER JACOBS: That's beautiful.

4 CO-CHAIR WALTERS: Any other comments?

5 MS. SHAHAB: I just want to remind
6 everyone to speak into the microphones because
7 people on the webinar are having a little bit of
8 trouble hearing some of us.

9 CO-CHAIR WALTERS: Okay. To vote.

10 MR. TILLY: So the polling is now open
11 on the ACS-CDC harmonized procedure specific
12 surgical site infection (SSI) outcome measure,
13 MUC15-534. The options are support, conditional
14 support and do not support.

15 (Voting.)

16 MR. TILLY: We're just missing a
17 couple responses.

18 (Voting.)

19 MR. TILLY: Okay. And the results are
20 52 percent support, 48 percent conditional
21 support.

22 MS. O'ROURKE: So to clarify, this

1 would be a result of conditional support, and the
2 condition would be pending NQF review of the
3 update.

4 CO-CHAIR WALTERS: All right. So that
5 happened again because support was less than 60
6 percent, but with the sum is certainly greater
7 than 60 percent. That's how you end up there.

8 Okay. Let's move on to Measure 3,
9 which is --

10 MS. MITCHELL: Question about that,
11 Ron. I take it you guys who figured out this
12 process considered the fact that if you add
13 conditional support and support together, you got
14 an overwhelming favorable vote for a measure, but
15 because the one that's the strongest one didn't
16 get 60 percent, it doesn't get the nod. There's
17 something --

18 CO-CHAIR WALTERS: You're exactly
19 correct.

20 MS. MITCHELL: There's something wrong
21 with that.

22 CO-CHAIR WALTERS: No, you're exactly

1 correct.

2 MS. MITCHELL: All right.

3 CO-CHAIR WALTERS: It doesn't meet, it
4 doesn't have the magic 60 percent to be fully
5 supported. But you're exactly right, it clearly
6 is supported. It's just that the only thing you
7 can do is conditional support.

8 MS. MITCHELL: Yes, it's a sexist
9 remark, but it's like being a little bit
10 pregnant.

11 CO-CHAIR TRAVIS: Well, one thing I
12 will point out; and Erin did it with this
13 particular one, especially when it falls into
14 something like this, the staff will put forth
15 what they consider to be the condition. If for
16 some reason we don't agree with the condition, we
17 can have a conversation around the condition. It
18 does fall into the conditional support category.
19 And we may see some of this as we go through this
20 agenda where staff will summarize what seems to
21 be the condition and then we'll see what
22 conditions we put on it. It was one I had very

1 early in the process, Delores, so I understand.

2 CO-CHAIR WALTERS: So when we do
3 conditional supports, yes, make sure to spell out
4 your conditions. Nancy mentioned one and then we
5 talked about another one.

6 Okay. Item No. 3, INR monitoring for
7 individuals on warfarin. And Nancy Foster pulled
8 it, so she will be up first.

9 MS. SHAHAB: I just want to remind
10 everyone the staff recommendation for this is
11 support.

12 MS. MARINELARENA: And before we get
13 started, this is a fully developed measure. It's
14 AHRQ's IQI measure. No, I'm sorry. This is not
15 -- I'm sorry. This is fully developed and it is
16 endorsed. It got endorsed as of December 10th.
17 So the staff recommendation is support. We
18 didn't attach any conditions to it because it's
19 already endorsed, but again you're welcome to
20 have that discussion.

21 MEMBER FOSTER: Great. Ready? So
22 this is again one of those areas where we have

1 this unique juxtaposition of the two programs
2 here in one. I would suggest that this be a
3 conditional support and that the condition be
4 that the measure be used only as part of the
5 IQR's eCQM reporting pathway rather than being
6 required of all hospitals.

7 We surely agree that medication safety
8 is an important area and this is a particularly
9 potentially dangerous drug, so very good that
10 we're looking at this. This measure is largely
11 built on eSpecifications and we, as you heard
12 from Akin earlier, have been very concerned about
13 the reliability and validity of the eMeasures
14 going forward. And we have as yet to see the
15 accuracy of this one.

16 So we think it's a little premature
17 and would recommend that in fact it be
18 conditional support, conditional upon being
19 demonstrated that it is effectively collected in
20 all eCQM platforms and able to be reported and
21 that in fact all vendors are willing to support
22 this data collection.

1 CO-CHAIR WALTERS: Thank you. Clearly
2 stated that.

3 Lead discussant, Leslie?

4 MEMBER SCHULTZ: Thank you. We
5 disagree with the staff's recommendation,
6 particularly applying this to the hospitals. We
7 do believe this measure is better suited to
8 accountable care organizations to individual
9 physician measurement systems as hospitals in
10 many cases are unable to track these patients and
11 these INRs are done in on outpatient basis and
12 they may not be on the same information system.
13 So that's our rationale.

14 CO-CHAIR WALTERS: Andrea?

15 MEMBER BENIN: I don't have anything
16 to add to those two conversations, but I do think
17 that the -- it does seem as though the issues
18 around being able to make this happen
19 electronically seem untested.

20 CO-CHAIR WALTERS: Okay. Open for any
21 other comments. Marty? No. Yes. Oh, I'm
22 sorry. Greg.

1 DR. ALEXANDER: Yes, being new to this
2 process I was reading this description and it
3 seems like it says adult inpatient hospital
4 discharges to home, that that's a little bit
5 narrow. Some people go home; some don't. And
6 INR measures are important in lots of different
7 areas post-discharge, including nursing homes or
8 other settings where people go that may not be a
9 home. So I don't know how to address that other
10 than I just sort of think the language is a
11 little bit not complete there.

12 MS. MARINELARENA: So just a
13 clarification. Discharges to home is actually an
14 exclusion. I know it's in the denominator, the
15 description discharges to home, but then you have
16 -- well, inpatient discharges for which the
17 individuals are monitoring INR at home is an
18 exclusion, so they would not be counted in this
19 measure.

20 DR. HAYDEN: Hello, this is Megan
21 Hayden. So that was correct. I mean, they have
22 to I believe look first to see if the patients

1 are monitoring INR at home. And I know we have
2 our measure developers on the line that can speak
3 to this exclusion if we need to clarify that.

4 INR DEVELOPER: Yes, the additional --
5 to address the question that was posed regarding
6 discharge to alternate locations, the presumption
7 was that the INR would be monitored in those
8 alternate locations. The primary concern of this
9 measure is going from a well-tracked condition
10 where you are in the inpatient facility to going
11 to home where there is less oversight and less
12 availability. So the target of this measure is
13 specifically for those who may not have that
14 follow-up care in something like an nursing home,
15 a skilled nursing facility or another post-acute
16 care facility.

17 CO-CHAIR WALTERS: Yes, I'll remind
18 everyone that under the discussion guide you can
19 clearly click up the measure specs as an easy
20 link. And to get back to the home page, you just
21 click back.

22 DR. BURSTIN: And just one more quick

1 point. And it also links you to the evaluation
2 and the endorsement process. Again, we're trying
3 to link those more closely for you. So again, we
4 don't want to have you feel like you have to dive
5 into redoing endorsement. That's there for you
6 to reference really what can you can do about it
7 at the program set level? Is it applicable?
8 Does it make sense?

9 CO-CHAIR WALTERS: Ann Marie?

10 DR. SULLIVAN: I just think this is a
11 very important measure. I think it's very high-
12 risk. I think it fits a lot of categories of why
13 it should be supported. It's also one of those
14 coordination measures which was mentioned where
15 the hospital does very directly -- makes sure
16 that the patients they discharge on something
17 like this drug that the kind of follow-up care
18 they need if they're not in another setting. I
19 understand there might be some problems with
20 collection, but I think sometimes when you make
21 these measures, then the collection phenomena
22 follows. So I would support it.

1 CO-CHAIR WALTERS: Yes, Sean?

2 DR. MORRISON: I'm sorry, Ron, could
3 I just -- Nancy, could you just elaborate just a
4 little bit more on your concerns about the HR
5 collection, because I think that's what I'm
6 having an issue with.

7 MEMBER FOSTER: So, Sean, thank you
8 for asking. We did a study a couple of years
9 ago. We continued to work with our members to
10 helpfully try and understand what's going wrong
11 with the EHR data collection. What we have heard
12 consistently from them is that when they collect
13 a measure using the eSpecified version, using
14 their electronic health reporting tool, they get
15 a different answer than when they do the chart
16 abstraction. And it is in many cases a very
17 different answer. So I mean, like 90 percent
18 different in some cases. So getting to that
19 accurate data point is what we want to make sure
20 can happen. That was one of the conditions I was
21 offering.
22 The other thing, as you may have heard

1 from Akin earlier, is that not all EHR vendors
2 are supporting all EHR collection methods, or
3 measures; excuse me, so if this gets put into an
4 electronic program that is required, it still
5 doesn't force the vendors hand at supporting it.
6 And in some cases vendors have not been very
7 responsive to the requests from the hospitals
8 that they come up with a package to support it.
9 So you are in a sense imposing a requirement on a
10 hospital, but the EHR vendor will not support it.
11 So you create that challenge. And I'm only
12 asking that we make sure that all the vendors are
13 supporting it and that the data can accurately be
14 collected on all of those platforms before it's
15 put into a required program.

16 MS. HAYDEN: Hi, this is Megan Hayden
17 from CMS. So if I could just speak to maybe a
18 couple of Nancy's concerns. And I think first
19 and foremost this data was conducted a couple of
20 years ago. If we can kind of touch on that
21 first. And that would be we heard concerns as
22 far as accurate data collection. I think the

1 question to the hospitals or the vendors would be
2 how are they utilizing the specifications? Are
3 they taking the human rateable and hard coating
4 it? Are they consuming our electronic
5 specifications, which would be our preference so
6 that there's consistency. I think maybe that
7 would have to be delved into a little bit further
8 to try to figure out what the exact issue is.

9 And then when it comes to vendors as
10 far as collecting and submitting on a specific
11 measure, then I can understand there is that
12 concern. CMS does have meetings with the vendor
13 community on a regular basis, as well as
14 obviously we would be putting forth any measure
15 that would be potentially proposing for public
16 comment and to alert the community as to what we
17 are having come forth in the very near future.

18 So we would hope that this could move
19 in the right direction and that they would be
20 listening to the hospitals that need the measure
21 to be reported to CMS and try to work through
22 these types of issues.

1 (Off mic comments.)

2 MEMBER BENIN: -- this metric really
3 potentially favors organizations where the labs
4 and the inpatient and outpatient are all in one
5 system. Like I can't even imagine, you know,
6 it's complicated to know. Sometimes we discharge
7 a patient from the location, if they're not your
8 primary patient, whether or not they got the lab,
9 you communicate that to the outpatient provider,
10 and then whether or not the lab gets back to you
11 as the inpatient doctor, if you're cared for by a
12 hospitalist or whatever else is happening, and
13 then you have the hospital.

14 So I think that there are some real
15 challenges and that that conditional support
16 should be really around working out the nuances
17 and clearly whether or not it's possible for
18 hospitals to accrue this kind of information.
19 Because who then in the hospital -- you're not
20 making the hospital potentially responsible for
21 something that actually the primary care doctors
22 are responsible for. And I think that that's a

1 tension. So in some environments it may be that
2 they're hospital-based physicians and whether
3 it's the cardiologist or whoever who's also
4 hospital-based, but it may or may not be that way
5 in all environments.

6 And so I think there are some nuances
7 to this that deserve further exploration because
8 this, you know, it heavily favors organizations
9 where everything is really integrated including
10 the laboratory and other things, because if you
11 go to a laboratory that's not owned by your
12 hospital, there's all of those challenges. So I
13 just think that the idea of working out some of
14 those nuances are --

15 CO-CHAIR WALTERS: Okay. Let's do
16 Mitchell and then Pierre will give a response.
17 Yes, he may have a response to what Mitchell
18 says, too. So that's why I'm trying to -- and
19 then we'll have a vote.

20 DR. LEVY: All right. Yes, so while
21 I agree, I think that this is a philosophical
22 issue because the fractured nature of EHRs is

1 going to be true for every measure we talk about.
2 And I think it's a question of whether we think
3 mandating something like this drives change or
4 change is driven by the threat of it. And so
5 from my view, even though I agree with what
6 you're saying, Andrea, a measure like this will
7 -- individual practitioners will not be able to
8 change electronic health records, but
9 institutions can drive it, especially when
10 they're mandated to report something like this.
11 So I think we're going to deal with this issue
12 over and over again on many different measures.

13 CO-CHAIR WALTERS: Cristie also had a
14 clarifying question.

15 CO-CHAIR TRAVIS: And then Pierre.
16 Try to keep track of all of them.

17 I just want to have a feel for if this
18 measure is recommended support and if CMS decides
19 to move forward and put it in the program, when
20 would it start collecting information? When
21 would it be reported in IQR?

22 DR. YOUNG: So I just want to --

1 because I think these are important issues that
2 Andrea and Mitchell raise. We just did want to
3 clarify that this particular measure is a hybrid
4 measure, so there is information that comes both
5 from the electronic health record and from claims
6 data. So whether or not the patient follows up
7 and has an INR check comes from the claim system.
8 So it's not that you would need information from
9 an EHR for both the inpatient and the outpatient
10 settings. So the information comes from
11 different places.

12 MEMBER BENIN: So just to clarify that
13 clarification then, so only CMS would be able to
14 calculate it? You would not be able to calculate
15 it yourself because you wouldn't necessarily get
16 the claim for the lab?

17 DR. YOUNG: Right.

18 MEMBER BENIN: Perhaps. I mean, you
19 can do all kinds of other things to calculate
20 around it, but then the burden of measurement
21 goes to CMS?

22 DR. YOUNG: And in terms of

1 implementation, I mean, I don't think we -- we
2 haven't -- we want to get MAP input. We haven't
3 made decisions about timeline for implementation.
4 Obviously this would be -- potentially go into a
5 program, would be -- would go into a rule, excuse
6 me, in the FY '17 rule. But we also have other
7 measures, so we're cognizant of burden. And so,
8 it would probably be a year or two before we
9 would ultimately be able to implement such a
10 measure.

11 CO-CHAIR TRAVIS: I appreciate that it
12 might not, but just helps me know what the
13 earliest something could do, because there's time
14 between now and then to perhaps have things move
15 forward in such a way that it might not be as
16 difficult once they're implemented.

17 CO-CHAIR WALTERS: Nancy?

18 MEMBER FOSTER: Thank you, Mr. Chair.
19 One data point just to help people. I mean,
20 hospitals are supposed to be collecting and
21 submitting data using electronic health records
22 now. They have the opportunity to either share

1 that data that they are collecting through their
2 EHRs on the Hospital Compare web site, or not, or
3 something attest to the fact that they are
4 submitting. Ninety-five percent of hospitals
5 currently attest to the submission because they
6 don't believe the data that's coming in.

7 CO-CHAIR WALTERS: All right.
8 Jennifer's on the line and has a comment.

9 MS. HUFF: Hi, I just wanted to make
10 a couple of quick comments. The first is just
11 again emphasizing that this is a really important
12 patient safety issue and it addresses a couple of
13 key things that are high priority, including the
14 adverse drug events.

15 I also think this is a measure similar
16 to other measures that we'll see where it's
17 looking at not just the care that is occurring
18 within the hospital, but the ability of bring
19 providers together and doing more care
20 coordination by having us look at the 14 days
21 afterwards. I think hospitals are increasingly
22 being responsible for care that is associated

1 with a hospitalization. That doesn't necessarily
2 occur within the hospital. We've seen that in
3 other measures. So I think this helps move in
4 that direction again of where we seeing of
5 encouraging work across different provider
6 sectors.

7 In terms of the data issue, I think
8 this really comes to the point of the balancing
9 act. We've seen this with measures. It's not
10 unusual to have challenges with the data. And
11 then it becomes at what point do we start
12 including it in accountability programs? We have
13 seen in the past when the data hasn't been
14 perfect you include it in an accountability
15 program and the pace at which the data improves
16 is much faster.

17 So I'd say one of my concerns about
18 not supporting this measure is that it will be
19 much longer for it to really be coming to
20 fruition for the data to be improved. And this
21 is an important measure to be looking at. Thank
22 you.

1 CO-CHAIR WALTERS: Thank you very
2 much. We'll have a vote now.

3 MR. TILLY: The polling is now open
4 for INR monitoring for individuals on warfarin
5 after a hospital discharge, MUC15-1015. The
6 options are support, conditional support or do
7 not support.

8 (Voting)

9 MR. TILLY: And the results are 50
10 percent support, 46 percent conditional support,
11 and 4 percent do not support. So the result is a
12 conditional support.

13 CO-CHAIR WALTERS: Dolores, so this is
14 the second one that ends up for the -- the
15 Dolores Rule we're going to call it now.

16 MS. O'ROURKE: So the conditions that
17 we have at this time are that it not be a
18 required measure. It would rather go into the
19 optional eMeasure reporting pathway and that this
20 be monitored for some of the data issues, the
21 accuracy, reliability, validity and resolution of
22 conditions that not all vendors would support

1 this measure.

2 CO-CHAIR WALTERS: Does that capture
3 the conditions?

4 (No audible response)

5 CO-CHAIR WALTERS: Thank you. And we
6 really do appreciate the rich discussion that's
7 occurring about these measures. Those of you who
8 have been on the Committee for a while, know that
9 IQR is the one that takes a long time to get
10 through.

11 Measure No. 4, vaginal birth after
12 Cesarean delivery rate. This was pulled by Nancy
13 and Andrea, so I think since Andrea is going to
14 discuss it as a lead discussant, we'll go with
15 Nancy first.

16 MS. SHAHAB: So the staff
17 recommendation for this measure is conditional
18 support pending NQF review and endorsement.

19 MEMBER FOSTER: So, gosh, I actually
20 hated pulling this measure. I think it is
21 critically important that we move the measures
22 from what seem to be fairly heavily centered on

1 the conditions of the elderly; understandably so,
2 since it's a Medicare program, to including more
3 measures of young adults and the issues that
4 confront children as well.

5 That said, to the best of my
6 knowledge, as I looked at the specifications,
7 this is driven off of claims data. And the last
8 time we had a conversation with Pierre and his
9 colleagues, the claims they have access to are
10 Medicare fee-for-service for this kind of
11 calculation. I just don't think VBAC in Medicare
12 fee-for-service is going to be telling.

13 So I would recommend either do not
14 support or conditional upon getting a broader
15 sampling of a population of -- that might work.

16 CO-CHAIR WALTERS: Pierre, we can wind
17 up your response in a second.

18 Andrea?

19 MEMBER BENIN: Thank you. This is
20 obviously an important issue. There are a couple
21 of problems with this metric. I think the first
22 one is that it's not NQF-endorsed and it's not

1 been submitted for NQF endorsement. The second
2 one is that it's based on claims. And there are
3 times when it's appropriate not to have feedback,
4 and it's not really known what is the correct
5 rate of feedback.

6 And so the idea that we could measure
7 this using claims data with appropriate
8 exclusions I think is a little bit lofty. This I
9 think is more useful again as an epidemiological
10 understanding of what are our feedback rates
11 looking like and not really as hospital
12 accountability metrics.

13 When I pulled the ACOG guideline this
14 is not the metric that's recommended in the ACOG
15 guideline. The recommended metric in the ACOG
16 guideline is more around was the trial of labor
17 discussed with the mother? And I do think that
18 different people will value -- one to five, or
19 depending on what percent chance you find in the
20 literature, chance of uterine rupture, which is
21 close to a death sentence in many ways, will
22 value that differently.

1 And so I am not in favor of this
2 metric as a part of IQR and I think that the
3 reasons that the Nancy mentions adds to that, the
4 fact it may not be appropriate data set
5 regardless of all of those things.

6 I think that it is nice to be able to
7 try to get some issues for women and children
8 into some of these things, but there are probably
9 other venues for that.

10 CO-CHAIR WALTERS: Leslie?

11 MEMBER SCHULTZ: To be incremental, I
12 have nothing to add. I agree with both of my
13 colleagues.

14 CO-CHAIR WALTERS: Thank you. Other
15 comments? Wei Ying?

16 MEMBER YING: First of all, I want to
17 say it's great to see that there is --

18 DR. BURSTIN: Could you please get
19 closer to your microphone?

20 MEMBER YING: Oh, I'm sorry. I was
21 saying it's great to see that we have a measure
22 in the IQR set for discussion that it's can

1 beyond the older population. Like Delores
2 mentioned earlier, whatever CMS put out, it has
3 the ripple effect downstream. So for the
4 commercial population that we look at to the CMS
5 measure set, these type of measures is very
6 appealing. And on the topic of C-section there's
7 definitely one thing that we heavily focus on on
8 the woman population during that age range.

9 And my question is there is another C-
10 section measure which covers broader -- well
11 different set of population but similar topics, a
12 primary C-section measure. I think CMS already
13 publicly reporting it. It's not in IQR Program,
14 but the data is available. So I'm just curious
15 why CMS is proposing this measure versus the PC-
16 02, the primary C-section measure. That's one
17 question.

18 And another comment. If there is a
19 solid reason why PC-02 is not actually as good as
20 this one, then the concern of the claims data --
21 again, it seems just like the discussion on EHR,
22 there is never one data source that's perfect,

1 but if it is using a data source capturing the
2 data for a very important topic and the
3 performance threshold or performance target being
4 measured on that imperfect data universally I
5 think is doable.

6 CO-CHAIR WALTERS: Okay. We'll see if
7 Dolores can add to Pierre's list of responses.
8 Delores?

9 MS. MITCHELL: Well, I'm very
10 supportive of this measure. I do not consider
11 the claims data are not reliable sources of
12 information. From all the complaints I've heard
13 from my physician friends about some of the
14 electronic health record systems, they leave a
15 lot to be desired, my most recent visit to my own
16 physician having shown me two contradictory drugs
17 which that particular record system didn't
18 recognize and suggested that my doctor go ahead
19 and do both of them. So I now will associate
20 myself with skepticism as to all the data sources
21 rather than focusing on the shortcomings of the
22 claims system.

1 But more importantly, although I would
2 like to hear the answer to the question that was
3 just raised from CMS about why they chose this
4 one rather than whatever; I forget the number,
5 the other one was, in which case I'd be happy to
6 switch my allegiance -- but I really do think
7 that the enormity of the overuse of C-sections is
8 of epidemic quality in this country. And I know
9 from previous years; if you've been around long
10 enough, you know this, that C-section rates
11 plummeted 25 years ago. And there they are,
12 right back up again. And I think this is a
13 societal problem. It's a fiscal problem. It's a
14 health problem.

15 I was concerned that a lot of people
16 thought that there were countervailing concerns
17 about the risk of a vaginal delivery after C-
18 section going bad, but as I read the measure, it
19 did say without complications. And it is my
20 understanding that these deliveries do take place
21 in hospitals that are only supposed to take place
22 in hospitals that do have surgical staff nearby

1 in case they go south during the course of the
2 labor. And so I strongly support this measure.

3 CO-CHAIR WALTERS: Pierre?

4 DR. YOUNG: Thanks, Ron. Thanks for
5 saving them all up for me.

6 (Laughter)

7 DR. YOUNG: So I'm going to respond,
8 but also just a quick request because there are a
9 couple of CMS staff on the phone with me and
10 they're having a little bit of a hard time
11 hearing, so just to reiterate the request to
12 please speak into the microphone when you're
13 speaking.

14 But certainly we appreciate the
15 feedback that this is an important topic, that
16 there is a desire to see conditions or measures
17 added to the program which expand beyond
18 conditions highly prevalent in the elderly
19 population. And certainly we also appreciate
20 that the issue of C-sections is a high-priority
21 condition for CMS to tackle.

22 Certainly because it's a claims-based

1 measure, we only have access to Medicare claims.
2 We don't have unfortunately access to all care
3 claims, though we certainly are interested in
4 including measures that have all the aspects as
5 the denominator. And we certainly do have those
6 measures in the program, but that is a
7 limitation, as several folks have noted, for this
8 particular measure.

9 There are some differences between PC-
10 02 and this particular measure, and I was going
11 to ask Megan -- are you -- can you address that?

12 MS. HAYDEN: Sure. I apologize. I am
13 one of the individuals on the phone that was
14 having a little trouble hearing the exact
15 questions that were being posed about PC-02. So
16 I apologize if I am not answering your questions,
17 but please let me know.

18 So I guess potentially the question
19 was why IQI 22 is on? I know you've seen PC-02
20 at the MAP in the past. And so, PC-02 would be a
21 different denominator. So if PC-02 is not
22 looking at a vaginal birth after Cesarean. It is

1 looking at individuals that receive a Cesarean
2 when the baby is in a vertex position. So it is
3 a different measure. You did I think see it last
4 year.

5 It is still under development at this
6 time and anybody that may look at our measures
7 development and then the web site could see we've
8 been out for public comment recently. So that is
9 still in the works at the eQCM. And I hope that
10 answers your question, but it hasn't, then please
11 let me know what additional questions you have.

12 MS. SHAHAB: Jennifer, you had a
13 comment as well?

14 MS. HUFF: Yes, thank you. A couple
15 quick comments again. I think, one, what people
16 have said, really important measure and an
17 important area to have attention to, and both
18 consumers and purchasers are really interested in
19 seeing more information on this.

20 I will say to the point of it not
21 being an NQF-endorsed measure, but this is an
22 AHRQ IQI measure, which is in widespread use. I

1 think we're familiar with AHRQ and how it
2 develops its measures. And it's really
3 transparent in terms of the information it
4 provides on the measure. So I think there's a
5 lot available to be able to make decisions or
6 assessments that would have occurred during the
7 NQF process.

8 I think this is also an area that is
9 ripe for consumer decision making, and with IQR
10 being a place for public transparency and using
11 Hospital Compare I think we would all agree
12 there's a lot of information that sometimes go up
13 in public reporting, some that grabs the
14 attention of consumers and others and others,
15 consumers in particular and others that doesn't.
16 This is one that really consumers are looking for
17 this information.

18 In terms of ACOG, I will say in their
19 comments they were one of the organizations that
20 comment during the week time period and they
21 indicated their support for the measure. I think
22 their only concern is just how the measure is

1 classified in terms of they want to move it to an
2 intermediate outcome. So there is support and
3 ACOG has come forth with being strongly
4 supportive of the measure.

5 Since I'm also channeling Helen in
6 terms of sitting in for her, I do have a couple
7 comments from Helen, particularly from the
8 patient safety standpoint. And she wanted to
9 raise both for C-sections and VBACs, there are
10 patient safety issues. And VBAC I think we've
11 heard particularly the uterine rupture, while
12 it's rare, it does have a high consequence in
13 terms of what would happen. And so she wanted to
14 make the point about a concern about unintended
15 consequences about this measure and being it out.

16 She also had one suggestion. She
17 thinks there needs to be balancing measures; that
18 is, complementary measures that are about the
19 outcomes. For example, looking at maternal
20 mortality or infant mortality as well.

21 CO-CHAIR WALTERS: Thank you. Pamela
22 Owens is on the phone from AHRQ.

1 DR. OWENS: Thank you very much. AHRQ
2 feels that this is actually quite a strong
3 measure as it's applied to all payer data. So
4 that would include Medicaid and private insurance
5 and the uninsured.

6 We have not submitted it for NQF
7 endorsement. We certainly could. We don't feel
8 that there's anything wrong methodologically with
9 the measure. And then we can talk about some of
10 the issues that were just raised in terms of the
11 patient safety issues, et cetera.

12 We have seen this applied, this
13 measure applied in state reporting. We applaud
14 consumers for wanting to be able to help them
15 report out in terms of both making a choice
16 around VBAC, but also choosing the hospital to go
17 to if they're choosing VBAC. This measure was
18 not intended to be applied to Medicare fee-for-
19 service data, however. That calculation is 65-
20 plus or those with disability. And in terms of
21 our reliability and validity of the measure we
22 have not explicitly tested it on Medicare fee-

1 for-service data.

2 We feel it's a strong measure as
3 applied to all payer data, but -- to Nancy's
4 point.

5 CO-CHAIR WALTERS: Thank you very
6 much. Comments around the room? Michael?

7 DR. PHELAN: I mean it sounds like it
8 would be a great Medicaid measure. And I mean, I
9 understand why CMS -- and I don't understand what
10 measures actually apply to Medicaid. And I'm
11 sorry I'm ignorant on that, but are there are --
12 because it's a shared program with the states,
13 are there measures that CMS says we really want
14 you to have this measure? Would this measure
15 fall into that category then?

16 DR. YOUNG: I mean, for this
17 particular considerations it's just for IQR,
18 which is focused on the Medicare Program, but
19 certainly we have discussions with the Medicaid
20 colleagues and have had discussions about program
21 priorities including VBAC.

22 DR. PHELAN: Because clearly this

1 doesn't fall into a Medicare -- I mean, I don't
2 know what the numbers could be, but it's got to
3 be almost negligible, because -- maybe the
4 disability, but if you're 65 and older or you're
5 disabled, those two kind of -- the 65 and older
6 automatically eliminates you from pregnancy. The
7 disabled might, but I can't imagine that's a
8 huge, huge population.

9 DR. YOUNG: The numbers are very, very
10 -- are small, yes.

11 DR. PHELAN: Right. So I guess, I
12 mean, I think it's a good measure to have out
13 there and to be promoting, but it would
14 definitely not to me fall into the IQR Program
15 and it would be something that I would encourage
16 going into the Medicaid side, or wherever that
17 can be promoted on that direction.

18 CO-CHAIR WALTERS: Okay. Let's vote.

19 MR. TILLY: So for the measure IQI 22,
20 vaginal birth after Cesarean delivery rate,
21 uncomplicated, MUC15-1083, the options are
22 support, conditional support or do not support.

1 (Voting)

2 MR. TILLY: So the results of the vote
3 are 28 percent support, 28 percent conditional
4 support, 44 percent do not support. The result
5 of the vote is do not support.

6 CO-CHAIR WALTERS: Okay. In case
7 anyone's been wondering and getting a little bit
8 antsy, we are going to take a brief break after
9 this measure so that we at least complete
10 Calendar 1 of 3 of one program.

11 The fifth measure is NHSN
12 antimicrobial use measure, and that was pulled by
13 Nancy and Andrea. So, Nancy, go first.

14 MEMBER FOSTER: Thank you again. This
15 measure is an important first step in getting us
16 to a good measure of actual effective antibiotic
17 use. CDC developed this so that they could get
18 the baseline of information, is my understanding;
19 and, Dan, please correct me if I'm wrong. But
20 they wanted the baseline of information about how
21 antibiotics are currently being used so that they
22 could take the next step and really look at

1 what's appropriate use and what's not appropriate
2 use so that we can get to a measure of; however
3 you're going to develop it, either the positive
4 appropriate use or the maligning inappropriate
5 use of antibiotics.

6 But that's what we want to focus on,
7 not just this generic use. There's no risk
8 adjustment here, there's no nothing. This is
9 just collecting the baseline data around use, is
10 my understanding. And for that reason I think
11 it's not ripe for public reporting right now.
12 It's ripe for measure development, it's ripe for
13 perhaps quality improvement as hospitals begin to
14 look at their own usage of this. And we're fully
15 supportive of hospitals looking at that usage,
16 but I don't know what a measure strictly of use
17 without any risk adjustment, without anything
18 else tells the public about antibiotics.

19 CO-CHAIR WALTERS: Also pulled by
20 Andrea.

21 MEMBER BENIN: So the antimicrobial
22 stewardship community is very excited about this

1 metric and I think very excited about working
2 with NHSN about developing a way to understand
3 the utilization of antibiotics. And I think that
4 the purpose of this work has really been around
5 getting that group to collaborate around starting
6 to think about these issues. I think the metric
7 just had NQF review maybe last week or something.
8 It's very fresh, very hot off the presses.

9 (Off mic comments.)

10 MEMBER BENIN: Right, I mean it just
11 literally --

12 DR. BURSTIN: It really was endorsed,
13 not just reviewed. It was just endorsed like a
14 week ago.

15 MEMBER BENIN: Last week, right? Like
16 it just came through the cycle last week. Do I
17 finish the endorsement?

18 (No audible response)

19 MEMBER BENIN: Okay. And so, I think
20 that people are very excited to start to be able
21 to use this as a way to understand how
22 antibiotics are being used, but it's definitely

1 not ready for a hospital accountability level
2 program, and I think actually that that has the
3 potential to negate some of the collaboration and
4 the ability for people to enthusiastically work
5 together around what this looks like.

6 The way the metric is set up it's not
7 clear that if you have a hospital with higher
8 acuity where you need more antibiotics for good
9 reason -- but that's going to look like you're
10 using more antibiotics, because you are, because
11 maybe you have more patients with bad cancers and
12 things where they need antibiotics, or maybe
13 you're capturing your septic patients earlier,
14 like you should be, I don't know.

15 And so, I think that until this
16 antimicrobial stewardship community really has
17 the time and is given the space to really work
18 through this and use this metric in a way that
19 it's been developed with all good intent to do
20 the right work for patient safety -- it's not
21 time to put it in the accountability programs.
22 And the higher levels of terror as it stands

1 right now will clearly look worse on this metric.
2 And it's just not the right time for this and I
3 think we need to understand this better and hear
4 about it more at some point in the future.

5 CO-CHAIR WALTERS: Leslie, you're the
6 other lead discussant.

7 MEMBER SCHULTZ: Yes, again, we
8 completely support these efforts to assess
9 antimicrobial use and to work on the
10 appropriateness, however, this is a brand new
11 measure. There is minimal national experience
12 and there are challenges in the collection and
13 reporting. Moreover, the measure developer has
14 stated that this measure ought to be used for
15 several years before it's used in public
16 reporting and accountability. So I would suggest
17 that we heed their advice in that manner.

18 CO-CHAIR WALTERS: Okay. Any other
19 comments? Mitchell?

20 DR. LEVY: I'm amazed. I actually
21 completely agree with Nancy on this. I'm
22 surprised this is endorsed in that -- and I am a

1 strong proponent of metrics, but I'm not sure I
2 view this as a metric. It's such a broad brush
3 that I'm hard-pressed to really understand --
4 and, Andrea, you already alluded to it, that --
5 where it's -- I don't even know how you would
6 risk adjust a measure like this, but it just
7 paints a broad brush of how many antibiotics.
8 It's almost to me as if in order to reduce
9 hospital admissions we just count the number of
10 admissions. And I really -- I understand the
11 desire for antibiotics stewardship, but this
12 feels honestly misguided to me.

13 CO-CHAIR WALTERS: Let's go to Dan
14 first as almost the natural Pierre for this
15 situation.

16 DR. POLLOCK: Thank you. So the
17 measure that we have proposed and that has --
18 that we proposed submitted to NQF in April has,
19 as we said, just been endorsed by the NQF Board.
20 For those of you who are not familiar with the
21 actual measure submission form, a measure
22 developer is required to indicate to state

1 explicitly the intent of the measure, how it's
2 supposed to be used. And we were very explicit
3 that we see this measure as a valuable measure
4 for internal and external benchmarking and for
5 public health surveillance, but for public
6 reporting and not for accountability for an
7 incentive payment program. Very explicit.

8 Now we've done numerous presentations,
9 public presentations on that score, so it should
10 come as no surprise to anyone that we are
11 advocating use of this measure, but not for
12 public reporting and accountability purposes.

13 Why are we advocating use of this
14 measure? Because the measure and of itself does
15 provide an important indicator of potentially
16 overuse of antibiotics in certain patient payer
17 locations where we have other information to
18 indicate there is indeed a performance gap here
19 that amounts to an overuse of antimicrobial
20 agents. So the metric itself is actually a set
21 of 14 specific combinations of patient care
22 locations and antimicrobial categories.

1 Without going down into the weeds too
2 far; I'll just poke in there for a second, if you
3 have a hospital that's reporting three times or
4 more what would be predicted -- and we do have
5 predictive modeling in this measure. If the
6 hospital's use of, for example, broad spectrum
7 agents predominantly used for community-acquired
8 infections is three, four, five times what the
9 national aggregate would be using the national
10 aggregate data what would be predicted for those
11 patient care locations, there's a potential
12 problem there that warrants investigation.

13 And that's what this measure is
14 intended to do. That's what benchmarking is
15 about. You benchmark against nationally
16 aggregate data that are presented to you in an
17 actionable form that will require further
18 evaluation to determine whether there has been
19 appropriate or inappropriate use at three, four
20 or five times what would be predicted for that
21 hospital and patient care location.

22 So I just want everyone to understand

1 we're not proposing this measure to collect more
2 data and improve the measure itself. Certainly
3 more data can be used for that purpose, but first
4 and foremost we've got a serious problem with not
5 only antimicrobial resistance in this society,
6 we've got a serious problem of misuse of
7 antimicrobial agents in this society. And if
8 we're not measuring it and if we're not looking
9 at the data, we're not going to be in a position
10 to address those problems.

11 This is a first step, but I don't want
12 the point to get lost in the shuffle here that
13 this is a measure that's ready for use by
14 hospitals right now. And CDC is encouraging its
15 use by hospitals right now. This is a measure
16 that is included in Meaningful Use Stage 3 as an
17 option for reporting to public health registries.
18 It is a purely electronic measure. The data are
19 captured as a byproduct of the record keeping
20 that's done using electronic bedside medication
21 administration systems.

22 So it's a measure that helps us move

1 in the direction of using electronic data that
2 are increasingly available. It's a measure that
3 connects with the antimicrobial stewardship
4 community and helps drive patient care practices
5 in a positive direction. But again, although
6 we're not advocating use for public reporting or
7 accountability purposes at this time, we are
8 certainly advocating use of this measure and
9 we're working very closely with several large
10 healthcare systems and hospitals already that are
11 using these data in their stewardship programs
12 and are using these data in operational purposes
13 to drive change.

14 CO-CHAIR WALTERS: Before we get to
15 Pierre to answer the question why it was
16 proposed, Shek and then Michael.

17 MEMBER MEHTA: Yes, thanks. I didn't
18 want to take up too much time. I just have a
19 question about the process. And in the list it
20 says "pending additional use." In terms of like
21 the condition, if your vote's on conditional
22 support, what does that mean exactly? Would it

1 be reviewed next year for inclusion, or is the
2 additional use just some other requirement?

3 MS. O'ROURKE: Sure, I can take the
4 first pass at what staff was thinking and Helen
5 will clarify.

6 I think we were trying to address some
7 of the concerns that Dan just raised, that while
8 this is an endorsed measure, at this point it
9 seems more ready for benchmarking than public
10 reporting. However, perhaps this measure could
11 go into the IQR program at this time and have a
12 slower path on Hospital Compare and allow
13 hospitals to gain some experience with the use of
14 this measure rather than immediately putting the
15 results publicly.

16 DR. BURSTIN: Perhaps I wouldn't have
17 been direct, but we very clearly heard from Dan
18 and CDC as part of this, the endorsement process
19 that this measure -- I think the Committee agreed
20 completely was very, very important, very early
21 stages, and they wanted further experience,
22 although they also made it very clear, back to

1 Mitch's point of why it was endorsed, this
2 measure is ultimately intended for
3 accountability, but it felt like additional
4 experience was needed prior that happening. So
5 that was the logic of potentially wrapping that
6 in the conditional recommendation.

7 CO-CHAIR WALTERS: Michael?

8 DR. PHELAN: And I guess this is a
9 critically important question, and I mean I
10 couldn't imagine CDC putting the amount of time
11 and effort to doing this. Hospitals I'm sure
12 would want to see this data. But I think it's
13 promoted in the IQI. And after hearing Dan say a
14 number of times we did not want this for
15 reporting, we did not want this public reported,
16 I guess I'd like to hear what the response is
17 going to be if we say, yes, this is a critically
18 important question. We need to have a measure on
19 it. What's going to happen with the data? Is
20 there a category in the IQI that says not for
21 public reporting, but just for hospital use to
22 make improvements in this area of care that is a

1 critical question?

2 So I guess my question is if we
3 support it -- because, I mean, this is a critical
4 question that needs to be answered. It's
5 affecting hospitals across the country. If we
6 say we support it, what kind of assurance do we
7 have that it's not going to end up in a public
8 reporting arena, I guess?

9 CO-CHAIR WALTERS: So that's teed up
10 for you, Pierre.

11 DR. YOUNG: Thank you very much. I'm
12 going to say thank you a lot today. But so, one
13 -- I think we're heartened to hear how much
14 support there is for this particular -- to
15 address this particular topic. I think we all --
16 what I've heard from everybody who's spoken is
17 that there is a big issue here that needs to be
18 addressed, and that's reflected not just in your
19 comments, but also initiative ongoing within the
20 Federal Government such as the White House's
21 Combatting Antimicrobial-Resistant Bacteria
22 Initiative.

1 In recognition of that we were
2 interested in trying to fill that gap in the
3 space. As several people have mentioned, we
4 thought this could potentially be a first step
5 forward in terms of trying to address this
6 particular issue in the IQR Program. But also
7 understanding that there are limitations to this
8 measure as a number of people have pointed out.
9 Certainly the intent isn't to undermine any
10 ongoing and vigorous efforts to combat
11 antimicrobial resistance and antibiotic overuse,
12 but rather to support it.

13 I think I would just say that CMS is
14 aware that there are issues relating to potential
15 public reporting, that it may not go far enough
16 and address actual appropriate use of
17 antibiotics. These are all important
18 considerations that we are thinking through and
19 it's helpful to hear feedback from you on.

20 In terms of the specific question
21 about sort of public reporting, certainly if
22 measures are implemented into IQR, the general

1 expectations that they will be publicly reported
2 on their results, there's no separate category
3 that says this is just for -- not public -- you
4 have to submit data, but we're not going to
5 publicly report it.

6 I mean, if we were to pursue putting
7 this measure into the IQR Program, I think we are
8 trying to internally figure out what potential
9 options there could be in terms of the public
10 reporting issue, but I think the general
11 expectation is if a measure is in IQR, it would
12 be publicly reported. And that's been the goal.

13 CO-CHAIR WALTERS: Okay. Looking
14 around, ready to vote. I think we've heard all
15 the issues, all the concerns.

16 MR. TILLY: Okay. For the measure on
17 national healthcare safety network antimicrobial
18 use, MUC15-131, the options are support,
19 conditional support and do not support.

20 (Voting)

21 MR. TILLY: We're missing about four
22 responses. Just go ahead and scan your clicker

1 and --

2 (Voting)

3 MR. TILLY: Okay. The results are in.
4 Twenty-five percent support, forty-percent
5 conditional support, thirty-three percent do not
6 support. So the measure has conditional support.

7 CO-CHAIR WALTERS: We may need to
8 clarify those conditions a little bit after all
9 that discussion.

10 MS. O'ROURKE: I was afraid of that.

11 (Laughter)

12 MS. O'ROURKE: So from what we've
13 heard from the discussion I would say it would be
14 pending the resolution of some of these issues
15 we've heard that the measure is not ready for
16 broad scale use in public reporting.

17 DR. POLLOCK: That's exactly right.
18 It's not ready for public reporting, but if
19 there's an opportunity for voluntary reporting in
20 a program, we're fully supportive of that. But
21 if there's no opportunity for voluntary reporting
22 in a program, we're not supportive of it. You

1 can't be any clearer than that.

2 The measure from our perspective at
3 CDC is ready for wide use, voluntary use. By
4 voluntary we mean no associated incentive or
5 penalty, willingly reported and with the
6 expectation that the data by virtue of being
7 willingly reported and voluntarily reported are
8 going to have value for the institution. And we
9 fully support that idea, but we can't support use
10 for public reporting.

11 CO-CHAIR WALTERS: Mitchell, you have
12 conditions?

13 DR. LEVY: Yes, and I completely
14 support what Dan's saying, but I'm just trying to
15 separate the measure from what we're voting on.
16 Are we voting on support to include an IQR?

17 (No audible response)

18 DR. LEVY: Right. So --

19 CO-CHAIR WALTERS: That's the program
20 it came under.

21 DR. LEVY: -- if all of us are saying
22 it's not ready for public reporting, I'm not sure

1 how we could -- I mean, we're --

2 DR. BURSTIN: Trying to spell out the
3 conditions for which it would be --

4 DR. LEVY: Right. So I guess to me
5 the condition would be not being in IQR.

6 (Laughter)

7 DR. LEVY: Not public reporting. I
8 just want to make sure we all understand that
9 we're voting when we say support to be included
10 in public reporting.

11 CO-CHAIR WALTERS: So the problem is
12 that got 33 percent of the vote, so -- or
13 whatever it is. Thirty-eight. Do not support
14 did not win.

15 DR. PHELAN: I mean, hearing that from
16 Dan and -- I mean, these are two large federal
17 organizations here, you've got a program -- and I
18 don't know how malleable CMS is when we have a
19 critically important measure like this that
20 people want to support for a number of different
21 reasons and you have the measure developer, a
22 pretty reliable measure developer saying --

1 (Laughter)

2 DR. PHELAN: Pretty reliable. Very
3 reliable, actually. But saying that it's not
4 ready for public reporting, I think taking that
5 as our condition, that we recommend that it can
6 be part of the measure -- but until we have
7 better data, more information, more comfort with
8 its use, not to be public reported until a
9 reevaluation by this body, by the MAP again may
10 be something to consider as a condition of
11 support.

12 CO-CHAIR TRAVIS: One thing that I
13 guess hit me as I was talking -- and really to
14 follow up on what Michael said, what I thought
15 about was condition upon CDC's recommendation
16 that it is now ready for public reporting,
17 because I don't really know that we'd be in a
18 better position to reevaluate that in the future.
19 So to me, I would like to suggest at least that
20 we consider that as the condition.

21 CO-CHAIR WALTERS: Marty?

22 MEMBER HATLIE: I'm really just

1 agreeing with the last two speakers. I mean, I
2 thought I was voting for its use on a slower
3 pathway after further use and testing.

4 DR. BURSTIN: Do people feel
5 comfortable with what Cristie just raised as the
6 condition to move forward with, that it would be
7 conditional upon CDC's agreement that it is ready
8 to move forward?

9 MEMBER BENIN: CDC's agreement and
10 coming back here.

11 DR. POLLOCK: So also part of the very
12 astutely revised NQF submission process, if the
13 developer does not specify a public reporting or
14 accountability purpose, the developer needs to
15 describe a strategy for getting to a public
16 reporting and accountability purpose. And so our
17 strategy is really several-fold: We're going to
18 work with hospitals and antimicrobial stewardship
19 programs to better understand how the measure can
20 be honed in ways that dovetail as effectively as
21 possible with stewardship efforts.

22 The AU, antimicrobial use reporting to

1 NHSN is part of what we call our AUR module,
2 antimicrobial use and resistance. And so the
3 resistance part of that is only now available.
4 And what the resistance part enables is
5 electronic reporting, capture of pathogen
6 information, including resistance. And that
7 pathogen information is a likely candidate to
8 include in our predictive modeling that addresses
9 the very important fundamental of there are
10 reasons to administer antimicrobials. And
11 pathogens are the reasons to administer those
12 antimicrobials.

13 So when we have pathogen data in hand,
14 when we have antimicrobial stewardship
15 experience, we will be in a much better position
16 to say that the measure in its next iteration can
17 be used as an appropriate indicator of
18 judiciousness or injudiciousness of antimicrobial
19 use. That's the point we want to get to. But we
20 don't want to throw out the fact that right now
21 the measure itself can have value in terms of
22 having an impact on injudicious use.

1 So we're very fine with the status for
2 the next duration of the endorsement period:
3 non-publicly reporting, not using for the
4 accountability. We're directly opposed to that,
5 just to be as clear as possibly can be. But
6 we're not opposed to voluntary reporting and
7 we're not opposed to using any and every means
8 that we can to encourage voluntary reporting.
9 There is a lot of competition out there for
10 capturing and delivering measure data. We happen
11 to think that this particular arena, given where
12 we are right now with resistance to antimicrobial
13 use, is a very, very, high priority for quality
14 measurement and improvement purposes.

15 CO-CHAIR WALTERS: So the last
16 proposed condition, because the vote is what the
17 vote is -- the last proposed condition was that
18 again support for the measure, but CDC has the
19 final say as to when the data is mature enough to
20 move into IQR.

21 DR. POLLOCK: Well, we don't have the
22 final say. We have a role as the measure

1 developer of factoring in all the very valuable
2 input; and we've gotten lots of valuable input,
3 and will continue to get valuable input, and put
4 forward a next generation. Iteration sounds
5 perhaps too minimal. It's going to be a next
6 generation when we get to the point of being able
7 to include in the predictive model the burden of
8 infectious disease. That's going to be a next
9 generation.

10 CO-CHAIR WALTERS: So representation
11 of the data back to MAP, which is what was
12 mentioned over on this side anyway.

13 MS. O'ROURKE: So I have that we
14 conditionally support this measure pending that
15 it's not public reported until better data is
16 available and reevaluation by the MAP and
17 recommendation by the CDC that it's ready for
18 public reporting.

19 DR. POLLOCK: Could we say "additional
20 data" rather than "better data?"

21 MS. O'ROURKE: Additional? I can --

22 (Laughter)

1 CO-CHAIR WALTERS: Thank you very
2 much. And thank you to everybody for what has
3 been a long couple hours, but a lot of good
4 input.

5 We're going to take a five-minute
6 break, because we have to get to Calendar 2. So
7 get up and do what you need to do.

8 (Whereupon, the above-entitled matter
9 went off the record at 11:54 a.m. and resumed at
10 12:05 p.m.)

11 CO-CHAIR TRAVIS: Okay, please take
12 your seats. And, if we can ask the people in the
13 back of the room to kind of have softer
14 conversations?

15 Okay, the reward, if we can get
16 through the rest of what we're supposed to do as
17 quickly as possible is that we get to have lunch
18 at 1:00.

19 Now, you know that that is going to be
20 a challenge because we just took a significant
21 amount of time, although I think it was very
22 valuable conversations that we had, on our first

1 calendar. And we actually got about three
2 calendars to cover before lunch.

3 We do still want to be sure that we
4 have good conversations, though, as we move
5 forward.

6 So, we are going to go on and get
7 started with the goal that we can eat at 1:00.
8 And, we're going to go to Consent Calendar 2.
9 And, we're going to do this calendar a little bit
10 differently than we did the first calendar
11 because there are some common themes across some
12 of the measures that have been included in this
13 calendar.

14 So, just to kind of set it up for you
15 how we would like this part to work for Calendar
16 Number 2 is that there are four measures that are
17 clinical episode-based payment measures.

18 And, we feel that there's a common
19 theme around the clinical episode-based payment
20 approach.

21 So, what we would like to do for those
22 four measures is to have a conversation first

1 around the payment approach that essentially
2 would be impacting all four measures.

3 If there are issues relative to the
4 particular clinical aspects, we will, after we've
5 had a general conversation around the approach,
6 we will come and address any particular issues
7 there are relative to the clinical conditions.

8 So, hopefully, that will help us have
9 the conversation once about the payment approach
10 and not have the conversation four times about
11 the payment approach.

12 We will then after those first four,
13 we will come back and cover Measure Number 3
14 which is the hospital level risk standardized 30-
15 day episode of care payment measure for pneumonia
16 and it is different than the other four measures.

17 So, hopefully, that will make sense to
18 you all. We will see how this goes, but let's
19 try during the first part of the conversation to
20 focus on the payment approach and then we will
21 move to any concerns around the individual
22 clinical conditions.

1 And, we'll try to kind of correct
2 ourselves if we get diverted.

3 As you will see, the other thing we
4 don't have to worry about for this measure -- for
5 this set is whether or not there's a Consent
6 Calendar.

7 All of these measures have been pulled
8 so we will be discussing all of them in the
9 format that I just laid out.

10 So, we're going to start with the four
11 clinical episode payment measures and we're going
12 to start with the people who pulled the measure,
13 just like we did the last time. And, that kind
14 of makes it easy to have our new approach because
15 some of the same people pulled all these
16 measures.

17 So, I am going to start with Jennifer
18 Eames Huff who did pull -- asked to pull all four
19 of these clinical episode-based payment measures.
20 And then, we will move on to the others that
21 wanted to pull the measures.

22 But, Jennifer, if you can please start

1 us off and if you will, kind of focus your
2 comments around the payment approach at this
3 time.

4 MS. HUFF: Yes. Thank you.

5 So, I think we're all well aware of
6 the health care spending in the United States is
7 a problem. We've seen it \$3 trillion for 2014
8 and it continues to eat up the gross domestic
9 product.

10 And, we also know that about one-third
11 of health care spending goes to things that
12 aren't making us healthier. They're going to
13 things that actually do not provide added benefit
14 to patients.

15 Even with this higher spending,
16 though, we still have quality issues with
17 mortality, issues related to patients' experience
18 with care and other things. And, we've made
19 progress, I would say, but we still, particularly
20 in the affordability realm, have a ways to go.

21 Cost resource use and the spending
22 payment measures are badly needed, help us get

1 to, I think, the overall goal which we're trying
2 to get to which is understanding what is high-
3 value care and who our high-value providers.

4 The NQF endorsed measure portfolio has
5 assembled a large portfolio of quality measures,
6 way more preponderance of quality measures than
7 measures related to cost resource use and
8 spending. So, we really applaud the effort of
9 bringing these measures forward.

10 In regards to the group of the
11 episode-based measures, the clinical episodes,
12 they represent a substantial portion of payment.
13 And, I mean like a relative substantial portion
14 of payment when looking at how much is spent on
15 this.

16 And, the hospital care can influence
17 near term outcomes for these procedures or
18 conditions. It also shows that post-acute care
19 payments are high.

20 And then, there is sizable variation
21 in payment. Those were the requirements for
22 determining what measures to look for in

1 developing measures related to payment and
2 affordability for the clinical episodes.

3 So, I think those are all important
4 issues and good reasons that make these measures
5 important for us to be looking at.

6 It also so happens that this calls
7 attention to conditions and procedures that are
8 known for overuse and waste. And from both cost
9 and a patient safety and quality perspective,
10 both consumers and purchasers are really
11 concerned about unnecessary treatments and how
12 they're happening.

13 Let's say these clinical episode-based
14 payment measures also address efficiency of care
15 over a relevant time period. So it, again, like
16 was mentioned previously, encourages hospitals to
17 work together with other providers.

18 It looks at more of instead of a
19 discrete experience, starting to look at more of
20 the continuum of care, the patient as a whole.
21 It's a more patient centered approach.

22 There was one of the rationales for

1 not supporting these measures was that there is
2 an overall Medicare spending per beneficiary
3 measure in the program. I actually don't see
4 that as a negative issue. I see it as a positive
5 and I think it's important for areas that are
6 really important to prioritize them. And, by
7 having measures that may have some overlaps that
8 does it.

9 I also think it's good to have an
10 overall measure. It doesn't get at, though, the
11 variation that is happening at the condition and
12 procedure level. So, this provides a little bit
13 more information in terms of what's doing --
14 what's happening and what's driving that Medicare
15 spending per beneficiary.

16 Thank you.

17 CO-CHAIR TRAVIS: Thank you, Jennifer.

18 So, the lead discussant for this is
19 Nancy Foster, so I'm going to turn to her in a
20 moment.

21 I just want to let you all know that
22 Kelly Trautner won't be here until this

1 afternoon, so unfortunately, she won't be able to
2 comment on this particular calendar.

3 So, Nancy, do you have some issues
4 relative kind of to these four measures from the
5 payment approach standpoint?

6 MEMBER FOSTER: Sure, thank you,
7 Cristie.

8 We actually thought that the staff
9 recommendation was exactly the right one, that
10 while cost is an important thing to be measured
11 and having good measures of cost would be useful,
12 these are not yet NQF endorsed. My understanding
13 is they haven't even come to the NQF yet.

14 We've never seen these measures. We
15 don't know about the -- what the variation is.
16 We don't know anything about sort of how much of
17 this is variation in utilization of post-acute
18 care services.

19 If it's predominantly hospital
20 services that are being used, it's kind of odd
21 for Medicare to portray something as being
22 overpayment because the only thing that they're

1 portraying is what they paid us, right?

2 So, it's as if they're saying well,
3 we've paid them this but it's too much but they
4 determine how they're going to pay us, so that's
5 just a really freaky thing.

6 So, you know, really understanding
7 what's here, what's in the measures, what's
8 causing the variation is critically important and
9 that occurs when we see things as they come
10 through the NQF process and we get a little
11 experience with them.

12 So, you know, maybe right direction,
13 but, you know, far too little information here
14 for us to think that supporting this at this time
15 is the right thing to do.

16 CO-CHAIR TRAVIS: Thank you, Nancy.

17 And, Jennifer, I failed to ask you
18 what your recommendation would have been in terms
19 of when you pulled them. What would be your
20 alternative recommendation?

21 MS. HUFF: Yes, yes, and that actually
22 flows very nicely from Nancy's comment of the

1 recommendation would be conditional support
2 pending NQF review.

3 And, I would agree that there is not
4 as much information. For example, like on the
5 IQI measures available publicly on these
6 measures. So it would be helpful as a part of
7 the NQF process to get more information on that.

8 I will say there is some public
9 information and there is some public information
10 on how much the average payment per hospital for
11 these episodes and looking at variation from the
12 25th to the 75th percentile. And, it does show,
13 you know, high cost and there is variation in
14 looking at the payments.

15 So, I think that the identification of
16 the areas are right in terms of looking at the
17 conditions and procedures. And, the NQF review
18 would provide more information that people look
19 at in terms of like reliability and validity of
20 measures.

21 I do also want to add, I do have a
22 question for CMS. As these areas typically cover

1 areas that are related to appropriateness and as
2 it's an episode-based measure, it's getting at
3 only the payment of the episode.

4 And, like I said, I think the
5 significant cost and the variation is a rationale
6 for these being important and looking at them.

7 But, it doesn't address whether or not
8 the episode should have happened. So, I'd like
9 to hear from CMS in terms of comments around
10 plans for maybe a supplemental or a complimentary
11 measures on actual appropriateness.

12 Though, I don't think that should hold
13 it up in terms of the conditional support.

14 CO-CHAIR TRAVIS: Pierre, would you
15 like to respond?

16 DR. YOUNG: So, thank you for that
17 comment.

18 Certainly it is appropriateness of
19 care, overuse, under use of services is an
20 important topic.

21 I'll just say that, you know, it is an
22 area that is specifically called out in MIPS and

1 so, something that we're thinking about is we're
2 thinking towards MIPS.

3 Thank you.

4 CO-CHAIR TRAVIS: Okay. We would like
5 now to open it up to the committee for discussion
6 kind of around the basic approach. And then,
7 after that, we'll see if anybody has any comments
8 in the particular clinical areas.

9 So, Michael?

10 DR. PHELAN: And, I guess this goes to
11 what my question was with the first comment that
12 we had about how do we support these? Is it
13 going to be conditionally support where, I'm
14 going to say it again, at the MAP, or do we do
15 not support knowing that full well that the next
16 iteration will make it back to the MAP?

17 I think the one thing I'd worry about
18 and with all of these kind of episode group of
19 things is matching it with some type of quality
20 outcome, to me, is very important to these -- not
21 just the raw financial aspect of it.

22 So, I always want to see some kind of

1 quality measure because there may be a place
2 where they have a much higher spend but they're
3 outcomes are much more -- they're getting better
4 care for whatever reason.

5 So, I always worry that when you just
6 say, well, we'll just look at the cheapest
7 denominator, so unless these are kind of care or
8 some kind of quality outcome associated with it,
9 whether it's patient satisfaction or an actual
10 outcome, you know, a functional outcome or
11 whatever you want to look at.

12 I just worry when these just care
13 episode group what we're able to.

14 CO-CHAIR TRAVIS: Thank you, Michael.

15 Leslie?

16 MEMBER SCHULTZ: Thank you.

17 I agree with the staff's
18 recommendation. The condition specific payment
19 measures overlap with the Medicare spending per
20 beneficiary measure that is currently in both
21 HIQR and the VBP. Adding segments of this
22 creates unnecessary duplication in the programs.

1 And, while the payment measures would
2 create alignment with the physician value
3 modifier in later MIPS, MAP requires
4 establishment of patient relationship categories
5 and codes to attribute patients and episodes.

6 This significantly changes the way the
7 episode groupers are implemented and could lead
8 to a lack of alignment between the hospital and
9 the physician specifications.

10 And so, it would suggest that the
11 measure not be added to the hospital programs in
12 the advance of finalizing the measures with the
13 physician programs.

14 And, additionally, in general, we have
15 ongoing concerns about these measures. As
16 measures of federal spending, they're not
17 necessarily true indicators of value from the
18 perspective of the beneficiary.

19 Because now they're capture the
20 quality of care or are paired with measures that
21 so do. Moreover, they don't give the beneficiary
22 a real sense of their financial obligations so

1 they're not -- the payment reporting and
2 beneficiary engagement purposes and the
3 crosscutting measures that are not appropriate
4 for evaluating care exclusively in the inpatient
5 setting.

6 Most use a various range in
7 differences in both the market availability of
8 these services and some of it is not with real
9 control.

10 CO-CHAIR TRAVIS: Thank you.

11 Dolores?

12 MS. MITCHELL: Thank you.

13 First of all, I'm moderately, maybe
14 very moderately, pleased that the issue of costs
15 and price, that all is beginning to percolate
16 into the discussion in the quality community.

17 And, I understand and I will comment
18 on this issue about where does quality fit in?

19 But, let me say, I left Massachusetts
20 yesterday to come down here while we are --
21 because we're on a fiscal year that begins in
22 July, in the middle of rate negotiations. One of

1 my most favorite activities because I'm basically
2 a bully and I like to bully the health plans into
3 lowering their premium requests.

4 But, you know, quite seriously, it's
5 scary. It isn't just irritating or upsetting or
6 annoying, it's scary.

7 After a number of years in which
8 utilization was down and prices moderated a
9 little bit, it's gone right back up. Last year,
10 I had to go to the legislature with a \$190
11 million shortfall in my spending.

12 Now, in Washington, that may be chump
13 change, but let me tell you, that in the
14 Commonwealth of Massachusetts and as an agency
15 head, that huge personal, professional
16 embarrassment to have to go back and say, oops, I
17 overspent by a \$190 million.

18 The concern that I have is in thinking
19 about this because this is my problem, not your
20 problem. But, I think it's very important to
21 separate what I think are the basic components
22 and how they affect the quality agenda.

1 There's the issue of resource use
2 which I suppose you could say has partly to do
3 with waste or unnecessary duplication. And so,
4 that's different from appropriateness of care,
5 though related. And I think we have to do more
6 and more and more in that. I think we have huge
7 gaps in that area.

8 I separate the words price from the
9 word cost. Cost doesn't tell you very much.
10 It's my beef with actuaries. They can tell you
11 what something is going to cost, they don't tell
12 you what it might cost if you did a better job or
13 what it ought to cost.

14 And so, we have not just a cost
15 problem, we also have a price problem. And, I
16 think that it is an issue that this society has
17 been extremely reluctant to address with the
18 exception of the recent Mr. Turing -- how do you
19 pronounce his name -- who sort of maybe pushed
20 that envelop a little further than even his
21 supporters thought was reasonable to defend.

22 But, except for that one, I think the

1 issue of cost and, excuse me, of price has been -
2 - we've all been too polite with one another and
3 in the public press about saying that people or
4 institutions are charging more than is
5 appropriate or ethical or reasonable.

6 And, I think we've just got to stop
7 being so polite and address those issues.

8 But, closely related to price then and
9 most egregiously unfair is disparities in price.
10 I mean that's an ethical question in my view.

11 The people least -- the people, the
12 institutions, the communities, the organizations
13 least able to pay are the ones who are over and
14 over and over again charged the most. There's
15 just something basically wrong with that. And, I
16 think we've just got to address that. That is a
17 quality measure. It's an ethical measure or
18 issue.

19 And then, finally, I think there's a
20 point after which cost and price begin to become
21 a quality issue. And, I think those who say,
22 well, cost isn't our problem, cost isn't our

1 issue, quality is issue, I think maybe that was
2 true 20 years ago. I think it no longer is true.

3 And, in what way is it true? If cost
4 and price begin to affect access, then you've got
5 a quality measure and I think we need to keep
6 that higher up in our personal and professional
7 agenda.

8 And, I don't know how many years it
9 takes for people to understand that when the cost
10 gets too high what people do is not just cut out
11 the unnecessary, not just cut out the
12 duplicative, they cut out and abstain from taking
13 necessary preventive care as well as stuff that
14 is optional.

15 Going all the way back to I don't know
16 how many years ago the Rand study was, I don't
17 know, probably 20, 30 years ago.

18 But, you look at the data about high
19 deductible plans and the experience is universal.
20 People don't use necessary as well as unnecessary
21 care.

22 So, the notion that people are all of

1 a sudden going to become prudent shoppers and
2 know whether or not they need an MRI or they need
3 25 or 30 or 40 rehab or physical therapy sessions
4 versus three is just, I think, it's a fantasy.

5 And, yes, we should let people know
6 what things cost and, yes, we should be
7 transparent about prices. And, yes, we should
8 make judgments about quality. But, I think to
9 put the burden on the patient rather than to
10 solve the problem is just an evasion of our
11 professional responsibilities.

12 So, I will get off my pulpit. But, I
13 really think those points need to be issued,
14 excuse me, need to be kept on the agenda and on
15 the agenda of the quality community, not just
16 those of us who are penny pinching Simon Legree's
17 who are trying to deprive our patients or our
18 enrollees of their just desserts.

19 I think it's untrue, unfair, even of
20 insurance companies, the evil insurance
21 companies. Most of them these days, you know,
22 their customers are largely self-insured anyhow,

1 so the notion that they're the evil ones and that
2 everybody else is a saint, I think is a bit of
3 self-deception that we ought not to indulge in.

4 CO-CHAIR TRAVIS: Thank you, Dolores.

5 And, Andrea, I'm going to call on you
6 and, I apologize, I realize you also pulled one
7 of these measures and but thank you for your
8 patience.

9 MEMBER BENIN: Oh, that's okay, no
10 worries.

11 Dolores brings up the question about
12 appropriateness and I think that it would be
13 helpful to have some understanding from CMS maybe
14 not necessarily today but as part of the
15 evolution of these types of metrics, a little
16 better understanding about how we think any kind
17 of risk adjustment really is working.

18 Because, as best I can figure out from
19 the limited materials I could sort through,
20 there's not really any risk adjustment, so you
21 can't tell. Is there some -- I mean they call it
22 risk adjustment but it's like about dollars, it's

1 not about severity of illness. I can't sort it
2 out.

3 So, you know, I think that's like if
4 I look at the hospitals in Connecticut, the ones
5 that take care of more acute care, you know,
6 sicker patients, the higher level of care
7 hospitals seem to have the higher, you know,
8 dollars attributed to them on the metrics that we
9 have so far on Hospital Compare versus the
10 smaller, you know, community hospitals that don't
11 have the sicker patients.

12 And so, I'm just not sure that -- I
13 think that before we could do anything other
14 than, you know, the do not support that's been
15 recommended, that we would need to understand
16 that a little bit better in a more robust way and
17 understand how that evolves and how that
18 methodology on each evolve over time.

19 I think that that's the -- that to me
20 -- I think there is also potential that I do not
21 understand around geographical differences. And,
22 as Nancy mentions, how the pricing gets worked

1 and how the payments get worked is not
2 necessarily uniform, is my understanding,
3 different organizations will have different
4 agreements. And so, I'm not sure how that works
5 out.

6 So, those are kind of the types of
7 questions that I have that make me feel as though
8 these metrics are -- I mean we have some of these
9 payment metrics but we need to understand the
10 ones we have better before we layer it with more
11 of them. That's where my mind was.

12 Thanks.

13 CO-CHAIR TRAVIS: Would CMS like to
14 respond kind of to the methodological issues that
15 Andrea brought up? Because that may influence
16 some of the other questions.

17 MS. SPALDING BUSH: Yes, thanks for
18 the opportunity to respond to that.

19 I'm Kim Spalding Bush from CMS. I'm
20 the lead on these measures and I'm sorry, I don't
21 have my placard.

22 So, there is risk adjustment for all

1 of these episode-based payment measures. We
2 actually sent a detailed methodologies document.
3 I'm not sure whether that made its way, but we
4 can provide that after this if you didn't get it.

5 The risk adjustment follows along with
6 the existing Medicare spending per beneficiary
7 measures construct in that it takes into account
8 the diagnoses built during the 90 days that
9 precede the episode and as well as the patient's
10 age.

11 So, it does look at the beneficiaries
12 clinical picture as well as the MS-DRG for the
13 admission to the hospital because these are all -
14 - we'll talk about IPPS hospital episodes.

15 So, it is risk adjusted and I think
16 that's separate maybe what you're thinking of,
17 too, is the payment standardization that we do
18 which removes geographic payment adjustments,
19 differences in wage index, geographic practice
20 costs index so that you can make those
21 comparisons across geographically different
22 areas.

1 The standardization also removes
2 things like if you have teaching hospitals that
3 get an additional payment for IME, those come out
4 so they don't look more expensive just by virtue
5 of receiving that add-on payment or if they serve
6 a disproportionate share of uninsured patients,
7 we take the payment out.

8 So, the standardization, you know,
9 serves to kind of level the playing field in
10 those respects and all of the measures are risk
11 adjusted at the facility level.

12 I hope that helps.

13 CO-CHAIR TRAVIS: Thank you.

14 Wei?

15 MEMBER YING: My comment is the
16 previous comments that of these set of measures
17 are sort of a duplicate of the total expenditure
18 measure. I think the opposite.

19 I think the total expenditure measure
20 is more of affordability measure. Actually, for
21 these set of procedure-based measures, does get
22 into quality because if there is major

1 complication or readmission happens post-hospital
2 discharge, then the cost will go up.

3 So, it's definitely implicitly there
4 is a quality component procedure-based measure.

5 But, I do have a question for CMS.
6 So, just like hospital readmission measures,
7 there is this overall hospital wide and there is
8 a specific condition readmission measure for a
9 procedure. If we go down this path, there will
10 be endless procedures that you can pick.

11 So, these four procedures you put out
12 here, I assume you have done some analysis.
13 These are high-volume, maybe even see -- we have
14 already seen the variation in the highest on the
15 top of the procedure list, how you pick them?
16 And, the question for CMS.

17 And, another comment is probably more
18 for the NQF endorsement, is if this measure ever
19 come up to NQF consideration is there are many
20 procedure groupers out there.

21 If CMS approach is very different from
22 what is out there either on the market or other

1 organization has developed by themselves, it will
2 cause some disruption, let's put it that way,
3 because if CMS put out it, it becomes sort of the
4 gold standard. But, if it's very different from
5 some of the procedure groupers that have been in
6 existence for a long time, it will cause
7 problems.

8 CO-CHAIR TRAVIS: Would you all like
9 to respond about why these particular conditions
10 were selected?

11 MS. SPALDING BUSH: Yes, thank you.

12 So, they were based on analysis as you
13 had suggested about high prevalence, so they have
14 to represent a high proportion of Medicare
15 payment, being that they're, you know, Medicare
16 payment measures. So, just to narrow down, we
17 did look at high cost conditions and high
18 prevalence conditions.

19 They also have to have significant
20 variation within the measure so that there is an
21 opportunity to gain efficiencies here. Whereas,
22 if it's an episode where we didn't see a lot of

1 variation, we didn't select those.

2 There's also a high proportion of
3 post-discharge care that happens with these. So,
4 I think that also gets at one of -- Leslie or
5 Nancy raised that concern. Oh, Nancy, yes, about
6 whether or not these were really drive by CMS's
7 set, you know, IPPS payment system which they're
8 not. So we made sure to pick episodes that had a
9 lot of post -- high proportion of the included
10 costs are post-discharge payments.

11 And also, they were selected because
12 the clinical panel determined that they were
13 conditions over which the hospital had a lot of
14 influence on the downstream charges.

15 So, that's how we went about selecting
16 these measures. And, they do, as people have
17 noted, they overlap in a sense with the spending
18 per beneficiary measure.

19 I think that the key difference there
20 is that these measures are -- when we say
21 clinical episode-based, we mean that we've only
22 included charges that are related to the

1 admission in these and they've had a lot of
2 clinical panel reviews, CMS doctors, Acumen,
3 Stanford doctors.

4 So, the clinicians have agreed that
5 these are the services that are related. So,
6 that's a key difference between these clinical
7 measures. And, I think that was responsive to
8 some of the public comments we received when we
9 proposed the original overall MSVP measure that
10 since become NQF endorsed but, at that point,
11 wasn't and the public had said, you know, we feel
12 like we need some measures that are more
13 clinically oriented and clinically cohesive.

14 And so, that's what these measures are
15 as well as that the public felt we should really
16 expand our measure sets that we use for resource
17 use measurements so that it's not kind of all
18 dependent on this one.

19 CO-CHAIR TRAVIS: Thank you.

20 Nancy?

21 MEMBER FOSTER: So, I'm also curious
22 about the grouper methodology. It's very

1 different than what's been used before. We
2 haven't had a chance to kick the tires on this
3 nor has NQF. So, we really don't know how it
4 behaves very well.

5 And so, I'm curious as to why we've
6 gone down a path that's a very different grouper
7 methodology than used before. We're using a 90-
8 day look back period when previously in other
9 measures that CMS has developed or contracted to
10 develop, they've used a year, two year look back
11 period in order to get a more accurate assessment
12 of the underlying diseases and disorders of the
13 patients.

14 So, this is a very different approach
15 and I think it's that difference without an
16 understanding of why that, in part, makes me
17 nervous about whether this will do what it's
18 supposed to do.

19 And, the other thing I don't know
20 about this methodology, but I think it is
21 important when we talk about all cost
22 methodologies, all cost outcomes, is to look for

1 whether there are socio-demographic factors that
2 will really affect the total cost here.

3 And, one could easily imagine that a
4 patient who comes from an impoverished condition
5 and has not -- to Dolores's earlier comments --
6 not accessed the health care system previously
7 would have higher costs in many respects, even
8 with the ongoing treatment in order to address
9 all of those problems.

10 And, you know, to what extent has this
11 begun to address that SDS issue?

12 CO-CHAIR TRAVIS: I'll give you just
13 a brief response to that and then we'll see if
14 anybody has any clinical specific questions.

15 MS. SPALDING BUSH: Thanks, I'll try
16 to talk quickly.

17 So, with respect to the methodology
18 here, it is more aligned with the Medicare
19 spending per beneficiary measure that's in the
20 hospital VBP program. That one uses the 90-day
21 look back as well.

22 And, I think the rationale there

1 that's different than like an annual total per
2 capita measure is we were looking for the
3 conditions that most directly affect the
4 hospitalization rather than like if you have a
5 total per capita cost measure that spans a year,
6 you might want to look at just the CMS score for
7 the year that preceded it where that, you know,
8 may not actually accurately reflect the
9 conditions that have occurred more closely to
10 this inpatient hospitalization.

11 And, we also use the MS-DRG for the
12 hospitalization which the total per capita
13 measures don't need to do it because they're just
14 sort of looking at the costs over the course of
15 the year.

16 And, there was another part to that,
17 yes. So, we are cognizant of the work that's
18 underway that NQF is currently working on, the
19 tier project to look at SDS adjustments and also
20 the Assistant Secretary for Planning and
21 Education has undertaken another analysis that's
22 required under the IMPACT Act.

1 So, we are aware that those are going
2 on. We're certainly open to future refinements
3 once we get the outcomes of those projects that
4 are underway with NQF currently.

5 CO-CHAIR TRAVIS: Thank you.

6 Before we move to a vote on these four
7 measures, does anyone have any questions specific
8 to any clinical area or comments, not just
9 questions?

10 So, Leslie?

11 MEMBER SCHULTZ: Just in regards to
12 the aortic aneurysm repair. That strikes me as a
13 heterogeneous population. I can see a little bit
14 more homogeneity from certain cholecystectomy and
15 stuff like that.

16 But, the triple-A kind of -- I don't
17 see that as clinical on here. There's very
18 different patients involved. So, just to kind of
19 --

20 MS. FEINBERG: Hi, I'm Laurie Feinberg
21 and I'm with Physician who works for Acumen and
22 we're in measure development working with CMS.

1 There are really two subgroups in the
2 triple-A's. There's the thoracics and the
3 abdominals and that, we thought, were there
4 relevant ways of separating them.

5 And, if you look at the data which
6 here on page 25 of the 37-page document you
7 hopefully should have gotten, it shows that
8 indeed they are different.

9 Does that answer your question?

10 CO-CHAIR TRAVIS: Thank you.

11 Are there any other questions about
12 any specific clinical conditions?

13 Michael, do you have a question?

14 DR. PHELAN: It was regarding the
15 spinal fusion episode grouper for that. I
16 remember seeing it when it first came out last
17 year or not last year, maybe earlier in the
18 spring, and I never follow up, but there was some
19 concerns about that measure specifically with the
20 group of patients that were going to be selected
21 for evaluation.

22 And, I thought -- I cannot remember

1 the detail now, but did they change their
2 specifications that they were going to look at?
3 Because there's some that are pretty
4 straightforward like the spinal fusion versus
5 more complex patients. And, I didn't know how
6 they addressed that question.

7 MS. FEINBERG: Hi. Based on the
8 negative comments from the American Congress of
9 Neurosurgeons, we actually had them give us some
10 neurosurgeons to work with us and we developed a
11 methodology that we think is far superior.

12 What we did is eliminate the cases
13 where there was trauma and the large spinal
14 deformities which we think are quite different
15 and actually maybe not.

16 But what we were looking at now is
17 focusing on CPT codes that looked at the elective
18 surgeries of which there were lots for
19 degenerative diseases.

20 And, we had the neurosurgeons help us
21 pick out the right codes. I happen to be a
22 physiatrist and it looks right to me and it looks

1 like our data showed that they're right.

2 So, we actually did quite a bit of
3 refinement here.

4 CO-CHAIR TRAVIS: Andrea?

5 MEMBER BENIN: So, these kind of
6 metrics, what's the relevance around IDC-10
7 stuff? So, do they have to be redone for ICD-10?
8 Because all of these metrics will come into play
9 in an ICD-10 environment. So, how does that --

10 MR. FEINBERG: We will crosswalk them.

11 CO-CHAIR TRAVIS: Okay. I don't see
12 any other cards at this point. So, what we're
13 going to do is we're going to vote on each
14 measure because that's our process.

15 And so, I'm going to turn it over to
16 staff to lead us through the vote on each one of
17 these measures.

18 DR. PHELAN: Is this about the vote
19 again?

20 CO-CHAIR TRAVIS: Yes, Michael?

21 DR. PHELAN: So, these are -- it goes
22 back to that initial question we had. These are

1 fully developed measures or are these --

2 CO-CHAIR TRAVIS: Yes, they are fully
3 developed.

4 DR. PHELAN: So, they don't have the
5 -- it's not that middle category that we can
6 select? Either can select conditionally support
7 which means they're no NQF endorsed or that --
8 but there's no middle ground?

9 CO-CHAIR TRAVIS: It's support,
10 conditional support or do not support. So, thank
11 you for helping us clarify that. They are not
12 NQF endorsed at this point, though.

13 Okay, so I'll turn it over to Jean-
14 Luc.

15 MR. TILLY: Thank you.

16 So, for the first measure, Aortic
17 Aneurysm Procedure --

18 CO-CHAIR TRAVIS: Sorry.

19 MEMBER FOSTER: So, I'm less than
20 clear on what the condition would be if we were
21 voting to conditionally support. Is it pending
22 NQF endorsement or is it something more?

1 MS. O'ROURKE: So, I think we can take
2 them one at a time. NQF endorsement seems to be
3 the one that we've heard. Are there additional
4 conditions we'd attach to the aortic aneurysm
5 measure?

6 CO-CHAIR TRAVIS: And, we will get a
7 chance, let's see where it ends up and if it is
8 conditional support, we'll just reaffirm that it
9 would be NQF endorsed meant as the condition.

10 And, if it's not, then we'll talk
11 about what that would be for each measure.

12 MR. TILLY: And so, the three choices
13 are support, conditional support and do not
14 support.

15 MS. SHAHAB: This voting is open.

16 MR. TILLY: And we're just missing one
17 more, so if you guys just want to give one final
18 shot.

19 MS. SHAHAB: Is everyone voting?

20 CO-CHAIR TRAVIS: How many votes have
21 been cast? Okay.

22 MS. O'ROURKE: We have one vote

1 missing it looks like, if everyone could click
2 one more time.

3 CO-CHAIR TRAVIS: Ready to vote again?

4 MS. O'ROURKE: Just one second,
5 please.

6 MR. TILLY: And so, polling is open
7 again.

8 CO-CHAIR TRAVIS: Still on Aortic
9 Aneurysm, vote again.

10 MR. TILLY: Okay, so the results are
11 in.

12 Eight percent for support, 32 percent
13 for conditional support, 60 percent for do not
14 support.

15 So, the recommendation is do not
16 support.

17 CO-CHAIR TRAVIS: Okay. Thank you
18 all. Thank you for your patience and trying to
19 be sure everybody gets their vote in.

20 We'll go to the next measure,
21 Cholecystectomy and Common Duct Exploration
22 Clinical Episode-Based Payment Measure.

1 MR. TILLY: Okay, the voting is now
2 open on Cholecystectomy and Common Duct
3 Exploration Clinical Episode-Based Payment
4 Measure, 115-836.

5 The options are support, conditional
6 support and do not support.

7 The results are 20 percent for
8 support, 28 percent for conditional support and
9 52 percent for do not support.

10 So, the result is do not support.

11 CO-CHAIR TRAVIS: Okay, we're going to
12 skip down to number four which is Spinal Fusion.

13 MR. TILLY: Okay, the voting is now
14 open for Spinal Fusion Clinical Episode-Based
15 Payment Measure 15-837.

16 The results are 16 percent support, 36
17 percent conditional support, 48 percent do not
18 support.

19 So, the recommendation is do not
20 support.

21 CO-CHAIR TRAVIS: Okay, and now
22 Measure Number 5.

1 MR. TILLY: Okay, the polling is now
2 open for Transurethral Resection of the Prostate
3 for Benign Prostatic Hyperplasia Clinical
4 Episode-Based Payment Measure, 15-838.

5 So, we're actually just missing one
6 more, if you'd all try again. And we got it.

7 Okay, so the results are 20 percent
8 support, 24 percent conditional support, 56
9 percent do not support.

10 So, the recommendation is do not
11 support.

12 CO-CHAIR TRAVIS: Okay. Well, thank
13 all of you. Now, we have experience with just
14 about every possible voting outcome, I think.
15 So, that'll help us as we move forward to
16 understand how this works. So, thank you very
17 much for that.

18 We have one final measure that's in
19 this calendar. It is the Hospital-Level Risk
20 Standardized 30-Day Episode of Care Payment
21 Measure for Pneumonia.

22 This was pulled by Nancy, Andrea and

1 Jennifer. Since Nancy is the lead discussant,
2 we'll go to Andrea first then Jennifer and then
3 Nancy.

4 MEMBER BENIN: You know, I don't have
5 any particular concrete things, I just felt as
6 though this needed a little bit of discussion and
7 explanation about how this metric was thought
8 that it would perform as well as the, you know,
9 what do we need to know about this type of
10 metric. And so I just wanted to make sure we got
11 all the information proper.

12 CO-CHAIR TRAVIS: Well, maybe, Andrea,
13 what might work is for us to have a conversation
14 and then if you have a specific question still
15 outstanding we can come back to that. Would that
16 be okay?

17 Okay, Jennifer, in terms of why you
18 chose to pull this measure?

19 MS. HUFF: Yes, I think so a lot of
20 the comments we made for the clinical episode
21 apply here. So, I'll just focus on some that are
22 different.

1 So, pneumonia is the leading cause of
2 hospitalization for the older population.
3 They're costly and have variation.

4 The pneumonia measure has a
5 complimentary outcome measure. It has a
6 mortality measure. But, I think the discussions
7 around the linking the two together, CMS has been
8 doing a good job in moving in that direction with
9 some of the measures and this is one of them.

10 So, the improvements and the relative
11 resources can also be viewed in terms of the
12 quality of care that is being provided.

13 And then, I would also say -- let me
14 see -- this measure is currently in use in this
15 program. It's only that it's changing the
16 population and then it's expanding it, the
17 population, to make it more similar to the
18 mortality measure.

19 So, for me, it didn't seem like this
20 was a significant change and it's nice to bring
21 alignment between measures. I saw it more modest
22 alteration, so I would suggest changing the

1 recommendation from conditional support to
2 support.

3 CO-CHAIR TRAVIS: Thank you, Jennifer.
4 Nancy?

5 MEMBER FOSTER: So, thank you.

6 I am going to make a recommendation
7 that we add an additional condition on the
8 conditional support that was the staff
9 recommendation.

10 But, before I do, I would note that I
11 continue to be a little bit surprised that the
12 previous measure did not undergo further NQF
13 review because this is a substantial change in
14 the population that's included in the measure.
15 It basically doubles the size of the patient
16 population and that, to me -- and it incorporates
17 a lot of patients that never would have been in
18 the measure before.

19 So, I see this as pending NQF review
20 as a conditional support and that would be
21 appropriate as far as I'm concerned.

22 The other issue for us continues to be

1 socio-demographic factor adjustment. We
2 understand that when this was submitted to CMS
3 under the trial period that, in fact, there were
4 some SDS factors explored with this one.

5 What I would say is that we thoroughly
6 agreed with the task force that NQF had on socio-
7 demographic factors that suggested that race
8 should never -- probably never, that almost
9 always never, should ever, ever, ever, never be a
10 potential adjustment factor here.

11 And, yet, when this came forward to
12 NQF for review, it was proposed as an adjustment
13 factor. I can think of no conceptual reason why
14 race should be an adjustment here. But, I can
15 think of a lot of reasons why the differences in
16 the poverty rates in the communities, the access
17 to ongoing care and other such factors would
18 create differences in performance that should be
19 considered for adjustment.

20 So, we are supporting this with NQF
21 review and deep consideration of SDS factors that
22 do not involve race.

1 Thank you.

2 CO-CHAIR TRAVIS: Thank you, Nancy.

3 And, I'm just trying to be sure I've
4 gotten everybody who pulled it. Yes, I have.

5 So, now we'll open it up to those on
6 the committee.

7 Wei?

8 MEMBER YING: My comment here is very
9 similar to one other comment I made about the
10 procedure-based measure.

11 When it comes to NQF assessment of all
12 these measures, it's not only endorsing this
13 particular measure, it's probably also endorsing
14 the grouping as knowledge.

15 There is an industry standard,
16 probably more than one out there, that either
17 health care -- the providers or the insurance
18 company have been using, especially on the
19 clinical condition.

20 Procedure-based is relatively new, but
21 condition-based on episode has been going -- has
22 been in the market -- on the market for quite

1 some time.

2 If CMS knowledge is very different
3 from the sort of quote, unquote standard out
4 there on the market, then it really will cause
5 problems, especially for those, let's say
6 insurance companies serving different population
7 then there will be a lot discrepancies in
8 between.

9 CO-CHAIR TRAVIS: Thank you, Wei.

10 Any other -- Marty?

11 MEMBER HATLIE: Excuse me, Sean.

12 I'm concerned about Nancy's additional
13 condition. I don't know that I understand it.

14 My concern is that I think there are
15 situations, I'm not sure if this is one of them,
16 where racial bias is a determining factor where
17 if you adjust for education level or socio-
18 economic status, you still see outcomes differing
19 because of color of skin.

20 And so, I don't like -- my knee jerk
21 reaction is, is I don't like taking that factor
22 out of the equation. But, I'll admit that I just

1 don't really have granular knowledge about this
2 particular condition.

3 MEMBER FOSTER: So, Marty, I hope you
4 are wrong in that assessment. I fear you may be
5 right. But, the adjustment factor would
6 essentially take it out of the equation. It
7 would never illuminate differences as a result of
8 race. But we are talking about analyzing things
9 by race, I would say to you, yes, let's do that.

10 In fact, we have a major effort
11 underway to encourage hospitals to break down
12 some of their measures by what we call real data,
13 race, ethnicity and language data to look and see
14 if there are any disparities in care despite
15 whatever efforts they have underway to make sure
16 that there aren't, we know there possibly can be.

17 But, this is an adjustment factor that
18 would blend that out and I don't -- we don't see
19 that as a legitimate adjustment factor and that's
20 what I'm saying

21 CO-CHAIR TRAVIS: Leslie?

22 MEMBER SCHULTZ: Thank you.

1 I agree with the staff's
2 recommendation on this one, that it go back
3 through the process. They've really changed the
4 population when they introduced aspiration
5 pneumonia and the subcohort, it's radically
6 different as Nancy alluded to.

7 You double the populations of
8 something meaningful. It has changed clinically.

9 CO-CHAIR TRAVIS: Thank you.

10 Michael?

11 DR. PHELAN: I'm just wondering,
12 because there seems to be a concern for some of
13 the other people, I'm wondering if CMS can
14 comment on why that was done and why it matters?

15 CO-CHAIR TRAVIS: Which particular
16 part?

17 DR. PHELAN: The double the
18 population.

19 CO-CHAIR TRAVIS: The change in the
20 population?

21 DR. PHELAN: The change in the metric
22 which I don't -- I'm not, as a clinician, too

1 concerned, but I just wanted to hear what CMS
2 thoughts were on that.

3 CO-CHAIR TRAVIS: Okay. That sounds
4 good.

5 DR. YOUNG: So, we discussed this on
6 a couple of the other pneumonia measures that we
7 have in the IQR program last year, last year's
8 MAP.

9 So, this is an update to -- a
10 substantive change to the payment measure to
11 align it with the other pneumonia measures which
12 is essentially to update it to attempt for, you
13 know, some -- what we've noted in terms of coding
14 practices, in terms of coding of severity of
15 pneumonia to capture folks who are now designed
16 as sepsis with the primary -- as their primary
17 diagnosis on a discharge with a secondary
18 condition of pneumonia as well as to capture
19 those patients that have aspiration pneumonia.

20 So, we believe overall this is a more
21 comprehensive assessment of the pneumonia
22 population that a hospital treats.

1 I would also turn to Suzannah Bernheim
2 who helped developed this measure and led those
3 efforts if she has additional comments.

4 But, the other thing I think we just
5 want to clarify was also that, while we looked at
6 race as part of the SDS trial in NQF, race is not
7 part of the risk adjustment methodology.

8 CO-CHAIR TRAVIS: Thank you.

9 MS. BERNHEIM: I mean I'm happy to add
10 more, although I think Pierre basically covered
11 it. Right? We brought, you know, to this
12 committee both the mortality and readmission
13 pneumonia measures last year with this cohort
14 expansion on a pretty extensive discussion about
15 why the cohort was being expanded.

16 That went into last year's rule and we
17 actually, in response -- you can see, Nancy --
18 okay, just hold it a bit closer, okay, sorry.

19 So, the expansion of the cohort for
20 the mortality and readmission measure came to
21 this group last year in response to some great
22 stakeholder input. We actually narrowed the

1 expansion so the mortality and readmission
2 measures have been finalized and moved forward
3 with a cohort that is expanded from the previous
4 one but actually somewhat narrower than what came
5 in front of this group last year.

6 This work is now to bring the
7 mortality measure cohort expansion to the payment
8 measure so that those two measures stay aligned.

9 And, yes, we -- the payment measures
10 were one of the first to go through the SDS trial
11 as an ad hoc review and we looked at a wide
12 range, not that wide a range, but as wide a range
13 of SDS variables as we could to see the impact on
14 the measures.

15 So, we looked at race but we in no way
16 proposed race being infiltrated into these
17 measures and don't intend to do so.

18 CO-CHAIR TRAVIS: Okay. Thank you.

19 MS. SHAHAB: Cristie, Jennifer has a
20 comment as well.

21 CO-CHAIR TRAVIS: Yes, Jennifer?

22 MS. HUFF: Hi, I have a question for

1 clarification and it's around the addition of the
2 conditional support regarding looking at SDS.

3 I'm on the NQF Cost and Resource Use
4 Standing Committee, so have some knowledge about
5 what's been going through that process and this
6 pneumonia measure, the current pneumonia measure
7 and the IQR program has gone through that
8 endorsement process and also gone through the SDS
9 trial process of being reviewed.

10 The committee's given feedback to the
11 measure developer that has led to what different
12 measures to look at.

13 So, I'm wondering is it like is it --
14 is that suffice for the condition that's being
15 put forward? Is it being looked at since it has
16 had some review already? And, I think it may
17 have gone to the Board recently.

18 But, I know it has completed the
19 Standing Committee review.

20 CO-CHAIR TRAVIS: I'm going to ask NQF
21 staff to kind of answer that for us so that we
22 get the right answer.

1 MS. O'ROURKE: Sure. I can attempt to
2 take that and I may look to Helen or Taroon who
3 are also involved in this project.

4 So, the current version of the measure
5 that is used in the program has been NQF endorsed
6 and was looked at by the Cost and Resource Use
7 Standing Committee for consideration of adding
8 SDS factors in the risk adjustment model.

9 The committee, at the time, did not
10 recommend that those factors be included in the
11 risk adjustment model. So, that measure has
12 undergone the Standing Committee's review and
13 will be going to CSAC as the Board for
14 finalization in the coming months.

15 However, this update to the cohort has
16 not been reviewed by the Standing Committee for
17 either the change to the population included in
18 the measure and if that change in the measure
19 should be also again considered for SDS
20 adjustment.

21 CO-CHAIR TRAVIS: And, just to be sure
22 I'm on the same page, assuming that this measure

1 comes back in for the update and the review,
2 potential review and re-endorsement during the
3 SDS trial period, they would go through the SDS
4 review at that time for this measure.

5 So, I think that will happen if,
6 assuming those things I just said.

7 MS. O'ROURKE: And, I just wanted to
8 be explicit about it, that's my only thing.

9 CO-CHAIR TRAVIS: Right.

10 All right, we'll let's take a vote.

11 MR. TILLY: The polling is now open on
12 Hospital Level Risk Standardized 30-Day Episode
13 of Care Payment Measure for Pneumonia, MUC 15-
14 378.

15 The options are support, conditional
16 support and do not support.

17 Okay, so the results are support, 32
18 percent, conditional support, 60 percent and do
19 not support, 8 percent.

20 So, the result is conditional support.

21 MS. O'ROURKE: Sure, so I think the
22 conditions I've heard is that it's NQF review and

1 endorsement of this update to the cohort with
2 particular attention paid to inclusion of social
3 demographic factors.

4 CO-CHAIR TRAVIS: Okay, well, not
5 hearing any opposition to that, that's the
6 condition that will go forth.

7 And, I know I said I was going to try
8 to get us through all three of these calendars
9 before lunch, but I'm personally very hungry.

10 So, we will take a break, but before
11 we do, I'd like to see what Tom would like to
12 share with us.

13 MEMBER LUTZOW: Yes, as you follow
14 through on those convictions, do you actually
15 look at raw data? In this case, are intercity
16 hospitals at a disadvantage to suburban or rural
17 are dually eligible patients in the fee-for-
18 service system actually costing more than non-
19 duals? Do you look at the hard data? Can you
20 see a difference and what is it?

21 MEMBER FOSTER: I was going to say,
22 there have been a number of studies that look at

1 socio-demographic effect on readmissions, on
2 cost, on anything else.

3 These particular conditions, I'm not
4 -- pneumonia yes, people have looked at that.
5 And, yes, there is clearly an effect of poverty,
6 if you will. So, whether you're measuring that
7 by dual eligibility, which gets a little funky
8 because some states have expanded their Medicaid
9 population and others have not. And so, you've
10 got sort of a strange confounding factor in
11 there.

12 Or, you look at it by Census track
13 which is probably a more rigorous way to look at
14 it. Or zip code, some people have suggested.

15 You can find a poverty factor in there
16 that affects total cost, total number of
17 readmissions, I'm not aware of the mortality, but
18 somebody can correct me if I'm wrong.

19 MS. BERNHEIM: So, when we brought
20 these measures back again, it was much later and
21 the current version of, not the version that's in
22 front of you, we did exactly that.

1 So, we looked at hospitals with high
2 proportions of dual eligible patients, hospitals
3 with high proportions of patients coming from
4 neighborhoods indicated by our SES index. I
5 think we did that one for payment, we've done
6 this for a lot of measures right now as you can
7 image because they're all coming back. And, we
8 looked at race.

9 And, what's surprises people with
10 these payment measures, because they are looking
11 at an episode and because, unfortunately,
12 sometimes patients in poor communities are less
13 likely to get procedures or are less likely to
14 get follow up care and sometimes they are more
15 likely -- at most, it comes out in the wash. You
16 see much less difference than you might expect
17 with these actual measures and those factors.

18 And, all of the stuff that we did is
19 public. It's on the NQF website because we
20 brought it back to the committee. So, you can
21 look at it in detail.

22 But, I think it surprised the

1 committee how little in the case of these
2 measures and the versions of SDS that we can
3 feasibly include, how little difference it made.

4 MR. AMIN: So just a few
5 clarifications. So, I just wanted to provide --
6 take a step back from this question and just sort
7 of articulate a little bit of what we're doing in
8 the SDS trial and the approach that we're asking
9 measure developers to undertake.

10 I think it might help to provide a
11 little bit of clarity and hopefully some
12 confidence about, you know, what happens with
13 these measures when you ask -- well not even when
14 you ask us to look at the SDS question because
15 this is being implemented across all NQF projects
16 in the next -- for the next few years.

17 By the way, my name is Taroon Amin, by
18 the way. I'd just like to introduce myself. I'm
19 the Staff Support for the MAP Coordinating
20 Committee and also Staff Support on the SDS Trial
21 Period along with my colleague Karen Johnson here
22 and others.

1 So, with this change, NQF convened an
2 expert panel to look at the question of the
3 appropriateness of including SDS factors in risk
4 adjusted models.

5 Many of you were on that panel and the
6 main summary statement there, while it was a very
7 extensive report and I highly encourage you to
8 take a look at it if you haven't seen it yet, the
9 main operational impact was that it removed this
10 consideration that SDS factors should just not be
11 included in risk adjusted models which was our
12 prior guidance.

13 And so, we lifted this ban, if you
14 will, but that, I want to be clear that lifting
15 that ban means a few specific things.

16 The question of whether SDS factors
17 should be included in risk adjusted models is
18 dependent on each individual measure and should
19 follow a pretty defined process within our NQF
20 endorsement process.

21 The first is that there is a
22 conceptual analysis on whether and how these SDS

1 factors influence the outcomes of interest.

2 So, there should be sort of an
3 underlying conceptual rationale for the way
4 that's low income, for instance, or the dual
5 eligibility variable influence the outcome of
6 interest.

7 That is a critical element of how one
8 should decide whether or not these factors should
9 be included in risk adjusted models.

10 The second is once you have that
11 conceptual understanding, to then be able to test
12 it empirically to understand how much these
13 factors are influenced in the outcome.

14 Now, there are clear challenges in the
15 field about how well the data that we have, the
16 individual variables represents the underlying
17 conceptual construct.

18 And, that's a discussion that's going
19 to be well beyond our two year trial period and,
20 quite honestly, well beyond what many measure
21 developers can do with the current state of the
22 data that they have to test this.

1 So, this is going to be a learning
2 process for us as a field to continue to
3 understand, you know, I think some interesting
4 findings so far in the context of these measures.

5 And then, as this measure expands to
6 expand the population, you know, we'll have to go
7 back and take a look at this question and I'm
8 sure Suzannah and the CMS team are going to do
9 that.

10 But, I wanted to provide context in
11 the fact that we're looking at these measures
12 individually. Every single measure starting this
13 past calendar -- well, 2005 is in this trial
14 period. There were -- 2015, I'm ten years off --
15 2015 are in this trial period.

16 The NQF Board asked that certain
17 measures that were in 2014 to go back into the
18 trial period, so that's where these measures --
19 these three measures that Suzannah talked about
20 of large number of readmissions measures went
21 back into this trial period and then all, you
22 know, all these measures in the next few years

1 will have to go through this conceptual analysis
2 and then an empirical analysis.

3 But there are going to still going to
4 be underlying data challenges, you know, my
5 summary statement.

6 And so, we can go into a discussion
7 about how well dual eligibility represents
8 underlying SDS factors or low income or how that
9 data can be collected. And those are definitely
10 conversations that need to be had and we are
11 convening a Disparities Standing Committee to
12 really address some of these more long term
13 issues that we're going to need to grapple with
14 that are going to require many of us to, you
15 know, help advise the field in where we need to
16 go forward.

17 So, Cristie, I just wanted to provide
18 this background of what we're doing and hopefully
19 that addresses the question that was raised.

20 CO-CHAIR TRAVIS: Thank you.

21 And, I'm sure that'll be an ongoing
22 conversation as it goes on.

1 Michael, did you have a question?

2 DR. PHELAN: You know, I'm sure you're
3 familiar with the Barnett's paper that internal
4 medicine with the different patient
5 characteristics.

6 Because I heard someone from CMS say
7 that they didn't really see this kind of a wash
8 out, but there's other studies out there showing
9 that some of the, for at least for the all cause
10 readmission, there's a Barnett, I think they had
11 a paper that looked at 29 different factors that
12 may be contributing to the differences in
13 readmission.

14 So, whether or not the data coming out
15 from CMS actually explored each of those, I don't
16 know if they did or not, but there are factors
17 that are there. I just I got this impression
18 that it was kind of being minimized --

19 CO-CHAIR TRAVIS: Trust me, the review
20 process -- participating on that side of it as
21 several people around here do, it is thorough.
22 So but, there are these challenges that, you

1 know, this trial period is actually helping to
2 uncover which is why it is a trial period so that
3 we can learn what it takes to do it the right
4 way.

5 So, your comments are right on target
6 in terms of what is going on in the trial period.
7 So, thank you for that.

8 And, I'll go to David for the last
9 comment before lunch.

10 MEMBER ENGLER: Thank you very much.

11 So, I don't want to stand between us
12 and lunch.

13 But, to your point, what we have done
14 in the last couple of years at America's
15 Essential Hospitals and it's a resource that we'd
16 like to offer all members of MAP if you're
17 interested in, we've published the results of at
18 least 18 or 19 different studies looking at the
19 impact that SDS has on outcome measures. And,
20 that's all available on our website.

21 And, to generalize from those 19
22 studies or so, it has a significant impact on

1 selected metrics. Okay? In particular,
2 pneumonia, in particular, stroke, and in
3 particular, of the admissions as a general theme.

4 So, we offer that as a resource to all
5 members of MAP and as you're looking at the
6 impact that socio-demographic factors have, we've
7 published also race, ethnicity and language tools
8 that are available through our site as well.

9 So, I just wanted to offer that.

10 CO-CHAIR TRAVIS: Well, thank you,
11 David.

12 MEMBER ENGLER: Thank you.

13 CO-CHAIR TRAVIS: Thank you very much.

14 Okay, well, like I said, we had a
15 reward for three. We only got through one, but
16 we're doing continuous improvement and
17 adjustment.

18 So, we're going to have lunch right
19 now and I'm going to staff, though, as to what
20 time we need to come back.

21 MS. O'ROURKE: 1:45, 30 minute lunch.

22 CO-CHAIR TRAVIS: Are people up for a

1 working lunch? Okay.

2 MS. O'ROURKE: Maybe we can take 15
3 minutes to get your lunch and decompress a little
4 and then come back at 1:30 for a working lunch.

5 CO-CHAIR TRAVIS: That sounds good.
6 Thank you all.

7 (Whereupon, the above-entitled matter
8 went off the record at 1:17 p.m. and resumed at
9 1:35 p.m.)

10 CO-CHAIR WALTERS: Okay, Helen
11 Haskell, one housekeeping thing for you, would
12 you just tell the group about your conflicts or
13 lack thereof?

14 MS. HASKELL: Hello, I'm Helen Haskell
15 for Mothers Against Medical Error and Consumers
16 Advancing Patient Safety and I have no conflicts
17 to report.

18 CO-CHAIR WALTERS: Thank you very
19 much.

20 Okay. We're moving into Consent
21 Calendar 3, the 11:00 item. And so, I'm pleased
22 to inform you that when we started to put

1 together these Consent Calendars, we purposefully
2 did that in kind of groupings to facilitate some
3 of the discussion that, like you just saw on the
4 last Consent Calendar, so we knew might be able
5 to catch up a little ground.

6 And, this one almost naturally groups
7 into numbers two, three and four because they are
8 all about ischemic stroke mortality. And, I'm
9 sure we'll need --

10 And then, the first one has to do with
11 the excess days which is a different type
12 concept.

13 But, before we get to two, three and
14 four and then one, let's talk about number five
15 which is the RPSI composite. That, to this point
16 in time, has not been pulled by anyone. So, I
17 want to see if everyone wants to leave it on the
18 Consent Calendar which was recommended by staff
19 for support?

20 Is there anybody in the room that
21 wants to pull that from the Consent Calendar?

22 Good. Okay, thank you.

1 We will now go over two, three and
2 four which is those group of measures regarding
3 ischemic stroke mortality.

4 They were pulled by a combination of
5 Nancy, Sean and Andrea, either two at a time or
6 three at a time.

7 So, who doesn't have food in their
8 mouth? Let's see, Sean, no you're not there.

9 DR. MORRISON: I'm here.

10 CO-CHAIR WALTERS: You have food in
11 your mouth yet.

12 DR. MORRISON: No, not yet.

13 CO-CHAIR WALTERS: Andrea, do you have
14 -- okay, Sean, you go first.

15 DR. MORRISON: Okay.

16 CO-CHAIR WALTERS: And, this is taking
17 two, three and four kind of as a group because I
18 suspect where we're going end up is talking about
19 the three measures together and what's the same
20 about them and what's different and so on.

21 DR. MORRISON: Right. So, these are
22 the three measures around adjusted stroke

1 mortality. And, I had a couple of concerns about
2 those and let me just preface by the data that
3 are out there.

4 The first element is that there,
5 particularly related to stroke, there are a
6 number of data point -- or a number of studies
7 out there that demonstrate that there really is
8 something that patients consider a fate worse
9 than death and that is living with either
10 profound cognitive or functional impairment and
11 that is often a result following a severe stroke.

12 The second data element out there is
13 that we know that patients goals of care are not
14 discussed well by physicians in the acute care
15 setting.

16 And, the third point of data is that
17 it is very easy, or relatively easy, to keep
18 somebody alive for a prolonged period of time
19 following a severe stroke if you place a
20 tracheostomy into their larynx and then put a
21 gastrostomy tube into their stomach.

22 And, many of us who work in this area

1 are very familiar with the comment by our
2 neurosurgeons and our neurologists, it is time
3 for a trach and PEG. Trach, PEG and send them
4 home.

5 So, the idea of putting a mortality
6 measure out there without any consideration as to
7 whether (a) goals of care were discussed, (b)
8 whether there was any consideration as to whether
9 patients were enrolled in hospice following a
10 severe stroke means that we are not protecting
11 our most vulnerable patient population and,
12 indeed, may be placing many of them in a
13 situation which they would consider to be a fate
14 worse than death.

15 And, I think unless there is some
16 accountability for either goals of care
17 discussions, patients preferences, that mortality
18 in and of itself for this measure is a poor
19 measure and I would vote either (a) to support
20 continued development with that indicated or (b)
21 not move it forward at all.

22 CO-CHAIR WALTERS: Thank you.

1 Nancy, you asked that it be pulled,
2 too?

3 MEMBER FOSTER: Thank you.

4 And, I appreciate Sean's comments very
5 much that very important concerns.

6 My question was really about why three
7 measures? What's it going to tell us if we
8 endorse all three of them? What's the difference
9 between the three of them?

10 I appreciate the fact that you have --
11 that CMS and its measure development team has
12 taken the step of trying to adjust these for
13 stroke severity which is clinically the most
14 important thing, I understand, in determining
15 stroke outcome.

16 So, great step, but help me understand
17 why three are on the MUC list.

18 CO-CHAIR WALTERS: The spec to that
19 came up and I think we're going to get a response
20 to that as the discussion unfolds. That's why
21 they're kind of grouped together.

22 And, Andrea, you had a problem with

1 three and four. You asked that that be pulled,
2 those be pulled.

3 MEMBER BENIN: No, my comments were
4 similar and I think Sean made some excellent
5 points and I think we need to understand what the
6 differences are between these three and why
7 there's three and what the implications are
8 around them.

9 CO-CHAIR WALTERS: Okay. Let's head
10 into the response. That was anticipated to be
11 the number one question. So, let's head into
12 two, three and four as a group. Why all three of
13 them are there, what their differences are, why
14 all three of them should to be important or not
15 and then we'll get into comments after that.

16 DR. YOUNG: Sure, so thank you for the
17 comments and if there are specific comments about
18 the technical specifications, though, I'll ask
19 Suzannah to help answer those.

20 But, we felt as we were developing
21 these measures with Suzannah and her team, we
22 wanted to move forward but were also cognizant

1 that the landscape of data sources and movement
2 towards use of electronic health records as a
3 data source for quality measures was also
4 happening.

5 And, as I mentioned before, usually
6 take several years before CMS can implement a
7 measure into a program.

8 So, the main difference between the
9 different versions, if you will, of these
10 measures, is essentially the data sources we
11 essentially have one claims-based measure.

12 We have a hybrid measure which uses
13 data from claims information as well as data from
14 EHRs and then an EHR version.

15 So, the reason we included all three
16 was really because we were cognizant that, you
17 know, we want to move forward with ultimately
18 achieving this vision of having quality data
19 pulled from EHRs.

20 And so, we wanted to have some --
21 thought it would provide some flexibility if we
22 had different versions that we may consider

1 appropriate for the program at different times
2 depending on what data source was -- and what the
3 stage of development is with EHRs.

4 CO-CHAIR WALTERS: Yes, open for
5 discussion.

6 MEMBER FOSTER: So, Pierre, if I could
7 say that back to you in a slightly different way,
8 it is not your intent to implement more than one
9 of these at a time, in essence. You are looking
10 for guidance on whether to move a measure forward
11 and, if so, whether one of these is preferred.
12 Is that right?

13 DR. YOUNG: Certainly that would be
14 valuable input. I mean sometimes we have had two
15 versions. Right? We've had paper measures and
16 the voluntary ECQM version of that measure. So,
17 certainly we've had that situation in the past.

18 So, there are possibilities that you
19 may have different versions of the same measure
20 in the program at the same time. But, I think
21 the goal here is really to have a measure in the
22 program.

1 CO-CHAIR WALTERS: I'll address it
2 before I get to David. Greg as the lead
3 discussant.

4 DR. ALEXANDER: Thank you.

5 So, I've reviewed all the comments on
6 these and the only thing that I have to add is
7 there was one comment about the sort of
8 usability, human computer interaction components
9 of EHRs.

10 And, since I have some experience with
11 that, I thought it was an interesting comment in
12 that different users, the different EHRs and the
13 ways EHRs are designed should be considered in
14 relationship to this measure because the measure
15 is only as good as the data underlying it.

16 And, if the data isn't collected
17 consistently and reliable across different
18 vendors, then you're not really measuring the
19 same thing across different settings.

20 And so, this was a concern that was
21 raised and I think it's a valid concern that
22 should be considered.

1 So, I guess I would recommend
2 conditional acceptance based on this.

3 CO-CHAIR WALTERS: And, the other lead
4 discussant, Heather?

5 MEMBER LEWIS: I have to say that in
6 concur with Sean's comments and I do have a
7 question regarding risk standardization and
8 selectively with this stroke mortality measure,
9 it selectively disadvantages of hospitals as
10 we've seen in some of our experience.

11 CO-CHAIR WALTERS: And, I'll go back
12 to David.

13 MEMBER ENGLER: So, thank you very
14 much.

15 So, I had both a comment and a
16 question.

17 So, when we looked at the metric
18 itself, we were very supportive. American's
19 Essential Hospitals was very supportive in the
20 sense that the adjustment was going to be made
21 for the stroke severity scale. So, thank you for
22 doing that.

1 But the follow up question for that is
2 whether or not in the collection of the data both
3 claims-based and EHR, if those data elements are
4 routinely collected for the purposes of the
5 scale, if they are not, then we would withdraw
6 our support for it. If they are, then we would
7 continue to endorse it.

8 CO-CHAIR WALTERS: Pierre?

9 DR. YOUNG: So, with this switch to
10 ICD-10, there is -- we now do -- or will be
11 collecting eventually NIH Stroke Scales as part
12 of the claims data, so that's how we can include
13 that as part of the risk adjustment model with
14 even just the claims-based measure.

15 CO-CHAIR WALTERS: Leslie?

16 MEMBER SCHULTZ: Very similar theme,
17 applaud the inclusion of the adjustment for the
18 stroke scale. However, unsure if those elements
19 can capture consistently across EHRs.

20 And CE HTR requirements need to be
21 incorporate the elements prior to the
22 implementation.

1 CO-CHAIR WALTERS: Jack?

2 DR. FOWLER: I'm on Sean's team, I
3 guess, that the notion of having a quality
4 measure that encourages hospitals to keep people
5 alive given the fact that we know there's an
6 awful lot of over treatment at the end of life,
7 it doesn't strike me as rational.

8 CO-CHAIR WALTERS: Sean?

9 DR. MORRISON: I would just add that
10 I would suggest that mortality is not the right
11 measure here but it's cognitive and functional
12 outcome and that mortality is just -- it's just a
13 wrong outcome for this condition.

14 DR. LEVY: Yes, I was about to say the
15 exact same thing that Sean said. I'm not sure
16 that mortality is a measure of quality here
17 because the outcomes of stroke could cognitive.
18 I think that's much better.

19 But, the relationship between stroke
20 and mortality in terms of quality is very unclear
21 to me.

22 CO-CHAIR WALTERS: I have kind of a

1 question myself. With three measures of kind of
2 different sources, mixture of sources, et cetera,
3 it's kind of a version of the one that someone
4 asked earlier.

5 And, if they're all in the program,
6 and if it all happens to be at the same time,
7 how's that work for an individual hospital?

8 DR. YOUNG: So, I don't know -- so,
9 from the CMS perspective, we, I don't think we've
10 made any formal decisions in terms of which
11 measure or all measures to potentially propose
12 for IQR.

13 So, certainly if all three are in, we
14 recognize that there would be these complications
15 because then it becomes, well, which one would a
16 hospital submit?

17 What I can say is, you know, in the
18 past, we have had paper -- we've had two versions
19 of the same measure in the IQR program. We've
20 had, you know, a paper -- like a chart extracted
21 measure and a voluntary ECQM version of that same
22 measure that hospitals could voluntarily submit

1 data on instead of the paper of the measure.

2 So, that could be one possibility for
3 how we could have multiple versions of the same
4 measure in there.

5 As far as I know, we've never had
6 three versions of the same measure in the
7 program. I think just to emphasize our thinking
8 here, I think we want to encourage the movement
9 towards EHR based a type of clinical quality
10 measures but also recognize that based on, as
11 we've heard in some other discussion earlier,
12 there are concerns about the data quality and how
13 reliable that data quality is at this point. So,
14 we recognize that's a moving target.

15 But so, but these are very good
16 questions that we need to fully think through
17 before we would make any proposals through a
18 notice and comment rulemaking about how to
19 include these measures.

20 CO-CHAIR WALTERS: Mitchell?

21 DR. LEVY: Yes, so, based on your
22 comment, I think this is another one of those

1 times before we vote that we're really sure and
2 clear about what we're voting on because this --
3 the conditional support that's recommended by the
4 staff is conditional support for public reporting
5 into patient quality as opposed to conditional
6 support for further development of the measure.

7 So, to me, we need to clarify -- be
8 sure of what we're -- what one of those is.

9 CO-CHAIR WALTERS: Did you have
10 another comment?

11 MEMBER ENGLER: Yes, thank you.

12 I need more clarity on whether or not
13 it's all three metrics. I wouldn't wish three
14 metrics on my worst enemy on the same measure.

15 So, and particularly as we try to
16 adjudicate the differences across the three, so
17 again, while we support it given the fact that
18 there's a stroke scale in it and given the notion
19 that the EHRs will eventually catch up with
20 humanity, but I do need some clarity for purposes
21 of the vote as to which of the three we're voting
22 on.

1 CO-CHAIR WALTERS: So, Nancy's going
2 to give us that clarity.

3 MEMBER FOSTER: Well, listening to the
4 comments, I think the NQF review is really the
5 ideal place to address the question of are these
6 there equal measures, is one superior to the
7 other? Which one should be endorsed? Or is one
8 simply the electronic equivalent of the paper-
9 based measure and there are really two sides of
10 the same coin?

11 I'm not sure we are constituted to do
12 that or have the time to do that given how much
13 time we've taken already.

14 But, so I leave that question to NQF
15 review. But, I'm seriously concerned about the
16 questions that Mitch and Sean and others have
17 raised about how this aligns with what are the
18 real outcomes of interest and how it aligns with
19 patient preferences and DNR decisions and so
20 forth.

21 So, I'd love to hear CMS's response on
22 whether any or all of these measures have taken

1 into account patient decision making and whether
2 -- why you thought these were the outcomes of
3 interest for stroke.

4 DR. YOUNG: So, thank you.

5 And so, we -- these are really
6 important questions about sort of patient
7 preferences and engagement of patients,
8 particularly in our measure development process.

9 And, I just want to ask Suzannah
10 actually to talk a little bit more specifically
11 about how we did that with this particular
12 measure.

13 MS. BERNHEIM: Can people hear me
14 okay?

15 So, these are really important
16 questions and, remember that CMS has in the IQR
17 program right now a 30-day hospital stroke
18 mortality measure. So, these are coming forward
19 as a revision to that measure if you stick with
20 the claims-based measure to respond to one of the
21 key criticisms of that measure when it first came
22 out which is that we did not have a way to

1 accurately account for patient severity.

2 That is not the same in any way as end
3 of life desires, but it is related because those
4 issues are going to come up much more in these
5 severe strokes.

6 So, it's not a solution to a problem
7 that, as a measure developer, I've had for a long
8 time which is I would love for you to tell me
9 who, based on their condition when they come into
10 the hospitals makes end of life decisions? And,
11 we can't tell that.

12 So, we can't tell the difference
13 between patients who have had terrible aspiration
14 pneumonia because of poor care and ended up
15 ventilated and had mortality issues that were
16 related and hospice decisions that were related
17 to poor care versus based on the time they enter.

18 So, just a plug for hospitals to help
19 resolve this problem.

20 In the meantime, what we do for this
21 measure is we account for hospice on the day of
22 admission. So, if hospitals are proactively

1 identifying this, that's something we can do with
2 the claims measure.

3 So, that's an exclusion for all of
4 these measures, patients who are hospice prior --
5 any time in the prior year or on the day of
6 admission are out of the measure.

7 And, now, we have the ability at least
8 to account for how severe the stroke is which
9 helps us get better.

10 So, that's the story of this measure.
11 And, the true story is that it started as an EHR
12 measure because we didn't know how to get stroke
13 severity any other way. And, in the process of
14 developing it, a new ICD-9 code came forward, an
15 ICD-10, excuse me, which would allow us to do a
16 claims-based only measure.

17 And, I think you're right, Nancy, we
18 need the neurology committee and all of these
19 measures are going to the neurology committee in
20 January to tell us about validity. But, they're
21 all pretty strong measures based on my biased
22 viewpoint.

1 What you guys can reflect back to us
2 is, is the effort to start pulling the clinical
3 data out of the EHR and the NIH Stroke Scale out
4 of the EHR important enough to the stakeholder
5 community that leading with an EHR risk adjusted
6 model is more valuable or is it better to just
7 bring the claims data from the NIH Stroke Scale
8 in and stick with a claims-based measure which is
9 lower burden?

10 Although I heard well earlier comments
11 about the fact that it's not that these claims
12 measures are no burden.

13 CO-CHAIR WALTERS: So, the last
14 statement was clear about what they were looking
15 for out of this. So, as we vote on measures two,
16 three and four, I would say take into
17 consideration what you heard from Sean and from
18 Nancy.

19 Take into consideration that if you
20 vote three supports, take into consideration all
21 permutations of the vote on three different
22 measures and vote the way that you think

1 describes these situations.

2 But, you heard what they were looking
3 for. They were looking for direction about which
4 way to go with which one of these preferred.

5 MS. O'ROURKE: So, before we vote,
6 while Jean-Luc is cuing that up, could -- Kelly,
7 could you -- would you mind introducing yourself
8 and disclosing?

9 CO-CHAIR WALTERS: Yes, Kelly, we need
10 your disclosure.

11 MS. TRAUTNER: Hi, my name is Kelly
12 Trautner, I'm the Director of AFT Nurses and
13 Health Professionals. Do you need me to say
14 anything else? I have no conflict of interest
15 and no disclosures to make.

16 CO-CHAIR WALTERS: Start this out with
17 measure two.

18 MEMBER BENIN: So, I don't know, who
19 I'm going to ask to answer this, but the -- so,
20 if these metrics are based on ICD-10 codes, how
21 are they possibly even validated because nobody's
22 been using ICD-10 except for like a month?

1 So, they're not validated at all for
2 ICD-10? No, she just said it only became
3 possible because of ICD-10, sorry.

4 MS. BERNHEIM: So, great question.
5 So, the way these measures were developed,
6 because, as you note, we don't have the data, is
7 that we used registry data as a proxy and we
8 combined registry and claims data. So, we
9 created a data set that was made of claims data
10 with the NIH Stroke Scale as it came from the
11 registry data.

12 So, it shows that the measure works
13 with the NIH Stroke Scale, we can't say 100
14 percent that what they put in the registry is
15 what they would have put in the claims, but
16 they're pulling it from the same place as the
17 chart.

18 CO-CHAIR WALTERS: Okay.

19 DR. PHELAN: So, I have a question.

20 CO-CHAIR WALTERS: I'm sorry.

21 DR. PHELAN: So, number two is a
22 measure that is currently endorsed by NQF but has

1 some modifications? Which is the measure -- is
2 that the correct one that's in the IQR?

3 MS. BERNHEIM: Number two --

4 CO-CHAIR WALTERS: It's in
5 administrative claims.

6 MS. BERNHEIM: Right, and it is in
7 IQR. This is a refinement to one in IQR. It is
8 not NQF endorsed.

9 No, the current version of number two,
10 without the NIH Stroke Scale is used in IQR.
11 We're bringing to the MAP a revision of the
12 current measure that would incorporate the NIH
13 Stroke Scale and we reselected variables in that.
14 That is number two.

15 Okay, so three is a measure that uses
16 claims data to identify the cohorts with an
17 identical cohort and it uses claims data for the
18 outcome. It has an identical outcome but we used
19 a combination of data elements that could be
20 pulled from the EHR, primarily labs and vital
21 signs, and claims data and the NIH Stroke Scale
22 and we chose the strongest risk model. And that

1 new risk model has a combination of claims and
2 EHR data elements in the risk model.

3 Number three is similar to that, it
4 only uses EHR-based variables in the risk model.

5 CO-CHAIR WALTERS: And, you say that
6 again in number four, right?

7 MS. BERNHEIM: I'm sorry.

8 CO-CHAIR WALTERS: Yes, so let's go --
9 again, this has to be perfectly clear because
10 it's muddy enough already.

11 MS. BERNHEIM: Yes, and I really
12 apologize. I'm going to look at the screen while
13 I say this.

14 CO-CHAIR WALTERS: Describe two, three
15 and four again.

16 MS. BERNHEIM: Yes.

17 Measure number two is a refinement to
18 the current IQR measure. It is claims-based and
19 it includes the NIH Stroke Scale.

20 Measure three is a hybrid measure,
21 meaning that it uses both claims and electronic
22 health record data and it's risk model, the risk

1 variables come from both claims and electronic
2 health record data.

3 Number four is still considered a
4 hybrid measure in that the cohort is defined
5 through claims data, but it only uses elements
6 that would come from an EHR including the NIH
7 Stroke Scale for the risk variables in the model.

8 I apologize.

9 MEMBER ENGLER: Thank you, Ron.

10 So, I've just got one more question.

11 I apologize.

12 As the developer, if you list down
13 those three, could you tell me what the receiver
14 operator curve is for each one of those three and
15 whether or not it got better as you added EHR
16 data, please?

17 MS. BERNHEIM: I can't tell you them
18 off the top of my head. If you want to know the
19 actual numbers, somebody can pull them up for me.

20 I can tell you they are quite close
21 and that the third one, the one that has both
22 claims and EHR data is the strongest, but not by

1 much.

2 If you want real numbers, I can
3 provide them.

4 Number three.

5 CO-CHAIR WALTERS: Is there everybody
6 clear on what they're voting on?

7 Mitch?

8 DR. LEVY: So, and I assume when you
9 say EHR data it's been validated on across
10 platforms in the EHR?

11 MS. BERNHEIM: So, what we've been
12 able to do is validate all of the elements that
13 are in there except for the NIH Stroke Scale.
14 Hospitals do not standardly have the NIH Stroke
15 Scale now in a structured field. But, all the
16 other elements are part of what is CMS's four
17 clinical data elements.

18 CO-CHAIR WALTERS: Are we ready?
19 Okay, tee up number two.

20 MR. TILLY: All right. So, the
21 polling now open for Hospital 30-Day Mortality
22 Following Acute Ischemic Stroke Hospitalization

1 Measure, MUC 15-294, what we were calling number
2 two.

3 And the options are support,
4 conditional support and do not support.

5 All right, so the results are in, 24
6 percent support, 44 percent conditional support,
7 32 percent do not support.

8 So, the verdict is conditional
9 support.

10 CO-CHAIR WALTERS: And?

11 MS. O'ROURKE: Thanks, Ron.

12 So, again, this is a little bit of a
13 tricky one, but just to summarize what we've been
14 hearing, so I would say the conditions I've heard
15 are NQF review of this update, that CMS consider
16 which version of this measure to require at a
17 given time and to consider a phased approach to
18 not require three versions of the same measure in
19 the same program and for strong consideration
20 that from the patient perspective, mortality is
21 not the most meaningful outcome and to consider
22 moving towards measures that would address

1 patient goals and quality of life.

2 MEMBER FOSTER: So, while CMS will
3 certainly have to consider that, I was hoping we
4 were also going to hear that the NQF Steering
5 Committee would be asked to review all -- two or
6 three of the measures, how many CMS really wants
7 to advance simultaneously to make recommendations
8 about whether the juice is worth the squeeze, to
9 borrow a phrase from this morning.

10 MS. O'ROURKE: I think that makes
11 sense that the three would be submitted and
12 reviewed together.

13 CO-CHAIR WALTERS: Doing it too,
14 measure number three on your list.

15 MR. TILLY: The polling is now open
16 for Hybrid 30-Day Risk Standardized Acute
17 Ischemic Stroke Mortality Measure with Claims and
18 Clinical Electronic Health Record Risk Adjustment
19 Variables, MUC 15-1135.

20 The options are support, conditional
21 support and do not support.

22 So, the results are 17 percent

1 support, 54 percent conditional support, 29
2 percent do not support.

3 The verdict is conditional support.

4 CO-CHAIR WALTERS: And now, number
5 four. Conditions, sorry.

6 MS. O'ROURKE: I just wanted to
7 confirm that the committee would have the same
8 conditions for this measure as the previous.

9 CO-CHAIR WALTERS: Okay. The fourth
10 measure on your list, the third of this group.

11 MR. TILLY: Okay, the polling is now
12 open for Hybrid 30-Day Risk Standardized of Acute
13 Ischemic Stroke Mortality Measure with Electronic
14 Health Record Extracted and Risk Adjustment
15 Variables, MUC 15-1033.

16 Okay, and the results are 8 percent
17 support, 36 percent conditional support, 56
18 percent do not support.

19 So the verdict is do not support.

20 CO-CHAIR WALTERS: So, if anybody who
21 voted do not support would like to clarify why
22 they voted do not support for this one

1 specifically and may have voted either support or
2 conditional support for the other two. You know,
3 well, that's the only way I can word it, I mean,
4 you know. I don't see any takers on that.

5 MR. AMIN: Ron, it seems like maybe
6 that it might be related to Suzannah's comment
7 about the one that performed the most was the
8 hybrid or performed the best might have been the
9 hybrid measure and so, focusing there might not
10 be the best place.

11 CO-CHAIR WALTERS: So, happy for
12 feedback on that without identifying the --

13 MR. AMIN: Is that a fair feedback on
14 why it was do not support?

15 CO-CHAIR WALTERS: So, I hope that
16 gave you your direction and guidance.

17 MEMBER FOSTER: I know this is
18 supposed to be part of the NQF process anyway,
19 but if you -- when this comes up to the NQF
20 Steering Committee for review, if you could make
21 sure to include the comments that Sean and Mitch
22 and others made about concern that this is

1 perhaps not the right thing to be looking at, it
2 would be I think a useful thing for them to probe
3 on.

4 MS. O'ROURKE: Absolutely. Just to
5 step back for a second, we are continually
6 developing the processes and trying to improve
7 them of how we feed feedback from the MAP to the
8 Standing Committees and from the Standing
9 Committees to the MAP. So, we are working to
10 make sure that everything you say goes along with
11 these measures when they come along for
12 endorsement review. So, staff will be -- not
13 everything -- a summary of the most salient
14 points.

15 CO-CHAIR WALTERS: Greg?

16 DR. ALEXANDER: Thank you.

17 So, there -- so I came here from the
18 NQF Health Information Technology and Patient
19 Safety Panel that reviewed and made
20 recommendations for measures about EHR at patient
21 safety.

22 And, I kept that in mind as I was

1 thinking about this and I think it would be good
2 for NQF as they review these measures to think
3 about those measures in that panel that are now
4 being commented on as recommended measures
5 because they will affect, you know, some
6 underlying assumptions made about EHRs in this
7 measure.

8 CO-CHAIR WALTERS: Okay. We now move
9 to measure one in Calendar 3 which only has one
10 version of it, that's the good news, which is the
11 excess days hospitalization for pneumonia.

12 It was pulled by Nancy Foster and
13 Andrea. Nancy, would you like to go first?

14 MEMBER FOSTER: Okay. We're actually
15 fairly concerned about this measure and would
16 recommend do not support for it.

17 One, because of the need to look at
18 SDS for this. We believe that this would be
19 exclusively sensitive to the lack of other
20 resources in the community for care as patients
21 come back to the hospital if they have no other
22 source of care and think that that needs to be

1 carefully looked at.

2 And, you know, this measure in large
3 part should be duplicative of the existing
4 hospital readmission measure.

5 So, I wonder if we really need to have
6 this additional focus on the same issue.

7 So, those were our major comments.

8 CO-CHAIR WALTERS: Thank you.

9 Andrea?

10 MEMBER BENIN: I would agree with
11 Nancy's comments around the readmission. You
12 know, the readmissions are a portion of this and
13 the duplicative aspect of it.

14 The other piece of this for me is that
15 there are, I guess, last time around, there are a
16 couple of other excess days metrics that are
17 going to start to play out I think in '18 -- of
18 fiscal '18, the other two metrics.

19 And, to my mind, I think understanding
20 how those metrics perform and how they play in
21 this space is important before adding in new
22 ones. I think that adding in the new ones seems

1 to be before we're really added in the other ones
2 it seems a little bit in advance of things.

3 And so, understanding how the other
4 ones I think it's DMI and heart failure it looks
5 like, seeing how those actually play out once
6 they come into play is relevant for understanding
7 how these metrics really work.

8 MS. O'ROURKE: And, I did want to
9 clarify for the committee, MAP has reviewed this
10 measure previously. This is another one where
11 the cohort is being changed to include aspiration
12 pneumonia and sepsis. So, just to focus on that
13 this is another update for the pneumonia cohort
14 and we've reviewed this measure previously.

15 MEMBER BENIN: What did we say
16 previously?

17 MS. O'ROURKE: I believe we
18 conditionally supported it pending NQF
19 endorsement.

20 CO-CHAIR WALTERS: Lead discussant,
21 Greg?

22 DR. ALEXANDER: The only comment that

1 I have on this was that the three categories that
2 are going into the calculation of this measure
3 including PD treatment and release visits,
4 observation stays and readmissions are all pretty
5 distinct measures and observation stays are a
6 little bit of an ambiguous kind of a measure.

7 And so, I don't know that I felt
8 comfortable with how this complete
9 operationalized.

10 CO-CHAIR WALTERS: And, Heather?

11 MEMBER LEWIS: I have nothing to add
12 to the previous comments.

13 CO-CHAIR WALTERS: And Dolores?

14 MS. MITCHELL: I'm about to give
15 another one of my pious sermons.

16 But, I do so not with the expectation
17 that it will affect or should affect how anybody
18 votes on this, but again, one of those concerns
19 that I think tie us into knots sometimes over
20 some of these issues.

21 I have been supportive and am
22 supportive of the responsibility of hospitals,

1 particularly as they grow into larger delivery
2 system organizations where I think there is an
3 ongoing responsibility for what happens to the
4 patient not just inside the walls of the
5 hospital.

6 Nevertheless, I think it's not quite
7 fair to the hospitals to assume that they are
8 responsibility for picking up the societal
9 burdens that create those conditions in which
10 socio-demographic criteria are involved and
11 should be considered in some cases.

12 But, I think you don't want a hospital
13 responsibility creep and that's what I see
14 happening. To go without thinking about, well,
15 wait a minute, what are the other alternatives
16 and who's responsibility is it to deal with those
17 other alternatives?

18 I don't think that one can expect
19 hospitals to be in charge of solving poverty, war
20 and injustice. Those are our responsibilities as
21 citizens.

22 And, without sounding, you know,

1 without making the hospital -- I'm looking at you
2 for obvious reasons -- for once I'm on your side.

3 So, again, as an organization which
4 isn't just bean counters and has a social agenda,
5 I think we need to sort of start suggesting other
6 alternatives.

7 And that gets us into tough territory
8 because you may be talking about how we spend our
9 tax dollars and how decides.

10 Nevertheless, I don't think we ought
11 to be guilty of saying that everything is the
12 responsibility of the hospital because, at some
13 point, not only is it probably not fair, but it's
14 also outside of their area of expertise. They
15 are not social workers, they have some, but they
16 are not themselves basically social workers, they
17 are not economists who are responsible for
18 solving economic injustice.

19 And, I think, you know, those are the
20 kinds of issues that we as citizens need to be
21 thinking about over the next decade. Otherwise,
22 we're going to find ourselves asking the

1 hospitals to do things that they are neither
2 competent to do nor equipped to do nor is it fair
3 to ask them to do.

4 CO-CHAIR WALTERS: Does that take it
5 that encompasses most of your -- of these two?
6 Okay.

7 Michael?

8 DR. PHELAN: I think we have to look
9 at this measure as the next iteration of a
10 quality measure around pneumonia readmission.

11 So, I think this brings more clarity
12 of what actually is happening. Are these
13 patients showing in a outpatient setting? Are
14 they going to an ED or are they getting admitted
15 under observation?

16 So, we already have a readmission
17 measure for pneumonia. I think this just gets it
18 a little bit more granular and will provide data
19 for hospitals or hospital systems to better
20 understand what's actually happening with their
21 patients. Are they just showing up in the ED?
22 Are they coming back within two days and getting

1 readmitted to observation and then getting a full
2 admit?

3 So, actually, I think this is the
4 progress of quality measures that we've got. We
5 have a really, you know, raw one on pneumonia
6 readmissions. The addition of a couple extra
7 patients as CMS has mentioned before, patient
8 categories, the aspiration pneumonia and the
9 sepsis one, I don't think really changes the
10 measure in itself. It's more additive.

11 And, from that perspective, everyone's
12 going to be affected equally. So, if patients
13 have aspiration pneumonia or sepsis related to
14 that, I have a feeling that that's going to just
15 wash out in the end anyways.

16 But, I don't see it as Dolores sees it
17 as the ills of society being put upon us. I
18 actually just see this as a better measure for
19 hospitals to be able utilize to try to figure out
20 what actually is going on instead of just a raw
21 readmission measure.

22 DR. SULLIVAN: Yes, I agree with

1 everything you just said.

2 So, then I have a question for CMS.
3 If this were to happen, would you then drop the
4 readmission or what happens? Now you have two
5 measures or --

6 CO-CHAIR WALTERS: I knew you were
7 going to have a question so that's why I held
8 Pierre for answering -- dealing with everything.
9 What is the strategy about excess stays and
10 what's the answer to Ann Marie's question and
11 anything else you can think of?

12 DR. YOUNG: Right, so as several folks
13 have noted, we do have condition specific
14 readmission measures already in the IQR program.

15 The idea behind -- but those only
16 capture readmissions, but that doesn't -- is not
17 the entire universe of acute care following a
18 hospitalization. So, that's why the thought was
19 to try and capture that more fully by including
20 ED visits and ops in addition to readmissions in
21 a single measure.

22 The other big difference between this

1 measure and the readmission measure is that the
2 readmission measures are expressed as rates, so
3 readmission rates.

4 These are actually expressed as a
5 period of time because the thought was this would
6 be a more patient consumable, patient friendly
7 way to present the information about how much
8 time they are spending in acute care after a
9 hospitalization.

10 It is not intended to replace the
11 readmission measures. We think the readmission
12 measures provide very useful information and is
13 intended to compliment and expand the information
14 that's provided by that particular measure.

15 CO-CHAIR WALTERS: Are there any other
16 comments or questions for CMS?

17 Go ahead.

18 MEMBER LUTZOW: Yes, I think this is
19 a general question as to whether care transitions
20 are really appropriately funded within the system
21 and whether there's a real investment.

22 And, I know that we don't have the

1 right people here to answer that question, but it
2 seems to me that more could be done here if -- in
3 strengthening transitions if they were properly
4 funded.

5 Medicare, unless you're homebound,
6 there's no extension and reach into the home
7 really. I know there's some experimentation
8 about educational visits and so on, but I think
9 this whole area of readmission prevention is not
10 properly funded. And, we're trying to squeeze
11 the turnip to get more blood out of it but the
12 very structure is getting in our way.

13 And so, you know, as part of a review,
14 you know, these transitions, yes, we want them to
15 be sounder, but are we really structured to
16 support them? And I think not.

17 CO-CHAIR WALTERS: Thank you for the
18 comment.

19 Looking around, are we ready for a
20 vote? Okay.

21 MR. TILLY: The polling is now open
22 for Excess Days in Acute Care After

1 Hospitalization for Pneumonia, MUC 15-391.

2 The options are support, conditional
3 support and do not support.

4 The results are 23 percent support, 42
5 percent conditional support, 35 percent do not
6 support.

7 So the result is conditional support.

8 MS. O'ROURKE: So, for this one, I
9 would say the conditions we heard are NQF review
10 and endorsement as well as a particular attention
11 to socio-demographic factors in the risk
12 adjustment model and being cognizant that
13 measures like this test what really is the role
14 of the hospital and to be cognizant of what is a
15 hospital problem and what is society's problem.
16 I'll find a more elegant way to say that for the
17 report, Dolores.

18 DR. SULLIVAN: And, can we also maybe
19 also recommend that there be some thought given
20 to having one measure even if they are looking at
21 different things? It's like piling measure upon
22 measure I think is a problem and we talked about

1 parsimony, so maybe put that in, too, that
2 perhaps there should be some thought about not
3 just adding this one on top of the previous one.

4 That's all.

5 CO-CHAIR WALTERS: All right, are you
6 teed up? Is she going to make her presentation
7 now? This is from the 1140, yes, the measure
8 concepts. Right. It was on the --

9 MS. O'ROURKE: So, if none one pulled
10 the measure, we do not have to --

11 CO-CHAIR WALTERS: That's why I asked
12 again before we started that whether anybody
13 wanted to pull that. You did? Oh, it went by
14 all of us.

15 Hold that presentation a second.

16 Okay. It went right by us.

17 All right, the PSA, the composite
18 patient safety measure. Leslie, why would you --

19 MEMBER SCHULTZ: I just want to softly
20 disagree with the staff recommendation and take
21 it down a level to conditional.

22 The reason I do that is we strongly

1 encourage and support the changes in the recently
2 endorsed version which is a vastly improved
3 measure, to be sure.

4 But, version 6.0 has not been out. It
5 hasn't been used nationally yet. So, our
6 recommendation would be rather that the current
7 measure be replaced with this new version 6.0 in
8 the IQR program and only then after we gain
9 experience with this brand new measure,
10 essentially, should the measure then be moved
11 into other programs such as VBP and the hack
12 reduction program.

13 CO-CHAIR WALTERS: Thank you.

14 Greg?

15 DR. ALEXANDER: I have nothing to add.

16 CO-CHAIR WALTERS: Heather?

17 MEMBER LEWIS: Nothing to add.

18 CO-CHAIR WALTERS: Comment?

19 Mitchell?

20 DR. LEVY: But, it sounds like you're
21 not pulling the measure off of IQR.

22 MS. O'ROURKE: So, can I just clarify?

1 So, this would be for IQR, that could be a
2 condition that you could use because it's also
3 for VBP and Hacks. So, for IQR, it would go into
4 RQR the form, the most recent form, correct.

5 MEMBER SCHULTZ: And the most
6 currently endorsed version 6.0, yes, that that be
7 in IQR and then -- so it replace the current
8 version.

9 MS. O'ROURKE: Right. So, the
10 condition would be for a different program. So,
11 right now, you are in agreement of the staff's
12 recommendation which is full support for IQR?

13 MEMBER SCHULTZ: For IQR version 6.

14 MS. O'ROURKE: Yes.

15 CO-CHAIR WALTERS: Vote?

16 UNKNOWN PARTICIPANT: So, if
17 everybody's okay with it, we can leave it on the
18 Consent Calendar if we all agree with that.

19 CO-CHAIR WALTERS: For the --

20 UNKNOWN PARTICIPANT: I guess Leslie
21 rescinds her pull for IQR and we'll discuss the
22 conditions when we get to this for VBPN and Hack

1 RV.

2 CO-CHAIR WALTERS: Okay. Good. Now,
3 we can tee up for a presentation?

4 MS. LEMONS: Okay, so the purpose --
5 I'm Tara Lemons, sorry, with CMS one of the
6 measure leads.

7 And so, I'm here today to just give
8 you a little bit of -- some background
9 information on the episode-based payment measure
10 concepts under consideration for the hospital
11 value-based purchasing program which we are about
12 to embark upon.

13 The clinical episode-based payment
14 measures are designed to assess the resources
15 used for clinically related services provided in
16 the treatment of an episode of care.

17 These types of measures allows for
18 meaningful comparisons between providers based on
19 resource use and certain clinical conditions or
20 procedures.

21 The principle goal of episode cost
22 reporting is to encourage efficient patterns of

1 care. This creates identified opportunities for
2 care coordination and improved health care
3 affordability.

4 The Affordable Care Act requires
5 measures adopted into the hospital value-based
6 purchasing program to include efficiency
7 measures. And, currently, MSPB or the Medicare
8 Spending Per Beneficiary Measure is the only cost
9 measure in the program.

10 CMS is considering the role of
11 additional cross measures for the value-based
12 purchasing program, so we, therefore, would
13 appreciate the MAPs careful consideration of
14 various episode-based payment measures.

15 And so, the next slide, what we
16 provided for you is a chart for you to review
17 some of the episode-based payment measures that
18 will be discussed and some of the complimentary
19 quality measures that are in the value-based
20 purchasing program or another hospital quality
21 program.

22 And then, we also have measures to ---

1 and we can speak more directly to some of the
2 questions.

3 MR. AMIN: Can I ask a quick question?
4 I think Wei mentioned a bit earlier when we were
5 talking about the episode payer measures, if the
6 CMS and the measure developer can just clarify
7 whether these are as a result of an episode
8 grouper or they're just designed as episode-based
9 cost of care measures?

10 MEMBER HATLIE: I couldn't hear the
11 question.

12 MS. O'ROURKE: So, I can try to
13 paraphrase for Taroon.

14 If CMS could clarify if these measures
15 are the result of an episode grouper or they're
16 episode-based cost measures?

17 MS. SPALDING BUSH: Thanks.

18 Kim Spalding Bush from CMS.

19 So, these are episode-based cost
20 measures. I think the distinction really with
21 the terminology about episode grouper is
22 generally that those are episode-based cost

1 measures that are developed on the physician
2 side.

3 But it's a really similar construct
4 here where we're looking at clinically related
5 services when we define an episode as opposed to
6 one that is more of an all cost during a given
7 window after a condition or procedure.

8 MS. O'ROURKE: So, hearing no further
9 questions, at this time I can just begin by
10 giving you a brief overview of the hospital
11 value-based purchasing program.

12 This is a pay-for-performance program.
13 Medicare bases a portion of hospital
14 reimbursement on performance through the VBP
15 program. Medicare began withholding a portion of
16 its regular hospital reimbursements to form a
17 pool of VBP incentive payments. These are
18 increasing over time.

19 So, for fiscal year 2016, it's 1.75
20 percent. For fiscal year 2017 and the future, it
21 will be 2 percent.

22 Hospitals have a chance to either earn

1 a penalty or a reward through this program. So,
2 to be clear, that it's not a strict reward
3 program that you might not earn back what you put
4 in to fund the payment program.

5 And hospitals are scored on their
6 performance relative either to each other or to
7 their performance over time. So, there is a
8 component for improvement.

9 The goals of this program are to
10 improve health care quality by realigning
11 financial incentives and to provide incentive
12 payments to hospitals that meet or exceed
13 performance standards.

14 CO-CHAIR TRAVIS: Okay, well thank
15 you.

16 Since we're entering into a new
17 program, we will, operator, like to open up the
18 lines for public comment.

19 And, I would first like to see if
20 there are any public comments in the room?

21 PARTICIPANT: Thanks for the
22 opportunity to comment again.

1 At this time, on the slate of measures
2 that you have in front of you for the VBP
3 program, this particular comment doesn't relate
4 to any of the measures on the list, but it's a
5 concern that's been on the minds of our members
6 very much over the past couple of years.

7 And, that relates to the pain
8 management questions that are a part of the
9 HCAHPS survey that constitutes part of hospital
10 score on VBP.

11 And, just to be specific about what
12 I'm talking about, there are three questions that
13 get at pain management that ask whether patients
14 receive medicine for pain, whether they felt
15 their pain was well controlled during
16 hospitalization and whether hospitals did all
17 they could to control pain during the
18 hospitalization.

19 In raising the concern about this, I
20 want to be very clear that the AHA has been and
21 will remain a strong supporter of the HCAHPS
22 survey and of assessing hospitals on whether they

1 are adequately controlling the pain of patients.

2 That being said, there have been
3 important questions that have been raised in the
4 past couple of years about the interplay of these
5 pain management questions and the increasing
6 epidemic of prescription opioid abuse in this
7 country.

8 And, just to underscore just how big
9 a problem this is becoming nationally, the rate
10 of drug poisoning deaths related to opioids
11 quadrupled between 1999 and 2013. There were --
12 the CDC estimates that 44 people die each year as
13 a result of opioid overdoses.

14 So, where does the HCAHPS fit in here?

15 Our members have communicated to us
16 that the questions included on the HCAHPS
17 measure, and in particular, the question that
18 asks whether hospitals are doing all they can to
19 manage pain may create some unintentional but
20 potential pressures to prescribe opioids.

21 And, since opioids do carry just by
22 dint of what they are, the potential risk for

1 abuse, we are concerned about whether these
2 questions are creating these kinds of incentives.

3 We think responding to the opioid
4 abuse epidemic really does require a holistic
5 approach that involves patients, that involves
6 all stakeholders that have a hand in all of this.

7 And, we also know that there are
8 patients that benefit enormously through the use
9 of opioid pain relievers and we want them to
10 continue to be able to do so.

11 But, we also think that given the
12 severity of the epidemic, that it would be wise
13 to examine those questions and see whether they
14 need to be recrafted and to assess the potential
15 unintended consequences of it.

16 And so, we would encourage you to
17 think about making a recommendation to the CMS
18 about reexamining these pain management questions
19 in the HCAHPS survey, and while that happens, to
20 consider suspending the use of the pain
21 management questions from scoring hospitals in
22 the VBP.

1 Thank you.

2 CO-CHAIR TRAVIS: Okay, thank you.

3 Thank you very much.

4 And, just to kind of remind those who
5 are making public comments, we appreciate all
6 comments, but given the agenda that we have
7 today, we really need to focus the public
8 comments on the measures that are before us to
9 make a decision today.

10 There are other opportunities for
11 public comment around some of these issues such
12 as this and it is an important issue, but we need
13 to be able to get through these particular --

14 We will have opportunity for public
15 comment, a global public comment at the end of
16 the day today and at the end of the day tomorrow.

17 So, thank you for that and we
18 appreciate that thought process but if the others
19 can think about trying to keep your comments to
20 the measures under consideration for today, that
21 will help us get through it.

22 So, operator, would you please see if

1 there are any public comments under the measures
2 -- for the measures under consideration for
3 value-based purchasing program that are on the
4 line?

5 OPERATOR: Yes, ma'am.

6 At this time, if you would like to
7 make a comment, please press star then the number
8 one.

9 There are no comments at this time.

10 CO-CHAIR TRAVIS: Thank you, operator.

11 Okay, so we are going to go to our
12 first Consent Calendar which, as you will see has
13 four measures in it, all of which have been
14 pulled for discussion, so we no longer have a
15 Consent Calendar to approve.

16 They all are dealing with hospital
17 level risk standardized 30-day episode of care
18 payment measures.

19 One is for pneumonia, one AMI, one
20 heart failure and one for primary elective total
21 hip or total knee arthroplasty.

22 This reminds me a little bit of our

1 previous conversation where we tried to group our
2 thoughts into looking at the approach or the
3 payment model first and then addressing any of
4 the particular condition specific issues after
5 we've had that broader conversation.

6 I'm sure that that will probably work
7 out pretty well because Shelley is the one that
8 pulled all four of these measures.

9 So, if we, Shelley, can talk first
10 about pulling them from the payment methodology
11 approach and then later on if you have any
12 clinical specific issues, we can bring those up
13 when we get to the second part.

14 MEMBER FULD NASSO: Great, and I don't
15 have -- they're not clinically based, it's more
16 of the principle of, you know, I just wanted to
17 have a little bit more discussion about the
18 rationale for pulling these because it would be,
19 I guess, double-dinging.

20 And, you know, I think some of these
21 are really important in terms of, I guess my
22 question is, for discussion is, is there a value

1 in really important measures in pulling them out
2 in addition to having them as part of these other
3 measures.

4 And, obviously, the staff recommended
5 that you to not support them, but I think that
6 there is some value to having them reported
7 separately and included separately in the measure
8 in addition to as part of the more composite
9 measures.

10 CO-CHAIR TRAVIS: Thank you.

11 And, just to clarify, to be sure I'm
12 on the same page as you. Is part of your
13 discussion around the fact that the staff
14 indicated that it overlapped with the current
15 Medicare spending per beneficiary --

16 MEMBER FULD NASSO: Right.

17 CO-CHAIR TRAVIS: -- measure? Okay,
18 I just wanted to be sure in my own thinking.

19 So, thank you for that, Shelley.

20 So, we're now going to go to our lead
21 discussants.

22 David Engler?

1 MEMBER ENGLER: Thank you.

2 So, Marty and I drew the discussant
3 straw here. And, you know, when we started
4 looking at the measures themselves, there are now
5 four suggested measures to be added to the one
6 existing measure that's already out there on
7 Medicare beneficiaries spend.

8 So, there are four additional measures
9 to be added to this particular domain. The
10 domain in this value-based purchasing category
11 has 25 percent weight. So, it's significant.

12 I would also note for the committee
13 that three out of the four measures are
14 diagnosis-based. Okay? So, we're accumulating
15 costs across the episode of care for 30 days from
16 admission to 30 days later.

17 So, there is a cost accumulation
18 that's done in the calculation on it.

19 I would also draw the committee's
20 attention to the fact that there is the overlap
21 between the current one measure that's in there
22 which gave us some pause and we agree with

1 staff's assessment that that can cause a double,
2 triple or quadruple dinging effect if we were to
3 add these additional four measures to value-based
4 purchasing.

5 I will agree strongly with Dolores
6 that the issue now and there was just a great
7 study that was just featured in yesterday's New
8 York Times, that the issue is really about price,
9 much more so than particular cost or payment, at
10 least in the non-Medicare population.

11 The study showed that their analysis
12 which features very specifically on Medicare data
13 may not always lead to the right result. But, as
14 we do have markets out there that are dominated
15 predominantly by large hospitals and large
16 systems that have prices that will throw off the
17 average price considering in comparison to what
18 Medicare is showing on their data.

19 So, I just want to add that additional
20 feature because that's a brand new study that was
21 just released yesterday.

22 So, for both Marty and myself as

1 discussants, we agree with the staff's nonsupport
2 for these metrics given the fact that it overlaps
3 with the existing measure and given the fact that
4 since they are diagnosis-based, they don't add
5 any additional to the equation and may, in fact,
6 wind up penalizing hospitals even further double
7 and triple penalizing them because of the cost
8 variation.

9 And, one other fact is that
10 historically, I think this committee has looked
11 at this metric before and has said that we should
12 not over extend or add additional measures to
13 this one particular cost measure.

14 Thanks.

15 CO-CHAIR TRAVIS: Marty, do you have
16 any additional comments?

17 MEMBER HATLIE: Yes, I'm actually torn
18 about this measure. I do certainly agree with
19 David that I'm worried about double dinging. I
20 mean if this -- for a reporting program, it's
21 fairly easy for me to weigh in because I'm in
22 favor of more, faster, in general.

1 Here, I am worried about the impacts
2 on hospitals, especially the hospitals that
3 David's organization represents. I mean, I live
4 in Chicago. Hospitals there have not been
5 reimbursed for Medicaid since June. And there
6 are 600 hospitals that are just running on fumes.
7 So, I really get that.

8 The question here, I also know that
9 this is a major transformation vector for Obama
10 Care, for the Affordable Care Act. And, I want
11 to support the program, but I am concerned about
12 the double dinging that David mentioned as, you
13 know, maybe not being necessary if it's already
14 an incentive for hospitals to be paying attention
15 to these issues. Do we really need another set
16 of incentives?

17 So, that's where I am. I'm really
18 interested in hearing discussion from others here
19 because I don't really know how I'm going to vote
20 yet.

21 Thank you.

22 CO-CHAIR TRAVIS: Okay. So, this is

1 when we open it up to the full committee. Any
2 comments or questions?

3 Pierre?

4 DR. YOUNG: Thank you.

5 I just want to -- just teeing off of
6 what Tara presented earlier, we would also like
7 to hear the MAP's input. And, I think it's --
8 there's a grouping -- two groupings of resource
9 use measures under consideration with this
10 calendar and the second one.

11 One of the distinctions between them
12 is this particular set, they do have accompanying
13 quality measures. And so, that's, you know, an
14 issue that came up earlier in the discussions of
15 resource use measures for IQR.

16 So, we were also wanted to hear the
17 committee's feedback about, you know, if we were
18 to implement additional resource use measure into
19 the program, what kinds of resource use measures
20 would be appropriate?

21 Thank you.

22 CO-CHAIR TRAVIS: Okay, thank you.

1 Nancy?

2 MEMBER FOSTER: So, sorry, Pierre, I'm
3 not going to get at your specific questions, but
4 I have to say that it makes me nervous to think
5 about endorsing measures for use in a value-based
6 purchasing program before we've seen them in real
7 life in the IQR program.

8 That, in fact, I believe, in part
9 because I was part of the conversations, that
10 when Congress passed that two-step process, they
11 really meant for people to take a look at the
12 function of the measure when it got into the IQR
13 program, understand whether there were unintended
14 consequences as there can be from some measures,
15 understand whether there is an SDS -- a need for
16 an SDS adjustment or other kinds of things before
17 putting them into a program that tied measures to
18 money.

19 Which, you know, one can argue that
20 the money is not that much and, in some -- most
21 hospitals the VBP money isn't really moving a
22 whole lot around.

1 But, it's this notion that the
2 government is saying, we really, really want you
3 to focus on this one or this aspect of care
4 because we've included it in a payment measure or
5 a payment program.

6 So, I think we really need to think
7 about that as we bring measures to the MAP for
8 inclusion in a value-based purchasing program
9 that we really do need at least some experience
10 with it before this group can effectively comment
11 on whether it should be included or not.

12 CO-CHAIR TRAVIS: Pierre, can you
13 clarify that for me because on prior years,
14 serving on this work group, I guess I had
15 interpreted it that it did need to be in IQR
16 before it comes into value-based purchasing. So,
17 can you clarify that, please?

18 DR. YOUNG: Sure, and that's correct,
19 Cristie.

20 So, for HVBP, hospital value-based
21 purchasing programs, specifically, we have a
22 statutory requirement that the measure be

1 publicly reported in Hospital Compare for at
2 least a year so meaning it's in the IQR program
3 before it gets implemented into the HVBP program.

4 CO-CHAIR TRAVIS: So, are these
5 measures already lined up to go into IQR?

6 DR. YOUNG: So, right. So, these
7 measures are in IQR already.

8 CO-CHAIR TRAVIS: Okay. So, they are
9 already and have they been publicly reported or
10 do you know? And they have been publicly
11 reported?

12 And, is there some response to Nancy's
13 concern over how these measures have performed
14 since they are in IQR and have been publicly
15 reported? Do you have experience with these
16 measures in terms of their performance and what
17 you're learning from that and as to how then it
18 would fit into the value-based purchasing
19 program?

20 PARTICIPANT: Well, I was just going
21 to comment that this measure is -- has been -- is
22 on Hospital Compare, has been reported on. It's

1 on the list for the updated cohort.

2 So, I'm not sure if your question is,
3 Nancy, that you want them to go back through IQR
4 before they come to VBP with the updated cohort?

5 CO-CHAIR TRAVIS: Okay, thank you.

6 I get it now, maybe.

7 MEMBER FOSTER: And, when we get to
8 the second set, we can talk about whether they
9 every publicly appeared or not.

10 CO-CHAIR TRAVIS: Okay. So, in my own
11 mind, we were thinking about all of these
12 measures at once. When you say this measure,
13 you're talking about pneumonia, correct?

14 MEMBER FOSTER: Right, sorry.

15 CO-CHAIR TRAVIS: Okay, okay, I just
16 wanted to be on the right page.

17 MEMBER FOSTER: Well, actually heart
18 failure, AMI are also reported on the Hospital
19 Compare.

20 CO-CHAIR TRAVIS: Okay, so all three
21 are currently reported to the point that we know
22 like on pneumonia that we're looking at a

1 different version of that measure. It's not the
2 new version that's out there. I would assume
3 it's the existing version. Okay.

4 MS. HAYDEN: Hi, this is Megan.

5 So, the version that is under review
6 is the updated cohort for the pneumonia payment.

7 And, just to add on to what my
8 colleagues are stating, the pneumonia, AMI and
9 heart failure payment measures are already
10 reported on Hospital Compare on last year's rule
11 that went out, you were -- you could have seen
12 the GI and urinary tract infection payment
13 measures as well as the THA and TKA were just
14 adopted.

15 So, these have not been publicly
16 reported as of yet, but they will be in the near
17 future.

18 So, I hope that just provides a little
19 bit more clarification and I'm happy to answer
20 any more questions that you have.

21 CO-CHAIR TRAVIS: Thank you.

22 That helped me. I hope it helped

1 others.

2 Wei?

3 MEMBER YING: One comment on the cost
4 measure. I just actually, the comment on the
5 resource use measure, there are other measures
6 out there that basically take out the price as a
7 factor, basically standardize the price and it
8 becomes a sort of a utilization versus outcome
9 ratio measure.

10 I'm just curious, for CMS when they
11 develop -- when they think about resource use and
12 knowing the price is a factor in the total cost,
13 can they instead of bring the unit price into the
14 picture, but actually, you're just looking at the
15 frequency of the utilization and then pair it
16 with the outcome. That becomes more fair and
17 more reasonable for hospitals to look at. So
18 that's one comment.

19 And the other is, in the commercial
20 market, there is a quest for us and for consumers
21 to see is the condition specific or procedure
22 specific cost because they, as consumer, they

1 have the copay. They have the deductible. So,
2 they have to make these decisions. They can make
3 these decisions based on this information.

4 So, it becomes the transparency
5 becomes true for consumers to make these educated
6 selections in their where or what type of care
7 they should be given.

8 I'm just wondering for these type of
9 measures, from CMS point of view, you put it on
10 the public reporting. If a consumer looks at it
11 and they don't have those pressures under the
12 copay type of arrangement, what is tell the
13 consumers? What's the value of there for public
14 reporting?

15 CO-CHAIR TRAVIS: We'd be glad to hear
16 any comments that CMS wants to make.

17 This particular, and just to kind of
18 reorient myself here, but this particular
19 calendar is for the payment, is for hospital
20 value-based purchasing program.

21 So, it is in a payment program our
22 consideration of this at this point. These

1 measures are already in IQR at different levels
2 of having been publicly reported. But, they are
3 in IQR.

4 So, you know, certainly, we might want
5 to come back to that kind of question about the
6 value for IQR. But, they're already in that.

7 So, just kind of focusing on the fact
8 that now we're thinking about should they go into
9 the payment program.

10 Mitchell?

11 DR. LEVY: I'm going to ask another
12 question. So, it would help, if you're looking
13 for the committee to support the move from IQR
14 into VBP, it would be helpful to know what are
15 the data that should drive that move?

16 First of all, what do you -- what data
17 do you use to want to move it into VBP? And, is
18 it a bell curve? What are you seeing so that we
19 would have a sense of is it a valid -- has it
20 proved to be a valid measure and, therefore, we
21 would support it being in VBP?

22 I don't know if that's a clear --

1 CO-CHAIR TRAVIS: Pierre?

2 DR. YOUNG: So, thank you for the
3 questions.

4 So, I think when it comes to, this
5 sort of references back to, I think, Nancy's
6 question when we first opened thinking about, you
7 know, what measures are appropriate for any
8 particular program. I know those are made on a
9 program by program basis.

10 The way we look at HVBP, we certainly
11 don't put every measure that's in IQR into HVBP.
12 That would not be appropriate as there are like
13 70 measures in IQR.

14 But, we want as parsimonious a set of
15 measures as possible in HVBP that reflect the
16 priorities that we have identified as we
17 discussed before including patient safety,
18 resource use, clinical care and care
19 coordination. And that fit within the national
20 quality strategy.

21 We do look at -- want to use measures
22 that we believe add value to the program as a

1 payment program that stimulates additional
2 quality improvement by providers. Meaning that
3 there is variation in care or variation in the
4 quality of the providers in that measure, that we
5 believe that there are no significant unintended
6 consequences from using that measure.

7 But, that being said, you know, new
8 information emerges as we gain more experience
9 with the measure in a program. And, we certainly
10 are receptive and are always looking for feedback
11 as those experience and feedback on those
12 measures that we use in our programs emerge.

13 In terms of the question about sort of
14 assessing utilization versus price or cost, I
15 mean I think that's -- we appreciate that
16 feedback. Certainly, there is a statutory
17 requirement which for a resource use measure in
18 hospital value-based purchasing, so that's why we
19 have the MSPB measure currently in the program.

20 But, it is definitely an interesting
21 thought to sort of take out the price and really
22 focus on the utilization.

1 I think there is this bigger question
2 that I think many folks are struggling with which
3 is how you assess value in health care which is a
4 difficult question to struggle with. And, I
5 don't know that anybody -- any single person has
6 the -- has figured that out yet but certainly
7 there is this sort of idea of quality and
8 price/cost and perhaps sort of outcomes as well
9 in how you sort of factor all of those in in sort
10 of assessing value.

11 But, those are, right now, the
12 measures we have for utilization look at resource
13 use in terms of cost but also we have
14 utilizations such as, you know, readmissions and
15 other types and other measures.

16 CO-CHAIR TRAVIS: David, is your card
17 still up?

18 MEMBER ENGLER: Yes, thank you.

19 So, I would strongly suggest, and I'd
20 love the opportunity to engage in the
21 conversation about looking further into price in
22 particular. So, I'm really heartened to hear

1 that CMS is interested in looking at that as
2 well.

3 The issue of the overlap between these
4 four measures relative to the existing measure
5 continues to sort of plague me. And, I think it
6 historically when it was brought up before in
7 front of MAP, there was this issue of if you are
8 double-dipping that we were responding to, and
9 perhaps the staff is responding to as well.

10 So, I wonder if you could give us a
11 little bit more clarity if you've looked at --
12 I'm sure you have -- if you've looked at this,
13 given that you have AMI, heart failure and
14 pneumonia as three of the highest volume drivers
15 in Medicare payment, given that you have those
16 three in these separate measures, are we really
17 going to be picking up more cost variants or are
18 we truly duplicating?

19 So, I guess I'm trying to get to
20 whether or not you can validate the assumption
21 that at least this person here is operating under
22 that there is a lot of duplication and potential

1 multiple penalties because of adding these
2 additional measures to VBP?

3 Thank you.

4 CO-CHAIR TRAVIS: Any response,
5 Pierre?

6 DR. YOUNG: I mean, we have heard from
7 stakeholders before about desire for -- and I
8 think there are people on both sides, I think
9 we've heard that there are concerns about overlap
10 as we've discussed here.

11 We've also heard a desire for
12 additional sort of granularity that we find a
13 little more condition-specific procedure,
14 specific measures.

15 So, that's why we wanted to bring this
16 forward and wanted to get that input from the
17 group.

18 CO-CHAIR TRAVIS: Okay, Ron?

19 CO-CHAIR WALTERS: Just trying to make
20 sure I have my facts straight here.

21 So, the first three measures are
22 endorsed and have been in IQR and they're coming

1 up for value-based purchasing. Okay, I think
2 that I get.

3 Then, knee one, the knee and hip one,
4 is scheduled to go in IQR, has never been
5 endorsed, never submitted for endorsement and was
6 submitted for value-based purchasing. That's
7 what I'm looking at here.

8 And, I mean I didn't think that was
9 the way it was supposed to go.

10 Now, I understand you have a knee and
11 hip program now, so it'd be darn nice to have an
12 endorsed measure that goes with that. But, it
13 seems to me that, again, for statutory purposes,
14 they should go through IQR -- they should be
15 endorsed, they should go through IQR then, after
16 being in IQR should go to value-based purchasing.

17 And, yet, the knee and hip one is
18 already slated for -- it says for IQR for 2018's
19 measure set.

20 Could you explain some of that?

21 MS. HAYDEN: Hi, Ron, Megan Hayden
22 here.

1 So, we would, of course, follow the
2 statute and understand that the measure is not
3 being moved into VBP until it's publicly been --
4 it's been publicly reported on Hospital Compare
5 for one year. We would definitely follow that.

6 This is just a request for MAP to
7 weigh in on the measure concept for HVBP and that
8 would be the purpose.

9 And, it is -- and Suzannah can correct
10 me if I'm wrong, but it is slated for interest
11 submittal for an open project or has been
12 submitted at this point, I'm not sure. Suzannah
13 could probably state whether it has at this
14 point.

15 But, that's just to provide a little
16 bit more clarification.

17 MS. BERNHEIM: We're just waiting for
18 a project. The measure is ready, but NQF, as
19 efficient as they are, can't evaluate every
20 measure all the time. So, we're just waiting for
21 the hip and knee project to bring it forward.

22 CO-CHAIR TRAVIS: And, just one more

1 clarification for me. There is a pneumonia
2 hospital level risk standardized 30-day episode
3 of care payment measure in IQR, but this one that
4 we're thinking about today, this is the one that
5 has the updated or changed, broadened
6 specifications to bring in the other pneumonia
7 cases that are associated with aspiration and
8 sepsis.

9 So, it's not the one we're looking at
10 here is not the exact same one that's been on --
11 in IQR and on Hospital Compare. It is the same
12 one we thought about in an earlier program for
13 IQR.

14 MS. BERNHEIM: Yes.

15 CO-CHAIR TRAVIS: So, I do want to --
16 so two and three that are on here, the specs
17 aren't changing from the IQR to value-based
18 purchasing, but the specs are changing on one
19 from what's currently in IQR into value-based
20 purchasing.

21 So, I'm hoping that I got that right.
22 I see a lot of nodding heads. I'm getting

1 affirmation from my colleagues here. But, it can
2 be a little confusing.

3 And, number four has not gone through
4 NQF endorsement at all. And, is slated for IQR
5 in 2018.

6 So, do we have our facts right? Okay.
7 I just wanted everybody to at least have the same
8 --

9 MS. HAYDEN: Okay, let me see if I can
10 answer all of your questions.

11 CO-CHAIR TRAVIS: Okay.

12 MS. HAYDEN: So, the measure that you
13 are looking at for VBP, the pneumonia payment
14 measure, is the updated cohort. It is the one
15 that you just reviewed for IQR. This is the
16 version that we would prefer to go into VBP but,
17 of course, we understand that it would have to be
18 publicly displayed on Hospital Compare for one
19 year prior to that.

20 And then, I think the second question
21 you're asking whether number four is slated for
22 NQF endorsement. That is correct.

1 And, I apologize, was there an
2 additional question?

3 CO-CHAIR TRAVIS: Just that it's also
4 the hip and knee is -- has already been approved
5 to go into IQR in 2018, I think it's --

6 MS. HAYDEN: Okay, sure. Let me also
7 just comment on that.

8 So, in the rule that was published
9 last year, we did adopt this measure for IQR. I
10 believe this one is going to be publicly reported
11 in July of '17, at least that was -- that is the
12 plan at this current point in time.

13 So, you are correct, everything on the
14 MUC list for VBP has been adopted for IQR and it
15 is -- some of them are pending public reporting.
16 Those would be the ones that were adopted in rule
17 last year for IQR.

18 CO-CHAIR TRAVIS: Okay, I think we've
19 got it.

20 MS. HAYDEN: And, AMI and heart
21 failure and pneumonia have all been publicly
22 reported on Hospital Compare already. Those are

1 the ones that have been and, again, that
2 pneumonia would have been the older cohort. So,
3 we would have had -- we will have to wait for the
4 updated cohort to be publicly displayed.

5 And, I know that's all very confusing
6 and hopefully everyone is on track now, but if
7 not, I can repeat myself.

8 CO-CHAIR TRAVIS: So, but you did say
9 something I think that was very important around
10 the pneumonia measure is that assuming everything
11 moves forward with the new specifications, that
12 would be publicly reported on Hospital Compare
13 one year, collected and reported that way under
14 the new specs prior to moving into a value-based
15 purchasing?

16 MS. HAYDEN: That is correct. And,
17 again, that was the measure that we just reviewed
18 so that version of the measure has not been
19 adopted into IQR at this point. So, we would
20 have to wait on that.

21 CO-CHAIR TRAVIS: Okay, thank you.
22 That was helpful to me.

1 So, let me go back and see where we
2 were.

3 Andrea, you were next.

4 MEMBER BENIN: You know, I think
5 Mitchell brought up a good point and something
6 that I think we have struggled with as a group
7 over the years here with these programs.

8 And, I don't know whether this is a
9 task for our group or whether it's a task for
10 CMS, but the, you know, we don't have agreed upon
11 principles for what necessarily moves things from
12 one program to the next.

13 I mean, I think we've heard a couple
14 of different things bantered around, right?
15 Mitchell says, well, the distribution of the data
16 or we have, you know, understanding what the IQR
17 performance looks like for a year or we have, you
18 know, not double-dipping as principles that any
19 one of us might adhere to.

20 But, we don't have an overarching, you
21 know, comprehensive mental model that we all
22 share about how to think about these things.

1 And, I think that that presents itself with some
2 struggle.

3 And so, some kind of a framework that
4 says, you know, this is our mental model for what
5 moves things from one program to the other would
6 make this feel a little more cohesive and a
7 little like every time we do this, it's like this
8 scattershot thing and then kind of you just vote
9 because you got tired.

10 And, I think that there's -- and I
11 think we do this like kind of year after year and
12 these things move from one program to another
13 without any sense of rhyme or reason. Perhaps
14 there is rhyme or reason, but I'm sure CMS spends
15 a lot more time thinking about it than we do.

16 But so, I have, as part of that
17 comment, I would also say that, in my mind, it
18 being in IQR for a year and so people to
19 understand it, should be more than just it's on
20 IQR for a year, check the box, move it to VBP.

21 The concept behind that, for me, would
22 be that it's on IQR for a year so we could review

1 it. So, I ask that there's a little bit of time
2 so that you could -- we would make this decision
3 informed by being on IQR for a year, that seems
4 to me the spirit of that concept, not like let's
5 just check the box and move it through, because
6 you know, we can just fill out a spreadsheet up
7 to 2021 at this point.

8 And, so, I just think that a little
9 bit of attention to thinking about a more
10 comprehensive mental model would make this
11 process feel more satisfying and potentially
12 build a better product.

13 And, I don't know whether that
14 information really comes from CMS, comes from
15 NQF, comes from us as a committee, I don't know
16 how we think about these things.

17 CO-CHAIR TRAVIS: Mitch?

18 DR. LEVY: It's kind of a natural
19 follow up to Andrea's question. Can you help me
20 understand how -- so, some of these measures are
21 already in IQR, some of them are about to go into
22 IQR. And, yet, you're asking for all of them,

1 for us to support going to VBP. And, yet, and
2 you don't do that with all the measures.

3 So, I feel it's the same question,
4 like some of them you're looking for the go ahead
5 in IQR and go to VBP. And some of them are
6 already in IQR but we're not reporting it.

7 So, I just would like a little more
8 insight into how are you -- what's driving your
9 request, all of them at once, to go into VBP as
10 opposed to waiting until they've been in IQR and
11 you have a sense of it and then making the
12 request?

13 DR. YOUNG: Right, so in terms of
14 implementation, we would not be able to implement
15 a measure into HVBP until it had been publicly
16 reported for a year in IQR.

17 But, I think what I hear from the
18 comments from the MAP is suggestion to CMS that,
19 you know, we bring forward measures for IQR and
20 then wait until if we want to consider them for
21 HVBP to bring them back at a later point once
22 they've been publicly reported. That's what I've

1 been hearing from folks.

2 CO-CHAIR TRAVIS: I think you're
3 definitely hearing that.

4 But, I will also -- so I want you to
5 -- yes, I confirm that you've been hearing that.

6 But, I guess -- and I'll take my chair
7 hat off for a moment -- I guess where I struggle
8 with that, because that sounds rational to me and
9 I understand why we would do it that way, what I
10 struggle with is how far out in advance we have
11 to -- you have to, actually, think about when
12 measures will come on.

13 And so, if things are not publicly
14 reported for a year until 2018 or 2019, and then
15 we've got to take it and we've got to look at it
16 and see whether or not it makes sense to put it
17 into hospital -- into the value-based purchasing,
18 I mean we are talking like 2020, 2021.

19 I mean I'm just -- and I think where
20 I struggle with that is that that's a long way
21 away from now to being able to use what I think
22 are some pretty strong levers that CMS has to

1 help see improvement.

2 And so, you know, what I think would
3 be helpful to me is to understand maybe it's in
4 your backpack, this is the way I would look at
5 it, that it's in your backpack and you can use it
6 but that there'd be some way to say, it's not
7 ready to be used yet, you know, or the data shows
8 there's not as much variation as we thought there
9 was going to be so it doesn't make any sense to
10 come into the program.

11 And so, I just struggle with how long,
12 if we do a linear approach to all of this, it
13 just pushes it so far out that we miss lots of
14 opportunities where there are improvement
15 opportunities.

16 So, you know, trying -- if you can
17 help me understand kind of -- and it goes back to
18 what Andrea was saying, having a mental framework
19 and, you know, how do things progress through
20 this, but don't take 50 years to get where we
21 want to go.

22 DR. YOUNG: So, thank you, Cristie,

1 because I think that is one of the issues we
2 struggle with on the I think implementation side
3 because of the way the HVBP program is set up,
4 there is a scoring methodology and there are
5 benchmarks that need to be set and met in order
6 to earn or earn potential incentives or to -- or
7 not incentives, but essentially, there are
8 benchmarks which need to be set. We need to be
9 able to provide notice of those benchmarks in
10 advance before we actually then score those
11 measures and count them in the performance score.

12 But, when you play that out, that does
13 put us out to 2021 even though, you know, we're
14 now in 2015.

15 But, Megan, do you have any additional
16 details that you want to share about sort of the
17 time line issues that we face?

18 MS. HAYDEN: No, I mean I think care
19 really has captured it and we do have to, of
20 course, propose a good ways out.

21 And, your input does provide us with
22 that ability to plan and to, you know, factor in

1 all the time lines that we work with.

2 So, that is why we have requested this
3 input early in and that is helpful to us. I mean
4 I think that also requesting you to look at, you
5 know, multiple payment measures at the same time
6 is really trying to get your input on, you know,
7 if you like a particular type of measure or not,
8 it just it does help us moving forward with the
9 program and for planning purposes.

10 So, that is kind of why we are asking
11 it even though we know that some of these
12 measures have not been displayed on Hospital
13 Compare, we're just trying to provide you with an
14 overall picture of the measures that, you know,
15 could be potentially put into the program.

16 And so, having that input with a whole
17 picture would be helpful to us.

18 CO-CHAIR TRAVIS: Okay.

19 Nancy?

20 MEMBER FOSTER: So, Cristie, if I can
21 bring this back to a discussion we had in the
22 early fall or late summer, whenever we had the

1 conference call.

2 I think Andrea's comments about having
3 a mental model make a whole lot of sense and
4 would be very helpful to us.

5 But, it also speaks to the need, I
6 think, here to get more input up front about what
7 should be produced that would then roll into
8 programs. And, for me, the vital signs report
9 from the IOM, back when it was still IOM,
10 provides some of that direction which could be
11 further illuminated by a group such as this with
12 a coordinating committee of the MAP.

13 But, I kind of end up where, I think,
14 some people report they are this election season,
15 which is a really -- these are the things I get
16 to choose from? You know, where's the really
17 good choice?

18 And, so helping all of us to think
19 through and to get input from particularly
20 patients, consumers and other payers as well as
21 providers, but around, you know, what is it we
22 really want to be measuring? How do we get

1 there? And, you know, get us all teed up so that
2 when things are coming to us for the IQR and then
3 for the VBP or other programs that we understand
4 the purpose and how it links to not only what's
5 going on in the hospital programs, but what's
6 going on in physician and the post-acute care and
7 the other programs because there's this sort of
8 coordinated purpose driven set of measurement.

9 And, I'll get off my soapbox.

10 CO-CHAIR TRAVIS: Thank you, Nancy.

11 Michael?

12 DR. PHELAN: Just, you know,
13 piggybacking on what Cristie had said, it's
14 getting late.

15 Not even a mental framework, but just
16 a framework for taking and, you know, we're
17 saying that some of these are good for IQR. The
18 next step should probably be the responsibility
19 of the MAP to say, okay, it's passed the IQR,
20 we're going to request data from CMS. Show us
21 what it is and why you think it's still valuable
22 to move into VBP.

1 I think we do a disservice by kind of
2 piggybacking on all these things hoping, you
3 know, well, if it's good for the IQR for a year
4 then it's just fine.

5 So, I think having that idea from NQF
6 at least and the people in NQF to say, hey, we
7 submitted this for an IQR, we really shouldn't be
8 piggybacking on it three years from now, we
9 should really be looking at that data. And, it
10 may not be this group, you know, it may be new
11 members, but people should say, oh, they
12 submitted that for the IQR back in 2015, oh, it
13 was a good idea. Well, what does the data show?
14 And is it valuable data? Does it make sense to
15 put in the value-based purchasing not just to be
16 this kind of follows down a path of, you know,
17 least resistance so to speak?

18 CO-CHAIR TRAVIS: Thank you.

19 Marty?

20 MEMBER HATLIE: I mean, I saw a rhyme
21 or reason to these four measures. I mean they
22 all -- I think they were high prevalence, the

1 measures seemed really well developed.

2 I mean, I think there is something to
3 a plan there. But, again, if we don't have it,
4 if there's not a roadmap or something that we can
5 see, then I think we get into the situation that
6 you mentioned, Cristie, and that is just kicking
7 this down the road for years and years and years
8 and we don't want that.

9 So, I think a plan, a map, a
10 framework, something like that would be really
11 helpful to be moving things like this forward.

12 CO-CHAIR TRAVIS: Brock?

13 MR. SLABACH: Well, I think that
14 clearly the MAP has some previous conversations
15 advocating keeping the parsimonious set of
16 measures for the VBP program.

17 And, to that end, I'm wondering why we
18 couldn't consider a family of measures around
19 this type with a composite being that the top
20 line and then the dropping down to the various
21 disease specific points.

22 And then, have it one measure but with

1 three or four different roll ups into that one
2 measure? Because then it's not double-dinging or
3 triple or quadruple-dinging hospitals, number
4 one.

5 And, number two, it gives me, as a
6 manager of a hospital, an understanding better
7 about what the problems are that I'm addressing
8 in my facility and where I can make improvement.

9 And so, I think that kind of ingenuity
10 I think is what I would like to see applied to
11 these kinds of measures.

12 CO-CHAIR TRAVIS: I'm trying to
13 remember, I think there's a readmission measure
14 that kind of does it that way where you actually
15 can see -- it's the all cause, actually. I think
16 you can actually see down at the clinical level
17 so that it's actionable for the hospitals but
18 it's a build-up measure.

19 So, thank you for your thoughts on
20 that.

21 Taking off my chair hat and asking one
22 other question to the data point which actually

1 we have addressed that in prior MAPs where we've
2 wondered if things were topped out, whether there
3 is variation.

4 In other words, if all these were to
5 move into the program, would it really help the
6 program from that perspective?

7 And, I think you alluded to this
8 earlier, but for any of these four measures, is
9 there data such that we realize there is an
10 opportunity for improvement?

11 In other words, there's a gap in the
12 performance and that there is a performance
13 variation across facilities that would make it
14 something we would want to incentivize
15 improvement around?

16 I mean, if every is already performing
17 at the top of their game, it's not really, from
18 my person perspective, appropriate for this type
19 of a program because we want to incentivize
20 improvement.

21 So, I don't know if you all know that
22 data or the results. I think you alluded to it

1 earlier, but if you do, if you could share that
2 with us, I think it would be helpful.

3 DR. YOUNG: So, that's a great
4 question and certainly it's something that we
5 look at not only when we develop measures, but
6 also when we consider potentially implementing
7 them, what is the opportunity for improvement?

8 It's also, you know, one of the things
9 that the CDP process looks at, too, when they
10 consider endorsement.

11 And so, the measures -- three of these
12 measures have already been through endorsement,
13 so that have been through that scrutiny and we're
14 waiting for another -- the project to open to
15 submit the hip and knee, so it will get that
16 scrutiny, too.

17 But so, we believe that there is
18 opportunity. There is variation and opportunity
19 for improvement.

20 CO-CHAIR TRAVIS: I do think it would
21 be helpful if we start making a list of things
22 that next year would be helpful would be to bring

1 the data.

2 And, we've done that a couple of times
3 in the past, but I do think that, especially when
4 we get into these programs, we want -- I mean
5 marrying the right measure with the right program
6 is critical if you want to have the desired
7 result of improvement.

8 So, just maybe file that away in your
9 head that it might be helpful to have some of
10 that data next time.

11 Okay, I don't --

12 MS. O'ROURKE: Cristie?

13 CO-CHAIR TRAVIS: Yes?

14 MS. O'ROURKE: Can I just clarify,
15 there is data here. If you go into the
16 preliminary analysis, you can look at a high
17 value measure. They do provide the range on the
18 episode of care and it ranges from 12,000 to
19 37,000 and they provide the mean, and they do it
20 for all of the measures.

21 CO-CHAIR TRAVIS: Well, thank you very
22 much. Another way for us to remember that we

1 need to use all of the resources that are at our
2 fingertips.

3 So, maybe while I'm trying to get us
4 to a vote, you all can be taking a look. And,
5 you get to that off of the electronic guide
6 direct.

7 Okay, thank you, thank you for that.

8 Okay, I don't see any other cards up.
9 So, before we go to a vote, though, we did
10 indicate that if there were any clinical specific
11 comments or questions that people had that we
12 would give you an opportunity to bring those up
13 as well.

14 So, does anybody have anything
15 specific for pneumonia, AMI, heart failure or hip
16 and knee?

17 Okay, well, seeing none, then I think
18 we will tee this up for a vote.

19 MR. TILLY: The polling is now open
20 for Hospital Level Risk Standardized 30-Day
21 Episode of Care Payment Measure for Pneumonia,
22 MUC 15-378.

1 The options are support, conditional
2 support and do not support.

3 And the results are 31 percent
4 support, 15 percent conditional support, 54
5 percent do not support.

6 So, the verdict is do not support.

7 The polling is now open for Hospital
8 Level Risk Standardized Payment Associated with a
9 30-Day Episode of Care for Acute Myocardial
10 Infarction, MUC 15-369.

11 The options are support, conditional
12 support and do not support.

13 The results are 27 percent support, 15
14 percent conditional support, 58 percent do not
15 support.

16 So, the verdict is do not support.

17 The polling is now open for Hospital
18 Level Risk Standardized Payment Associated with a
19 30-Day Episode of Care for Heart Failure, MUC 15-
20 322.

21 The results are in, 27 percent
22 support, 8 percent conditional support, 65

1 percent do not support.

2 So, the verdict is do not support.

3 The polling is now open for Hospital
4 Level Risk Standardized Payment Associated with
5 an Episode of Care for Primary Elective Total Hip
6 and/or Total Knee Arthroplasty, MUC 15-295.

7 MS. SHAHAB: We need two more votes
8 please.

9 MR. TILLY: The votes are in, the
10 results are 19 percent support, 12 percent
11 conditional support, 69 percent do not support.

12 So, the recommendation is do not
13 support.

14 CO-CHAIR WALTERS: Okay, what we're
15 going to try to do before a short break is to get
16 the Calendar 2 done.

17 There are three measures, as you can
18 see and that they are all episode-based payment
19 measures. So, as we have done, we'll talk about
20 the concept in general and then we'll go into any
21 specific clinically relevant issues.

22 They were all pulled by Andrea and/or

1 Shelley. So, Andrea, would you talk about your
2 pulling of the three measures under Consent
3 Calendar 2?

4 MEMBER BENIN: I'm just thinking, I
5 didn't really realize -- I don't know what the
6 staff recommendation was for these metrics.

7 CO-CHAIR WALTERS: Do not support.

8 MEMBER BENIN: Do not support, okay.

9 I will support the do not support.
10 Sorry, I thought that all the Consent Calendars
11 were all supports.

12 So, anyway, I will support the do not
13 support. I feel extremely strongly that these
14 are in IQR for 2019. We won't see the metrics
15 until then.

16 There's high likelihood when I went
17 through the details of these measure sets, we
18 could end up penalizing places that have more
19 severity when you look at the different, you
20 know, the cellulitis.

21 When cellulitis is not cellulitis is
22 not cellulitis, when you look at the list of

1 codes that are on there, it's quite a range of
2 like, you know, two cellulitis to, you know,
3 severe massive, really bad cellulitis.

4 And so, the costs are going to be very
5 dependent on the type of cellulitis and what is
6 going on.

7 And so, I did not feel at all that for
8 any of these three metrics that it was
9 appropriate to move them into a payment program
10 until we had really watched them play out in a
11 more of a just understanding of the way first.

12 So, that's what it was and I'm real
13 sorry I pulled them out now that I realize the
14 staff had already said do not support.

15 DR. PHELAN: Can we revisit that if
16 the Consent Calendar is all do not support? Can
17 we -- it's not that? Okay.

18 MS. O'ROURKE: Sorry, yes, for these.
19 I thought you meant in general. Yes, with these,
20 it's all do not support.

21 DR. PHELAN: No, but if it's all do
22 not support, can we -- and none of these are

1 going to be pulled out, so I don't want to pulled
2 it out and say that we --

3 CO-CHAIR WALTERS: It would have been
4 nice if nobody had pulled any out.

5 Shelley, would you comment about your
6 pull out?

7 MEMBER FULD NASSO: I pulled it for
8 the same kind of discussion that we just had so I
9 can -- if we can rescind our pulling it out, I
10 would do that.

11 DR. PHELAN: And then, the Consent
12 Calendar vote would be for do not support,
13 correct?

14 CO-CHAIR WALTERS: You're exactly
15 correct.

16 DR. PHELAN: I may save you some time
17 here on that. I mean, unless there's someone who
18 had one of these pulled out and wants to discuss
19 it, just a thought.

20 CO-CHAIR WALTERS: The two people that
21 have done that have withdrawn. So, does anybody
22 -- thank you.

1 Does anybody else wish to pull any of
2 these measures out of the Consent Calendar which
3 is do not support?

4 Okay, I might mention, none of the
5 measures are endorsed.

6 Okay, that was a very quick Consent
7 Calendar.

8 Short break, I mean like five minutes.
9 That means ten minutes, I know.

10 (Whereupon, the above-entitled matter
11 went off the record at 3:30 p.m. and resumed at
12 3:40 p.m.)

13 CO-CHAIR TRAVIS: Okay. We're going
14 to go on and get started. And now we're looking
15 at Consent Calendar 3 for Value-Based Purchasing.

16 And just a couple of housekeeping
17 items beforehand. Unfortunately LaDonna was not
18 able to be with us. So, one of our lead
19 discussants won't be here.

20 Jeff is our other lead discussant.
21 But because we've been delayed so significantly
22 on the time from when this was supposed to come

1 up, Jeff does have to step out at 4:00.

2 So, we're going to -- wherever we are
3 in the process, if he hasn't had an opportunity
4 to make his comments, we will just kind of stop
5 and let him make his comments before we proceed.

6 And I'm sure you all will appreciate
7 that. And we'll do the same for you under any
8 similar circumstances.

9 So, these are three different
10 measures. And so, we're going to take them one
11 at a time.

12 And they've all been pulled from the
13 Consent Calendar. So, they're all up for
14 discussion and for a vote on each measure.

15 So, let's start out with Measure
16 Number 1. Which is the ACS-CDC Harmonized
17 Procedure Specific Surgical Infection Outcome
18 Measure.

19 And this was pulled by Nancy. So,
20 Nancy?

21 MEMBER FOSTER: Sorry, getting myself
22 reorganized here. So, we have discussed this

1 measure for inclusion in the IQR Program. And I
2 believe endorsed or approved it for inclusion in
3 the IQR Program.

4 But again, we're now at a point of
5 whether or not it should be included in value-
6 based purchasing without us seeing the data to
7 know how it works.

8 So, there were modest modifications
9 here. But, just sort of on principle, wondered
10 if someone could explain to me what data
11 differences we should expect to see.

12 And will hospitals be able to see the
13 results and understand how this has affected the
14 measure they -- the measurement that they have
15 known and loved for the last year, around this
16 measure before it would go live if you will.

17 CO-CHAIR TRAVIS: Is that in the form
18 of a question?

19 MEMBER FOSTER: Sorry, yes. That was
20 in the form of a question about procedure. The
21 second was in the form of a question about
22 procedure, yes.

1 CO-CHAIR TRAVIS: Okay. Any response
2 from CMS on that?

3 DR. YOUNG: Sure. To -- the reason we
4 put SSI on the MUC list for HVBP was similar to
5 why we put it on IQR. Which may be some of the
6 ARM.

7 And certainly if we were to move from
8 the SIR to the ARM, that would -- we're trying to
9 -- we're just having internal discussions about,
10 you know, the present concept of doing that.

11 But, certainly anything that we can
12 make do that, we would have to go through, that
13 would be substantive change and would go through
14 public comment.

15 CO-CHAIR TRAVIS: Okay. Jeff, do you
16 have any comments?

17 MEMBER JACOBS: For this one the only
18 thing I would say is I think it's good to see
19 collaboration between the CDC and the American
20 College of Surgeons. And I think that represents
21 a very important collaboration when it comes to
22 measuring surgical site infections.

1 And therefore, I'm supportive of this
2 initiative. On that principle alone I think it
3 merits support.

4 CO-CHAIR TRAVIS: And if you all will
5 allow me, just because I'm not sure how long the
6 discussion and the vote may take on this measure.
7 Jeff, do you have some comments relative to
8 measure number two and measure number three that
9 you want to be sure we have before you have to
10 step out?

11 MEMBER JACOBS: Measure number two was
12 the one I was really hopeful I could be involved
13 in the dialog with. Because there's potential
14 dialog about -- about the measurement of 30 day
15 mortality that is similar to the dialog related
16 to 30 day mortality that took place earlier today
17 for management of brain injury.

18 So, I think that's a potentially
19 important dialog. And the other issue related to
20 that measure is a discussion about the fact that
21 there's this administrative measure that looks at
22 outcomes after CABG.

1 There's also a clinical measure that's
2 been developed by the Society of Thoracic
3 Surgeons, which is used by 96 percent of the
4 adult cardiac surgical programs in the United
5 States.

6 So, I think there's some fairly
7 important discussion that needs to take place
8 regarding measure two, around those two topics.

9 And then measure number three, I
10 really don't have anything important to say. I'm
11 supportive of measure number three.

12 CO-CHAIR TRAVIS: Okay. Well, let's
13 see if we can help Jeff out and see if we go back
14 to measure number one, which is where we started.

15 Are there other comments or questions
16 from the Committee?

17 MEMBER FOSTER: I'm sorry, I'm not
18 sure if I quite understood Pierre's response.
19 So, was your -- was that an indication that in
20 fact hospitals would be able to get and the
21 public would be able to get some sense from CMS
22 about how this reconfiguration of the measure

1 might be expected to affect the values that get
2 displayed on Hospital Compare?

3 So that they have a sense of, you
4 know, this may have gone up. But that's -- it's
5 to be expected because we changed the measure?
6 Or something of that nature?

7 DR. YOUNG: Yes. So, I think -- and
8 again, no decisions have been made about whether
9 or not to make a switch.

10 But certainly, if there is a switch,
11 we would -- one thing we are cognizant of is that
12 it can impact the -- probably impact the rates.
13 And essentially just distribution of hospitals
14 and where they're classified.

15 So, there would be a lot of, I think,
16 education and outreach we would need to do. And
17 we acknowledge that.

18 CO-CHAIR TRAVIS: Thank you, Nancy.
19 Mitch?

20 DR. LEVY: Pierre, so it's just in
21 this measure, the only change is from SIR to ARM,
22 is that correct?

1 DR. YOUNG: It is to accommodate. So,
2 the measure is currently calculated using the
3 SIR. But when CDC did measure maintenance, they
4 allowed an alternative way to calculate the
5 rates. Which is the ARM methodology.

6 So, this is to accommodate that.
7 Because that would be a substantive change.

8 DR. LEVY: And so, -- and that's what
9 I understood. But you're saying CMS hasn't made
10 the decision yet whether to go with that?

11 But this is -- this measure is saying
12 the decision's been made, because it's a
13 different measure. I'm not sure I -- am I making
14 sense?

15 Are we voting on the measure and then
16 you still haven't decided at CMS whether to use
17 it or not? Is that the idea?

18 DR. YOUNG: Right. Because -- well,
19 the measure itself is already in the program.

20 DR. LEVY: Right. Right.

21 DR. YOUNG: Right. So, I think the --
22 there is still ongoing discussions internally

1 about whether it would be beneficial to change
2 the calculation methodology.

3 And that's -- but, if we do do that,
4 we want to be as consistent as possible between
5 IQR and HVBP.

6 DR. LEVY: And so are we voting on --
7 is this measure already in VBP? And all we're
8 voting on is the change from SIR -- the reporting
9 methodology? Right. That's what I thought.
10 Okay.

11 DR. YOUNG: Yes. It's already in SSI.
12 The NHS and SSI measures are already in the
13 program.

14 CO-CHAIR TRAVIS: Thank you for that
15 clarification. Any other comments or questions?

16 (No response)

17 CO-CHAIR TRAVIS: Okay. I'm going to
18 take that, that that means we're ready to vote on
19 this measure.

20 MR. TILLY: The polling is now open
21 for ACS-CDC Harmonized Procedure Specific
22 Surgical Site Infection Outcome Measure, MUC 15-

1 535. The options are support, conditional
2 support, and do not support.

3 It looks like we need just three more.
4 So if you guys want to give it another shot.

5 Okay, so the results are 58 percent
6 support. Thirty-three percent conditional
7 support. Eight percent do not support.

8 So, the recommendation is conditional
9 support.

10 MS. MITCHELL: We have a late voter.

11 MS. O'ROURKE: We're not ready yet.

12 MS. MITCHELL: Yes, give Jean-Luc a
13 minute to reset the poll and we'll --

14 Oh, okay. We knew -- we have another
15 rejoining. So, we'll revote. We've got another
16 vote, so. We'll revote on --

17 MR. TILLY: So, the polling is back
18 open for ACS-CDC Harmonized Procedure Specific
19 Surgical Site Infection Outcome Measure, MUC 15-
20 534.

21 And we're missing just three
22 responses. And now we're missing just one

1 response. Oh, there we go.

2 Okay, so the results are 58 percent
3 support. Thirty-five percent conditional
4 support. And eight percent do not support.

5 So the verdict is conditional support.

6 MS. O'ROURKE: And just to make sure
7 I heard the conditions correctly. So they would
8 be pending NQF annual update.

9 And that the measure is put in through
10 the program all in the proper statutorily path --
11 or statutory path versus the IQR. Then publicly
12 reported. And then to VBP. With education.

13 MEMBER JACOBS: Yes, I know that
14 there's two NQF endorsed measures regarding
15 mortality after coronary artery bypass grafting.
16 One -- and they're actually developed jointly
17 between the Society of Thoracic Surgeons and CMS
18 as a collaborative initiative.

19 So, my disclosure is that I was
20 involved in the development of both of them.
21 Because they were developed jointly.

22 That being said, it surprises me that

1 one of them is here and one's not when they're
2 both NQF endorsed companion measures. And it
3 seems that they both should be there.

4 The second issue that may come up is
5 that I've heard previously criticisms about after
6 coronary artery bypass grafting, a 30-day
7 mortality measure is problematic because it
8 perversely incentivizes providers to keep a
9 patient alive until day 31.

10 And that topic may or may not come up.
11 But, I think one of the advantages of the measure
12 from the clinical registry, from the STS
13 Registry, is that it eliminates that as a
14 problem.

15 Because the end point is not 30 days.
16 But operative mortality, which is defined as the
17 union of 30 days plus survival, or lack of
18 survival at discharge.

19 So, the measure then becomes is the
20 patient alive at the time of going home? And
21 eliminates potential incentive to keep somebody
22 alive to day 31 just to meet the metric. And

1 it's a matter of being alive and well enough to
2 be discharged.

3 So, I think those are two potential
4 topics. The main issue is, I wonder why only one
5 of those measures is here and not both of them?

6 CO-CHAIR TRAVIS: Thank you, Jeff.
7 Any thoughts, Pierre, while he's in the room?

8 DR. YOUNG: Sure. And thank you for
9 those questions. And thank you also for working
10 with the collaboration on development of those
11 measures.

12 And I just want to confirm, but I
13 believe the STS version is a registry-based
14 measure. And so that was a big limitation for us
15 on the hospital side.

16 Because we do not have the ability to
17 permit registry-based reporting for hospitals.
18 So, we are limited to claims-based measures, the
19 HR measures and chart abstraction.

20 MEMBER JACOBS: So this is a registry
21 that has 96 percent penetrance in the country.
22 The only hospitals that don't participate are a

1 few VA hospitals.

2 So, it was surprising. But I guess
3 registry-based measures even with 96 percent
4 penetrance are not a candidate for utilization.

5 I'm sorry, I've said -- I said it --
6 the registry is a registry used by 96 percent of
7 the hospitals in the country. And only not used
8 really by VA hospitals.

9 But, I guess if the issues are that
10 registry-based measures, even if they have
11 complete -- almost complete penetrance in the
12 country, are non-candidates, then that issue
13 about why that's not here is really a moot point.

14 The other issue though remains with
15 the challenge of using an endpoint of 30 day
16 mortality. And I don't know how to address that.

17 Because I've heard the issue raised
18 that that creates an incentive to keep a patient
19 alive until 31 days to comply with the measure.
20 And you can do that after a coronary bypass with
21 a tracheostomy and a peg and a variety of other
22 things.

1 That's why an endpoint of operative
2 mortality, which is survival to discharge from
3 the hospital eliminates that perverse incentive.
4 So, that's kind of a problem with an isolated 30-
5 day mortality measure versus survival to
6 discharge that, you know, as a cardiac surgeon,
7 I'm fairly sensitive to that.

8 And I'm not sure how to address that
9 if the endpoint is just 30 day mortality.

10 CO-CHAIR TRAVIS: All right. Other
11 thoughts or comments from the work group on this
12 measure? And Sean was the one to pull it, so
13 you're next.

14 DR. MORRISON: Yes, I just wanted to
15 echo what Jeff said for -- and two data points.
16 The first is actually data from two very large
17 programs, including one of mine.

18 Where the average time to palliative
19 care consultation and serious complications
20 following discharge for all surgeries except for
21 cardiothoracic runs around ten days post op. For
22 the cardiothoracic group, it's in the mid 30s.

1 So, if you want a look at what's the
2 perverse incentive, it's significantly longer in
3 the cardiothoracic group, which this measure is.
4 And when you look at focus groups with the
5 cardiothoracic surgeons, they are very concerned
6 about that. It is -- this is what's driving it.

7 The second is, the Joint Commission
8 just came in, certified our group yesterday. And
9 when the comment that came out over and over was,
10 this is a national issue when every palliative
11 care program they are certifying, where does
12 palliative care not get involved? It's in
13 cardiothoracic surgery.

14 Now one can argue that there's
15 something very specific about cardiothoracic
16 surgeons versus the other surgical world. But I
17 would also suggest that it is this issue, the 30-
18 day mortality.

19 Jeff, I don't know what to do about
20 it. I think this really -- mortality following
21 -- bypass surgery, is a big issue. It's one we
22 should be doing.

1 But I think we should be aware that
2 there really are perverse incentives around the
3 30 day number.

4 MEMBER JACOBS: Yes. I'd like to make
5 one more comment on that. I think if the
6 endpoint has changed to survival to discharge
7 from the hospital, it eliminates the perverse
8 incentive to keep somebody alive until 31 days.

9 And there's no doubt that mortality
10 after heart surgery is an extremely important
11 metric. Because risk adjusted mortality after
12 heart surgery has substantial variation across
13 programs.

14 For any form of heart surgery.
15 Whether it's coronary artery bypass grafting, or
16 pediatric heart surgery. And therefore, it's a
17 very important metric to follow because there's
18 variation.

19 And there's opportunities for
20 improvement. But, if the endpoint is just 30
21 days, it's problematic.

22 Most heart surgeons track 30 day

1 mortality, discharge mortality, and then use a
2 term called operative mortality, which is the
3 union of both. And that term, operative
4 mortality, is a form of mortality that eliminates
5 incentivization just to keep somebody alive for
6 31 days to meet a metric.

7 And that's the answer. But that
8 answer's not part of this measure. And that
9 makes it somewhat challenging.

10 I'm supportive in general of the
11 administrative measure from CMS because we helped
12 develop it. But, I think that the 30-day
13 endpoint is somewhat limited.

14 And I'm sorry I have to step back
15 because I have a 4:00 p.m. phone conference with
16 a patient's family that I just cannot miss.

17 CO-CHAIR TRAVIS: Thank you, Jeff.
18 Michael?

19 DR. PHELAN: I think all these
20 measures can potentially be perversely
21 incentivized. Survival to discharge from the
22 hospital, well, they'll just move people to a

1 SNF, and then that could happen.

2 So, I think they all have that. I
3 would really love to see multiple measures in
4 there. And end up being a composite. But as a
5 first step, I think this is not a bad way to go
6 to support the move forward with it.

7 Just my thoughts.

8 CO-CHAIR TRAVIS: Any other comments?

9 Yes, oh Jeff -- that's Jeff's card. Would
10 somebody put that down so I won't keep looking at
11 it? Thank you.

12 I'm going to take my chair hat off for
13 just a moment. And I have a feeling that I've
14 said this in prior years at the MAP.

15 I guess I find it extremely disturbing
16 and disappointing to think that the provider
17 community would actually react to an incentive,
18 and actually keep a patient alive one extra day
19 in order to have their metrics look better.

20 And I hear that type of comment every
21 year when we come in here. And quite honestly, I
22 really question whether it's true.

1 I know that there's -- where Jeff was
2 saying there is some evidence, maybe it's just
3 that I don't want it to be true.

4 But, I think that what that shows for
5 us isn't necessarily that the measure is wrong,
6 but that there is something wrong in the provider
7 community. Because their first responsibility is
8 to the patient.

9 And I think that we always are kind of
10 trying to take it away from the measure, when I
11 think the reality of the situation is if there
12 are providers who are treating their patients in
13 this way, I can't think of anybody who would
14 agree with that. Even probably the providers who
15 it appears must be doing that.

16 So, that's my soapbox. Of course,
17 which I think I can be counted on once a year at
18 least, to bring up in front of everybody.

19 But, I think that it's not assigning
20 -- it's not making the measure a bad measure. I
21 think it's actually reflecting on the provider
22 community.

1 And if indeed this is what is
2 happening in the provider community, I would
3 expect the provider community to do a better job
4 of policing itself. And shining the light on
5 people who are doing this.

6 And it's not appropriate. Because I
7 can't imagine keeping somebody alive, and say
8 okay, well, it's 31 days. You know, the hour's
9 hit. You know, now we can let them die.

10 I just -- that entire thing just
11 disturbs me and disappoints me. So, enough said.
12 I am sure.

13 So, thank you for letting me say that.

14 (Laughter)

15 CO-CHAIR TRAVIS: I think it is time.
16 I think that was -- Wei, did you have something
17 to say?

18 MEMBER YING: Yes. This is not the
19 first standardized mortality measure for VBP,
20 right? Currently is there a similar measure in
21 there already?

22 This is not the first standardized,

1 risk standardized measure mortality to be
2 considered for VBP Program, right? Currently in
3 VBP, do they already have a same type of measure
4 just for different clinical condition?

5 MS. HAYDEN: That's right. We have a
6 -- the AMI and pneumonia mortality measures in
7 the program.

8 MEMBER YING: Right. So, that's what
9 I thought. If we didn't -- well, the 30-day
10 issue didn't become an issue at the time I think
11 for this round.

12 Understanding it will be some desired
13 reaction from the provider community. Even maybe
14 isolated. But still then it should not be an
15 issue preventing us from thinking this is a
16 measure, important measure to be included into
17 the VBP program.

18 CO-CHAIR TRAVIS: Thank you, Wei.
19 Tom?

20 MEMBER LUTZOW: Yes. My question has
21 to do -- and certainly, I mean, I am against
22 perversity wherever it exists. Whether in

1 measures or in human behavior.

2 But, we have pretty much control over
3 the measure, don't we? I mean, isn't it -- can't
4 it be redesigned so that we don't have to worry
5 about perversity in human behavior?

6 Is it so sacred that, you know is it
7 one of the Commandments and we can't take it out?
8 Or is it something less important than one of the
9 Ten Commandments?

10 CO-CHAIR TRAVIS: I'm going to assume
11 that was a comment, not a question.

12 (Laughter)

13 CO-CHAIR TRAVIS: Sean?

14 DR. MORRISON: Cristie, I look forward
15 to that comment every year. But, as somebody who
16 monthly meets with the surgeons and goes through
17 every single mortality, I do -- I wish that was
18 the case.

19 I wish that providers would do that.
20 But the reality is, they're under so much
21 pressure that this is just -- the lightbulb goes
22 off at 30 days.

1 And you know, what's the difference
2 between 14 days or 30 days or 35? You know, and
3 in their mind well, 30 days is a realistic amount
4 of time.

5 And I would argue that for some
6 patients it is. For some it's not. And this is
7 going to drive their behavior whether we like it
8 or not.

9 But, I do appreciate the comment every
10 year.

11 CO-CHAIR TRAVIS: Thank you. And I
12 think you make your same response to me every
13 year.

14 So, this is our discussion, Sean.
15 Thank you so much for having that. Nancy?

16 MEMBER FOSTER: So, a measure not yet
17 on Hospital Compare. So, not up for a year. We
18 can't really look at variation in performance and
19 know what it means one way or the other.

20 And I'm -- I was trying to glean, and
21 I'm sorry Jeff had to leave the room. Though his
22 priorities are in the right spot.

1 I'm trying to understand, are there
2 outcomes that are more important? Is there a
3 better construct of the outcome that would give
4 us more valuable information?

5 And give patients and families who are
6 trying to understand these data, more important
7 information than 30 day mortality. Which 30 day
8 is an arbitrary cutoff by anybody's tally.

9 So, I don't know that. I would
10 appreciate clinical input on whether there is
11 something better.

12 And I suspect Jeff would probably be
13 the best clinician to give that to me. But, I'm
14 -- but Sean, you have your fingers deeply into
15 this.

16 And Mitch? Michael? I -- you know,
17 somebody help me here, please.

18 CO-CHAIR TRAVIS: Oh, come on.
19 Somebody needs to help Nancy. Any answers to her
20 concerns? Or comments around them?

21 PARTICIPANT: If I may, just to
22 clarify. The measure was publicly released or

1 publicly reported in July of this year.

2 So, it is on Hospital Compare. And it

3 --

4 CO-CHAIR TRAVIS: Thank you. And
5 Mitch?

6 DR. LEVY: Yes, I mean, this has been
7 publicly reported for a long time. I do think in
8 this case mortality is a good quality indicator.

9 I think, Nancy, I think there are
10 others. Long term functioning, et cetera, et
11 cetera. There's no question that there are other
12 measures.

13 But, if I were going to a cardiac
14 surgeon, I would definitely want to know what his
15 30-day mortality is. Given the fact -- and I
16 work in a medical ICU, and at 31 days, I get
17 these folks.

18 Because then they don't -- well, for
19 reasons that Sean knows. But I still think 30
20 day mortality is a really good quality indicator.

21 MS. MARINELARENA: And I think what
22 Jeff was saying, one of the measures is the one,

1 the STS measure, which he talked about, you know,
2 survival at discharge. Which that measure
3 exists.

4 But, because of the data source, it
5 can't be used in this program. So, if we want to
6 make a statement about that, maybe encourage a
7 different data source or something like that.

8 That's certainly something that we
9 could include in our report.

10 CO-CHAIR TRAVIS: Michael?

11 DR. PHELAN: I agree, it's what we
12 got. You know, it's a measure we got.

13 But, I don't think it's unreasonable
14 to put a comment in there that there are other
15 measures out there in good data registries that
16 according to Jeff and every other surgeon I know,
17 the STS Registry, I mean, that is the gold
18 standard of registries that I'm aware of.

19 And to not use it for whatever reason,
20 and there may be, you know, data quality issues
21 and stuff like that. But, I'm like really? We
22 got a phenomenal data registry that's got 96

1 percent penetrance.

2 Maybe we can get 100 percent if they
3 mandated it. But, to use that data registry for
4 other measures like the survival to discharge and
5 the -- what was the other one he mentioned? So
6 the mortality and the survival to discharge.

7 But, having a composite measure of all
8 the things that revolve around that, I think
9 patients -- I think it would benefit patients to
10 see that.

11 CO-CHAIR TRAVIS: Leslie?

12 MEMBER SCHULTZ: Well, this pales in
13 comparison to the perverse incentive to keep
14 people alive. The current measure I don't
15 believe is fully adjusted for SDS either.

16 CO-CHAIR TRAVIS: Thank you. Oh, Ann
17 Marie put her card down. I forget who -- oh, did
18 you want to say something Ann Marie?

19 DR. SULLIVAN: Yes. Just to add that
20 I think we could make a recommendation that the
21 other measures that the physician was
22 recommending could be added to this. If you

1 think that would be some kind of precautionary
2 measure that would stop people from just
3 spreading the mortality out for 30 days.

4 And then we have many measures that
5 have like one or two things associated with them.
6 So, we could make a recommendation that you add
7 something like survival to whatever, discharge.
8 That kind of thing.

9 So, I think that, you know, you could
10 make that recommendation. And then if you have
11 that, you kind of can still see what the, you
12 know, you could prevent the kind of perverse
13 incentives.

14 So, maybe we could make that
15 recommendation in addition.

16 CO-CHAIR TRAVIS: You all are
17 capturing some of these thoughts?

18 MS. O'ROURKE: Yes.

19 CO-CHAIR TRAVIS: Thank you. Thank
20 you, Ann Marie. Heather?

21 MEMBER LEWIS: Just to state something
22 quite obvious. We have other measures where

1 we're using ER -- EHR information.

2 Is there any reason why we couldn't
3 use EHR discharge status as an indicator? Rather
4 than the SDS data point?

5 CO-CHAIR TRAVIS: I think that was a
6 question for CMS to think about. I don't know if
7 you have a comment now or whether it's just
8 something you want to consider.

9 DR. YOUNG: Yes. Thank you. We'll
10 take that under consideration.

11 CO-CHAIR TRAVIS: And I apologize. I
12 may not be getting everybody in order. But, I
13 had Andrea next.

14 MEMBER BENIN: I mean, what I'm
15 hearing from this conversation really is that
16 the, you know, the metric is in IQR, which
17 satisfies I think Mitchell's comment and
18 Michael's comment that we would, as consumers, be
19 able to see the data.

20 And then I think in order to avoid the
21 financial penalties that cause some of the
22 problems with the metric, it makes sense in my

1 mind not to put this into value-based purchasing,
2 which adds these additional financial penalties,
3 which are real for the hospitals and for the
4 providers involved.

5 So, to my mind, this is one of those
6 situations where if we understood really well
7 what our criteria were for one program versus the
8 other, it would be helpful.

9 But, we already are in a situation
10 where there's complete transparency around this
11 metric. So, that's not up for discussion.

12 What's up for discussion is, do we add
13 another financial penalty to a metric that we've
14 already ascertained is being perversely impacted
15 by just transparency alone, let alone adding
16 financial penalty.

17 So, I think that to my mind, it seems
18 pretty clear that that's maybe not the best idea
19 based on this discussion.

20 CO-CHAIR TRAVIS: Mitchell?

21 DR. LEVY: So, two things. One, a lot
22 of these recommendations, we're bordering on

1 trying to create another measure.

2 And so I just want to -- I would --
3 we're not talking about making this conditional.
4 Because our suggestions are suggestions for other
5 measures to be developed.

6 Right? So, because we're weighing in
7 on this measure.

8 And then the second thing I would say,
9 is I guess I disagree. Although I understand the
10 perverse incentives that this creates, I do not
11 feel it outweighs the benefit of making this in
12 VPB.

13 I think that drives -- I think that
14 drives quality. And I do think that this is a
15 good measure.

16 And there is always going to be gaming
17 that goes on. But I don't think that outweighs
18 the value of holding people accountable and
19 keeping their feet to the fire by putting them in
20 VPB.

21 CO-CHAIR TRAVIS: Helen?

22 MEMBER HASKELL: Yes, I just -- I

1 think, you know, from the beginning, the heart
2 surgeons have always said that they shouldn't be
3 measured because they will game the measures.

4 And I think that I assume, I've always
5 assumed that one reason for the 30-day measure
6 was because that's a little more difficult to
7 game then survival to discharge. Because you did
8 use discharge to a skilled nursing facility.

9 So, I think it's fine to suggest, you
10 know, additional measures. And look at them as
11 composites.

12 But I certainly don't think getting
13 rid of 30 days is any kind of answer.

14 MS. MARINELARENA: And if you look in
15 the preliminary analysis summary, the last bill
16 that impacts on quality of care for patients, we
17 do provide a summary of the performance rates
18 from Hospital Compare.

19 So, if you look, what we have is that
20 there was a mean rate of 3.2 percent with a range
21 from 1.5 to 7.9 percent. And then the developer
22 found a median rate of 3 percent.

1 So, that the 25th and 75th percentiles
2 are 2.6 and 3.6 respectively. So, we do have
3 data on the performance of this measure.

4 CO-CHAIR TRAVIS: Thank you for
5 pointing that out, of course. I'm taking my co-
6 chair hat off for a moment. I'm not seeing any
7 other cards.

8 I too kind of, you know, think that no
9 matter what the measure is, there's probably a
10 way to game it in some form or fashion, to
11 Helen's point.

12 And I also though do support us giving
13 some commentary to CMS around some of the things
14 that we've talked about today that could perhaps
15 ultimately result in a better way of doing this.

16 But, given, you know, where we are in
17 this measure, my tendency is to support it. But,
18 I think we would have an unintended consequence
19 discussion around every measure that could come
20 up.

21 I mean, you could discharge somebody
22 early out of the hospital to get to discharge

1 them while they are alive. So, I mean, and then
2 we'd be having that discussion, that that's a
3 perverse incentive to discharge people early.

4 So, you know, that's just kind of
5 where I'm standing on the measure. So, any other
6 comments before we move to a vote?

7 (No response)

8 CO-CHAIR TRAVIS: Okay. I think we're
9 ready.

10 MR. TILLY: All right. The polling is
11 now open for Hospital 30-Day, All-Cause, Risk
12 Standardized Mortality Rate Following Coronary
13 Artery Bypass Graft Surgery, MUC 15-395. The
14 options are support, conditional support, and do
15 not support.

16 So the results are in. Seventy-six
17 percent support. Eight percent conditional
18 support. And 16 percent do not support.

19 So, the recommendation is to support.

20 CO-CHAIR TRAVIS: All right. Thank
21 you all very much. And now we'll move to the
22 third measure in this Calendar.

1 And it's the Patient Safety for
2 Selected Indicators/AHRQ Patient Safety Indicator
3 Composite, affectionately known as PSI-90. And
4 this was originally pulled by Nancy Foster.

5 So, Nancy?

6 MEMBER FOSTER: We have just talked
7 about this for the IQR Program. And so, the
8 question of whether the revised version ought to
9 be moved into VBP or not, was what was on my
10 mind.

11 And, you know, understanding exactly
12 what's the difference here. And the other thing
13 is, and I've spared you this stump speech this
14 far, but PSI-90 is not our idea of a reliable
15 measure when done on the Medicare data.

16 This version of it seems to be
17 slightly better. But the real problem with the
18 measure is in what would -- I'm sure Dan would
19 tell me, is case finding.

20 It is that you cannot identify in any
21 of these things through the claims data. There
22 is plenty of evidence out there to that effect,

1 including probably the seminal article by David
2 Klassen and colleagues written several years ago
3 that appeared in Health Affairs.

4 I have seen recent data from one of
5 our major systems that suggests that when they
6 looked at their claims data for one of these
7 measures, they identified one event. When they
8 went back and used their electronic health record
9 to look for those events, they found many, many
10 more of the same events, as in more than tenfold
11 more.

12 So, it is that level of inaccurate.
13 And we need to get to a better measure. We just
14 simply need to get to a better measure.

15 So, this is a step forward. A small
16 step forward in making a better measure. But,
17 it's still not where we need to be.

18 CO-CHAIR TRAVIS: And just to be
19 clear, what would be your recommendation?

20 MEMBER FOSTER: I would recommend
21 conditional support for this. And that condition
22 would be that hospitals be given information on

1 the difference between this measure and the old
2 measure.

3 And be able to understand the impact
4 prior to it going live in the VBP Program.

5 CO-CHAIR TRAVIS: Thank you, Nancy.
6 Jeff's not with us. But I think he indicated his
7 support for the measure.

8 So, I'll open it up to the work group.
9 Helen?

10 MEMBER HASKELL: Well, I think the
11 consumer group strongly supports this measure.
12 It's the basis for most public reporting that's
13 done on hospitals.

14 The measure has been considerably
15 revised. It -- and I would say, you know, the
16 components in it are much weaker than they have
17 been.

18 I think the issue that people are not
19 honestly or accurately billing Medicare, is a
20 whole different issue from whether this should be
21 measured on that. I think the problem is
22 elsewhere.

1 So, that's my comment. And also, the
2 -- you know, people are now beginning to game
3 this measure as well. And have been for a while
4 so that they are going through the records and,
5 you know, and looking at things that could be
6 construed as something that would be part of PSI-
7 90.

8 So, I think you will soon find that
9 the records will agree more with the claims.
10 Whether that's a good thing or not is up for
11 debate. But, I think that's what's happening.

12 CO-CHAIR TRAVIS: Thank you, Helen.
13 Leslie?

14 MEMBER SCHULTZ: I'm going to concur
15 with Nancy. And would recommend conditional.

16 I think we need to see it and get
17 experience with it in IQR before we put it into
18 VBP. Because we don't know what kind of
19 information, actionable information variation
20 we're getting yet. Too soon.

21 CO-CHAIR TRAVIS: Thank you, Leslie.
22 Mitchell?

1 DR. LEVY: So, I would speak out
2 strongly in favor of this. I totally understand
3 what Nancy's saying about the difficulty in
4 identifying some of these.

5 But, I think that would be true across
6 the board. I think these -- each of these
7 represents where safety is.

8 There are iatrogenic conditions, I
9 think the addition of the exclusion criteria for
10 present on mission really helps this metric. It
11 has to go into IQR first anyway.

12 And this is the kind of measure that
13 I would like to see facilitated. So,
14 recommending it now for VBP, knowing that it has
15 to go into IQR first, there's so much face
16 validity to the -- to the individual elements in
17 this measure in terms of avoidable complications
18 and patient safety that I find it very compelling
19 to support this.

20 CO-CHAIR TRAVIS: Thank you. Yes?

21 DR. POLLOCK: So, to Mitchell's point,
22 I would say there are many different adverse

1 events of course that are included in this
2 composite I think that speak to -- there's one
3 associated blood stream infection component of
4 this composite.

5 And there are numerous studies of
6 under ascertainment in the use discharge
7 diagnostic data to identify some of the
8 associated blood stream infection events.

9 So, while I think we would all agree
10 that the events included in this composite
11 measure merit quality reporting, there are
12 alternative ways for at least some of these
13 adverse events in terms of ascertaining whether
14 an event occurred.

15 CO-CHAIR TRAVIS: Thank you. Any
16 other thoughts? Andrea?

17 MEMBER BENIN: I mean, I will say that
18 I have been bothered by this metric for years for
19 all of the reasons that are stated. That any
20 time you really dig into it and either try to
21 validate it in your own place, or look at some of
22 the studies that have been put out there, the

1 individual components don't validate well.

2 And then the idea that by somehow
3 combining them together makes it mathematically
4 stronger, I've never entirely understood. But, I
5 think in addition to that, this idea of
6 transitioning to ICD-10 with a set of -- with a
7 metric that we're already not 100 percent clear
8 of how well it actually foots to reality.

9 And then we're now going to change up
10 our entire coding bases that is based on -- and
11 are we just going to do that on a cross walk? Or
12 is that going to need to be revalidated, is
13 suspect to me.

14 Especially for this purpose. I think
15 that until it's really been properly vetted in an
16 ICD-10 environment, until some of the
17 considerations that Dan had mentioned are taken
18 into consideration, I find it hard to support
19 this at least for years.

20 CO-CHAIR TRAVIS: Marty?

21 MEMBER HATLIE: I mean, this measure's
22 been talked about for so long, it's taken a long

1 time to get it here. I think it's just a really
2 important statement to the hospital community
3 about where safety is now important is all.

4 And I think it's just very important
5 we build it into this program in particular.
6 It's a very strong recommend.

7 And it's never going to be perfect.
8 But I think it still has value. Great value.

9 CO-CHAIR TRAVIS: Thank you. Michael?

10 DR. PHELAN: I still conditionally
11 support the metric. But I continue to have grave
12 concerns about some of the methodology that the
13 data is attributable to.

14 And whether or not it actually has any
15 valid quality programs that come out of it. I
16 like the pressure ulcer measure.

17 But, I think there still needs to be
18 work done around some of the undifferentiated
19 pressure ulcers that -- how they categorize them.
20 But, it is really difficult not to have a measure
21 in this space on patient safety.

22 And there currently isn't anything

1 better. That they're kind of stuck with the
2 person they brought to the dance, so to speak.

3 But, I would like to make sure that
4 there is more work done on the waiting and the
5 understanding of some of the biases associated
6 with the measure.

7 And whether or not it's impactful or
8 not, really concerns me. Because from what I
9 hear from the hospital communities that I deal
10 with, is yes, we just do it to report that.

11 That's not where our focus is. We're
12 focusing on improving DVT prophylaxis. We're
13 focusing on this.

14 So, I'm wonder if the measure
15 themselves, although they look good and it's
16 important to publicly report them, if it's not
17 having the impact that we actually need to have,
18 I think we need to put some serious consideration
19 in what are the next generation of measures going
20 to come out there.

21 And, does it need to be in a composite
22 format the way this is? Are there more

1 individualized measures that we can select from
2 that could replace or be a better -- that
3 actually addresses some of the concerns that
4 people have around patient safety in a hospital
5 setting.

6 CO-CHAIR TRAVIS: Dolores?

7 MS. MITCHELL: Just a small point on
8 the issue of composite measures. In a way we're
9 trapped with wanting to have our cake and eat it
10 too.

11 Everybody has said, oh, people don't
12 use the measures because there are so many of
13 them. And there are so many that are so highly
14 technical that they don't give you the big
15 picture.

16 We've got to have families of
17 measures. We've got to have composite measures.
18 The fact of the matter is, if you're going to
19 have composite measures, they are going to
20 include some things that you like less well than
21 you like other components.

22 It's just an inevitable outcome of

1 having composite measures. So, since we -- most
2 of ours are in fact rather discrete. It seems to
3 me appropriate to have some that are composites.

4 And in the safety field, I think
5 that's particularly acute. So, I'm in favor of
6 supporting it.

7 CO-CHAIR TRAVIS: Thank you. Oh, I
8 can't tell, is that yours, David? Okay.

9 MEMBER ENGLER: Yes. So, I've had
10 some practical experience about doing this. A
11 number of years ago, I published a paper in a
12 community in Columbus, Ohio that put together a
13 community of harm index based upon composite
14 measures.

15 And all the hospitals in that
16 community are placed into the index, these
17 various measures of harm. And it -- in addition,
18 they worked on the individual measures for the
19 quality comparison purposes in performance
20 improvement.

21 And it was incredibly impactful. The
22 medical leaders and the infection control

1 practitioners got together and started really
2 paying a great of attention to the level of harm
3 in the community. This is community based.

4 So, imagine a situation where you
5 could spread that kind of view of composite harm
6 across the country. And you know, I'm a very big
7 believer and have spent a long time in my career
8 moving harm down to zero.

9 And I think it can occur. And I think
10 this is yet a wonderful tool. And I'm not
11 usually very supportive of multiple measures.

12 But, I think this is a very
13 interesting opportunity to do that. And I've
14 seen it work.

15 CO-CHAIR TRAVIS: Thank you. Nancy?

16 MEMBER FOSTER: So, I want to join
17 with David and respond to Dolores' comment. This
18 is really not about it being a composite per se.

19 In my ideal world, we'd be at an all
20 cause harm measure generated out of electronic
21 health records. Where you have sufficient data
22 to really look at what happened to the patient.

1 Know -- and know better whether it was
2 caused during the hospitalization, something the
3 patient came in with. Something much more
4 reliable than what we've got right now.

5 There are such things under
6 development. Some in testing. I'm really
7 looking forward to the day when we can talk about
8 that kind of measurement.

9 But, when you -- with regard to this
10 measure, it's really ten things that don't test
11 out very well as individual components that get
12 rolled together in a sort of the kind of ten
13 wrongs make a right kind of philosophy.

14 And that -- it just doesn't quite
15 work. And the lack of validity and reliability
16 when people go back and do it, Andrea was talking
17 about, and try and match this to their clinical
18 records, means that it doesn't have the kind of
19 credibility among the clinical world that is
20 needed to really generate quality improvement.

21 And so, for me this -- and it's also
22 data that are now two years old by the time you

1 get them. So, it's trying to drive safety, the
2 critically important issue of safety, by looking
3 in a rearview mirror a couple of miles back.

4 And it's just not working right.
5 That's my issue with this measure.

6 CO-CHAIR TRAVIS: Dolores?

7 MS. MITCHELL: I just have to say, you
8 know, it's been 15 years or going on to 16 since
9 To Err is Human was released. And my
10 understanding is that the data show that in fact
11 our statistics have not gotten any better.

12 In fact, they've gotten worse. So, it
13 seems to me anything we can do is worth the shot.
14 Even if it's imperfect, as is life.

15 It's my brain at this hour of the day.

16 DR. OWENS: This is Pamela from the
17 Agency for Healthcare Research and Quality. When
18 everybody's spoken in the room, I'd like to say
19 something about the measure.

20 CO-CHAIR TRAVIS: Okay. Thank you.
21 Wei?

22 MEMBER YING: I haven't looked at the

1 details of this new measure. In the previous
2 version, two of the -- two indicators among this
3 whole set was heavily weighted.

4 At the time for us, we had concerns,
5 I mean, for our organization, we had the concern
6 that if only two out of say, seven or eight
7 indicators were heavily weighted, then there --
8 basically hospitals can cherry pick.

9 They basic -- if they say, oh, I do --
10 I can pick up a couple of measures that have the
11 greater impact of the composite, then we just
12 work on that.

13 But, then because it's a composite
14 measure, and when the consumer looks at it, they
15 basically say, oh, this is a safer hospital.
16 That may not be the truth if they are only good
17 at those two heavily weighted ones.

18 So, I just wonder, can the developer
19 or CMS comment in this newer version whether this
20 is still an issue?

21 CO-CHAIR TRAVIS: Well, perhaps that's
22 a good segue to Pamela on the phone, who just

1 indicated she did want to have an opportunity to
2 make some comments.

3 So, if you can take that last question
4 into account in your comments, we would
5 appreciate it.

6 DR. OWENS: Absolutely. So, in terms
7 of Andrea's comments regarding the conversion to
8 ICD-10, I think this applies to all claims-based
9 measures.

10 In terms of the comments regarding two
11 year old data, again, this applies to all claims-
12 based measures. And so, you may have a larger
13 issue with those things. But, it's not specific
14 to PSI-90.

15 I will tell you this, PSI-90's
16 building blocks are largely the same as the
17 previous PSI-90. Which is in HPVP as well as in
18 the HAC reduction.

19 This one has been redesigned. And we
20 would consider this a substantial change, which
21 is why you're seeing this now.

22 It has been substantially changed

1 based on user feedback and stakeholders that are
2 involved in NQF. And now is a composite of ten
3 indicators.

4 The previous version was eight
5 indicators. And no longer includes PSI-7, so to
6 the point of the -- measure that there are other
7 ways of measuring it, that's true.

8 And CDC does have a PSI-7 measure that
9 in the HAC reduction is part of the composite.
10 And -- or Class C is part of the HAC reduction
11 composite.

12 And so we've taken PSI-7 out of it.
13 We have significantly looked at PSI-12 and PSI-15
14 to state specifically, I believe, to what Nancy
15 is talking about, and Andrea is talking about,
16 regarding validation.

17 And going back to what the medical
18 records and our own studies of medical records
19 versus the claims data, and specified the
20 indicators so that it is much more precise.

21 There, you know, in terms of PSI-12,
22 we respecified to omit the isolated calf vein

1 DVTs from the numerator. We omitted patients
2 with any diagnosis of acute brain and/or spinal
3 injuries in the denominator just to give you some
4 indication.

5 The other significant -- one of the
6 most significant differences between the pervious
7 version of PSI-90 and the current version of PSI-
8 90 is the harms weighting. So, there are two
9 components to the weight now.

10 It used to be just volume weights.
11 And now it's harms weights. And the harms
12 weights are based upon estimates of excess harms
13 associated with patient safety events.

14 And we gather this information
15 specifically from CMS, Medicare fee-for-service
16 data. And then we have the volume weights as
17 well.

18 In terms of how the weights turn out,
19 I think where you were concerned particularly
20 about PSI-15 had a large component of the weight.
21 Which is -- it has been redesigned. But it was
22 the accidental puncture measure.

1 It's now unrecognized abdominal pelvic
2 accidental puncture laceration rate. Just --
3 detailed there.

4 And, I think your other one was the
5 concern was PSI-12, which is the perioperative
6 pulmonary embolism and deep vein thrombosis. And
7 as I mentioned, we respecified those particular
8 indicators so that they're much more precise.

9 The weights now for PSI-15 is less
10 than one percent. And the weight for PSI-12 is
11 only 18 percent in the new weighting scheme.

12 The new composite includes three
13 additional indicators that were not in the
14 previous one. That includes perioperative
15 hemorrhage and hematoma rate, post-operative
16 acute kidney injury, and post-operative
17 respiratory failure rate.

18 In terms of the overall signal to
19 noise ratio reliability, it is computed to be
20 .768. I don't know what it is in the Medicare
21 fee-for-service data.

22 And I know Nancy, you are particularly

1 interested in it. The memo that I think you're
2 thinking about, is actually pretty dated now. I
3 know those measures are not at all what the
4 measures are that are in the composite.

5 We have recalibrated PSI-90 so that it
6 is calibrated to Medicare fee-for-service data in
7 terms of the parameter estimates that go into it,
8 et cetera.

9 I hope that gives a broad brush stroke
10 of the indicator. If you have questions, I'm
11 happy to answer them.

12 CO-CHAIR TRAVIS: Thank you. Any
13 questions or any additional comments from the
14 Workgroup?

15 MEMBER HASKELL: I have a question
16 Pam. Maybe I missed it.

17 But, what percentage of the weighting
18 is pressure ulcers now?

19 DR. OWENS: Pressure ulcers is now 3.6
20 percent. It was 3.3 percent. So, it didn't
21 change that much.

22 CO-CHAIR TRAVIS: Okay. Looks like

1 we're ready for a vote.

2 MR. TILLY: The polling is now open
3 for Patient Safety for Selected Indicators/AHRQ
4 Patient Safety Indicator Composite, MUC15-604.
5 The options are support, conditional support, and
6 do not support.

7 (Voting)

8 MR. TILLY: And the results are 68
9 percent support. Twenty-four percent conditional
10 support. And eight percent do not support.

11 So, the recommendation is support.

12 CO-CHAIR WALTERS: Okay. How's
13 everybody holding up? We are going to move
14 cancer to tomorrow and just finish out the day
15 with HAC.

16 So, Zehra will give an overview of the
17 HAC Program.

18 MS. SHAHAB: So, I'll be brief. But,
19 I just wanted to give a quick overview.

20 So, HAC provides incentives for
21 hospitals to reduce the number of HACs, which are
22 Hospital Acquired Conditions. This is both a pay

1 for performance and public reporting program.

2 HAC scores are reported on the
3 Hospital Compare website since December 2014.
4 The incentive structure for this program is that
5 25 percent of hospitals that have the highest
6 rate of HACs will have their Medicare payments
7 reduced by one percent.

8 And the measures in this program are
9 classified according to two domains. One is the
10 PS -- Domain One, which includes PSI-90. And
11 then Domain Two, which includes CDC's National
12 Health Safety Network.

13 The HAC program goals include to
14 increase the awareness of HACs, eliminate the
15 incidents of these HACs, and improve patient
16 outcomes and the costs of care by reducing the
17 HACs.

18 And there's two measures on the
19 Consent Calendar for this. One is an update to a
20 measure currently in the program. And one is
21 PSI-90 that we just discussed.

22 So, before we go into the Consent

1 Calendar, we're going to open for public comment
2 on this program.

3 CO-CHAIR WALTERS: Is there any public
4 comment in the room?

5 (No response)

6 CO-CHAIR WALTERS: They're asleep. Is
7 there any public comment on the phone?

8 OPERATOR: Okay. At this time, if you
9 would like to make a comment, please press star
10 then the number one.

11 (No response)

12 OPERATOR: There are no comments at
13 this time.

14 CO-CHAIR WALTERS: Okay. As you can
15 see, there's two measures. One of them is the --
16 so far a lot discussed, the SSI measure, which is
17 being applied to this program.

18 That was not pulled by anyone. And so
19 currently would be the only measure on a consent
20 calendar for support.

21 That was -- staff was conditional
22 support pending the NQF Annual Update and a lot

1 of the issues we've talked about all day long.

2 Is there anybody that wants to pull
3 that measure?

4 (No response)

5 CO-CHAIR WALTERS: Good.

6 The second measure has also been
7 discussed a few times today. And it's the PSI-90
8 again. Was pulled by Nancy.

9 So, Nancy, would you comment on that?

10 MEMBER FOSTER: I actually have no
11 different comments than previously. But, I would
12 just ask that if we do move this forward, that
13 indeed relative to the conversation we've just
14 had and the information from Pam, I suspect there
15 will be significant shifts in how hospital
16 performance appears on this measure, versus the
17 old PSI-90.

18 And that, as we have discussed
19 previously, it would be very useful if CMS would
20 provide some educational information, both for
21 hospitals, and then subsequently for all the rest
22 of the public who will be watching this measure,

1 to understand what those shifts mean.

2 And whether they are actually reflect
3 a difference in performance at the hospital,
4 which would be hard on this one to know.

5 Or are really reflective of the
6 differences in the measure itself.

7 CO-CHAIR WALTERS: First lead
8 discussant is Mitchell.

9 DR. LEVY: So, we just finished
10 talking about both of these. I don't have
11 anything to add.

12 Certainly they qualify as HAC
13 measures. And the recommendation from staff was
14 conditional support and support.

15 And I agree with both of those for the
16 reasons I stated on the previous measures in
17 discussion.

18 CO-CHAIR WALTERS: The recommendation
19 from staff on this one was support.

20 DR. LEVY: The first one was
21 conditional support, no? And then the second one
22 was support.

1 CO-CHAIR WALTERS: Yes, that's
2 correct.

3 DR. LEVY: Yes. I'm sorry, that's
4 what I said, but --

5 CO-CHAIR WALTERS: Yes. Brock?

6 MEMBER SLABACH: Yes, I just echo some
7 of the things that Nancy said. I mean, the
8 degree difficulty here is increasing as we move
9 this into a program that's going to have
10 increasing penalties for hospitals.

11 And I think that by having this
12 reported in IQR and then the information related
13 to hospitals for training and improvement, would
14 be very important before it's put into a penalty
15 program.

16 CO-CHAIR WALTERS: Okay. Open for
17 comment. Andrea?

18 MEMBER BENIN: So, I guess I'm
19 wondering, does this metric even really qualify
20 as the same metric? Can it just be the same
21 metric with all of these changes in addition?

22 And just get the same name? And -- I

1 mean, is that --

2 MS. MARINELARENA: They did change the
3 name as well.

4 MEMBER BENIN: It's not called PSI-90
5 anymore?

6 MS. MARINELARENA: No, now it is
7 called -- they've changed it to the Patient
8 Safety and Adverse Support Events Composite.

9 MEMBER BENIN: But, I'm just saying,
10 it's getting treated like it was there all along.
11 But, it's actually a totally different metric
12 that we think is going to have totally different
13 performance.

14 I'm just not super comfortable with
15 this anyway. I think that it's a different
16 metric. And we're just treating it like it was
17 the same metric.

18 It has different components in it. It
19 has different weighting. I mean, it's not really
20 --

21 CO-CHAIR WALTERS: PSI-90.

22 MEMBER BENIN: PSI-90 -- I guess it's

1 PSI-90 point whatever. But, it's -- I mean, it's
2 like PSI-90.

3 I think that there is some -- it's
4 sort of inherent unfairness to just calling this
5 thing PSI-90 and passing it through as it were.
6 I mean, we can vote on it like it is.

7 But I think that CMS should take into
8 consideration perhaps rebranding it. Or whatever
9 it is, in a way that kind of makes it clear that
10 this is different.

11 I mean, if I were going to do this in
12 my place, you wouldn't just show this on a run
13 chart or whatever. And say, oh, here's been our
14 performance.

15 And now whoopsie, here's our
16 performance. And you put all those little arrows
17 on it that explains to the board why the thing is
18 now totally different.

19 I mean, this is like it's a different
20 metric is what I'm hearing. And so, it's not how
21 I would use it.

22 I mean, I wouldn't -- we don't use

1 this metric anyway because of it's sort of lack
2 of value. But, regardless, if I were to use it,
3 I wouldn't just try to -- and try to bill it to a
4 bunch of doctors as the same old metric.

5 It just doesn't -- there's nothing
6 about it that has sort of face validity to me.
7 So, I guess I would just say maybe there's a way
8 in the packaging of it that can address the fact
9 that it is a little bit different.

10 CO-CHAIR WALTERS: Mitchell?

11 DR. LEVY: Again, my understanding
12 from the last discussion is this does go back
13 into IQR first. Is that correct?

14 And so, that's not what's happening,
15 Andrea. I think it's being repackaged and
16 retested in IQR.

17 So, what we're voting on is whether
18 after it goes through IQR again, whether we're
19 recommending first DPB, and now the HAC program.

20 So, I do see that as very different
21 than just passing it off as the same old thing.

22 MS. MARINELARENA: And I think one

1 thing to take into consideration is that right
2 now there are two versions of PSI-90 floating
3 around. So, maybe the end goal would be to get
4 all versions into all the programs.

5 Because the first one had, I believe,
6 eight components. Then it went to eleven. And
7 now we're at ten.

8 So, think of that as the goal as well.

9 CO-CHAIR WALTERS: Would you clarify
10 too, I don't -- I think that while it has to be
11 in IQR and for a year to go through value-based
12 purchasing. Is that true of HAC also? I don't
13 believe so. No.

14 MS. MARINELARENA: And again, it's
15 already in HAC, so you would be reporting a
16 different version of this measure.

17 MEMBER FOSTER: To Andrea's point,
18 it's not in HAC. It's not in IQR. It's not in
19 VBP.

20 It will be in IQR. Because this is a
21 different measure. It has some of the same
22 components, but it's a different measure.

1 CO-CHAIR WALTERS: Michael?

2 DR. PHELAN: To the same question that
3 we had about another previous measure. If we
4 support it for going into IQR, then evaluating
5 it, it seems like we're doing multiple tasks on a
6 measure before we have the actual data to support
7 moving forward with some of the other programs
8 that it belongs into.

9 Because we don't have any data to base
10 it on. And I agree 100 percent with Adrian --
11 Andrea, the same --

12 MEMBER BENIN: I think one of these
13 days you'll get it.

14 DR. PHELAN: One of these days I'll
15 get it.

16 MEMBER BENIN: Maybe tomorrow.

17 DR. PHELAN: But, the same issue of
18 this, repackaging -- these repackaging of metrics
19 where they completely change the whole -- I keep
20 on thinking of it as PSI-90.

21 But, it's not PSI-90 anymore. From
22 what we've heard, there's five or six new

1 measures that are in there.

2 The weighting is completely different.
3 So the idea that this just the same measure and
4 we need to support it and move forward, concerns
5 me.

6 CO-CHAIR WALTERS: I think that's the
7 first time that's come up all day. Renaming it.

8 Any other discussion?

9 (No response)

10 CO-CHAIR WALTERS: Ready for a vote?
11 So, what would you recommend it be? Support,
12 conditional support, do not support?

13 Either one of you, or anybody that
14 wants to talk.

15 DR. PHELAN: Do not support until we
16 have the data.

17 MR. AMIN: Ron, can I just get one
18 piece of clarification here, Erin actually? Can
19 you clarify if this is a version that's been
20 reviewed?

21 This updated version is the one that
22 was reviewed by the Patient Safety Committee just

1 this last year. And just confirm?

2 Because this version in question
3 that's come up, just what is the endorsed
4 version? And what was the conclusion of the
5 standing committee on this particular version?

6 Because, you know, there are updates
7 to measures. That does happen. That is
8 something we see. It's not limited to just this
9 issue.

10 But, we need to at least get clarity
11 on what it is that's endorsed in terms of
12 version.

13 MEMBER BENIN: I mean, I think the
14 bigger burden --

15 DR. OWENS: So, the sense -- the
16 pending indicator I know is the endorsed version.
17 The indicator item -- the indicator composite is
18 no longer endorsed.

19 So, the one you're voting on right now
20 is the endorsed version that went all the way
21 through CSAC two weeks ago. Or one week ago.

22 MEMBER BENIN: I think the bigger

1 problem then, and this is probably what Pamela is
2 thinking about, is that the -- then it leaves you
3 with HAC, with what we all agree to be a
4 substandard PSI-90 in it.

5 And we've always felt it to be
6 substandard PSI-90. So, if we don't have this
7 version, then we leave HAC in its debilitated
8 state versus sort of adding this measure.

9 You know what I mean, it's like we're
10 saying that this other measure is not as good as
11 the new one. I mean, it's a little bit of a
12 catch-22, unless -- because I don't think we have
13 the ability to say that we don't want the old.

14 Like it's a little bit complicated.
15 And I don't know whether our job is just to vote
16 straight on that since we don't have the ability
17 to go back to the old one.

18 Unless we're saying, I do not support
19 this PSI-90. Does the old one go away, too? Or
20 the old ones stays, right. Because it's a
21 different metric.

22 So, the problem is that it's not so

1 clear what to vote -- do you see what I'm getting
2 at here? Does that make sense?

3 So, I don't know about --

4 MR. AMIN: Well, the vote in front of
5 you is, let's just be clear, I mean, the vote in
6 front of you is clear.

7 It is to decide about this composite
8 for this program. What CMS does with the old
9 composite is another question.

10 And that's not really in front of you
11 at this moment.

12 MEMBER BENIN: Right. That's sort of
13 a problem.

14 MR. AMIN: I mean, you should vote on
15 this one for this program. That's the question
16 in hand.

17 MEMBER BENIN: So, but if we don't
18 support this, the old ones stays is the problem.

19 MR. AMIN: Well, that's up to CMS.

20 MEMBER BENIN: We don't know. That's
21 up to CMS. Okay. All right. Okay.

22 MR. AMIN: We're not commenting on

1 finalized measures that are currently in the
2 program. I mean, that -- we could have a whole
3 conversation about that.

4 But, yes, that's, you know, let's all
5 -- the principal question at hand is this
6 measure, as this version two, or whatever we want
7 to call it, of PSI-90, for this program. That's
8 the question.

9 And it is the version that was
10 reviewed by the NQF's Patient Safety Committee.
11 And it was just most recently -- most recently
12 went through CSAC.

13 So, I just wanted to give you that
14 update because it is updated based on what was in
15 your discussion guide.

16 MEMBER FOSTER: But I think, Taroon,
17 rather that Andrea's point was performance on
18 this will shift a great deal. It will have both
19 the effect of meaning that hospitals who thought
20 they were very safe before at -- will now
21 discover that they have -- they're in the HAC
22 penalty area and looking bad.

1 More importantly then getting the
2 penalty, they'll be on the list of the hospitals
3 that CMS considers the worst in the country.
4 Which is how all the headlines read.

5 Which is devastating to a hospital.
6 So, you can't just tell them 30 days in advance,
7 hey by the way, you know, all that performance
8 you thought you knew about, well, we've got a new
9 version of the measure. And now you look really
10 bad.

11 You need to give them more opportunity
12 to see how the measure functions, what it means
13 for them. What they can do about it so that they
14 can respond more effectively to the new measure
15 in ways that -- it's to the reason you have a
16 public reporting before you pull it into a
17 payment program.

18 Is you want to be able to give people
19 an opportunity to understand and use the measure.
20 And I'm with you, Andrea.

21 I don't -- if this is a better version
22 of what used to be PSI-90, I think I kind of want

1 it used in HAC more than I want the old ugly
2 version. But, I don't want the surprise.

3 So, that's the dilemma.

4 CO-CHAIR TRAVIS: Ron called on me.
5 He might not know it. No, I'm just kidding. He
6 did call on me.

7 So, I -- you know, I think that that
8 is a good question. Because any time you
9 essentially swap out, that's what we're doing,
10 we're swapping out a measure. Then the
11 performance on that measure could change -- that
12 part of it could change substantially for
13 individual hospitals.

14 So, to that point, what would be the
15 earliest state that you think this -- if you all
16 decided to move forward with it, what would be
17 the earliest state?

18 And why type of preparation would you
19 be providing, what kind of information in
20 advance? And not just 30 days in advance, but in
21 advance, for hospitals to be able to understand
22 the differences so that -- and I don't know

1 whether they're probably given everything.

2 There's probably not enough time for
3 them to go around making changes to everything.
4 But, I guess I'm just trying to think about the
5 -- how they would have an opportunity to know far
6 enough in advance to where perhaps they could
7 begin to tweak some of their internal improvement
8 efforts to understand, you know, where they're
9 going to be on this measure.

10 So, just kind of understanding that
11 sequence would be helpful to me.

12 DR. YOUNG: So, I always need to draw
13 this out. Because the timelines are never quite
14 -- I'm sorry? Oh, I'm sorry.

15 Yes, the time line question's a good
16 one. But, it's complicated as you know.

17 So, theoretically, we could propose it
18 in this upcoming rule cycle for the FY17 IPPS
19 rule. But, we've already finalized the measures
20 for FY16, and I believe FY17 as well.

21 So, I would have to double check.
22 But, probably FY18 or beyond is my guess. But I

1 would need to double check those timelines.

2 CO-CHAIR TRAVIS: Just as a follow up.
3 Is there any process for doing, I guess you all
4 might call it a dry-run or something, against --
5 with the new specs early?

6 So that hospitals could have the
7 benefit of understanding at least, you know, if
8 you'll be using the new specs, where they would
9 have fallen? And they can see the difference
10 between the existing measure and that one?

11 I'm just trying to understand how far
12 in advance they could actually understand how
13 they would perform on these measures. So they
14 could do something for improvement.

15 DR. YOUNG: Right. And so thank you
16 for that suggestion. We can definitely talk
17 about this internally and think it through what
18 the options might be in terms of educating
19 hospitals and sort of sharing the results with --
20 under the new calculation of the composite.

21 CO-CHAIR WALTERS: Dolores?

22 MS. MITCHELL: Well, I don't mean to

1 do CMS's work for them. But, it does seem to me,
2 or I should say, I find it very hard to believe
3 that the measures that are changed, are changed
4 to go in an opposite direction.

5 So that the concerns that Nancy has
6 raised, which, you know, might be reasonable,
7 should not really worry her that much. In other
8 words, if cutting off the wrong leg last year was
9 a terrible thing to do, but this year it's fine,
10 go right ahead, then you've got a real problem.

11 Because that -- but, if they are in
12 fact gradations of, or changing the formula so
13 that the cut points were a little different, or I
14 would assume, some of the changes came as a
15 result of what happened in the past year or two.

16 And that were brought to their
17 attention by the hospitals themselves, so that
18 they would, from their point of view in fact, see
19 that it was a net gain.

20 So, could you give us some kind of an
21 idea when you say -- you or Pam or whoever, that
22 this isn't your old PS, whatever it -- 90, or

1 whatever it is. But, it's a newer, better, and
2 you're going to like it better?

3 Or, you know, if you were a C minus
4 last year, you're going to be an A plus this
5 year, or vice versa?

6 DR. YOUNG: Pam, are you on? Do you
7 want to address that?

8 DR. OWENS: Well, from a sort of a
9 methodologic approach, I mean, we can sort of say
10 -- do that. Because that is an interesting
11 scenario.

12 But, it's just that each of these
13 indicators within the composite are basically --
14 we took away the noise in terms of making it just
15 a much more precise measure.

16 I would expect hospitals to shift.
17 How they shift within the HAC reduction, that's
18 actually quite a complicated question.

19 Because, remember PSI-90 is just one
20 component. I think it's Domain -- is it Domain
21 One or Domain Two?

22 But, it's only a small percentage

1 relative to the entire composite. But then
2 there's the whole other domain.

3 So, it's hard for me to assess which
4 way hospitals are going to go. I know that's
5 something we are looking at carefully.

6 I'm sure CMS is looking at it
7 carefully. We don't, you know, we don't
8 typically run it on Medicare fee-for-service data
9 ourselves.

10 But, I don't know, Pierre, if you want
11 to think about it from a program standpoint.

12 DR. YOUNG: Right. So, we are
13 certainly from the CMS. So, we do look at the --
14 and are cognizant that there can be changes in
15 sort of the hospital -- the distribution in where
16 hospitals are classified.

17 And we do do internal analyses as we
18 are thinking about implementing measures and
19 updates to measures. In the program, we're
20 looking at how that affects, you know, which
21 hospitals get penalized and how that affects the
22 distribution.

1 So, I mean, we do do those analyses
2 and sort of think about them before implementing
3 them.

4 CO-CHAIR WALTERS: Dolores?

5 MS. MITCHELL: -- performance of --
6 evaluations of physicians. And we have very
7 carefully, as we make each year's changes, tested
8 to make sure that there isn't motion -- movement
9 from Tier One to Tier Three, or from Tier Three
10 to Tier One.

11 Understanding that there will be
12 changes between Tier One and Tier Two. And
13 between -- to that, Tier Three and Tier Two. But
14 that going from an A plus to a D minus is just
15 not acceptable.

16 And if we can do it with our bench
17 strength of -- well, we don't have any actuaries.
18 That's where we're ahead of you.

19 But, sorry if I insulted anybody.
20 But, I mean, I just don't know if the scenario
21 that Nancy's worried about is in fact a likely
22 outcome.

1 And I gather from what you've both
2 said, that that's not in fact likely to happen.

3 CO-CHAIR WALTERS: Marty?

4 MEMBER HATLIE: Dolores, it's actually
5 been 16 years since the IOM Report. It was
6 November 30, 1999.

7 And I think as a country, we have just
8 dragged our feet in coming up with a composite
9 measure. I think that the fear of hospitals
10 being embarrassed is just not enough of a
11 rationale to drag our feet anymore.

12 I mean, CMS got serious about
13 eliminating HACs. They're expediting action.

14 I would hope that if this composite
15 measure is so bad, it will just incentivize all
16 of us. Especially the hospital who needed to
17 work on coming up with a better measure.

18 I just don't think we can afford to
19 drag our feet anymore on this. It's just been
20 too long.

21 We've been too tolerant of too much
22 harm in our healthcare system.

1 CO-CHAIR WALTERS: It sounds like your
2 recommendation is a support?

3 MEMBER HATLIE: It is a support.
4 Thank you.

5 CO-CHAIR WALTERS: Did I see Nancy
6 over here? Oh, Ann Marie.

7 DR. SULLIVAN: You know, I -- before
8 I was in the position I'm in now, I was running a
9 couple of hospitals.

10 And I think one of the problems is
11 that the hospitals work very hard on the quality
12 measures for what they're going to either get
13 dinged for, or what they're going to get praised,
14 you know, money for.

15 But the reality is if you're really
16 going to -- which is I think partly why we
17 haven't moved so far. Because I think hospitals
18 have to get used to the fact that they're going
19 to have to do quality across the board.

20 And it's not just the particular
21 indicators. That we have to use something to
22 measure and something to pay for.

1 But, you can't depend on that. You've
2 got to say that my quality agenda has to be wide
3 and broad and deep.

4 And I think we're getting there. But,
5 we're not there yet. So, I think the panic that
6 hospitals still have when something changes, is
7 yes, I'm not going to look so good.

8 But, ultimately, if they're not
9 looking good in whatever is now the new thing,
10 then there's a problem. And they should be
11 facing that and thinking of it in an ongoing
12 basis.

13 So, I think we're at a point of
14 evolution here for hospitals. Hopefully, we will
15 get to the point where quality in everything is
16 kind of important, so we move that agenda.

17 Which it has not moved. Partly I
18 think because we still get too bogged down in the
19 very specifics. Right now that's where we are.
20 Good.

21 But, that's why I'm not too much in
22 favor of saying, you know, this is going to be

1 too hard for hospitals. I think they have to
2 face the facts that if they have serious problems
3 with these issues, they've got problems with
4 these issues and whether they've got to fix them
5 and fix them relatively quickly.

6 CO-CHAIR WALTERS: What is your
7 recommendation?

8 DR. SULLIVAN: For.

9 CO-CHAIR WALTERS: Jack?

10 DR. FOWLER: Yes, it seems like also,
11 we're not here to micromanage with CMS, which we
12 can't do anyway. And I mean, mainly my
13 understanding is there are -- what we're supposed
14 to do is say whether we think it would be a good
15 idea to have this measure as one of the measures
16 that was figured into the HAC program.

17 And that will count about three
18 percent, I think that she said, of the final
19 score. So, it seems to me I could vote on
20 whether this is a good idea or not from that
21 context.

22 And I think it is a good idea.

1 CO-CHAIR WALTERS: All right. Any
2 other comments?

3 (No response)

4 CO-CHAIR WALTERS: Okay. Let's vote.

5 MR. TILLY: Polling is now open on
6 Patient Safety and Adverse Events Composite,
7 MUC15-604. The options are support, conditional
8 support, and do not support.

9 (Voting)

10 MR. TILLY: And the results are 73
11 percent support. Twenty-three percent
12 conditional support. Four percent do not
13 support.

14 The recommendation is support.

15 CO-CHAIR WALTERS: So, at this time,
16 we want to open up the lines again for public
17 comment. And take any comments from the room in
18 general, about anything discussed today.

19 (No response)

20 CO-CHAIR WALTERS: How about on the
21 phone?

22 OPERATOR: Once again, to make a

1 comment, please press star then the number one.

2 (No response)

3 OPERATOR: There are no public
4 comments.

5 CO-CHAIR WALTERS: Thank you. Thank
6 you again, for everybody for their patience.
7 We've actually made up a lot of ground this
8 afternoon.

9 Looking forward to tomorrow again,
10 breakfast is at 8:30. We'll start at 9:00 unless
11 that's changed.

12 We'll redo the agenda probably a
13 little bit. But, this is what you do, right?

14 Cancer, probably -- it probably will
15 be first. There's five measures of which one's
16 been pulled. Then Renal has seven measures of
17 which three have been pulled.

18 All except one now. It changes
19 hourly, yes. OQR has two measures. Both of
20 which have been pulled.

21 ASC has one measure which was pulled.
22 And the psychiatric core measures has two. One

1 of which has been pulled, unless that's changed.

2 We've had a -- we'll see how time
3 goes. We had a request to do psychiatric maybe a
4 little different timing -- or a little different
5 sequence as some people are going to be leaving.

6 But, I think as long as we come
7 prepared to get through. I think, as everybody
8 knows, the bulk of the work was today.

9 And a lot of good work and discussion
10 went on today. There was a lot of good views
11 about some very important things.

12 So, thank you again. And I certainly
13 appreciate all your involvement. Cristie?

14 CO-CHAIR TRAVIS: Oh. Nothing other
15 than thank you from my perspective. And I look
16 forward to seeing you all tomorrow.

17 Please do come back.

18 (Whereupon, the above-entitled matter
19 went off the record at 5:04 p.m.)
20
21
22

A			
\$10,000 9:14	159:7 161:3 169:14	373:6 375:12 404:11	221:5,17,19 224:7
\$190 189:10,17	169:16 171:4 244:16	add-on 198:5	227:8,11,20 239:17
\$3 177:7	accountable 50:21	added 142:17 177:13	250:20 251:13,17
a.m 1:9 6:2 173:9	87:21 95:11 120:8	187:11 265:15 274:1	268:18 269:14 283:12
abdominal 398:1	376:18	299:5,9 372:22	304:16
abdominals 207:3	accrue 127:18	adding 41:16 186:21	adjustments 197:18
ability 61:18 76:5 84:17	accumulated 95:2	227:7 273:21,22	205:19
88:18 95:6 132:18	accumulating 299:14	284:3 316:1 375:15	administer 170:10,11
153:4 259:7 329:22	accumulation 299:17	413:8	administration 158:21
357:16 413:13,16	accuracy 119:15	addition 29:19 90:5	administrative 263:5
able 24:3 30:12 31:2	134:21	226:1 279:6 280:20	349:21 362:11
36:10 42:6 65:21 87:5	accurate 76:1 124:19	298:2,8 373:15 384:9	administrator 15:4
119:20 120:18 129:7	125:22 203:11	386:5 390:17 405:21	admission 197:13
130:13,14 131:9	accurately 125:13	additional 46:7 52:18	202:1 258:22 259:6
138:6 145:5 147:14	205:8 258:1 382:19	62:7 66:18 68:8 90:7	299:16
152:20 172:6 181:1	ACEP's 22:15	122:4 144:11 159:20	admissions 155:9,10
186:13 191:13 234:11	achieving 247:18	160:2 161:3 172:19	239:3
241:4 266:12 279:19	acknowledge 80:9	172:21 198:3 211:3	Admissions/Readmi...
294:10 295:13 326:14	351:17	217:7 220:12 224:3	10:15
327:21 329:9 345:18	ACO 95:8 97:4	273:6 288:11 299:8	admit 220:22 279:2
347:12 350:20,21	ACOG 137:13,14,15	300:3,19 301:5,12,16	admitted 278:14
374:19 382:3 416:18	145:18 146:3	303:18 313:1 316:2	admonition 33:11
417:21	Acquired 5:9,17 400:22	316:12 321:2 329:15	adopt 321:9
above-entitled 173:8	ACS 110:3 114:1	375:2 377:10 398:13	adopted 46:8 288:5
240:7 345:10 430:18	ACS-CDC 115:11	399:13	308:14 321:14,16
absolute 54:11	346:16 353:21 354:18	additionally 32:13	322:19
absolutely 34:5,16 42:7	act 92:14 133:9 205:22	187:14	adoption 18:18 73:16
43:1 52:4 271:4 395:6	288:4 302:10	additive 279:10	Adrian 410:10
abstain 192:12	action 424:13	address 40:8 54:17	adult 79:17 80:17 106:5
abstentions 66:16	actionable 157:17	93:22 104:12,15	121:3 350:4
abstraction 124:16	335:17 383:19	121:9 122:5 143:11	adults 136:3
357:19	active 18:10 113:2	158:10 160:6 162:15	advance 105:1 187:12
abuse 293:6 294:1,4	activities 17:12,13	163:5,16 175:6	268:7 274:2 327:10
accept 45:21 62:17	34:21 84:2 189:1	179:14 184:7 190:17	329:10 416:6 417:20
107:6	activity 84:3	191:7,16 204:8,11	417:20,21 418:6
acceptable 423:15	actual 113:11 150:16	236:12 249:1 256:5	419:12
acceptance 250:2	155:21 163:16 184:11	267:22 358:16 359:8	Advancing 240:16
accepted 62:16	186:9 231:17 265:19	408:8 421:7	advantages 356:11
accepting 62:12	410:6	addressed 50:1 162:18	adverse 23:18 132:14
access 136:9 143:1,2	actuaries 190:10	208:6 336:1	384:22 385:13 406:8
192:4 218:16	423:17	addresses 40:4 132:12	428:6
accessed 204:6	acuity 153:8	170:8 236:19 389:3	advertising 93:12
accidental 397:22	Acumen 202:2 206:21	addressing 297:3 335:7	advice 154:17
398:2	acute 195:5 243:14	adds 138:3 375:2	advise 236:15
accidentally 57:16	266:22 268:16 269:12	adequately 293:1	advisor 14:5 18:22
accommodate 352:1,6	280:17 281:8 282:22	adhere 323:19	advocacy 14:14
accommodation 112:7	340:9 390:5 397:2	adherence 23:19	advocating 156:11,13
accompanied 39:13	398:16	adjudicate 255:16	159:6,8 334:15
80:9	acute-care 83:22	adjust 155:6 220:17	Affairs 381:3
accompanying 303:12	ad 225:11	245:12	affect 39:4 189:22
account 197:7 257:1	add 37:19 44:16 53:9	adjusted 197:15 198:11	192:4 204:2 205:3
258:1,21 259:8 395:4	70:11 109:16 112:15	233:4,11,17 234:9	272:5 275:17,17
accountability 82:1	116:12 120:16 138:12	242:22 260:5 361:11	351:1
86:17 87:2,14 94:4	140:7 183:21 217:7	372:15	affectionately 80:20
105:3 133:12,14	224:9 249:6 252:9	adjustment 110:5 151:8	380:3
137:12 153:1,21	275:11 285:15,17	151:17 194:17,20,22	affirmation 320:1
154:16 156:6,12	300:3,19 301:4,12	196:22 197:5 218:1	afford 424:18
	308:7 312:22 372:19	218:10,12,14,19	affordability 177:20

179:2 198:20 288:3
Affordable 92:13 288:4
 302:10
afraid 71:12 165:10
AFT 2:1 11:2 261:12
aftermath 113:5
afternoon 11:1 181:1
 429:8
age 139:8 197:10
agency 2:9 18:16 34:4
 189:14 393:17
agenda 19:1 57:20
 61:14 62:2 107:5
 117:20 189:22 192:7
 193:14,15 277:4
 295:6 426:2,16
 429:12
agents 156:20 157:7
 158:7
aggregate 157:9,10,16
aggressive 91:4
ago 37:3 68:11 124:9
 125:20 141:11 152:14
 192:2,16,17 381:2
 390:11 412:21,21
agree 51:17 55:17 64:9
 64:10 88:15 104:19
 105:16 117:16 119:7
 128:21 129:5 138:12
 145:11 154:21 183:3
 186:17 222:1 273:10
 279:22 286:18 299:22
 300:5 301:1,18
 364:14 371:11 383:9
 385:9 404:15 410:10
 413:3
agreed 110:3 160:19
 202:4 218:6 323:10
agreeing 169:1
agreement 169:7,9
 286:11
agreements 196:4
Ah 107:14
AHA 292:20
ahead 24:9 62:1 75:2
 89:2 140:18 164:22
 281:17 326:4 420:10
 423:18
AHRQ 2:9 24:5 144:22
 145:1 146:22 147:1
AHRQ's 118:14
aims 54:18
AKA 7:17
Akin 3:13 75:4 119:12
 125:1
Albuquerque 24:18
alert 126:16
Alexander 2:4 18:4,5,6

121:1 249:4 271:16
 274:22 285:15
algorithm 55:10
align 223:11
aligned 49:19 204:18
 225:8
aligning 35:2 37:6
alignment 32:8 36:18
 36:19 40:5 52:7 55:1
 187:2,8 216:21
aligns 256:17,18
alive 243:18 252:5
 356:9,20,22 357:1
 358:19 361:8 362:5
 363:18 365:7 372:14
 379:1
All-Cause 379:11
allegiance 141:6
Allen 1:18 13:7,9,19
 46:1
Allen's 48:11
Alliance 1:17 13:15
 14:6 15:12
allow 112:6 160:12
 259:15 349:5
allowed 352:4
allows 287:17
alluded 155:4 222:6
 336:7,22
alteration 216:22
alternate 122:6,8
alternative 182:20
 352:4 385:12
alternatives 276:15,17
 277:6
amazed 154:20
AMB 72:17
ambiguous 275:6
ambulatory 12:1,3,6
America's 1:13 11:14
 238:14
American 1:13 3:10,13
 11:7 22:14 24:19 75:4
 76:19 208:8 348:19
American's 250:18
Americans 83:21 93:18
AMI 296:19 307:18
 308:8 315:13 321:20
 339:15 366:6
Amin 2:16 232:4,17
 270:5,13 289:3
 411:17 414:4,14,19
 414:22
amount 75:21 86:20
 114:1 161:10 173:21
 368:3
amounts 156:19
analyses 55:9 87:5,6

422:17 423:1
analysis 37:21 43:5
 44:10,10,13,14 55:4
 59:17 60:3,8 61:9
 62:13 64:4,9 199:12
 200:12 205:21 233:22
 236:1,2 300:11
 338:16 377:15
analyst 2:19 27:17
analytics 87:16
analyzing 221:8
and/or 341:6,22 397:2
Anderson 10:20
Andrea 1:12 12:14,16
 12:22 79:20 86:9
 88:15,20 109:14
 120:14 129:6 130:2
 135:13,13 136:18
 150:13 151:20 155:4
 194:5 196:15 209:4
 214:22 215:2,12
 242:5,13 245:22
 272:13 273:9 323:3
 328:18 341:22 342:1
 374:13 385:16 392:16
 396:15 405:17 408:15
 410:11 416:20
Andrea's 325:19 331:2
 395:7 409:17 415:17
aneurysm 206:12
 210:17 211:4 212:9
Ann 2:7 7:17,21 22:19
 22:21 90:10 123:9
 280:10 372:16,18
 373:20 425:6
announced 81:20
annoying 94:13 189:6
annual 72:16 73:11
 205:1 355:8 402:22
answer 33:19 35:16
 42:10 91:13 95:15
 96:3 124:15,17 141:2
 159:15 207:9 226:21
 226:22 246:19 261:19
 280:10 282:1 308:19
 320:10 362:7 377:13
 399:11
answer's 362:8
answered 162:4
answering 143:16
 280:8
answers 144:10 369:19
anti-smoking 96:9
antibiotic 150:16
 163:11
antibiotics 150:21
 151:5,18 152:3,22
 153:8,10,12 155:7,11

156:16 163:17
anticipated 246:10
antimicrobial 23:17
 150:12 151:21 153:16
 154:9 156:19,22
 158:5,7 159:3 163:11
 164:17 169:18,22
 170:2,14,18 171:12
Antimicrobial-Resist...
 162:21
antimicrobials 170:10
 170:12
antsy 150:8
anybody 9:19 30:17
 79:8 93:2 144:6 185:7
 204:14 241:20 269:20
 275:17 284:12 314:5
 339:14 344:21 345:1
 364:13 403:2 411:13
 423:19
anybody's 369:8
anymore 79:14 406:5
 410:21 424:11,19
anyone's 150:7
anyway 172:12 270:18
 342:12 384:11 406:15
 408:1 427:12
anyways 279:15
aortic 206:12 210:16
 211:4 212:8
apologies 25:2
apologize 143:12,16
 194:6 264:12 265:8
 265:11 321:1 374:11
appealing 139:6
appear 64:13
appeared 307:9 381:3
appears 364:15 403:16
applaud 147:13 178:8
 251:17
applicable 72:16 73:10
 123:7
application 90:2
APPLICATIONS 1:3
applied 147:3,12,13,18
 148:3 335:10 402:17
applies 83:17 395:8,11
apply 148:10 215:21
applying 120:6
appreciate 28:19 109:4
 131:11 135:6 142:14
 142:19 245:4,10
 288:13 295:5,18
 313:15 346:6 368:9
 369:10 395:5 430:13
appreciation 35:12
approach 4:4 38:7,13
 93:11 174:20 175:1,5

175:9,11,20 176:14
 177:2 179:21 181:5
 185:6 199:21 203:14
 232:8 267:17 294:5
 297:2,11 328:12
 421:9
approaches 113:12
appropriate 33:14
 52:13 53:17 54:3 95:9
 137:3,7 138:4 151:1,1
 151:4 157:19 163:16
 170:17 188:3 191:5
 217:21 248:1 303:20
 312:7,12 336:18
 343:9 365:6 390:3
appropriately 47:22
 281:20
appropriateness
 154:10 184:1,11,18
 190:4 194:12 233:3
approve 296:15
approved 55:13 321:4
 347:2
April 155:18
arbitrary 369:8
area 1:19 16:20 26:9
 63:12 86:11,15 90:19
 119:8 144:17 145:8
 161:22 184:22 190:7
 206:8 243:22 277:14
 282:9 415:22
areas 63:3 95:4 96:4,17
 118:22 121:7 180:5
 183:16,22 184:1
 185:8 197:22
arena 98:1,6 162:8
 171:11
argue 93:2 304:19
 360:14 368:5
argument 105:2
ARM 112:8,10 113:19
 348:6,8 351:21 352:5
arrangement 310:12
arrangements 17:15
arrows 407:16
artery 355:15 356:6
 361:15 379:13
arthroplasty 296:21
 341:6
article 381:1
articulate 232:7
articulated 49:3
ASC 1:21 11:19 429:21
ascertained 375:14
ascertaining 385:13
ascertainment 385:6
ASHB 15:8,10
asked 50:2 67:14 86:7

95:21 108:6 176:18
 235:16 245:1 246:1
 253:4 268:5 284:11
asking 29:22 58:3
 110:22 124:8 125:12
 232:8 277:22 320:21
 325:22 330:10 335:21
asks 55:10 293:18
asleep 402:6
aspect 185:21 273:13
 305:3
aspects 50:12 143:4
 175:4
aspiration 222:4 223:19
 258:13 274:11 279:8
 279:13 319:7
assembled 178:5
assess 154:8 287:14
 294:14 314:3 422:3
assessing 292:22
 313:14 314:10
assessment 203:11
 219:11 221:4 223:21
 300:1
assessments 145:6
assigning 364:19
assist 57:5 84:21 85:21
Assistant 205:20
associate 13:3,11 94:8
 94:16 140:19
associated 23:17 62:16
 98:9 132:22 166:4
 186:8 319:7 340:8,18
 341:4 373:5 385:3,8
 388:5 397:13
Association 1:12,13,21
 3:13 11:8 12:20 15:3
 24:19 75:5
assume 56:3 199:12
 266:8 276:7 308:2
 367:10 377:4 420:14
assumed 109:21 377:5
assuming 227:22 228:6
 322:10
assumption 77:16
 315:20
assumptions 272:6
assurance 162:6
assure 46:15
astutely 169:12
attach 118:18 211:4
attempt 60:4,19 61:21
 223:12 227:1
attempted 60:17
attendees 24:13
attention 144:17 145:14
 179:7 229:2 283:10
 299:20 302:14 325:9

391:2 420:17
attest 132:3,5
attributable 85:7
 387:13
attribute 187:5
attributed 195:8
AU 169:22
audible 19:9 25:22 78:9
 105:22 135:4 152:18
 166:17
augmented 82:19
august 20:19
AUR 170:1
automatically 40:18
 41:8 149:6
availability 122:12
 188:7
available 45:18 139:14
 145:5 159:2 170:3
 172:16 183:5 238:20
 239:8
average 183:10 300:17
 359:18
avoid 69:13 374:20
avoidable 18:14 384:17
aware 81:19 85:12
 163:14 177:5 206:1
 230:17 361:1 371:18
awareness 401:14
awful 65:11 252:6

B

b 244:7,20
baby 144:2
back 8:1 9:20 11:17
 26:7,8 40:13 41:5,10
 41:11 48:18 52:9
 63:19 88:6 97:12
 100:21 104:14 122:20
 122:21 127:10 141:12
 160:22 169:10 172:11
 173:13 175:13 185:16
 189:9,16 192:15
 203:8,10 204:21
 209:22 215:15 222:2
 228:1 230:20 231:7
 231:20 232:6 235:7
 235:17,21 239:20
 240:4 248:7 250:11
 260:1 271:5 272:21
 278:22 291:3 307:3
 311:5 312:5 323:1
 326:21 328:17 330:21
 331:9 333:12 350:13
 354:17 362:14 381:8
 392:16 393:3 396:17
 408:12 413:17 430:17
background 18:9

236:18 287:8
backpack 328:4,5
Bacteria 162:21
bad 21:10 141:18
 153:11 343:3 363:5
 364:20 415:22 416:10
 424:15
badly 177:22
balance 78:2
balanced 83:5
balancing 133:8 146:17
ban 90:14 233:13,15
bantered 323:14
Barnett 237:10
Barnett's 237:3
base 410:9
based 25:18 45:13 47:2
 60:10 92:4 94:15
 98:20 102:14 104:9
 137:2 200:12 208:7
 250:2 254:9,10,21
 256:9 258:9,17
 259:21 261:20 287:18
 297:15 310:3 347:6
 375:19 386:10 390:13
 391:3 395:12 396:1
 397:12 415:14
baseline 150:18,20
 151:9
bases 290:13 386:10
basic 83:4 185:6 189:21
 394:9
basically 189:1 191:15
 217:15 224:10 277:16
 309:6,7 394:8,15
 421:13
basis 95:17 120:11
 126:13 312:9 382:12
 426:12
basket 72:17 73:11
bat 33:7
bean 277:4
beautiful 115:3
becoming 293:9
bedside 158:20
beef 190:10
began 290:15
beginning 27:5 51:2,12
 51:15 74:16 188:15
 377:1 383:2
begins 188:21
begun 50:19 75:14
 204:11
behalf 70:12
behaves 203:4
behavior 367:1,5 368:7
Behavioral 80:18
believe 27:4 52:13

53:19 57:13 65:16
 81:14 82:2,18 83:3,10
 84:1,19 85:9,20 92:18
 96:9 120:7 121:22
 132:6 223:20 272:18
 274:17 304:8 312:22
 313:5 321:10 337:17
 347:2 357:13 372:15
 396:14 409:5,13
 418:20 420:2
believer 391:7
bell 311:18
belong 94:5
belongs 410:8
bench 423:16
benchmark 157:15
benchmarking 156:4
 157:14 160:9
benchmarks 329:5,8,9
beneficial 353:1
beneficiaries 197:11
 299:7
beneficiary 180:2,15
 186:20 187:18,21
 188:2 197:6 201:18
 204:19 288:8 298:15
benefit 58:7,13 177:13
 294:8 372:9 376:11
 419:7
Benign 214:3
Benin 1:12 12:14,15,16
 68:9 74:7 86:10 88:3
 108:7 109:15 110:11
 110:14,21 111:5,9,11
 111:13,19,22 112:3,9
 112:12 120:15 127:2
 130:12,18 136:19
 151:21 152:10,15,19
 169:9 194:9 209:5
 215:4 246:3 261:18
 273:10 274:15 323:4
 342:4,8 374:14
 385:17 405:18 406:4
 406:9,22 410:12,16
 412:13,22 414:12,17
 414:20
Bernheim 3:11 224:1,9
 230:19 257:13 262:4
 263:3,6 264:7,11,16
 265:17 266:11 318:17
 319:14
best 7:6 8:10 33:17
 45:8 85:2 99:13 136:5
 194:18 270:8,10
 369:13 375:18
Beth 24:11,16
better 8:6,9 25:13 87:18
 101:18 102:11 120:7

154:3 168:7,18
 169:19 170:15 172:15
 172:20 186:3 190:12
 194:16 195:16 196:10
 252:18 259:9 260:6
 265:15 278:19 279:18
 325:12 335:6 363:19
 365:3 369:3,11
 378:15 380:17 381:13
 381:14,16 388:1
 389:2 392:1 393:11
 416:21 421:1,2
 424:17
beyond 34:18 49:17
 88:19 139:1 142:17
 234:19,20 418:22
bias 220:16
biased 259:21
biases 25:10 388:5
big 51:20 90:12 91:3
 98:11 162:17 280:22
 293:8 357:14 360:21
 389:14 391:6
bigger 38:9 314:1
 412:14,22
biggest 37:19
bill 377:15 408:3
billing 382:19
billions 101:2
binding 60:6
Birfiss 80:20
birth 135:11 143:22
 149:20
bit 16:8 17:11 33:4 41:7
 43:10 52:17 59:4
 60:15 61:5 66:11,19
 87:7 88:7 103:10
 115:7 117:9 121:4,11
 124:4 126:7 137:8
 142:10 150:7 165:8
 174:9 180:12 189:9
 194:2 195:16 206:13
 209:2 215:6 217:11
 224:18 232:7,11
 257:10 267:12 274:2
 275:6 278:18 287:8
 289:4 296:22 297:17
 308:19 315:11 318:16
 325:1,9 408:9 413:11
 413:14 429:13
blank 31:9
blend 221:18
blocks 395:16
blood 282:11 385:3,8
blue 2:2,2 12:8,11 57:2
BMJ 82:14
board 21:18 49:8
 155:19 226:17 227:13

235:16 384:6 407:17
 425:19
body 85:12 168:9
bogged 426:18
bordering 375:22
borrow 268:9
Bossley 3:10 76:18,18
Boston 19:2
bothered 41:20 45:15
 385:18
box 324:20 325:5
brain 349:17 393:15
 397:2
brand 154:10 285:9
 300:20
break 150:8 173:6
 221:11 229:10 341:15
 345:8
breakfast 429:10
breaks 66:19
BRFSS 80:19 83:12
 86:11 87:19
brief 10:4 55:16 103:9
 150:8 204:13 290:10
 400:18
briefly 99:4
bring 10:17 18:2 41:5
 41:10,12 52:14 53:8
 86:2 132:18 216:20
 225:6 260:7 297:12
 305:7 309:13 316:15
 318:21 319:6 326:19
 326:21 330:21 337:22
 339:12 364:18
bringing 8:16 15:17
 25:10 35:4 69:11
 178:9 263:11
brings 25:5 29:15 98:2
 98:3,4 194:11 278:11
broad 94:14 155:2,7
 157:6 165:16 399:9
 426:3
broad-based 92:9
broadened 319:5
broader 96:10 97:9
 98:14 136:14 139:10
 297:5
broadly 81:16 85:19
Brock 1:20 14:22 15:2
 92:22 94:22 334:12
 405:5
brought 31:12 44:9
 196:15 224:11 230:19
 231:20 315:6 323:5
 388:2 420:16
Brown 19:17
brush 155:2,7 399:9
BSN 1:21

buddy 28:6
build 325:12 387:5
build-up 335:18
building 36:9 395:16
built 66:18 119:11
 197:8
bulk 430:8
bulky 35:22
bully 189:2,2
bunch 79:1 408:4
burden 32:9 93:21
 130:20 131:7 172:7
 193:9 260:9,12
 412:14
burdens 276:9
Burstin 2:15 7:19,20
 10:4,22 11:11,17 12:7
 12:14,22 13:7,19 14:2
 14:9,22 15:5,13,21
 16:11,17 17:1,7 18:19
 19:7,10,13 20:6,15
 21:22 22:4,19 23:3,10
 23:21 24:7,12,22 26:1
 37:13 43:17 44:8 90:5
 107:12,15,17 113:18
 113:22 122:22 138:18
 152:12 160:16 167:2
 169:4
Bush 3:18 196:17,19
 200:11 204:15 289:17
 289:18
Business 1:19 10:10
 16:21
busy 29:17 100:5
button 71:11
buttons 69:20
buy-in 100:16
bypass 355:15 356:6
 358:20 360:21 361:15
 379:13
byproduct 158:19

C

C 139:9 141:17 396:10
 421:3
C-O-N-T-E-N-T-S 4:1
C-section 139:6,12,16
 141:10
C-sections 141:7
 142:20 146:9
CABG 349:22
cake 389:9
calculate 130:14,14,19
 352:4
calculated 352:2
calculation 112:7
 136:11 147:19 275:2
 299:18 353:2 419:20

calendar 4:9,11,19,21
5:7,18 55:6 57:21
58:1 61:8,13,17,19
62:11,14,15,18 63:8,8
63:13,21 78:20 79:2,5
79:7,14 108:14
150:10 173:6 174:1,8
174:9,10,13,15 176:6
181:2 214:19 235:13
240:21 241:4,18,21
272:9 286:18 296:12
296:15 303:10 310:19
341:16 342:3 343:16
344:12 345:2,7,15
346:13 379:22 401:19
402:1,20
calendars 78:21 174:2
229:8 241:1 342:10
Calender 4:13
calf 396:22
calibrated 399:6
call 36:4 74:18 134:15
170:1 194:5,21
221:12 331:1 415:7
417:6 419:4
called 184:22 362:2
406:4,7 417:4
calling 267:1 407:4
calls 179:6
Campaign 20:3
campaigns 85:19 92:9
93:12
cancer 1:14 10:20
14:13,14 46:22 101:1
400:14 429:14
cancers 153:11
candidate 170:7 358:4
capacity 94:13
capita 205:2,5,12
capture 42:12 57:10
69:8 135:2 170:5
187:19 223:15,18
251:19 280:16,19
captured 158:19 329:19
capturing 77:22 140:1
153:13 171:10 373:17
card 36:3 57:7 112:18
314:16 363:9 372:17
cardiac 16:4 83:8 350:4
359:6 370:13
cardiologist 80:6 128:3
cardiothoracic 359:21
359:22 360:3,5,13,15
cardiovascular 46:22
cards 37:14 86:6 89:1
114:5 209:12 339:8
378:7
care 1:15,18 13:13,14

13:15,17,18 14:14
15:15 18:13 19:17
20:10,11 27:11 28:11
28:14 32:13,14 34:20
49:14 51:5 52:5 73:22
82:17 84:22 91:22
92:14 101:1 113:11
120:8 122:14,16
123:17 127:21 132:17
132:19,22 143:2
156:21 157:11,21
159:4 161:22 175:15
177:6,11,18 178:3,16
178:18 179:14,20
181:18 184:19 186:4
186:7,12 187:20
188:4 190:4 192:13
192:21 195:5,5,6
201:3 204:6 214:20
216:12 218:17 219:17
221:14 228:13 231:14
243:13,14 244:7,16
258:14,17 272:20,22
280:17 281:8,19
282:22 287:16 288:1
288:2,2,4 289:9
291:10 296:17 299:15
302:10,10 305:3
310:6 312:18,18
313:3 314:3 319:3
329:18 332:6 338:18
339:21 340:9,19
341:5 359:19 360:11
360:12 377:16 401:16
cared 127:11
career 391:7
careful 288:13
carefully 273:1 422:5,7
423:7
caregiver 32:15
Carroll 92:7
carrot 100:11,13 101:18
102:10
carry 293:21
CASC 1:21
case 141:5 142:1 150:6
229:15 232:1 367:18
370:8 380:19
cases 50:4,5 120:10
124:16,18 125:6
208:12 276:11 319:7
cast 211:21
catalyzed 84:3
catch 241:5 255:19
catch-22 413:12
categories 38:14 39:12
55:22 123:12 156:22
187:4 275:1 279:8

categorize 387:19
category 40:17 41:16
43:16,22 45:11,18
46:10 48:12 69:8
117:18 148:15 161:20
164:2 210:5 299:10
cause 96:6 112:17
200:2,6 216:1 220:4
237:9 300:1 335:15
374:21 391:20
caused 392:2
causes 94:20
causing 182:8
CDC 23:13 81:4,5 83:11
83:19 84:20 85:20
87:4 96:1 99:14 110:3
114:1 150:17 158:14
160:18 161:10 166:3
171:18 172:17 293:12
348:19 352:3 396:8
CDC's 168:15 169:7,9
401:11
CDP 10:17 46:16 337:9
CE 251:20
Cedar 26:17
cellulitis 342:20,21,21
342:22 343:2,3,5
Census 83:9 230:12
center 10:20 12:1,6,18
20:12 51:18 80:8,14
92:6
centered 135:22 179:21
centers 2:10,11 3:11,14
3:16,18 12:3 18:11
23:12 80:15 84:4,5
cents 44:17
CEO 10:10 14:12 15:15
certain 48:5 68:20
86:20 90:14,19
156:16 206:14 235:16
287:19
certainly 30:13 32:9
34:18 35:3 51:11 52:4
52:12 96:16 105:9
116:6 142:14,19,22
143:3,5 147:7 148:19
158:2 159:8 163:9,21
184:18 206:2 248:13
248:17 253:13 268:3
301:18 311:4 312:10
313:9,16 314:6 337:4
348:7,11 351:10
366:21 371:8 377:12
404:12 422:13 430:12
certified 73:16 360:8
certifying 360:11
Cesarean 135:12
143:22 144:1 149:20

cessation 49:2,14
50:16 82:16 85:18
93:11 94:3
cetera 147:11 253:2
370:10,11 399:8
chair 16:5 59:6 131:18
327:6 335:21 363:12
378:6
chairing 30:9
chairs 1:10 6:7 10:7
25:12 62:3
challenge 7:13 125:11
173:20 358:15
challenges 127:15
128:12 133:10 154:12
234:14 236:4 237:22
challenging 362:9
chance 29:12 42:16
50:11 59:1 67:17,19
137:19,20 203:2
211:7 290:22
change 37:12 41:6
62:18 65:19 66:3,11
71:16 129:3,4,8
159:13 189:13 208:1
216:20 217:13 222:19
222:21 223:10 227:17
227:18 233:1 348:13
351:21 352:7 353:1,8
386:9 395:20 399:21
406:2 410:19 417:11
417:12
changed 37:8 222:3,8
274:11 319:5 351:5
361:6 395:22 406:7
420:3,3 429:11 430:1
changes 37:20 85:5
92:13 112:2 187:6
279:9 285:1 405:21
418:3 420:14 422:14
423:7,12 426:6
429:18
changing 216:15,22
319:17,18 420:12
channeling 146:5
characteristics 237:5
charge 276:19
charged 191:14
charges 201:14,22
charging 191:4
chart 124:15 253:20
262:17 288:16 357:19
407:13
chase 94:21
chasing 94:21
chat 70:16
cheaper 22:1
cheapest 186:6

check 130:7 324:20 325:5 418:21 419:1 checking 29:22 cherry 394:8 Chicago 302:4 Chicago-based 15:16 Chief 2:15 7:20 13:12 children 136:4 138:7 Children's 1:12 12:18 12:20 Childrens 16:5 choice 47:19 95:13 147:15 331:17 choices 65:17 73:3 89:20 106:9 211:12 cholecystectomy 206:14 212:21 213:2 choose 72:18 97:12 331:16 choosing 147:16,17 chose 141:3 215:18 263:22 chosen 95:10 Chris 7:21 chronic 49:16 chump 189:12 cigarettes 93:10 circles 81:22 circumstance 86:7 circumstances 346:8 citizens 276:21 277:20 city 90:13,15 91:7,9,15 92:6 claim 130:7,16 claims 77:16 78:3 130:5 136:7,9 137:2,7 139:20 140:11,22 143:1,3 247:13 251:12 259:2 260:7 260:11 262:8,9,15 263:5,16,17,21 264:1 264:21 265:1,5,22 268:17 380:21 381:6 383:9 395:11 396:19 claims-based 113:6 142:22 247:11 251:3 251:14 257:20 259:16 260:8 264:18 357:18 395:8 clarification 89:18 110:1 121:13 130:13 226:1 308:19 318:16 319:1 353:15 411:18 clarifications 232:5 clarified 57:22 clarify 62:5 66:10 91:13 115:22 122:3 130:3 130:12 160:5 165:8	210:11 224:5 255:7 269:21 274:9 285:22 289:6,14 298:11 305:13,17 338:14 369:22 409:9 411:19 clarifying 129:14 clarity 56:12 232:11 255:12,20 256:2 278:11 315:11 412:10 Class 396:10 classified 47:18,22 88:2 146:1 351:14 401:9 422:16 clear 56:10 86:16 153:7 160:22 171:5 210:20 233:14 234:14 255:2 260:14 264:9 266:6 291:2 292:20 311:22 375:18 381:19 386:7 407:9 414:1,5,6 clearer 166:1 clearly 117:5 120:1 122:19 127:17 148:22 154:1 160:17 230:5 334:14 Cleveland 22:11 85:4 click 62:19 67:8 122:19 122:21 212:1 clicker 57:2 69:20 70:1 70:15 164:22 clickers 70:8 clicking 70:20 71:8 clinic 22:12 85:4 94:16 100:5 101:14 clinical 15:7 174:17,19 175:4,7,22 176:11,19 178:11 179:2,13 185:8 197:12 201:12 201:21 202:2,6 204:14 206:8,17 207:12 212:22 213:3 213:14 214:3 215:20 219:19 254:9 260:2 266:17 268:18 287:13 287:19 297:12 312:18 335:16 339:10 350:1 356:12 366:4 369:10 392:17,19 clinically 202:13,13 222:8 245:13 287:15 290:4 297:15 341:21 clinician 222:22 369:13 clinicians 202:4 clock 71:2 close 137:21 265:20 closely 123:3 159:9 191:8 205:9 closer 138:19 224:18	CMM 21:4 CMS 2:11 3:12,15,17,19 4:3,14 20:5 23:7,7 28:15 29:1,4,7,22 31:1 33:11 34:17,18 36:21 37:5,10 41:4,9 42:17 47:5 50:8 51:3 51:6 53:1 68:6 74:12 79:19 80:4 81:16 84:10 87:4 88:15 99:14 101:17 125:17 126:12,21 129:18 130:13,21 139:2,4,12 139:15 141:3 142:9 142:21 148:9,13 163:13 167:18 183:22 184:9 194:13 196:13 196:19 199:5,16,21 200:3 202:2 203:9 205:6 206:22 216:7 218:2 220:2 222:13 223:1 235:8 237:6,15 245:11 247:6 253:9 257:16 267:15 268:2 268:6 279:7 280:2 281:16 287:5 288:10 289:6,14,18 294:17 309:10 310:9,16 315:1 323:10 324:14 325:14 326:18 327:22 332:20 348:2 350:21 352:9,16 355:17 362:11 374:6 378:13 394:19 397:15 403:19 407:7 414:8,19,21 416:3 422:6,13 424:12 427:11 CMS's 201:6 256:21 266:16 420:1 co-chair 1:11,11 6:3,12 6:15,18 7:3,8,17 10:9 10:19 13:15 26:3 27:21 30:16 33:5 35:6 35:7 36:2 44:16 46:1 47:7 48:3,13 50:10 54:5 62:11 68:22 70:18 71:15 74:15 78:7,10,17 79:12,16 86:4 87:22 88:5,12,22 90:10 91:12 92:21 94:6,22 97:14 103:1,5 104:18 105:11,20 106:1,20 107:20 108:3,10 109:1,13 112:16 114:5,15 115:4,9 116:4,18,22 117:3,11 118:2 120:1 120:14,20 122:17	123:9 124:1 128:15 129:13,15 131:11,17 132:7 134:1,13 135:2 135:5 136:16 138:10 138:14 140:6 142:3 146:21 148:5 149:18 150:6 151:19 154:5 154:18 155:13 159:14 161:7 162:9 164:13 165:7 166:11,19 167:11 168:12,21 171:15 172:10 173:1 173:11 180:17 182:16 184:14 185:4 186:14 188:10 194:4 196:13 198:13 200:8 202:19 204:12 206:5 207:10 209:4,11,20 210:2,9 210:18 211:6,20 212:3,8,17 213:11,21 214:12 215:12 217:3 219:2 220:9 221:21 222:9,15,19 223:3 224:8 225:18,21 226:20 227:21 228:9 229:4 236:20 237:19 239:10,13,22 240:5 240:10,18 242:10,13 242:16 244:22 245:18 246:9 248:4 249:1 250:3,11 251:8,15 252:1,8,22 254:20 255:9 256:1 260:13 261:9,16 262:18,20 263:4 264:5,8,14 266:5,18 267:10 268:13 269:4,9,20 270:11,15 271:15 272:8 273:8 274:20 275:10,13 278:4 280:6 281:15 282:17 284:5,11 285:13,16 285:18 286:15,19 287:2 291:14 295:2 296:10 298:10,17 301:15 302:22 303:22 305:12 306:4,8 307:5 307:10,15,20 308:21 310:15 312:1 314:16 316:4,18,19 318:22 319:15 320:11 321:3 321:18 322:8,21 325:17 327:2 330:18 332:10 333:18 334:12 335:12 337:20 338:13 338:21 341:14 342:7 344:3,14,20 345:13 347:17 348:1,15
---	--	--	---

349:4 350:12 351:18 353:14,17 357:6 359:10 362:17 363:8 365:15 366:18 367:10 367:13 368:11 369:18 370:4 371:10 372:11 372:16 373:16,19 374:5,11 375:20 376:21 378:4 379:8 379:20 381:18 382:5 383:12,21 384:20 385:15 386:20 387:9 389:6 390:7 391:15 393:6,20 394:21 399:12,22 400:12 402:3,6,14 403:5 404:7,18 405:1,5,16 406:21 408:10 409:9 410:1 411:6,10 417:4 419:2,21 423:4 424:3 425:1,5 427:6,9 428:1 428:4,15,20 429:5 430:14 Co-Chairs 61:15 co-partner 15:18 coalition 1:14,19 14:13 15:16 16:21 coating 126:3 code 230:14 259:14 codes 113:1 187:5 208:17,21 261:20 343:1 coding 223:13,14 386:10 cognitive 243:10 252:11,17 cognizant 131:7 205:17 246:22 247:16 283:12 283:14 351:11 422:14 cohesive 202:13 324:6 cohort 224:13,15,19 225:3,7 227:15 229:1 263:17 265:4 274:11 274:13 307:1,4 308:6 320:14 322:2,4 cohorts 263:16 coin 256:10 collaborate 152:5 collaboration 1:22 11:20 12:2 82:21 153:3 348:19,21 357:10 collaborative 355:18 collapsed 61:2 colleague 232:21 colleagues 30:4 94:9 136:9 138:13 148:20 308:8 320:1 381:2	collect 83:12 124:12 158:1 collected 81:1,4 113:10 119:19 125:14 236:9 249:16 251:4 322:13 collecting 126:10 129:20 131:20 132:1 151:9 251:11 collection 26:19 119:22 123:20,21 124:5,11 125:2,22 154:12 251:2 collective 49:12 College 22:14 348:20 color 220:19 Columbus 390:12 combat 163:10 Combatting 162:21 combination 242:4 263:19 264:1 combinations 156:21 combined 262:8 combining 386:3 come 9:20 25:12 31:7 36:15 43:19 46:19 47:6 57:5 63:19 86:21 87:4 88:6 101:4 104:14 125:8 126:17 146:3 156:10 175:6 175:13 181:13 182:9 188:20 198:3 199:19 209:8 215:15 239:20 240:4 258:4,9 265:1,6 271:11 272:21 274:6 307:4 311:5 327:12 328:10 345:22 356:4 356:10 363:21 369:18 378:19 387:15 388:20 411:7 412:3 430:6,17 comes 42:3 45:9,20 52:21 54:3 126:9 130:4,7,10 133:8 204:4 219:11 228:1 231:15 270:19 305:16 312:4 325:14,14,15 348:21 comfort 168:7 comfortable 169:5 275:8 406:14 coming 6:4 7:7 30:5 31:3 35:19 96:7 97:1 114:4 132:6 133:19 169:10 227:14 231:3 231:7 237:14 257:18 278:22 316:22 332:2 424:8,17 command 36:16 Commandments 367:7	367:9 comment 4:7,17 5:12 5:20 6:13 33:9 36:3,9 52:1,10 67:3,13,18 68:2 78:13 103:9 105:11 126:16 132:8 139:18 144:8,13 145:20 181:2 182:22 184:17 185:11 188:17 198:15 199:17 219:8 219:9 222:14 225:20 238:9 244:1 249:7,11 250:15 254:18,22 255:10 270:6 274:22 282:18 285:18 291:18 291:22 292:3 295:11 295:15,15 296:7 305:10 306:21 309:3 309:4,18 321:7 324:17 344:5 348:14 360:9 361:5 363:20 367:11,15 368:9 371:14 374:7,17,18 383:1 391:17 394:19 402:1,4,7,9 403:9 405:17 428:17 429:1 commentary 378:13 commented 272:4 Commenters 67:14 commenting 67:3 414:22 comments 29:14 32:6 59:2,16 67:7,9,14,16 67:22 68:4 74:18,19 75:1 76:21 78:8,11,16 81:8 89:3 97:16 109:4 115:4 120:21 127:1 132:10 138:15 144:15 145:19 146:7 148:6 152:9 154:19 162:19 177:2 184:9 185:7 198:16 202:8 204:5 206:8 208:8 215:20 224:3 238:5 245:4 246:3,15,17,17 249:5 250:6 256:4 260:10 270:21 273:7,11 275:12 281:16 291:20 295:5,6,8,19 296:1,9 301:16 303:2 310:16 326:18 331:2 339:11 346:4,5 348:16 349:7 350:15 353:15 359:11 363:8 369:20 379:6 395:2,4,7,10 399:13 402:12 403:11 428:2 428:17 429:4 commercial 139:4	309:19 Commission 20:18 360:7 commissioner 22:22 committee 6:19 9:15,22 10:15 17:14 22:15 24:20 29:11 34:14 55:14 58:6,12,17,22 68:5 69:5,12,16 75:12 86:3 94:10 96:8 97:7 97:11 135:8 160:19 185:5 219:6 224:12 226:4,19 227:7,9,16 231:20 232:1,20 236:11 259:18,19 268:5 269:7 270:20 274:9 299:12 301:10 303:1 311:13 325:15 331:12 350:16 411:22 412:5 415:10 committee's 17:17 226:10 227:12 299:19 303:17 committees 10:16 271:8,9 common 174:11,18 212:21 213:2 commonality 75:9,15 Commonwealth 20:18 189:14 communicate 127:9 communicated 293:15 communities 94:15 98:7 99:12 100:16 102:21 191:12 218:16 231:12 388:9 community 85:10 94:14 95:7 98:19 99:19 100:2,8 101:20 102:2 102:14 103:21 104:6 104:8,22 105:7 126:13,16 151:22 153:16 159:4 188:16 193:15 195:10 260:5 272:20 363:17 364:7 364:22 365:2,3 366:13 387:2 390:12 390:13,16 391:3,3 community's 95:11 community-acquired 157:7 community-based 82:11 85:13 96:15 98:20 companies 193:20,21 220:6 companion 356:2 company 219:18
--	---	---	---

Compare 132:2 145:11
160:12 195:9 306:1
306:22 307:19 308:10
318:4 319:11 320:18
321:22 322:12 330:13
351:2 368:17 370:2
377:18 401:3
comparison 48:16
300:17 372:13 390:19
comparisons 197:21
287:18
compelling 384:18
competency 54:22
competent 278:2
competition 171:9
complaints 140:12
complementary 146:18
complete 121:11 150:9
275:8 358:11,11
375:10
completed 226:18
completely 64:11 115:1
154:8,21 160:20
166:13 410:19 411:2
complex 208:5
complicated 94:19
127:6 413:14 418:16
421:18
complication 199:1
complications 141:19
253:14 359:19 384:17
compliment 281:13
complimentary 184:10
216:5 288:18
comply 358:19
component 82:16 85:1
96:8 199:4 291:8
385:3 397:20 421:20
components 189:21
249:8 382:16 386:1
389:21 392:11 397:9
406:18 409:6,22
composite 241:15
284:17 298:8 334:19
363:4 372:7 380:3
385:2,4,10 388:21
389:8,17,19 390:1,13
391:5,18 394:11,13
396:2,9,11 398:12
399:4 400:4 406:8
412:17 414:7,9
419:20 421:13 422:1
424:8,14 428:6
composites 377:11
390:3
comprehensive 223:21
323:21 325:10
computed 398:19

computer 249:8
concept 42:20 77:7
80:12,17 83:5 241:12
318:7 324:21 325:4
341:20 348:10
concepts 4:14 284:8
287:10
conceptual 218:13
233:22 234:3,11,17
236:1
concern 42:8 122:8
126:12 139:20 145:22
146:14 189:18 201:5
220:14 222:12 249:20
249:21 270:22 292:5
292:19 306:13 394:5
398:5
concerned 25:15 76:8
95:3 119:12 141:15
179:11 217:21 220:12
223:1 256:15 272:15
294:1 302:11 360:5
397:19
concerns 25:9 32:9
42:13 104:13,15
124:4 125:18,21
133:17 141:16 160:7
164:15 175:21 187:15
207:19 243:1 245:5
254:12 275:18 316:9
369:20 387:12 388:8
389:3 394:4 411:4
420:5
conclusion 412:4
concrete 215:5
concur 250:6 383:14
condition 5:10,17 66:1
66:3 116:2 117:15,16
117:17,21 119:3
122:9 142:21 159:21
167:5 168:5,10,15,20
169:6 171:16,17
180:11 186:18 199:8
204:4 210:20 211:9
217:7 219:19 220:13
221:2 223:18 226:14
229:6 252:13 258:9
280:13 286:2,10
290:7 297:4 309:21
366:4 381:21
condition-based
219:21
condition-specific
316:13
conditional 40:16,18,22
41:8 42:15 44:19 45:3
45:4 46:5 60:10 61:3
66:2,5,6,9,12,13,14

72:1 76:14 108:22
115:13,20 116:1,13
117:7,18 118:3 119:3
119:18,18 127:15
134:6,10,12 135:17
136:14 149:22 150:3
159:21 161:6 164:19
165:5,6 169:7 183:1
184:13 210:10 211:8
211:13 212:13 213:5
213:8,17 214:8 217:1
217:8,20 226:2
228:15,18,20 250:2
255:3,4,5 267:4,6,8
268:20 269:1,3,17
270:2 283:2,5,7
284:21 340:1,4,11,14
340:22 341:11 354:1
354:6,8 355:3,5 376:3
379:14,17 381:21
383:15 400:5,9
402:21 404:14,21
411:12 428:7,12
conditionally 39:20
45:19 46:17 47:2,16
60:22 66:8 172:14
185:13 210:6,21
274:18 387:10
conditions 39:21 49:17
65:18 66:10 70:6
117:22 118:4,18
124:20 134:16,22
135:3 136:1 142:16
142:18 165:8 166:12
167:3 175:7,22
178:18 179:7 183:17
200:9,17,18 201:13
205:3,9 207:12 211:4
228:22 230:3 267:14
269:5,8 276:9 283:9
286:22 287:19 355:7
384:8 400:22
conducted 55:4 125:19
conference 1:8 331:1
362:15
confidence 37:5 232:12
confirm 269:7 327:5
357:12 412:1
conflict 18:1 21:16 25:7
261:14
conflicts 20:1 240:12
240:16
confounding 230:10
confront 136:4
confused 43:10 111:14
112:20
confusing 320:2 322:5
confusion 47:12

Congress 208:8 304:10
Connecticut 12:17
195:4
connects 83:18 159:3
consensus 10:13 51:11
53:22 71:20
consent 4:9,11,13,19
4:21 5:7,18 55:6 56:3
57:20 58:1 61:7,13,17
61:19 62:11,14,15,18
63:8,8,21 78:19 79:7
79:14 107:5 174:8
176:5 240:20 241:1,4
241:18,21 286:18
296:12,15 342:2,10
343:16 344:11 345:2
345:6,15 346:13
401:19,22 402:19
consequence 146:12
378:18
consequences 146:15
294:15 304:14 313:6
consider 30:1 32:5,5
44:11 53:15 54:21
67:11 75:12 117:15
140:10 168:10,20
243:8 244:13 247:22
267:15,17,21 268:3
294:20 326:20 334:18
337:6,10 374:8
395:20
considerably 382:14
consideration 4:7,17
5:13 28:17 35:4 39:4
39:11 40:6 49:13
53:21 54:2 55:5,12
57:19 58:5 59:15,21
60:2 65:13 67:4 69:17
89:22 199:19 218:21
227:7 233:10 244:6,8
260:17,19,20 267:19
287:10 288:13 295:20
296:2 303:9 310:22
374:10 386:18 388:18
407:8 409:1
considerations 32:4,18
33:18 148:17 163:18
386:17
considered 43:8 68:5
116:12 218:19 227:19
249:13,22 265:3
276:11 366:2
considering 29:5 73:6
288:10 300:17
considers 90:12 416:3
consistency 126:6
consistent 65:1 353:4
consistently 124:12

249:17 251:19
Consortium 34:21
consternation 42:3
constituted 256:11
constitutes 292:9
constraints 53:1
construct 197:7 234:17
 290:3 369:3
constructs 110:4
construed 21:17 383:6
consultant 14:5 76:19
consultation 359:19
consulting 17:15
consumable 281:6
consumer 14:6 145:9
 309:22 310:10 382:11
 394:14
consumers 36:20 73:2
 144:18 145:14,15,16
 147:14 179:10 240:15
 309:20 310:5,13
 331:20 374:18
consuming 126:4
contact 86:22 113:8
context 52:19 59:7
 235:4,10 427:21
continually 271:5
continue 43:20 58:18
 75:12 82:6,10 110:7
 114:9 172:3 217:11
 235:2 251:7 294:10
 387:11
continued 43:22 44:21
 102:6 105:9 106:6,7
 106:17,18 107:17
 124:9 244:20
continues 114:11 177:8
 217:22 315:5
continuous 8:4 239:16
continuum 179:20
contracted 203:9
contradictory 140:16
contribute 97:16
contributing 237:12
control 2:10 23:12
 80:16 92:15 188:9
 292:17 367:2 390:22
controlled 292:15
controlling 293:1
convened 233:1
convening 236:11
conversation 37:4
 47:13,20 48:2 87:7
 117:17 136:8 174:22
 175:5,9,10,19 215:13
 236:22 297:1,5
 314:21 374:15 403:13
 415:3

conversations 90:6
 120:16 173:14,22
 174:4 236:10 304:9
 334:14
conversion 395:7
convictions 229:14
Conway 80:14
cooperate 98:10
cooperation 98:5
coordinated 82:19 84:2
 84:7 332:8
coordinating 34:14
 55:14 58:6,11,17,22
 68:5 69:5,12,16
 232:19 331:12
coordination 27:12
 32:13 48:22 49:4,7,11
 49:21 50:4,6 51:5
 52:5 73:22 81:18
 89:15 105:6 123:14
 132:20 288:2 312:19
copay 310:1,12
COPD 101:1,5,11
core 34:20 35:2 110:4
 429:22
corner 68:21 70:8
 108:12
coronary 355:15 356:6
 358:20 361:15 379:12
correct 56:7,8,9,15
 72:14 74:11 77:22
 91:15 112:11 114:21
 115:2 116:19 117:1
 121:21 137:4 150:19
 176:1 230:18 263:2
 286:4 305:18 307:13
 318:9 320:22 321:13
 322:16 344:13,15
 351:22 405:2 408:13
correctly 56:3 355:7
correlated 85:6
correlates 89:5
cost 77:14 177:21
 178:7 179:8 181:10
 181:11 183:13 184:5
 190:9,9,11,12,13,14
 191:1,20,22,22 192:3
 192:9 193:6 199:2
 200:17 203:21,22
 204:2 205:5 226:3
 227:6 230:2,16
 287:21 288:8 289:9
 289:16,19,22 290:6
 299:17 300:9 301:7
 301:13 309:3,12,22
 313:14 314:13 315:17
costing 229:18
costly 216:3

costs 188:14 197:20
 201:10 204:7 205:14
 299:15 343:4 401:16
count 66:17 71:15
 155:9 329:11 427:17
counted 71:12 121:18
 364:17
counters 277:4
countervailing 141:16
counties 83:14 95:3
country 141:8 162:5
 293:7 357:21 358:7
 358:12 391:6 416:3
 424:7
county 81:1,4 82:20
 83:1,3,13,17,22 84:19
 85:3 90:3,4,6 94:16
 95:18
county-based 83:10
 85:7
county-level 95:16
couple 30:17 37:8 38:9
 41:20 43:21 75:6,16
 103:6 112:13 115:17
 124:8 125:18,19
 132:10,12 136:20
 142:9 144:14 146:6
 173:3 223:6 238:14
 243:1 273:16 279:6
 292:6 293:4 323:13
 338:2 345:16 393:3
 394:10 425:9
course 51:5 73:19 74:1
 142:1 205:14 318:1
 320:17 329:20 364:16
 378:5 385:1
cover 174:2 175:13
 183:22
covered 224:10
covers 139:10
CPA 1:19
CPD 16:15
CPT 113:1 208:17
create 96:19 97:6
 125:11 187:2 218:18
 276:9 293:19 376:1
created 55:10 92:8
 262:9
creates 186:22 288:1
 358:18 376:10
creating 294:2
credibility 392:19
creep 276:13
crisis 94:1
Christie 1:9,11 6:6 10:8,9
 14:20 30:9 38:10 52:3
 55:3 57:6 129:13
 169:5 181:7 225:19

236:17 305:19 328:22
 330:20 332:13 334:6
 338:12 367:14 430:13
criteria 38:12,15 48:21
 54:9 55:13 61:10
 276:10 375:7 384:9
critical 8:15 19:17 40:4
 40:8 54:21 77:11
 81:15 84:22 85:14
 162:1,3 234:7 338:6
critically 86:14 135:21
 161:9,17 167:19
 182:8 393:2
criticisms 257:21 356:5
cross 2:2 12:8,11 50:19
 288:11 386:11
Cross/Blue 12:11
crosscutting 188:3
crossover 17:5
crosswalk 209:10
crowd 97:19
CSAC 10:14 14:21
 227:13 412:21 415:12
cuing 261:6
cultural 54:22
culture 15:18 37:11
curious 139:14 202:21
 203:5 309:10
current 38:22 39:5
 75:21 79:18 80:17
 88:13 106:5 226:6
 227:4 230:21 234:21
 263:9,12 264:18
 285:6 286:7 298:14
 299:21 321:12 372:14
 397:7
currently 13:12 40:20
 41:14 109:8 132:5
 150:21 186:20 205:18
 206:4 216:14 262:22
 286:6 288:7 307:21
 313:19 319:19 352:2
 365:20 366:2 387:22
 401:20 402:19 415:1
curve 265:14 311:18
customers 193:22
cut 91:8 192:10,11,12
 420:13
cutoff 369:8
cutting 8:14 420:8
Cuyahoga 85:3
CVs 9:21 10:1 17:17
cycle 152:16 418:18

D

D 423:14
D.C 1:9
damaged 92:16

Dan 23:10,11 150:19
 155:13 160:7,17
 161:13 167:16 380:18
 386:17
Dan's 166:14
dance 388:2
dangerous 119:9
DANIEL 2:10
darn 317:11
Darshak 80:6 86:5
data 46:3 76:1,5 77:22
 80:22 84:20 91:21
 93:7,9 95:2,4,9 99:3
 112:22 119:22 124:11
 124:19 125:13,19,22
 130:6 131:19,21
 132:1,6 133:7,10,13
 133:15,20 134:20
 136:7 137:7 138:4
 139:14,20,22 140:1,2
 140:4,11,20 147:3,19
 148:1,3 151:9 157:10
 157:16 158:2,3,9,18
 159:1,11,12 161:12
 161:19 164:4 166:6
 168:7 170:13 171:10
 171:19 172:11,15,20
 172:20 192:18 207:5
 209:1 221:12,13
 229:15,19 234:15,22
 236:4,9 237:14 243:2
 243:6,12,16 247:1,3
 247:10,13,13,18
 248:2 249:15,16
 251:2,3,12 254:1,12
 254:13 260:3,7 262:6
 262:7,8,9,9,11 263:16
 263:17,19,21 264:2
 264:22 265:2,5,16,22
 266:9,17 278:18
 300:12,18 311:15,16
 323:15 328:7 332:20
 333:9,13,14 335:22
 336:9,22 338:1,10,15
 347:6,10 359:15,16
 369:6 371:4,7,15,20
 371:22 372:3 374:4
 374:19 378:3 380:15
 380:21 381:4,6 385:7
 387:13 391:21 392:22
 393:10 395:11 396:19
 397:16 398:21 399:6
 410:6,9 411:16 422:8
Database 16:6
date 7:15 112:15
dated 68:17 399:2
David 1:13 11:11,13
 238:8 239:11 249:2

250:12 298:22 301:19
 302:12 314:16 381:1
 390:8 391:17
David's 302:3
DaVita 13:13,18
day 5:22 8:17 10:20
 67:19 175:15 203:8
 258:21 259:5 295:16
 295:16 349:14,16
 356:9,22 358:15
 359:5,9 360:18 361:3
 361:22 363:18 369:7
 369:7 370:20 392:7
 393:15 400:14 403:1
 411:7
days 7:16 8:22 18:22
 26:12 27:15 29:17,19
 38:9 49:15 68:11
 103:6 132:20 193:21
 197:8 241:11 272:11
 273:16 278:22 282:22
 299:15,16 356:15,17
 358:19 359:21 361:8
 361:21 362:6 365:8
 367:22 368:2,2,3
 370:16 373:3 377:13
 410:13,14 416:6
 417:20
deal 25:13 129:11
 276:16 388:9 415:18
dealing 78:22 280:8
 296:16
Dean 13:11
death 137:21 243:9
 244:14
deaths 293:10
debate 383:11
debated 104:1
debilitated 413:7
decade 277:21
December 1:6 68:3
 118:16 401:3
decide 33:21 34:6
 94:15 99:12,13 234:8
 414:7
decided 21:7 352:16
 417:16
decides 129:18 277:9
decision 38:13 39:10
 39:13,14 42:4,14 45:2
 45:13 48:4 55:22 58:4
 58:12,14 59:12,19
 60:13 66:6 145:9
 257:1 295:9 325:2
 352:10
decision's 352:12
decisions 19:1,5 34:17
 35:14,15 39:12 54:13

58:15 131:3 145:5
 253:10 256:19 258:10
 258:16 310:2,3 351:8
declare 15:20
decompress 240:3
decrease 98:7 100:14
dedicated 15:17
deductible 192:19
 310:1
deemed 56:7
deep 218:21 398:6
 426:3
deeply 369:14
default 66:9
defend 190:21
define 290:5
defined 233:19 265:4
 356:16
definitely 100:2 139:7
 149:14 152:22 199:3
 236:9 313:20 318:5
 327:3 370:14 419:16
definitions 114:19,22
deformities 208:14
degenerative 208:19
degree 405:8
delayed 345:21
deliberations 60:11
 67:11
deliver 28:15
delivered 53:13
deliveries 141:20
delivering 82:15 171:10
delivery 135:12 141:17
 149:20 276:1
Delores 29:14 33:5
 34:11 35:16 57:21
 118:1 139:1 140:8
delved 126:7
DEMEHIN 3:13
Demihin 75:3,4
demographic 89:5
 218:7 229:3
demonstrate 243:7
demonstrated 119:19
demonstrating 82:3
denominated 110:9
denominator 40:12
 66:18 121:14 143:5
 143:21 186:7 397:3
denominators 83:2
department 99:5
depend 45:5 426:1
dependent 202:18
 233:18 343:5
depending 44:5 137:19
 248:2
deprive 193:17

derived 83:8 105:17
describe 39:11 169:15
 264:14
described 57:21
describes 261:1
describing 38:14
description 121:2,15
deserve 128:7
deserves 96:6
designation 56:4
designed 223:15
 249:13 287:14 289:8
desire 43:20 50:13
 142:16 155:11 316:7
 316:11
desired 140:15 338:6
 366:12
desires 258:3
despite 221:14
desserts 193:18
detail 17:11 208:1
 231:21
detailed 197:2 398:3
details 59:16 329:16
 342:17 394:1
determine 157:18 182:4
determined 43:2
 201:12
determining 178:22
 220:16 245:14
devastating 416:5
develop 12:2 21:18
 50:13 104:5 151:3
 203:10 309:11 337:5
 362:12
developed 20:4 38:18
 39:18,18 42:19 43:9
 43:14,18 44:4 47:19
 47:21 52:10 53:15,19
 55:12 90:1,12 107:3
 118:13,15 150:17
 153:19 200:1 203:9
 208:10 210:1,3 224:2
 262:5 290:1 334:1
 350:2 355:16,21
 376:5
developer 12:5 43:20
 44:6 91:1 122:4
 154:13 155:22 167:21
 167:22 169:13,14
 172:1 226:11 258:7
 265:12 289:6 377:21
 394:18
developers 46:20 47:4
 104:12 122:2 232:9
 234:21
developing 84:21 85:21
 152:2 179:1 246:20

259:14 271:6
development 10:13
 13:16 40:3,4 43:6,22
 44:21 45:6 47:17
 51:12 53:9 54:1 89:20
 89:21 102:6 103:14
 103:14 104:11 105:10
 105:18 106:7,8,17,18
 106:22 107:17 108:1
 108:15,20 144:5,7
 151:12 206:22 244:20
 245:11 248:3 255:6
 257:8 355:20 357:10
 392:6
develops 145:2
diagnoses 197:8
diagnosis 223:17 397:2
diagnosis-based
 299:14 301:4
diagnostic 385:7
dialog 349:13,14,15,19
die 293:12 365:9
difference 73:8,12
 201:19 202:6 203:15
 229:20 231:16 232:3
 245:8 247:8 258:12
 280:22 368:1 380:12
 382:1 404:3 419:9
differences 64:20 75:8
 143:9 188:7 195:21
 197:19 218:15,18
 221:7 237:12 246:6
 246:13 255:16 347:11
 397:6 404:6 417:22
different 9:2,6 17:10
 36:22 41:21 42:22
 44:14 60:15 64:11
 65:4,5 76:2,8 87:7
 103:10 105:14 109:19
 121:6 124:15,17,18
 129:12 130:11 133:5
 137:18 139:11 143:21
 144:3 167:20 175:16
 190:4 196:3,3 197:21
 199:21 200:4 203:1,6
 203:14 205:1 206:18
 207:8 208:14 215:22
 220:2,6 222:6 226:11
 237:4,11 238:18
 241:11 242:20 247:9
 247:22 248:1,7,19
 249:12,12,17,19
 253:2 260:21 283:21
 286:10 308:1 311:1
 323:14 335:1 342:19
 346:9 352:13 366:4
 371:7 382:20 384:22
 403:11 406:11,12,15

406:18,19 407:10,18
 407:19 408:9,20
 409:16,21,22 411:2
 413:21 420:13 430:4
 430:4
differently 9:5 137:22
 174:10
differing 220:18
difficult 58:11 131:16
 314:4 377:6 387:20
difficulty 384:3 405:8
dig 385:20
dilemma 417:3
dinged 425:13
dinging 300:2 301:19
 302:12
dint 293:22
direct 20:10 160:17
 339:6
direction 97:10 98:17
 126:19 133:4 149:17
 159:1,5 182:12 216:8
 261:3 270:16 331:10
 420:4
directly 17:13 81:5
 88:18 96:1 123:15
 171:4 205:3 289:1
director 2:17 12:1,10
 15:7 16:20 19:16
 20:17 26:6 80:7,14
 261:12
dis-inform 21:9
disability 147:20 149:4
disabled 149:5,7
disadvantage 229:16
disadvantages 250:9
disagree 55:18 120:5
 284:20 376:9
disagreed 64:4
disagreeer 97:19
disappointing 363:16
disappoints 365:11
discharge 122:6 123:16
 127:6 134:5 199:2
 223:17 356:18 359:2
 359:6,20 361:6 362:1
 362:21 371:2 372:4,6
 373:7 374:3 377:7,8
 378:21,22 379:3
 385:6
discharged 357:2
discharges 121:4,13,15
 121:16
disclose 9:13,17 10:21
 11:10,15 12:5,13,21
 13:6 14:8 15:4 16:8
 16:16,22 17:6,22
 21:20 22:17 23:2

disclosing 261:8
disclosure 9:12 261:10
 355:19
disclosures 4:2 8:20
 9:5 10:5,11 13:17
 16:2 17:12 19:7,11
 20:14 25:4,6,9,20
 261:15
discouraged 66:17
discouraging 101:15
discover 415:21
discrepancies 220:7
discrete 179:19 390:2
discuss 56:6 62:8,10
 64:2,22 65:5,8 81:10
 135:14 286:21 344:18
discussant 88:8 109:14
 120:3 135:14 154:6
 180:18 215:1 249:3
 250:4 274:20 299:2
 345:20 404:8
discussants 64:6 65:7
 86:9 104:13 298:21
 301:1 345:19
discussed 34:16 52:8
 54:7 58:22 61:15 62:2
 67:21 77:1 137:17
 223:5 243:14 244:7
 288:18 312:17 316:10
 346:22 401:21 402:16
 403:7,18 428:18
discussing 8:14 65:17
 99:4 108:5 176:8
discussion 8:12 25:16
 34:12 55:7 58:18,21
 59:7,8,9,20 60:1,6,7
 61:20 64:1,14 65:12
 67:5,13 68:10 69:9
 75:8 79:4 80:1 81:9
 107:21 108:11 112:17
 118:20 122:18 135:6
 138:22 139:21 165:9
 165:13 185:5 188:16
 215:6 224:14 234:18
 236:6 241:3 245:20
 248:5 254:11 296:14
 297:17,22 298:13
 302:18 330:21 344:8
 346:14 349:6,20
 350:7 368:14 375:11
 375:12,19 378:19
 379:2 404:17 408:12
 411:8 415:15 430:9
discussions 25:6 34:13
 34:19 42:12 52:15,19
 55:17 79:22 148:19
 148:20 216:6 244:17
 303:14 348:9 352:22

disease 2:10 12:19
 23:12 80:16 101:5
 172:8 334:21
diseases 203:12 208:19
disorders 203:12
disparities 54:21 73:21
 191:9 221:14 236:11
displayed 320:18 322:4
 330:12 351:2
disproportionate 198:6
disruption 200:2
disservice 333:1
distinct 275:5
distinction 44:18
 289:20
distinctions 303:11
distributed 85:22
distribution 323:15
 351:13 422:15,22
District 94:18
disturbing 363:15
disturbs 365:11
dive 123:4
diversity 29:10 30:6
diverted 176:2
divided 9:1 59:22
dividing 44:22
Division 19:16
DMI 274:4
DNP 2:4
DNR 256:19
doable 140:5
doctor 12:19 127:11
 140:18
doctors 127:21 202:2,3
 408:4
document 35:22 197:2
 207:6
doing 31:1 70:12 73:19
 90:18,22 98:12
 102:16 114:2,10
 132:19 161:11 180:13
 216:8 232:7 236:18
 239:16 250:22 268:13
 293:18 348:10 360:22
 364:15 365:5 378:15
 390:10 410:5 417:9
 419:3
dollars 49:20 194:22
 195:8 277:9
Dolores 2:6 20:15,16
 21:22 22:8 134:13,15
 140:7 188:11 194:4
 194:11 275:13 279:16
 283:17 300:5 389:6
 391:17 393:6 419:21
 423:4 424:4
Dolores's 204:5

domain 50:7 299:9,10
401:10,11 421:20,20
421:21 422:2
domains 401:9
domestic 177:8
dominated 300:14
Donna 1:21 11:19,22
double 222:7,17 300:1
301:6,19 302:12
418:21 419:1
double-dinging 297:19
335:2
double-dipping 315:8
323:18
doubles 217:15
doubt 361:9
dovetail 169:20
downloaded 68:11
downstream 96:17
139:3 201:14
DPB 408:19
DR 7:19 10:4,22 11:11
11:17 12:7,14,22 13:7
13:19 14:2,9,22 15:5
15:13,21 16:11,17
17:1,7 18:5,19,21
19:7,9,10,13,15 20:6
20:7,15 21:22 22:4,7
22:10,19,21 23:3,6,10
23:11,21 24:2,7,12,22
26:1 29:2 31:14 34:11
37:13 40:13,15 41:12
42:18 43:10,17 44:3,8
45:9 52:3 64:12 80:5
89:3 90:5,11 91:14
93:1 95:15 97:18
107:2,12,14,15,16,17
107:19 110:2,13,20
111:2,17,21 112:1,5,6
112:11,20 113:2,14
113:18,21,22 114:3
114:21 115:2 121:1
121:20 122:22 123:10
124:2 128:20 129:22
130:17,22 138:18
142:4,7 147:1 148:7
148:16,22 149:9,11
152:12 154:20 155:16
160:16 161:8 162:11
165:17 166:13,18,21
167:2,4,7,15 168:2
169:4,11 171:21
172:19 184:16 185:10
207:14 209:18,21
210:4 222:11,17,21
223:5 237:2 242:9,12
242:15,21 246:16
248:13 249:4 251:9

252:2,9,14 253:8
254:21 257:4 262:19
262:21 266:8 271:16
274:22 278:8 279:22
280:12 283:18 285:15
285:20 303:4 305:18
306:6 311:11 312:2
316:6 325:18 326:13
328:22 332:12 337:3
343:15,21 344:11,16
348:3 351:7,20 352:1
352:8,18,20,21 353:6
353:11 357:8 359:14
362:19 367:14 370:6
371:11 372:19 374:9
375:21 384:1,21
387:10 393:16 395:6
399:19 404:9,20
405:3 408:11 410:2
410:14,17 411:15
412:15 418:12 419:15
421:6,8 422:12 425:7
427:8,10
drag 424:11,19
dragged 424:8
draw 299:19 418:12
drew 299:2
drive 37:11 87:6 129:9
159:4,13 201:6
311:15 368:7 393:1
driven 129:4 136:7
332:8
drivers 89:5 315:14
drives 129:3 376:13,14
driving 87:12 180:14
326:8 360:6
drop 280:3
dropping 334:20
drug 119:9 123:17
132:14 293:10
drugs 140:16
dry-run 419:4
dual 2:12 230:7 231:2
234:4 236:7
dually 229:17
duals 17:6 229:19
Duct 212:21 213:2
due 30:14 114:7
duplicate 198:17
duplicating 315:18
duplication 186:22
190:3 315:22
duplicative 192:12
273:3,13
durable 95:21
duration 171:2
DVT 388:12
DVTs 397:1

E

Eames 14:4 70:13
176:18
earlier 47:13 52:8 55:3
74:16 78:20 104:13
119:12 125:1 139:2
153:13 204:5 207:17
253:4 254:11 260:10
289:4 303:6,14
319:12 336:8 337:1
349:16
earliest 131:13 417:15
417:17
early 95:22 118:1
160:20 330:3,22
378:22 379:3 419:5
earn 290:22 291:3
329:6,6
easily 204:3
easy 77:17 78:4 83:3
122:19 176:14 243:17
243:17 301:21
eat 174:7 177:8 389:9
echo 7:14 359:15 405:6
economic 220:18
277:18
economists 277:17
eCQM 75:16,18,22
76:15 119:5,20
248:16 253:21
eCQMs 76:1,3,7,10,13
ED 101:10 102:18
278:14,21 280:20
edge 8:14
educated 310:5
educating 419:18
education 205:21
220:17 351:16 355:12
educational 282:8
403:20
effect 33:20 49:10,11
90:15 139:3 230:1,5
300:2 380:22 415:19
effective 93:10,13
96:12 150:16
effectively 119:19
169:20 305:10 416:14
effects 85:17
efficiencies 200:21
efficiency 73:20 179:14
288:6
efficient 8:19 287:22
318:19
effort 97:10 161:11
178:8 221:10 260:2
efforts 8:4 82:20 92:19
94:3 154:8 163:10
169:21 221:15 224:3

418:8
egregiously 191:9
EHR 73:5,16 75:9 76:2
76:8 105:15,16
124:11 125:1,2,10
130:9 139:21 247:14
251:3 254:9 259:11
260:3,4,5 263:20
264:2 265:6,15,22
266:9,10 271:20
374:1,3
EHR-based 264:4
EHRs 73:18 128:22
132:2 247:14,19
248:3 249:9,12,13
251:19 255:19 272:6
eight 212:12 354:7
355:4 379:17 394:6
396:4 400:10 409:6
either 35:14 39:19 40:3
57:19 100:11 131:22
136:13 151:3 199:22
210:6 219:16 227:17
242:5 243:9 244:16
244:19 270:1 290:22
291:6 372:15 385:20
411:13 425:12
elaborate 124:3
elderly 136:1 142:18
election 331:14
elective 208:17 296:20
341:5
electronic 59:9 124:14
125:4 126:4 129:8
130:5 131:21 140:14
158:18,20 159:1
170:5 247:2 256:8
264:21 265:1 268:18
269:13 339:5 381:8
391:20
electronically 120:19
elegant 283:16
element 48:5 234:7
243:4,12
elements 251:3,18,21
263:19 264:2 265:5
266:12,16,17 384:16
eleven 409:6
ELIGIBILITIES 2:12
eligibility 230:7 234:5
236:7
eligible 229:17 231:2
eliminate 60:17 62:19
65:21 208:12 401:14
eliminates 149:6
356:13,21 359:3
361:7 362:4
eliminating 424:13

ELIZABETH 2:4	44:21 45:21 47:3 48:6	296:17 299:15 319:2	evasion 193:10
email 61:22 62:4	52:21 53:5,7 54:1,2	338:18 339:21 340:9	event 381:7 385:14
embark 287:12	54:15 123:2,5 135:18	340:19 341:5	events 23:18 132:14
embarrassed 424:10	137:1 147:7 152:17	episode-based 174:17	381:9,10 385:1,8,10
embarrassment 189:16	160:18 171:2 199:18	174:19 176:19 178:11	385:13 397:13 406:8
embolism 398:6	210:22 211:2 226:8	179:13 184:2 197:1	428:6
eMeasure 134:19	229:1 233:20 271:12	201:21 212:22 213:3	eventually 251:11
eMeasures 119:13	274:19 283:10 317:5	213:14 214:4 287:9	255:19
emerge 313:12	320:4,22 337:10,12	287:13 288:14,17	everybody 6:8,9 7:22
emergency 22:11,14,18	endorsing 41:22	289:8,16,19,22	25:4,5 26:9 45:1
99:4	219:12,13 304:5	341:18	70:18 72:8,10 74:15
emerges 313:8	endpoint 358:15 359:1	episodes 178:11 179:2	105:20 162:16 173:2
Emeritus 13:10	359:9 361:6,20	183:11 187:5 197:14	194:2 212:19 219:4
emphasize 254:7	362:13	201:8	266:5 320:7 364:18
emphasizing 132:11	ends 134:14 211:7	eQCM 144:9	374:12 389:11 400:13
empirical 236:2	enemy 255:14	equal 66:1 256:6	429:6 430:7
empirically 234:12	engage 314:20	equally 279:12	everybody's 28:19
employed 16:13	engagement 188:2	equation 220:22 221:6	286:17 393:18
employee 13:18 92:3	257:7	301:5	everyone's 279:11
employer 102:15	engaging 73:21	equipped 278:2	Everything's 111:21
employers 85:3	Engler 1:13 11:11,12,13	equivalent 256:8	evidence 82:3 85:12
employment 85:5	238:10 239:12 250:13	ER 374:1	364:2 380:22
enable 110:8	255:11 265:9 298:22	Erin 2:18 27:2 37:17	evil 193:20 194:1
enables 170:4	299:1 314:18 390:9	38:4 55:20 68:9	evolution 194:15
encompasses 278:5	enhanced 91:21	117:12 411:18	426:14
encounters 82:7	enormity 141:7	Erin's 56:17	evolve 195:18
encourage 40:4,6 44:21	enormous 75:20 83:19	Err 393:9	evolves 195:17
47:16 88:16 89:21,21	enormously 294:8	Error 13:21 240:15	exact 126:8 143:14
100:3,19 103:13,14	enrolled 244:9	ESLISA 2:15	252:15 319:10
104:10,10 106:6,7,17	enrollees 193:18	especially 8:8 36:14	exactly 116:18,22 117:5
106:18,21 108:15,19	ensued 47:13	49:16 50:20 75:22	159:22 165:17 181:9
149:15 171:8 221:11	enter 258:17	117:13 129:9 219:18	230:22 344:14 380:11
233:7 254:8 285:1	entering 291:16	220:5 302:2 338:3	examine 294:13
287:22 294:16 371:6	enthusiastically 153:4	386:14 424:16	example 34:5 35:2
encouraged 105:17	entire 49:18 63:5 65:8	eSpecifications 119:11	46:21 52:15,17 67:7
107:22	74:20 280:17 365:10	eSpecified 124:13	77:14 82:9 85:3 90:13
encourages 179:16	386:10 422:1	essence 44:3 248:9	91:6 96:13,16 146:19
252:4	entirely 386:4	Essential 1:13 11:14	157:6 183:4
encouraging 133:5	entirety 110:9	238:15 250:19	examples 39:21 43:21
158:14	entitled 21:6	essentially 95:19 175:1	44:1
ended 43:5 258:14	entity 9:14	221:6 223:12 247:10	exceed 291:12
endless 199:10	envelop 190:20	247:11 285:10 329:7	Excel 38:19 39:1
endorse 103:15 245:8	environment 209:9	351:13 417:9	excellent 15:21 17:7
251:7	386:16	establishment 187:4	28:1,3 246:4
endorsed 40:21 43:11	environments 128:1,5	estimates 293:12	exception 190:18
43:12,18 44:9,12	envision 99:17	397:12 399:7	excess 241:11 272:11
46:13 80:14,21 82:12	epidemic 141:8 293:6	et 147:11 253:2 370:10	273:16 280:9 282:22
118:16,16,19 152:12	294:4,12	370:10 399:8	397:12
152:13 154:22 155:19	epidemiological 86:12	etcetera 45:7,7	excited 27:5 37:9
160:8 161:1 178:4	86:15 87:1,19 137:9	ethical 191:5,10,17	151:22 152:1,20
181:12 202:10 210:7	epidemiologist 24:6	ethnicity 221:13 239:7	exclusion 121:14,18
210:12 211:9 227:5	episode 175:15 176:11	evaluate 95:5 318:19	122:3 259:3 384:9
256:7 262:22 263:8	184:3,8 185:18	evaluating 188:4 410:4	exclusions 137:8
285:2 286:6 316:22	186:13 187:7 197:9	evaluation 123:1	exclusively 188:4
317:5,12,15 345:5	200:22 207:15 214:20	157:18 207:21	272:19
347:2 355:14 356:2	215:20 219:21 228:12	evaluations 423:6	excuse 112:8 125:3
412:3,11,16,18,20	231:11 287:16,21	Evans 2:4 24:10,11,13	131:5 191:1 193:14
endorsement 39:22	289:5,7,15,21 290:5	24:16,16	220:11 259:15

executive 11:22 20:17
exist 83:7
existence 200:6
existing 197:6 273:3
 299:6 301:3 308:3
 315:4 419:10
exists 366:22 371:3
expand 142:17 202:16
 235:6 281:13
expanded 224:15 225:3
 230:8
expanding 216:16
expands 235:5
expansion 224:14,19
 225:1,7
expect 9:8 63:4,18
 231:16 276:18 347:11
 365:3 421:16
expectation 164:11
 166:6 275:16
expectations 164:1
expected 351:1,5
expediting 424:13
expenditure 198:17,19
expensive 198:4
experience 7:10 8:7
 40:1 154:11 160:13
 160:21 161:4 170:15
 177:17 179:19 182:11
 192:19 214:13 249:10
 250:10 285:9 305:9
 306:15 313:8,11
 383:17 390:10
experimentation 282:7
expert 19:18 21:7 24:11
 57:2 233:2
expertise 277:14
experts 2:3 9:4,21 17:9
 58:9
explain 64:3 317:20
 347:10
explains 39:14 407:17
explanation 215:7
explicit 156:2,7 228:8
explicitly 147:22 156:1
exploration 104:4
 128:7 212:21 213:3
explored 218:4 237:15
express 92:9
expressed 75:20 281:2
 281:4
extend 301:12
extension 282:6
extensive 224:14 233:7
extensively 22:13
extent 48:20 50:3 76:2
 76:7 204:10
external 156:4

extra 279:6 363:18
extracted 253:20
 269:14
extremely 38:1 190:17
 342:13 361:10 363:15

F

FAAN 2:4
face 329:17 384:15
 408:6 427:2
Facebook 7:1
FACEP 2:7
FACHE 1:20 21:4
facilitate 55:6 241:2
facilitated 384:13
facilities 336:13
facility 122:10,15,16
 198:11 335:8 377:8
facing 19:5 426:11
FACP 1:18
fact 49:9 56:7 76:13
 102:1 114:2 116:12
 119:17,21 132:3
 138:4 170:20 218:3
 221:10 235:11 245:10
 252:5 255:17 260:11
 298:13 299:20 301:2
 301:3,5,9 304:8 311:7
 349:20 350:20 370:15
 389:18 390:2 393:10
 393:12 408:8 420:12
 420:18 423:21 424:2
 425:18
factor 80:19 218:1,10
 218:13 220:16,21
 221:5,17,19 230:10
 230:15 309:7,12
 314:9 329:22
factoring 172:1
factors 45:14 48:4
 204:1 218:4,7,17,21
 227:8,10 229:3
 231:17 233:3,10,16
 234:1,8,13 236:8
 237:11,16 239:6
 283:11
facts 316:20 320:6
 427:2
failed 182:17
failure 274:4 296:20
 307:18 308:9 315:13
 321:21 339:15 340:19
 398:17
fair 48:2 270:13 276:7
 277:13 278:2 309:16
fairly 135:22 272:15
 301:21 350:6 359:7
fall 45:11 117:18 148:15

149:1,14 330:22
fallen 419:9
falls 117:13
familiar 26:21 72:10
 114:11 145:1 155:20
 237:3 244:1
families 369:5 389:16
family 32:14 36:11
 73:22 334:18 362:16
fantasy 193:4
far 27:20 35:17 36:10
 56:1 71:6 86:18 87:9
 89:18 94:10 99:8
 125:22 126:10 157:2
 163:15 182:13 195:9
 208:11 217:21 235:4
 254:5 327:10 328:13
 380:14 402:16 418:5
 419:11 425:17
fashion 378:10
FASN 1:18
fast 114:16
faster 61:5 133:16
 301:22
fate 243:8 244:13
favor 138:1 301:22
 384:2 390:5 426:22
favorable 116:14
favorite 189:1
favorites 127:3 128:8
FCCM 2:5
FCCP 2:5
fear 221:4 424:9
feasibly 232:3
feature 300:20
featured 300:7
features 300:12
federal 2:8 9:4 23:4
 33:15 34:3 162:20
 167:16 187:16
Federation 3:10 76:19
fee 147:22
fee-for 147:18 229:17
fee-for-service 136:10
 136:12 397:15 398:21
 399:6 422:8
feed 271:7
feedback 6:21,22 42:17
 52:18 137:3,5,10
 142:15 163:19 226:10
 270:12,13 271:7
 303:17 313:10,11,16
 396:1
feel 6:22 28:1,7 35:16
 35:19 48:18 62:6
 64:19 70:2 123:4
 129:17 147:7 148:2
 169:4 174:18 196:7

202:11 324:6 325:11
 326:3 342:13 343:7
 376:11
feeling 36:15 93:15
 279:14 363:13
feels 89:7 147:2 155:12
feet 376:19 424:8,11,19
Feinberg 206:20,20
 208:7 209:10
felt 161:3 202:15 215:5
 246:20 275:7 292:14
 413:5
field 60:11 198:9
 234:15 235:2 236:15
 266:15 390:4
fifth 27:4 150:11
figure 109:21 126:8
 164:8 194:18 279:19
figured 116:11 314:6
 427:16
file 338:8
fill 54:20 163:2 325:6
filter 39:1
final 35:10,13 41:19
 42:1 52:1 53:4 58:12
 84:15 171:19,22
 211:17 214:18 427:18
finalization 227:14
finalized 225:2 415:1
 418:19
finalizing 187:12
finally 66:16 85:20
 191:19
financial 20:1 21:20
 185:21 187:22 291:11
 374:21 375:2,13,16
find 36:12 55:7 60:4
 96:18 137:19 230:15
 277:22 283:16 316:12
 363:15 383:8 384:18
 386:18 420:2
finding 25:14 380:19
findings 82:15 235:4
fine 171:1 333:4 377:9
 420:9
fingers 369:14
fingertips 339:2
finish 63:13 152:17
 400:14
finished 404:9
fire 376:19
first 6:20 9:18 14:16
 18:3,6,6 26:7 27:13
 30:20 31:18 38:16
 53:7 61:6 64:2 74:17
 74:21 79:1 80:3 81:13
 95:2,16 103:3,11
 108:6,14 109:10

118:8 121:22 125:18
 125:21 132:10 135:15
 136:21 138:16 150:13
 150:15 155:14 158:3
 158:11 160:4 163:4
 173:22 174:10,22
 175:12,19 185:11
 188:13 207:16 210:16
 215:2 225:10 233:21
 241:10 242:14 243:4
 257:21 272:13 291:19
 296:12 297:3,9
 311:16 312:6 316:21
 343:11 359:16 363:5
 364:7 365:19,22
 384:11,15 404:7,20
 408:13,19 409:5
 411:7 429:15
fiscal 141:13 188:21
 273:18 290:19,20
fit 188:18 293:14
 306:18 312:19
fits 38:9 123:12
five 53:10 79:2 101:11
 137:18 157:8,20
 241:14 345:8 410:22
 429:15
five-minute 173:5
fix 427:4,5
flexibility 247:21
flipping 79:1
flips 101:19
floating 409:2
floor 1:8 59:8 65:7
flow 59:4
flows 182:22
FNKF 1:18
focus 33:14 54:14
 139:7 151:6 175:20
 177:1 215:21 273:6
 274:12 295:7 305:3
 313:22 360:4 388:11
focused 14:14 37:1
 148:18
focusing 140:21 208:17
 270:9 311:7 388:12
 388:13
folks 29:3 143:7 223:15
 280:12 314:2 327:1
 370:17
follow 46:2 97:13
 168:14 207:18 229:13
 231:14 233:19 251:1
 318:1,5 325:19
 361:17 419:2
follow-up 122:14
 123:17
following 243:11,19

244:9 266:22 280:17
 359:20 360:20 379:12
follows 59:21 123:22
 130:6 197:5 333:16
food 242:7,10
foots 386:8
for-service 148:1
force 125:5 218:6
foremost 125:19 158:4
forget 28:13 141:4
 372:17
form 155:21 157:17
 286:4,4 290:16
 347:17,20,21 361:14
 362:4 378:10
formal 42:16 62:17 68:2
 253:10
format 176:9 388:22
former 13:11 15:3
forms 19:5
formula 420:12
forth 31:4 117:14
 126:14,17 146:3
 229:6 256:20
fortune 36:10
forty-percent 165:4
Forum 1:1,8
forward 8:11,16 17:21
 25:12 26:12 27:14
 29:8,14 31:7,12 37:7
 43:19 46:7 50:1 52:12
 52:15 69:5 119:14
 129:19 131:15 163:5
 169:6,8 172:4 174:5
 178:9 214:15 218:11
 225:2 226:15 236:16
 244:21 246:22 247:17
 248:10 257:18 259:14
 316:16 318:21 322:11
 326:19 330:8 334:11
 363:6 367:14 381:15
 381:16 392:7 403:12
 410:7 411:4 417:16
 429:9 430:16
Foster 1:13 11:4,5,6
 21:8 30:20 47:8 48:10
 56:12,16 94:7 105:13
 114:7 118:7,21 124:7
 131:18 135:19 150:14
 180:19 181:6 202:21
 210:19 217:5 221:3
 229:21 245:3 248:6
 256:3 268:2 270:17
 272:12,14 304:2
 307:7,14,17 330:20
 346:21 347:19 350:17
 368:16 380:4,6
 381:20 391:16 403:10

409:17 415:16
found 38:3 377:22
 381:9
foundation 19:2,2
four 19:19 79:3 101:11
 102:2 157:8,19
 164:21 174:16,22
 175:2,10,12,16
 176:10,18 181:4
 199:11 206:6 213:12
 241:7,14 242:2,17
 246:1,12 260:16
 264:6,15 265:3
 266:16 269:5 296:13
 297:8 299:5,8,13
 300:3 315:4 320:3,21
 333:21 335:1 336:8
 428:12
fourth 15:9 21:13 269:9
Fowler 2:5 18:20,21,21
 19:9,12 89:3 252:2
 427:10
fraction 46:4
fractured 128:22
frame 36:14
frames 109:19
framework 324:3
 328:18 332:15,16
 334:10
frameworks 38:18,21
framing 31:11
freaky 182:5
free 6:22 28:2,7
frequency 309:15
frequently 35:13
fresh 152:8
Frieden 80:15
friendly 281:6
friends 140:13
front 51:18 57:2 225:5
 230:22 292:2 315:7
 331:6 364:18 414:4,6
 414:10
fruition 133:20
frustrated 93:15
frustration 75:21
Fuld 1:14 14:11,12,19
 297:14 298:16 344:7
fulfill 85:16
full 8:11 10:1 29:17
 59:16 67:9 185:15
 279:1 286:12 303:1
full-time 13:17
fully 39:17,18 42:19
 43:8,14,18 44:4 47:18
 47:21 52:10 53:15,19
 65:15 90:1 103:15
 107:3 117:4 118:13

118:15 151:14 165:20
 166:9 210:1,2 254:16
 280:19 372:15
fumes 302:6
function 87:19 304:12
functional 186:10
 243:10 252:11
functioning 370:10
functions 416:12
fund 291:4
fundamental 170:9
funded 281:20 282:4,10
funding 20:12
funky 230:7
further 39:22 40:1,6
 44:5,11,13 47:17
 89:22 104:4 105:18
 106:21 108:15,19
 126:7 128:7 157:17
 160:21 169:3 190:20
 217:12 255:6 290:8
 301:6 314:21 331:11
fusion 207:15 208:4
 213:12,14
future 35:19 87:17
 89:21 97:22 103:13
 103:14 104:10 126:17
 154:4 168:18 206:2
 290:20 308:17
FY 131:6
FY16 418:20
FY17 418:18,20
FY18 418:22

G

gain 160:13 200:21
 285:8 313:8 420:19
game 336:17 377:3,7
 378:10 383:2
gaming 376:16
gap 156:18 163:2
 336:11
gaps 32:2 39:6 54:21
 190:7
gastrostomy 243:21
gather 397:14 424:1
gathered 112:22
Geisinger 1:16 13:3
general 50:8 54:12 80:1
 163:22 164:10 175:5
 187:14 239:3 281:19
 301:22 341:20 343:19
 362:10 428:18
generalize 238:21
generally 76:21 289:22
generate 392:20
generated 391:20
generation 48:17 172:4

172:6,9 388:19
generic 151:7
geographic 81:7,13
 83:2 84:5 197:18,19
geographical 195:21
geographically 83:20
 197:21
geriatrics 20:8
getting 70:15 71:13
 76:1 124:18 136:14
 150:7,15 152:5
 169:15 184:2 186:3
 278:14,22 279:1
 282:12 319:22 332:14
 346:21 374:12 377:12
 383:20 406:10 414:1
 416:1 426:4
GI 308:12
give 6:22 7:11 17:11
 33:11 37:10 40:18
 46:8 50:11 52:1 54:8
 54:10 59:6 60:5 64:6
 101:21 128:16 187:21
 204:12 208:9 211:17
 256:2 275:14 287:7
 315:10 339:12 354:4
 354:12 369:3,5,13
 389:14 397:3 400:16
 400:19 415:13 416:11
 416:18 420:20
given 34:2 36:14 42:2
 80:22 88:18 101:6
 153:17 171:11 226:10
 252:5 255:17,18
 256:12 267:17 283:19
 290:6 294:11 295:6
 301:2,3 310:7 315:13
 315:15 370:15 378:16
 381:22 418:1
gives 35:15 335:5 399:9
giving 290:10 378:12
glad 14:19 50:8 310:15
glean 368:20
global 67:18 103:21
 104:7 295:15
go 8:18 18:3 22:5 24:9
 37:14 40:13 42:17
 45:1 48:4 51:4 52:9
 53:3,6 59:10 63:4,5,7
 65:13 68:16 69:5
 70:22 75:2 79:19,21
 80:2 83:11 84:12 89:2
 89:18 97:21 98:18
 99:15 108:10 117:19
 121:5,8 128:11 131:4
 131:5 134:18 135:14
 140:18 142:1 145:12
 147:16 150:13 155:13

160:11 163:15 164:22
 174:6,8 177:20
 189:10,16 199:2,9
 212:20 215:2 222:2
 225:10 228:3 229:6
 235:6,17 236:1,6,16
 238:8 242:1,14
 250:11 261:4 264:8
 272:13 276:14 281:17
 286:3 296:11 298:20
 306:5 307:3 311:8
 317:4,9,14,15,16
 320:16 321:5 323:1
 325:21 326:4,5,9
 328:21 338:15 339:9
 341:20 345:14 347:16
 348:12,13 350:13
 352:10 355:1 363:5
 384:11,15 392:16
 399:7 401:22 408:12
 409:11 413:17,19
 418:3 420:4,10 422:4
goal 72:21 164:12
 174:7 178:1 248:21
 287:21 409:3,8
goals 31:17 32:1 53:12
 54:19 73:15 243:13
 244:7,16 268:1 291:9
 401:13
goes 42:14 99:22
 130:21 175:18 177:11
 185:10 209:21 236:22
 271:10 317:12 328:17
 367:16,21 376:17
 408:18 430:3
going 7:6,11 8:18 10:7
 11:3 15:9 17:8 22:1
 25:17 28:21,22 33:6
 37:6,17 38:6,11 42:5
 45:2,5,21 46:7 47:5
 48:8,18 50:1,17 56:17
 59:4 60:19 63:2,7,9
 63:17 69:1,16,19
 70:12,13 72:6 74:17
 76:20 81:2,8 88:5
 95:5 97:11 100:18,19
 100:22 101:21 102:3
 105:6 107:8 109:8
 112:17 113:19 114:8
 119:14 122:9,10
 124:10 129:1,11
 134:15 135:13 136:12
 141:18 142:7 143:10
 149:16 150:8 151:3
 153:9 157:1 158:9
 161:17,19 162:7,12
 164:4 166:8 169:17
 172:5,8 173:5,19

174:6,8,9 176:10,11
 176:17 177:12 180:19
 182:4 185:13,14
 190:11 192:15 193:1
 194:5 206:1 207:20
 208:2 209:13,13,15
 213:11 217:6 219:21
 226:5,20 227:13
 229:7,21 234:18
 235:1,8 236:3,3,13,14
 238:6 239:18,19
 242:18 245:7,19
 250:20 256:1 258:4
 259:19 261:19 264:12
 268:4 273:17 275:2
 277:22 278:14 279:12
 279:14,20 280:7
 284:6 296:11 298:20
 302:19 304:3 306:20
 311:11 315:17 321:10
 326:1 328:9 332:5,6
 332:20 341:15 343:4
 343:6 344:1 345:13
 346:2,10 353:17
 356:20 363:12 367:10
 368:7 370:13 376:16
 382:4 383:4,14 386:9
 386:11,12 387:7
 388:19 389:18,19
 393:8 396:17 400:13
 402:1 405:9 406:12
 407:11 410:4 418:9
 421:2,4 422:4 423:14
 425:12,13,16,18
 426:7,22 430:5
gold 200:4 371:17
good 7:21 11:12 12:15
 15:1,6 16:12 22:5
 27:7 35:16,19 36:10
 38:10 45:22 90:21
 98:12 99:3 119:9
 139:19 149:12 150:16
 153:8,19 173:3 174:4
 179:4 180:9 181:11
 216:8 223:4 240:5
 241:22 249:15 254:15
 272:1,10 287:2 323:5
 329:20 331:17 332:17
 333:3,13 348:18
 370:8,20 371:15
 376:15 383:10 388:15
 394:16,22 403:5
 413:10 417:8 418:15
 426:7,9,20 427:14,20
 427:22 430:9,10
gosh 135:19
gotten 172:2 207:7
 219:4 393:11,12

government 2:8 162:20
 305:2
grabs 145:13
gradations 420:12
gradually 81:22
Graft 379:13
grafting 355:15 356:6
 361:15
grants 17:14 18:9 22:16
granular 221:1 278:18
granularity 316:12
grapple 236:13
grave 42:8 387:11
great 14:9 24:7 27:14
 27:19 41:18 42:3
 88:14 107:19 118:21
 138:17,21 148:8
 224:21 245:16 262:4
 297:14 300:6 337:3
 387:8 391:2 415:18
greater 65:22 116:6
 394:11
Greg 18:4,5,19 120:22
 249:2 271:15 274:21
 285:14
GREGORY 2:4
gross 177:8
ground 210:8 241:5
 429:7
group 2:18 10:10 13:16
 14:14 17:6 18:12
 20:17 21:14 23:13
 26:6 36:6 61:7 64:19
 80:12 81:12 101:17
 103:18,19 104:6,10
 104:14 152:5 178:10
 185:18 186:13 207:20
 224:21 225:5 240:12
 242:2,17 246:12
 269:10 297:1 305:10
 305:14 316:17 323:6
 323:9 331:11 333:10
 359:11,22 360:3,8
 382:8,11
group's 107:8
grouped 78:21 245:21
grouper 202:22 203:6
 207:15 289:8,15,21
groupers 187:7 199:20
 200:5
grouping 219:14 303:8
groupings 241:2 303:8
groups 9:2,6 59:22
 104:22,22 241:6
 360:4
grow 276:1
guess 7:22 45:9 75:11
 77:5 143:18 149:11

161:8,16 162:2,8
 167:4 168:13 185:10
 250:1 252:3 273:15
 286:20 297:19,21
 305:14 315:19 327:6
 327:7 358:2,9 363:15
 376:9 405:18 406:22
 408:7 418:4,22 419:3
guidance 54:12 233:12
 248:10 270:16
guide 55:7 59:9,20 60:7
 67:6 68:10 108:11
 122:18 339:5 415:15
guideline 137:13,15,16
guidelines 15:8 67:2
 106:21
guiding 31:16
guilty 277:11
guys 8:20 26:2 116:11
 211:17 260:1 354:4

H

HAC 64:21 395:18
 396:9,10 400:15,17
 400:20 401:2,13
 404:12 408:19 409:12
 409:15,18 413:3,7
 415:21 417:1 421:17
 427:16
hack 285:11 286:22
Hacks 286:3
HACRP 5:10,14
HACs 400:21 401:6,14
 401:15,17 424:13
half 14:7
hammer 93:6
hand 57:4 108:18 125:5
 170:13 294:6 414:16
 415:5
happen 76:4 89:8 92:17
 120:18 124:20 146:13
 161:19 171:10 208:21
 228:5 280:3 363:1
 412:7 424:2
happened 86:8 116:5
 184:8 391:22 420:15
happening 127:12
 161:4 179:12 180:11
 180:14 247:4 276:14
 278:12,20 365:2
 383:11 408:14
happens 40:17 46:4,6
 66:22 179:6 199:1
 201:3 232:12 253:6
 276:3 280:4 294:19
happy 6:6 21:12 23:9
 81:9 141:5 224:9
 270:11 308:19 399:11

hard 26:10 51:19 52:20
 126:3 142:10 229:19
 386:18 404:4 420:2
 422:3 425:11 427:1
hard-pressed 155:3
harm 390:13,17 391:2,5
 391:8,20 424:22
harmonized 79:6 88:10
 110:2 113:15,16
 115:11 346:16 353:21
 354:18
harmonizing 115:1
harms 397:8,11,11,12
Hartford 12:18
Haskell 13:21 37:4
 70:14 240:11,14,14
 376:22 382:10 399:15
hat 45:11 327:7 335:21
 363:12 378:6
hate 41:16 97:18
hated 135:20
Hattie 1:15 15:13,14,15
 36:8 69:1 104:19
 168:22 220:11 289:10
 301:17 333:20 386:21
 424:4 425:3
Hayden 3:14 121:20,21
 125:16,16 143:12
 308:4 317:21,21
 320:9,12 321:6,20
 322:16 329:18 366:5
HCAHPS 292:9,21
 293:14,16 294:19
head 189:15 246:9,11
 265:18 338:9
headlines 416:4
heads 319:22
headway 35:1
health 1:16,19,20 2:1
 10:11 11:2 12:11 13:3
 13:4,13,18 15:3 16:21
 19:4 23:1 27:12 54:21
 73:20 74:1,2 81:16,18
 84:4 88:16 92:5 93:4
 94:1,5 95:12 97:9
 98:3,6,8,9 102:13,21
 103:21 104:7,22
 124:14 129:8 130:5
 131:21 140:14 141:14
 156:5 158:17 177:6
 177:11 189:2 204:6
 219:17 247:2 261:13
 264:22 265:2 268:18
 269:14 271:18 288:2
 291:10 314:3 381:3,8
 391:21 401:12
healthcare 2:9 18:16
 23:14,16 33:22 37:2

37:12 43:13 49:6
 53:12 80:8 98:1,17
 159:10 164:17 393:17
 424:22
healthcare-associated
 113:13
healthier 92:7 177:12
Healthwise 19:3
hear 11:21 33:20 141:2
 154:3 161:16 162:13
 163:19 184:9 223:1
 256:21 257:13 268:4
 289:10 303:7,16
 310:15 314:22 326:17
 363:20 388:9
heard 25:18 65:6
 119:11 124:11,22
 125:21 140:12 146:11
 160:17 162:16 164:14
 165:13,15 211:3
 228:22 237:6 254:11
 260:10,17 261:2
 267:14 283:9 316:6,9
 316:11 323:13 355:7
 356:5 358:17 410:22
hearing 17:21 29:14
 115:8 142:11 143:14
 161:13 167:15 229:5
 267:14 290:8 302:18
 327:1,3,5 374:15
 407:20
heart 16:5 274:4 296:20
 307:17 308:9 315:13
 321:20 339:15 340:19
 361:10,12,14,16,22
 377:1
heartened 162:13
 314:22
Heather 1:16 13:1,2
 250:4 275:10 285:16
 373:20
heavily 128:8 135:22
 139:7 394:3,7,17
heavy 100:4
heed 154:17
Heidi 3:10 76:18
held 87:21 280:7
Helen 2:15 7:18,19 11:5
 13:21 14:7 30:10 37:4
 70:14 146:5,7 160:4
 227:2 240:10,14
 376:21 382:9 383:12
Helen's 378:11
Hello 27:1 121:20
 240:14
help 31:3,6,13 36:4
 55:6 131:19 147:14
 175:8 177:22 208:20

214:15 232:10 236:15
 245:16 246:19 258:18
 295:21 311:12 325:19
 328:1,17 330:8 336:5
 350:13 369:17,19
helped 224:2 308:22,22
 362:11
helpful 38:2 78:6 87:17
 108:16 163:19 183:6
 194:13 311:14 322:22
 328:3 330:3,17 331:4
 334:11 337:2,21,22
 338:9 375:8 418:11
helpfully 124:10
helping 38:2 109:3
 210:11 238:1 331:18
helps 33:3 54:4 131:12
 133:3 158:22 159:4
 198:12 259:9 384:10
hematoma 398:15
hemorrhage 398:15
heterogeneous 206:13
hey 333:6 416:7
Hi 10:9 11:22 14:11
 16:19 18:5,21 22:21
 23:6 26:4 27:16
 125:16 132:9 206:20
 208:7 225:22 261:11
 308:4 317:21
high 54:14 123:11
 132:13 146:12 171:13
 178:2,19 183:13
 192:10,18 200:13,14
 200:17,17 201:2,9
 231:1,3 333:22
 338:16 342:16
high-level 54:10
high-priority 142:20
high-value 178:3
high-volume 199:13
higher 99:19 101:21
 153:7,22 177:15
 186:2 192:6 195:6,7
 204:7
highest 199:14 315:14
 401:5
highly 54:16 142:18
 233:7 389:13
hip 296:21 317:3,11,17
 318:21 321:4 337:15
 339:15 341:5
HIQR 4:6,7 186:21
hire 102:16
hiring 92:3
historically 35:17
 301:10 315:6
hit 48:16 71:17 168:13
 365:9

hitting 71:13
HMO 17:4
hoc 225:11
hodgepodge 31:10
 36:19
hog 99:16
hold 50:21 86:6 97:12
 184:12 224:18 284:15
holding 376:18 400:13
hole 94:20
holiday 8:2
holidays 8:10
holistic 294:4
Holters 112:22
home 121:4,5,9,13,15
 121:17 122:1,11,14
 122:20 244:4 282:6
 356:20
homebound 282:5
homes 121:7
homogeneity 206:14
hone 38:2
honed 169:20
honestly 93:17 155:12
 234:20 363:21 382:19
honor 21:5
hope 34:8 38:3 54:3
 126:18 144:9 198:12
 221:3 270:15 308:18
 308:22 399:9 424:14
hopeful 349:12
hopefully 8:4 33:3 61:4
 175:8,17 207:7
 232:11 236:18 322:6
 426:14
hoping 268:3 319:21
 333:2
Hopkins 16:4
hospice 244:9 258:16
 258:21 259:4
hospital 1:3,12,13 2:17
 3:13 4:5,8,10,12,15
 4:18,20 5:5,9,16 8:13
 11:8 12:20 15:3 18:12
 26:6,17 27:3,14,18
 31:7 35:13 38:20
 46:12 58:10 73:2 75:4
 82:5 83:7,22 87:2
 89:14 90:8 92:2,7
 99:13,15 104:6 121:3
 123:15 125:10 127:13
 127:19,20 128:12
 132:2,18 133:2 134:5
 137:11 145:11 147:16
 153:1,7 155:9 157:3
 157:21 160:12 161:21
 175:14 178:16 181:19
 183:10 187:8,11

195:9 197:13,14
 199:6,7 201:13
 204:20 223:22 228:12
 253:7,16 257:17
 266:21 272:21 273:4
 276:5,12 277:1,12
 278:19 283:14,15
 287:10 288:5,20
 290:10,13,16 292:9
 296:16 305:20 306:1
 306:22 307:18 308:10
 310:19 313:18 318:4
 319:2,11 320:18
 321:22 322:12 327:17
 330:12 332:5 335:6
 339:20 340:7,17
 341:3 351:2 357:15
 359:3 361:7 362:22
 368:17 370:2 377:18
 378:22 379:11 387:2
 388:9 389:4 394:15
 400:22 401:3 403:15
 404:3 416:5 422:15
 424:16
hospital's 88:18 91:10
 95:6 157:6
hospital-based 82:17
 87:15 128:2,4
Hospital-Level 214:19
hospitalist 127:12
hospitalization 133:1
 205:4,10,12 216:2
 266:22 272:11 280:18
 281:9 283:1 292:16
 292:18 392:2
hospitalizations 18:14
 96:6 113:5,6,9
hospitalized 89:13
 93:19
hospitals 1:13 3:10
 11:14 21:8 72:15,18
 72:22 73:18 74:12
 75:20 76:9,17,20 77:2
 77:17 82:11,12,20
 83:15,17,18 84:16
 85:14,16 86:17,21
 87:11,17,20 89:8
 90:16,17,20,22 91:2
 91:10,17 92:11,15
 93:8 94:12,17 95:10
 95:12 96:2 98:8 99:15
 102:7,21 103:20
 104:6,21 105:3 113:3
 119:6 120:6,9 125:7
 126:1,20 127:18
 131:20 132:4,21
 141:21,22 151:13,15
 158:14,15 159:10

160:13 161:11 162:5
 169:18 179:16 195:4
 195:7,10 198:2
 221:11 229:16 231:1
 231:2 238:15 250:9
 250:19 252:4 253:22
 258:10,18,22 266:14
 275:22 276:7,19
 278:1,19 279:19
 290:22 291:5,12
 292:16,22 293:18
 294:21 300:15 301:6
 302:2,2,4,6,14 304:21
 309:17 335:3,17
 347:12 350:20 351:13
 357:17,22 358:1,7,8
 375:3 381:22 382:13
 390:15 394:8 400:21
 401:5 403:21 405:10
 405:13 415:19 416:2
 417:13,21 419:6,19
 420:17 421:16 422:4
 422:16,21 424:9
 425:9,11,17 426:6,14
 427:1
hot 152:8
hour 393:15
hour's 365:8
hourly 429:19
hours 29:18 173:3
House's 162:20
housekeeping 56:21
 240:11 345:16
Houston 10:21
how's 253:7 400:12
HPVP 395:17
HR 124:4 357:19
HTR 251:20
Huff 14:1,4,4 70:13
 132:9 144:14 176:18
 177:4 182:21 215:19
 225:22
huge 78:4 90:15 149:8
 149:8 189:15 190:6
human 126:3 249:8
 367:1,5 393:9
humanity 255:20
hungry 229:9
HVBP 4:17 305:20
 306:3 312:10,11,15
 318:7 326:15,21
 329:3 348:4 353:5
hybrid 130:3 247:12
 264:20 265:4 268:16
 269:12 270:8,9
Hyperplasia 214:3
hypertension 98:21

I
iatrogenic 384:8
Icahn 20:9
iCare 17:4
ICD-10 209:7,9 251:10
 259:15 261:20,22
 262:2,3 386:6,16
 395:8
ICD-9 259:14
ICU 370:16
IDC-10 209:6
idea 41:17,18 103:22
 104:2,3,4,16 109:21
 110:17 128:13 137:6
 166:9 244:5 280:15
 314:7 333:5,13
 352:17 375:18 380:14
 386:2,5 411:3 420:21
 427:15,20,22
ideal 256:5 391:19
identical 81:2 114:18
 263:17,18
identification 183:15
identified 39:5 51:6
 64:6 288:1 312:16
 381:7
identify 61:16 75:2
 113:4 263:16 380:20
 385:7
identifying 259:1
 270:12 384:4
ignorant 148:11
ignore 33:12
illness 195:1
ills 279:17
illuminate 41:7 221:7
illuminated 331:11
image 231:7
imagine 32:21 99:17
 127:5 149:7 161:10
 204:3 365:7 391:4
IME 198:3
immediately 160:14
impact 34:8 49:12
 50:18 82:13 83:19
 84:18 86:13,21 91:3,4
 91:15,18 92:2 93:3,17
 98:13 99:14 100:6,17
 102:9,14,20 170:22
 205:22 225:13 233:9
 238:19,22 239:6
 351:12,12 382:3
 388:17 394:11
impacted 82:4 375:14
impactful 388:7 390:21
impacting 50:22 85:18
 175:2
impacts 82:17 91:9

92:1,4 96:20 302:1
377:16
impairment 243:10
impede 92:18
imperfect 140:4 393:14
implement 53:2 131:9
247:6 248:8 303:18
326:14
implementation 26:20
50:14 131:1,3 251:22
326:14 329:2
implemented 32:3,22
45:14 131:16 163:22
187:7 232:15 306:3
implementing 337:6
422:18 423:2
implications 246:7
implicitly 199:3
importance 8:13
important 8:9 30:22
49:13 58:19 77:3 83:6
86:11,12,15 94:1,10
94:11 96:5 119:8
121:6 123:11 130:1
132:11 133:21 135:21
136:20 140:2 142:15
144:16,17 150:15
156:15 160:20 161:9
161:18 163:17 167:19
170:9 179:3,5 180:5,6
181:10 182:8 184:6
184:20 185:20 189:20
203:21 245:5,14
246:14 257:6,15
260:4 273:21 293:3
295:12 297:21 298:1
322:9 348:21 349:19
350:7,10 361:10,17
366:16 367:8 369:2,6
387:2,3,4 388:16
393:2 405:14 426:16
430:11
importantly 25:8 141:1
416:1
imposing 125:9
impoverished 204:4
impress 89:16
impression 237:17
improve 28:11 98:6
158:2 271:6 291:10
401:15
improved 38:17 92:16
133:20 285:2 288:2
improvement 7:4 8:5
15:8,16,18 19:21,21
28:14 37:11 77:19
82:8 151:13 171:14
239:16 291:8 313:2

328:1,14 335:8
336:10,15,20 337:7
337:19 338:7 361:20
390:20 392:20 405:13
418:7 419:14
improvements 161:22
216:10
improves 133:15
improving 32:14,15
53:12 73:22 388:12
in-patient 102:18
inaccurate 381:12
inappropriate 151:4
157:19
incentive 72:13,22 73:5
73:13 75:10 99:3
156:7 166:4 290:17
291:11 302:14 356:21
358:18 359:3 360:2
361:8 363:17 372:13
379:3 401:4
incentives 98:18
100:11 101:19 291:11
294:2 302:16 329:6,7
361:2 373:13 376:10
400:20
incentivization 362:5
incentivize 73:17 96:14
98:2 102:3,7 105:8
336:14,19 424:15
incentivized 98:10
362:21
incentivizes 356:8
incidents 401:15
include 54:20 73:19
133:14 147:4 166:16
170:8 172:7 232:3
251:12 254:19 270:21
274:11 288:6 371:9
389:20 401:13
included 158:16 167:9
174:12 201:9,22
217:14 227:10,17
233:11,17 234:9
247:15 293:16 298:7
305:4,11 347:5
366:16 385:1,10
includes 38:21 264:19
396:5 398:12,14
401:10,11
including 38:13 84:5
121:7 128:9 132:13
133:12 136:2 143:4
148:21 170:6 233:3
265:6 275:3 280:19
312:17 359:17 381:1
inclusion 160:1 229:2
251:17 305:8 347:1,2

income 234:4 236:8
incomprehensible
20:22
incorporate 99:18
251:21 263:12
incorporated 67:5
incorporates 217:16
incorporating 46:16
increase 54:22 100:14
401:14
increased 91:16
increasing 34:2 81:22
93:9 290:18 293:5
405:8,10
increasingly 36:21
132:21 159:2
incredible 33:20 34:8
incredibly 30:21 390:21
incremental 97:16
138:11
independent 14:5
independently 51:10
index 197:19,20 231:4
390:13,16
indicate 155:22 156:18
339:10
indicated 43:20 145:21
231:4 244:20 298:14
382:6 395:1
indication 101:7 350:19
397:4
indicator 156:15 170:17
370:8,20 374:3 380:2
399:10 400:4 412:16
412:17,17
indicators 24:5 187:17
394:2,7 396:3,5,20
398:8,13 421:13
425:21
Indicators/AHRQ 380:2
400:3
individual 2:3 9:4 17:18
34:15 57:20 61:20
62:2 63:22 110:8
120:8 129:7 175:21
233:18 234:16 253:7
384:16 386:1 390:18
392:11 417:13
individualized 389:1
individually 31:20
61:15 235:12
individuals 17:10 95:17
118:7 121:17 134:4
143:13 144:1
indulge 194:3
industry 219:15
industry-related 20:14
inevitable 389:22

infant 146:20
Infarction 340:10
infection 96:15 113:13
115:12 308:12 346:17
353:22 354:19 385:3
385:8 390:22
infections 23:17 157:8
348:22
infectious 12:19 172:8
infiltrated 225:16
influence 88:18 178:16
196:15 201:14 234:1
234:5
influenced 234:13
inform 240:22
information 19:4 40:11
45:13 59:13 73:1,2
74:3 77:10,15 81:3
83:12 92:5 106:8,19
107:21 113:9 120:12
127:18 129:20 130:4
130:8,10 140:12
144:19 145:3,12,17
150:18,20 156:17
168:7 170:6,7 180:13
182:13 183:4,7,9,9,18
215:11 247:13 271:18
281:7,12,13 287:9
310:3 313:8 325:14
369:4,7 374:1 381:22
383:19,19 397:14
403:14,20 405:12
417:19
informed 19:1 20:19
73:3 325:3
ingenuity 335:9
inherent 407:4
initial 209:22
initials 20:21 22:8
initiated 85:4
initiative 162:19,22
349:2 355:18
initiatives 90:19
injurious 170:22
injuriousness 170:18
injuries 397:3
injury 349:17 398:16
injustice 276:20 277:18
Innovation 80:8
Innovations 18:12
inpatient 4:5,8,10,12
49:15 84:22 91:22
121:3,16 122:10
127:4,11 130:9 188:4
205:10
inpatients 82:10
input 4:8,10,12,18,20
5:5,16 28:19 30:1,3,6

58:13 131:2 172:2,2,3
173:4 224:22 248:14
303:7 316:16 329:21
330:3,6,16 331:6,19
369:10
INR 118:6 121:6,17
122:1,4,7 130:7 134:4
INRs 120:11
insecure 36:15
inside 276:4
insight 326:8
insofar 113:8
instance 40:19 234:4
instances 110:8 113:4
Institute 16:5 20:10
institution 22:12 93:22
166:8
institutions 129:9
191:4,12
insufficient 40:10 106:8
106:19
insulted 423:19
insurance 20:17 147:4
193:20,20 219:17
220:6
integrated 128:9
intend 225:17
intended 55:15 147:18
157:14 161:2 281:10
281:13
intent 51:15 153:19
156:1 163:9 248:8
intention 53:21
intentional 51:3
intentionally 50:20
interacting 102:17
interaction 249:8
interchangeably 42:21
intercity 229:15
interest 4:2 9:14 20:1
65:9 234:1,6 256:18
257:3 261:14 318:10
interested 81:17 143:3
144:18 163:2 238:17
302:18 315:1 399:1
interesting 8:12 81:3
103:22 104:3 235:3
249:11 313:20 391:13
421:10
interests 9:10 17:19
intermediate 146:2
internal 156:4 237:3
348:9 418:7 422:17
internally 77:21 164:8
352:22 419:17
Internet 59:18
interplay 293:4
interpreted 305:15

interventions 82:5
85:13 96:11
introduce 14:3 16:1
23:5 232:18
introduced 109:11
222:4
introducing 261:7
introductions 4:2 8:19
10:5 25:21
introductory 59:5
investigation 157:12
investigators 20:2
investment 100:20
281:21
invited 9:10
involve 218:22
involved 10:12 28:5
34:19 47:10,11
101:15 206:18 227:3
276:10 349:12 355:20
360:12 375:4 396:2
involvement 430:13
involves 294:5,5
IOM 331:9,9 424:5
IPPS 197:14 201:7
418:18
IQI 118:14 143:19
144:22 149:19 161:13
161:20 183:5
IQR 10:2 64:21 72:4,12
73:5 74:10 75:6,9,17
81:7,14 96:4 97:1
105:15 109:11,22
110:6,16 129:21
135:9 138:2,22
139:13 145:9 148:17
149:14 160:11 163:6
163:22 164:7,11
166:16 167:5 171:20
223:7 226:7 253:12
253:19 257:16 263:2
263:7,7,10 264:18
280:14 285:8,21
286:1,3,7,12,13,21
303:15 304:7,12
305:15 306:2,5,7,14
307:3 311:1,3,6,13
312:11,13 316:22
317:4,14,15,16,18
319:3,11,13,17,19
320:4,15 321:5,9,14
321:17 322:19 323:16
324:18,20,22 325:3
325:21,22 326:5,6,10
326:16,19 332:2,17
332:19 333:3,7,12
342:14 347:1,3 348:5
353:5 355:11 374:16

380:7 383:17 384:11
384:15 405:12 408:13
408:16,18 409:11,18
409:20 410:4
IQR's 119:5
irritating 189:5
ischemic 241:8 242:3
266:22 268:17 269:13
ISIJOLA 2:17
isolated 359:4 366:14
396:22
issue 57:14 58:19,20
94:11 95:8 124:6
126:8 128:22 129:11
132:12 133:7 136:20
142:20 162:17 163:6
164:10 180:4 188:14
188:18 190:1,16
191:1,18,21 192:1,1
204:11 217:22 273:6
295:12 300:6,8
303:14 315:3,7
349:19 356:4 357:4
358:12,14,17 360:10
360:17,21 366:10,10
366:15 382:18,20
389:8 393:2,5 394:20
395:13 410:17 412:9
issued 193:13
issues 8:15,16 19:6
25:13,20 44:14 59:18
65:4 69:12,15 71:13
83:10 120:17 126:22
130:1 134:20 136:3
138:7 146:10 147:10
147:11 152:6 163:14
164:15 165:14 175:3
175:6 177:16,17
179:4 181:3 191:7
196:14 236:13 258:4
258:15 275:20 277:20
295:11 297:4,12
302:15 329:1,17
341:21 358:9 371:20
403:1 427:3,4
it'd 317:11
item 57:20 61:14 79:17
118:6 240:21 412:17
items 56:21 62:2
345:17
iteration 170:16 172:4
185:16 278:9

J

Jack 2:5 18:20,21 89:2
93:17 252:1 427:9
Jacobs 1:15 16:3,4
103:8 114:16,22

115:3 348:17 349:11
355:13 357:20 361:4
January 68:4 259:20
JD 1:15
Jean 210:13
Jean-Luc 2:19 27:17
57:5 70:8 261:6
354:12
Jeff 1:15 15:21 16:3
70:21 92:22 97:15
103:7 114:15 345:20
346:1 348:15 349:7
350:13 357:6 359:15
360:19 362:17 363:9
364:1 368:21 369:12
370:22 371:16
Jeff's 363:9 382:6
Jennifer 13:22 14:4
70:13 106:10 144:12
176:17,22 180:17
182:17 215:1,2,17
217:3 225:19,21
Jennifer's 132:8
jerk 220:20
job 10:20 28:4 98:12
105:4 190:12 216:8
365:3 413:15
Johns 16:4
Johnson 232:21
join 30:5 391:16
joining 11:1
Joint 360:7
jointly 355:16,21
judgments 193:8
judicious 78:5
judiciousness 170:18
juice 77:4 268:8
July 188:22 321:11
370:1
jump 56:22
June 302:5
juxtaposition 119:1

K

Kansas 92:6
Karen 1:19 3:18 16:17
16:19 232:21
keep 6:8 7:12 51:18
54:11 63:19 70:20
71:7,13 94:7 103:5
129:16 192:5 243:17
252:4 295:19 356:8
356:21 358:18 361:8
362:5 363:10,18
372:13 410:19
keeping 113:11 158:19
334:15 365:7 376:19
Kelly 2:1 11:1 180:22

261:6,9,11
kept 193:14 271:22
key 57:17 69:15 83:15
 97:7 132:13 201:19
 202:6 257:21
kick 203:2
kicking 334:6
kidding 417:5
kidney 1:18 13:14,15
 13:16 398:16
Kim 196:19 289:18
kind 31:9 36:9 38:2
 40:16,16 41:22 44:22
 48:16 50:11,18 51:18
 52:1 54:10 76:15 80:1
 97:18 98:16 99:21
 123:17 125:20 127:18
 136:10 149:5 162:6
 173:13 174:14 176:1
 176:13 177:1 181:4
 181:20 185:6,18,22
 186:7,8 194:16 196:6
 196:14 198:9 202:17
 206:16,18 209:5
 226:21 237:7,18
 241:2 242:17 245:21
 252:22 253:1,3 275:6
 295:4 310:17 311:5,7
 324:3,8,11 325:18
 328:17 330:10 331:13
 333:1,16 335:9,14
 344:8 346:4 359:4
 364:9 373:1,8,11,12
 377:13 378:8 379:4
 383:18 384:12 388:1
 391:5 392:8,12,13,18
 407:9 416:22 417:19
 418:10 420:20 426:16
kinds 17:16 89:9
 130:19 277:20 294:2
 303:19 304:16 335:11
kit 84:21 85:21
Klassen 381:2
knee 220:20 296:21
 317:3,3,10,17 318:21
 321:4 337:15 339:16
 341:6
knew 112:16 241:4
 280:6 354:14 416:8
knots 275:19
know 9:1 10:22 13:21
 17:17 20:22 21:1,8
 23:21 28:1,12 29:3,16
 29:18 30:13 32:10
 34:12 36:17 38:1
 40:15 42:1,10 46:21
 47:8 51:22 59:3,11,18
 66:21 76:22 77:9

84:22 85:2 87:11 89:4
 91:10 92:13 99:17
 107:8 108:8 109:7
 110:16 121:9,14
 122:1 127:5,6 128:8
 131:12 135:8 141:8
 141:10 143:17,19
 144:11 149:2 151:16
 153:14 155:5 167:18
 168:17 173:19 177:10
 180:21 181:15,16
 182:6,12,13 183:13
 184:21 186:10 189:4
 192:8,15,17 193:2,5
 193:21 195:3,5,7,10
 195:14 198:8 200:15
 201:7 202:11 203:3
 203:19 204:10 205:7
 208:5 215:4,8,9
 220:13 221:16 223:13
 224:11 226:18 229:7
 232:12 235:3,6,22
 236:4,15 237:2,16
 238:1 243:13 247:17
 252:5 253:8,17,20
 254:5 259:12 261:18
 265:18 270:2,4,17
 272:5 273:2,12 275:7
 276:22 277:19 279:5
 281:22 282:7,13,14
 294:7 297:16,20
 299:3 302:8,13,19
 303:13,17 304:19
 306:10 307:21 311:4
 311:14,22 312:7,8
 313:7 314:5,14 322:5
 323:4,8,10,16,18,21
 324:4 325:6,13,15
 326:19 328:2,7,16,19
 329:13,22 330:5,6,11
 330:14 331:16,21
 332:1,12,16 333:3,10
 333:16 336:21,21
 337:8 342:5,20 343:2
 343:2 345:9 347:7
 348:10 351:4 355:13
 358:16 359:6 360:19
 364:1 365:8,9 367:6
 368:1,2,19 369:9,16
 370:14 371:1,12,16
 371:20 373:9,12
 374:6,16 377:1,10
 378:8,16 379:4
 380:11 382:15 383:2
 383:5,18 391:6 392:1
 392:1 393:8 396:21
 398:20,22 399:3
 404:4 412:6,16 413:9

413:15 414:3,20
 415:4 416:7 417:5,7
 417:22 418:5,8,16
 419:7 420:6 421:3
 422:4,7,10,20 423:20
 425:7,14 426:22
knowing 185:15 309:12
 384:14
knowledge 19:22 136:6
 219:14 220:2 221:1
 226:4
known 80:20 137:4
 179:8 347:15 380:3
knows 25:4 42:12
 370:19 430:8
kudos 37:10

L

lab 127:8,10 130:16
labeled 68:20
labor 137:16 142:2
laboratory 128:10,11
labs 127:3 263:20
laceration 398:2
lack 187:8 240:13
 272:19 356:17 392:15
 408:1
LaDonna 345:17
laid 176:9
landscape 247:1
language 121:10
 221:13 239:7
large 30:14 36:6 84:4
 92:8 159:9 167:16
 178:5 208:13 235:20
 273:2 300:15,15
 359:16 397:20
largely 119:10 193:22
 395:16
larger 32:22 98:14
 276:1 395:12
larynx 243:20
lastly 23:3 25:3
late 16:9 330:22 332:14
 354:10
latest 68:18
Laughter 6:11,14,17
 7:2 10:3 14:18 16:10
 21:2,11,21 22:3,9
 24:15 33:8 70:3 71:22
 79:15 103:4 108:2
 142:6 165:11 167:6
 168:1 172:22 365:14
 367:12
Laurie 206:20
lawyer 15:19
layer 196:10
lead 20:2 23:13 24:5

64:5 65:6 79:21 86:9
 88:7 109:14 120:3
 135:14 154:6 180:18
 187:7 196:20 209:16
 215:1 249:2 250:3
 274:20 298:20 300:13
 345:18,20 404:7
leader 80:15
leaders 390:22
leading 46:21 216:1
 260:5
leads 287:6
learn 238:3
learning 47:9 235:1
 306:17
leave 76:4 79:13 140:14
 241:17 256:14 286:17
 368:21 413:7
leaves 413:2
leaving 430:5
led 224:2 226:11
left 57:16 63:20 68:21
 107:8,10 108:12
 188:19
leg 420:8
legislature 189:10
legitimate 221:19
legitimately 84:16
Legree's 193:16
Lemons 3:16 287:4,5
lengthy 53:4,6
Leslie 1:20 16:11,12,17
 79:10 88:7,10 108:5
 109:1,2 120:3 138:10
 154:5 186:15 201:4
 206:10 221:21 251:15
 284:18 286:20 372:11
 383:13,21
let's 18:3 28:13 108:3
 116:8 128:15 149:18
 155:13 175:18 179:13
 200:2 211:7 220:5
 221:9 228:10 241:14
 242:8 246:9,11 264:8
 325:4 346:15 350:12
 414:5 415:4 428:4
letting 365:13
level 34:14 43:2,4 44:9
 44:10,12,14 80:21
 81:1,4 82:6 83:10,13
 84:19 85:8 90:2,3,4,6
 92:20 123:7 153:1
 175:14 180:12 195:6
 198:9,11 220:17
 228:12 284:21 296:17
 319:2 335:16 339:20
 340:8,18 341:4
 381:12 391:2

levels 41:21 83:3
153:22 311:1
levers 327:22
Levy 2:5 19:15,15 64:12
107:2,14,16,19
128:20 154:20 166:13
166:18,21 167:4,7
252:14 254:21 266:8
285:20 311:11 325:18
351:20 352:8,20
353:6 370:6 375:21
384:1 404:9,20 405:3
408:11
Lewis 1:16 13:1,2,2
250:5 275:11 285:17
373:21
LHRM 1:21
LIAISON 2:12
liaisons 2:8 9:5
lieu 110:17
life 66:21 252:6 258:3
258:10 268:1 304:7
393:14
lift 78:4 100:4
lifted 233:13
lifting 233:14
light 71:11 365:4
lightbulb 367:21
likelihood 342:16
limit 67:14,15 81:8
limitation 143:7 357:14
limitations 88:17 163:7
limited 194:19 357:18
362:13 412:8
line 44:22 122:2 132:8
296:4 329:17 334:20
418:15
linear 328:12
lined 306:5
lines 44:15 49:3 102:7
291:18 330:1 428:16
linger 49:17
link 122:20 123:3
linking 216:7
links 123:1 332:4
list 10:6 11:3 24:14 29:4
31:15,21 32:6,19 33:3
34:9 36:13 41:10 49:1
51:14 52:13 53:20
59:15 63:5 76:12
79:17 113:17 140:7
159:19 199:15 245:17
265:12 268:14 269:10
292:4 307:1 321:14
337:21 342:22 348:4
416:2
listed 85:17 108:15
listen 36:11

listening 33:19 126:20
256:3
literally 15:22 152:11
literature 137:20
little 16:8 17:9 33:4
36:15 41:7 52:17 57:2
59:4 60:15 61:5 66:11
66:19 67:6 71:2 77:17
87:7 88:7 103:10
115:7 117:9 119:16
121:4,11 124:4 126:7
137:8 142:10 143:14
150:7 165:8 174:9
180:12 182:10,13
189:9 190:20 194:15
195:16 206:13 215:6
217:11 230:7 232:1,3
232:7,11 240:3 241:5
257:10 267:12 274:2
275:6 278:18 287:8
296:22 297:17 308:18
315:11 316:13 318:15
320:2 324:6,7 325:1,8
326:7 377:6 407:16
408:9 413:11,14
420:13 429:13 430:4
430:4
live 89:10 302:3 347:16
382:4
lives 98:13 100:7 102:9
living 243:9
local 79:18 80:17 88:13
106:5
local-based 92:1
located 83:20 89:9
location 43:13 127:7
157:21
locations 122:6,8
156:17,22 157:11
lofty 137:8
logic 161:5
long 53:11 135:9 141:9
173:3 200:6 236:12
258:7 327:20 328:11
349:5 370:7,10
386:22,22 391:7
403:1 424:20 430:6
long-term 18:13
longer 28:6 58:6 66:19
73:12 74:12 133:19
192:2 296:14 360:2
396:5 412:18
look 7:11 8:11 29:8,13
31:9,9,19,21,22 32:1
32:7 36:13,18 39:1
42:6 48:18 51:8,19
77:3,14,18 86:11
90:21 96:16 98:22,22

114:13 121:22 132:20
139:4 144:6 150:22
151:14 153:9 154:1
178:22 179:19 183:18
186:6,11 192:18
195:4 197:11 198:4
200:17 203:8,10,22
204:21 205:6,19
207:5 208:2 221:13
226:12 227:2 229:15
229:19,22 230:12,13
231:21 232:14 233:2
233:8 235:7 264:12
272:17 278:8 304:11
309:17 312:10,21
314:12 327:15 328:4
330:4 337:5 338:16
339:4 342:19,22
360:1,4 363:19
367:14 368:18 377:10
377:14,19 381:9
385:21 388:15 391:22
416:9 422:13 426:7
430:15
looked 39:3 87:9 101:3
136:6 208:17 224:5
225:11,15 226:15
227:6 230:4 231:1,8
237:11 250:17 273:1
301:10 315:11,12
381:6 393:22 396:13
looking 8:15 17:21
18:17 26:12 27:14
37:15 73:19 78:3
86:13 92:5 94:17
102:12 119:10 132:17
133:21 137:11 143:22
144:1 145:16 146:19
151:15 158:8 164:13
178:14 179:5 183:11
183:14,16 184:6
205:2,14 208:16
226:2 231:10 235:11
238:18 239:5 248:9
260:14 261:2,3 271:1
277:1 282:19 283:20
290:4 297:2 299:4
307:22 309:14 311:12
313:10 314:21 315:1
317:7 319:9 320:13
326:4 333:9 345:14
363:10 383:5 392:7
393:2 415:22 422:5,6
422:20 426:9 429:9
looks 153:5 179:18
208:22,22 212:1
274:4 310:10 323:17
337:9 349:21 354:3

394:14 399:22
lost 158:12
lot 7:5 8:15,21 19:20
26:16,21 36:11 45:5
51:13 65:11 87:16
89:4 100:16 102:8
109:15 123:12 140:15
141:15 145:5,12
162:12 171:9 173:3
200:22 201:9,13
202:1 215:19 217:17
218:15 220:7 231:6
252:6 304:22 315:22
319:22 324:15 331:3
351:15 375:21 402:16
402:22 429:7 430:9
430:10
lots 87:3 121:6 172:2
208:18 328:13
Louis 1:19 16:20
love 6:21 110:1 256:21
258:8 314:20 363:3
loved 347:15
lovely 10:6
low 234:4 236:8
lower 260:9
lowering 189:3
Luc 210:14
lucky 30:12
Luke's 92:6
lunch 66:19 173:17
174:2 229:9 238:9,12
239:18,21 240:1,3,4
Lutzow 2:13 17:2,3,3
48:14 229:13 281:18
366:20

M

ma'am 296:5
magic 70:10 117:4
magnitude 34:2
main 19:20 59:10 233:6
233:9 247:8 357:4
maintain 74:2
maintenance 114:4
352:3
major 92:12 96:5
198:22 221:10 273:7
302:9 381:5
majority 103:11
making 35:1 127:20
145:9 147:15 177:12
257:1 277:1 294:17
295:5 326:11 337:21
352:13 364:20 376:3
376:11 381:16 418:3
421:14
maligning 151:4

malleable 167:18
manage 293:19
manageable 8:7
management 292:8,13
 293:5 294:18,21
 349:17
manager 2:17,18,19
 27:2,9 335:6
mandate 76:9,17
mandated 20:5 129:10
 372:3
mandating 129:3
mandatory 75:18
manner 81:2 154:17
map 2:12 8:1,3,13,13
 10:18 11:15 14:15
 15:9 18:6 19:19 23:2
 26:7,9 27:4,14,18
 29:9 30:1,2 31:1 32:6
 32:7 34:13 38:12,20
 39:9 40:22 41:3,11
 42:9 46:16 50:13 53:8
 55:13,14 58:5 60:11
 61:9 96:8 131:2
 143:20 168:9 172:11
 172:16 185:14,16
 187:3 223:8 232:19
 238:16 239:5 263:11
 271:7,9 274:9 305:7
 315:7 318:6 326:18
 331:12 332:19 334:9
 334:14 363:14
MAP's 17:5 303:7
MAPs 12:12 288:13
 336:1
MARCIA 2:20
Marie 2:7 22:20 90:10
 123:9 372:17,18
 373:20 425:6
Marie's 280:10
Marinelarena 2:17 26:4
 26:5,15 46:11 72:5
 74:11 111:7,10,12,15
 118:12 121:12 370:21
 377:14 406:2,6
 408:22 409:14
market 72:16 73:11
 188:7 199:22 219:22
 219:22 220:4 309:20
markets 300:14
marrying 338:5
Martin 1:15 15:13
Marty 15:14 36:7 68:22
 97:15 104:18 120:21
 168:21 220:10 221:3
 299:2 300:22 301:15
 333:19 386:20 424:3
Maryland 84:6 92:7

94:18
Mass 12:12
Massachusetts 2:2
 20:18 188:19 189:14
massive 343:3
match 392:17
matching 185:19
material 36:16
materials 38:20 55:8
 194:19
maternal 146:19
mathematically 386:3
matter 2:3 9:4,21 17:9
 19:18 21:7 45:20 57:2
 58:9,19 63:3 173:8
 240:7 345:10 357:1
 378:9 389:18 430:18
matters 222:14
mature 171:19
Mayo 94:16
MBA 1:11,19 2:2,13
MD 1:11,12,15,18 2:2,5
 2:6,7,7,10,11,15 3:11
 10:20
mean 18:1 25:7 41:1
 42:19 44:22 45:7
 52:21 90:18 93:1
 101:3 107:6 109:4
 111:22 121:21 124:17
 130:18 131:1,19
 148:7,8,16 149:1,12
 152:10 159:22 161:9
 162:3 164:6 166:4
 167:1,15,16 169:1
 178:13 191:10 194:21
 196:8 201:21 224:9
 248:14 270:3 301:20
 302:3 313:15 316:6
 317:8 323:13 327:18
 327:19 329:18 330:3
 333:20,21 334:2
 336:16 338:4,19
 344:17 345:8 366:21
 367:3 370:6 371:17
 374:14 377:20 378:21
 379:1 385:17 386:21
 394:5 404:1 405:7
 406:1,19 407:1,6,11
 407:19,22 412:13
 413:9,11 414:5,14
 415:2 419:22 421:9
 423:1,20 424:12
 427:12
meaning 264:21 306:2
 313:2 415:19
meaningful 48:16,22
 49:4 64:20 73:13,18
 74:10 105:15 158:16

222:8 267:21 287:18
meaningfully 98:12
 100:6 101:12 102:9
 102:17
means 46:9 171:7
 210:7 233:15 244:10
 345:9 353:18 368:19
 392:18 416:12
meant 43:13 211:9
 304:11 343:19
measure 1:3 4:9,11,13
 4:14,19,21 5:7 12:5
 13:16 23:16 26:18
 33:2 35:2 38:14,18
 39:2,6 40:7 41:4,5,10
 41:18 42:4 43:3,6,7,9
 43:11 44:4,7 45:6,22
 46:14,20 47:6,18 48:7
 50:3,3 52:11,16 53:2
 53:9,15 54:8,20 55:5
 55:13 57:19,22 58:4
 58:14 59:14,15,21
 60:1,5,20 61:3 64:1,9
 64:15 65:3,13,14,15
 65:22 74:20 79:5,5,6
 79:12,21 80:11 81:7
 81:14,15 83:6,17
 84:11 86:8 88:11,13
 88:16,19 89:19 93:14
 99:11,16 103:3,16,20
 104:11,11,15 105:17
 106:2,2,3 107:3 108:4
 108:14,18,20,21
 109:8 110:3,4 112:21
 112:21 113:7,8,15
 114:11,12,18 115:12
 116:8,14 118:13,14
 119:4,10 120:7
 121:19 122:2,9,12,19
 123:11 124:13 126:11
 126:14,20 129:1,6,18
 130:3,4 131:10
 132:15 133:18,21
 134:18 135:1,11,17
 135:20 137:6 138:21
 139:5,10,12,15,16
 140:10 141:18 142:2
 143:1,8,10 144:3,16
 144:21,22 145:4,21
 145:22 146:4,15
 147:3,9,13,17,21
 148:2,8,14,14 149:12
 149:19 150:9,11,12
 150:15,16 151:2,12
 151:16 154:11,13,14
 155:6,17,21,21 156:1
 156:3,3,11,14,14
 157:5,13 158:1,2,13

158:15,18,22 159:2,8
 160:8,10,14,19 161:2
 161:18 163:8 164:7
 164:11,16 165:6,15
 166:2,15 167:19,21
 167:22 168:6 169:19
 170:16,21 171:10,18
 171:22 172:14 175:13
 175:15 176:4,12
 178:4 180:3,10 184:2
 186:1,20 187:11
 191:17,17 192:5
 198:18,19,20 199:4,8
 199:18 200:20 201:18
 202:9,16 204:19
 205:2,5 206:22
 207:19 209:14 210:16
 211:5,11 212:20,22
 213:4,15,22 214:4,18
 214:21 215:18 216:4
 216:5,6,14,18 217:12
 217:14,18 219:10,13
 223:10 224:2,20
 225:7,8 226:6,6,11
 227:4,11,18,18,22
 228:4,13 232:9
 233:18 234:20 235:5
 235:12 244:6,18,19
 245:11 247:7,11,12
 248:10,16,19,21
 249:14,14 250:8
 251:14 252:4,11,16
 253:11,19,21,22
 254:1,4,6 255:6,14
 256:9 257:8,12,18,19
 257:20,21 258:7,21
 259:2,6,10,12,16
 260:8 261:17 262:12
 262:22 263:1,12,15
 264:17,18,20,20
 265:4 267:1,16,18
 268:14,17 269:8,10
 269:13 270:9 272:7,9
 272:15 273:2,4
 274:10,14 275:2,6
 278:9,10,17 279:10
 279:18,21 280:21
 281:1,1,14 283:20,21
 283:22 284:7,10,18
 285:3,7,9,10,21 287:6
 287:9 288:8,9 289:6
 293:17 298:7,17
 299:6,21 301:3,13,18
 303:18 304:12 305:4
 305:22 306:21 307:12
 308:1 309:4,5,9
 311:20 312:11 313:4
 313:6,9,17,19 315:4

317:12,19 318:2,7,18
 318:20 319:3 320:12
 320:14 321:9 322:10
 322:17,18 326:15
 330:7 334:22 335:2
 335:13,18 338:5,17
 339:21 342:17 346:14
 346:15,18 347:1,14
 347:16 349:6,8,8,11
 349:20,21 350:1,8,9
 350:11,14,22 351:5
 351:21 352:2,3,11,13
 352:15,19 353:7,19
 353:22 354:19 355:9
 356:7,11,19 357:14
 358:19 359:5,12
 360:3 362:8,11 364:5
 364:10,20,20 365:19
 365:20 366:1,3,16,16
 367:3 368:16 369:22
 371:1,2,12 372:7,14
 373:2 376:1,7,15
 377:5 378:3,9,17,19
 379:5,22 380:15,18
 381:13,14,16 382:1,2
 382:7,11,14 383:3
 384:12,17 385:11
 387:16,20 388:6,14
 391:20 392:10 393:5
 393:19 394:1,14
 396:6,8 397:22
 401:20 402:16,19
 403:3,6,16,22 404:6
 409:16,21,22 410:3,6
 411:3 413:8,10 415:6
 416:9,12,14,19
 417:10,11 418:9
 419:10 421:15 424:9
 424:15,17 425:22
 427:15 429:21
measure's 106:4
 386:21
measure-specific 48:9
measured 80:18 140:4
 181:10 377:3 382:21
measurement 2:16,20
 12:10 58:10 84:12
 97:21 120:9 130:20
 171:14 332:8 347:14
 349:14 392:8
measurements 98:18
 202:17
measures 4:7,17 5:13
 12:2,6 16:15 18:17
 21:19 23:8 26:18,21
 28:16,16 29:20 31:7
 31:10,12,22 32:2,20
 33:1,17 34:7,20 35:3

37:15 38:22 39:3,10
 39:12,18,19 40:3,19
 41:13 42:20,21 43:14
 43:14,19 46:4,12,17
 47:1,5 48:15,21 49:1
 49:7,10,13 50:2,14,15
 50:19 51:4,13,14,20
 52:6,12 53:19 54:15
 55:11 58:21 61:7,13
 62:4,7,9 63:6,19,22
 64:13,18 67:4,15
 69:14 73:6 74:19
 76:12 77:3,6,9,15
 78:22 79:2 80:3 81:17
 81:19 82:12 88:6
 103:18 104:5 108:13
 110:5 113:13,20
 121:6 123:14,21
 125:3 129:12 131:7
 132:16 133:3,9 135:7
 135:21 136:3 139:5
 142:16 143:4,6 144:6
 145:2 146:17,18
 148:10,13 163:22
 174:12,16,17,22
 175:2,16 176:7,11,16
 176:19,21 177:22
 178:5,6,7,9,11,22
 179:1,4,14 180:1,7
 181:4,11,14 182:7
 183:5,6,20 184:11
 186:19 187:1,12,15
 187:16,20 188:3
 194:7 196:20 197:1,7
 198:10,16,21 199:6
 200:16 201:16,20
 202:7,12,14 203:9
 205:13 206:7 209:17
 210:1 216:9,21
 219:12 221:12 223:6
 223:11 224:13 225:2
 225:8,9,14,17 226:12
 230:20 231:6,10,17
 232:2,13 235:4,11,17
 235:18,19,20,22
 238:19 242:2,19,22
 245:7 246:21 247:3
 247:10 248:15 253:1
 253:11 254:10,19
 256:6,22 259:4,19,21
 260:12,15,22 262:5
 267:22 268:6 271:11
 271:20 272:2,3,4
 275:5 279:4 280:5,14
 281:2,11,12 283:13
 287:14,17 288:5,7,11
 288:14,17,19,22
 289:5,9,14,16,20

290:1 292:1,4 295:8
 295:20 296:1,2,13,18
 297:8 298:1,3,9 299:4
 299:5,8,13 300:3
 301:12 303:9,13,15
 303:19 304:5,14,17
 305:7 306:5,7,13,16
 307:12 308:9,13
 309:5 310:9 311:1
 312:7,13,15,21
 313:12 314:12,15
 315:4,16 316:2,14,21
 325:20 326:2,19
 327:12 329:11 330:5
 330:12,14 333:21
 334:1,16,18 335:11
 336:8 337:5,11,12
 338:20 341:17,19
 342:2 345:2,5 346:10
 353:12 355:14 356:2
 357:5,11,18,19 358:3
 358:10 362:20 363:3
 366:6 367:1 370:12
 370:22 371:15 372:4
 372:21 373:4,22
 376:5 377:3,10 381:7
 388:19 389:1,8,12,17
 389:17,19 390:1,14
 390:17,18 391:11
 394:10 395:9,12
 399:3,4 401:8,18
 402:15 404:13,16
 411:1 412:7 415:1
 418:19 419:13 420:3
 422:18,19 425:12
 427:15 429:15,16,19
 429:22
measuring 28:12,13
 158:8 230:6 249:18
 331:22 348:22 396:7
median 377:22
Medicaid 2:11 3:12,15
 3:17,19 18:12 23:2
 49:20 97:3 147:4
 148:8,10,19 149:16
 230:8 302:5
medical 12:18 13:12,13
 13:21 19:1,6 33:22
 49:18 101:6,9 113:7
 113:11 240:15 370:16
 390:22 396:17,18
Medicare 2:11 3:11,14
 3:16,18 18:11 49:20
 75:9 80:8 136:2,10,11
 143:1 147:18,22
 148:18 149:1 180:2
 180:14 181:21 186:19
 197:6 200:14,15

204:18 282:5 288:7
 290:13,15 298:15
 299:7 300:12,18
 315:15 380:15 382:19
 397:15 398:20 399:6
 401:6 422:8
medication 119:7
 158:20
medicine 13:11 19:17
 20:8,9 22:11,18 237:4
 292:14
meet 48:21 53:12 117:3
 291:12 356:22 362:6
meeting 4:2 6:4,5,8
 18:7 25:8 28:9,19,20
 30:13 59:11 72:7,14
meetings 33:14 126:12
meets 367:16
Megan 3:14 121:20
 125:16 143:11 308:4
 317:21 329:15
Mehta 1:17 15:6,7
 159:17
Melissa 2:17 26:5 72:3
member 10:14 11:5,12
 11:21 12:9,15 13:2,9
 13:20 14:11,19,21
 15:1,6,14 16:3,12,19
 17:3 19:12 30:20 36:8
 46:2 47:8 48:10,14
 56:12,16 61:18 64:1
 65:4 68:9 69:1 74:7
 79:10 86:10 88:3,9,14
 94:7 95:1 103:8
 104:19 105:13 108:7
 109:2,15 110:11,14
 110:21 111:5,9,11,13
 111:19,22 112:3,9,12
 114:7,16,22 115:3
 118:21 120:4,15
 124:7 127:2 130:12
 130:18 131:18 135:19
 136:19 138:11,16,20
 150:14 151:21 152:10
 152:15,19 154:7
 159:17 168:22 169:9
 181:6 186:16 194:9
 198:15 202:21 206:11
 209:5 210:19 215:4
 217:5 219:8 220:11
 221:3,22 229:13,21
 238:10 239:12 245:3
 246:3 248:6 250:5,13
 251:16 255:11 256:3
 261:18 265:9 268:2
 270:17 272:14 273:10
 274:15 275:11 281:18
 284:19 285:17 286:5

- 286:13 289:10 297:14
298:16 299:1 301:17
304:2 307:7,14,17
309:3 314:18 323:4
330:20 333:20 342:4
342:8 344:7 346:21
347:19 348:17 349:11
350:17 355:13 357:20
361:4 365:18 366:8
366:20 368:16 372:12
373:21 374:14 376:22
380:6 381:20 382:10
383:14 385:17 386:21
390:9 391:16 393:22
399:15 403:10 405:6
405:18 406:4,9,22
409:17 410:12,16
412:13,22 414:12,17
414:20 415:16 424:4
425:3
members 8:8 9:3,18
29:12,13 36:12 67:10
80:10 81:11 124:9
238:16 239:5 292:5
293:15 333:11
memo 399:1
Memphis 10:10
mental 23:1 323:21
324:4 325:10 328:18
331:3 332:15
mention 345:4
mentioned 57:6 74:16
78:20 85:22 118:4
123:14 139:2 163:3
172:12 179:16 247:5
279:7 289:4 302:12
334:6 372:5 386:17
398:7
mentions 138:3 195:22
merit 385:11
merits 104:4 349:3
met 1:8 329:5
methodologic 421:9
methodological 196:14
methodologically
147:8
methodologies 95:19
197:2 203:22
methodology 83:11
86:12 110:5 112:10
113:18 195:18 202:22
203:7,20 204:17
208:11 224:7 297:10
329:4 352:5 353:2,9
387:12
methods 125:2
metric 87:2,14,20 98:22
109:17,18 110:15
111:6 127:2 136:21
137:14,15 138:2
152:1,6 153:6,18
154:1 155:2 156:20
215:7,10 222:21
250:17 301:11 356:22
361:11,17 362:6
374:16,22 375:11,13
384:10 385:18 386:7
387:11 405:19,20,21
406:11,16,17 407:20
408:1,4 413:21
metrics 20:4 74:9
112:13 137:12 155:1
194:15 195:8 196:8,9
209:6,8 239:1 255:13
255:14 261:20 273:16
273:18,20 274:7
301:2 342:6,14 343:8
363:19 410:18
Mexico 24:18
MHA 1:11
mic 127:1 152:9
Michael 2:7 97:14,17
112:19 148:6 159:16
161:7 168:14 185:9
186:14 207:13 209:20
222:10 237:1 278:7
332:11 362:18 369:16
371:10 387:9 410:1
Michael's 46:3 47:12
374:18
micromanage 427:11
microphone 57:9,15
138:19 142:12
microphones 57:13
115:6
mid 359:22
middle 188:22 210:5,8
Mike 22:6,10,19 92:22
miles 393:3
million 189:11,17
millions 101:1
Milwaukee 17:4
mind 51:19 54:11 71:16
103:6 196:11 261:7
271:22 273:19 307:11
324:17 368:3 375:1,5
375:17 380:10
minds 292:5
mine 359:17
minimal 154:11 172:5
minimized 237:18
minimum 95:17
minority 69:3,11,14
minus 421:3 423:14
minute 239:21 276:15
354:13
minutes 30:17 67:16
81:9 107:21 240:3
345:8,9
MIPS 184:22 185:2
187:3
mirror 393:3
misalignment 32:10
misguided 155:12
missed 25:1 62:3
399:16
missing 115:16 164:21
211:16 212:1 214:5
354:21,22
mission 384:10
Missouri 18:8
misuse 158:6
Mitch 107:1 256:16
266:7 270:21 325:17
351:19 369:16 370:5
Mitch's 161:1
Mitchell 2:5,6 19:15
20:16,16 21:3,12 33:6
33:9 56:2,9 62:21
63:2,9,11,14,16
116:10,20 117:2,8
128:16,17 130:2
140:9 154:19 166:11
188:12 254:20 275:14
285:19 311:10 323:5
323:15 354:10,12
375:20 383:22 389:7
393:7 404:8 408:10
419:22 423:5
Mitchell's 374:17
384:21
mix 54:20
mixture 253:2
modal 82:5
model 172:7 227:8,11
251:13 260:6 263:22
264:1,2,4,22 265:7
283:12 297:3 323:21
324:4 325:10 331:3
modeling 157:5 170:8
models 233:4,11,17
234:9
moderated 189:8
moderately 188:13,14
modest 216:21 347:8
modifications 7:5
263:1 347:8
modifier 187:3
module 170:1
moment 180:20 327:7
363:13 378:6 414:11
money 100:18,22
101:20,22 304:18,20
304:21 425:14
monitored 122:7
134:20
monitoring 118:6
121:17 122:1 134:4
month 261:22
monthly 367:16
months 27:19 53:18
101:11 227:14
moot 358:13
morning 7:21 11:12
12:15 14:7 15:1,6,14
16:12 27:7 38:11 75:3
268:9
Morrison 2:6 20:7,7
93:1 124:2 242:9,12
242:15,21 252:9
359:14 367:14
mortality 146:20,20
177:17 216:6,18
224:12,20 225:1,7
230:17 241:8 242:3
243:1 244:5,17 250:8
252:10,12,16,20
257:18 258:15 266:21
267:20 268:17 269:13
349:15,16 355:15
356:7,16 358:16
359:2,5,9 360:18,20
361:9,11 362:1,1,2,4
362:4 365:19 366:1,6
367:17 369:7 370:8
370:15,20 372:6
373:3 379:12
mother 137:17
Mothers 13:20 240:15
motion 423:8
Mount 20:9
mouth 242:8,11
move 17:8 52:2 63:15
63:21 78:19 79:16
94:2 100:5 103:6
108:3 116:8 126:18
129:19 131:14 133:3
135:21 146:1 158:22
169:6,8 171:20 174:4
175:21 176:20 206:6
214:15 244:21 246:22
247:17 248:10 272:8
311:13,15,17 324:12
324:20 325:5 332:22
336:5 343:9 348:7
362:22 363:6 379:6
379:21 400:13 403:12
405:8 411:4 417:16
426:16
moved 77:12 86:19
225:2 285:10 318:3
380:9 425:17 426:17

movement 97:20 247:1
254:8 423:8
moves 61:4 322:11
323:11 324:5
moving 7:13 57:17
216:8 240:20 254:14
267:22 304:21 322:14
330:8 334:11 391:8
410:7
MPH 1:20 2:11
MRI 193:2
MS-DRG 197:12 205:11
MSHA 21:5
MSHA 1:11
MSPB 288:7 313:19
MSVP 202:9
MUC 29:4 31:15,21
32:19 33:3 36:13
41:10 47:1 51:14
52:12 53:20 228:13
245:17 267:1 268:19
269:15 283:1 321:14
339:22 340:10,19
341:6 348:4 353:22
354:19 379:13
MUC15-1015 134:5
MUC15-1083 149:21
MUC15-131 164:18
MUC15-534 115:13
MUC15-604 400:4
428:7
MUCs 61:16,19 62:14
muddy 264:10
multi 82:4
multi-modal 96:7,22
multiple 83:14 84:4
98:3 254:3 316:1
330:5 363:3 391:11
410:5
MUNTHALI 2:15
Myocardial 340:9

N

N.W 1:9
nail 93:6
name 15:2,6 16:3 20:21
24:4,16 26:5 27:8,16
36:5 75:3 80:5 111:8
111:9,11,17 190:19
232:17 261:11 405:22
406:3
Nancy 1:13 11:4,6 21:8
30:19 47:7 57:22
92:22 94:6 105:12
114:6 118:4,7 124:3
131:17 135:12,15
138:3 150:13,13
154:21 180:19 181:3

182:16 195:22 201:5
201:5 202:20 214:22
215:1,3 217:4 219:2
222:6 224:17 242:5
245:1 259:17 260:18
272:12,13 304:1
307:3 330:19 332:10
346:19,20 351:18
368:15 369:19 370:9
380:4,5 382:5 383:15
391:15 396:14 398:22
403:8,9 405:7 420:5
425:5
Nancy's 33:10 125:18
148:3 182:22 220:12
256:1 273:11 306:12
312:5 384:3 423:21
narrow 48:19 50:9
121:5 200:16
narrowed 224:22
narrower 225:4
Nasso 1:14 14:11,12,19
297:14 298:16 344:7
nation 53:13
national 1:1,8,14,20
14:12 15:2 16:6 20:11
23:14 31:17 54:17
81:20 154:11 157:9,9
164:17 312:19 360:10
401:11
nationally 20:5 87:8,9
157:15 285:5 293:9
natural 155:14 325:18
naturally 241:6
nature 128:22 351:6
NCQA 21:18
near 126:17 178:17
308:16
nearby 141:22
nebulous 40:17
necessarily 25:7 75:13
130:15 133:1 187:17
194:14 196:2 323:11
364:5
necessary 70:10
192:13,20 302:13
need 28:2 35:8 51:4,8
51:18 59:13 64:19
68:12 71:6 77:11,21
96:18 98:19 106:14
122:3 123:18 126:20
130:8 153:8,12 154:3
161:18 165:7 173:7
192:5 193:2,2,13,14
195:15 196:9 202:12
205:13 215:9 236:10
236:13,15 239:20
241:9 246:5 251:20

254:16 255:7,12,20
259:18 261:9,13
272:17 273:5 277:5
277:20 294:14 295:7
295:12 302:15 304:15
305:6,9,15 329:5,8,8
331:5 339:1 341:7
351:16 354:3 381:13
381:14,17 383:16
386:12 388:17,18,21
411:4 412:10 416:11
418:12 419:1
needed 65:8 161:4
177:22 215:6 392:20
424:16
needing 44:11
needs 41:4 50:1,6,7
97:21 98:18 146:17
162:4,17 169:14
272:22 350:7 369:19
387:17
negate 153:3
negative 180:4 208:8
negligible 101:8 149:3
negotiations 188:22
neighborhoods 231:4
neither 278:1
nephrologist 13:10
nephrology 24:17,19
nervous 203:17 304:4
net 420:19
network 23:15 164:17
401:12
neurologists 244:2
neurology 259:18,19
neurosurgeons 208:9
208:10,20 244:2
neurosurgical 83:8
never 10:1 139:22
181:14 207:18 217:17
218:8,8,9,9 221:7
254:5 317:4,5 386:4
387:7 418:13
Nevertheless 276:6
277:10
new 6:13 20:10 22:22
24:18 27:22 28:4
29:13 90:13 103:19
104:16 108:11 111:5
111:8,18 121:1
154:10 176:14 219:20
259:14 264:1 273:21
273:22 285:7,9
291:16 300:7,20
308:2 313:7 322:11
322:14 333:10 394:1
398:11,12 410:22
413:11 416:8,14

419:5,8,20 426:9
newer 394:19 421:1
news 272:10
NHS 353:12
NHSN 109:17 110:3,7
110:10,15 112:21
113:12,15 114:20
150:11 152:2 170:1
NHSN-related 113:20
nice 138:6 216:20
317:11 344:4
nicely 182:22
NIH 20:12 251:11 260:3
260:7 262:10,13
263:10,12,21 264:19
265:6 266:13,14
Ninety-five 132:4
Nissenson 1:18 13:8,9
13:10 46:2
nobody's 261:21
nod 116:16
nodding 319:22
noise 398:19 421:14
nominated 17:20
non 229:18
non-candidates 358:12
non-financial 21:17
non-Medicare 300:10
non-profit 19:3
non-publicly 171:3
Non-voting 2:8
nonsupport 301:1
note 55:14 57:12 77:13
108:17 217:10 262:6
299:12
noted 143:7 201:17
223:13 280:13
notes 60:7 62:3
notice 31:20 55:2 89:1
254:18 329:9
notion 89:12 192:22
194:1 252:3 255:18
305:1
November 424:6
NQF 2:14 7:20 8:3
10:13 24:20 25:12
26:8,11 27:10,18
29:19 35:12 39:21
40:21 43:11 44:20
45:20 46:15 47:2 48:6
53:16 54:15 59:6
80:20 108:22 114:8
114:12 116:2 135:18
137:1 145:7 147:6
152:7 155:18,19
169:12 178:4 181:12
181:13 182:10 183:2
183:7,17 199:18,19

202:10 203:3 205:18
 206:4 210:7,12,22
 211:2,9 217:12,19
 218:6,12,20 219:11
 224:6 226:3,20 227:5
 228:22 231:19 232:15
 233:1,19 235:16
 256:4,14 262:22
 263:8 267:15 268:4
 270:18,19 271:18
 272:2 274:18 283:9
 318:18 320:4,22
 325:15 333:5,6 355:8
 355:14 356:2 396:2
 402:22
NQF's 53:22 415:10
NQF-endorsed 40:20
 41:1 42:21 43:7,15
 46:18 136:22 144:21
NSQIP 109:17 110:3,19
 113:15 114:19
nuances 127:16 128:6
 128:14
number 64:13 67:6
 78:13 80:22 95:17
 98:10 141:4 155:9
 161:14 163:8 167:20
 174:16 175:13 189:7
 213:12,22 229:22
 230:16 235:20 241:14
 243:6,6 246:11
 262:21 263:3,9,14
 264:3,6,17 265:3
 266:4,19 267:1
 268:14 269:4 296:7
 320:3,21 335:3,5
 346:16 349:8,8,11
 350:9,11,14 361:3
 390:11 400:21 402:10
 429:1
numbers 149:2,9 241:7
 265:19 266:2
numerator 40:12 397:1
numerous 92:8 156:8
 385:5
nurse 13:5 18:7 24:17
Nurses 2:1 11:2 261:12
nursing 24:19 121:7
 122:14,15 377:8

O

O'Rourke 2:18 27:1,2
 37:18 41:3 42:7 43:1
 56:20 63:1,7,10,12,15
 63:18 64:16 68:13
 69:7 70:4,19 71:4,7
 71:10,19 72:1 89:17
 115:22 134:16 160:3

165:10,12 172:13,21
 211:1,22 212:4 227:1
 228:7,21 239:21
 240:2 261:5 267:11
 268:10 269:6 271:4
 274:8,17 283:8 284:9
 285:22 286:9,14
 289:12 290:8 338:12
 338:14 343:18 354:11
 355:6 373:18
Obama 302:9
objection 62:12
objections 62:15
objective 28:18 37:22
 40:5,9
objectives 4:2 28:10
 61:10
obligated 41:5
obligations 187:22
observation 275:4,5
 278:15 279:1
obvious 108:9 277:2
 373:22
obviously 18:1 43:18
 83:5 126:14 131:4
 136:20 298:4
occur 82:5 133:2 391:9
occurred 145:6 205:9
 385:14
occurring 132:17 135:7
occurs 182:9
odd 181:20
offer 238:16 239:4,9
offering 124:21
Office 23:1
Officer 2:15 7:20 13:13
oftentimes 53:14
oh 24:8 70:21 71:1,4
 78:3 120:21 138:20
 194:9 201:5 284:13
 333:11,12 354:14
 355:1 363:9 369:18
 372:16,17 389:11
 390:7 394:9,15
 407:13 418:14 425:6
 430:14
Ohio 390:12
okay 19:10 24:12 36:2
 37:13 40:2 48:10 56:9
 56:11,17 63:11 68:11
 71:7,17 74:15 78:10
 79:12 80:1 88:14
 91:12 106:4,13,16
 109:1,13 110:21,22
 111:13 112:15 113:17
 113:21 115:9,19
 116:8 118:6 120:20
 128:15 140:6 149:18

150:6 152:19 154:18
 164:13,16 165:3
 173:11,15 185:4
 194:9 209:11 210:13
 211:21 212:10,17
 213:1,11,13,21 214:1
 214:7,12 215:16,17
 223:3 224:18,18
 225:18 228:17 229:4
 239:1,14 240:1,10,20
 241:22 242:14,15
 246:9 257:14 262:18
 263:15 266:19 269:9
 269:11,16 272:8,14
 278:6 282:20 284:16
 286:17 287:2,4
 291:14 295:2 296:11
 298:17 299:14 302:22
 303:22 306:8 307:5
 307:10,15,15,20
 308:3 316:18 317:1
 320:6,9,11 321:6,18
 322:21 330:18 332:19
 338:11 339:7,8,17
 341:14 342:8 343:17
 345:4,6,13 348:1,15
 350:12 353:10,17
 354:5,14 355:2 365:8
 379:8 390:8 393:20
 399:22 400:12 402:8
 402:14 405:16 414:21
 414:21 428:4
old 382:1 392:22
 395:11 403:17 408:4
 408:21 413:13,17,19
 413:20 414:8,18
 417:1 420:22
older 139:1 149:4,5
 216:2 322:2
omit 396:22
omitted 397:1
on-one 98:14
once 41:1 62:9 63:20
 65:6 71:12 131:16
 175:9 206:3 234:10
 274:5 277:2 307:12
 326:9,21 364:17
 428:22
one's 356:1 429:15
one-third 177:10
ones 18:10 58:10 61:22
 69:21 191:13 194:1
 195:4 196:10 273:22
 273:22 274:1,4
 321:16 322:1 394:17
 413:20 414:18
ongoing 76:6 162:19
 163:10 187:15 204:8

218:17 236:21 276:3
 352:22 426:11
oops 189:16
op 359:21
open 25:16 53:18 59:8
 65:7 79:22 80:3 106:3
 106:5 115:10 120:20
 134:3 185:5 206:2
 211:15 212:6 213:2
 213:14 214:2 219:5
 228:11 248:4 266:21
 268:15 269:12 282:21
 291:17 303:1 318:11
 337:14 339:19 340:7
 340:17 341:3 353:20
 354:18 379:11 382:8
 400:2 402:1 405:16
 428:5,16
opened 53:17 312:6
opening 4:3 28:22
operating 10:16 315:21
operational 159:12
 233:9
operationalized 275:9
operative 356:16 359:1
 362:2,3
operator 78:12,15
 265:14 291:17 295:22
 296:5,10 402:8,12
 428:22 429:3
opinion 64:7,11 69:3,11
opinions 21:10 30:6
 69:10,15
opioid 293:6,13 294:3,9
opioids 293:10,20,21
opportunities 7:4 32:8
 85:10 87:3 288:1
 295:10 328:14,15
 361:19
opportunity 4:7,17 5:12
 5:20 7:12 35:22 40:21
 49:21 67:12 75:5 82:8
 86:2 97:8,20 99:1
 131:22 165:19,21
 196:18 200:21 291:22
 295:14 314:20 336:10
 337:7,18,18 339:12
 346:3 391:13 395:1
 416:11,19 418:5
opposed 83:2 171:4,6,7
 255:5 290:5 326:10
opposite 198:18 420:4
opposition 229:5
ops 280:20
option 40:2,10 58:17
 75:17 158:17
optional 134:19 192:14
options 39:19 103:13

115:13 134:6 149:21
 164:9,18 213:5
 228:15 267:3 268:20
 283:2 340:1,11 354:1
 379:14 400:5 419:18
 428:7
OQR 429:19
order 6:7 53:2 87:6
 155:8 203:11 204:8
 329:5 363:19 374:12
 374:20
Oregon 84:6
organization 11:9
 17:20 19:3 20:20
 97:13 200:1 277:3
 302:3 394:5
organizational 9:3,7,11
 9:18 13:20 57:1
organizations 120:8
 127:3 128:8 145:19
 167:17 191:12 196:3
 276:2
organized 59:20
oriented 202:13
original 202:9
originally 380:4
ought 154:14 190:13
 194:3 277:10 380:8
outcome 32:15 81:15
 83:6 99:9,10 109:10
 115:12 146:2 185:20
 186:8,10,10 214:14
 216:5 234:5,13
 238:19 245:15 252:12
 252:13 263:18,18
 267:21 309:8,16
 346:17 353:22 354:19
 369:3 389:22 423:22
outcomes 32:14 146:19
 178:17 186:3 203:22
 206:3 220:18 234:1
 252:17 256:18 257:2
 314:8 349:22 369:2
 401:16
outlined 31:17
outpatient 102:19
 120:11 127:4,9 130:9
 278:13
outreach 351:16
outside 29:19 92:15
 94:3 113:10 277:14
outstanding 215:15
outweighs 376:11,17
overall 178:1 180:2,10
 199:7 202:9 223:20
 330:14 398:18
overarching 323:20
overdoses 293:13

overlap 186:19 201:17
 299:20 315:3 316:9
overlapped 298:14
overlaps 40:7 180:7
 301:2
overlay 32:17
overpayment 181:22
oversight 122:11
overspent 189:17
overuse 141:7 156:16
 156:19 163:11 179:8
 184:19
overview 4:4,5,15 5:9
 38:11 54:8,10 72:6,7
 74:4 290:10 400:16
 400:19
overwhelming 36:13
 116:14
Owens 2:9 23:21 24:2,4
 146:22 147:1 393:16
 395:6 399:19 412:15
 421:8
owned 128:11

P

P 2:7
P-R-O-C-E-E-D-I-N-G-S
 6:1
p.m 70:15 173:10 240:8
 240:9 345:11,12
 362:15 430:19
pace 133:15
package 125:8
packaging 408:8
page 122:20 207:6
 227:22 298:12 307:16
pages 79:1
paid 182:1,3 229:2
pain 292:7,13,14,15,17
 293:1,5,19 294:9,18
 294:20
paints 155:7
pair 309:15
paired 187:20
pales 372:12
palliative 20:8,10,11
 359:18 360:10,12
Pam 23:21,22 24:4,7
 399:16 403:14 420:21
 421:6
Pamela 2:9 146:21
 393:16 394:22 413:1
panel 201:12 202:2
 233:2,5 271:19 272:3
panic 426:5
paper 25:1 237:3,11
 248:15 253:18,20
 254:1 256:8 390:11

paradigm 103:17 105:2
parallel 75:13 97:2
parameter 399:7
paraphrase 289:13
parliamentary 56:5
parsimonious 312:14
 334:15
parsimony 284:1
part 9:12,22 19:3 28:15
 30:14 47:20 57:20
 75:7 85:14 96:10 97:9
 105:4 107:4,5 111:3
 119:4 138:2 160:18
 168:6 169:11 170:1,3
 170:4 174:15 175:19
 183:6 194:14 203:16
 205:16 222:16 224:6
 224:7 251:11,13
 266:16 270:18 273:3
 282:13 292:8,9
 297:13 298:2,8,12
 304:8,9 324:16 362:8
 383:6 396:9,10
 417:12
part-time 18:22
PARTICIPANT 26:13
 286:16,20 291:21
 306:20 369:21
participate 9:11 29:18
 66:22 72:18 73:13
 95:11 357:22
participated 60:16
participating 3:22
 237:20
particular 8:13 9:9
 18:11 30:9 32:1 43:12
 52:14 58:20 86:7
 117:13 130:3 140:17
 143:8,10 145:15
 148:17 162:14,15
 163:6 171:11 175:4,6
 181:2 185:8 200:9
 215:5 219:13 221:2
 222:15 229:2 230:3
 239:1,2,3 257:11
 281:14 283:10 292:3
 293:17 295:13 297:4
 299:9 300:9 301:13
 303:12 310:17,18
 312:8 314:22 330:7
 387:5 398:7 412:5
 425:20
particularly 17:12 34:1
 58:18 76:3 119:8
 120:6 146:7,11
 177:19 243:5 255:15
 257:8 276:1 331:19
 390:5 397:19 398:22

partly 190:2 425:16
 426:17
partnering 104:21
partners 1:18 13:13,14
 13:18 34:22 98:3
partnership 1:3 85:11
 92:6,11
parts 90:14
pass 58:2,6 160:4
passed 56:7,13,14
 92:13 304:10 332:19
passes 66:3
passing 407:5 408:21
path 160:12 199:9
 203:6 333:16 355:10
 355:11
pathogen 170:5,7,13
pathogens 170:11
pathway 39:17 43:6
 89:20 119:5 134:19
 169:3
pathways 43:2 54:7
patience 194:8 212:18
 429:6
patient 1:15 11:7 12:17
 14:13 15:15,17 16:15
 22:15 28:11,14 32:14
 74:2 85:15 110:10
 127:7,8 130:6 132:12
 146:8,10 147:11
 153:20 156:16,21
 157:11,21 159:4
 179:9,20,21 186:9
 187:4 193:9 204:4
 217:15 237:4 240:16
 244:11 255:5 256:19
 257:1,6 258:1 267:20
 268:1 271:18,20
 276:4 279:7 281:6,6
 284:18 312:17 356:9
 356:20 358:18 363:18
 364:8 380:1,2 384:18
 387:21 389:4 391:22
 392:3 397:13 400:3,4
 401:15 406:7 411:22
 415:10 428:6
patient's 197:9 362:16
patients 19:5 36:11
 73:21 98:13 99:4
 100:3,7 102:9,18
 110:18 120:10 121:22
 123:16 153:11,13
 177:14,17 187:5
 193:17 195:6,11
 198:6 203:13 206:18
 207:20 208:5 217:17
 223:19 229:17 231:2
 231:3,12 243:8,13

244:9,17 257:7	pelvic 398:1	354:5,6,7 355:2,3,4	perspectives 29:10
258:13 259:4 272:20	penalize 89:8	357:21 358:3,6 372:1	pertinent 45:5
278:13,21 279:7,12	penalized 90:17 422:21	372:2 377:20,21,22	perverse 359:3 360:2
292:13 293:1 294:5,8	penalizing 301:6,7	379:17,17,18 386:7	361:2,7 372:13
331:20 364:12 368:6	342:18	398:10,11 399:20,20	373:12 376:10 379:3
369:5 372:9,9 377:16	penalties 316:1 374:21	400:9,9,10 401:5,7	perversely 356:8
397:1	375:2 405:10	410:10 427:18 428:11	362:20 375:14
Patrick 80:14	penalty 166:5 291:1	428:11,12	perversity 366:22 367:5
patterns 83:9 287:22	375:13,16 405:14	percentage 72:16,19	pervious 397:6
pause 64:19 66:10	415:22 416:2	73:10,11 99:21	Pharmacy 1:17 15:11
78:14 106:15 299:22	pending 108:22 116:2	399:17 421:22	PharmD 1:17
pay 6:5 33:16 100:14	135:18 159:20 165:14	percentile 183:12	phased 267:17
182:4 191:13 400:22	172:14 183:2 210:21	percentiles 378:1	PhD 1:13,20 2:4,5,9,13
425:22	217:19 274:18 321:15	percolate 188:15	Phelan 2:7 22:7,10,10
pay-for 73:7	355:8 402:22 412:16	perfect 133:14 139:22	40:13,15 41:12 97:18
pay-for-performance	penetrance 357:21	387:7	112:20 113:14,21
290:12	358:4,11 372:1	perfectly 264:9	148:7,22 149:11
pay-for-reporting 72:12	penny 193:16	perform 87:4 215:8	161:8 167:15 168:2
payer 34:1 147:3 148:3	people 8:2 18:2 25:15	273:20 419:13	185:10 207:14 209:18
156:16 289:5	27:22,22 28:4 35:9,9	performance 12:10	209:21 210:4 222:11
payers 34:20 331:20	86:21 87:9 89:10	19:21 90:9 140:3,3	222:17,21 237:2
paying 302:14 391:2	93:15 101:4,16 115:7	156:18 218:18 290:14	262:19,21 278:8
payment 72:17 73:11	121:5,8 131:19	291:6,7,13 306:16	332:12 343:15,21
81:21 82:1 99:21	137:18 141:15 144:15	323:17 329:11 336:12	344:11,16 362:19
156:7 174:17,19	152:20 153:4 163:3,8	336:12 368:18 377:17	371:11 387:10 410:2
175:1,9,11,15,20	167:20 169:4 173:12	378:3 390:19 401:1	410:14,17 411:15
176:11,19 177:2,22	176:12,15 183:18	403:16 404:3 406:13	phenomena 123:21
178:12,14,21 179:1	191:3,11,11 192:9,10	407:14,16 415:17	phenomenal 113:22
179:14 181:5 183:10	192:20,22 193:5	416:7 417:11 423:5	371:22
184:3 186:18 187:1	201:16 222:13 230:4	performed 270:7,8	philanthropy 20:13
188:1 196:9 197:1,17	230:14 231:9 237:21	306:13	philosophical 128:21
197:18 198:3,5,7	239:22 252:4 257:13	performing 336:16	philosophy 392:13
200:15,16 201:7	282:1 293:12 304:11	performs 87:10	phone 9:19 13:22 14:17
212:22 213:3,15	316:8 324:18 331:14	period 49:17 67:4,19	24:1 74:21 78:11
214:4,20 223:10	333:6,11 339:11	68:2 145:20 171:2	142:9 143:13 146:22
225:7,9 228:13 231:5	344:20 362:22 365:5	179:15 203:8,11	362:15 394:22 402:7
231:10 287:9,13	372:14 373:2 376:18	218:3 228:3 232:21	428:21
288:14,17 291:4	379:3 382:18 383:2	234:19 235:14,15,18	phrase 268:9
296:18 297:3,10	389:4,11 392:16	235:21 238:1,2,6	physiatrist 208:22
300:9 305:4,5 308:6,9	416:18 430:5	243:18 281:5	physical 193:3
308:12 310:19,21	percent 66:1,7,8 69:4,4	periodic 109:9	physician 22:11 120:9
311:9 313:1 315:15	82:9 89:12 93:18,19	perioperative 398:5,14	140:13,16 187:2,9,13
319:3 320:13 330:5	99:5 102:1,3 106:17	permit 357:17	206:21 290:1 332:6
339:21 340:8,18	106:18,19,21 115:20	permutations 260:21	372:21
341:4,18 343:9	115:20 116:6,7,16	person 14:16 18:4	physicians 22:14 128:2
416:17	117:4 124:17 132:4	23:22 64:10 86:7	243:14 423:6
payments 72:20 92:20	134:10,10,11 137:19	90:12 314:5 315:21	pick 9:22 99:2 199:10
178:19 183:14 196:1	150:3,3,4 165:4,5	336:18 388:2	199:15 201:8 208:21
201:10 290:17 291:12	167:12 212:12,12,13	person's 36:5	394:8,10
401:6	213:7,8,9,16,17,17	personal 189:15 192:6	picking 276:8 315:17
PC 139:15 143:9	214:7,8,9 228:18,18	personally 229:9	picture 38:9 46:9 51:21
PC-02 139:19 143:15,19	228:19 262:14 267:6	perspective 10:18	197:12 309:14 330:14
143:20,21	267:6,7 268:22 269:1	29:15,20 53:1,11 77:1	330:17 389:15
PCORI 20:13	269:2,16,17,18 283:4	77:20 78:3 93:3 94:5	piece 25:1 86:15 273:14
PD 275:3	283:5,5 290:20,21	100:1,2 101:18 166:2	411:18
pediatric 12:19 80:6	299:11 340:3,4,5,13	179:9 187:18 253:9	piecemeal 99:2,7
361:16	340:14,14,21,22	267:20 279:11 336:6	pieces 77:11
peg 244:3,3 358:21	341:1,10,10,11 350:3	336:18 430:15	Pierre 2:11 23:4,6 28:22

- 30:18,20 41:6 50:11
51:22 128:16 129:15
136:8,16 142:3
155:14 159:15 162:10
184:14 224:10 248:6
251:8 280:8 303:3
304:2 305:12 312:1
316:5 351:20 357:7
422:10
Pierre's 33:9 140:7
350:18
piggybacking 332:13
333:2,8
piling 283:21
pinching 193:16
pious 275:15
pipeline 35:20
placard 196:21
place 31:19 51:16 91:8
108:7 110:15 141:20
141:21 145:10 186:1
243:19 256:5 262:16
270:10 349:16 350:7
385:21 407:12
placed 390:16
places 26:16 84:5 89:9
92:16 130:11 342:18
placing 244:12
plague 315:5
plan 321:12 329:22
334:3,9
planned 114:14
planning 205:20 330:9
plans 184:10 189:2
192:19
plate 8:22
platforms 76:8 119:20
125:14 266:10
play 85:14 104:21 209:8
273:17,20 274:5,6
329:12 343:10
playing 198:9
please 6:22 9:16 22:6
25:11 36:3 55:14 57:4
57:7,8,15 59:11,17
66:22 78:13 83:1
103:5 106:10 138:18
142:12 143:17 144:10
150:19 173:11 176:22
212:5 265:16 295:22
296:7 305:17 341:8
369:17 402:9 429:1
430:17
pleased 7:9 188:14
240:21
pleasure 8:1 21:16
23:20 29:3
plenty 380:22
- plug** 258:18
plummeted 141:11
plus 147:20 356:17
421:4 423:14
pneumonia 175:15
214:21 216:1,4 222:5
223:6,11,15,18,19,21
224:13 226:6,6
228:13 230:4 239:2
258:14 272:11 274:12
274:13 278:10,17
279:5,8,13 283:1
296:19 307:13,22
308:6,8 315:14 319:1
319:6 320:13 321:21
322:2,10 339:15,21
366:6
point 25:8 46:3 51:7
53:21 55:16 60:5 70:7
70:9 75:7 82:13 83:16
94:12 103:15 105:14
117:12 123:1 124:19
131:19 133:8,11
144:20 146:14 148:4
154:4 158:12 160:8
161:1 170:19 172:6
191:20 202:10 209:12
210:12 238:13 241:15
243:6,16 254:13
277:13 307:21 310:9
310:22 318:12,14
321:12 322:19 323:5
325:7 326:21 335:22
347:4 356:15 358:13
374:4 378:11 384:21
389:7 396:6 407:1
409:17 415:17 417:14
420:18 426:13,15
pointed 91:20 93:18
163:8
pointing 378:5
points 65:10 72:16
193:13 246:5 271:14
334:21 359:15 420:13
poisoning 293:10
poke 157:2
policing 365:4
policy 8:16 11:7 26:20
58:19
polished 104:14
polite 191:2,7
poll 354:13
polling 115:10 134:3
212:6 214:1 228:11
266:21 268:15 269:11
282:21 339:19 340:7
340:17 341:3 353:20
354:17 379:10 400:2
- 428:5
Pollock 2:10 23:11,11
42:18 43:10 44:3 45:9
110:2,13,20 111:2,17
111:21 112:1,5 113:2
114:3,21 115:2
155:16 165:17 169:11
171:21 172:19 384:21
pool 290:17
poor 231:12 244:18
258:14,17
pop 22:4
population 12:11 27:12
74:1 80:7 81:16 83:20
85:15 88:16 89:12,15
99:6 102:15 110:10
136:15 139:1,4,8,11
142:19 149:8 206:13
216:2,16,17 217:14
217:16 220:6 222:4
222:18,20 223:22
227:17 230:9 235:6
244:11 300:10
population-based
81:18 82:1 92:20
populations 222:7
portfolio 178:4,5
portion 178:12,13
273:12 290:13,15
portray 181:21
portraying 182:1
posed 122:5 143:15
position 108:9 144:2
158:9 168:18 170:15
425:8
positive 151:3 159:5
180:4
possibilities 248:18
possibility 82:21 84:2
254:2
possible 33:17 42:2
65:2 66:20 127:17
169:21 173:17 214:14
262:3 312:15 353:4
possibly 95:13 171:5
221:16 261:21
post 201:9 359:21
post-acute 122:15
178:18 181:17 332:6
post-discharge 121:7
201:3,10
post-hospital 199:1
post-operative 398:15
398:16
potential 25:10 87:15
153:3 157:11 163:14
164:8 195:20 218:10
228:2 293:20,22
- 294:14 315:22 329:6
349:13 356:21 357:3
potentially 32:21 33:1
35:1 44:9 85:6 97:4
119:9 126:15 127:3
127:20 131:4 143:18
156:15 161:5 163:4
253:11 325:11 330:15
337:6 349:18 362:20
poverty 218:16 230:5
230:15 276:19
powers 84:17
practical 390:10
practice 101:3 197:19
practices 23:19 85:2,5
92:3 159:4 223:14
practitioner 24:17
practitioners 129:7
391:1
praised 425:13
pre 26:8
pre-rulemaking 4:4,8
4:10,12,18,20 5:5,16
38:7,12
precautionary 373:1
precede 197:9
preceded 205:7
precise 396:20 398:8
421:15
predicted 157:4,10,20
predictive 157:5 170:8
172:7
predominantly 157:7
181:19 300:15
preface 243:2
prefer 320:16
preference 126:5
preferences 244:17
256:19 257:7
preferred 54:16 248:11
261:4
pregnancy 149:6
pregnant 117:10
preliminary 37:21 55:4
55:9,18 59:17 60:2,8
60:8 61:9 62:13 64:4
338:16 377:15
premature 87:14
119:16
Premier 1:20 16:13,14
premium 189:3
preparation 417:18
prepared 430:7
preponderance 178:6
prescribe 293:20
prescription 293:6
presence 31:2
present 1:10 2:13 3:8

61:7 87:5 281:7 348:10 384:10 presentation 4:14 79:19 80:4 284:6,15 287:3 presentations 59:5 156:8,9 presented 65:10 157:16 303:6 presents 324:1 President 2:15,20 11:6 11:13 12:16 13:4 17:4 presiding 1:10 press 191:3 296:7 402:9 429:1 presses 152:8 pressure 367:21 387:16 387:19 399:18,19 pressures 293:20 310:11 presumption 122:6 pretty 6:8 8:5 22:13 35:18 167:22 168:2 208:3 224:14 233:19 259:21 275:4 297:7 327:22 367:2 375:18 399:2 prevalence 79:18 80:18 81:15 82:4,18 85:8 89:7 92:1,10 106:6 200:13,18 333:22 prevalent 142:18 prevent 18:13 373:12 preventable 96:6 preventing 366:15 prevention 2:10 23:13 23:19 80:7 282:9 preventive 192:13 previous 141:9 198:16 217:12 225:3 269:8 275:12 284:3 297:1 334:14 394:1 395:17 396:4 398:14 404:16 410:3 previously 108:11 179:16 203:8 204:6 274:10,14,16 356:5 403:11,19 price 85:18 188:15 190:8,15 191:1,8,9,20 192:4 300:8,17 309:6 309:7,12,13 313:14 313:21 314:21 price/cost 314:8 prices 189:8 193:7 300:16 pricing 195:22 primarily 263:20	primary 122:8 127:8,21 139:12,16 223:16,16 296:20 341:5 prime 77:8 principal 415:5 principle 287:21 297:16 347:9 349:2 principles 31:16 57:17 323:11,18 prior 6:5 28:20 32:6,7 161:4 233:12 251:21 259:4,5 305:13 320:19 322:14 336:1 363:14 382:4 priorities 32:12,16 39:2 51:6 52:5 148:21 312:16 368:22 prioritize 180:6 priority 39:6 132:13 171:13 privacy 74:2 private 20:13 34:19,22 98:4 147:4 privilege 16:14 proactively 258:22 probably 41:7 45:8,11 90:7 93:19 97:15 98:11 103:9 111:13 131:8 138:8 192:17 199:17 218:8 219:13 219:16 230:13 277:13 297:6 318:13 332:18 351:12 364:14 369:12 378:9 381:1 413:1 418:1,2,22 429:12,14 429:14 probe 271:2 problem 141:13,13,14 157:12 158:4,6 167:11 177:7 189:19 189:20 190:15,15 191:22 193:10 245:22 258:6,19 283:15,15 283:22 293:9 356:14 359:4 380:17 382:21 413:1,22 414:13,18 420:10 426:10 problematic 356:7 361:21 problems 123:19 136:21 158:10 200:7 204:9 220:5 335:7 374:22 425:10 427:2 427:3 procedural 62:21 72:2 89:18 procedure 115:11 180:12 199:9,15,20	200:5 210:17 290:7 309:21 316:13 346:17 347:20,22 353:21 354:18 procedure-based 198:21 199:4 219:10 219:20 procedures 57:18 178:17 179:7 183:17 199:10,11 231:13 287:20 proceed 30:14 346:5 process 9:22 10:13 29:7 35:18 37:20 38:17 40:20 41:2 45:1 45:21 47:9 48:6 51:12 52:21 53:5,5,6,16 54:1 56:2,18,22 60:14 61:22 63:4 109:4,8 114:8 116:12 118:1 121:2 123:2 145:7 159:19 160:18 169:12 182:10 183:7 209:14 222:3 226:5,8,9 233:19,20 235:2 237:20 257:8 259:13 270:18 295:18 304:10 325:11 337:9 346:3 419:3 processes 271:6 produced 331:7 product 41:19 42:1 177:9 325:12 professional 17:12 189:15 192:6 193:11 Professionals 2:1 11:2 261:13 professor 13:11 18:8 20:8 profile 55:16 profound 243:10 program 4:6,16,19,21 5:6,10,17 23:8 31:20 31:21,22 32:19,22 34:4 35:3 38:18,22 39:5 40:5,8,9 43:5 48:1 52:13 53:2 54:19 61:11 64:14,15,17,21 65:5 67:13,15 72:12 72:13,19,21 73:5,8,15 74:14,17,20 75:6,10 75:14 77:4 86:17 87:15 93:16,22 94:4 94:10,11 105:15,18 111:16 123:7 125:4 125:15 129:19 131:5 133:15 136:2 139:13 142:17 143:6 148:12	148:18,20 149:14 150:10 153:2 156:7 160:11 163:6 164:7 165:20,22 166:19 167:17 180:3 204:20 216:15 223:7 226:7 227:5 247:7 248:1,20 248:22 253:5,19 254:7 257:17 267:19 280:14 285:8,12 286:10 287:11 288:6 288:9,12,20,21 290:11,12,15 291:1,3 291:4,9,17 292:3 296:3 301:20 302:11 303:19 304:6,7,13,17 305:5,8 306:2,3,19 310:20,21 311:9 312:8,9,9,22 313:1,9 313:19 317:11 319:12 323:12 324:5,12 328:10 329:3 330:9 330:15 334:16 336:5 336:6,19 338:5 343:9 347:1,3 352:19 353:13 355:10 360:11 366:2,7,17 371:5 375:7 380:7 382:4 387:5 400:17 401:1,4 401:8,13,20 402:2,17 405:9,15 408:19 414:8,15 415:2,7 416:17 422:11,19 427:16 programmatic 59:7 programs 31:8 32:1,3 32:10 33:15,16 39:6 50:15,20 51:5,9,20 52:7,7 65:3 72:11 73:7 74:13 75:13,13 75:15 77:12 84:7 93:5 96:15,19 97:3,4,10 99:14 101:14 102:8 109:12 119:1 133:12 153:21 159:11 169:19 186:22 187:11,13 285:11 305:21 313:12 323:7 331:8 332:3,5,7 338:4 350:4 359:17 361:13 387:15 409:4 410:7 progress 177:19 279:4 328:19 project 1:15 2:17,18,19 2:19 15:15 27:2,8,11 27:17 53:17 54:3 80:12 205:19 227:3 318:11,18,21 337:14
--	--	--	---

projects 27:13 36:22
46:19 206:3 232:15
prolonged 243:18
promote 81:17
promoted 149:17
161:13
promotes 40:5
promoting 149:13
pronounce 190:19
proper 215:11 355:10
properly 282:3,10
386:15
prophylaxis 388:12
proponent 155:1
proportion 200:14
201:2,9
proportions 231:2,3
proposals 254:17
propose 253:11 329:20
418:17
proposed 28:16 48:1
53:3 77:7 80:13
105:14 155:17,18
159:16 171:16,17
202:9 218:12 225:16
proposing 126:15
139:15 158:1
Prostate 214:2
Prostatic 214:3
protecting 244:10
proved 311:20
provide 29:20 52:18
55:15 67:21 72:21
73:1,16 156:15
177:13 183:18 197:4
232:5,10 235:10
236:17 247:21 266:3
278:18 281:12 291:11
318:15 329:9,21
330:13 338:17,19
377:17 403:20
provided 40:12 216:12
281:14 287:15 288:16
provider 50:22 101:12
127:9 133:5 363:16
364:6,21 365:2,3
366:13
providers 48:17,22
50:21 73:17 132:19
178:3 179:17 219:17
287:18 313:2,4
331:21 356:8 364:12
364:14 367:19 375:4
provides 19:4 30:1
60:12 145:4 180:12
308:18 331:10 400:20
providing 38:11 417:19
proxy 70:12 262:7

prudent 193:1
PS 401:10 420:22
PSA 284:17
PSI 383:6 397:7
PSI-12 396:13,21 398:5
398:10
PSI-15 396:13 397:20
398:9
PSI-7 396:5,8,12
PSI-90 380:3,14 395:14
395:17 397:7 399:5
401:10,21 403:7,17
406:4,21,22 407:1,2,5
409:2 410:20,21
413:4,6,19 415:7
416:22 421:19
PSI-90's 395:15
psychiatric 429:22
430:3
public 4:7,17 5:12,20
59:1,15 67:3,3,6,12
67:18,20 68:2,4 72:12
74:1,18,19 75:1 78:15
93:4,12 94:1,4 97:9
98:4 104:22 126:15
144:8 145:10,13
151:11,18 154:15
156:5,5,9,12 158:17
159:6 160:9 161:15
161:21 162:7 163:15
163:21 164:3,9
165:16,18 166:10,22
167:7,10 168:4,8,16
169:13,15 172:15,18
183:8,9 191:3 202:8
202:11,15 231:19
255:4 291:18,20
295:5,7,11,14,15
296:1 310:10,13
321:15 348:14 350:21
382:12 401:1 402:1,3
402:7 403:22 416:16
428:16 429:3
public.qualityforum....
68:16
publicly 139:13 160:15
164:1,5,12 183:5
306:1,9,10,14 307:9
308:15 311:2 318:3,4
320:18 321:10,21
322:4,12 326:15,22
327:13 355:11 369:22
370:1,7 388:16
published 238:17 239:7
321:8 390:11
pull 57:22 59:19 60:4
61:17 62:4,7 79:9
176:18,18,21 215:18

241:21 265:19 284:13
286:21 344:6 345:1
359:12 403:2 416:16
pulled 61:13 62:6 64:1
64:3,10 79:3,11,13,20
80:3 86:8 108:4,6
112:22 118:7 135:12
137:13 150:12 151:19
176:7,12,15 182:19
194:6 214:22 219:4
241:16 242:4 245:1
246:1,2 247:19
263:20 272:12 284:9
296:14 297:8 341:22
343:13 344:1,1,4,7,18
346:12,19 380:4
402:18 403:8 429:16
429:17,20,21 430:1
pulling 63:6 135:20
260:2 262:16 285:21
297:10,18 298:1
342:2 344:9
pulmonary 19:16 398:6
pulpit 193:12
puncture 397:22 398:2
purchaser 14:6 34:1
purchasers 16:22
144:18 179:10
purchasing 4:15,19,21
5:6 287:11 288:6,12
288:20 290:11 296:3
299:10 300:4 304:6
305:8,16,21 306:18
310:20 313:18 317:1
317:6,16 319:18,20
322:15 327:17 333:15
345:15 347:6 375:1
409:12
purely 113:7 158:18
purpose 92:9 152:4
158:3 169:14,16
287:4 318:8 332:4,8
386:14
purposefully 241:1
purposes 23:16 110:7
114:4 156:12 159:7
159:12 171:14 188:2
251:4 255:20 317:13
330:9 390:19
pursue 164:6
push 84:12
pushed 190:19
pushes 328:13
pushing 58:13
put 6:7 7:15 23:8 29:5
30:15 32:18 36:3
38:22 41:9 42:13
43:22 52:12 53:8,20

57:7 81:21 93:21 95:4
98:19 104:5 117:14
117:22 125:3,15
129:19 139:2 153:21
172:3 193:9 199:11
200:2,3 226:15
240:22 243:20 262:14
262:15 279:17 284:1
291:3 310:9 312:11
327:16 329:13 330:15
333:15 348:4,5 355:9
363:10 371:14 372:17
375:1 383:17 385:22
388:18 390:12 405:14
407:16
putting 30:11 31:15
32:5 84:7 103:20
126:14 160:14 161:10
164:6 244:5 304:17
376:19

Q

quadruple 300:2
quadruple-dinging
335:3
quadrupled 293:11
qualify 404:12 405:19
quality 1:1,8,17,21 2:9
2:15,20 4:5,9,11,13
8:4 11:6,19 12:1,2,17
13:4,15 14:14 15:8,11
18:16,17 19:21 22:13
22:15,18 23:8 24:5
31:18 32:2 37:6 54:15
54:17 72:22 73:2,20
77:19 81:17 87:20
92:16 93:5 97:21
98:17 141:8 151:13
171:13 177:16 178:5
178:6 179:9 185:19
186:1,8 187:20
188:16,18 189:22
191:17,21 192:1,5
193:8,15 198:22
199:4 216:12 247:3
247:18 252:3,16,20
254:9,12,13 255:5
268:1 278:10 279:4
288:19,20 291:10
303:13 312:20 313:2
313:4 314:7 370:8,20
371:20 376:14 377:16
385:11 387:15 390:19
392:20 393:17 425:11
425:19 426:2,15
quarter 72:15
quest 309:20
question 29:22 33:10

35:17 47:12 48:11
 50:2 56:3 62:22 64:12
 70:1 81:13 95:16 96:3
 107:2 114:17 116:10
 122:5 126:1 129:2,14
 139:9,17 141:2
 143:18 144:10 159:15
 159:19 161:9,18
 162:1,2,4 163:20
 183:22 185:11 191:10
 194:11 199:5,16
 207:9,13 208:6
 209:22 215:14 225:22
 232:6,14 233:2,16
 235:7 236:19 237:1
 245:6 246:11 250:7
 250:16 251:1 253:1
 256:5,14 262:4,19
 265:10 280:2,7,10
 281:19 282:1 289:3
 289:11 293:17 297:22
 302:8 307:2 311:5,12
 312:6 313:13 314:1,4
 320:20 321:2 325:19
 326:3 335:22 337:4
 347:18,20,21 363:22
 366:20 367:11 370:11
 374:6 380:8 395:3
 399:15 410:2 412:2
 414:9,15 415:5,8
 417:8 421:18
question's 418:15
questions 25:19 28:7
 30:18 55:11,21 68:8
 69:18 72:3 76:6 95:1
 95:20 143:15,16
 144:11 196:7,16
 204:14 206:7,9
 207:11 254:16 256:16
 257:6,16 281:16
 289:2 290:9 292:8,12
 293:3,5,16 294:2,13
 294:18,21 303:2
 304:3 308:20 312:3
 320:10 339:11 350:15
 353:15 357:9 399:10
 399:13
quick 54:8 56:2 69:19
 72:3,6 74:4 89:3
 122:22 132:10 142:8
 144:15 289:3 345:6
 400:19
quickly 173:17 204:16
 427:5
quite 76:8 77:7 93:17
 147:2 189:4 208:14
 209:2 219:22 234:20
 265:20 276:6 343:1

350:18 363:21 373:22
 392:14 418:13 421:18
quitting 101:14
quote 47:18 82:14
 220:3

R

R 2:6
rabbit 94:20
race 218:7,14,22 221:8
 221:9,13 224:6,6
 225:15,16 231:8
 239:7
racial 220:16
radically 222:5
raise 57:4 130:2 146:9
raised 75:7 84:10
 104:13 141:3 147:10
 160:7 169:5 201:5
 236:19 249:21 256:17
 293:3 358:17 420:6
raising 292:19
rallying 100:9
ramifications 34:17
Rand 192:16
range 139:8 188:6
 225:12,12,12 338:17
 343:1 377:20
ranges 338:18
rare 146:12
rate 89:14 91:18 98:20
 98:21,21 99:6,20
 135:12 137:5 149:20
 188:22 293:9 377:20
 377:22 379:12 398:2
 398:15,17 401:6
rateable 126:3
rates 84:18 91:8 98:7
 102:20 137:10 141:10
 218:16 281:2,3
 351:12 352:5 377:17
ratio 309:9 398:19
rational 69:8 252:7
 327:8
rationale 39:14 42:13
 51:15 60:12 89:15
 104:9 120:13 184:5
 204:22 234:3 297:18
 424:11
rationales 35:14 179:22
raw 185:21 229:15
 279:5,20
re-discuss 64:20
re-download 68:12
re-endorsement 109:9
 228:2
re-votes 69:13
reach 39:9 46:20 58:4

282:6
reaching 47:3
react 59:2 363:17
reaction 220:21 366:13
read 35:10,22 54:9 67:9
 67:10 141:18 416:4
reading 121:2
readmission 49:5 51:1
 199:1,6,8 224:12,20
 225:1 237:10,13
 273:4,11 278:10,16
 279:21 280:4,14
 281:1,2,3,11,11 282:9
 335:13
readmissions 18:13
 27:11 50:21 230:1,17
 235:20 273:12 275:4
 279:6 280:16,20
 314:14
readmitted 279:1
ready 7:19 74:16 77:8
 87:20 89:1 105:20
 118:21 153:1 158:13
 160:9 164:14 165:15
 165:18 166:3,22
 168:4,16 169:7
 172:17 212:3 266:18
 282:19 318:18 328:7
 353:18 354:11 379:9
 400:1 411:10
reaffirm 211:8
real 25:13 32:11 127:14
 187:22 188:8 221:12
 256:18 266:2 281:21
 304:6 343:12 375:3
 380:17 420:10
realign 92:19
realigning 291:10
realistic 46:9 368:3
reality 93:9 364:11
 367:20 386:8 425:15
realize 194:6 336:9
 342:5 343:13
really 16:7 22:17 25:7
 25:11,16 30:1,12,14
 37:7,7,11 41:17,19,22
 42:4 43:2 44:18 45:17
 49:8 53:12 60:3 64:7
 65:21 69:7 86:11,12
 86:18 87:1,11,18 89:6
 94:5 97:22 98:12,12
 99:10 100:4 123:6
 127:2,16 128:9
 132:11 133:8,19
 135:6 137:4,11 141:6
 144:16,18 145:2,16
 148:13 150:22 152:4
 152:12 153:16,17

155:3,10 168:13,17
 168:22 169:17 178:8
 179:10 180:6 182:5,6
 193:13 194:17,20
 201:6 202:15 203:3
 204:2 207:1 220:4
 221:1 222:3 236:12
 237:7 243:7 245:6
 247:16 248:21 249:18
 255:1 256:4,9 257:5
 257:15 264:11 268:6
 273:5 274:1,7 279:5,9
 281:20 282:7,15
 283:13 289:20 290:3
 294:4 295:7 297:21
 298:1 300:8 302:7,15
 302:17,19 304:11,21
 305:2,2,6,9 313:21
 314:22 315:16 325:14
 329:19 330:6 331:15
 331:16,22 333:7,9
 334:1,10 336:5,17
 342:5 343:3,10
 349:12 350:10 358:8
 358:13 360:20 361:2
 363:3,22 368:18
 370:20 371:21 374:15
 375:6 384:10 385:20
 386:15 387:1,20
 388:8 391:1,18,22
 392:6,10,20 404:5
 405:19 406:19 414:10
 416:9 420:7 425:15
realm 177:20
rearview 393:3
reason 25:3 41:12
 97:22 117:16 139:19
 151:10 153:9 186:4
 218:13 247:15 284:22
 324:13,14 333:21
 348:3 371:19 374:2
 377:5 416:15
reasonable 190:21
 191:5 309:17 420:6
reasons 52:14 138:3
 167:21 170:10,11
 179:4 218:15 277:2
 370:19 385:19 404:16
reassure 30:2
rebranding 407:8
recalibrated 399:5
receive 20:12 72:15
 144:1 292:14
received 59:2,16 67:7
 202:8
receiver 265:13
receives 65:22
receiving 198:5

receptive 313:10	96:14 155:8 400:21	relate 292:3	repackaging 410:18,18
recognition 163:1	reduced 401:7	related 9:15 18:17	repair 206:12
recognize 8:12 42:8	reducing 73:20 92:10	22:17 49:6 59:22	repeat 322:7
58:9 140:18 253:14	93:11,13 401:16	94:13 177:17 178:7	repeating 65:10
254:10,14	reduction 5:10,17	179:1 184:1 190:5	rephrase 110:12
recommend 14:17	64:21 72:20 73:9,14	191:8 201:22 202:5	replace 281:10 286:7
76:12 88:3 102:5	85:7 99:5,19,20 102:3	243:5 258:3,16,16	389:2
109:11 119:17 136:13	285:12 395:18 396:9	270:6 279:13 287:15	replaced 285:7
168:5 227:10 250:1	396:10 421:17	290:4 293:10 349:15	report 28:15 57:11
272:16 283:19 381:20	reductions 101:22	349:19 405:12	72:22 76:5,9 129:10
383:15 387:6 411:11	reevaluate 168:18	relates 90:8 292:7	147:15 164:5 233:7
recommendation 56:13	reevaluation 168:9	relating 163:14	240:17 283:17 331:8
58:2,8 62:13 65:2	172:16	relationship 187:4	331:14 371:9 388:10
66:15 67:22 75:11	reexamining 294:18	249:14 252:19	388:16 424:5
88:1 107:22 108:17	refer 8:2	relative 175:3,7 178:13	reported 81:3,5 82:14
108:19,21 109:7	reference 35:12 123:6	181:4 216:10 291:6	96:1 110:10 119:20
114:9 118:10,17	referenced 108:11	315:4 349:7 403:13	126:21 129:21 161:15
120:5 135:17 161:6	references 312:5	422:1	164:1,12 166:5,7,7
168:15 172:17 181:9	referral 83:7,8	relatively 219:20	168:8 172:15 298:6
182:18,20 183:1	referring 55:3	243:17 427:5	306:1,9,11,15,22
186:18 212:15 213:19	refinement 209:3 263:7	release 275:3	307:18,21 308:10,16
214:10 217:1,6,9	264:17	released 300:21 369:22	311:2 318:4 321:10
222:2 284:20 285:6	refinements 206:2	393:9	321:22 322:12,13
286:12 294:17 341:12	reflect 113:19 205:8	relevance 209:6	326:16,22 327:14
342:6 354:8 372:20	260:1 312:15 404:2	relevant 17:13,16	355:12 370:1,7 401:2
373:6,10,15 379:19	reflected 162:18	179:15 207:4 274:6	405:12
381:19 400:11 404:13	reflecting 47:11 61:8	341:21	reporting 4:5,9,11,13
404:18 425:2 427:7	364:21	reliability 77:10 119:13	72:13 73:8 75:17,18
428:14	reflection 109:6	134:21 147:21 183:19	75:22 76:16 96:1
recommendations	reflective 404:5	392:15 398:19	110:7 119:5 124:14
55:19 62:16 76:14	refrain 65:9	reliable 76:1 140:11	134:19 139:13 145:13
107:13 268:7 271:20	regard 31:5 392:9	167:22 168:2,3	147:13 151:11 154:13
375:22	regarding 25:20 46:19	249:17 254:13 380:14	154:16 156:6,12
recommended 129:18	122:5 207:14 226:2	392:4	157:3 158:17 159:6
137:14,15 195:15	242:2 250:7 350:8	relievers 294:9	160:10 161:15,21
241:18 255:3 272:4	355:14 395:7,10	reluctant 190:17	162:8 163:15,21
298:4	396:16	remain 292:21	164:10 165:16,18,19
recommending 372:22	regardless 138:5 408:2	remaining 62:14	165:21 166:10,22
384:14 408:19	regards 178:10 206:11	remains 107:13 358:14	167:7,10 168:4,16
reconfiguration 350:22	regions 83:7	remark 117:9	169:13,16,22 170:5
record 101:6,9 113:11	registered 18:7	remarks 4:3 29:1 94:9	171:3,6,8 172:18
130:5 140:14,17	registries 158:17	remember 6:16 29:21	188:1 255:4 287:22
158:19 173:9 240:8	371:15,18	37:3 207:16,22	301:20 310:10,14
264:22 265:2 268:18	registry 262:7,8,11,14	257:16 335:13 338:22	321:15 326:6 353:8
269:14 345:11 381:8	356:12,13 357:20	421:19	357:17 382:12 385:11
430:19	358:6,6 371:17,22	remind 103:2 115:5	401:1 409:15 416:16
records 113:7 129:8	372:3	118:9 122:17 295:4	reports 32:7 83:13
131:21 247:2 383:4,9	registry-based 357:13	reminder 72:9	represent 9:9,10,16
391:21 392:18 396:18	357:17 358:3,10	reminds 296:22	16:21 17:19 178:12
396:18	regular 61:14 126:13	remote 95:4	200:14
recrafted 294:14	290:16	removed 61:19 62:10	representation 172:10
red 71:10	rehab 193:3	233:9	representative 9:12
redesigned 97:3 367:4	reimbursed 302:5	removes 197:18 198:1	17:5 57:1
395:19 397:21	reimbursement 290:14	Renal 24:20 429:16	representatives 9:7
redo 429:12	reimbursements	Renaming 411:7	23:4
redoing 123:5	290:16	reorganized 346:22	represented 15:10
redone 209:7	reiterate 77:2 142:11	reorient 310:18	29:10
reduce 86:14 93:8	rejoining 354:15	repackaged 408:15	representing 11:8

12:20 13:14 15:11
23:7,12 24:18
represents 234:16
236:7 302:3 348:20
384:7
request 58:5 142:8,11
318:6 326:9,12
332:20 430:3
requested 330:2
requesting 330:4
requests 125:7 189:3
require 39:22 157:17
236:14 267:16,18
294:4
required 54:16 119:6
125:4,15 134:18
155:22 205:22
requirement 75:18
125:9 160:2 305:22
313:17
requirements 54:19
178:21 251:20
requires 44:13 187:3
288:4
requiring 74:12
rescind 344:9
rescinds 286:21
research 2:9 16:20 18:9
18:16,22 20:11 22:17
60:11 81:10 393:17
Resection 214:2
reselected 263:13
reset 354:13
resistance 23:18 158:5
163:11 170:2,3,4,6
171:12 333:17
resolution 134:21
165:14
resolve 258:19
resource 177:21 178:7
190:1 202:16 226:3
227:6 238:15 239:4
287:19 303:8,15,18
303:19 309:5,11
312:18 313:17 314:12
resources 49:7 216:11
272:20 287:14 339:1
respecified 396:22
398:7
respect 44:6 47:22
75:22 114:7 204:17
respectively 378:2
respects 198:10 204:7
respiratory 398:17
respond 50:11 54:18
142:7 184:15 196:14
196:18 200:9 257:20
391:17 416:14

responding 294:3
315:8,9
response 19:9 25:22
33:10 47:12,15 48:11
78:9 105:22 128:16
128:17 135:4 136:17
152:18 161:16 166:17
204:13 224:17,21
245:19 246:10 256:21
306:12 316:4 348:1
350:18 353:16 355:1
368:12 379:7 402:5
402:11 403:4 411:9
428:3,19 429:2
responses 71:6 115:17
140:7 164:22 354:22
responsibilities 193:11
276:20
responsibility 38:1
105:7 275:22 276:3,8
276:13,16 277:12
332:18 364:7
responsible 23:14
89:14 103:20 104:7
127:20,22 132:22
277:17
responsive 125:7 202:7
rest 33:21 97:13,19
173:16 403:21
resubmitting 114:3
result 116:1 134:11
150:4 213:10 221:7
228:20 243:11 283:7
289:7,15 293:13
300:13 338:7 378:15
420:15
results 60:7 61:8 66:4
106:16 114:17 115:19
134:9 150:2 160:15
164:2 165:3 212:10
213:7,16 214:7
228:17 238:17 267:5
268:22 269:16 283:4
336:22 340:3,13,21
341:10 347:13 354:5
355:2 379:16 400:8
419:19 428:10
resumed 173:9 240:8
345:11
retested 408:16
returned 11:18
returning 29:12
revalidated 386:12
review 4:2 29:19 32:7
41:4,9,11 42:16 56:18
59:1 72:8 80:11 82:15
101:9 109:9 116:2
135:18 152:7 183:2

183:17 217:13,19
218:12,21 225:11
226:16,19 227:12
228:1,2,4,22 237:19
256:4,15 267:15
268:5 270:20 271:12
272:2 282:13 283:9
288:16 308:5 324:22
reviewed 56:1 103:18
152:13 160:1 226:9
227:16 249:5 268:12
271:19 274:9,14
320:15 322:17 411:20
411:22 415:10
reviewers 8:7
reviewing 73:4
reviews 202:2
revised 169:12 380:8
382:15
revision 257:19 263:11
revisit 40:22 64:15
343:15
revolve 372:8
revote 354:15,16
reward 173:15 239:15
291:1,2
rhyme 324:13,14
333:20
rich 21:9 135:6
rid 377:13
right 18:10 26:1 33:7
34:16 36:5 46:12
47:15 56:14 63:14
64:16 71:3 86:1,16,18
87:18 94:14 104:1
107:16 108:13 116:4
117:2,5 126:19
128:20 130:17 132:7
141:12 149:11 151:11
152:10,15 153:20
154:1,2 158:14,15
165:17 166:18 167:4
170:20 171:12 181:9
182:1,12,15 183:16
189:9 208:21,22
209:1 221:5 224:11
226:22 228:9,10
231:6 238:3,5 239:18
242:21 248:12,15
252:10 257:17 259:17
263:6 264:6 266:20
267:5 271:1 280:12
282:1 284:5,8,16,17
286:9,11 298:16
300:13 306:6 307:14
307:16 314:11 319:21
320:6 323:14 326:13
338:5,5 352:18,20,20

352:21 353:9 359:10
365:20 366:2,5,8
368:22 376:6 379:10
379:20 392:4,13
393:4 409:1 412:19
413:20 414:12,21
419:15 420:10 422:12
426:19 428:1 429:13
rigorous 230:13
ripe 145:9 151:11,12,12
ripple 33:20 139:3
rise 69:3
risk 80:19 110:4 123:12
141:17 151:7,17
155:6 175:14 194:17
194:20,22 196:22
197:5,15 198:10
214:19 224:7 227:8
227:11 228:12 233:3
233:11,17 234:9
250:7 251:13 260:5
263:22 264:1,2,4,22
264:22 265:7 268:16
268:18 269:12,14
283:11 293:22 296:17
319:2 339:20 340:8
340:18 341:4 361:11
366:1 379:11
RN 1:16,19 2:4 21:1,1,3
road 101:2 334:7
roadmap 334:4
robust 25:16 195:16
role 34:3 104:21 171:22
283:13 288:10
roll 331:7 335:1
rolled 392:12
rolls 41:1
Ron 7:8,9 10:19 29:2
30:8 35:6 47:14 74:5
108:7 116:11 124:2
142:4 265:9 267:11
270:5 316:18 317:21
411:17 417:4
Ronald 1:9,11
room 1:8 35:9 45:2
70:21 74:21 78:8 79:8
148:6 173:13 241:20
291:20 357:7 368:21
393:18 402:4 428:17
Roth 1:19 16:18,19,19
round 45:17 366:11
routine 80:2 82:16
routinely 251:4
RPSI 241:15
RQR 286:4
rubric 37:22 96:10
rule 35:10,13 50:8 53:4
53:4,9 131:5,6 134:15

224:16 308:10 321:8
321:16 418:18,19
rulemaking 53:3 254:18
rules 34:7 54:11
run 11:3 34:6 94:20
407:12 422:8
running 68:3 302:6
425:8
runs 359:21
rupture 137:20 146:11
rural 1:20 15:3 95:3
229:16
RV 287:1

S

S 1:9,11
sacred 367:6
safe 415:20
safer 394:15
safety 11:7 12:17 13:4
16:15 19:18 22:15
23:14 37:6 73:20
119:7 132:12 146:8
146:10 147:11 153:20
164:17 179:9 240:16
271:19,21 284:18
312:17 380:1,2 384:7
384:18 387:3,21
389:4 390:4 393:1,2
397:13 400:3,4
401:12 406:8 411:22
415:10 428:6
saint 194:2
salaried 13:18
salient 271:13
sample 110:19,20
sampling 109:19 110:9
136:15
Sanghavi 80:5,6 91:14
95:15
sarcasm 21:15
sat 101:12
satisfaction 186:9
satisfies 374:17
satisfying 42:10 325:11
save 344:16
saving 100:22 142:5
saw 16:11 216:21 241:3
333:20
saying 21:14 74:7
100:18 110:12 129:6
138:21 166:14,21
167:22 168:3 182:2
191:3 221:20 277:11
305:2 328:18 332:17
352:9,11 364:2
370:22 384:3 406:9
413:10,18 426:22

says 121:3 128:18
148:13 159:20 161:20
164:3 317:18 323:15
324:4
scale 165:16 250:21
251:5,18 255:18
260:3,7 262:10,13
263:10,13,21 264:19
265:7 266:13,15
Scales 251:11
scan 164:22
scared 6:13
scary 189:5,6
scattershot 324:8
scenario 421:11 423:20
scheduled 317:4
scheme 49:6 398:11
School 13:12 20:9
schools 22:1
Schultz 1:20 16:11,12
16:13 79:10,11 88:9
88:10,14 109:2 120:4
138:11 154:7 186:16
206:11 221:22 251:16
284:19 286:5,13
372:12 383:14
scientific 2:15 7:20
24:5
scope 34:2 88:19
113:10
score 156:9 205:6
292:10 329:10,11
427:19
scored 291:5
scores 401:2
scoring 294:21 329:4
screen 264:12
screens 90:1
scroll 108:12
scrutiny 337:13,16
SDS 41:14 204:11
205:19 218:4,21
224:6 225:10,13
226:2,8 227:8,19
228:3,3 232:2,8,14,20
233:3,10,16,22 236:8
238:19 272:18 304:15
304:16 372:15 374:4
se 391:18
Sean 2:6 20:6,7 92:22
92:22 112:17 124:1,7
220:11 242:5,8,14
246:4 252:8,15
256:16 260:17 270:21
359:12 367:13 368:14
369:14 370:19
Sean's 245:4 250:6
252:2

season 8:3,3 331:14
seats 173:12
second 14:16 40:2 52:9
79:4 89:11 95:8 96:3
134:14 136:17 137:1
157:2 212:4 234:10
243:12 271:5 284:15
297:13 303:10 307:8
320:20 347:21 356:4
360:7 376:8 403:6
404:21
secondary 223:17
Secretary 205:20
section 139:10 141:18
sector 20:13
sectors 133:6
security 74:2
see 7:4 9:19 29:9,12
30:4 33:3 36:20 38:19
39:16 41:19 50:19
51:2,9,13,13,20 55:21
67:6 68:17 69:20
71:10 75:14 77:6,11
77:12 80:21 97:20
99:10 100:13 101:10
107:14 109:10,22
117:19,21 119:14
121:22 132:16 138:17
138:21 140:6 142:16
144:3,7 156:3 161:12
175:18 176:3 180:3,4
182:9 185:7,22
199:13 200:22 204:13
206:13,17 209:11
211:7 216:14 217:19
220:18 221:13,18
224:17 225:13 229:11
229:20 231:16 237:7
241:17 242:8 270:4
276:13 279:16,18
291:19 294:13 295:22
296:12 309:21 319:22
320:9 323:1 327:16
328:1 334:5 335:10
335:15,16 339:8
341:18 342:14 347:11
347:12 348:18 350:13
350:13 363:3 372:10
373:11 374:19 383:16
384:13 402:15 408:20
412:8 414:1 416:12
419:9 420:18 425:5
430:2
seeing 36:18,21 37:13
133:4 144:19 207:16
274:5 311:18 339:17
347:6 378:6 395:21
430:16

seeks 44:6
seen 9:21 36:9 50:12
84:3 133:2,9,13
143:19 147:12 177:7
181:14 199:14 233:8
250:10 304:6 308:11
381:4 391:14
sees 279:16
segments 186:21
segue 394:22
select 40:11 54:14
201:1 210:6,6 389:1
selected 200:10 201:11
207:20 239:1 380:2
400:3
selecting 49:13 201:15
selection 38:14 54:8
55:13 61:10
selections 310:6
selectively 250:8,9
self-deception 194:3
self-insured 193:22
seminal 381:1
send 106:11 244:3
senior 2:17,17,18,20
11:13 12:16 14:5 26:5
27:2
sense 35:11 98:15,16
123:8 125:9 175:17
187:22 201:17 250:20
268:11 311:19 324:13
326:11 327:16 328:9
331:3 333:14 350:21
351:3 352:14 374:22
412:15 414:2
sensitive 32:11 272:19
359:7
sent 197:2
sentence 137:21
separate 74:13 76:15
164:2 166:15 189:21
190:8 197:16 315:16
separately 298:7,7
separating 207:4
sepsis 19:20 20:3 96:16
223:16 274:12 279:9
279:13 319:8
septic 153:13
sequence 418:11 430:5
sequentially 53:7
series 31:11 55:10
59:22
serious 158:4,6 359:19
388:18 424:12 427:2
seriously 30:3 189:4
256:15
sermons 275:15
serve 94:14,18 102:22

198:5
served 83:14,22 85:15
serves 85:4 198:9
service 49:19 93:12
 147:19 229:18
services 2:11 3:12,15
 3:17,19 73:1 181:18
 181:20 184:19 188:8
 202:5 287:15 290:5
serving 7:22 220:6
 305:14
SES 231:4
sessions 193:3
set 4:9,11,13,19,21 5:7
 31:6 33:2 77:3 95:9
 123:7 138:4,22 139:5
 139:11 153:6 156:20
 174:14 176:5 198:16
 198:21 201:7 262:9
 302:15 303:12 307:8
 312:14 317:19 329:3
 329:5,8 332:8 334:15
 386:6 394:3
sets 35:2 38:18 39:5
 202:16 342:17
setting 43:4 50:17
 98:14 102:18,19,19
 123:18 188:5 243:15
 278:13 389:5
settings 39:7 121:8
 130:10 249:19
seven 394:6 429:16
Seventy-six 379:16
several-fold 169:17
severe 243:11,19
 244:10 258:5 259:8
 343:3
severity 195:1 223:14
 245:13 250:21 258:1
 259:13 294:12 342:19
sexist 117:8
Shahab 2:19 27:7,8
 37:18 38:10 40:14
 54:6 56:8,11,15,17
 70:11 106:10 108:16
 115:5 118:9 135:16
 144:12 211:15,19
 225:19 341:7 400:18
share 75:6 131:22
 198:6 229:12 323:22
 329:16 337:1
shared 42:8 148:12
SharePoint 68:15,15
sharing 419:19
Shek 15:5,7 159:16
SHEKHAR 1:17
Shelley 1:14 14:10,11
 297:7,9 298:19 342:1

344:5
Shield 2:2
shift 103:17 105:2
 415:18 421:16,17
shifts 403:15 404:1
shining 365:4
shoppers 193:1
short 10:4 94:7 341:15
 345:8
shortcomings 140:21
shorter 78:21
shortfall 189:11
shot 42:6 211:18 354:4
 393:13
show 44:17 79:2 91:21
 102:2 183:12 332:20
 333:13 393:10 407:12
showed 209:1 300:11
showing 237:8 278:13
 278:21 300:18
shown 140:16
shows 178:18 207:7
 262:12 328:7 364:4
shuffle 158:12
shut 104:2,17
shy 28:8,8
sicker 195:6,11
side 10:17 22:13 26:20
 26:20 49:18,19 51:12
 77:18 90:1 149:16
 172:12 237:20 277:2
 290:2 329:2 357:15
sides 69:9,10 256:9
 316:8
signal 398:18
signaling 82:21
significant 8:5 82:2,11
 85:12 91:21 93:3
 101:5,22 173:20
 184:5 200:19 216:20
 238:22 299:11 313:5
 397:5,6 403:15
significantly 84:18
 92:15 102:20 187:6
 345:21 360:2 396:13
signs 263:21 331:8
siloing 49:10
similar 50:15 132:15
 139:11 216:17 219:9
 246:4 251:16 264:3
 290:3 346:8 348:4
 349:15 365:20
similarly 64:22
Simon 193:16
simple 28:10
simpler 11:4
simplicity 83:5
simply 53:16 96:7

256:8 381:14
Simultaneous 111:4
 112:4
simultaneously 268:7
Sinai 20:9 26:17
single 99:2 101:12
 235:12 280:21 314:5
 367:17
SIR 112:7 348:8 351:21
 352:3 353:8
sit 17:10,18 21:18 72:11
site 68:15,15 115:12
 132:2 144:7 239:8
 348:22 353:22 354:19
sitting 7:9 16:14 29:21
 146:6
situation 155:15 244:13
 248:17 334:5 364:11
 375:9 391:4
situations 220:15 261:1
 375:6
six 101:11 410:22
sizable 178:20
size 34:2 217:15
skepticism 140:20
skilled 122:15 377:8
skin 220:19
skip 213:12
Slabach 1:20 15:1,2
 95:1 334:13 405:6
slate 31:9 292:1
slated 317:18 318:10
 320:4,21
slide 22:5 38:16 39:8,16
 40:13 44:17,18 55:2
 56:19 59:3 60:14
 61:12 62:20 65:19
 67:2 68:7 73:4 83:1
 84:15 288:15
slides 25:2 56:1
slightly 248:7 380:17
Slosburg 1:21 11:19,21
 11:22
slower 160:12 169:2
small 22:16 32:20 89:22
 95:3 101:3 105:4
 149:10 381:15 389:7
 421:22
smaller 195:10
smoke 82:10 91:7
 100:3 101:4,7 102:16
smokers 93:20
smoking 49:2,14 50:16
 79:18 80:18 81:14
 82:3,13,16,18 84:18
 85:8 86:13,13 88:13
 89:5,7,14 90:14,15,19
 91:4,8,18 92:1,10

93:3,8,11 94:3 95:6
 96:5 98:20 99:6,20
 100:9 101:21 102:1
 102:20 106:6
smoothly 30:14
SNF 363:1
soapbox 332:9 364:16
social 49:19 229:2
 277:4,15,16
societal 91:3 93:2
 141:13 276:8
society 1:15 16:6 86:14
 90:19 158:5,7 190:16
 279:17 350:2 355:17
society's 283:15
socio 218:6 220:17
socio-demographic
 204:1 218:1 230:1
 239:6 276:10 283:11
socioeconomic 45:14
softer 173:13
softly 284:19
sole 96:8
solid 139:19
solution 258:6
solve 193:10
solving 276:19 277:18
somebody 25:10 29:22
 56:6 230:18 243:18
 265:19 356:21 361:8
 362:5 363:10 365:7
 367:15 369:17,19
 378:21
somebody's 25:9
somewhat 103:17
 225:4 362:9,13
soon 383:8,20
sorry 19:14 24:3,9 71:2
 118:14,15 120:22
 124:2 138:20 148:11
 196:20 210:18 224:18
 262:3,20 264:7 269:5
 287:5 304:2 307:14
 342:10 343:13,18
 346:21 347:19 350:17
 358:5 362:14 368:21
 405:3 418:14,14
 423:19
sort 25:14 31:8,10,16
 31:17 32:9,17 35:1
 52:4,10,11 54:2 96:10
 97:12 112:3 121:10
 163:21 181:16 190:19
 194:19 195:1 198:17
 200:3 205:14 220:3
 230:10 232:6 234:2
 249:7 257:6 277:5
 309:8 312:5 313:13

313:21 314:7,8,9,9 315:5 316:12 329:16 332:7 347:9 392:12 407:4 408:1,6 413:8 414:12 419:19 421:8 421:9 422:15 423:2 souder 282:15 sounding 276:22 sounds 41:18 148:7 172:4 223:3 240:5 285:20 327:8 425:1 source 139:22 140:1 247:3 248:2 272:22 371:4,7 sources 140:11,20 247:1,10 253:2,2 south 142:1 space 32:15 153:17 163:3 273:21 387:21 Spalding 3:18 196:17 196:19 200:11 204:15 289:17,18 spans 205:5 spared 380:13 speak 28:5 45:22 50:3,5 50:6 57:7 67:17 76:20 115:6 122:2 125:17 142:12 289:1 333:17 384:1 385:2 388:2 speaker 103:11 speakers 104:20 169:1 speaking 17:15 57:9 111:4 112:4 142:13 speaks 49:1 331:5 spec 245:18 specific 17:19 54:18 85:6 115:11 126:10 156:21 163:20 186:18 199:8 204:14 206:7 207:12 215:14 233:15 246:17 280:13 292:11 297:4,12 304:3 309:21,22 316:14 334:21 339:10,15 341:21 346:17 353:21 354:18 360:15 395:13 specifically 52:17 122:13 184:22 207:19 257:10 270:1 300:12 305:21 396:14 397:15 specifications 59:14 126:2,5 136:6 187:9 208:2 246:18 319:6 322:11 specifics 426:19 specified 43:3,8 396:19 specify 169:13 specs 122:19 319:16,18	322:14 419:5,8 spectrum 157:6 speech 380:13 speed 109:3 spell 118:3 167:2 spend 29:18 186:2 277:8 299:7 spending 177:6,11,15 177:21 178:8 180:2 180:15 186:19 187:16 189:11 197:6 201:17 204:19 281:8 288:8 298:15 spends 324:14 spent 49:20 178:14 391:7 spinal 207:15 208:4,13 213:12,14 397:2 spirit 325:4 split 58:15 69:2 spoken 50:7 162:16 393:18 spot 368:22 spread 391:5 spreading 373:3 spreadsheet 325:6 spring 29:6 207:18 squeeze 77:5 268:8 282:10 SSI 79:6 88:10 108:4,21 115:12 348:4 353:11 353:12 402:16 SSIs 113:4 St 1:19 16:20 92:5 staff 2:14,16 6:22 8:9 25:12 26:3,11 28:1 30:10 37:22 55:4 56:13 58:1 59:6 60:2 60:9 61:6 64:4,9 66:9 69:11 107:12,22 108:8,17,19,21 111:2 113:3 114:9 117:14 117:20 118:10,17 135:16 141:22 142:9 160:4 181:8 209:16 217:8 226:21 232:19 232:20 239:19 241:18 255:4 271:12 284:20 298:4,13 315:9 342:6 343:14 402:21 404:13 404:19 staff's 55:18 59:17 109:7 120:5 186:17 222:1 286:11 300:1 301:1 stage 158:16 248:3 stages 160:21 stakeholder 224:22	260:4 stakeholders 294:6 316:7 396:1 stand 238:11 standard 200:4 219:15 220:3 371:18 standardization 197:17 198:1,8 250:7 standardize 309:7 standardized 112:8 175:14 214:20 228:12 268:16 269:12 296:17 319:2 339:20 340:8 340:18 341:4 365:19 365:22 366:1 379:12 standardly 266:14 standards 291:13 standing 10:15 24:20 226:4,19 227:7,12,16 236:11 271:8,8 379:5 412:5 standpoint 51:3 146:8 181:5 422:11 stands 153:22 Stanford 202:3 star 78:13 296:7 402:9 429:1 start 29:4 31:14,19 61:21 74:22 129:20 133:11 152:20 176:10 176:12,17,22 260:2 261:16 273:17 277:5 337:21 346:15 429:10 started 30:19 37:14 74:6 118:13 174:7 240:22 259:11 284:12 299:3 345:14 350:14 391:1 starting 29:6 55:16 60:5 152:5 179:19 235:12 starts 75:19 84:11 state 22:22 75:21 80:21 90:2 147:13 155:22 234:21 318:13 373:21 396:14 413:8 417:15 417:17 stated 120:2 154:14 385:19 404:16 statement 39:13 233:6 236:5 260:14 371:6 387:2 states 148:12 177:6 230:8 350:5 statewide 84:5 97:3 stating 308:8 statistic 52:20 statistics 393:11 status 171:1 220:18	374:3 statute 318:2 statutorily 355:10 statutory 305:22 313:16 317:13 355:11 stay 49:15 225:8 stays 275:4,5 280:9 413:20 414:18 Steering 268:4 270:20 step 38:17 61:6,12 66:21 90:7 150:15,22 158:11 163:4 232:6 245:12,16 271:5 332:18 346:1 349:10 362:14 363:5 381:15 381:16 stewardship 151:22 153:16 155:11 159:3 159:11 169:18,21 170:14 stick 100:12 101:19 102:11 257:19 260:8 stimulates 313:1 stomach 243:21 stop 86:1 95:6 191:6 346:4 373:2 story 259:10,11 straight 316:20 413:16 straightforward 208:4 strange 230:10 strategic 58:20 84:10 84:13 95:13 strategies 81:21 83:6 96:14 strategy 31:18 37:10 54:17 81:20 84:12 96:7,9,22,22 97:2 105:6 169:15,17 280:9 312:20 straw 299:3 stream 385:3,8 Street 1:9 strength 423:17 strengthening 282:3 strict 291:2 strictly 151:16 strike 252:7 strikes 87:1,18 93:4,14 206:12 striving 83:4 99:11 stroke 239:2 241:8 242:3,22 243:5,11,19 244:10 245:13,15 250:8,21 251:11,18 252:17,19 255:18 257:3,17 259:8,12 260:3,7 262:10,13 263:10,13,21 264:19
--	---	--	--

265:7 266:13,14,22
 268:17 269:13 399:9
strokes 258:5
strong 69:3,10,14 147:2
 148:2 155:1 259:21
 267:19 292:21 327:22
 387:6
stronger 386:4
strongest 116:15
 263:22 265:22
strongly 102:12 142:2
 146:3 284:22 300:5
 314:19 342:13 382:11
 384:2
struck 33:13
structure 72:13 282:12
 401:4
structured 266:15
 282:15
struggle 314:4 324:2
 327:7,10,20 328:11
 329:2
struggled 109:20 323:6
struggling 314:2
STS 356:12 357:13
 371:1,17
stuck 388:1
studies 229:22 237:8
 238:18,22 243:6
 385:5,22 396:18
study 124:8 192:16
 300:7,11,20
stuff 192:13 206:15
 209:7 231:18 371:21
stump 380:13
subcohort 222:5
subgroups 207:1
subject 2:3 9:4,20 17:9
 19:18 21:7 44:5,20
 57:1 58:9 63:3
subjected 60:21
submission 132:5
 155:21 169:12
submit 47:5 53:22
 74:13 110:18,20
 164:4 253:16,22
 337:15
submittal 318:11
submitted 62:1 67:9
 68:6 137:1 147:6
 155:18 218:2 268:11
 317:5,6 318:12 333:7
 333:12
submitting 110:17
 126:10 131:21 132:4
subsequently 403:21
subset 32:20
substandard 413:4,6

substantial 41:6 69:10
 82:7,17 84:1,20 85:4
 85:10 91:22 92:2,4
 178:12,13 217:13
 361:12 395:20
substantially 82:4,19
 91:16 395:22 417:12
substantive 223:10
 348:13 352:7
substituting 14:7 70:14
suburban 229:16
success 49:5
sudden 193:1
suddenly 91:7,16
suffice 226:14
sufficient 391:21
suggest 82:15 94:2
 114:8 119:2 154:16
 168:19 187:10 216:22
 252:10 314:19 360:17
 377:9
suggested 140:18
 200:13 218:7 230:14
 299:5
suggesting 277:5
suggestion 146:16
 326:18 419:16
suggestions 376:4,4
suggests 93:7,9 381:5
suited 120:7
Sullivan 2:7 22:21,21
 90:11 123:10 279:22
 283:18 372:19 425:7
 427:8
sum 71:21 116:6
summarize 117:20
 267:13
summary 5:22 80:11
 233:6 236:5 271:13
 377:15,17
summed 66:12
summer 330:22
summing 66:4,14
super 406:14
superior 208:11 256:6
supplemental 184:10
support 2:16 26:10
 28:1 39:19,20,20
 40:16,18 41:1,8 42:5
 42:14,15,15 44:20
 45:3,4,10,12,16,18,19
 46:5 47:16 60:9,10,10
 61:1,3,3,4 65:17,18
 65:18 66:2,2,2,5,5,6,7
 66:8,9,13,13,14,14,15
 70:4,5,6 72:1 74:8
 76:2,4,15 88:4,20,21
 89:16 94:2 107:11,15

108:22 109:6 114:9
 115:13,14,14,20,21
 116:1,5,13,13 117:7
 117:18 118:11,17
 119:3,18,21 123:22
 125:8,10 127:15
 129:18 134:6,6,7,10
 134:10,11,12,22
 135:18 136:14 142:2
 145:21 146:2 149:22
 149:22,22 150:3,4,4,5
 154:8 159:22 162:3,6
 162:14 163:12 164:18
 164:19,19 165:4,5,6,6
 166:9,9,14,16 167:9
 167:13,20 168:11
 171:18 172:14 183:1
 184:13 185:12,13,15
 195:14 210:6,9,10,10
 210:21 211:8,13,13
 211:14 212:12,13,14
 212:16 213:5,6,6,8,8
 213:9,10,16,17,18,20
 214:8,8,9,11 217:1,2
 217:8,20 226:2
 228:15,16,16,17,18
 228:19,20 232:19,20
 241:19 244:19 251:6
 255:3,4,6,17 267:3,4
 267:4,6,6,7,9 268:20
 268:21,21 269:1,1,2,3
 269:17,17,18,19,21
 269:22 270:1,2,14
 272:16 282:16 283:2
 283:3,3,4,5,6,7 285:1
 286:12 298:5 302:11
 311:13,21 326:1
 340:1,2,2,4,4,5,6,11
 340:12,12,13,14,15
 340:16,22,22 341:1,2
 341:10,11,11,13
 342:7,8,9,9,12,13
 343:14,16,20,22
 344:12 345:3 349:3
 354:1,2,2,6,7,7,9
 355:3,4,4,5 363:6
 378:12,17 379:14,14
 379:15,17,18,18,19
 381:21 382:7 384:19
 386:18 387:11 400:5
 400:5,6,9,10,10,11
 402:20,22 404:14,14
 404:19,21,22 406:8
 410:4,6 411:4,11,12
 411:12,15 413:18
 414:18 425:2,3 428:7
 428:8,8,11,12,13,14
supported 27:11 46:18

47:2 60:21,22 65:15
 117:5,6 123:13
 274:18
supporter 292:21
supporters 190:21
supporting 27:3,4,9,17
 74:9 125:2,5,13
 133:18 180:1 182:14
 218:20 390:6
supportive 140:10
 146:4 151:15 165:20
 165:22 250:18,19
 275:21,22 349:1
 350:11 362:10 391:11
supports 118:3 260:20
 342:11 382:11
suppose 69:2 190:2
supposed 108:8 131:20
 141:21 156:2 173:16
 203:18 270:18 317:9
 345:22 427:13
sure 7:11 21:6 28:12
 30:3 31:14 35:8 36:4
 36:5 40:14 42:11 47:4
 48:5,7 52:3 57:15
 72:10 77:4,8,21 90:11
 90:22 91:9,14 107:3
 110:13,14 114:13
 118:3 123:15 124:19
 125:12 143:12 155:1
 160:3 161:11 166:22
 167:8 174:3 181:6
 195:12 196:4 197:3
 201:8 212:19 215:10
 219:3 220:15 221:15
 227:1,21 228:21
 235:8 236:21 237:2
 241:9 246:16 252:15
 255:1,8 256:11
 270:21 271:10 285:3
 297:6 298:11,18
 305:18 307:2 315:12
 316:20 318:12 321:6
 324:14 346:6 348:3
 349:5,9 350:18
 352:13 355:6 357:8
 359:8 365:12 380:18
 388:3 422:6 423:8
surely 119:7
surgeon 16:4 359:6
 370:14 371:16
surgeons 1:16 16:6
 348:20 350:3 355:17
 360:5,16 361:22
 367:16 377:2
surgeries 208:18
 359:20
surgery 12:1,3,6 360:13

360:21 361:10,12,14
361:16 379:13
surgical 115:12 141:22
346:17 348:22 350:4
353:22 354:19 360:16
surprise 156:10 417:2
surprised 154:22
217:11 231:22
surprises 231:9 355:22
surprising 358:2
surprisingly 9:8
surveillance 23:15
80:19 113:3 156:5
survey 95:18,20,21
292:9,22 294:19
survival 356:17,18
359:2,5 361:6 362:21
371:2 372:4,6 373:7
377:7
Surviving 20:3
Survivorship 1:14
14:13
suspect 242:18 369:12
386:13 403:14
suspending 294:20
Suzannah 3:11 224:1
235:8,19 246:19,21
257:9 318:9,12
Suzannah's 270:6
swap 417:9
swapping 417:10
switch 141:6 251:9
351:9,10
system 1:16 13:3,5
23:15 49:18 70:2
71:20 80:19 95:5
110:6 120:12 127:5
130:7 140:17,22
201:7 204:6 229:18
276:2 281:20 424:22
systems 98:3,8,9 99:15
102:13,22 120:9
140:14 158:21 159:10
278:19 300:16 381:5

T

table 8:8 18:2 25:5,11
29:15 30:5 31:2 58:11
72:11
tackle 142:21
take 30:2 35:22 51:16
60:19 63:2 67:8 68:8
69:22 82:9 100:15,18
105:19 114:12 116:11
141:20,21 150:8,22
159:18 160:3 173:5
173:11 195:5 198:7
211:1 221:6 227:2

228:10 229:10 232:6
233:8 235:7 240:2
247:6 260:16,19,20
278:4 284:20 304:11
309:6 313:21 327:6
327:15 328:20 346:10
349:6 350:7 353:18
363:12 364:10 367:7
374:10 395:3 407:7
409:1 428:17
taken 20:5 38:13 49:14
51:8 245:12 256:13
256:22 386:17,22
396:12
takers 270:4
takes 135:9 192:9 197:7
238:3
talk 26:13 28:2 38:7
44:2 52:16 81:5 84:13
129:1 147:9 197:14
203:21 204:16 211:10
241:14 257:10 297:9
307:8 341:19 342:1
392:7 411:14 419:16
talked 44:19 118:5
235:19 283:22 371:1
378:14 380:6 386:22
403:1
talking 53:10 168:13
221:8 242:18 277:8
289:5 292:12 307:13
327:18 376:3 392:16
396:15,15 404:10
tallied 71:14
tally 369:8
tallying 65:20
Tara 3:16 287:5 303:6
target 94:11 122:12
140:3 238:5 254:14
Taroon 2:16 227:2
232:17 289:13 415:16
task 218:6 323:9,9
tasks 410:5
tax 93:10 277:9
taxes 90:14 91:17
teaching 198:2
team 26:10 38:4 80:10
235:8 245:11 246:21
252:2
technical 246:18
389:14
technically 41:3
technology 73:17
271:18
tee 266:19 287:3 339:18
teed 162:9 284:6 332:1
teeing 303:5
telephone 3:22

telephone-based 95:20
tell 9:16 27:21 35:8
189:13 190:9,10,11
194:21 240:12 245:7
258:8,11,12 259:20
265:13,17,20 310:12
380:19 390:8 395:15
416:6
telling 136:12
tells 151:18
ten 235:14 345:9
359:21 367:9 392:10
392:12 396:2 409:7
tend 28:8
tendency 378:17
tenfold 381:10
tension 47:15 128:1
tent 36:3 57:7
term 178:17 236:12
362:2,3 370:10
terminology 289:21
terms 34:22 89:6
130:22 133:7 145:3
145:18 146:1,6,13
147:10,15,20 159:20
163:5,20 164:9
170:21 180:13 182:18
183:16,19 184:9,13
215:17 216:11 223:13
223:14 238:6 252:20
253:10 297:21 306:16
313:13 314:13 326:13
384:17 385:13 395:6
395:10 396:21 397:18
398:18 399:7 412:11
419:18 421:14
terrible 258:13 420:9
territory 277:7
terror 153:22
test 56:19 69:19 70:1,5
70:7 234:11,22
283:13 392:10
tested 43:4,8 76:7 90:3
147:22 423:7
testing 40:1 41:14 43:3
43:21 44:5,12,13 45:7
70:2 71:20 90:8 169:3
392:6
THA 308:13
thank 7:8,16 10:18,22
11:5,16 12:7,21 13:7
13:19 14:9,22 17:1,7
18:18 20:15 21:5,22
23:3 24:2,20 25:2
26:9 29:16 30:7,8,10
30:15 34:11 35:4 38:4
50:10 56:9,16 63:17
75:1,5 76:17 78:7,10

78:17 80:5 86:2,4
88:9,22 91:13 92:21
103:1,8 105:10 106:1
109:3 114:1 120:1,4
124:7 131:18 133:21
134:1 135:5 136:19
138:14 144:14 146:21
147:1 148:5 150:14
155:16 162:11,12
173:1,2 177:4 180:16
180:17 181:6 182:16
184:16 185:3 186:14
186:16 188:10,12
194:4,7 198:13
200:11 202:19 206:5
207:10 210:10,15
212:17,18 214:12,16
217:3,5 219:1,2 220:9
221:22 222:9 224:8
225:18 236:20 238:7
238:10 239:10,12,13
240:6,18 241:22
244:22 245:3 246:16
249:4 250:13,21
255:11 257:4 265:9
271:16 273:8 282:17
285:13 291:14 295:1
295:2,3,17 296:10
298:10,19 299:1
302:21 303:4,21,22
307:5 308:21 312:2
314:18 316:3 322:21
328:22 332:10 333:18
335:19 338:21 339:7
339:7 344:22 351:18
353:14 357:6,8,9
362:17 363:11 365:13
366:18 368:11,15
370:4 372:16 373:19
373:19 374:9 378:4
379:20 382:5 383:12
383:21 384:20 385:15
387:9 390:7 391:15
393:20 399:12 419:15
425:4 429:5,5 430:12
430:15
thanks 6:3,4 7:7,14
12:22 16:17 18:19,19
20:6 22:19 24:7 29:2
30:21 37:19 38:10
54:6,6 56:20 105:13
142:4,4 159:17
196:12,17 204:15
267:11 289:17 291:21
301:14
theirs 57:16
theme 174:19 239:3
251:16

themes 174:11
theoretically 418:17
therapy 193:3
thereof 240:13
thing 6:21 12:4 38:3
 45:17 74:17 77:13
 86:18 111:7 117:6,11
 124:22 139:7 168:12
 176:3 181:10,22
 182:5,15 185:17
 203:19 224:4 228:8
 240:11 245:14 249:6
 249:19 252:15 271:1
 271:2 324:8 348:18
 351:11 365:10 373:8
 376:8 380:12 383:10
 407:5,17 408:21
 409:1 420:9 426:9
things 17:15 34:6,9
 41:14 58:7 59:4 60:12
 83:16 84:9 91:3,17
 92:17 97:7 98:8,11
 100:6 101:1 102:17
 128:10 130:19 131:14
 132:13 138:5,8
 153:12 177:11,13,18
 182:9 185:19 193:6
 198:2 215:5 221:8
 228:6 233:15 274:2
 278:1 283:21 304:16
 323:11,14,22 324:5
 324:12 325:16 327:13
 328:19 331:15 332:2
 333:2 334:11 336:2
 337:8,21 358:22
 372:8 373:5 375:21
 378:13 380:21 383:5
 389:20 392:5,10
 395:13 405:7 430:11
think 7:6 10:17 19:12
 19:13,19 21:13,16
 26:1 30:22 31:16,18
 32:16,17 33:1,10,18
 34:9,13,13 36:12,17
 36:20 37:7,9,10,14
 41:15 42:9 43:21 44:1
 45:1 46:8 47:21 48:3
 48:17 49:22 50:8 51:3
 51:7 52:4,11 60:9
 64:17 68:7 71:6 74:22
 76:11 78:5 83:15 84:9
 86:10 87:3,16 88:19
 89:4 90:7 93:2,16
 96:4,18,21 99:1
 100:15 101:16,17
 102:10,11,19 104:2,4
 104:16,20 105:1,2,7
 110:11 111:17 114:10

119:16 120:16 121:10
 123:10,11,12,20
 124:5 125:18,22
 126:6 127:14,22
 128:6,13,21 129:2,2
 129:11 130:1 131:1
 132:15,21 133:3,7
 135:13,20 136:11,21
 137:8,9,17 138:2,6
 139:12 140:5 141:6
 141:12 144:3,15
 145:1,4,8,11,21
 146:10 149:12 151:10
 152:1,3,6,6,19 153:2
 153:15 154:3 160:6
 160:19 161:12 162:13
 162:15 163:13 164:7
 164:10,14 168:4
 171:11 173:21 177:5
 178:1 179:3 180:5,9
 182:14 183:15 184:4
 184:12 185:17 189:20
 189:21 190:5,6,16,22
 191:6,16,19,21 192:1
 192:2,5 193:4,8,13,19
 194:2,12,16 195:3,13
 195:19,20 197:15
 198:18,19 201:4,19
 202:7 203:15,20
 204:22 208:11,14
 211:1 214:14 215:19
 216:6 218:13,15
 220:14 224:4,10
 226:16 228:5,21
 231:5,22 232:10
 235:3 237:10 244:15
 245:19 246:4,5
 248:20 249:21 252:18
 253:9 254:7,8,16,22
 256:4 259:17 260:22
 268:10 271:2 272:1,2
 272:22 273:17,19,22
 274:4 275:19 276:2,6
 276:12,18 277:5,10
 277:19 278:8,11,17
 279:3,9 280:11
 281:11,18 282:8,16
 283:22 289:4,20
 294:3,11,17 295:19
 297:20 298:5 301:10
 303:7 304:4 305:6,6
 309:11 312:4,5
 313:15 314:1,2 315:5
 316:8,8 317:1,8
 320:20 321:5,18
 322:9 323:4,6,13,22
 324:1,10,11 325:8,16
 326:17 327:2,11,19

327:21 328:2 329:1,2
 329:18 330:4 331:2,6
 331:13,18 332:21
 333:1,5,22 334:2,5,9
 334:13 335:9,10,13
 335:15 336:7,22
 337:2,20 338:3
 339:17 348:18,20
 349:2,18 350:6 351:7
 351:15 352:21 356:11
 357:3 360:20 361:1,5
 362:12,19 363:2,5,16
 364:4,9,11,13,17,19
 364:21 365:15,16
 366:10 368:12 370:7
 370:9,9,19,21 371:13
 372:8,9,20 373:1,9
 374:5,6,17,20 375:17
 376:13,13,14,17
 377:1,4,9,12 378:8,18
 379:8 382:6,10,18,21
 383:8,11,16 384:5,6,9
 385:2,9 386:5,14
 387:1,4,8,17 388:18
 390:4 391:9,9,12
 395:8 397:19 398:4
 399:1 405:11 406:12
 406:15 407:3,7
 408:15,22 409:8,10
 410:12 411:6 412:13
 412:22 413:12 415:16
 416:22 417:7,15
 418:4 419:17 421:20
 422:11 423:2 424:7,9
 424:18 425:10,16,17
 426:4,5,13,18 427:1
 427:14,18,22 430:6,7
thinking 29:4 31:15
 34:22 35:18 52:6
 86:18 96:10 160:4
 163:18 185:1,2
 189:18 197:16 254:7
 272:1 276:14 277:21
 298:18 307:11 311:8
 312:6 319:4 324:15
 325:9 342:4 366:15
 399:2 410:20 413:2
 422:18 426:11
thinks 146:17
third 11:14 12:3,12
 14:15 243:16 265:21
 269:10 379:22
Thirty-eight 167:13
Thirty-five 355:3
thirty-three 165:5 354:6
Thomas 2:13 17:1
Thoracic 1:15 16:6
 350:2 355:17

thoracics 207:2
thorough 237:21
thoroughly 218:5
thought 31:11,16
 101:13 141:16 163:4
 168:14 169:2 181:8
 190:21 207:3,22
 215:7 247:21 249:11
 257:2 280:18 281:5
 283:19 284:2 295:18
 313:21 319:12 328:8
 342:10 343:19 344:19
 353:9 366:9 415:19
 416:8
thoughts 31:11 38:3
 75:6 223:2 297:2
 335:19 357:7 359:11
 363:7 373:17 385:16
threat 129:4
three 19:19 20:20 37:3
 38:16 49:14 54:18
 57:13 102:2 107:4
 157:3,8,19 174:1
 193:4 211:12 229:8
 235:19 239:15 241:7
 241:13 242:1,6,17,19
 242:22 245:6,8,9,17
 246:1,6,7,12,12,14
 247:15 253:1,13
 254:6 255:13,13,16
 255:21 260:16,20,21
 263:15 264:3,14,20
 265:13,14 266:4
 267:18 268:6,11,14
 275:1 292:12 299:13
 307:20 315:14,16
 316:21 319:16 333:8
 335:1 337:11 341:17
 342:2 343:8 346:9
 349:8 350:9,11 354:3
 354:21 398:12 423:9
 423:9,13 427:17
 429:17
three-and-a-half 27:19
three-patient 49:15
three-quarters 73:10
threshold 140:3
thrombosis 398:6
throw 109:22 170:20
 300:16
tie 275:19
tied 304:17
tier 205:19 423:9,9,9,10
 423:12,12,13,13
Tilly 2:19 27:16,17
 68:19 71:1,5,9,17
 106:4,13,16 115:10
 115:16,19 134:3,9

149:19 150:2 164:16
 164:21 165:3 210:15
 211:12,16 212:6,10
 213:1,13 214:1
 228:11 266:20 268:15
 269:11 282:21 339:19
 341:9 353:20 354:17
 379:10 400:2,8 428:5
 428:10
time 6:9,20 8:20 15:22
 25:13 26:2 27:13
 28:21 29:6,16 36:14
 36:20 41:4 50:13
 53:10,11 57:14 61:4
 62:1,5 63:3,10,12
 65:9 66:19 68:1 77:8
 78:12,16 79:1 86:1
 95:22 103:16 109:12
 131:13 134:17 135:9
 136:8 142:10 144:6
 145:20 153:17,21
 154:2 159:7,18
 160:11 161:10 173:21
 176:13 177:3 179:15
 182:14 195:18 200:6
 211:2 212:2 220:1
 227:9 228:4 239:20
 241:16 242:5,6
 243:18 244:2 248:9
 248:20 253:6 256:12
 256:13 258:8,17
 259:5 267:17 273:15
 281:5,8 290:9,18
 291:7 292:1 296:6,9
 318:20 321:12 324:7
 324:15 325:1 329:17
 330:1,5 338:10
 344:16 345:22 346:11
 356:20 359:18 365:15
 366:10 368:4 370:7
 385:20 387:1 391:7
 392:22 394:4 402:8
 402:13 411:7 417:8
 418:2,15 428:15
 430:2
timeline 131:3
timelines 418:13 419:1
timer 71:3
times 20:20 101:11
 137:3 157:3,8,20
 161:14 175:10 248:1
 255:1 300:8 338:2
 403:7
timing 52:22 430:4
tired 324:9
tires 203:2
titled 38:20
TKA 308:13

tobacco 52:16 85:17,18
 91:16 93:7
today 7:13 8:12 9:12
 10:2 11:9,15 17:14
 23:22 24:4 29:5 37:16
 65:12,17 69:22 76:20
 80:10 104:3,17
 162:12 194:14 287:7
 295:7,9,16,20 319:4
 349:16 378:14 403:7
 428:18 430:8,10
told 70:9
tolerant 424:21
Tom 17:3 48:13 50:10
 51:17 80:15 229:11
 366:19
tomorrow 6:10 295:16
 400:14 410:16 429:9
 430:16
tool 59:10 84:21 85:21
 87:1 124:14 391:10
tools 239:7
top 68:20 69:20 199:15
 265:18 284:3 334:19
 336:17
topic 34:12 39:2 45:5
 139:6 140:2 142:15
 162:15 184:20 356:10
topics 139:11 350:8
 357:4
topped 336:2
torn 301:17
total 49:6 198:17,19
 204:2 205:1,5,12
 230:16,16 296:20,21
 309:12 341:5,6
totally 20:21 68:19 70:9
 384:2 406:11,12
 407:18
touch 49:17 50:17
 125:20
tough 44:18 277:7
trach 244:3,3
tracheostomy 243:20
 358:21
track 63:19 76:15
 120:10 129:16 230:12
 322:6 361:22
tracking 77:20
tracks 83:9
tract 308:12
training 13:5 15:20 24:6
 405:13
transcriptionist 57:10
transformation 15:19
 37:1 302:9
transitioning 386:6
transitions 281:19

282:3,14
translation 19:22
transparency 145:10
 310:4 375:10,15
transparent 145:3
 193:7
Transurethral 214:2
trapped 389:9
trauma 208:13
Trautner 2:1 11:1
 180:22 261:11,12
Travis 1:9,11 7:3,8 10:9
 10:9 30:16 33:5 35:6
 36:2 46:1 47:7 48:13
 50:10 54:5 68:22
 70:18 71:15 117:11
 129:15 131:11 168:12
 173:11 180:17 182:16
 184:14 185:4 186:14
 188:10 194:4 196:13
 198:13 200:8 202:19
 204:12 206:5 207:10
 209:4,11,20 210:2,9
 210:18 211:6,20
 212:3,8,17 213:11,21
 214:12 215:12 217:3
 219:2 220:9 221:21
 222:9,15,19 223:3
 224:8 225:18,21
 226:20 227:21 228:9
 229:4 236:20 237:19
 239:10,13,22 240:5
 291:14 295:2 296:10
 298:10,17 301:15
 302:22 303:22 305:12
 306:4,8 307:5,10,15
 307:20 308:21 310:15
 312:1 314:16 316:4
 316:18 318:22 319:15
 320:11 321:3,18
 322:8,21 325:17
 327:2 330:18 332:10
 333:18 334:12 335:12
 337:20 338:13,21
 345:13 347:17 348:1
 348:15 349:4 350:12
 351:18 353:14,17
 357:6 359:10 362:17
 363:8 365:15 366:18
 367:10,13 368:11
 369:18 370:4 371:10
 372:11,16 373:16,19
 374:5,11 375:20
 376:21 378:4 379:8
 379:20 381:18 382:5
 383:12,21 384:20
 385:15 386:20 387:9
 389:6 390:7 391:15

393:6,20 394:21
 399:12,22 417:4
 419:2 430:14
treated 406:10
treating 364:12 406:16
treatment 204:8 252:6
 275:3 287:16
treatments 179:11
treats 223:22
tremendous 93:21
 100:21 102:13
trends 18:18
trial 137:16 218:3 224:6
 225:10 226:9 228:3
 232:8,20 234:19
 235:13,15,18,21
 238:1,2,6
tricky 267:13
tried 21:9 297:1
tries 81:21
trillion 177:7
Trinity 92:5
triple 300:2 301:7 335:3
triple-A 206:16
triple-A's 207:2
trouble 89:11 115:8
 143:14
true 87:20 92:12 129:1
 187:17 192:2,2,3
 259:11 310:5 363:22
 364:3 384:5 396:7
 409:12
truly 315:18
trump 89:6
trust 48:5,12 237:19
truth 394:16
try 6:7,8,9 7:12 53:11
 58:14 66:22 81:8
 92:19 98:6 103:8
 104:12 124:10 126:8
 126:21 129:16 138:7
 175:19 176:1 204:15
 214:6 229:7 255:15
 279:19 280:19 289:12
 341:15 385:20 392:17
 408:3,3
trying 18:13 69:13 99:7
 100:5,17 103:2 105:1
 123:2 128:18 160:6
 163:2,5 164:8 166:14
 167:2 178:1 193:17
 212:18 219:3 245:12
 271:6 282:10 295:19
 315:19 316:19 328:16
 330:6,13 335:12
 339:3 348:8 364:10
 368:20 369:1,6 376:1
 393:1 418:4 419:11

tube 243:21
Turing 190:18
turn 28:21 37:17 38:6
 55:20 64:5 72:3 74:5
 180:19 209:15 210:13
 224:1 397:18
turning 57:15
turnip 282:11
tweak 418:7
Twenty-five 165:4
Twenty-four 400:9
Twenty-three 428:11
Twitter 7:1
two 7:16 8:22 9:2 26:12
 27:14 29:17,19 37:3
 39:17 44:17 67:7,8,16
 71:6 74:13 77:11 81:8
 89:3 95:1,20 104:20
 119:1 120:16 131:8
 140:16 149:5 167:16
 169:1 203:10 207:1
 216:7 225:8 234:19
 241:7,13 242:1,5,17
 246:12 248:14 253:18
 256:9 260:15 261:17
 262:21 263:3,9,14
 264:14,17 266:19
 267:2 268:5 270:2
 273:18 278:5,22
 280:4 303:8 319:16
 335:5 341:7 343:2
 344:20 349:8,11
 350:8,8 355:14 357:3
 359:15,16 373:5
 375:21 392:22 394:2
 394:2,6,17 395:10
 397:8 401:9,11,18
 402:15 409:2 412:21
 415:6 420:15 421:21
 423:12,13 429:19,22
two-and-a-half 27:10
two-step 304:10
tying 86:16 91:1
type 39:3 43:12 139:5
 185:19 215:9 241:11
 254:9 310:6,8,12
 330:7 334:19 336:18
 343:5 363:20 366:3
 417:18
types 39:17 54:20
 92:17 96:11 103:17
 126:22 194:15 196:6
 287:17 314:15
typically 43:11,17
 183:22 422:8

U

UCLA 13:12

ugly 417:1
ulcer 387:16
ulcers 387:19 399:18
 399:19
ultimate 114:17
ultimately 96:18 131:9
 161:2 247:17 378:15
 426:8
Umbdenstock 21:9
unable 59:12 120:10
unclear 252:20
uncomplicated 149:21
uncover 238:2
underestimated 104:20
undergo 217:12
undergoing 41:14
undergone 41:6 227:12
underlies 81:10 84:20
underlying 203:12
 234:3,16 236:4,8
 249:15 272:6
undermine 163:9
underscore 293:8
understand 18:2 31:3,6
 31:13 33:15 38:8 65:3
 83:4 87:10,17 103:12
 107:7 109:20 110:15
 118:1 123:19 124:10
 126:11 148:9,9 152:2
 152:21 154:3 155:3
 155:10 157:22 167:8
 169:19 188:17 192:9
 195:15,17,21 196:9
 214:16 218:2 220:13
 234:12 235:3 245:14
 245:16 246:5 278:20
 304:13,15 317:10
 318:2 320:17 324:19
 325:20 327:9 328:3
 328:17 332:3 347:13
 369:1,6 376:9 382:3
 384:2 404:1 416:19
 417:21 418:8 419:11
 419:12
understandably 136:1
understanding 109:16
 137:10 141:20 150:18
 151:10 163:7 178:2
 181:12 182:6 194:13
 194:16 196:2 203:16
 234:11 273:19 274:3
 274:6 323:16 335:6
 343:11 366:12 380:11
 388:5 393:10 408:11
 418:10 419:7 423:11
 427:13
understood 350:18
 352:9 375:6 386:4

undertake 232:9
undertaken 205:21
underway 205:18 206:4
 221:11,15
undifferentiated 387:18
unfair 105:4 191:9
 193:19
unfairness 407:4
unfolds 245:20
unfortunately 21:19
 52:22 100:10 143:2
 181:1 231:11 345:17
uniform 196:2
uninsured 147:5 198:6
unintended 146:14
 294:15 304:13 313:5
 378:18
unintentional 293:19
union 356:17 362:3
unique 119:1
unit 309:13
United 177:6 350:4
universal 192:19
universally 140:4
universe 280:17
University 18:8 19:17
UNKNOWN 286:16,20
unnecessary 179:11
 186:22 190:3 192:11
 192:20
unquote 220:3
unreasonable 371:13
unrecognized 398:1
unsure 251:18
untested 120:19
untrue 193:19
unusual 133:10
up-front 100:20
upcoming 418:18
update 46:14 72:17
 73:12 108:22 110:22
 111:11 112:9 114:13
 116:3 223:9,12
 227:15 228:1 229:1
 267:15 274:13 355:8
 401:19 402:22 415:14
updated 68:13 113:18
 307:1,4 308:6 319:5
 320:14 322:4 411:21
 415:14
updates 46:13 68:10,18
 412:6 422:19
updating 114:10
upper 108:12
ups 335:1
upsetting 189:5
Upshaw 1:9,11
upstream 96:19

urinary 308:12
usability 249:8
usage 151:14,15
use 23:17 34:7,7 43:12
 48:1 73:13,18 74:10
 87:14 93:7 97:2
 105:15 110:6 114:18
 144:22 150:12,17
 151:1,2,4,5,7,9,16
 152:21 153:18 154:9
 156:11,13 157:6,19
 158:13,15,16 159:6,8
 159:20 160:2,13
 161:21 163:16 164:18
 165:16 166:3,3,9
 168:8 169:2,3,22
 170:2,19,22 171:13
 177:21 178:7 184:19
 188:6 190:1 192:20
 202:16,17 205:11
 216:14 226:3 227:6
 247:2 286:2 287:19
 294:8,20 303:9,15,18
 303:19 304:5 309:5
 309:11 311:17 312:18
 312:21 313:12,17
 314:13 327:21 328:5
 339:1 352:16 362:1
 371:19 372:3 374:3
 377:8 385:6 389:12
 407:21,22 408:2
 416:19 425:21
useful 81:11 114:12
 137:9 181:11 271:2
 281:12 403:19
user 396:1
users 249:12
uses 204:20 247:12
 263:15,17 264:4,21
 265:5
usual 68:1
usually 9:9 103:18
 247:5 391:11
uterine 137:20 146:11
utilization 152:3 181:17
 189:8 309:8,15
 313:14,22 314:12
 358:4
utilizations 314:14
utilize 279:19
utilizing 126:2

V

VA 358:1,8
vaginal 135:11 141:17
 143:22 149:20
valid 249:21 311:19,20
 387:15

validate 266:12 315:20
385:21 386:1
validated 261:21 262:1
266:9
validation 396:16
validity 77:11 119:13
134:21 147:21 183:19
259:20 384:16 392:15
408:6
valuable 41:15 156:3
172:1,2,3 173:22
248:14 260:6 332:21
333:14 369:4
value 30:5 49:22 91:2
137:18,22 166:8
170:21 178:3 187:2
187:17 297:22 298:6
310:13 311:6 312:22
314:3,10 338:17
347:5 376:18 387:8,8
408:2
value-based 4:15,18,20
5:6 287:11 288:5,11
288:19 290:11 296:3
299:10 300:3 304:5
305:8,16,20 306:18
310:20 313:18 317:1
317:6,16 319:17,19
322:14 327:17 333:15
345:15 375:1 409:11
values 48:15 351:1
variable 234:5
variables 225:13
234:16 263:13 264:4
265:1,7 268:19
269:15
variants 315:17
variation 178:20 180:11
181:15,17 182:8
183:11,13 184:5
199:14 200:20 201:1
216:3 301:8 313:3,3
328:8 336:3,13
337:18 361:12,18
368:18 383:19
variety 19:4 27:13
358:21
various 188:6 288:14
334:20 390:17
vastly 285:2
VBAC 136:11 146:10
147:16,17 148:21
VBACs 146:9
VBP 186:21 204:20
285:11 286:3 290:14
290:17 292:2,10
294:22 304:21 307:4
311:14,17,21 316:2

318:3 320:13,16
321:14 324:20 326:1
326:5,9 332:3,22
334:16 353:7 355:12
365:19 366:2,3,17
380:9 382:4 383:18
384:14 409:19
VBPN 286:22
vector 302:9
vehicles 37:1
vein 396:22 398:6
vendor 76:3 125:10
126:12
vendors 76:2 119:21
125:1,5,6,12 126:1,9
134:22 249:18
ventilated 258:15
venues 56:5 138:9
verdict 267:8 269:3,19
340:6,16 341:2 355:5
verify 48:12
versa 421:5
version 7:6 68:14,17,20
124:13 227:4 230:21
230:21 247:14 248:16
253:3,21 263:9
267:16 272:10 285:2
285:4,7 286:6,8,13
308:1,2,3,5 320:16
322:18 357:13 380:8
380:16 394:2,19
396:4 397:7,7 409:16
411:19,21 412:2,4,5
412:12,16,20 413:7
415:6,9 416:9,21
417:2
versions 232:2 247:9
247:22 248:15,19
253:18 254:3,6
267:18 409:2,4
versus 45:3 139:15
193:4 195:9 208:4
258:17 309:8 313:14
355:11 359:5 360:16
375:7 396:19 403:16
413:8
vertex 144:2
vertically 57:8
vetted 386:15
vice 2:15,20 11:6,13
12:16 13:3 421:5
view 129:5 155:2
191:10 310:9 391:5
420:18
viewed 216:11
viewpoint 9:9 259:22
views 430:10
vigorous 163:10

Virginia 94:18
virtue 166:6 198:4
vision 84:10,13 247:18
visit 140:15
visits 275:3 280:20
282:8
vital 31:2 263:20 331:8
voice 15:17
volume 315:14 397:10
397:16
voluntarily 166:7
253:22
voluntary 75:16 165:19
165:21 166:3,4 171:6
171:8 248:16 253:21
vote 46:9 55:19 57:4,18
60:19,20 61:2 62:17
65:13 69:19 70:5,7,12
71:11,16 89:16 105:9
105:19,21 106:5,11
106:14 115:9 116:14
128:19 134:2 149:18
150:2,5 164:14
167:12 171:16,17
206:6 209:13,16,18
211:22 212:3,9,19
228:10 244:19 255:1
255:21 260:15,20,21
260:22 261:5 282:20
286:15 302:19 324:8
339:4,9,18 344:12
346:14 349:6 353:18
354:16 379:6 400:1
407:6 411:10 413:15
414:1,4,5,14 427:19
428:4
vote's 159:21
voted 70:18 112:12
269:21,22 270:1
voter 354:10
votes 65:20 67:1 70:16
211:20 275:18 341:7
341:9
voting 2:3 56:18,19,22
57:18 59:8 60:1,14,17
60:18,21,22 61:1
63:21 66:21 68:8 69:2
70:2,17 71:20 74:8
106:3,12 107:10,11
111:19 115:15,18
134:8 150:1 164:20
165:2 166:15,16
167:9 169:2 210:21
211:15,19 213:1,13
214:14 255:2,21
266:6 352:15 353:6,8
400:7 408:17 412:19
428:9

VPB 376:12,20
vulnerable 244:11

W

wage 197:19
wait 45:16 53:11 276:15
322:3,20 326:20
waiting 318:17,20
326:10 337:14 388:4
walk 386:11
walked 15:22
walls 276:4
Walters 1:9,11 6:3,12
6:15,18 7:17 10:19,19
26:3 27:21 35:7 44:16
48:3 74:15 78:7,10,17
79:12,16 86:4 87:22
88:5,12,22 90:10
91:12 92:21 94:6,22
97:14 103:1,5 104:18
105:11,20 106:1,20
107:20 108:3,10
109:1,13 112:16
114:5,15 115:4,9
116:4,18,22 117:3
118:2 120:1,14,20
122:17 123:9 124:1
128:15 129:13 131:17
132:7 134:1,13 135:2
135:5 136:16 138:10
138:14 140:6 142:3
146:21 148:5 149:18
150:6 151:19 154:5
154:18 155:13 159:14
161:7 162:9 164:13
165:7 166:11,19
167:11 168:21 171:15
172:10 173:1 240:10
240:18 242:10,13,16
244:22 245:18 246:9
248:4 249:1 250:3,11
251:8,15 252:1,8,22
254:20 255:9 256:1
260:13 261:9,16
262:18,20 263:4
264:5,8,14 266:5,18
267:10 268:13 269:4
269:9,20 270:11,15
271:15 272:8 273:8
274:20 275:10,13
278:4 280:6 281:15
282:17 284:5,11
285:13,16,18 286:15
286:19 287:2 316:19
341:14 342:7 344:3
344:14,20 400:12
402:3,6,14 403:5
404:7,18 405:1,5,16

406:21 408:10 409:9
 410:1 411:6,10
 419:21 423:4 424:3
 425:1,5 427:6,9 428:1
 428:4,15,20 429:5
want 18:1 23:4 26:9
 28:11,11 29:15 30:2,3
 30:8 32:11 33:16 36:3
 37:9,18 38:4 42:11
 45:16 46:15 51:22
 52:9,18 56:21 57:12
 62:5 64:14 67:21
 70:11 76:13 78:2
 89:17 98:1,21,22
 99:10,12 105:7 109:9
 114:12 115:5 118:9
 123:4 124:19 129:17
 129:22 130:2 131:2
 138:16 146:1 148:13
 151:6 157:22 158:11
 159:18 161:12,14,15
 167:8,20 170:19,20
 174:3 180:21 183:21
 185:22 186:11 205:6
 211:17 224:5 233:14
 238:11 241:17 247:17
 254:8 257:9 265:18
 266:2 274:8 276:12
 282:14 284:19 292:20
 294:9 300:19 302:10
 303:5 305:2 307:3
 311:4,17 312:14,21
 319:15 326:20 327:4
 328:21 329:16 331:22
 334:8 336:14,19
 338:4,6 344:1 349:9
 353:4 354:4 357:12
 360:1 364:3 370:14
 371:5 372:18 374:8
 376:2 391:16 395:1
 413:13 415:6 416:18
 416:22 417:1,2 421:7
 422:10 428:16
wanted 33:11 36:8 54:7
 55:21 56:10 77:2
 103:9 132:9 146:8,13
 150:20 160:21 176:21
 215:10 223:1 228:7
 232:5 235:10 236:17
 239:9 246:22 247:20
 269:6 284:13 297:16
 298:18 303:16 307:16
 316:15,16 320:7
 359:14 400:19 415:13
wanting 147:14 389:9
wants 241:17,21 268:6
 310:16 344:18 403:2
 411:14

war 276:19
warfarin 118:7 134:4
warrants 157:12
wash 231:15 237:7
 279:15
Washington 1:9 189:12
wasn't 22:2 24:10 33:6
 202:11
waste 179:8 190:3
watched 343:10
watching 403:22
way 21:15 28:9 56:4
 60:6 63:5 83:11,18
 91:5 93:13 94:19 98:2
 100:10 101:18 128:4
 131:15 152:2,21
 153:6,18 178:6 187:6
 192:3,15 195:16
 197:3 200:2 225:15
 230:13 232:17,18
 234:3 238:4 248:7
 257:22 258:2 259:13
 260:22 261:4 262:5
 270:3 281:7 282:12
 283:16 312:10 317:9
 322:13 327:9,20
 328:4,6 329:3 335:14
 338:22 343:11 352:4
 363:5 364:13 368:19
 378:10,15 388:22
 389:8 407:9 408:7
 412:20 416:7 422:4
ways 84:11 96:18
 137:21 169:20 177:20
 207:4 249:13 329:20
 385:12 396:7 416:15
we'll 8:19 9:5,18,19,20
 37:14 38:8 52:16,18
 56:18 57:18 58:13
 59:5,7,10 63:10,13,21
 64:5 65:7,8,13,16,20
 66:4 67:12 68:1 69:21
 74:5,20 79:4,19,22
 80:2 106:3 114:3
 117:21 128:19 132:16
 134:2 135:14 140:6
 176:1 185:7 186:6
 197:14 204:13 211:8
 211:10 212:20 215:2
 219:5 228:10 235:6
 241:9 246:15 286:21
 341:19,20 346:7
 354:13,15,16 374:9
 379:21 429:10,12
 430:2
we're 8:15 10:7 15:16
 17:8,21 26:12 28:12
 37:16 41:21 50:9 51:2

51:12 52:6 53:10
 60:19 63:7,9 69:13,19
 70:6 73:6,19 74:9,17
 77:8 78:22 80:3 88:5
 88:12 97:11 99:11
 100:18,19 101:20,21
 102:3 103:2 105:5
 108:8,13 115:16
 119:10 123:2 129:11
 131:7 134:15 145:1
 151:14 158:1,8,8,9
 159:6,9 162:13 164:4
 164:21 165:20,22
 166:15 167:1,9
 169:17 171:1,4,6,7
 173:5,16 174:8,9
 176:10,11 177:5
 178:1 185:1,1 186:13
 188:21 203:7 206:2
 206:22 209:12,13
 211:16 213:11 214:5
 232:7,8 235:11
 236:13,18 239:16,18
 240:20 242:18 245:19
 255:1,2,8,21 263:11
 272:14 274:1 277:22
 282:10 290:4 291:16
 298:20 299:14 307:22
 311:8 318:17,20
 319:4,9 326:6 329:13
 330:13 332:16,20
 337:13 341:14 345:13
 345:14 346:2,10
 347:4 348:8,9 353:7
 353:18 354:11,21,22
 374:1 375:22 376:3,6
 379:8 383:20 386:7,9
 388:11,12 389:8
 400:1 402:1 406:16
 408:17,18 409:7
 410:5 413:9,18
 414:22 417:9,10
 422:19 423:18 426:4
 426:5,13 427:11,13
we've 7:4 9:21 30:12
 31:1 32:18 36:9 38:13
 38:17 39:3,5 47:10
 64:16 65:6,11 75:14
 104:20 133:2,9 144:7
 146:10 156:8 158:4,6
 164:14 165:12,15
 172:2 175:4 177:7,18
 181:14 182:3 191:2,6
 191:16 201:21 203:5
 211:3 223:13 231:5
 238:17 239:6 248:15
 248:17 250:10 253:9
 253:18,19 254:5,11

256:13 266:11 267:13
 274:14 279:4 297:5
 304:6 305:4 316:9,10
 316:11 321:18 323:13
 327:15,15 336:1
 338:2 345:21 354:15
 375:13 378:14 389:16
 389:17 392:4 396:12
 403:1,13 410:22
 413:5 416:8 418:19
 424:21 429:7 430:2
weaker 382:16
web 72:7,14 132:2
 144:7
webinar 115:7
website 231:19 238:20
 401:3
WEDNESDAY 1:5
weeds 157:1
week 145:20 152:7,14
 152:15,16 412:21
weeks 412:21
Wei 2:2 12:7,9 138:15
 198:14 219:7 220:9
 289:4 309:2 365:16
 366:18 393:21
weigh 67:20 301:21
 318:7
weighing 376:6
weight 299:11 397:9,20
 398:10
weighted 394:3,7,17
weighting 397:8 398:11
 399:17 406:19 411:2
weights 397:10,11,12
 397:16,18 398:9
welcome 4:2 6:3,18 7:7
 11:17 26:22 29:13
 30:9 62:4 64:7 118:19
welcomed 10:6
well-tracked 122:9
wellness 97:22 98:6
 100:1 105:1
went 10:1 26:19 173:9
 201:15 224:16 235:20
 240:8 284:13,16
 308:11 342:16 345:11
 381:8 409:6 412:20
 415:12 430:10,19
White 162:20
who've 27:22 60:16
wholeheartedly 55:17
wholesale 99:7
whoopsie 407:15
wide 166:3 199:7
 225:11,12,12 426:2
widely 92:10
widespread 73:16

144:22
wild 99:16
willing 119:21
willingly 166:5,7
WILSON 2:20
win 167:14
wind 136:16 301:6
window 290:7
wise 294:12
wish 33:12 57:6 58:20
 62:8 255:13 345:1
 367:17,19
wishes 56:6
withdraw 251:5
withdrawn 344:21
withholding 290:15
woman 139:8
women 138:7
wonder 42:18 273:5
 315:10 357:4 388:14
 394:18
wondered 42:2 336:2
 347:9
wonderful 14:2 21:14
 29:9 391:10
wondering 150:7
 222:11,13 226:13
 310:8 334:17 405:19
word 24:8 190:9 270:3
words 190:8 336:4,11
 420:8
work 6:5 7:15 8:10,21
 9:15 15:19 17:14,17
 19:20,20 22:13 23:7
 26:2,10 27:6 30:11,12
 30:15 34:18 38:8 46:7
 46:16,16,22,22 48:18
 50:13 70:10 77:17
 86:16 92:19 97:9
 102:10,14 114:1
 124:9 126:21 133:5
 136:15 152:4 153:4
 153:17,20 154:9
 169:18 174:15 179:17
 205:17 208:10 215:13
 225:6 243:22 253:7
 274:7 297:6 305:14
 330:1 359:11 370:16
 382:8 387:18 388:4
 391:14 392:15 394:12
 420:1 424:17 425:11
 430:8,9
worked 20:2 26:17,17
 109:22 195:22 196:1
 390:18
worker 102:15
workers 277:15,16
Workforce 16:7

workgroup 1:3,8 2:12
 23:2 27:3,9,18 29:11
 30:10 35:13 38:21
 39:15 42:9 58:8 59:6
 61:18 62:10 65:4,8
 67:10,22 399:14
workgroups 34:15 39:9
 42:9 58:3
working 26:11 33:17
 51:9 100:8 127:16
 128:13 152:1 159:9
 194:17 205:18 206:22
 240:1,4 271:9 357:9
 393:4
works 87:10 101:18
 106:2 114:14 144:9
 196:4 206:21 214:16
 262:12 347:7
world 33:22,22 34:1,1
 360:16 391:19 392:19
worried 301:19 302:1
 423:21
worries 194:10
worry 176:4 185:17
 186:5,12 367:4 420:7
worse 154:1 243:8
 244:14 393:12
worst 255:14 416:3
worth 77:4 94:21 268:8
 393:13
worthwhile 114:10
wouldn't 95:9 130:15
 160:16 255:13 407:12
 407:22 408:3
wrapping 161:5
write 7:1
written 68:2 381:2
wrong 89:9,9 93:21,22
 94:11,11 104:2
 116:20 124:10 147:8
 150:19 191:15 221:4
 230:18 252:13 318:10
 364:5,6 420:8
wrongs 392:13
WUNMI 2:17

X

Y

year 7:10 8:2 11:15
 12:4,12 14:15 15:10
 18:6 21:13 26:7 27:4
 27:6 29:21 31:8,12
 35:11 36:13 37:20
 46:19 47:1 58:3 60:15
 60:18,20 62:19 65:20
 66:4,11,20 68:3 73:5
 82:14 89:13 112:12

114:4 131:8 144:4
 160:1 188:21 189:9
 203:10,10 205:5,7,15
 207:17,17 223:7
 224:13,21 225:5
 234:19 259:5 290:19
 290:20 293:12 306:2
 318:5 320:19 321:9
 321:17 322:13 323:17
 324:11,11,18,20,22
 325:3 326:16 327:14
 333:3 337:22 347:15
 363:21 364:17 367:15
 368:10,13,17 370:1
 395:11 409:11 412:1
 420:8,9,15 421:4,5
year's 223:7 224:16
 308:10 423:7
year-long 29:7
years 7:5 8:6 18:18
 19:19 20:3 27:10
 30:22 35:11 37:3,8
 47:9 53:10 65:1 75:16
 110:16 124:8 125:20
 141:9,11 154:15
 189:7 192:2,8,16,17
 232:16 235:14,22
 238:14 247:6 292:6
 293:4 305:13 323:7
 328:20 333:8 334:7,7
 334:7 363:14 381:2
 385:18 386:19 390:11
 392:22 393:8 424:5
yesterday 68:14 188:20
 300:21 360:8
yesterday's 300:7
Ying 2:2 12:7,9,9
 138:15,16,20 198:15
 219:8 309:3 365:18
 366:8 393:22
York 20:10 22:22 90:13
 300:8
young 2:11 23:6,6 29:2
 31:14 34:11 52:3
 112:6,11 129:22
 130:17,22 136:3
 142:4,7 148:16 149:9
 162:11 184:16 223:5
 246:16 248:13 251:9
 253:8 257:4 280:12
 303:4 305:18 306:6
 312:2 316:6 326:13
 328:22 337:3 348:3
 351:7 352:1,18,21
 353:11 357:8 374:9
 418:12 419:15 421:6
 422:12

Z

Zehra 2:19 27:8 37:18
 42:18 54:5 56:20 60:3
 400:16
Zehra's 109:4
zero 50:4 391:8
zip 230:14

0

0 106:18
02 139:16 143:10

1

1 4:9,19 79:2,17 150:10
 346:16
1.5 377:21
1.75 290:19
1:00 70:14 173:18 174:7
1:17 240:8
1:30 240:4
1:35 240:9
1:45 239:21
10 99:5
100 262:13 372:2 386:7
 410:10
1030 1:8
10th 118:16
11:00 240:21
11:54 173:9
1140 284:7
115-836 213:4
12 20:3 341:10
12,000 338:18
12/15 68:14,17
12:05 173:10
12th 68:4
14 132:20 156:21 368:2
15 89:12 93:18 102:1
 228:13 240:2 340:4
 340:13,19 353:22
 354:19 393:8
15-1033 269:15
15-1135 268:19
15-294 267:1
15-295 341:6
15-369 340:10
15-378 339:22
15-391 283:1
15-395 379:13
15-837 213:15
15-838 214:4
15th 1:8
16 1:6 213:16 379:18
 393:8 424:5
17 131:6 268:22 321:11
173 4:11
18 82:9 238:18 273:17
 273:18 398:11

19 238:18,21 341:10
1980s 95:22
1999 293:11 424:6
1A 69:21

2

2 4:11,21 79:5,12 108:4
 108:14 173:6 174:8
 174:16 290:21 341:16
 342:3
2.6 378:2
20 4:3 78:22 93:19
 192:2,17 213:7 214:7
2005 235:13
2008 26:8
2010 92:14
2012 110:6 112:5
2013 293:11
2014 82:14 177:7
 235:17 401:3
2015 1:6 73:9 235:14,15
 329:14 333:12
2016 75:19 290:19
2017 290:20
2018 320:5 321:5
 327:14
2018's 317:18
2019 327:14 342:14
2020 80:22 327:18
2021 325:7 327:18
 329:13
21 85:17
22 143:19 149:19
23 71:5 283:4
23rd 68:3
24 214:8 267:5
240 4:13
25 71:17 78:22 107:21
 141:11 193:3 207:6
 299:11 401:5
25th 183:12 378:1
26 70:19
27 340:13,21
28 150:3,3 213:8
287 4:16
29 237:11 269:1
291 4:17
296 4:19
2B 69:21

3

3 4:13 5:7 116:8 118:6
 150:10 158:16 175:13
 240:21 272:9 345:15
 377:22
3.1 68:20 108:12
3.2 377:20
3.3 399:20

3.6 378:2 399:19
3:30 345:11
3:40 345:12
30 102:1 175:14 192:17
 193:3 239:21 299:15
 299:16 349:14,16
 356:15,17 358:15
 359:4,9 360:17 361:3
 361:20,22 367:22
 368:2,3 369:7,7
 370:19 373:3 377:13
 416:6 417:20 424:6
30-day 214:20 228:12
 257:17 266:21 268:16
 269:12 296:17 319:2
 339:20 340:9,19
 356:6 362:12 366:9
 370:15 377:5 379:11
30s 359:22
31 340:3 356:9,22
 358:19 361:8 362:6
 365:8 370:16
32 212:12 228:17 267:7
322 340:20
33 167:12
341 4:21
345 5:7
35 69:4 283:5 368:2
36 213:16 269:17
37-page 207:6
37,000 338:19
378 228:14
38 4:4
3C 69:21

4

4 134:11 135:11
4:00 346:1 362:15
40 63:19 69:4 106:17
 193:3
400 5:10
402 5:14,18
42 283:4
428 5:20
429 5:22
44 150:4 267:6 293:12
46 134:10
48 115:20 213:17

5

5 66:7 213:22
5:04 430:19
50 134:9 328:20
52 115:20 213:9
534 354:20
535 354:1
54 269:1 340:4
55 66:7

56 214:8 269:17
58 340:14 354:5 355:2

6

6 4:2 286:13
6.0 285:4,7 286:6
60 66:1 106:17,21 116:5
 116:7,16 117:4
 212:13 228:18
600 302:6
65 147:19 149:4,5
 340:22
68 400:8
69 341:11

7

7.9 377:21
70 312:13
73 4:6 428:10
74 4:7
75th 183:12 378:1
768 398:20
78 4:9

8

8 228:19 269:16 340:22
8:30 429:10

9

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