NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATIONS PARTNERSHIP

POST-ACUTE CARE/LONG-TERM CARE (PAC/LTC)

WORKGROUP MEETING

+ + + + +

MONDAY

DECEMBER 10, 2018

+ + + + +

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., Gerri Lamb and Paul Mulhausen, Co-Chairs, presiding.

COMMITTEE MEMBERS (VOTING) PRESENT:
GERRI LAMB, PhD, Arizona State University, Co-Chair
PAUL MULHAUSEN, MD, MHS, Telligen, Co-Chair
ANDREW BAIRD, JD, Encompass Health
LORI BISHOP, MHA, BSN, RN, CHPN, National Hospice and Palliative Care Organization *
CHRISTINE HAWKINS, CRED, Centene Corporation
KURT HOPPE, MD, American Academy of Physical Medicine and Rehabilitation *
GAIL HUNT, National Alliance for Caregiving
JAMES LETT, II, MD, CMD, National Transitions of Care Coalition
DHEERAJ MAHAJAN, MD, CIC, CMD, AMDA, The Society for Post-Acute and Long-Term Care Medicine
DANIELLE PIEROTTI, RN, PhD, CENP, AOCN, CHPN, Visiting Nurse Associations of America
JOHN RICHARDSON, National Partnership for Hospice Innovation
PAM ROBERTS, PhD, OTR/L, SCRES, CPHQ, FAOTA, American Occupational Therapy Association
DEBRA SALIBA, MD, MPH, American Geriatrics Society
HEATHER SMITH, PT, MPH, American Physical Therapy Association

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

PRESENT:

CONSTANCE DAHLIN, MSN, ANP-BC, ACHPN, FPCN, FAAN

CAROLINE FIFE, MD, CWS, FUHM

RIKKI MANGRUM, MLS *

EUGENE NUCCIO, PhD

ASHISH TRIVEDI, PharmD

FEDERAL GOVERNMENT LIAISONS (NON-VOTING) PRESENT:
ANDREW GELLER, MD, Centers for Disease Control and Prevention
ALAN LEVITT, MD, Centers for Medicare and Medicaid Services
STELLA MANDL, RN, BSN, BSW, PHN, Centers for Medicare and Medicaid Services
CINDY MASSUDA, Centers for Medicare and Medicaid Services
TARA McMULLEN, PhD, MPH, Centers for Medicare and Medicaid Services
ELIZABETH PALENA HALL, MIS, MBA, RN, Office of the National Coordinator for Health Information Technology
VIRGINIA RANEY, Center for Medicaid and CHIP Services
MICHELLE SCHREIBER, MD, Centers for Medicare and Medicaid Services

NQF STAFF:
ELISA MUNTHALI, Senior Vice President, Quality Measurement

ERIN O'ROURKE, Senior Director

SAM STOLPE, Senior Director

ALSO PRESENT:

HEIDI BOSSLEY, Federation of American Hospitals

ILA BROYLES, RTI International *

RIKKI MANGRUM, American Institutes for Research

*** present by teleconference**

CONTENTS

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives 5

CMS Opening Remarks. 14

Overview of Pre-Rulemaking Approach. 27

Overview of IMPACT Act Programs. 45

Public Comment 94

Pre-Rulemaking Input on Measures Under Consideration for IMPACT Act: Transfer of Health Information to Provider-Post-Acute Care
MUC2018-131. 97
MUC2018-132. 155
MUC2018-133. 167
MUC2018-136. 169

Public Comment 178

Pre-Rulemaking Input on Measures Under Consideration for IMPACT Act: Transfer of Health Information to Patient-Post-Acute Care
MUC2018-135. 214
MUC2018-139. 215
MUC2018-141. 216
MUC2018-138. 216

Hospice Quality Reporting Program. 217

Public Comment 286

Summary of Day and Next Steps. 288

Adjourn. 289

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

9:14 a.m.

MS. O'ROURKE: Okay, so I think we are going to go ahead and get started. Thank you, everyone, for coming in today. Hopefully the storm yesterday in the South did not impact your travel, but thanks for bearing with us.

With that, I'd like to introduce the co-chairs of the PAC/LTC Work Group, Gerri Lamb and Paul Mulhausen, and thank them for their leadership in advance, and let them say a few words to call us to order.

CO-CHAIR LAMB: Good morning, everyone, it's so good to see you all. Like Erin was saying, thanks for making it in. I don't know how many of you had to skirt the storms in the Southeast, but we're here, and hopefully we have a quorum. And we've got some important measures to review.

And one thing Paul and I would encourage you is that to listen carefully when we do the overview of the voting procedures, because

we've got some new categories, and we have some new processes. And hopefully, between Paul and myself and the NQF staff, we will have a really, really productive day with lots of good discussion. So welcome.

CO-CHAIR MULHAUSEN: Gerri's the master, I'm her student. So, welcome. The only thing I'd like to add is thank you for all the time you've put into this. I know you all lead very busy lives, so it is a measure of your commitment to the patients that are served by the work we perform and the providers who serve the patients.

So thank you very much for that. Thanks to the NQF staff who've helped us put this together. They've spent many hours actually, putting this together, and many additional hours trying to help Gerri and myself be comfortable with the agenda and the material we're going to cover here.

The only thing I'd like to add about voting is we need you to vote. It's very

important that you be at the table, or if you're on the phone, using the voting application that's available to us to vote on the measures under consideration. So anyway, thanks for coming, make sure you stay at the table and play.

MS. O'ROURKE: Thank you both. A few housekeeping remarks. Our restrooms are out in the hallway around the corner. As Paul said, we'd ask you to stay at the table and try to take breaks as we've got them scheduled. If you wish to speak, just put your tent card up so the co-chairs can call on you.

And please let us know if anyone is having trouble with any of the technical issues, Wi-Fi password, the voting software, or if there's anything we can assist with.

With that, I'd like to introduce our Senior Vice President, Elisa Munthali, to run us through the introductions and disclosure of interest process.

MS. MUNTHALI: Great, thank you, Erin, Gerri, and Paul. And thank you all for being

here. We're so excited that you're here, and we thank you for all the hours that you've put into this work and will continue to put into this work.

So what we're going to do today is combine disclosures of interest with our introductions, and we're going to do it in two parts because there are two types of work group members. There are organizational representatives and there are subject matter experts.

And so for the subject -- for the organizational representatives, which is the majority of the work group, we did ask you one question. We expect you to come here with the perspective of your organization, and we wanted you to disclose if you had an interest of $10,000 or more that is relevant to the work in front of you.

So what we will do is go around the room. I understand we have one work group member who's on the phone. I will tell you who the

subject matter experts are. So with the exception of Connie, Caroline, Gene, and Ash, everyone else will go around this first time.

Tell us who you are, who you're with, and if you have anything to disclose. So we'll start with Raj. Raj, sorry, your microphone.

MEMBER MAHAJAN: I'm Raj Mahajan. I represent AMDA, The Society for Post-Acute and Long-Term Care. No disclosures.

MEMBER SALIBA: I'm Deb Saliba, I'm Board Chair for the American Geriatric Society. And I have no disclosures.

MEMBER SMITH: Hi, I'm Heather Smith. I'm representing the American Physical Therapy Association, and I have nothing to disclose.

MEMBER ROBERTS: Pam Roberts representing the American Occupational Therapy Association. I have nothing to disclose, although I did participate in the IMPACT Act data collection.

MEMBER HALE: I'm Jen Hale with Compassus Hospice and Palliative Care, and I have

nothing to disclose.

MEMBER BAIRD: I'm Andrew Baird. I'm with Encompass Health, and nothing to disclose.

MS. PALENA HALL: Good morning, I'm Liz Palena Hall with the Office of the National Coordinator for Health IT, ONC, and I have nothing to disclose.

MEMBER HAWKINS: Christine Hawkins, the Centene Corporation. I have nothing to disclose.

MEMBER LETT: Good morning, I'm Jim Lett. I represent the National Transitions of Care Coalition. And I'm not sure if I need to disclose it but I will, I work as a medical director for a private company that has a contract with CMS to oversee some work of quality improvement organizations.

MEMBER RICHARDSON: Good morning, everybody, I'm John Richardson from the National Partnership for Hospice Innovation, and I have nothing to disclose.

MEMBER PIEROTTI: I'm Danielle

Pierotti, I'm here from Elevating Home and Visiting Nurse Associations of America. We represent home care and hospice.

MS. MUNTHALI: So thank you to all the organizational representatives in the room. And so I understand that Arthur Stone from the National Pressure Ulcer Advisory Panel is on the phone. Arthur, can you hear us?

(No response.)

MS. MUNTHALI: Okay, perhaps you are on mute? Okay, we'll come back to Arthur. So thank you, everyone who's an organizational rep, for your disclosures. So now we're going to go to the subject matter experts. So your form, as you know, was a lot lengthier. We wanted to know about the activities, whether paid or unpaid, that were relevant to the work in front of you.

You sit on this committee not representing your organization or anyone who may have nominated you for this committee. We also wanted you to know that just because you disclose does not mean you have a conflict of interest.

We do this in the spirit of openness and transparency.

And so we will start with I think Gene is the first subject matter expert in the room.

MEMBER NUCCIO: Good morning, Gene Nuccio, University of Colorado, Anschutz Medical Campus. I am a subject matter expert in home healthcare. I've worked on quite a number of the home health measures in the past, albeit not the measures that we're reviewing today.

I also sit as a member of the NQF Scientific Methods Panel. And I have no financial disclosures.

MS. MUNTHALI: I think Caroline may be the next.

MEMBER FIFE: Hi, I'm Caroline Fife, and I myself question what I'm an expert in. But I am the Chief Medical Officer of a health information technology company and the Director of a qualified clinical data registry which develops quality measures, primarily for wound care for physicians to report under MIPS.

And we do not have any overlap with the measures under consideration. And the registry is a 501(c)(3) nonprofit, and sadly, I am not paid for any of that work. Although, if you can find a way to do that, I would be grateful.

MS. MUNTHALI: Thank you. Ash, before you start, I think I skipped Connie. And Connie, you're the next.

MEMBER DAHLIN: Hi, I'm Connie Dahlin. I am a specialist for palliative care and hospice, and I have nothing to disclose.

MS. MUNTHALI: Thank you. And Ash.

MEMBER TRIVEDI: Ash Trivedi, no financial disclosures. I do work for Novartis.

MS. MUNTHALI: Thank you. And your committee co-chairs are subject matter experts. I'll ask Paul to start with his disclosures, and then Gerri.

CO-CHAIR MULHAUSEN: Yes, so I'm Chief Medical Officer for a company called Telligen, which does quality improvement work for CMS and

provides operational support for a number of the innovation center demonstrations. But I don't perceive a conflict of interest with the measures being discussed today.

CO-CHAIR LAMB: I'm a subject matter expert in care coordination, and I have no new conflicts of interest.

MS. MUNTHALI: Thank you very much. In addition to the organizational representatives and subject matter experts, we also have federal government liaisons that are non-voting that are on the Committee. I think we have CMS, ONC, and SAMHSA there. So if representatives from those organizations can just introduce yourselves.

MS. McMULLEN: Hi, I'm Tara McMullen, I'm a Technical Advisor in the Division of Chronic and Post-Acute care with CMS.

MS. MANDL: I am Stace Mandl or Stella Mandl. I'm the Division Director for the Division of Chronic and Post-Acute Care.

DR. SCHREIBER: Good morning, I'm Michelle Schreiber. I am one month new into my

role as the Director of QMVIG, a quality measures and value-based incentives group. And you'll hear a bit from me more later. I have no disclosures.

MS. MUNTHALI: Thank you and welcome. Oops, sorry. Sorry.

MS. RAINEY: This is Virginia Rainey from the Center for Medicaid and CHIP Services in the Division of Quality and Health Outcomes. I'm a Technical Director for Performance Measurement.

MS. MUNTHALI: Thank you. Alan.

DR. LEVITT: Hi, I'm Alan Levitt, I'm the Medical Officer in the --

PARTICIPANT: This is --

MS. MUNTHALI: Oh, sorry, on the phone. We do have one introduction in the room, and then we'll go back to you on the phone.

DR. LEVITT: Hi, I'm Alan Levitt, I'm the Medical Officer in the Division of Chronic and Post-Acute Care. It's my sixth year here on the Committee, and thank you for having me back. No disclosures.

MS. MUNTHALI: Thank you. And on the phone?

DR. GELLER: Andrew Geller, CDC.

MS. MUNTHALI: Okay, thank you. Any other federal liaisons?

MS. PALENA HALL: This is Liz Palena Hall from the Office of the National Coordinator.

MS. MUNTHALI: Thank you and welcome. So it doesn't look like we have additional introductions. Now that you've heard all of the disclosures of interest -- okay, we do have another Committee member. This is real time. Rikki, your subject --

MS. MANGRUM: Before you move on --

MS. MUNTHALI: Yes, we do have a Committee member, Rikki. Are you on the phone?

MS. MANGRUM: Hi.

MS. MUNTHALI: Hi, could you introduce yourself?

MS. MANGRUM: I am on the phone. I am experiencing a very strange delay and lag.

MS. MUNTHALI: Okay, we can hear you

now. If you can hear us, if you can introduce yourself. Let us know who you're with and if you have any disclosures.

MS. MANGRUM: Sure, this is Rikki Mangrum, I am a Senior Researcher at American Care Institutes for Research. I have been in receipt of research funding in the last two years from the Agency for Healthcare Research and Quality to study quality measures. None of those are on the list today, so I don't consider them disclosures.

MS. MUNTHALI: Thank you very much. Anyone else on the phone who's joined us?

MS. DeBARDELEBEN: Hey, this is Maryellen DeBardeleben with Encompass Health.

MS. MUNTHALI: Thank you, Maryellen. So now that you've heard all of the disclosures from your colleagues, we want you to know that if at any time you remember that you have conflict, please speak up. You can do so in real time, or you can come and approach any one of us in the front, your co-chairs or the NQF staff.

Likewise, if you believe that one of your colleagues is acting in a biased manner, we want you to speak up and let us know. And so with that, I thank you, and have a great meeting.

MS. O'ROURKE: Great, thank you, Elisa. With that, I'd like to introduce Michelle Shreiber from CMS to provide a few framing comments and welcoming remarks from the CMS perspective.

DR. SCHREIBER: So thank you and good morning, everybody. You heard who I am. As I said, I'm new into this role. But on behalf of CMS, I'd really like to welcome you to the MAP and sincerely thank you for your participation in it.

Your input's really extremely valuable. We're looking forward to everything that you have to say today to help all of us make care better for patients and quality reporting better for everybody. Thank you to NQF for your leadership in convening this work as well.

As you know, probably better than I,

the Measure Applications Partnership is really an important annual process whereby NQF convenes multiple stakeholders to provide input on measures for use in federal programs, which will become part of rulemaking which kicks off almost now.

So this helps provide guidance on future direction and identifies gaps in measures as well. And finally, as we all know, there's an opportunity for public comment, and we look forward to hearing from the public as well.

For post-acute care measures, it's slightly different than some of the other MAP meetings that we'll be having later this week, because as you recognize the IMPACT Act, Improving Medicare Post-Acute Care Transitions, mandates certain categories of measures and reporting of measures in five domains: functional status, cognitive functions, skin integrity, medical reconciliation falls in the transfer of health information. It also requires reporting of resource utilization.

As I said before, I'm the new Director of QMVIG, Quality Measures Value-Based Improvement Group.

We're the group responsible for developing and stewarding measures, and those programs that I know you know and love, such as the value-based hospital programs, MIPS, Meaningful Use, also known as promoting inter-operability. Yes, I do know the correct word for it. And inpatient psych programs, as well as many others.

By way of background introduction, since I'm new to most of you, I am a primary care general internal medicine physician. I've been in the healthcare space for many years, most recently as the Chief Quality Officer of the Henry Ford Health System. And I also led their ethic implementation.

So I have a lot of experience with electronic medical records, and actually very much am interested in that intersection between quality and electronic medical records.

I have served on multiple state and national committees, including several here at NQF, which it's been a pleasure to be part of. But again, I haven't been part of the MAP process before, so I'll be doing a lot of listening to all of you today.

I think Alan in the past has actually presented to all of you presentations on our important initiative of meaningful measures. So let me just touch on a few things to frame this, and for you to keep in mind as you think about the measures that are before you today.

Meaningful measures was launched really just last year, and its main goal was to improve outcomes for patients and caregivers by empowering them with information that's meaningful to help them make decisions.

But additionally, meaningful measures is also about reducing the reporting burden to clinicians and healthcare organizations and to promote patients over paperwork. We do take that very seriously and have heard from many

stakeholders about the burdens of some of these measurement programs.

With this in mind, we actually narrowed down the initial 184 measures that were submitted to the MUC down to a parsimonious 32 measures that we'll be considering over the next several days.

We recognize that quality measurement and reporting is not a perfect science and that everything has an opportunity for refinement. And that's part of why we're here today. It's also why I chose to move from being involved in healthcare to the policy side.

This is a very exciting, fascinating, and frankly humbling opportunity to be in on the development on the policy side of all these measures that I've been on the receiving side of for so many years.

What I've really come to realize in a short order is that there's an amazing group of people at CMS, and frankly across the country. But at CMS, and we have many of our colleagues

here today, people are really sincerely committed to the ongoing improvement of these measures and the value-based programs. Again, to improve care for all. We're delighted to listen to your feedback and work with every one of you.

As part of the effort to reduce burden, last year, through the Meaningful Measures Program, we removed 79 measures and saved well over $100 million, while continuing to align measures across multiple programs.

The Meaningful Measures Program is committed to infusing the principles of innovation, value, and flexibility and following the principles of the CMS quality goals, making care safer -- I don't have a clicker, so we can follow the slides as much as we can. But, yeah, you're, I think we're doing okay keeping up, I just didn't want to confuse the group here, okay.

So the CMS quality goals, we're fine, making care safer, strengthening person and family care engagement, promoting effective communication in care coordination, promoting

effective prevention in the treatment of chronic disease, working with communities to provide best practices of healthy living, and of course, making care affordable.

But Meaningful Measures, as Alan has reminded me many times, is not just about measure removal and burden reduction. It also calls for identifying and filling in gaps where there's a lack of important measures. And for focusing more on outcomes measures, as well as patient-reported measures, and including the patient in all that we do.

We're also continuing to align our measures across all programs and payers, and I'm actually very excited about the re-institution of our partnership with National Quality Forum, AHIP, America's Health Insurance Plans, and CMS, called the Core Quality Measures Collaborative, which is a set of committees to align CMS measures with all the other health plans in the United States, or as many as we can, to create, hopefully, a seamless set of measures that all of

us can use and participate with.

So please think about these areas as you make your recommendations today. One, are we addressing a high impact area? Two, are the measures meaningful to patients and caregivers and include the patient voice? Three, is this an outcome or a process measure? I'm not saying one's necessarily better than the other, but a lot of people do think outcome measures show us something differently.

Four, what's the burden of the measure, or the burden or unintended consequence of including the measure in a value-based program? Five, is there a significant opportunity for improvement in the metric area, or is it really topped out and we shouldn't do it?

And six, does the measure fit with the population-based payment or an alternative payment model, and does it align with other programs and payers?

Finally, I encourage you to think

about equity as well as advancing interoperability and how this fits in with health information technology, and electronic measures ultimately.

Thank you to all of you for your time and dedication and all of the work that you do. On behalf of CMS, we look forward to working with each and every one of you. And thank you, I turn it back to the Committee Chairs.

MS. O'ROURKE: Thank you so much, that was, we always enjoy having CMS help us frame this conversation. So our main goal today is to review the measures under consideration for the post-acute care and long-term care programs.

As Paul and Gerri were mentioning, we have made a few changes to the process this year of how you'll actually be doing that work and making your decisions. This was in response to feedback we received from MAP members as well as other stakeholders.

So we hope that you'll find this new approach a little bit smoother, but we also want

to make sure that everyone understands it before we get into actually making decisions.

So with that, I'd like to turn it over to Shaconna Gorham, our Senior Project Manager to walk you through everything. And would encourage everyone to make sure if you have questions to please raise them so we can make sure we're all on the same page before we get into this.

MS. GORHAM: Good morning. So as Erin mentioned, MAP uses a three-step approach. First, the staff will provide an overview of the program and how is it structured. Next, we will review the current measures briefly. Finally, we will ask the work group members to evaluate the MUC for what they might add to the program measure set.

We asked the work group to make a recommendation about each measure under consideration. The decision categories have been standardized for consistency. Each decision will be accompanied by a statement explaining the work group's rationale.

Due to feedback from the work group last year, staff will ensure that the rationale statement also includes any relevant dissenting opinions, and also highlight for the Coordinating Committee when votes are close or there is strong minority opinion about a MUC.

As part of our meeting materials, you will see the staff have conducted a preliminary analysis of each measure under consideration. The preliminary analysis will help to facilitate the voting process. We've developed these based on the algorithm developed from the measure selection criteria. So that analysis is meant to offer you a succinct profile of each measure and serve as a starting point for deliberation.

The measure selection criteria, or MSC, are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules, rather they are meant to provide general guidance on the measure selection decisions and

to complement program specifics statutory and regulatory requirements.

While I won't read all seven listed on the slide, the central focus should be on the selection of high quality measures that fill critical measurement gaps.

The decision categories have been updated in this year, 2018/2019, in response to MAP member feedback. There are four decision categories: support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, and do not support for rulemaking.

Support for rulemaking, MAP supports implementation with the measure as specified has not identified any conditions that should be met prior to implementation. Conditional support, MAP supports implementation of the measure as specified, but has identified certain conditions or modifications that would ideally be addressed prior to implementation.

Do not support for rulemaking with

potential for mitigation is new this year. MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future.

Do not support for rulemaking with potential mitigation should go back one slide. With potential for mitigation replaces the refine and resubmit. And this was done to address the concerns that there was not meaningful difference between the refine and resubmit decision and the conditional support decision.

Do not support with potential for mitigation was created to preserve MAP's ability to show support for a measure concept but clarify that MAP does not think it is ready for implementation as is currently specified.

And then of course, there is Do not support for rulemaking. I think this may be a good time to stop and take any questions. Any questions?

All right, so we'll review the voting instructions. Quorum, we need 66 percent of the voting members present to be able to vote. Whether members are in person or on the phone, quorum must be established prior to a vote. If we do not have quorum, we'll proceed with discussion, but we'll vote via survey after the meeting.

We will take role at the start of, start to establish quorum, and we'll monitor it to ensure we have the minimum number of votes. We would ask work group members to please stay at your table or by the computer, and the phone, if you're on the phone, as much as possible. We have built-in breaks throughout the day.

Consensus is defined as greater than or equal to 60 percent of the work group voting for a recommendation.

As said a little earlier, every MUC will receive a decision. Staff and co-chairs will give context to each programmatic discussion, then voting will begin. The

discussion guide you received as part of your meeting materials divides the MUCs according to program.

It also contains the results of the preliminary analysis and provides rationale to support how each conclusion is reached.

We've updated the voting process for this year. First, staff review the results of the preliminary analysis. Next, the lead discussants will share their reflections. Then the co-chairs will ask for clarifying questions and discussion items from the work group. Co-chairs will compile all questions and potential discussion items, and then ask the appropriate parties to respond.

At the discretion of the co-chairs, measure developers can respond to clarify questions on the specifications. The first vote will be whether or not the work group agrees will accepting the results of the preliminary analysis as the work group recommendation. The vote will be framed as a yes or no vote to accept the

result.

So I'll emphasize this point: If a work group member wants to discuss a measure, they should vote no here, even if they agree with the PA assessment. That's an important thing to remember.

If greater than or equal to 60 percent vote yes, that concludes discussion and voting on the measure. The PA assessment will be the work group's recommendation. If we do not get to 60 percent voting, we open discussion of the MUC, on the MUC.

When discussion winds down, staff will summarize the work group's discussion. We will then proceed to a vote. The co-chairs will determine what decision category will be put to a vote first based on the potential consensus emerging from the discussion.

If the co-chairs do not feel there is a consensus position to use to begin voting, the work group will take a vote on each potential decision category one at a time, starting with

voting for support. If greater than or equal to 60 percent of the work group members vote yes for support, that will be the recommendation. If not, we will move on to the next decision category, so conditional support and so forth.

If no category gives greater than 60 percent, the results of the PA assessment will be passed on to the Coordinating Committee, and the measure will be flagged for their consideration.

Commenting guidelines. We have incorporated many public commenting opportunities. Earlier public comments have been incorporated into your discussion guide. We will also take additional comments before voting on the MUCs for each program. We ask that commenters limit their comments to the relevant program and limit comments to two minutes.

There will be a global public comment period at the end of the day. Finally, the public comment period from 12/21 to 1/10, I realize there's a typo on the slide. So the final public comment period ends on January 10,

to allow opportunity for the public to comment on work group recommendations.

So, congratulations, since most of the pre-rulemaking timeline is complete. After the three setting-specific in-person meetings, so today, tomorrow, and then Wednesday, there will be a public commenting period open from, as I said earlier, December 21, and close on January 10.

On January 22-23, the MAP Coordinating Committee will finalize MAP's input, and then staff will capture all of this information in a series of reports released in February and March.

So I will stop there and see if there's any questions.

CO-CHAIR MULHAUSEN: Shaconna, this is Paul, I have a question. So, do we know at this point if we have a quorum, and do we know our margin of participation for who can leave before we lose our quorum?

MS. GORHAM: We figured that out, but give me a minute, I'll get back to you while we

do that. We want, while I get an answer for you, Paul, we're going to do a test of voting, just to make sure that everyone can vote.

CO-CHAIR LAMB: Before we do that, I think Jim has a question.

MEMBER LETT: Yes, thank you, Gerri, I was just going to ask informationally, if a measure gets conditional support today, does that mean we can expect to see it return to this committee for further discussion and approval at a later date? Or it is -- they go on with our comments?

MS. O'ROURKE: So I can take that, and if the CMS team would want to chime in. The way the process works, and what CMS is statutorily required to do, is only put the measure on the MUC list once. If it does not change substantially, our understanding is it does not need to come back to MAP if you tagged a specific condition for it.

And this was actually one of the murky points that made us revise that refine and

resubmit, because technically if the measure hasn't changed substantially, there's no requirement for it to be brought back to the MAP.

So again, I defer to the CMS team if they have clarifying comments, but my guidance would be if it gets a conditional support and the measure is fairly well developed, I wouldn't expect for it to come back to the MAP next year.

DR. LEVITT: Yeah, thank you, Erin, this is Alan. I agree with what you said. And again, we take what you say very seriously in terms of our further development of the measure after we've met at the Committee.

And as you'll see in our proposals for rulemaking, we will discuss the deliberations that were done here, the recommendations of the MAP, and what we have done based on those recommendations. So we do take it very seriously.

As Erin said, we're not statutorily required to come back here. And in general, if we felt that we've met what the MAP work group

has asked us to do, at least in terms of looking at something, we would generally feel comfortable with proceeding forward.

MEMBER LETT: Thank you.

CO-CHAIR LAMB: Before we go into whether we've got a quorum and checking out the poll, does anybody have any questions about the process, any of the changes? Okay, Paul and I and everybody here from NQF will hopefully help to guide everybody through the new decisions and the new process. Okay, great.

MS. GORHAM: Okay, before we go into our numbers for quorum, I just wanted to make sure that we can test the voting system. So I know we had a lot of staff walking around to help you log in this morning. And I just want to be sure that everyone is logged into the voting platform, PollEverywhere, and ready to vote.

Do I have anyone that needs assistance? And if not -- you have a hand? Okay, Sheila's going to walk around and actually provide you with some assistance. So I'm just

going to give you a brief synopsis of what's going to happen.

This is a lot more of a simple process compared to what we're used to. Logging in is a little challenging because it's new, but after that hopefully, fingers crossed, everything will go seamlessly.

And so once I activate the voting poll, what you would do is quickly, you'll be able to see the option to be able to vote, and you just enter your vote. And I will be able to let you know when we can see the votes real time in the room. Okay?

All right, so we are going to go ahead and ActiVote our first voting poll. I am actually going to read the vote for you and let you know when it's time to vote. It looks like some people have already submitted their vote. The voting question is please input yes if you are able to cast your vote using PollEverywhere.

Option A is yes, Option B is no. And I'm assuming if you're hitting no, then that

means you actually are able to vote. So that helps anyway. So if you'll notice on the right-hand side, you'll be able to see the percentages of, and down below, of those who are voting. And we'll be able to toggle to see the results of those in number form as well.

MS. MANGRUM: This is Rikki. I'm on the PollEverywhere site, and it just says response history. But I'm not seeing the poll.

MS. GORHAM: Okay, Rikki, let's try to get you some help if you hang tight for one second. And we will actually chat to you, so to make sure that you're ready and you're ready to go once we start the vote. Okay?

MS. MANGRUM: Sure.

MS. GORHAM: Thanks. Rikki, quick question. Have you downloaded the app and registered on the app? Are you voting on your phone?

MS. MANGRUM: No, I'm on the web browser.

MS. GORHAM: Okay, all right, we'll be

chatting with you shortly.

MS. MANGRUM: Okay.

MS. O'ROURKE: Is anyone else having any challenges? Okay.

MS. GORHAM: And I'm going to look for Kurt Hoppe. Are you actually on and registering and ready to vote, or having any issues online?

(No response.)

MS. GORHAM: So if you notice, we have 11 people that have successfully voted, so we're missing a few. So in the bar graph, you'll see the number towards the end of the bar graph on the right.

CO-CHAIR LAMB: If you're ready to rock and roll, feel free to get coffee or whatever while we get everybody set up. But don't go too far, please.

(Pause.)

CO-CHAIR MULHAUSEN: We'll reconvene in one minute and then go through another voting test to make sure recently joined members will be able to vote, and then move on. So one minute.

Okay, if you could head back to your chairs, we're going to try and test the voting system one more time. We had some additional members join us since our initial test, and we want to make sure we're capturing the votes of everybody who is a voting member.

If you haven't already done so, clear the response from your last vote.

MS. GORHAM: All right, here were are. We are ready to vote now. If everyone, I'm going to clear the results one last time. If you could hold onto your vote for one second, I'll let everyone find their seats. And now, please input yes if you were able to cast your vote using PollEverywhere.

So what you'll notice here in the room is we'll see 100 percent as your percentage because only, let's see, and down at the right, you'll see the number 16, which is how many people are actually, have submitted their votes. So now we have 17 votes calculated. We're up to 18 votes calculated.

Okay, so we're looking for 22 votes. And I know we have one unaccounted for on the phone. Rikki, were you able to vote this time?

MS. MANGRUM: Yes, I was.

MS. GORHAM: Perfect, thank you.

MS. O'ROURKE: Kurt, on the phone, were you able to vote?

MEMBER HOPPE: Yes, I was, thank you.

MS. O'ROURKE: Okay, great, thank you. I think we have one in the back with some --

MS. GORHAM: Okay, Sheila's working with you. All right, thank you.

Now we're showing 18 votes. So we're missing two votes. If everyone could just double check their screen one last time to make sure that their vote actually was submitted.

Okay, it looks like we are at 19, and we know one we are working on. So it looks like we're good to go now, Erin. Thanks.

MS. O'ROURKE: Great, thank you, everyone, and thank you for bearing with us while we get that set up. It's a new software we're

using this year that will hopefully pay off in the long run, but we want to make sure that everyone is able to vote.

I also do want to note, we do have our quorum, and I'll have a slide when we get to actual votes to show you the numbers and walk through that with you all. But to clarify, we do have a quorum, and it looks like hopefully now everyone is able to vote.

After all that, we are actually going to turn it over to Sam to share some information on the programs under the IMPACT Act that you'll be reviewing measures for today. And then we're going to have a little bit of a more cross-cutting conversation before we dive into the specific measures.

Alan and Tara had a few specific items they'd like some feedback on about the programs more generally before we get into the specific measures under consideration. So with that, why don't I turn it to Sam, and then, Alan, if there's anything you wanted to add after we run

through that.

MR. STOLPE: Wonderful, thank you, Erin. So for this portion of our agenda, we'll be reviewing the salient features of the four quality reporting programs that were initiated through the IMPACT Act, namely the Home Health Quality Reporting Program, the In-Patient Rehab Facility Quality Reporting Program, the Long-Term Care Hospital Skilled Nursing Facility Quality Reporting Programs.

As Erin mentioned, CMS is interested in your feedback related to these programs, so I'll invite you during this next discourse to take careful consideration of these programs and formulate your thoughts, and share them with CMS after we go through this overview.

Of course, I'll be turning the time over to Paul to facilitate the discussion, but CMS will of course give us some input and framing remarks to help guide that discussion. So with that, let's go ahead and dive right in.

Here we go, all right, thanks very

much.

So the Home Health Quality Reporting Program is the first program we're going to consider. This program is, as you'll note for all of the programs that follow kind of a comparable structure, so this program type is penalty for failure to report. And you'll notice that for each of the programs.

In setup structure, again, all of these are fairly comparable, home health agencies that do not submit their quality data are subject to a two percentage point reduction in their annual home health market basket annual payment update. Now, the thing that you'll notice about these measures, which I'll show on the subsequent slides, is that the data sources kind of are ranged through three key areas.

The first is the outcome and assessment information set, OASIS. Then next, from CAHPS surveys. And then lastly from Medicare fee-for-service claims. The next slide, we'll see a handful of measures that are included

in the subsequent slide as well.

And just the thing to note from this is that we have a pretty good representation of both outcome and process measures. One, also the resource utilization. And then there's sort of a mix between NQF endorsement status and not having endorsement status for the measures within the set. Let's go to the next slide.

So the CMS high priority domains. So this is something where we could potentially be adding some additional measures. So the highest priority that CMS has identified here is for patient and family engagement, where care is personalized and aligned with patient goals.

So that's where we're going to be looking for future measure consideration. Next slide, sorry, let's go back one slide. Were these on there? I think you have one slide, go back. Oh, we're missing some slides. Yeah, forward one more. That's fine, yeah, right, just stay there. No, go back one, go back. Yeah. That's fine.

So the gaps identified during the November web meeting, I'll just speak to this without actually having the slides, that's fine. We're looking to potentially to develop additional measures to address improvement or stabilization of activities of daily living, specifically instrumental ADLs addressing more distal outcomes.

And then other comments from the November web meeting was that we could potentially look to have measures that provide a more holistic view of wound care. Technical issues. I like that.

CO-CHAIR MULHAUSEN: Thank you, appreciate your input. I'm teasing.

MS. GORHAM: We're having some technical issues with the slides. What you have posted online, if you're following on the phone, and what you have in your meeting materials in the room, please follow those until we can get the technical issues resolved.

MR. STOLPE: I actually like to

celebrate technical issues. There's been many studies that have shown when you go through a trial together, it brings everyone close. So let's unite through this.

CO-CHAIR MULHAUSEN: And we're seriously bonding.

MR. STOLPE: All right, let's jump back in here. So we just did home health, so let's go onto Inpatient Rehabilitation Facility Quality Reporting Program. So this, again, is a penalty for failure to report.

The IRF QRP was established under the Affordable Care Act, and similar to the others, failure to submit data is subject to a two percentage point reduction in the IRF perspective payment system payment update.

Now, just one piece of program information. The goal is to address the rehabilitation needs of individuals, including improved functional status and achievement of successful return to the community post-discharge. The data sources for this follow a

comparable pattern.

So it's from the IRF pie, in-patient rehabilitation facility patient assessment instrument, and also from claims and from HCAHPS as well. Let's go to the next slide. CDC, sorry, thank you.

These are the current program measurement information in front of you. You see that there's a mix of outcome and process measures, as well as cost and resource use. And also mixed on NQF status for endorsement.

So one thing to note for future measure consideration and priority domains that CMS has put out there is related to communication care coordination, specifically transfer of health information and interoperability.

During the November web meeting, appropriate use of and prescribing of opioids, as well as the, again, the improved transfer of medication information, were identified as measure gaps.

Moving on to our next program, we have

the Long-Term Care Hospital Quality Reporting Program. Again, failure to report is the structure on which incentives and disincentives are put out by CMS. This was a two percent point reduction of the applicable payment, annual payment update.

So for program information, of course a comparable goal of furnishing extended medical care to individuals with clinically complex problems. And the other point is that new, long-term care hospitals are required to begin reporting quality data no later than the first day of the calendar quarter subsequent to 30 days after the date of its CMS certification number notification letter.

Taking a brief look at the measures included inside of this program, again, a mix of outcome and process measures and a mix of endorsed and non-endorsed status for NQF. High priority domains that CMS has identified for potential future measure consideration is the communication care coordination transfer health

information and interoperability.

And during the November web meeting, it was noted that the availability of palliative care services is a potential gap to fill.

So our last program under consideration today is the Skilled Nursing Facility Quality Reporting Program. Penalty for failure to report, again, same program type. And also, failure to submit results and a reduction by two percentage points of the annual payment update to assess.

Data sources from the SNF QRP measures include claims data, the MDS data, and there's the next slide will show us the current measures within the program. So here you'll see again, note the mix of outcome and process measures, as well as the cost and resource use measure, and a mixed NQF status of both endorsed and non-endorsed measures.

CMS high priority domains for future measure consideration in this measure set include the transfer of health information in

interoperability.

And a number of gaps were identified in the November web meeting, to focus on improved care transitions, including the list of bidirectional transfer of information, patient and family empowerment, safety of transitions, improved EHR interoperability, and as well as improved communication about advance directives.

And with that, I'll hand it over to Paul to lead the discussion.

CO-CHAIR MULHAUSEN: Great.

So we wanted to give some time to Dr. Levitt and his team to get some input from our committee member -- work group members.

So Alan, I'm going to let you see if there's anything specifically you are interested in and then open the discussion for 10 or 15 minutes to provide some feedback on how the programs are doing.

DR. LEVITT: Okay, thank you. I'll talk a bit and then I may turn it over to Tara McMullen, Dr. McMullen, if she has anything

additional.

Well first of all, I wanted to introduce our program leads. The program leads from CMS normally would be coming to the table. It's a little bit different this year because of the cross-setting measure that we will be discussing later but they are all back there. They are all listening. During breaks, if you want to go back and talk to them to further discussion, as well, this is an opportunity to really both talk within the workgroup about these programs and then, if there is further discussion, the program leads are back there who are listening and certainly are interested in what you have to say.

One of the things that we are interested in, much like Michelle, I came from the real world and was running quality programs within my own hospital and used all different types of data to help in terms of the quality activities from the hospital. And I am interested in terms of the information that we

are now giving to you, back to you, how are you using it? What additional information are you using? Are there better ways we can prepare it so you can use it for your own quality activities?

Also understanding that there are other things that we now have available besides the data, have you looked at the data element library, for example, that's out there to get more feedback in terms of the data and use?

Tara, did you have anything additional?

CO-CHAIR MULHAUSEN: So on the screen are a couple of sort of trigger questions to get you thinking. How are organizations using the data from these programs and how are post-acute care researchers using CMS' standardized assessment data?

So this is an opportunity to provide some general feedback and reflection on the Quality Reporting Programs under the IMPACT Act.

Since I am full of verbiage, I will

make a couple of reflections. So many of you know I am a geriatrician and I spent a substantial part of my career working in long-term care post-acute care settings and I continue to work with post-acute care settings on their quality improvement and am familiar with the frustrations they experience.

And I will frame this in the spirit of optimism. I think we are in sort of a cultural tipping point moment, where people are trying very hard to incorporate the data into meaningful quality improvement but it has not been traditionally part of the provider culture. So I think they are struggling, which I think is the good news. It means they are not ignoring what we're asking them to do. It means they are trying hard but it has been difficult for them to start to incorporate the data into the kind of PDSA model for change cycling that I think many of us who have spent a lot of time thinking about how to do quality improvement are able to actually implement.

And then my second observation is around patient and family engagement, which I think is the new secret sauce. I make no claim to be a quality improvement expert. I'm a clinician who always wanted to do the right thing. But when I listen to much of the language of quality improvement, I go, okay, there's lots of different tongues out there. But the one thing that really strikes me as exciting is patient and family engagement, as incorporated beyond person-centered care and incorporated into quality improvement.

And one of the things that I think is an opportunity that we haven't fully capitalized, and I don't know how to incentivize it, is to actually bring patient and family engagement or resident engagement into quality improvement design. I am quite confident that people are holding resident councils and I'm quite confident that we're spending a lot of time encouraging clinicians and providers to get feedback from the patients and caregivers. I am not confident that

it has moved beyond lip service.

And in my own world, where I've asked colleagues let's do this, I routinely encounter sort of cultural barriers. So a huge opportunity out there but, again, I'm not sure we're there yet.

And thank you for the opportunity to opine.

Danielle.

MEMBER PIEROTTI: Good morning. I think that one of the challenges that we're having from homecare and hospice is trying to navigate the measures versus the stars. The stars added a level of complexity that seemed to be keeping people distracted. There's a lot talk about what star you're at, a lot of effort in the analysis of how the star was arrived at. That seems to be skimming over the core measure and what do I really do for the patient. And particularly in home care where the stars are now being mixed up as with secondary markers in making risk arrangements, with payers. We have a

variety of value-based purchasing programs that really are dominating the conversation.

So it's been difficult for the industry to really rally behind the actual patient and the measure that is closest to the patient because a lot of the resources are being spent trying to understand the multiple steps that these measures are being used for and people are getting kind of stuck at that financial stars sort of issue. The stars have become a shortcut for a lot of -- there's a variety of sort of third-party folks in the middle that are helping to make networks and to decide who has got contracts. So they are using stars as a shortcut to that, which means a lot of analysis time is being spent figuring out which one of these measures should I move two-tenths of a point to jack up my star by half a star. And we're coming at it from that level instead of who are my patients and what will my patients benefit most from.

So it's a little bit of a churn. I

mean there's work being done but it's coming from a real, I would say top-down effort as opposed to a patient op kind of a conversation.

CO-CHAIR MULHAUSEN: Andrew.

MEMBER BAIRD: Thanks. My name is Andrew Baird and I am from Encompass Health. We operate about 130 rehabilitation hospitals and about 250 home health locations, including 60 hospice locations.

And I would like to echo the theme that Danielle just made about having measures that are useful for clinicians at really a patient-by-patient level.

One of the -- and I feel that several of my friends from CMS have heard this in several iterations but one of the hallmarks of quality improvement is root cause analysis and understanding why people have the results and outcomes that they do. Currently, in the Rehabilitation Hospital Reporting Program, as well as several others, the measures that are based on claims, readmissions, discharge to

community, Medicare spending per beneficiary, those are only released to providers at a facility level, at a rote sort of aggregate facility level, on a relatively significant delay, too.

Our clinicians, our nurses, our doctors are looking for actionable information as to why somebody was readmitted or was -- excuse me -- or who was readmitted. So knowing at a patient-by-patient level what an outcome was on a claim for a claim-based measure, to us, that is one of the sort of central or single goals that we still have to reach for the interaction with our clinicians and the quality data that we receive vis-a-vis these programs.

So, again, it's that patient-level data on these key claims-based measures that is something we would like to set up sort of as a theme throughout because it's wonderful to know where you stand relative to another hospital or another homecare agency. How actionable that is for an individual patient is a more difficult

calculus. So having the patient-specific data we think would really improve the ability to actually put this data into high gear.

So, thanks.

CO-CHAIR MULHAUSEN: Raj.

MEMBER MAHAJAN: So I am just trying to see if we can put everything together. I think there are these echoes of some concepts that still are disjointed but, if there is a way to put all of it together. So truly, in this sector, it's all post-regulation. So it's not proactive. Okay, we want to do it because we want to do it or we are doing it because if we don't do it, we'll get a citation is generally the concept. And then complete the star rating and so people are working on the points, so how they can objectify stars is not truly what it means. So they will take the number, you know the whole point system there.

And then obviously, the outcry about not getting the meaningful dollars and that's why the technology piece is lagging.

I think if we could also standardize how things are done, the survey process is so different in different geographical locations, state-by-state. So having that process somehow standardized throughout the country and then top that off with technology and leverage that, as the basis of standard quality improvement process, would be the way to go. And Liz and her team have done very strong work in at least trying to define standard data elements but we still have to find the users for that so if you want to chime in after this.

So I think we are sitting at a tipping point but, still, there are silos between the clinicians and the technology folks, and the renders, and the operators, the state and CMS. If somehow we can bring everybody together to find the common themes and somehow harmonize all that work, that might work.

MS. PALENA HALL: Thanks, Raj.

So we, ONC and CMS have worked very hard this year on making some strong progress on

interoperability and particularly with the publishing of what's known as the CMS Data Element Library this year in June. And so I give a hats off to my colleague, Beth Connor, in DCPAC, where we were able to publish the Data Element Library, which maps health IT standards, primarily LOINC and SNOMED at this time, to the assessment data. So this is really the important first step in trying to get some of that information to move interoperably, particularly to support transitions and how like some of that information can flow, for instance, into a transition document.

So on going forward, some of the areas that we're looking at is how to then progress into the areas of FHIR into CDS. So this is future work that we are currently, again, to support interoperability.

And then I would just give a hats off to some of my colleagues at ONC who recently published an ONC data brief on the status of EHR adoption for SNFs in 2017. This is the second

year that we were able to publish data on EHR adoption for SNFs. And so in 2017, 66 percent of SNFs had an EHR, although the interoperability metrics were lower. I think it is really promising to see where those levels are. It shows that there is at least a certain level of infrastructure available out in industry.

And then with home health, we saw in 2017 that 78 percent of agencies had an EHR. Again, the interoperability levels are lower but I think it's very informative for policy about the opportunity and direction moving forward.

So thank you.

CO-CHAIR MULHAUSEN: First we'll go to Jim and then Lori will be after Jim.

MEMBER LETT: Thank you. As a clinician, I feel real empathy for facilities and the home health entities, among others, because they are -- since these measures come down as facility/institutional level judgments, they are, they being those entities, are dependent upon my behavior as a clinician. So they are being

judged by what I do. Well, if I'm having a good day, I may do it really well. If I'm having a bad day, it's why are you calling me; I'm pretty doggone busy.

So if there is some way to integrate the behavior of the clinicians with the facilities and the even deeper problem is if you go to a rural area or a deep urban area, these institutions are having a heck of a time finding clinicians to come. And now you want me to flog them because they are not coming in a timely fashion, or not submitting reports, or not doing a number of other things that I am going to be measured on?

So if there is some way to, number one, be forgiving to them until we can all get it together and find a way to measure joint behaviors and actions, that is, the institution in connection with the clinicians, I think that would be actionable behavior -- I'm sorry -- actionable information that can be acted on.

Thanks.

CO-CHAIR MULHAUSEN: Lori, go ahead.

MEMBER BISHOP: Thank you. Lori Bishop from the National Hospice and Palliative Care Organization.

I think interoperability is a big issues and post-acute services haven't gotten the incentives that the hospitals and medical groups have gotten to achieve interoperability. I think that's one thing that would really be helpful, I think, for the post-acute service world.

I think that's a patient safety issue. It horrifies me to think of the changes that might have been done to medications and other treatments in a home health episode and then I do show up in the ED and none of that is reflected in my record. And I don't really understand why we tolerate that as a society, other than I don't think consumers understand we don't communicate well today.

So certainly we support interoperability.

The other thing, to go back to the

claims discussion and that in relation to quality, I think the claims gives you a piece of information but not necessarily always tells the tale of quality.

And I would love to see if we are going to leverage claims data for quality reporting, that we somehow crosswalk it to patient experience, as much as possible, or use it more of information gathering to do a deeper dive. I think the hospice discharge measure, for example, you know you've got some discharges that revocations and that may be on the choice of the patient and so we also look at some of our principles being patient choice, patient autonomy, and goal attainment. And so maybe that was an alignment with their goal attainment because we know that people do change their minds.

However, if you have a large volume of revocation and you're an outlier, do we need to look at why is that and help understand what's causing that?

So I'm not saying that we're opposed to use of claims data but it shouldn't be, in and of itself, determining quality. It's a piece of information that needs to be cross-walked with other pieces of information to understand the quality issues.

Thank you.

CO-CHAIR MULHAUSEN: We have time for one more. So, Caroline, go ahead.

MEMBER FIFE: There was a recent New England Journal article about stop the stupid stuff. I don't know if you saw that but it was an analysis of EHR functionality and getting rid of things that were time-sucking. And the methodology that they used was really quite clever and it tremendously increased satisfaction. And it seems like that is something that could be repeated everywhere.

The biggest problem I see to interoperability is data blocking and Liz, I would like to know when you're going to put teeth in the 21st Century Cures Act because it

continues to be a problem, as a registry. We've just got people all over the place that are refusing to transmit data and I can name names. So you know, please do something about it.

The other thing that frustrates across the board is while it may be true that physicians are ending up being the barrier under MIPS, at least, a tremendous amount of the credit that physicians get on quality measures is work done by nurses. And that has never made sense to me that as long as my nurses do a heck of a good job, I can get bonus money. And I just think that is ridiculous.

And lastly, one of the things that troubles me a little bit as a supposed content expert here, which I keep wondering why you keep inviting me back, is that you know in the QCDR world, we have the chance under these registries to fail with minimal embarrassment. We can put out, assuming we can get a measure past Dr. Green and his team, we can use it for a period of time, realize that it doesn't do what we want it to do,

not hurt too many people, or embarrass ourselves horribly and then decide next year that was a bad idea.

And that is a great way to inch forward, particularly when some things are really hard to measure. I enjoy my arguments with them very much but it is, in some ways, less cumbersome and maybe a better way forward than some of the agonizing and very lengthy processes that we go through here with all the best intentions but without really enough information to know if we're making -- we have this elaborate process around voting but we don't actually have enough data to know if we're making the right vote. We've got a lot of good rules about voting -- if only we had information.

CO-CHAIR MULHAUSEN: All right, I'd like to give a few minutes for Alan and Tara to respond.

DR. LEVITT: First of all, thank you very much. This is exactly what we want. We want to know what's going on with our programs

and issues and concerns that everybody has. And we've been doing a lot of writing here, if you haven't noticed.

I did want to ask one other question, which really was the second bullet or just a reminder about the data that we now have, particularly in the post-acute care world and academic world is that we are now collecting standardized assessment data, particularly if you look at the functional data that we're collecting, cost-setting. And I guess it's a call to all the researchers out there within your world to start looking and saying well, this data is now out there in the hundreds of thousands, in the millions that can be longitudinal in terms of the collection. We can start answering some of the questions that we've had for decades, perhaps, in terms of what's going on with some of our patients, including the sickest and the most frail patients that we have. And can we start to use this sort of data not just in terms of the quality activities but then in terms of answering

some of these questions.

Tara, I don't know if you had any other comments.

MS. MCMULLEN: Just the recognition -- this is Tara. Just the recognition of what Lori and Jim's comments were pointing to and the focus on the person, the patient, and the resident, and their safety.

There are quality measures that go through -- I'm going to speak to this -- they are only as good as we can make them and they can only tell you so much. And the one thing that we hear a lot in post-acute care is how can standardization back-end some of these very important limitations that we need close care coordination, improve discharge planning? And many times we move into the quality measurement world building these constructs for public reporting but you know under Alan, and Stace's, and Mary -- Mary Pratt's back here -- guidance, it's always keep your eye on the person.

So I was appreciative of the comment

of this is about safety of real people. You know and I heard a quote one percent of their life they are in our care; 99 percent they are out, hopefully in their home. So what do we do that one percent of the time?

And I am also appreciative of the comment about clinicians, attribution for clinicians. Raj can probably speak to this, too, and his work with HES, but the attribution of the clinicians and what they do in the continuum.

We do have facility-based measurement; whereas, some of our sister programs have a lot of clinician-based quality measurements. I think that there is a lot of room for post-acute care and long-term care to grow in terms of measurement in a positive way. I focus on positive, too, positive aging. I'm a gerontologist. So I think that there's a lot of positive movement for us. What that means for the clinician or even the nurses on how you begin assessing for staffing, there's just so many areas for us to grow. And it does actually beg,

and I think this is where Alan comes in, it begs sometimes in my mind do we begin looking at composites. Are there better ways to look at quality instead of outcome process? Like how can we detail the story in greater detail where it's meaningful, not only to us but to people like my father?

So that's all. Thank you, Lori and Jim. I was appreciative of those comments. Thank you.

MS. MANDL: Hi, this is Stace Mandl. I just wanted to sort of piggyback off of Tara and Alan and the feedback that we received.

A couple of things to just sort of draw attention to, which I think is very important for post-acute care and Paul, you're very aware of this and we have Deb Weiland from DCPAC now. We provide real-time data reports that providers can run that will reveal the individuals that are triggering the measure, as well as the measure calculation itself in real-time. And so that's downloadable information

that the providers can use in their quality improvement teams and really talking about teams. To Tara's point, these are facility-based measures. So they're really looking at how the whole organization, as a whole, hopefully, is conducting itself to improve and address quality in those gaps that occur.

We are aware -- to Andrew's point, we are aware of the limitations of the readmissions measure. We've actually made some headway internally at CMS on how -- yes. Yay. And so we just wanted to make that point as well.

Thanks.

CO-CHAIR MULHAUSEN: Heather, I'm going to give you like 30 seconds.

MEMBER SMITH: I just wanted to say you know we really do appreciate all the efforts of the data standardization.

From a research perspective, though, I just want to put it in perspective that realistically, getting national data will take several more years. And so unless there is a way

to get that through cooperation and data arrangements from multiple facilities, I just don't know that a national -- you know we'd love to do a national study but I think that there's challenges in getting that data from CMS to do that kind of research at this point.

CO-CHAIR MULHAUSEN: Okay. So in the spirit of time management, we're going to move on to the section where we invite public comment on the measures under consideration. And to introduce that, go back a little --

MS. O'ROURKE: Actually, Tara has a view slides to clarify the POH measures.

CO-CHAIR MULHAUSEN: Yes.

MS. O'ROURKE: And I do have one housekeeping item.

CO-CHAIR MULHAUSEN: Okay.

MS. O'ROURKE: My apologies.

We had three late arrivals that I just want to make sure have disclosed, so that we have all of our technicalities in order. We have three organizational members who did not complete

the disclosure that you all did.

So I'm going to ask them to introduce themselves, briefly, remind everyone that organizational members represent the interest of a particular organization. We do expect you to come to the table representing those interests.

We have one specific question. We would ask you to disclose if you have an interest above $10,000 or more in an entity that is related to the work of this committee.

So with that in mind, I would like to ask Gail Hunt from the National Alliance for Caregiving, Kurt Hoppe from the American Academy of Physical Medicine and Rehabilitation, and Lori Bishop from the National Hospice and Palliative Organization to introduce themselves.

Lori, can I put you on the spot to go first?

MEMBER BISHOP: Hi, I'm Lori Bishop. I'm the vice president for Palliative and Advanced Care at NHPCO and here on behalf of NHPCO.

MS. O'ROURKE: Thank you.

Gail Hunt, for the National Alliance for Caregiving.

MEMBER HUNT: Yes, I'm the founder of the National Alliance for Caregiving and I'm also on the Board of PCORI, the Patient-Centered Outcomes Research Institute and I have nothing to disclose.

MS. O'ROURKE: And Kurt Hoppe.

MEMBER HOPPE: Hi, this is Kurt Hoppe. I'm the past president of the American Academy of Physical Medicine and Rehabilitation. And I apologize. I tried to speak a number of times at the beginning of the meeting but had technical problems. So I've changed phones.

I have no disclosures.

MS. O'ROURKE: Great, thank you, Kurt and apologies for the technical issues. And please let us know if you have any additional issues speaking.

I also did want to make sure that everyone is aware that Dr. Andrew Geller from the

Centers for Disease Control is also on the line and CDC serves as the third federal agency that is on as a liaison on this workgroup. So, Dr. Geller, please feel free to join in as well.

DR. GELLER: Thank you.

MS. O'ROURKE: Great, thank you.

So I think with that -- would it make sense, Tara, do you want to do your slides now or take public comments? Because I think based on the themes that we saw in the early public comments, Tara's comments may help clarify things for everyone.

MS. MCMULLEN: Yes, this is Tara McMullen. Yes, I think maybe I will present the slides. I wrote a little information that will help direct traffic because there have been many iterations of the measure, I think just to put things in focus. Does that work?

Okay. So hi, it's Tara McMullen and I will be leading the discussion for the Transfer of Health Measure set. There's two measures here. Both are collected at discharge; two

different populations of focus. One is looking at the transfer of health information to the provider and one is looking at the transfer of health information to the patient, the caregiver, the family.

So we first came to the MAP in 2016 -- oh, before I start I need to say a thank you to our measurement development contractors. I cannot forget them, RTI International and Abt Associates. Abt Associates led by Jennifer Riggs, who I think is here in the room, and RTI International led by Colene Byrne and Denise Tyler. And then also a thank you to DCPAC, our Division of Chronic and Post Acute Care. There was a lot of time and thought in the last three years put into these measures. Oh, and our collaboration with ONC, yes.

So as you can see on this slide -- can't forget ONC. Liz is down there. I feel her. I feel her looking at me. We love Liz. Thank you, Liz.

So as you can see on this slide, we

have been in the development phase of these two Transfer of Health measures for three years, two measures which are relatively simple but will allow CMS to evaluate the successful transfer of vital health information, reinforcing the importance and focus on success on successful transfers and improved coordination of care.

We know that nearly half of Medicare beneficiaries discharged from an acute care hospital are discharged to a post-acute care setting and from there, they are either discharged to a subsequent post-acute care setting or they are discharged home.

In 2013 alone, and these statistics still are stabilized through now, for the most part, 2017, almost 8 million inpatient stays accounting for 22.3 percent of all hospital discharges were discharges to post-acute care settings, including 11 percent that were discharged to home, and 9 percent that were discharged to a SNF.

Up to 90 percent of all patients

experience at least one medication discrepancy in that transition or those transitions from the hospital to the home and discrepancies occur within all therapeutic classes of medications.

And in that, communication has been cited as the third most frequent root cause in sentinel events, failed or ineffective patient handoffs are estimated to play a role in 20 percent of serious, preventable adverse events.

Health information that is incomplete or missing, such as medication information or reconciled medication lists that's the focus of these measures, increases the likelihood of a patient resident safety risk that is often life-threatening, as Lori just back ended there.

Medication discrepancies are common. Post-acute care providers often are in the position of starting complex new medication regimens with little knowledge of their patient or their patient's medication history. Thus, we hope with the collection of information from these two measures here that we'll discuss today

that we will draw national attention to the importance of the timely transfer of health information and care preferences at transitions, while being able to increase over time the secure, timely electronic transfer of a reconciled medication list using health IT standards with our partners at ONC.

We bring to you today two final measures that we feel would complete efforts or complement efforts to improve care and the outcomes of care reported by our quality reporting programs.

We first met in 2016 and was given guidance from this panel on how to improve these measures and for that we thank you. The principle concern in 2016, beyond the testing of the measure, was attribution associated with the admitting facility and what information the facility was responsible in receiving. We moved to amend the measures to ensure that the focus of the measures was to evaluate what is the locus of control of the provider who is assessed in the

measure, the discharging provider, and ensure that the measure is focusing on information as being sent, rather than received.

We heard from stakeholders that having multiple domains of transfer or information to transfer would be burdensome. And with the help of the TEP, and stakeholder input, and being mindful of the complex, costly and potentially hazardous adverse outcomes from and by medication discrepancies, we narrowed the focus of the measures today to information that was transferred, specifically, reconciled medication lists.

We recognize that every measure has a lifecycle but place emphasis on the importance of these process measures and the data that would yield from the measures to improve surveillance and to increase the opportunity for sound outcome measure development. We additionally emphasize that the intent of the measure's performance is to have an effect on overall rates of mortality and adverse events associated with a lack of

medication oversight during transitions of care.

We ultimately plan to monitor mortality and adverse events associated with transfers and transitions associated with medication events. We also intend to publicly report measure information for consumers to aid in shared decision-making.

We have listened to the input of the MAP and the stakeholders. We paid close attention to the data from our testing and have been mindful of the burden for the development of these measures that we bring to you today.

And if you go back one slide and I promise I'll speed up after this, what you see is a robust set of the last years of consensus vetting and testing. We first brought the measures to you all in 2016. We received a revised -- a refined and resubmit at that time. What we heard was there was not enough in terms of the testing of the measure, thinking what the measure meant to providers.

We went into the field twice since

that time in alpha testing. We've had four public comment periods, two to three technical expert panels. We've held subject matter expert groups. We've met with consumers. We started a robust collaboration with ONC. We've met with colleagues around CMS, our medical officers, and we've worked with all the regulation groups across who are working on discharge planning processes to ensure that these measure are solvent and timely. Next slide.

So the next two slides, quickly, we'll go through the multiple iterations of the measures so you all can see the transition of what we made when we amended the measures and where we ended. I guess for the sake of time, the most important row on this is the criteria to meet measures and really the understanding of what happened with the measure concept.

So when we originally brought this measure to the MAP in 2016, we had two measures; one that was collected at admission and one that was collected at discharge. There were a lot of

comments about attribution at admission.

Since that time, we have moved through multiple iterations and now we have two measures collected solely at discharge to look at the received portion of this work.

Also when we brought these measures to you in 2016, we had the transfer of at least 1 to 11 possible categories of health information. Do you remember that? There was a long list: function, pressure ulcer, medications. We heard a lot about that list, and the burden associated with that list, and how would post-acute care providers be sending that with the lack of incentives in post-acute care. We heard the whole list. Now we focus specifically on a reconciled medication list.

We also focus specifically now on providers, the subsequent provider, and the patient family and caregiver.

If you go to the next slide, you'll see here specifically in the second row, in 2016 we brought you a measure that looked at the

routes of health information. So this would be an additional items to measure, not used computationally in the measures but more of an assessment item. And it asked about everything from paper-based transfer to the electronic HIOs and HIEs.

When we were in the field, we heard a lot from our post-acute care providers about their level of understanding of incentives, and the frameworks, and what they're really doing in real-time. So you'll see that we amended that data element for these measures today.

And I think that's the most important -- those are the most important changes I have with the measure. Next slide.

A quick slide from our 2018 pilot test. This is the second of two tests that we held for these quality measures. Basically, we want to show you that we fulfilled the promise for the second time. The first time we were with 30 test sites. The second time we were with 24 test sites.

We looked at inter-rater reliability, face validity, completion time estimates attributable to burden, feasibility, and truly the cognitive aspect of the overall experience of collecting and submitting this work data for the QMs. We found that there was an 87 percent inter-rater agreement for the transfer of health measure, the provider measure. And you'll see here that QM scores range from 47 percent for IRFs to 94 percent for SNFs. So, we're running the gambit. We can say for three out of the four settings, there are definitely areas of improvement. For the SNF setting for the most part for the settings we were in, the QM score is pretty high. We'll see how that looks in real-time if this measure is adopted into the program. The average time to complete is 2 to 3 minutes.

For the transfer to patient measure, so this is the transfer of health to patient at discharge, 93 percent inter-rater reliability and we're holding an average of the high 70s for QM scores, and the average time to complete is 1.8

minutes. Next slide.

So we do -- and this is my last slide. We do get a lot of questions about the interoperability of these measures, as these measures do assess for the timely transfer of information and we want to backend that. We understand that the exchange of data will support personalized efficient healthcare. And that's why we started our relationship with ONC in developing these measures and working with the Data Element Library.

So the transfer of health information, specifically, reconciled medication lists will backend the support of multiple federal initiatives across multiple agencies and legislative efforts. And we have on here that the interoperability provisions in the 21st Century Cures Act, which you brought up Caroline, would provide a strong framework to enable electronic sharing and interoperable exchange of this information.

Further on the last bullet, we would

like to note that these measures backend or support the discharge planning requirements proposed in the Revisions to Requirements for Discharge Planning for Hospitals, Home Health Agencies, and Critical Access Hospitals and that is a proposal that is currently posted in the Federal Register. And you see that number there for that, if you want to look that work up.

CMS' intent, overall and over time, is that a medication list information, that information list itself, transferred by PAC and other providers, conforms with federally-recognized health IT standards that supports the exchange of medication information and aligns to the U.S. Core Data for Interoperability, the USCDI, and most importantly to the Data Element Library that we've developed -- Beth Connor has developed under the intent of the IMPACT Act.

And that's it. That's my presentation, if you have any questions. Thank you.

CO-CHAIR MULHAUSEN: So that sets the

stage for our opportunity for public comment. So, Caroline, I would ask you to table whatever question you may have for our own deliberations.

So because we're running a little bit behind, I wanted to make sure that we opened up the opportunity for public comment.

There may be people on the phone. We ask you to wait until our friends here in the room actually are given the opportunity.

For any of you here to make public comment who are present in the room, there is a microphone to my right, right over in front of the public area. So anybody who wishes to come up to the microphone to make public comment on the Transfer of Health Information to Provider -- Post-Acute Care measures under consideration.

So it doesn't look like anybody in the room is here to make a public comment. So I want to open up the lines for anybody on the telephone who wishes to make a public comment on the Transfer of Health Information to Provider -- Post-Acute Care measure under consideration.

OPERATOR: At this time, if you would like to make a public comment, please press * then the number 1.

CO-CHAIR MULHAUSEN: I'll call out one more time. Anybody on the telephone who wishes to make a public comment?

OPERATOR: And there are no public comments from the phone lines.

CO-CHAIR MULHAUSEN: Thank you. And I would also like to let any of you know on the telephone if you would like to make a public comment via chat that channel is available to you as well.

So we have somebody in the room who wishes to ask a question. Make sure you state your name and where you're from.

MS. BOSSLEY: Heidi Bossley on behalf of the Federation of American Hospitals. I just thought I would ask a question. It's a comment that we submitted but it might be useful.

This measure has gone through several iterations, as you said. It would be helpful to

understand what the definition of a reconciled medication list is now, just as -- especially when this goes out for comment, to understand that would be helpful.

Thank you.

MS. MCMULLEN: Yes, so the definition of a reconciled medication list -- let me back up.

So a reconciled medication list will be guidance. So the core critical element of the measure, the calculation is assessing the transfer of information.

The focus of the measure is a reconciled medication list and that will be guidance and, like we do in post-acute care, we will expand upon that in our guidance manuals. But it is parenthetically the same thing, just cut down, looking at medications, everything from you know anxiety meds, anything for allergies, we've very -- let me actually look it up a second. I don't want to over speak this.

Any information that can improve

medication safety and guidance applicable to information, including any medication that was given at the time of admission/during the stay, any new medications, medications reconciled, and we go into more detail about the types of medications in our guidance, like specific types.

It's pretty inclusive, basically all medications that are given within that stay. There's no parameters on that.

From the time we had the first measure in 2016 to the time now, so the medication list was just the medication list transfer item. It was a checkbox. The second iteration of the measure had a medication profile, what we call a profile. We worked with many providers and stakeholders and a lot of folks opined that the wording profile wouldn't make a lot of sense because people don't use medication profiles and the joint commission opined on that. The medication profile looked at everything from a patient's current status, their characteristics, their name, where they are, where they came from,

to the types of medication they use.

Now our reconciled medication list has the same type of information from who is your person to what is going on with them at the time of discharge in terms of what they're using and how they're using it. We just cut down on some specific areas of information that might be a little bit more difficult to retrieve and we specifically made the medication list guidance.

So the core critical element is the transfer of information. Does that help a little bit? Okay.

CO-CHAIR MULHAUSEN: Okay, I will put out one last call for public comment on the telephone or in the room.

And hearing none, I'll transfer the work over to Gerri.

CO-CHAIR LAMB: We're going to move now into the first MUC and start talking about the transfer of health information to provider -- post-acute care.

I'm going to do a quick review of the

process, just to make sure everybody is -- can you hear me okay? Thanks -- is on the same page.

Before we do that, though, a couple things. One is that the staff have proposed that we discuss this first set this to provider as a group. We will vote individually but we need to know if everyone will support talking about them as a group, as compared to going one-by-one-by-one-by-one. If anyone in the group would prefer to go one-by-one-by-one-by-one, that's how we will do it. So maybe let's start that way.

If anybody in the group would prefer to go measure-by-measure through these first four, please raise your hand.

Okay, then that's what we will do.

Okay, so let me just kind of go through the process and then Erin is going to talk about the numbers, in terms of consensus. And I think you were going to say a little bit about the differences between this process because many of us sit on standing committees that go through CDP and the difference between

this and the measure review process in CDP, correct, Erin?

MS. O'ROURKE: Correct.

CO-CHAIR LAMB: Okay. So let's just go quickly through the process and, if you have any questions, feel free.

Okay what we're going to do with each measure now of the first four, we're going to do a staff review and I think Erin is going to do that. Then, we have lead discussants for each of the measures. What I'm going to do at that point, and then when we go to the next four Paul will do it, is to identify any clarifying questions and we'll organize them and bring those either to the measure developers, to the staff, to CMS, or to our own measure reviewers.

And just a reminder and I'll remind you as we get to it, is the first step is going to be whether we accept the preliminary analysis. And if you wish to go into further discussion, we're going to vote no but we'll remind you about that.

If we accept the preliminary analysis, we go to the next MUC measure. So far so good? Everybody cool? Okay. If we don't, then we're going to go to the other four options and Shaconna reviewed those options: support, conditional support, do not support with potential for mitigation, no support.

Okay, so we're going to start with staff reviews and go from there.

Erin, numbers and CDP.

MS. O'ROURKE: Excellent. Thank you, Gerri.

Are we able to bring up the late edition slide to explain some of our numbers?

Okay so to confirm how we establish quorum and what the consensus threshold will be for your voting, we just want to walk through the exact numbers for everyone.

There are 27 members of the Post-Acute Care/Long-Term Care Workgroup. Three are nonvoting federal liaisons, so they do not count towards quorum as they are not able to vote,

since they are representatives of the federal government. That leaves us 24 eligible voters.

So 66 percent, we would need 16 members to participate to achieve quorum. We do have quorum. We have 20 people participating either on the phone or in the room.

If you feel you need to recuse based on the conflict of interest policy Elisa explained earlier this morning, recusals are removed from the denominator, as you are present at the meeting but choosing not to participate in the conversation for that particular measure.

Abstentions are included in the measure so you'll see our N is slightly different than 24, given that we have a folks who weren't able to join us for this meeting.

For consensus, we've set a threshold of greater than or equal to 60 percent voting for the decision in front of you. Again, we take the three federal liaisons out of that calculation. If we had all 24 people in the room, we'd have 15 to achieve consensus. And to point this out, it

was actually 14.4 people but we rounded up to the next whole person -- person-centered voting, is that a thing?

I did want to point out for the voting the recusals and abstentions are both removed from the denominator.

So for today, if you want to look at the four abstention voting line, our N is 20. So we're looking at 12 is our magic number to achieve consensus.

And again, I do want to point out that the numbers in the decision categories are tooled to make sure that we're passing things along accurately. We also summarize and put forward all of your comments, both in agreement or concerns about the majority opinion. That's reviewed by the Coordinating Committee and, as Alan was saying, CMS weighs all of that very heavily and we've heard a recurring theme from our CMS colleagues that the conversation is equally important to the voting.

But given our desire to make sure

everyone is on the same page and we have no voting irregularities, at least in the MAP, we wanted to put the magic numbers in front of you so that you know what you're looking for. And if you have any concern about the math or how we got to a decision at any point, please let us know and we can pause and walk through and make sure. I was not an accounting major so I always appreciate a check on my math.

So I can take any questions on that.

And if not, Gerri just asked me to make sure everyone is aware of the differences between the MAP and the other process that NQF convenes to review measures, the Consensus Development Process. The CDP is tasked with making decisions about NQF endorsement, whereas, the MAP is asked to review a specific set of measures to make a decision of whether you would support a specific measure for use in a specific program.

The CDP has a slightly different focus to their deliberations. They focus on reviewing

the evidence to support a specific measure, reviewing the results of the reliability and validity testing to determine if the committee believes it's scientifically acceptable.

They also take a deeper dive into the feasibility of the measure. Can it be realistically calculated? And then think about how it's being used and if it produces useful information.

So the focus of the deliberations are different but they are, we recognize, interrelated processes. So you'll see for some of our staff assessments, we have noted it may be a conditional support pending submission of the measure for NQF endorsement so that there is a committee that could take that deeper dive on the scientific merits of the measure.

We know it's a confusing line so we would encourage you to, if you do think there are issues around the evidence or reliability/validity to raise them and we can flag them for the CDP committee that would be

tasked with reviewing that measure. However, we will ask you to focus more on the application and the use of the measure, rather than specific results of reliability or validity testing. We know it's a fine line and can be a bit challenging but we wanted to highlight the differences between the two processes.

And with that, maybe I'll see if Gerri wants to provide any remarks or Elisa, as they are also intimately involved in our endorsement work.

CO-CHAIR LAMB: Any questions about that? We just thought it might be useful because so many of us also sit on standing committees where we go through that process.

So not seeing any, let's move right in. We're going to start with MUC2018-131, Transfer of Health Information to Provider and that's from Home Health QRP. And Erin, you're on.

MS. O'ROURKE: Great, thank you. So in the staff's preliminary analysis, we have some

data supporting that patients in the post-acute care settings are very likely to undergo a number of care transitions and emphasizing that medication reconciliation is an important safety element for these patients, as they transition across settings.

We provided some information supporting that this is an important outcome. The medication reconciliation is related to important safety outcomes, given their vulnerability during the transition process and the current challenges to care coordination.

We highlighted in the preliminary analysis that this measure would address an IMPACT Act requirement and would allow measurement across post-acute care and long-term care settings.

As far as your question on can the measure be feasibly reported, we note that measure is calculated using OASIS data for home health patients and that the measure is specified for the home health setting and tests the

facility level of analysis and has been tested to demonstrate some degree of reliability and validity for that setting and level of analysis.

With these factors in mind, the staff assessment was conditional support pending NQF endorsement.

We also received a number of public comments on the measure, seven to be exact. They are in your discussion guide if you want to review the exact comments but some key themes: commenters were supportive of the concept and the focus of the measure but did raise a few questions on the exact assessment items that will be used to calculate the measure, as well as noted by public comment in the room, the definition of medication list versus medication profile that was in the earlier version of the measures released for public comment.

CO-CHAIR LAMB: Thank you, Erin. We're going to move now into the reviewers who were assigned to this. And for this set of four, we have Ash, Jim, Kurt, and Andrew. I don't

think Frederick is here.

MS. O'ROURKE: Frederick was not able to join us.

CO-CHAIR LAMB: Okay. So how about if we just start on this one with Ash and then move around and in subsequent kind of comments, if you could avoid duplicating what the person before you have said. And after we have those four comments, then we'll kind of regroup and talk about discussion questions, organize them, and open that up to discussion.

So, Ash.

MEMBER TRIVEDI: Actually, I have no specific comments. I think the measures look pretty good. I actually had the question about how do you define medication reconciliation lists.

The other point was I know it's medications in the setting of care but what about OTC medications or complementary medicines as well?

So that's the only thoughts that I had

specific to the measures.

CO-CHAIR LAMB: Jim.

MEMBER LETT: Oh, thank you, Gerri.

I apologize to the group for asking to break these out but I had some general comments for all of them and then some specific ones for each one. So guide me, please, in how you would like me to make my comments.

CO-CHAIR LAMB: Why don't you do both and then when we go to the next people, we can talk through those. And then when we get to the other measures, you don't need to repeat them.

MEMBER LETT: Okay, thanks. I appreciate the guidance.

General for all four is the timeliness piece. It says at the time of discharge that this should be transmitted and isolating it out to skilled nursing facility world, which is what mine is, from the hospital to the facility, if we only get the medication list at the time of discharge, we're lost because many times we'll need to order a pump, a med pump. Sometimes it's

difficult to order the medications and we'll need lead time in order to get the drugs to the facility and in a rural area, you may have the delivery once a day.

So certainly by the time of discharge but even that may be too late to set out a proper plan of care and that applies to all.

I think also for all of them is we talk so much about a current reconciled medication list, in my experience, that has become a mindless checklist check. Did you do medication reconciliation? Oh, yes, we did that. Well, who did it, and when, and how well did it take into the over-the-counter medications? How well did it take in to what they were taking on the outside and whether it coincides now with the new medication list? Is it duplicated, et cetera?

And Tara, you mentioned how frequently there are medication discrepancies during a transition and the answer is lots of times.

Why does that matter? Eric Coleman

has done some work about transitions from the hospital to home that shows if you even have one medication discrepancy, you more than double the chance of having a hospital readmission within 30 days.

So this is big boy stuff. This is important.

The electronic issue, there are certainly problems in smaller SNFs where the only internet access computer may be in the DON's office, which means it gets locked up at night, on the weekends, and holidays. So there is some problem in terms of transmitting information and, indeed, receiving information.

Interoperability, that's really not a problem. Yes, everybody knows what a problem that is. And there is a difference between a transmitted medication list and one that is received, acknowledged, and acted upon.

So it's the old aphorism that if a tree falls in the forest and nobody's around, does it make noise. Does transmitting a

medication list matter if there is no acknowledgment from the other end yes, we got it and I have a few questions, can you help us with them.

So I think it goes back to the mantra you've heard from me about in the National Transitions of Care Coalition is bidirectional measures. Not did you just put a med list in the mail but did somebody get that letter, and did they open it, read it, act on it, and have the opportunity to ask you questions?

Exclusions for home health -- what about the patients who fire the home health agency, because we all know that happens, or who refuse care? Are they part of the denominator or do they get subtracted out? If there is no interoperability, should they be removed? Because how can you say you should have sent an electronic medication list when there is no interoperability with the next site of care?

For the IRFs, although it would be rare, exclusions: should someone who leaves

against medical advice be included in that?

Gaps, and I would put that in the IRF and also the LTAC, is kind of teasing apart the definition of a discharge. When some -- when a patient is sent to the emergency room, is that a discharge? Is there a responsibility for that medication list? I mean ethically, absolutely, but as part of the measures, is that?

CO-CHAIR LAMB: Jim, can I ask that when you have specific for IRF, and LTAC, and SNF, wait on those until we get to those measures?

MEMBER LETT: Oh, I'm sorry. I thought you said go ahead with them.

CO-CHAIR LAMB: Stay with the general ones and then go specific to home health. But if it's specific to IRF, SNF, LTAC, hold on it, okay?

MEMBER LETT: Okay, I will hold on it. Sorry.

MEMBER SALIBA: Transfer of information to provider or transfer of

information to patient?

CO-CHAIR LAMB: To provider.

MEMBER SALIBA: To provider, okay.

Did we vote on patient or are we just -- okay.

CO-CHAIR LAMB: That comes later.

We're going to do the first four for provider and vote, and then patient, and then hospice.

So Jim, stick to specifics when we get to them but you can do general ones.

MEMBER LETT: Those are the general ones. Thank you.

CO-CHAIR LAMB: Okay and do you have anything specific to the home health or you covered those as well?

MEMBER LETT: Those were covered. Thank you.

CO-CHAIR LAMB: Great. Kurt, I think Kurt you're online, if there are additional comments. You don't need to repeat the things that Ash and Jim have already said.

MEMBER HOPPE: I will add to what both of them said by emphasizing the need for more measure specifications. I agree with some of the public comments that that needs to be spelled out more.

My other two comments are in general as well. We have multiple problems across the country with opiates. It may be good for the developers of the measure to provide some more specifics regarding opiates. In other words, how much or how many pills, or what type of medication we provided and who will specifically hand off for those opiates. It can become a complete mess. And given the national scrutiny of prescribing, that would be something the developers could consider for all of these specific sites.

And the other comment regards IV medications. A number of our patients leave facilities, I'm in IRF at this point, and they are on IV medications. Jim pointed out to know ahead of time whether a pump is needed or what

other additional equipment is required to safely administer those drugs, some indication about start and stop times would be appropriate.

And lastly, Jim mentioned bidirectional measure discussions. I think when you look at the attribution, I realize they change it from the emphasis on what the discharge provider provided but you can't relieve responsibility from the receiving provider to understand and acknowledge that they have received those medications, and doses, quantity, schedules, and things such as that but also have some kind of indication from the receiving providers that they have acknowledged receipt and they have no additional questions.

CO-CHAIR LAMB: Thanks, Kurt. Kurt, you commented that you would like to see more on the measurement specs. Can you be specific about what you would like to see so that when we get back on this, we can answer that?

MEMBER HOPPE: Well, I think that one of the members from CMS indicated that there was

guidance provided on CMS websites. I think I heard that correctly. That would be helpful to acknowledge that and to provide some kind of link to that, so that providers know exactly what is required and in what kind of format.

As we continue through countrywide adoption of EHRs, we are concerned about interoperability but even being able to reconcile medications within our own system sometimes can be difficult.

So if we can provide that kind of information so venders of EHRs are ready to set up those sort of specifications, is it enough just to say that we have looked at the medications or are there specific aspects of the medications that we are providing a list to another provider, besides dose and schedule? Is there anything else that CMS specifically wants us to do, while recognizing the burden on providers?

Surely, CMS and the developers have thought about this.

CO-CHAIR LAMB: Thank you. We're going to be creating a list so that we can just go through them all at once because I know you're chomping at the bit to respond here.

Let's see, here, Drew -- Andrew.

MEMBER BAIRD: Hey, there. Thanks.

In terms of new comments, I think that and I'll just say this measure, we've been, you know as Tara said, we've been looking at this and thinking about this measure for a long time. And the way that it's even described in the actual legislation itself, you can tell it's a little different from the other ones because it's about three paragraphs long, as opposed to the other ones being like a pithy phrase about what it should measure.

So this is a giant concept and I think we appreciate CMS putting out -- doing all the work that they've done, multiple comments. We know and have seen that they've listened to a lot of the input.

I think for us the procedure of this

measure is still really hard to say let's just go for it, specifically because of these specifications. And I ask that because of the definition, Tara, that you read, answered I think at least some questions that people had about well what does a reconciled medication list actually mean. If that is not part of the specification, it's really hard to see what it is that we are voting here as this group here, other than just a general description of okay, well whatever is in a reconciled medication list, that's what we're going to say should be transferred.

I caught a phrase that you said about all medications given during that stay, given a particular PAC stay. Again, this is general. And that's a detail that I think that we would really want to hone in on because in the last iteration of this measure, there were specifications that were specifically about medications that were not given during the stay, ones that were held during the stay and to be

continued afterwards. And that's a big discrepancy. Is that now included or is that not now included?

So from sort of a procedural point of view, not knowing exactly what is in this measure at this time makes it hard to say this is great, let's go forward with it.

That being said, I want to emphasize the earlier comments. We know that this is a giant concept and one that CMS has appreciably had to work through on multiple iterations. So again, understanding but also we would certainly like to see more specifications as well or any specifications for that matter.

CO-CHAIR LAMB: Okay, thank you to the discussants.

So what we're going to do now is kind of put all of our comments, discussion topics that we want to bring back to the measure developers, to CMS, to NQF staff together so that we avoid doing the one-by-one-by-one-by-one questions.

So the list we're hearing so far from the discussants with appreciation for the amount of work that has gone into this complex concept and measurement: specifications: what does it mean, operationally, to have a reconciled med list?

Two, timeliness in terms of what does at discharge mean, with the example of there is some information about a reconciled med list that the next site needs pretty quickly?

Third, how to avoid a checklist approach and I think that goes back to specs, which is what information is required that avoids this yup, I did this; nope I didn't kind of thing. The issue of bidirectionality, which in care coordination we call the handshake sort of phenomena, which is if it's sent, is it received? How is that being addressed?

Okay, there are some comments about exclusions. If a patient -- and we're going to talk specifically here about MUC 131, home health, what if someone refuses care from the

home health agency or fires the home health agency?

And then the last one I had: Is there any special consideration for reconciled opioids?

Did I get them all? Okay, let's open it up for what other issues do you want to have on the table so that if we get to that first vote, in terms of accepting the preliminary analysis, which from NQF is conditional support, that we get those on the table?

Okay, so I think, Gene, you've had yours up for quite a while. So, go for it.

MEMBER NUCCIO: Thank you, Gerri. I do want to support all the previous comments but I did have -- and highlight on the bidirectional issue. It really speaks to the validity of the data. That is, if you don't have a bidirectional validation that the information was received, then we can't say that the checkbox yes, I did this is valid. And my guess is that it would fail any kind of review from the Scientific Methods Panel. I'd vote against it, but so

that's just yet another reason why you need that handshake approach.

I have two general questions. One is there a comparable measure to these four measures from the perspective of a hospital? That is when the hospital sends home health its patients, and about 50 percent of home health patients come from hospitals, I would presume more, a greater percentage go to SNFs and other settings but 50 percent come to us from a hospital, do they have this same requirement? And can we -- if they don't, can we help inform them that they should? And if they do, is there anything that we can learn from their measure that might help us with these measures, for example, on the definition of what a reconciled medication list is. That's comment number one.

And number two, in the time line, Tara, that you put up there or maybe on the matrix that followed, there appeared to be a different, a slightly different title to the name of the measure that specifically called out

medications. And there's a whole bunch of information that is in health information but if we're specifically talking about medications, then maybe there should be some reference.

I understand that there might be some legal requirement that it have this title. I think, way back when the IMPACT Act was sent, I thought that there was a request for health information or transfer of health information. And so that might be a recognition of why it is generic but I would suggest more specifically honing in on the fact that this is a medication list.

So those are my comments.

CO-CHAIR LAMB: Raj.

MEMBER MAHAJAN: So just -- I mean this is good. I'm all for it but just a few questions on how it gets done in the field and with specifics to SNF and home health, which is not acute care, per se, because of the status or the ability of the electronic health record.

So within IRFs, which are an extension

of hospitals, they have the same hospital EHRs that are fully capable of doing the med recs --

CO-CHAIR LAMB: Raj, excuse me. If your comment is going to be specific about IRF, let's hold it.

MEMBER MAHAJAN: No, no, I'm just saying --

CO-CHAIR LAMB: Okay, this is general. Okay.

MEMBER MAHAJAN: This is general. It's how it is done. It's my understanding from being at several facilities, that it is still not being done by either the physician, or the nurse practitioner, or the PAs. A lot of times it's being done by nurses. If there is a requirement that it should be done by a physician or an advanced practitioners, number one.

Number two, whether it's being done in some semi or fully electronic format, which is purely paper.

And then finally, when it's being reported -- I mean again that's for any measure,

if it's self-reported, how the reporting is happening because I'm guessing within hospitals, if you're doing a med rec, it won't let you go to the next screen until you're done with it in its entirety because of the system in place. And once it's done, I guess you can have a way to electronically transmit the fact that yes, this was done.

So but within post-acute, where we still have the medication list, even if it is electronic, is not part of the nursing home EHR. And the practitioner workflow might have its own EHR that they might be using their office EHR, which definitely does not have a med list.

So I think this is good to start with but it should be somehow tied into having practitioner workflow integrated within the EHR at the facility that does have some way of electronically reconciling the med list.

CO-CHAIR LAMB: Thank you.

Deb.

MEMBER SALIBA: Thank you. A couple

of things. One is I want to congratulate the CMS that it's going to take multiple data sources, that it's not just EHR; it could be paper, it can be a verbal telephone communication. And I think that's really important from the data we had earlier that a lot of these providers don't have an EHR, your concerns about the EHR issues as well.

So one of the questions I had, some folks have raised this issue of bidirectional and I think it's really important if we learned anything from the fax experience that you know hospitals will just fax data over and the doctors may or may not have received it.

I do want to clarify whether we're talking about that we're recommending that the measure actually look at the receiver to make sure that they confirm they got it or if we're just asking that the sender confirm that they confirmed receipt. I'm not really clear what we're asking for with bidirectional.

Finally, I think it doesn't have to be

a physician that does the med rec list because the pharmacist can do it, and advance practice nurse can do it. Any number of even if the medication list is clear and it includes things like the rationale for the diagnosis under which a particular medication is being prescribed, then it could be done by a licensed nurse. I would feel comfortable with that.

And finally, that gets back to the specifications. I do want to encourage that that includes something about the diagnosis or the reason that the medication is being given. In addition, something about a stop kind of thing, you know how long this medication is to be given for, particularly something like say an antibiotic, you know what the planned duration of therapy would be. That may be in the specs. I just don't know. But if not, I would encourage you to make sure that it is.

CO-CHAIR LAMB: Thank you.

Caroline, did you have a comment?

MEMBER FIFE: Question. I'm sure this

is a silly question but I don't understand why we're not using e-prescribing as a way to do this. It doesn't require that you have a full EHR. E-prescribing modules are bidirectional in that they are like a health information exchange. Anybody with access to e-prescribing can get the data and they look for drug interactions. And nurses can indicate -- even people who are not prescribers can indicate that the patient is no longer on this medicine.

You can see your med history for a year. You can indicate new medications have been started. It's got opioid, all kinds of valuable stuff. Everything that is done for opioids is done through e-prescribing and it is very precisely designed to know what medications the patient actually has gotten and is currently taking.

So it's like a magic pill, no pun intended, for figuring out what medicines the patient is one. That's how we do our med reconciliation. The nurses go into the e-

prescribing, which interfaced with our EHR, goes through the list, asks the patient, are you still taking it, are you still taking it, are you still taking it, and then when I prescribe the medicine, I can see all the interactions that it might have. I can even tell him you know your copay is going to be $12; it will be less if you go to Walmart.

And that just seems like so logical because then every other side of care has access to that same information. So you don't have to worry about faxing and OASIS, and all those other things.

This is a conversation I just had with a friend who works for a home health agency and expressed a tremendous frustration that she can't get an updated med list. And I said can't you get e-prescribing access? And she said, I don't even know what that is.

So it just seems like such a logical solution. There must be a logical explanation why that can't be the answer.

CO-CHAIR LAMB: Thank you.

Rikki is online and then we're going to have one more and we are going to summarize.

Rikki.

MS. MANGRUM: Yes, thank you. And since I am in North Carolina, I would just like to tell everyone it has finally stopped snowing here, which I am very excited about.

One thing that I wanted to pull out and emphasize and was just alluded to is that you know depending on the patient's particular situation and which of these facilities you're talking about, I'm a little bit concerned that the description of the measure, as written, as the medication list will be provided to the subsequent provider, as though there were going to always only be one. And so I wanted to put that on the table as something that we need to be thinking about.

There are sometimes multiple providers. And how is that handled? Does the facility get to pick one? As long as they send

it to one, is that a pass, and so forth?

Thank you.

CO-CHAIR LAMB: Thanks, Rikki.

Andrew.

MEMBER BAIRD: Thanks. I just wanted to respond to Caroline's point, and I'm sensitive to this fact as a provider in a home health space, these measures I think are intended to measure the providers' actions and their ability, I think as Tara said, to initiate, or transfer, or send something. And at least in the home health setting, home health providers don't prescribe the medications, unlike in a rehab setting, in which there is a pharmacist, and a medical director, or a physician who can have that ability. Home health providers, I don't want to say generally I mean in my experience, don't have that capability. And I'm not surprised to hear that your friend says I don't know.

And so my reaction too is saying well, is that a direction that we would want to go in,

if the vast majority of these providers don't even have that competency then? We'd be putting this towards them on e-prescribing. So, just as a home health-specific comment.

CO-CHAIR LAMB: Thank you. We're going to stick to --

MEMBER FIFE: The way to access it --

CO-CHAIR LAMB: Caroline, we're going to stay with the topic. Let's not get into lots of discussions yet.

Let's go back now to the summary of all of these and we're going to turn it back over. I think, Tara, you were getting ready to respond. Do you need me to review the list or are you good?

Okay, Tara's got it. All right, so Tara's going to go through the comments, the questions, and then we'll see where we get from there.

MS. MCMULLEN: Yes, thank you so much. I'm very excited to go through this list to what we can. Just a tee up. Liz is here and Stace

can speak to this as well.

So post-acute care did not receive the RF funding. So we don't have a lot of the not only the funding but the regulatory, I guess, gusto behind post-acute care and long-term care that might pick up adoption rates, that might put us in a different way. So when we talk about measures that are developed for meaningful use for the hospital setting, we're kind of talking about two different galaxies.

I think it's our intent, overall, in post-acute care to increase incentives, or the pickup of adoption and use, and to be able to electronically send and transfer this information back and forth, which is why developed the Data Element Library, as hopefully a tool and a mechanism to be able for us to do that in post-acute care.

There are measures that are used in the hospital setting and we did a robust environmental scan of what our colleagues are doing in those programs, as well as the measures

that have been endorsed here at the National Quality Forum, which there are two of them for the hospital setting. And with the intent of the measure is how it should be specified under the IMPACT Act to be standardized across the four settings. It's the same measure. And what's going on with the specifications, we could not and what's going on with all the meaningful use program in MIPS, we could not adopt those measures into our program at this time but we have had those discussions.

So I want to assure you there has been a lot of thought in that area.

Second, you guys have the measure specifications. They are in your discussion guide I just confirmed with Erin. They are also posted online. So that includes anything from the description to the numerator, to the denominator on down.

If you want to actually -- I don't know if you're asking for the actual what the item looks like. We typically don't submit that

but I'm happy to show you.

And I think it was a great point by the telephone comment about the providers and that's something we'll definitely look into, as well as the points about the exclusion and the bidirectionality.

We did, in 2016, have two measures that assess the bidirectionality. We had one at admission and one at discharge. And what we heard was that in that bidirectional relationship, attribution was very difficult, specifically at the time point of admission, and that we were attributing services to clinicians when they are receiving information and it might not look well upon them as they are receiving it because they actually didn't have a hand in that care.

So we did start in the bidirectional sense because we thought that was an efficient, feasible way to collect that measure and we actually backed off because we heard from the universe this is not good for now.

However, moving in that way seems like something we would want to assess next. We've got to set the paradigm. If we have the paradigm, hopefully we can build from there. Again, positivity. I think we can do this.

In the measure specifications, I heard a lot of questions about how this measure is collected. I do have the definition of a reconcile medication list up so, sorry for the vagueness before. I can be more concrete now. I have it in front of me.

But how this is collected: so these measures are collected via our assessment instruments. So we are focusing on home health. That would be the OASIS. But for like IRF, it's the IRF-PAI and the LTCH CARE Data Set for the LTCH program, LTCH CARE Data Set, and the MDS for SNFs.

So these are data elements and, like anything else, we have people collect these data elements. They submit that data electronically to CMS and we use that information to calculate

the measure. The measure is a construct.

And we are collecting that information or asking folks, rather, to collect that information and send it to us at the time of discharge or around the time of discharge.

It's unique in the home health setting that, at times, you know at discharge that you know folks may not have that information because something has happened to the patient in that stay and we do -- the only difference between all four of these measures is that in the home health measure, for the provider, we do have an N/A option, that the agency was not made aware of the timely transfer because they did not know what happened to that person in the home health agency setting, which, Jim, would give way to some of the comments that you gave. However, I do think that expanding upon that would be rather useful.

Also with the LTCH measure, and we did consider it for the IRF, we do have AMA in the measure, actually.

We do have the measure specifications,

if you want to see the items. They are currently posted online. We have a Post-Acute Care Quality Initiatives webpage, the IMPACT Act or I could give you the link.

The measure specifications have stayed stable over the last year and we had two public comment periods and a technical expert panel. And in fact, I brought it up on my phone. It's the second, the fourth, and the fifth attachments on that webpage under downloads and videos. If you guys want to see the specifications in item form, rather than what is in your discussion guide, we do have that there. And again, I could pull that up.

Ash, thank you for your comment on OTCs. For the purpose of providing guidance for the reconciled medication lists, I do have it in concrete in front of me. So sorry about that. It's a list of current prescribed and over-the-counter medications, nutritional supplements, vitamins, homeopathic and herbal products administered by any route to the resident at the

time of discharge or transfer. We also include TPN and oxygen and current medications that are active, including those that will be discontinued after discharge, those held during the episode and planned to be continued and resumed after discharge and if deemed relevant to the patient's care.

We go in a little bit more detail but this is guidance. The reason that we chose this definition of a reconciled medication list as guidance was because of the stakeholder comment. So we did receive a comment that well, what are we assessing if this is guidance. Well, this was the assessment but the comments were saying well, as an assessment, you need a little bit more flexibility to be able to make way for the provider in some of those care practices and to allow the facilities and the agencies to backend their own care practices. This came from the stakeholder comment.

So what we did is we made this as guidance and the core critical element is the

timeliness of that transfer of information at or around the time of discharge. That's what we're calculating. We're looking at that assessment and looking at the routes at which that was assessed.

Now, this is no readmission measure in terms of its complexity or nothing like you know the complex models that we developed for function but what this information does is it gives way to very important characteristics of the facility and what they're doing to back in that communication in the facility, among facilities, and with the family and the patient, the caregiver, and to other providers.

We also intend to build upon this with the data we've collected to improve on measures, bidirectional measures, or outcome measures that might focus on other types of medications, reconciliations, or whatnot.

And we do have a drug regimen and review measure that we did bring to the MAP, Alan and Stace, like two years ago. It's currently --

or three years ago now. It's currently used in all our programs. It's going to be collected and it started in the Home Health Quality Reporting Program and that measure does assess for discrepancies and what's going on in that reconciliation process. And so hopefully with that data, we can backend and build a very robust measurement set in that area.

We did hear a lot about opioids. Between Alan, Stace, and Mary, and myself, our ears are peeled, our eyes are open to what's going on and we're very aware that you can't close your eye or turn our head, or however the statement goes, to that. And we definitely can consider adding opioids or the use of in the definition of reconciled medication list and CMS has made it very clear that future measures would consider measurement in that area, particularly outcome measures and performance-based measures.

I think that's it. I do think that's it. Those were all the comments and questions we received.

If you guys want to see the items, let me know and I hope that helps backend some of those questions, questions about the medication list. Again, in the discussion guide, you'll see the specifications.

I do just want to backend the description for this measure reads that this is a process measure that calculates the proportion of patient or resident stays, or quality episodes with a discharge or transfer assessment, indicating that a reconciled medication list was provided to the subsequent provider at the time of discharge and transfer.

And I believe that's all I have, Stace or Alan, if you have any other comments.

MS. MANDL: No, Tara, I think you summed it up extremely well.

CO-CHAIR LAMB: Thank you, Tara. That was great.

Additional comments/questions before we go into the vote on preliminary analysis?

Danielle.

MEMBER PIEROTTI: Thank you. I just really wanted to point out we've been having this conversation for a couple of years now and the measure has evolved. And as a practicing professional registered nurse for 25 years, whenever I hand off a patient in whatever environment, it is my responsibility to ensure communication of core safety items. So regardless of whether this measure addresses the other guy, there is an obligation that I am doing my work, which means I am providing the information.

There is no measure that is going to be all things to all people. We have to be clear this is a measure about when we discharge, in this very specific conversation, from home care but applicable across the other settings, when we discharge a patient, are we providing an appropriate handoff. The measure isn't trying to fix everything and it's very clear about that.

The only question I have left is the definition of timely. And since it's part of

OASIS in this particular situation, I would assume it means within the way OASIS is defined as timely but that's the only piece that I'm still questioning. Thank you.

MS. MCMULLEN: Yes. Thank you, Danielle, that's correct in terms of the context of the assessment instruments and how the program yield that data and treat that data. So in the context of the OASIS, it is in how the OASIS data items are currently collected, with the consideration that sometimes the discharge assessment is not being filled out as the person is leaving that agency or that facility setting.

It's difficult to nail that down at discharge because discharge could mean different things, different collection periods and stuff.

CO-CHAIR LAMB: I'm not able to see. Is that Liz or -- it's Liz and Andrew, okay. So Liz, why don't you go first and then Andrew?

MS. PALENA HALL: I just wanted to offer another data point from the ONC data brief that we just published about two weeks ago.

So one of the questions that we asked was the percent of SNFs and home health agencies with an EHR that used medication management functions. So specifically, we asked about their ability using their EHRs to reconcile patient meds. Ninety-eight percent of home health agencies had the capability in their EHRs to reconcile the meds. Eighty-three percent of SNFs, similarly, had that capability. Ninety-nine percent of home health agencies had the ability to record patient meds and 87 percent of SNFs had the capability to record those medications.

So I just wanted to offer that data point.

CO-CHAIR LAMB: Thank you, Liz.

Andrew?

MEMBER BAIRD: So I'm going to hang myself up here on this procedural issue. Is the measure that you guys are specifying for which when the MUC list was released last week used different vocabulary words than the one was

specified in our draft specification back in March?

Is this the same measure?

MS. MCMULLEN: Yes.

MEMBER BAIRD: Because the definition that you just read, which is not available in any of the materials, at least associated formally with the MUC list -- is this the same measure as from March?

MS. MCMULLEN: Yes, I think I emailed you about this one last week, too.

MEMBER BAIRD: Right, that's why I'm confused.

MS. MCMULLEN: So we had a -- no it's the same response.

So what has changed from the time that -- so we run a very specific time line in development. So when the MUC list within an application that we called here as occupied, that's early, early, early 2018 and we're still doing a lot of development efforts in 2018.

So when we put this on the MUC list,

since that time what has been revised is the following: The term medication profile revised to the term reconciled medication list and the measure name. So now we just call it Transfer of Health Information to Provider Post-Acute Care when it had some sort of a robust name before. And that's actually on the second slide of my presentation.

The guidance for a reconciled medication list was pared down. So in early 2018, we were actually requiring that everyone send a reconciled medication list and then the stakeholder comment came in and said we should take a step back from that. And we reviewed and we said we can give this as guidance and have the element, the core critical element for calculation be the transfer of information. And that's how it's specified.

The guidance, at that time, was a bit more robust and was in checkbox form. Since that time, since we stepped back to guidance, it's just kind of a definition and that is

prototypical of what we do in quality measure development and our guidance manuals in post-acute care.

So after we develop a measure and it's proposed, and say adopted into our program, we conduct national training and provide guidance manuals. And in our guidance manual we tell the clinician this is how you can collect the data element; this is what this means. At that time, that's where the guidance goes.

The reason the guidance is not online nationally right now is because the measure is not even in proposal form. We're not educating on it yet. We were still -- we just capped off development. So this is all iterative and fluid.

But I do emphasize in backend the changes for the measure under consideration are just two changes: one, the measure name, and two, a medication profile to the name reconciled medication list.

MEMBER BAIRD: Thank you.

CO-CHAIR LAMB: Thank you. Any other

comments/questions before we move into the first vote?

MEMBER HOPPE: This is Kurt Hoppe. I appreciate that CMS is going to look at opiates and since I brought up that issue, I wanted to just submit a plea to CMS for whatever is done in that particular area, that they do it in coordination with other federal agencies, as well as the states.

There is so much going on in the area of opiates that we don't want to have multiple burdens upon the provider to provide those medications and other specifications in the measure that may conflict with what the states do or are in total contradiction.

Thank you.

CO-CHAIR LAMB: Thanks, Kurt.

Okay, we're ready for our first vote. This is a preliminary analysis assessment vote and it is specifically on MUC2018-131, which is the Home Health QRP. It's not all four. We are only voting on home health.

And if this is -- let me just make sure I read it correctly -- do you accept the results of the preliminary analysis assessment of the recommendation of conditional support, pending NQF endorsement?

MS. O'ROURKE: Sure, I can clarify here a little bit and, Gerri, please feel free to jump in.

So this vote is if you agree with the staff assessment -- or if you think we're prepared to accept this staff assessment, preliminary or conditional support pending NQF endorsement, you should vote yes here.

If you feel there is a need for further discussion and you want to throw that staff assessment out, you should vote no and we then we will go through the four categories of support, conditional support, do not support with potential for mitigation, and then the do not support option.

I can try to explain again. Staff put forward the conditional support pending NQF

endorsement, given that this is not an NQF-endorsed measure but recognizing the work that CMS has done to address public comments since MAP has reviewed it last time but submitting it for endorsement would provide that opportunity to resolve some of the questions around the specifications and exactly what items are on the measure that I think Tara was trying to do today, and do a deeper into the results of the reliability and validity testing that MAP is not really constituted to do. So that's why we wanted to highlight the potential need for NQF endorsement.

But again, all options would be available for the workgroup if you vote no here but hopefully that clarifies it.

CO-CHAIR LAMB: Desi, are we ready?

MS. QUINNONEZ: We are ready to vote for MUC2018-131 and this vote is do you support the preliminary analysis as the workgroup recommendation. Option 1 is yes; option 2 is no.

And you may enter your votes.

CO-CHAIR LAMB: And just to remind you, the preliminary analysis was conditional support pending NQF endorsement.

MS. QUINNONEZ: Okay, it looks like we have 20 votes in and it's 90 percent for yes and 10 percent for no.

MS. O'ROURKE: Gerri, can I make one more comment?

CO-CHAIR LAMB: Of course.

MS. O'ROURKE: I just want to thank everyone for that great discussion and let everyone know that we pass all of that along to CMS, the comments specifically about the measure, as well as some of the great ideas I think the workgroup had about future direction for measurement or ways to enhance this.

So we will capture all of that and put that out in -- we have two major deliverables that will come out of this workgroup: a spreadsheet that has every measure and your recommendation on it, as well as a report that gives us a chance to write out some of this

context and the points in discussion back and forth.

So we just want to highlight that this won't be lost and all goes on to CMS for their consideration.

MS. QUINNONEZ: And just to spell out the totals, so that 18 individuals that voted yes and two individuals that voted no.

CO-CHAIR LAMB: Thank you, everyone.

We just went through some general questions and concerns for all four. So I'm thinking if it's acceptable to everybody, we don't need to do all the general again as much as now we're going to become specific to the setting to see if there is differences or any things that you want to emphasize.

Alan, did you have a -- okay. All right.

All right, so we're going to move then into MUC2018-132, the Transfer of Health Information to Provider -- Post-Acute Care -- provider. We're going to go through patient

later. And this is specific to IRF QRP.

And we have the same reviewers, if I can find my list here somewhere. Here we go. All right, so how about if we just move it around a little bit and we're going to go backwards this time? Andrew, Kurt, Jim, and Ash.

Andrew, do you want to start? Specific to IRF, if there is anything general that you just can't stand not reinforcing again, you go for it, but otherwise, stay pretty specific to IRF.

MEMBER BAIRD: Sure. In the rehabilitation hospital world, we are required and routinely to provide a discharge summary for all our patients, since we operate like an acute care hospital and they are governed by the Acute Care Hospital COPs. Much of this information for the rehab providing setting is duplicative of what is provided in a typical IRF discharge summary.

So again, there's a little bit of ambiguity here as to what this measure is exactly

of everyone. And the reason I asked these questions about March is there was a list of about 25 specific items that CMS released that said that they needed to include the medication profile in order to satisfying transferring successfully a medication profile. And if I heard the response right, the only change is that the word medication profile is now reconciled medication list.

I guess I'm hearing that those 25 or 24 items are still going to be targeted for review to determine I guess measure success. And my point is that a lot of those things, including patient preferences in terms of like what types of packagings medication can use, adherence strategies, so on and so forth for patients. A lot of those are already covered in discharge summaries for rehab hospitals, specifically. I can't speak for the other settings.

CO-CHAIR LAMB: Thanks, Andrew.

Let's go to Kurt.

MEMBER HOPPE: I don't have any really

specific additional comments from Andrew, as well as the ones that I provided for general, except for the fact that the understanding that IRFs like long-term acute care hospitals tend to take perhaps sicker patients than some of our other settings.

And so being able to, as we move through our requirements for post-acute and IRF in particular, that there is some kind of congruency with what the acute hospitals are required to do because even though our EHR requires a certain amount of acceptability before a discharge summary or a medication reconciliation is sent to us, that sometimes we find that the acute hospitals have a different definition from us, at least in a practical operational standpoint, than what we consider to be a properly reconciled medication list.

And an example of that is some medications, for instance the patient has surgery, are taken off before surgery and that really doesn't become the medication

reconciliation activity that is transmitted to us when we have a patient that is recuperating and undergoing rehabilitation. And sometimes we struggle to figure out, especially from hospitals outside of our acute hospital wherein exactly and why those medications were taken off. We have not had any major patient issues but we have had some near misses.

So as we go through this, just a call for congruency between the acute hospital and an IRF, and perhaps even an LTCH, as to exactly which medications were left off within the last 30 days and the reason why. I'm not sure exactly how you do that but we do find that to be one of our biggest particular issues.

Otherwise, I don't have any more specific comments regarding the IRF measure.

CO-CHAIR LAMB: Great, thank you.

Jim.

MEMBER LETT: Oh, thank you.

Two brief comments. One is exclusions. Although it would be unusual if a

patient were to leave against medical advice, should that be removed from the denominator? And maybe some clarity in the specifications about a patient moving from the facility to the emergency department. Some people in the facility will call it a discharge, others will call it a transfer. It might be good to just clear up that gray area with some comments.

Thank you.

CO-CHAIR LAMB: Thank you.

Ash.

MEMBER TRIVEDI: I don't think I have anything different. I think some of my questions were already answered. So that was great.

I think sort of around the granularity around med rec lists, I think the OTC issue was answered.

Also I think you covered about medications that were held prior to even acute care. So just sort of having that medication history prior to acute care, and then post-acute care, and then upon discharge as well.

I think you also touched on specificity around what timely transfer means.

So beyond that, there's nothing else.

CO-CHAIR LAMB: All right, Tara, are you ready to go?

Actually, I'll open it up for other questions/comments about IRF.

MEMBER SALIBA: Just one question. I don't see just transferring the information to a PCP. Is there a reason for that?

MS. MCMULLEN: Yes -- I'm sorry, Gerri. I didn't mean to do that. I apologize.

CO-CHAIR LAMB: It's okay, Tara. We're in the same boat. Anything else? Okay.

MS. MCMULLEN: Yes, just two comments. Thank you, guys. Thank you everyone, for the comments, again.

A lot of good stuff here. The first one is about the congruency. We completely concur. In fact, having aligned measures across all the settings I think is the ideal state to launch data. Someone traverses the care

continuum, looking at them, me being a researcher, looking at longitudinal data, I think that's the ideal state. We totally concur.

I do want to add, though, in the current state where we don't have measures that align across the settings at the current time, we did take into account the COPs and all sorts of the SOWs, what was going on in the settings that guide care.

So with IRF and LTCH -- I know that we're not on LTCH -- but with IRF, we were looking at the COPs. We did look at the discharge planning requirements to ensure that we were not going over and beyond but that we were running the same race. So I do want to add that reassurance.

Specifically for PCPs, we do ask that the denominator for this measure be calculated by discharges that go to short-term general hospitals, SNFs, intermediate care, home care under an organized home health service organization or hospice, hospice in an

institutional setting, a swing bed, another IRF, an LTCH, a Medicaid nursing facility, and an inpatient psychiatric facility or critical access hospital.

So we're looking at the facility discharge in terms of the PCP. We did have that in the measure at some point and that is not in the measure now and I can look back to why. This was I think two and a half, three years ago that we were considering this in discussion but I could go back and look.

I know -- I forget. I'm foggy why that's not in there but we're looking at discharge location.

MEMBER SALIBA: And I was thinking about it with IRF especially because these folks are more likely to be discharged to the community, as opposed to another institutional setting.

MS. MCMULLEN: Yes, for sure. I can go back and look it up.

CO-CHAIR LAMB: Tara, any more

comments?

MS. MCMULLEN: No, that's it. Thank you. I'm sorry.

CO-CHAIR LAMB: Okay, any other comments before we go into the preliminary vote?

MEMBER HOPPE: I just wanted to comment upon the comments.

A lot of times we do -- I realize the discussion regarding PCP does not really fit this particular measure but we have to be cognizant. You'd be amazed how many people don't have a PCP to send this information on. And despite our best efforts to try to get them before they leave, that should not necessarily be part of a measure requirement.

CO-CHAIR LAMB: Any other? Drew.

MEMBER BAIRD: Hey, there. I'm going to defer to my colleague, who I was introduced on the phone earlier today. Her name is Mary Ellen DeBardeleben and she is our National Director of Quality. And she did have a comment and a specific question about this IRF-specific

measure. So I just wanted to defer to her, since you work very closely on this stuff together.

Mary Ellen, are you there and can you hear me?

MS. DeBARDELEBEN: Yes. Thanks, Andrew. Can you hear me?

MEMBER BAIRD: Yes.

MS. DeBARDELEBEN: Great. I just wanted to ask about the specifications and I appreciate Tara clarifying the specifications and where to find those. I wanted to ask about once the measure is formulated it goes into the program. One of the most important kind of end results of a measure is how it eventually gets displayed on the public reporting site.

And I just wanted to ask if there's been any consideration on how this measure will eventually be displayed in that format.

MS. MCMULLEN: Yes, this is Tara. That's a great question. We're still having those discussions.

The one thing that we do know, since

we just closed out the developmental phase, so we're looking at the construct right now thinking about what's going on with it. We do know that this measure yields a different type of information for us, looking at practices. And it's not like this performance could be/could not. We're discussing this but we do know that we want the information to help inform, like I said, shared decision-making and discharge planning. So at this point, we're still considering how that would look on a compare site.

MS. O'ROURKE: I just want to make all one process question -- or not question -- point. If organizations could make sure there's only one person representing them at a time. I know that was a very technical question but for discussion and voting, we can only allow one participant per organization at a time.

CO-CHAIR LAMB: Okay, so are we ready to move into the preliminary vote? This is on MUC2018-132, Transfer of Health Information to

Provider Post-Acute Care specific to IRF QRP.

Desi?

MS. QUINNONEZ: Yes, thank you. And you may now submit your votes for MUC2018-132 and the question reads: Do you vote to support the preliminary analysis as the workgroup recommendation?

You may enter your votes.

CO-CHAIR LAMB: And again, the preliminary recommendation was conditional support, pending NQF endorsement.

MS. QUINNONEZ: I'm looking for just a few more votes.

We're at 18 votes now. There we are. Thank you for submitting.

All right, voting is now closed. And we have 85 percent voted yes and 15 percent voted no.

And I will give you your totals. So for your total count, 16 individuals voted yes and three individuals voted no.

CO-CHAIR LAMB: Thanks, Desi.

Okay, we're going to move into 133, which is the LTCH. And again, do you have anything new to add on this?

MS. O'ROURKE: No, nothing new. The preliminary analysis assessment was, again, conditional support pending NQF endorsement.

CO-CHAIR LAMB: Okay, so then we're going to go to our discussants again. And again, since we're doing LTCH, if you would, make it specific to LTCH.

Ash, do you want to start us off?

MEMBER TRIVEDI: I have no specific comments for LTCH.

CO-CHAIR LAMB: That was easy.

Jim.

MEMBER LETT: Thank you. I addressed this issue with the last one, regarding clarity and specifications around discharge versus transfer when a patient is sent to the emergency room.

CO-CHAIR LAMB: Great. Thank you, Jim.

Kurt?

MEMBER HOPPE: I don't have any specific additional comments for LTCH.

CO-CHAIR LAMB: Thanks, Kurt.

Andrew?

MEMBER BAIRD: No, thanks.

CO-CHAIR LAMB: Okay, open it up. Anybody have any specific questions, concerns, issues related to LTCH?

We're making it too easy on Tara here. I'm sorry.

All right, are you ready for a vote? All right, Desi.

MS. QUINNONEZ: Okay, we are voting now for MUC2018-133. Do you vote to support the preliminary analysis as the workgroup recommendation? Thank you.

You may submit your votes.

Okay, we're looking for just a few more votes. We're at 17 now. Looking for one more vote. Okay. All right, voting is now closed.

We have 89 percent of individuals voted for yes and 11 percent voted for no. And I will get you your count for you. Okay, so that is a total of 17 individuals voted yes and two individuals voted no.

CO-CHAIR LAMB: Okay, we're going to move into the last measure in this set. This is to the provider. It is MUC2018-136 and it is the SNF measure.

Anything additional, Erin?

MS. O'ROURKE: No, nothing additional on the staff perspective.

CO-CHAIR LAMB: Okay, then we are going to go to our discussants and let's just do it again, Ash, we'll put the pressure on you. Anything specific to SNF?

MEMBER TRIVEDI: Nothing specific. No comments.

CO-CHAIR LAMB: Okay, thank you, Ash.

Jim?

MEMBER LETT: Just a few things. One exclusion -- patients who may leave or residents

who may leave against medical advice. Are they going to be in this measure?

The gap about discharge versus transfer. A large number of SNF patients will go to an outside specialist for a consult, may end up getting admitted to the hospital, get sent to the emergency, may get admitted to the hospital. And just some clarity and the specifications about how those should be handled.

Because the vast majority of people who are discharged from a skilled nursing facility will go to the community, I think Deb's point about primary care, whatever that definition may be is important but transferring these things electronically may be extremely difficult. If it is a clinic and it may be a free clinic that doesn't have electronic transfer, or electronic access to the internet, I'm just concerned about the ability to electronically transfer, trying to find the email address, all those types of things can be a problem. So I'm not saying it should be an

exclusion but at least write that into the specifications or into your consideration, please.

And if I may, Deb, your very good, germane point about what is a bidirectional transfer, whose responsibility, our position is that it would be the responsibility of the sending provider to document in the chart spoke with Mary Smith on 12/10/18 at 4:00 p.m.; they received it; and questions answered.

Thank you.

CO-CHAIR LAMB: Thanks, Jim.

Kurt?

MEMBER HOPPE: I have no additional comment.

CO-CHAIR LAMB: Thanks, Kurt.

Andrew?

MEMBER BAIRD: No, thank you.

CO-CHAIR LAMB: Okay, Tara, any -- oh, let me -- I jumped. We'll get this down, yet.

Any other comments, concerns, questions? Deb, is yours up?

MEMBER SALIBA: Just a couple of things. One is that I'm glad that you define it as sending. I just wanted to make sure that we did confirm that that's what it was because I agree.

The other in terms of the discharge or the receiver of information, I think if it's not PCP, and I just use that as a short-term, it's whoever the discharge follow-up appointment is being scheduled with. I mean it's sort of a standard of care that they should be being scheduled to be seen by someone within some window after discharge. So you know I use PCP as sort of a shorthand. And you're right, it may not always be a PCP.

And again, there are multiple modalities through which you can transfer this information. It doesn't have to be electronic.

And then I think AMA, I'm not sure I would encourage including that as an exclusion because, again, this is -- they're being discharged to a provider in this thing. So some

discharge planning has been taking place. And even it's not -- even if we don't want them to be going home at the time that they're going home, they're still going to need their meds when they leave and those meds still -- in fact, it may even be more chaotic and more of a need to make sure that that has been transmitted.

So I would say that I wouldn't necessarily add against medical advice as an exclusion or making sure there is a transmitted medication list.

CO-CHAIR LAMB: Other comments/questions? Gene. I'm sorry. He's right in front of me. Is it your turn?

MEMBER NUCCIO: Deb and I are not fighting.

Just a clarification about the provider set of measures and the ones we're going to be talking about later about patient. If provider, PCP or the responsible medical individual for the patient who we're sending home, if that's included in this set of

denominator, then every medical facility or home care agency will be getting measures on both this set of items and the next one; that is, if provider is part of this one.

If provider is part of the sent to the patient, is that also -- again, I didn't have the set of denominators for that second group but if it truly is discharge to the patient's home in some sort of independent state, then you could put it with that one and then everyone would get one or the other. But if we put PCP as part of the first one, then every healthcare provider is going to get two measures all the time.

CO-CHAIR LAMB: Jim.

MEMBER LETT: I apologize, I was just thinking about an unusual scenario that can happen within a skilled facility and that is a resident who is residential long-stay there gets ill, goes to the hospital, returns to the facility but in the skilled portion, and is then discharged from skilled back to the same bed they were in when this whole merry-go-round began. Is

that a discharge and maybe something in the specifications? I'm not trying to be too labyrinthine but it happens.

MS. MCMULLEN: Yes, that would be a discharge and this measure would be collected at the time of that discharge from the SNF. That would be a discharge, technically. The MDS would need to be occupied. For the skilled nursing facility setting, it would be the NPE. Tom said it would be a part APPS discharge and that's where this measure would be collected.

CO-CHAIR LAMB: Deb, is yours up again?

Okay, Raj.

MEMBER MAHAJAN: Just quickly on AMA, a lot of times when that happens it's fairly rapid and the providers -- and again, it's more important in the next discussion -- is that they don't want it and so providers should not be held liable for the fact that the patient left against and they didn't want it and there was not enough time to do it. So exclusion would probably make

sense.

CO-CHAIR LAMB: Tara, do you want to respond to anything? I think many of the issues that came up were kind of let's pay attention to these across all the measures. Is there anything that you'd like to address? Okay.

MS. MCMULLEN: Just the PCP/PMP discussion. I think we can definitely take them into consideration. Gene is right about the double documentation in the provider measure. The patient measure has a different denominator, has different settings and I think that that's definitely where we could take them into consideration. Those are the next four measures and that's the primary change minus the population between these two measure sets.

CO-CHAIR LAMB: Thanks, Tara.

Okay, are you ready to vote? The preliminary vote is on MUC -- we are on 136, provider SNF QRP. And the recommendation on the table -- whoops, sorry -- is conditional support pending NQF endorsement.

Desi?

MS. QUINNONEZ: Okay, thank you.

Voting is now open for MUC2018-136. Do you vote to support the preliminary analysis as the workgroup recommendation?

You may enter your votes. Looking for just a couple more votes.

All right, voting is now closed and we have a total of 19 votes in, 18 reflected on the screen as 94 percent voting yes and six percent voting no. I'm going to add in his vote.

Okay, as a count, we have 17 individuals voting yes and one individual voting no.

CO-CHAIR LAMB: Okay, thank you, all. We got through that. Excellent. Excellent. And thank you, Tara, for all of your wonderful comments.

Okay, so let's just kind of take a check on time here. We were supposed to go into a break about an hour ago so, thank you for sitting in your seats and voting. Would you be

willing to, because we were supposed to move into public comment, would you be willing for us to open it up for public comment at this point and then take break and lunch? And then perhaps shortcut, moving around at lunch -- you know take 15 minutes to get your lunch and then we'll go into the patient measures. Would that be acceptable to everybody?

Okay, thank you so much.

Okay, so let's move into public comment. And again, we'll start with folks in the room. If you would, if you have comments, please come up to the mike.

Okay and if you would open it up to people on the line or chat.

MS. QUINNONEZ: Hi, Cathy, Operator, could you open up the lines for public comment, please?

OPERATOR: Certainly. At this time, if you would like to make a public comment, please press *1 on your telephone keypad. Again, that is *1 for public comment.

CO-CHAIR LAMB: Okay, so thank you.

Let's everybody take a 15-minute break, get lunch, wander, whatever, come back at about a quarter of so that we can start into the next group.

Thank you all.

(Whereupon, the above-entitled matter went off the record at 12:31 p.m. and resumed at 12:48 p.m.)

CO-CHAIR MULHAUSEN: Because I am worried about time and losing some of our key people, due to time, I'd like to just make this a working lunch and get started on our next agenda item. And this will be to get your input on the measure under consideration which is the transfer of health information to patient post-acute care.

As with the transfer of health information to provider, we've chosen to organize this as sort of a combined review and discussion, but want to give you the option to review each of the measures individually. And again, the default is if a single member of the work group

wants to discuss these one by one, we will. And if not, we will go through the same procedure, except collectively.

All right? So is there anybody in the work group presently, either on the telephone or at the table, who prefers to go through these individually, especially in light of the process we just went through with the past measures?

Here in the room, I see nobody raising their hand. How about on the telephone? Okay, so we will review these measures as a group and we'll start the process by having our NQF staff review.

MR. STOLPE: Thanks very much, Paul. Wait, did you want to do this? You're sure? All right. Okay, thanks very much. This is Sam Stolpe with NQF.

Well, just to start off, the measure description for the transfer of health information to patient is remarkably similar to the measures that we just reviewed, but of course, the purpose of this measure is to assess

for and report on the timely transfer of health information when a patient is discharged from their current setting of care.

The thing that we wanted you to keep in mind about this is once again, this measure meets some IMPACT Act requirements, addresses the PAC/LTC core concepts not currently included in the program measure set and promotes alignment across these programs. So NQF staff did give this the same rating -- recommendation as the previous measure set which is that they do move forward conditional upon approval of -- sorry, endorsement by NQF.

So the only other thing that I'll note is that we had a couple of public comments on each of these measures, and I'll summarize those very briefly. Similar to the other ones, there was some requests that CMS tighten up specificity. There was a note that assessment items used to report data haven't been finalized. There was also a note that the route of transmission, the comment related to stressing

that the lack of association between the route and the quality of the record that's received. And then there was some more comments on what specified -- what constitutes a reconciled medication list as the primary comments. I'm sure we'll revisit some of those during our discourse to follow, but with that I'll turn it back over to Paul.

CO-CHAIR MULHAUSEN: Okay, great. Thank you. So we have four lead discussants that I'm aware of and I'm just going to list them off and then we'll go down the list of Gail Hunt, Danielle, Raj, and Deb. So why don't we start with Gail.

And again, as we go through the series of lead discussants, if you can, just for expediency to limit your input to that which has not already been discussed.

So Gail, why don't you go ahead?

MEMBER HUNT: Thank you. I didn't get the word incidentally that I was going to be a discussant until this very second because they

didn't even know I was coming. So how would they know. So I can pass on to the next discussant

CO-CHAIR MULHAUSEN: Very good. thank you, Gail, for your input and your willingness to be put on the spot.

So Danielle?

MEMBER PIEROTTI: For me, the primary point I just really want to make is the definition of a reconciled list is even more critical here than it is in communicating with the provider. Communicating with patient and family absolutely critical, but it has got to be only current meds. If it starts to try and include everything that they've ever had, anyone thought about giving them might have been in the room that they were inhabiting, useless, absolutely useless. So as long as the definition of a current reconciled medication list actually means only the meds you are supposed to continue taking, that for me, stands for all six.

CO-CHAIR MULHAUSEN: Raj?

MEMBER MAHAJAN: Just to add on to

Danielle's comment. I think there needs to be more guidance for providers to do it the right way because what goes to patients, if it's done exactly the same, if you're just printing out the same copy that's going to the provider, next provider, if that goes to the patient and the family, it just causes more trouble than help.

CO-CHAIR MULHAUSEN: And Deb?

MEMBER SALIBA: I agree that this is a good measure. It's important. I think that it would be helpful as more of a gap issue, not in condemnation of this measure at all, to also think about health literacy and the ability of the individual to report back that they understand the information that's been given to them. I'm wondering if that's in CAHPS or not. I can't remember, don't remember. But it would be a gap thing to add, but this measure I like.

CO-CHAIR MULHAUSEN: All right. Which gives us the opportunity to open it up to the work group for either comments in addition to what's already been discussed and needs to be

brought to the attention of CMS, or if there are issues regarding specific settings in which the measure will be applied.

Andrew.

MEMBER BAIRD: Thanks. I just reiterate Danielle's and Raj's comments here. If we're including things like just the straight list of all medications including prescribed, over-the-counter, nutritional supplements, vitamins, homeopathic, herbal products, TPN, and oxygen that were active, including those that will be discontinued after discharge, as well as those that were held during the current PAC stay and need to be resumed after discharge, that sounds like a confusing mix of things that could potentially add to patient confusion about which medications to take. And therefore, I think, using that specification which as I understand it is the specification for this measure for the definition of reconciled medication list, and that would potentially pose a greater risk to patients getting, like Danielle said, the

information that is most essential to what they need to avoid an in-home medication error.

CO-CHAIR MULHAUSEN: Gene?

MEMBER NUCCIO: Just some clarification in terms of the definition of numerator, denominator, and also following on Danielle's, I think, comment, if a PCP is not included in the transmission list, then while patients typically can't decode what a PCP needs to know. Giving the patient both versions, a PCP kind of version, and the more consumer-friendly version I think would be a good idea unless you added it in here.

Also, for clarification, if a patient goes to like an assisted living facility with hospice care, does the discharging agency -- is that required to go --- the information go to both? And is it sufficient for the assisted living facility to receive the consumer-sensitive version of the information, that is, if you have a patient with limited literacy discharged to his or her home, then you want a sort of simplistic

list of what they need to do and how often they need to take it. If it goes to a more formal setting like an assisted living setting, they might want the more rigorous provider level kind of documentation. So it's the question of what sort of documentation are you sending with level of detail.

CO-CHAIR MULHAUSEN: Jim?

MEMBER LETT: Thank you. Just hopefully, it's implicit somewhere in the specifications that this information that goes to the patient/family is given in a language that they understand and in a format that they understand, that is, with health literacy things at issue.

And also, just the conciseness of it. I was doing a lot of recent chart reviews and I noted that the discharge instructions could go 40 and 50 pages. Most of it, stuff that is simply, God bless them, bless their hearts, as we say in the South, it's mostly attorney verbiage. They are given instructions not to smoke when they're

not smokers. They're given instructions in English when the chart says they don't speak or read English. So hopefully that's implicit. If not, it would helpful if it is.

CO-CHAIR MULHAUSEN: Andrew.

MEMBER BAIRD: I guess I'm just -- I mean this is a great point. I think understanding the specifications as they've been given, the concern and just to maybe draw this back to our task is that the specifications will drive providers to over supply information and it becomes -- it just becomes a risk at that point. And so that's why I think this does really have relevance to like how is this measure specified? Because the measure as it's specified is what's going to ultimately shape what information a provider does send to a patient. If a provider is required to go through each medication, provide -- even things that are discontinued and provide patient sensitivities or patient-adhered strategies to medications that are no longer being used, then providers are going to do that.

I mean because it's going to be required. But I don't see that helping the patient to tie my other point back to Jim's.

CO-CHAIR MULHAUSEN: Okay. Any other comments or reflections from the group?

So I'll attempt to -- is someone --

MEMBER HOPPE: Kurt Hoppe. I just have one additional comment about these measures. A lot of times when patients, even my own parents, when they get a medicated reconcile -- a list of medications they should take, sometimes there isn't explicit instructions on certain medications where dietary restrictions are paramount. I'm thinking here about Warfarin. I'm thinking here about antibiotics and certain medications you shouldn't take with it or rather foods you shouldn't take with it. So I think that we don't want to overwhelm the patient. We do want them to understand that essential for compliance is not only taking medication, but in a few high-risk areas, however we define that, there may be dietary modifications or things to

look out for that you eat that may impair the physiology of metabolism.

CO-CHAIR MULHAUSEN: Thanks, Kurt. And I heard Rikki on the phone. You also had some reflections?

MS. MANGRUM: Yes, and I would start by echoing what was just said about the dietary restrictions and requirements. I think not only what to avoid, but in some cases, what to make sure you're getting. And I think -- I perceive a problem when patients are given -- the family are getting simplistic instructions like maintain a low potassium diet without ensuring that they understand what that means or providing them with dietary guidelines for what they can and cannot eat to achieve that.

I think a bigger question that I have, when you look at the specifications, this is for patients who are being discharged to some kind of home or home-like setting, but if there is going to be a concise, plain language, clear, patient-centered, oriented list generated, then I wonder

why it wouldn't be given to patients and family members regardless of where they're being discharged to. So if they're going from an LTAC to a home health agency, why not also provide the patient and family with this list. I think there's evidence that suggests that empowered, educated patients and family members are good safeguards against medication errors inside hospitals and other places if they have information to operate from. Thank you.

CO-CHAIR MULHAUSEN: Thank you. Anybody else on the telephone have any questions, comments, or reflections?

So Tara, I hope you kept better notes than me, but here's my summary of it.

So again, specifying what the definition of a reconciled medication list is, especially in the context of the patient, their family, their language and literacy needs. The second reflection was issues surrounding the context of the medication administration like dietary restrictions and requirements and timing.

And the last one was the restriction of the measure purely to settings in which residents or patients are discharged to a home-like setting.

MS. McMULLEN: Thank you. Thank you for all the comments. A few things. So again, the measure specifications are in the discussion guide. Currently, the denominator for these measures for all four settings are that we are assessing a discharge or transfer to a private home and an apartment, boarder care, assisted living, group home, transitional living or home care under an organized home health organization or hospice.

So there was a question about the settings and if you were discharged to an assisted living and there was a hospice, is that case that measure, the denominator would be triggered and this individual or whoever would fall into that population for reporting.

The medication list, the guidance that we have given and going back to the last measure, guidance is given when we're trying to

operationalize the measure. We're currently in the development phase, so CMS hasn't put up any final specifications. of course, we have to propose these measures before we implement them in a program. But the guidance that we have been thinking through would be analogous to the guidance given for the other measure.

However, in terms of health literacy, I did hear we need to make things understandable and clear for the individual, for their family and caregiver. And we give very specific guidance about plain language and the applicability of concepts that are understood to the individual. My father knew so much about medications, but didn't know the rest of the world which his discharging physician or his oncologist was telling him what was going on. So we ensure that plain language was in there.

However, there was a point about making that list not only universal and understood in plain language, but updating the current medications and I think that's a great

recommendation and we'll take that back.

There were a few more. Again, the primary care physician, taking that into consideration for this measure is something that we will definitely take back as well as it's 100 percent applicable.

Oh, I know what I was going to say. So for the -- also for the reconciled medication list, when we were developing the list for this measure, there was the consideration that there might be different circumstances given that you're talking to a proxy or a caregiver, a family member, and so we were falling in the line with clinical practice guidelines from JCAHO, their home care accreditation guidelines, as well as guidelines from AHRQ.

And specifically the Joint Commissions guidelines states that at discharge, medication information should be sent to the family, patient, caregiver, discharge transfer and in that information that's to be sent at discharge that the patient should be provided or family

member with written information on medications and that specifically means dose, route, purpose and the person's name, all their information about who they are. And that that discharging information should explain the importance of managing that medication information.

So JCAHO has suggested as a clinical guideline, which is seen as kind of a gold standard, that you go above and beyond and you give the information, all the information so that family caregiver or the patient could use that at discharge. We fell into line. We do not go into detail about the explaining the importance of, but we do go into detail about what are the medications and what's going on with that person at that point in time.

The AHRQ project re-engineered discharge is called the red tool kit includes a suggestion that at discharge a number of medication strategies considering active medication reconciliation and teaching for patients and caregivers be given at discharge.

So there is a stream of thought out there that a discharge home with a caregiver or whoever with the person, that you should be able to equip them with the information that they need to be successful in their setting and their home. And granted, plain language does help in consideration of that.

And then I believe that there was a question about guidance for providers and that's where Stace -- Stella Mandl wanted to say something about the impact of that.

MS. MANDI: This is Stace. I just wanted to reiterate that the actual domain, which is very lengthy and very wordy, does require that the measure include the information going with the individual. So I just wanted to point to that. It's sort of underscored, a point that someone had made.

MS. McMULLEN: And just to back-end that, thank you, Stace, and just to back-end that, that provisions around CMS again, the Medicare and Medicaid provisions ask that at

discharge medications be sent with the person. So this is just back-ending regulations that have either been set in stone or that are still under developed or proposed in the works of being finalized.

CO-CHAIR MULHAUSEN: Okay, so now we'll take a few more comments, and then just so you know, we'll be --

DR. SCHREIBER: I actually just have a question, if I may, for some of the group who brought this up. When patients are discharged from the hospital, their medications list includes medications that they're going to take, as well as medications to stop.

And so my question is: what would be your preference or recommendation, is it to -- because you made the point just take -- include the medications that you're taking, but should we be including these are ones that you should stop for clarification?

CO-CHAIR MULHAUSEN: So I'd first -- we have several people who want to make

reflections, but first, I think let's answer that question. If you have a specific response to that question, turn over your placard.

And we'll start with Deb, because Deb was first.

MEMBER SALIBA: Yes, I completely agree. The list should say don't take these medicines that you were on before, and I don't think it would be a bad thing if it's in a separate section to say these are the medicines you got in the hospital that you're not going to be taking any more in terms of -- especially if you're going to be giving it to the provider.

And I think most of the issues that people have raised are really important issues. I don't think though that they would prevent this measure from going ahead and being implemented. It's more food for thought in terms of how you operationalize it and/or gap, you know gap things to look at down the road as opposed to it being a fundamental problem with these proposed measures as a set.

CO-CHAIR MULHAUSEN: Danielle.

MEMBER PIEROTTI: Just to add a little bit more nuance to Deb's comments because there is a critical safety issue about we have to stop these things, and I don't know how many of you have gone into homes or think of your own aging loved ones who maybe have a pile of old prescription bottles.

We buy things in 90-day increments and dosages change and frequencies change, and it gets very confusing. So in general, I agree to tell people stop these, but that's where health literacy in the form of communication is so critical if they're all on the same page, if the font is the same, if you can't clearly delineate red light/green light, all it is is a mess.

And I would also just put my little plug in though that if you're discharging someone and you're not sure they can manage that, that's where home care comes in. Send the home care nurse.

CO-CHAIR MULHAUSEN: Raj.

MEMBER MAHAJAN: So a hybrid option, there should be a very clear red warning these are the only medications you are taking, but if you add another list that has names, even if it says do not take them, it registers in the brain as those are the list of the medications. It happened to me several times where we were getting calls about saline flushes, heparin shots, all these things that were in medications that were properly reconciled, but the family members are just looking at those names and the small print is not readable, so my practice would be have a list -- this is for patients. Have a list of things they will be taking and be in strong, bold things do not take anything other than these meds.

CO-CHAIR MULHAUSEN: Andrew?

MEMBER BAIRD: This is exactly what I was saying about operationalizing this measure. Whatever specifications we -- or get approved or voted on, those are going to dictate the parameters of how providers respond to this type

of measure. And so, for example, to your question, if someone needed a blood thinner for one day on the first day of the stay coming from an acute care hospital to a rehabilitation hospital, and that person received essentially 24 hours of a blood thinner to prepare them for their rehabilitation regimen that was ahead of them for the next two weeks, is that considered a current medication? They certainly received it during that particular post-acute stay, but that feels like information that wouldn't necessarily be helpful down the line to when it's transferring home.

I guess that just reiterating again every example that's been given here is: what will shape providers' response to this measure?

CO-CHAIR MULHAUSEN: Gail, did you have any? I noticed your placard was up.

MEMBER HUNT: Yes, but I took it down because you said you just wanted to address this one issue.

CO-CHAIR MULHAUSEN: Let's open it up

for more.

MEMBER HUNT: Okay. I'm curious. I noticed that this says family and/or caregiver, so when we're talking about caregivers here, are we talking about the paid person who might be hired by a home health agency, for example? Or are we really just talking about family members and maybe unpaid, essentially unpaid people?

MS. McMULLEN: Gail, it's Tara. I love that question because in my other life I'm a research CMA and I'm so happy to respond to you about this. It's formal and informal. So we didn't zero in on the type of care, whether it was familial or paid. The caregiver could work in a home health agency or the caregiver could be like a spouse. It was whether that information was sent to them, that was the most important. It was that element is whether they were able to be actionable on a piece of information to help with the plan of care. I mean we could further define it out.

MEMBER HUNT: The reason I was asking

is because if it's paid by the home health agency, doesn't that become part of the provider which was the previous set of -- isn't it the responsibility of the provider as in the home health agency?

MEMBER PIEROTTI: Can I jump in here?

MEMBER HUNT: Sure.

MEMBER PIEROTTI: Because there are different kinds of home health, and I think that that's the mushy place we're about to get into. There's certified home health that comes with a registered nurse. My cohort is over there nodding their heads. And then there is a whole lot of services called home health that are not certified, that are primarily unlicensed personnel. And certainly, an individual could designate that person as their caregiver, but they're not a licensed medical professional, so they're not receiving information from the provider road, only from the patient's road. So I think we just need to clarify when we say care in the home which of those categories we're

talking about.

CO-CHAIR MULHAUSEN: All right, so we're going to work down, so Jim, why don't you go first?

MEMBER LETT: I was going to talk about a prior subject when I put the card up. Should I hold off until this discussion is finished?

CO-CHAIR MULHAUSEN: If you don't mind, so we can just go straight to Lori.

MEMBER BISHOP: It just strikes me that we're getting very paternalistic in our discussion, and I want to get back to the patient and family and empowering them. Most of us care about what medications we take and we want to be informed at all times. And it should be in a manner that we can understand. So I just want to make sure that's a guiding principle for the measure and the intent of the measure. Thank you.

CO-CHAIR MULHAUSEN: You're up.

MEMBER DAHLIN: I'm up. So I just

wanted to kind of just make sure that when we're talking about all this, is the emergency room inclusive in this? Is this kind of -- or is that category is out and I just think what happens in the emergency room is just as important? And I will reflect on having elderly relatives who were admitted to an emergency room recently, had a 15 -- 12 microgram fentanyl patch slapped on them and sent home with no services, but not told when to take off the patch for a pain crisis and all that. What?

PARTICIPANT: Or if to.

MEMBER DAHLIN: Or if to, right. But then they had other medications at home. So I think there's this interesting part about what we're talking about to Lori's point of empowering. And I don't know if you all have experienced it, but I have some older adults that once they get a medication, they feel like they'll just hold on to it because they might need in the future.

PARTICIPANT: And they're expensive.

MEMBER DAHLIN: And they're expensive and then they just sort of mix and match. And so it's really a challenge, I think, of both empowering them and then having that information because I've tried to call and looked at their patient list. You know, I'm a nurse practitioner and I couldn't understand what the discharge instructions really were saying.

So I think it's an interesting place that we're at of what we're really trying to do and in my mind patient safety above anything else.

CO-CHAIR MULHAUSEN: Tara, why don't you go ahead and respond?

MS. McMULLEN: Thank you, Connie. I am very appreciative of your comment and I totally agree. The distinction about this measure is that this measure focuses on the setting of home or the beyond. You're out of that sort of prototypical facility for agency care, right? So you're transitioning out, hopefully appropriately. Whereas, the last

measure said that we just reviewed was really looking at the subsequent provider so the idea was that you are probably going to another PAC or you're being sent back to that hospital setting.

And so in the last measure denominator I was reading it does include those acute settings where in this measure you're looking at and then I think this would be argued but you're looking at assisted living, you're looking at the home, for an apartment, things like that.

Does that help a little bit?

MEMBER DAHLIN: Yes. I mean I just think like for the people that I know, they don't have those, right?

MS. McMULLEN: Right.

MEMBER DAHLIN: So they're flying high and not that it's safe, right? But they're so fiercely independent. They're not going to let people in and so I think that this gets a little blurry about who's what and where they are and if they only been in the emergency room a couple of hours, was that really an admission or not. It's

a fascinating thing when you start following a patient and really looking at their experience about what we think is theoretical and the number of near misses that happen. That, I think, is the part for me that I kind of think about.

MS. McMULLEN: You know, Connie, you echo what our technical expert panel members said. We heard this in the stakeholder comment. We heard this from the consumers. We did a lot of consumer testing and I think that's the one thing that the team is happy about this measure is that it does kind of formalize this mechanism that we know should be happening and probably does and sometimes does very poorly. But it's formalizing this transmission, this transfer of information should occur.

No matter what that information is, it should be going on, and there should be a clear communication between the family member and the caregiver and that provider. And so we're hoping that we can build on that paradigm and someday there will be more complex measures, you know,

since that's what happens. But we're setting the paradigm now, and I think that's a welcome change.

CO-CHAIR MULHAUSEN: Stace.

MS. MANDI: I think you're underscoring the reason why there's a category or a quality measure domain specific to medication reconciliation that Congress wrote.

(Laughter.)

I mean the anecdotal stories, they just go on and on. And we are addressing subsection 2 of this particular quality measure related to the transfer of health information from post-acute care, but there is one from the acute care, just to point that out. So thank you for that.

CO-CHAIR MULHAUSEN: So Caroline, do you have a new topic or a reflection on this?

MEMBER FIFE: A quick reflection which is the disconnects between what the patient receives as a list and what's on the label of the bottle. That continues to be really a source of

confusion because they'll have a generic name on one and the brand name on the other, and they can't figure out whether that's the medicine that is on the list. So labeling on the bottle continues to be a huge barrier, even if you get the list right. And there's -- I know that's not a measure issue, but I just don't know how to solve that they understand what's on the bottle.

CO-CHAIR MULHAUSEN: And Jim, we're going to give you the floor again.

MEMBER LETT: Thank you for remembering. I was just going to go back to the question of should you include on the medication, the correct medication list, which I think is a better term than the medication reconciliation, on the correct medicine list the medicines you shouldn't take.

And I rarely disagree with Deb, but I will on this account and I would use two words. One is credibility and the other is burden. That is, the burden of extracting from the chart of a hospital stay of what may be dozens of

medications that they're not taking at discharge is going to be confusing on a good day.

And also, so the burden of doing that I think would be high, and the other piece, why I say credibility is half the time when I tried that I would get calls from patients saying, Doctor, you're really not very bright because I never took that medicine.

(Laughter.)

So I'm not going to put anything else on the list, so those are my two issues around not putting on a list of things not to take.

CO-CHAIR MULHAUSEN: All right, anybody on the telephone who wants to make additional reflections or comments on the transfer of health information to patient measure?

MEMBER HOPPE: Paul, this is Kurt Hoppe. Just a couple of comments and approval of what my colleagues have said on the phone previously. This is a very difficult area, but a very important area, so I congratulate CMS and

NQF for trying to move through this. But be aware, this will come back multiple times for revisions because it's such an important area and such a difficult area to get your hands around. But given that, since we're talking about electronic health records, this is an area where CMS and the ONC need to really push back on vendors.

We, in our organization, had three separate, four separate vendors before we picked one and are in the process of bringing this one system on throughout the country. It points out the difficulty that we all have when we tried to get the vendors themselves to adhere to some kind of standard that would fit and work for most of us. It's been extremely difficult.

This is an area that the ONC really needs to crack down on the EHR vendors and to come up with some kind of standardization. It's equally, if not more, important than interoperability. Because what comes out of that computer and what we give that patient, depending

upon the vendor can look completely different. So I think that CMS needs to work with ONC and come up with a federal nationalized standard.

One thing that we find problematic in these particular patients, and people have commented on the fact that sometimes people are given brand names versus generic names. But we run into sometimes network formulary issues. We know that patients are admitted to the hospital and have automatic formulary substitutions and then that continues and they have a similar or same medication at home. And then consumers and beneficiaries are asked to do the most economical purchase of medications and that is usually a 90- to 100-day quantity. And that confuses a number of patients. But I think also making the firm statement that I don't want you to take any more than I'm giving you right now, because people are deluged with information from the Internet, and I can't tell you how many times patients or family members throw these patients on all kinds of supplements.

And so some kind of indication here that this should be firmly stated that this is a complete list, and that any provider that sends a patient home and gives patients and caregivers instructions should be sure that that medication list is complete and that patients and caregivers understand that supplements are also considered medication.

CO-CHAIR MULHAUSEN: Very good. Thank you, Kurt.

So I think we've heard all of the comments, so one by one we will be voting on whether to accept the recommendation, the preliminary recommendation from NQF staff and then go from there.

MS. QUINNONEZ: Okay, we will now be voting for MUC 2018-135, and the question reads: do you vote to support the preliminary analysis as the work group recommendation? Option 1 is yes, and Option 2 is no.

CO-CHAIR MULHAUSEN: And just as a reminder, the preliminary analysis result is

conditional support pending NQF endorsement.

MS. QUINNONEZ: All right, looking for a few more votes. Okay, voting is now closed. It looks like we have 95 percent voted yes, and 6 percent voted no. And those totals, the total count will be 17 individuals that voted yes and 1 individual that voted no.

CO-CHAIR MULHAUSEN: We'll move on to the next measure.

No, let's just go. We've discussed. We just need to vote.

MS. QUINNONEZ: All right, voting is now open for MUC 2018-139. Do you support the preliminary analysis as the work group recommendation? Option 1, yes. Option 2, no.

CO-CHAIR MULHAUSEN: And although I'm confirming this, I'm pretty sure it was -- yes, conditional support pending NQF endorsement.

MS. QUINNONEZ: All right, sounds good. It looks like our votes are in. Ninety-five percent of individuals voted yes, and five percent of individuals voted no. The count total

for that is 18 individuals voted yes, and 1 individual voted no.

CO-CHAIR MULHAUSEN: And we'll move on to MUC 2018-141.

MS. QUINNONEZ: Voting is now open for MUC 2018-141. Do you vote to support the preliminary analysis as the work group recommendation? Option 1 is yes. Option 2 is no.

CO-CHAIR MULHAUSEN: And I'm confirming conditional support pending NQF endorsement.

MS. QUINNONEZ: All right. The votes are in. It looks like our totals are 95 percent voted yes; 5 percent voted no. The total count for that is 18 individuals voted yes, and one individual voted no.

CO-CHAIR MULHAUSEN: And lastly in this set, we'll vote on MUC 2018-138.

MS. QUINNONEZ: Voting is now open for MUC 2018-138. Do you vote to support the preliminary analysis as the work group

recommendation? Option 1, yes; Option 2, no.

CO-CHAIR MULHAUSEN: And again the preliminary analysis result is conditional support pending NQF endorsement.

MS. QUINNONEZ: Okay, voting is closed. It looks like 94 percent of the individuals voted yes and 6 percent of individuals voted no. The total count for that is 17.

Did someone change their vote? Voting is closed. Has everyone finished submitting their votes? Okay, 17 individuals voted yes, and 1 individual voted no.

CO-CHAIR MULHAUSEN: Very good. I think that went very well. Thank you. Another round of applause.

Okay, so I think next, Gerri takes over to review the --

MS. O'ROURKE: If we can go back to the main slide deck, we're going to move on to the hospice quality reporting program.

Again, this is a penalty for a failure

to report program. The hospice QRP was also established under the Affordable Care Act. Starting back in 2014, all hospices that failed to submit the required data were subjected to a 2.0 percentage point reduction in their annual payment update.

The current data sources for the measures in this set include the hospice item set as well as hospice CAHPS.

Next slide.

Here, you can see the current measures, predominantly process measures, as well as one patient reported outcome.

Moving on to the next slide.

CMS has again identified some high priority domains for future measures including symptom management, outcome measures, measures assessing timeliness and responsiveness of care, as well as alignment of care coordination measures.

Next slide.

And then to bring everyone back to the

gap slide at note 5, when we met in November the group emphasized a need for measures that assessive care was delivered in alignment with the patient's goals.

Next slide.

So we have one measure under consideration for this program, and I think I can turn it over to the CMS team for some framing and clarifying comments.

DR. LEVITT: Okay, well, thank you, Erin. This is Alan Levitt. And actually I'll be presenting this measure. It's the first measure I've presented in six years.

(Laughter.)

It's an important measure to me. I do have back up from our measure contractor, RTI, who is on the phone. I'd like to thank Ila Broyles and Natalie Chong and the whole RTI team for development of this measure. It's been a challenging measure that we've turned upside down and inside out to try to do the right thing in terms of developing this measure.

In developing the measure, actually, we've done it. Look on the slide, first slide here.

Really based in line with the analysis and recommendations that have come from MedPAC and from the Office of Inspector General. They've really been looking at live discharges from hospice. And you can go back on the MedPAC report to MedPAC 2010, and at that time they found that a disproportionate share of live hospice discharges happened in those episodes that exceeded the hospice cap which was the limit of the average annual payment per beneficiary a hospice can receive. And it was felt that this was a practice that was driven by utilization. That's continued up through other MedPAC reports, even the most recent one in 2018 that it's continued.

And regarding our program, the Hospice QRP, they said that we should consider outcome measures, and we consider an outcome measure of the rate of the live discharge as a measure

that's representing quality.

As for the Office of Inspector General, they've issued a lot of reports on hospice, but if you have a chance, take a look. Earlier this year in July, they issued a 45-page summary report that was called Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity, an OIG Portfolio. It was a summary of 16 OIG reports on hospice care over 10 years. Findings including that beneficiaries and the families and caregivers often did not receive crucial information to making informed decisions about hospice care. Other OIG findings for that, hospices would often provide beneficiaries incomplete or inaccurate information about the hospice benefit, including coverage of or waiving of certain Medicare services by electing hospice benefit.

CMS didn't get away scot-free either. They had comments about our quality reporting program, and they have continued with recommendations that CMS should develop and adopt

claims-based measures of quality.

So this is something that we've looked at in terms of developing claims-based measures over the last couple of years. We've convened out technical expert panel. We've had a public comment period, listed the public comments and appreciate the comments that came back for that, and again for the measure that came before you today.

And we've developed this measure really with I have advantages and challenges, which is really advantages and challenges of using claims. The advantage is that it's minimal burden because the claims are already being submitted. Challenges that we're talking about only Medicare fee for service patients, and we're limited by whatever the data is on the claim as Lori was mentioning earlier.

But our approach to developing this measure was not really looking at it as a utilization measure, but to really look at the quality outcomes or really negative outcomes that

could be associated with this type of service utilization due to the live discharge. And it's also been noted and studied by others. And these were the two outcomes that we've called negative outcomes to be part of this measure, and that includes death within 30 days following live discharge from hospice and then the hospitalization or ER visit. Observations stay within seven days for hospice.

Although as Erin was showing gaps, it didn't specifically fill a gap in that program. It really does fill a gap because our experience of care measures are for only hospice decedents, only for patients who have died and so this is a measure that includes live discharge patients. So it does fill that gap.

And then that bold is very, very important that live discharges do happen. They happen due to patient and family preference. A certain percentage of those live discharges may be associated with these negative outcomes. It's all true. Those negative outcomes are not never

events.

So this measure is really constructed in many ways very similar to how we've constructed our readmission measures, which again from a readmission standpoint, readmissions do happen. And so the way that we really look at this measure is constructed in that way because we believe and we believe we're supported by MedPAC, by OIG, and by research in this area that higher rates of these negative outcomes of death and hospitalization can be improved by improvements in the enrollment, the care planning or in the discharge hospice process.

And so the construction, as noted here on this slide, is rate-based, risk-adjusted. It reflects the relative performance of a hospice compared to other hospices, and it's in the ratio of the -- as Gene would always know, the predicted over the expected, predicted number of negative outcomes over expected number of negative outcomes.

From a statistical standpoint, if

we're talking about 2015-2016 data, about 5.6 percent of discharges had these two negative outcomes associated with them. The mean rate was 8.86 for hospices, 10 percent of hospices, I'm reading off some of my stats here, 18.42 percent or more. So 10 percent are very high. Ten percentile at the low is 1.72. And so these do happen, but they do happen at a significant rate in certain hospices.

Go to the next slide.

Patients are excluded in this measure as a many claims based measure if we don't have the applicable, available data. So that would include patients who are not Medicare Part A for the 12 months. Medicare Advantage patients also are excluded because we may not have the full 12 months. Patients under 18 are excluded as well.

Then we get to the topic.

Go to the next slide.

We've received a lot of comments that we appreciate and we've looked at this measure upside down statistically, to try to say well,

what's the right thing to do here in terms of whether we should have any other exclusions in this measure? Because what we don't do is we don't exclude patients based on the reason for discharge codes on a hospice claim. So why do we do that?

We do that really because these are self-reported codes that we are concerned in terms of the reliability of those codes. I've already talked about MedPAC data that suggested that live discharges may be coded by this reason for discharge as being due to patient-family preference, but that they feel that they're often due to hospice preference as noted by the higher live discharge rates when the cost of care approaches those caps.

And then we did our own internal analysis, and that's what's shown on the validation. We tried to find the code that we could actually look at subsequent claims to see well, what really happened. And so the code that we were able to use was patients who were

discharged live due to moved out of service area code. And when we followed up two weeks later to check on the claims, 15 percent actually met that criteria; 27 percent were claimed back in the same hospice. And so we had questions about using such claim.

Other things to really just note that I listed there as well are that almost 24 percent of patients who are live discharged with a code of revocation die within 30 days of that live discharge; 45 percent of hospice patients again who have been discharged with a code that they've revoked the privileges have had a prior hospice stay also in that past year. And in fact, 5.5 percent of patients who once again revoke their hospice stay by the code. They have had two or more hospice stays than just that past year.

We also looked at what happens temporarily in terms of these live discharges compared to death. We did find that those coded no longer terminally ill did have less events by that 30-day period, but that for the other

reasons it was about 40 percent, and then we saw later on the later discharges occur.

And finally, just one thing is at the wide distribution. That this is very similar to what we've seen in our readmission measures that even in the quartiles, if you divide it up in live discharge rates from the highest to the lowest live discharge rate hospices, that within that highest quartile live discharge group that there was a wide distribution. And so that there were hospices that even if they had a high live discharge rate, had a lower transition rate because perhaps they had better discharge processes in terms of minimizing these negative outcomes from happening.

Go to the next slide.

We do risk adjust this measure to attempt to level the playing field, really to help to avoid cherry picking. We've listed the risk adjustment factors there. One factor that we tested and did not risk adjust for is race and ethnicity. It is interesting, the other social

risk factors actually did not make a difference in that testing. As you probably know from my -- I'm interested always in urban and rural and actually rural hospices in general did better on this measure.

There have been studies that have noted a higher incidence of live discharges and negative outcomes associated with live discharges amongst African-American patients, and we found this higher incidence as well, but we also found it with Asian and Hispanic population as well. If we did include race and ethnicity, our C-statistic improved from .70 to .71. However, there was minimal impact in the risk adjustment scores for the hospices.

As an agency, we continue to work to try to identify policy solutions to achieve the high equity for all beneficiaries. We do not mask disparities at this time. But this is something that we will watch as we do in all the measures. If this measure ever was adopted in our program, we would monitor for cherry picking

for all different risk factors including race and ethnicity.

Other points to make is that using two years of data measures reportable by 86 percent of hospices. We've done reliability and validity testing of this measure, and it's a good measure. Testing just at the discharge item itself, claims versus HIS is almost 100 percent. As I mentioned the C-statistic is .70 in terms of the risk adjustment model, producing consistent results.

Measure performance is reliable. If you look at Pearson correlation between 2013, '14, and 2015, '16, we're talking about l.65. ICC, split sample, again .65.

Importantly is that we always try to look for validation of our measures to see whether they make sense or not to other things that are within the program. And so what we wanted to look at was: how well do hospices that do well in this measure correlate with the scores that they get in CAHPS -- CAHPS measures? And it is statistically significant. It's a low to

moderate linear relationship in terms of hospices that do have lower transition rates to those hospices that are providing the positive experiences of care.

And as I mentioned there, our monitoring plans are to -- with measures such as this as we would really with all of our measures is to monitor and ensure that cherry picking would not occur due to any reason.

So to kind of summarize before going to the public comment and all the other discussion, we've fully developed the measure, follows the reports and recommendations that have been made by MedPAC, OIG. It measures performance on an important issue that hospices can improve upon. It fills the gap in the population. We don't measure this population with our experience of care measures.

Minimal burden, it follows the same claims-based models that have been successfully developed in our other programs. It excludes what we feel it should exclude, but it does not

exclude what we think it should not exclude.

It's risk adjusted to level the playing field, minimizes cherry picking, and it tests well and it could be reported by most hospices.

I'll turn it back over to you, Gerri.

CO-CHAIR LAMB: We're going to move into public comment. Thank you, Alan. That was a great overview. We're going to start with people in the room. If you would, get up to the microphone and ask your questions or make your comments. Not seeing any, could we get the people online or chat?

MS. QUINNONEZ: Operator, can you please open the lines for public comment?

OPERATOR: Yes, ma'am. At this time, if you would like to make a comment, please press star, and then the No. 1. There are no public comments from the phone lines at this time.

CO-CHAIR LAMB: Thank you, then we'll move into the regular discussion then. Erin, are you doing the review?

MS. O'ROURKE: I'll keep this very brief, in the interest of time. The staff preliminary analysis assessment was to conditionally support this measure, pending NQF endorsement. We summarized some of the data that Alan just highlighted from MEDPAC, noting this is a potential quality issue. There is variation among hospices and how they perform on this issue. Transitions at the end of life can be particularly traumatic to the patient. Reducing unnecessary re-admissions is obviously an essential way to reduce cost and reduce the burden on patients.

We noted the measure's not duplicative of what's currently in this set, but did think it should be conditionally supported, pending endorsement, so that the NQF process could examine some of the challenges that Alan raised around the risk adjustment model and the exclusion criteria, to make sure it's a scientifically acceptable measure and determined to be reliable and valid.

CO-CHAIR LAMB: Thanks, Erin. We're going to move, then, into lead discussants. Lori, let me just check with you. Carol was supposed to be, and I think she turned the baton to you. Are you prepared to --

MEMBER BISHOP: I am, thank you. First of all, I want to say thank you for the risk adjustment. I believe that was, early on, something that NHPCO had recommended, so I appreciate that you looked at that. Our concerns are in regards to using claims data for quality. Appreciate this might be a regulatory concern. I'm not totally sure that the claims, in and of themselves, can inform a quality issue. I think about a couple of the things here. Part of it is the coding for reason for discharge. Revocation is, or should be, at the patient's -- the patient initiates that.

One would think that we want to allow for that patient choice. I understand the connection you're making with more than one revocation by a patient. It sounds like that's a

percentage here that you're looking at.

We would expect that some of those patients could potentially die after they revoke. A lot of times, what happens is a patient changes their mind about what they wanted or don't want and may wish to seek aggressive treatment after they had originally said they wanted to do hospice.

Again, I'm not saying there aren't misuses. We would want to explore the misuses; I'm just not sure if in a quality measure is the right way to explore that, or is that a regulatory and compliance issue? The other thing is the transfers. There's discharges due to transfer, so they've moved from one hospice to another, which is also included in here. Then the other thing that I would express some concern about is: how does this compare to what we are required to do, based on regulation, when a patient does move out of service area?

They may be in one geographic location; they go to a university hospital for

treatments; move out of the service area; come back and re-enlist in that hospice. That does happen quite a bit, unfortunately.

Again, if we have a defined service area geography, perhaps they're seeking a treatment that is beyond the scope of that hospice plan of care, I think there's some interpretation by some of our programs that that's a discharge, and then they re-admit when they return back to the service area because they don't have the ability to serve them when they're out of that geography.

So there's nuances here of regulatory and compliance issues that I believe we need to work with our hospices on. Again, I'm not saying NHPCO isn't supportive of looking at the concerns with live discharges, especially if it's a live discharge due to the patient and family not being well-informed to begin with, and we want to address that. Those are some of the things that I think make this troubling as a quality measure versus something on the compliance end of the

spectrum. Would love to see, too, if we're going to move forward -- as you mentioned, you have the ability -- these are live discharges.

It would be great to look at some sort of patient experience survey that we can do with these patients, rather than wait until we are at the mercy of waiting until the end, and then getting that patient experience from the perspective of the primary care giver or patient's family.

That is the way hospice patient experience is measured. This is an opportunity, in this situation, to look at patient experience for live discharge. Maybe within seven days of live discharge, they should have a survey done. We would welcome that. Thank you.

CO-CHAIR LAMB: Thanks, Lori. Connie.

MEMBER DAHLIN: Going back to what this is, I am very mindful of this issue of live discharge, but I think we also have to move it upstream a bit. This whole end of life area, as you all know, is really fraught with many

controversies. If you look at the data on hospice and palliative care, it is mostly Caucasian, well-resourced people. We haven't done a great job in diversity, and we haven't done a great job with things that are not resourced.

It is putting some of the hospices in a really tough spot because for many patients -- I know that I've run a hospice and it was like this -- we have many patients, because of culture, actually can only stay in hospice until a certain point, and they cannot die at home.

That's not a failure of the hospice; it's a failure of us to recognize what is culturally acceptable and appropriate in those specific populations. That's a real challenge. I think the other part is when you think about advanced care planning -- there was a comment that was made about DNR.

The regs say that you don't have to be a DNR/DNI to be in hospice. Therein lies another Catch 22 because you could get to the very end

and, again, for some populations, just letting them die without doing something is not considered a good death. They may want some other pieces for that. There's a piece, also, that you could have some of these people being discharged to palliative care programs, which are a little more flexible for them and don't tie them in to some of the things that we may think are the right thing, but then again, for them are not.

This is an interesting part about -- a little bit about prognosis. Because I think people have to figure out where some of these people are. With the frailty being taken away as an indicator of whether people -- what their prognosis is.

We sort of use the palliative performance status of looking at loss of function, loss of how much people are eating, how much they're up every day, how much they're doing, which really speaks to frailty, but we can't use that as a diagnosis anymore for

hospice.

That's kind of hard, in the sense of a lot of times, that's why we would keep people on, but if we look at strict Medicare criteria, we better discharge them because we're going to get called on that. So it's a squeeze, a little bit, from that part. I think that one of the things we'll have to think about as we push forward this hospice is we are kind of trying to push palliative care upstream.

The good news is that we get people at diagnosis and we start having these conversations. The challenge will be, and continues to be, what programs have good relationships with hospice and -- we talked about transitions -- that transition goes well, or for what programs that the palliative care keeps them and they never go to hospice because they don't understand some of that continuum of care.

There's some concerning pieces about what is this saying about how care should be delivered beyond just the quality. I have a

sense this was trying to get at people who were just trying to get big senses and open access to when it was convenient, and then would sort of decide to get rid of people who were a little bit more care. I think we have to be really careful about how we look at that. Then that gets to Lori's thing about patient experience, culture, looking at regions of the country, looking at this rural population, and then looking at just, even regionally in the United States, how this is implemented. Thanks.

CO-CHAIR LAMB: Thank you. Jen.

MEMBER HALE: Thank you. I would like to echo some of Connie and Lori's comments, but with just a slightly different lens, which is, first of all, that claims data is probably a good dataset; it's very uniform. But if we're going to exclude Medicare Advantage participants, we're excluding a large number of patients.

That becomes an incomplete data picture when we're talking about hospice utilization. I think we also have to be careful

that we are appropriately correlating negative outcomes to specific discharge types. Connie mentioned prognosis. Lori has talked about what happens when the patients change their mind.

We've talked about frailty. I've seen, in my own practice, where hospice becomes the thing that helps patients actually bridge the terminal phase of a disease process to a longer term of life. When they are discharged from hospice, they lose a lot of those support mechanisms that are in place because there's simply a gap in care delivery. Because of that, patients then revert to the same practices that they had before, which was utilization of acute care, maybe because they're in a rural area or they're in suburban areas, or even deep urban areas, where they may not have good access to primary care.

They use that acute care or they die. This is not a fault of the hospice. This is an unfortunate outcome of the way that the benefit is constructed. I think, also, it's important

for us to utilize the current hospice item set data elements that we have, in order to observe outcomes which are related to preferences for hospitalization.

We already ask patients, at the time of admission, about their preferences for hospitalization and other end of life care interventions, so we have a mechanism for identifying whether or not we adhere to those particular mechanisms, if we can plug that in. The HIS is a process measure. Now, if we can correlate some outcomes measures with that process measure, we might be in a much better position than using claims data to look at what could be, and what likely is, a program integrity issue. The last thing that I want to say is that we really do have a fundamental issue, both from a cultural and social perspective.

The behaviors that have been reinforced along the healthcare continuum for 65 years at this point, to utilize EMS and life-saving interventions for symptom

exacerbation, especially in certain disease groups, such as pulmonary disease and cardiac disease, these are behaviors that are not changed overnight.

Even when patients agree to receive hospice care, the change of that particular practice does not occur with a switch. Oftentimes, patients and families respond in the way that is most visceral to them, which is to seek immediate care in the way that they know, and have been reinforced, will get them immediate care.

Sometimes the hospice finds out about it right away, and sometimes the hospice does not find out about it right away. Oftentimes, especially nowadays, it's harder and harder for hospices to obtain contracts with local hospitals for end patient acute care. That discharge code for hospice is moved out of the service area. If the patient is in an acute care facility with which the hospice does not have a contract, and the facility will not contract, and the patient

does not wish to revoke their hospice service, the hospice actually has no choice but to discharge the patient because they cannot manage the plan of care in that facility. That's all my comments.

MEMBER RICHARDSON: By going last, I get to say the least, I guess, other than just to endorse whatever -- summarize what my colleagues have already said. Especially glad, Jen, you just mentioned that last instance. NPHI, which is the group I represent, is an organization of the larger not-for-profit hospices across the country.

That was a very specific instance, when I canvased my members, when this measure was put out for public comment earlier this year. A lot of times, the contracting relationships with the local inpatient facilities are problematic, shall we say. There can be decisions made about what to do with a patient that may, from a claims-based perspective, appear to be a program integrity or a quality problem, but that is

really being driven by those local contracting circumstances.

Let me just back up from that specific thing for a second to say that we're somewhat torn about this issue. It's a meaningful measure of concept, but I think whether -- the question for us is whether this measure gets at what we want to get at.

I also like Lori's comment about maybe another way to do it would be to reflect on -- or gather information on patient experience. What is actually driving the revocation decision? How much of it was the patient's own preferences versus other things that may be coming into play there.

The measure in front of us is what it is. We have submitted several comments, trying to go at the measure specifications in a way that might make it a little more precise. First, I just want to say I really appreciate all of CMS's responsiveness to all of the comments that everyone has made. We also brought up the

race/ethnicity issue. Really appreciate you looking at that. The beneficiary leaving the service area, appreciate your data analysis there to verify whether the codes that are on the claims are reflecting that.

It's very gratifying to see you going through the effort of making sure that what you are doing is as best as it can be. Just a couple of other things quickly. One is to consider shortening the time periods might be another thing to look at.

Thirty days, a lot of things can happen in 30 days after a hospice discharge, there also could be -- in terms of the death component.

Then in terms of the inpatient admission component, one thing that some of our members run into is if there are hospices that are not able to contract for general inpatient care in their service area, sometimes they have to discharge, again, to get the person into the level of care that they need, the GIP level of

care. That would be another thing. Another issue -- the one last thing. I guess this could be a risk adjustment issue or an exclusion issue, but some of our members serve a disproportionate number of veterans. Oftentimes, they will have relationships with the local VA hospitals, where a veteran has expressed preferences to be discharged to the VA hospital to pass away with full military honors that they're afforded there.

That may be something that, again, in terms of the population served by a particular hospice, may distort what you're seeing in the claims data. That'll be the last thing I'll say. Thank you.

CO-CHAIR LAMB: Thank you all for such thoughtful and comprehensive comments. Let's open it up for other comments/discussion. Again, in the interest of time, not to repeat something that has been covered thoughtfully and comprehensively. Danielle.

MEMBER PIEROTTI: I appreciate a lot of the individual scenarios being brought out

here, but I have to come back to this is not a zero sum measure. It's proposed as a relative and comparative one. It has the opportunity to provide us the incentive to dig into those examples and to evaluate which of those examples is really driving conditions, and which ones we can impact and which ones we can't. Right now, we just don't know. These are all anecdotes.

I'm sure if I gave it a few thoughts, I can come up with six or seven more -- I'm sure each of you could as well -- of what-ifs or maybes, but we just don't know without any data around what is the true volume of people who are live discharged from hospice. We have to begin to start somewhere.

In a relative, comparative way, can we get this better next year? Can we get it better if we begin to break down some of the system issues that have been brought up? I have to bring back the core challenge in every conversation I've ever had around hospice.

Who is defining the core phrase

hospice is responsible for related to the treatment of the terminal condition. Every person I speak to has variations on that theme, even within the same IDG, around what might or might not be related. I think a lot of the circumstances that we bring out as a what if or a maybe or a yes but comes back to some of that definition of what's related. How are we defining it? How are we expressing it? How do patients understand it? How do their families understand it, when the patient's no longer talking? There's so much in there. We have to start -- again, we have to start somewhere.

As long as this isn't a zero sum game, and it's not suggesting that every live discharge is poor quality, I think -- I don't know. I just feel like we have to start somewhere being cognizant that we're not going to get to zero, much like the re-admission. There are valid reasons where people get re-admitted. There are valid reasons why people discharge from hospice.

CO-CHAIR LAMB: Thanks. Raj.

MEMBER MAHAJAN: Just a quick comment on the statistics. Especially in the cities, there are a lot of very small home hospice companies, and their census is in 30s and 40s. I'm not sure if, during your research, what did you see how that impacts?

Because one discharge for them can completely -- versus the hospice companies that have census in the thousands. Just for that, if there would be a way to differentiate based on their volume.

CO-CHAIR LAMB: Gene.

MEMBER NUCCIO: Similar to that comment, the ratio definition of predicted over expected is really comparing two make believe values, as opposed to an observed value someplace in the system.

That may go into the actual computation. Like Raj, when the expected value approaches zero, one event blows that agency out of the water. I appreciate that you're doing an N of 25 over, I presume, a 12-month period, but

I, frankly --

(Simultaneous speaking.)

MEMBER NUCCIO: Excuse me?

(Simultaneous speaking.)

MEMBER NUCCIO: Over a 24-month period. Okay. I was wondering how you managed to get the reportability rate up to 86, given that many of the agencies or hospice are pretty small. We can discuss the usefulness of predicted over expected versus observed over predicted or some difference model, in terms of your computation, but I won't go there.

CO-CHAIR LAMB: Lori.

MEMBER BISHOP: I was thinking about your related/unrelated. Honestly, if we thought these were unrelated, they would stay in hospice and wouldn't be discharged from hospice. I don't know how much of a factor related/unrelated is in particular to this measure, but I appreciate you bringing it up.

The other thing that struck me, as you were talking, John, was the conundrum of the

patient when they do enter a facility where that hospice doesn't have a contract. A hospice can certainly attempt to do an individual contract for that patient.

If that's refused, the burden of cost if that patient doesn't revoke ends up with the patient, oftentimes, because there's no mechanism for that hospice, in a compliant way, to cover the cost of that care. These are the conundrums that are out there.

Again, is that a quality issue? Is it a regulatory and compliance issue? It certainly is an issue, but these are some of the troubling things because of the way it's constructed. Thank you.

CO-CHAIR LAMB: Thanks. Any other comments before we summarize and ask Alan to respond?

CO-CHAIR MULHAUSEN: Can I ask a question?

CO-CHAIR LAMB: Yes, I didn't see yours.

CO-CHAIR MULHAUSEN: No, it just came up in the last second here. The reflections that have been made here, in my mind, have been deep and profound and leave me struggling. I don't know if this is appropriate to ask, but at some point, I have to vote.

I am curious, from our lead discussants -- first of all, I'm very sensitive to Gene's comment because I'm fascinated by this predicted over expected. I don't even know what to do with that. Are these reflections back to Alan and the team, or do you see the measure as fundamentally flawed?

Are you bringing up anecdotes that are at the margin, or are you talking, in your opinion, about something that's a fundamental concern at the foundation of this measure? In other words, what should I vote?

MEMBER BISHOP: I have concerns with it being fundamentally flawed as a quality measure. I have concerns about live discharge, in terms of program integrity and regulatory and

compliance. But in terms of quality, I would go about this a different way.

MEMBER RICHARDSON: Jen, do you want to go?

MEMBER HALE: Yes, my microphone is green. There it is. I concur with Lori. I have concerns that there is a flaw in the logic of the measure, in that it is exclusive of a large population of hospice utilizers if we're excluding MA participants, as well as looking at the universe of information that's available to us relative to the reasons that people leave hospice care.

I also believe that this is more related to program integrity, rather than quality of care. I think there are other ways to get at quality, relative to live discharge, revocation, and so on.

MEMBER RICHARDSON: I'll go next. I share the concerns of my colleagues. I'm probably leaning a little bit -- I thought this was an Australian ballot, by the way, so I'll

just reveal my preferences here, but leaning a little bit more toward the preliminary analysis. Honestly, it's very tough. It's a very tough call because it puts a fair amount of faith in the NQF process, and then the regulatory process, to surface these issues. I'm also, though, sensitive to Danielle's point that we have to start somewhere, so I'm hemming and hawing, essentially, not sure yet.

CO-CHAIR LAMB: Well put. For those of you who still have your mic on, could you turn it off, so that it's a little bit easier to get into? Any other comments? You comfortable with the list, or shall we go through? I think you know the sum here is that this is challenging, nuanced, important. Is it quality? Is it regulatory? Do we need to start somewhere?

Specifically, the issue related to the claims data for doing this, the exclusions of -- I think the one that I heard was the Medicare Advantage, dealing with the reasons for discharge, specifically transfers, dealing

directly with the cultural issues, which I think Alan addressed, in terms of some of the tensions and challenges with that, acknowledging that some of the nuance in this measure may be out of control and more due to contracts and benefits, and then the time period of the 30 days versus a shorter time frame. I think I also had small volume, how to handle small volume hospices. Start anywhere you would like.

DR. LEVITT: Thank you. I didn't realize my mic was on all the time, so I apologize. We really do appreciate the comments. Everything that you said was things that we actually were thinking about because obviously, we want to do the right thing, in terms of representing how we should model this.

Again, as a reminder, we, too, were not really looking at measuring it based on utilization. We're really trying to look at it based on quality or any sorts of negative outcomes that may occur because of such a practice.

Again, the expectation is not that there will be no live discharges or that there will be no transitions that result in negative outcomes at all. That's not at all -- we understand that. Regarding claims data, I would note that the same questions about Medicare Advantage would be, really, for all of our claims-based measures. This claims data is what claims data is. Again, we'll have certain exclusions because they are necessary in order to make sure that we have the same data available for risk adjustment or for actually making the determination as to what's going on with the patient.

Despite any of the limitations of the claims data, despite all the other limitations that we really talked about, the measure really does test well. That's what kind of was the reassuring piece when we kept going through the different types of testing, that it really did test well.

Gene, again, you're right, as with

really almost all claims-based measures, the smaller the facility, the worse the testing statistic may be, but it still does test well.

Going back to really using any sort of self-reported data, whether it's the discharge code on the claim, or even going back and using something on the HIS, which would still be self-reported, would really not help, in terms of whether or not we should really exclude or not. I would point out that the specifications were also based on what the TEP looked at and recommended as well. The TEP, by the way, did also have the same concerns with exclusions, so you're not alone with these concerns. Finally, this is not a never event. This is, again, as we've talked about before, we're looking at, really, the relative performance.

Because of that, we really feel that it's a measure that we're comfortable with, and we wanted to bring it forward to the committee. I've seen comments, the public comments. We read the public comments, and we really do appreciate

them.

There was talk of whether or not we should have a dry run, for example, in the measure as part of it. So again, that's something that we could consider if we went further, in terms of this measure. Because we, too, as an agency, we obviously want to do the right thing. We want to make sure that our providers are being treated fairly. Thank you.

CO-CHAIR LAMB: Alan, thanks for bringing up the dry run. For those of you who looked at the public comments, that question was raised, so thank you for responding to it. Let's open it up again for any further thoughts, comments, before we move into the preliminary vote. Anything else anybody wants to say? Okay, preliminary vote, then. NQF staff have recommended that this be conditional support, pending NQF endorsement. Desi.

MS. QUINNONEZ: Thank you. We are now voting for MUC2018-101. Do you vote to support the preliminary analysis as the workgroup

recommendation? Option 1 is A, Option 2 is B. You may submit your votes.

(Voting.)

MS. QUINNONEZ: Voting is now closed; 56 percent of individuals voted yes, and 44 percent of individuals voted no. I will give you your exact count. We have 10 individuals who voted yes, and 7 individuals who voted no.

MS. O'ROURKE: Our process now is that we'll open for full workgroup discussion. I think I'll turn it back over to Paul and Gerri. If there's things people want to say or continue to discuss, if that wraps up, we'll start moving on to voting for other categories.

CO-CHAIR MULHAUSEN: Gerri's going to have to leave, and I'm very sad about that because Gerri knew this particular process much better than I do, but we'll muddle through. I want to thank Gerri for everything today, all the time you put in before we even met today, traveling out here, everything I learned from you and all of the leadership to this workgroup, so

thank you.

We still have to get through the work. I do ask that everybody try their best to stay for a while, until we get through the voting. Once we're done voting on this measure, it becomes informational, so if you've got to go catch a plane or a train, I'm going to pressure you less to stick around, but please try to stick around through this.

Is there any additional discussion? We've chosen, at this particular juncture, not to accept the recommendation, the preliminary analysis recommendation, so any additional information that anybody would like to provide the workgroup at this time?

How about on the telephone? Some of you have been listening quietly. Any additional input you'd like to give to help us work through the sequence of voting we're about to undertake?

OPERATOR: If you would like to make a public comment, please press Star 1 on your telephone keypad. Again, that's Star 1 for

public comments.

MS. O'ROURKE: Just to clarify, I think we're only looking for comment from the workgroup, so workgroup members, please jump in. Public, we'll have another public comment before the end of the meeting.

CO-CHAIR MULHAUSEN: Thank you for being so attentive. I'm not hearing a lot of additional input. Alan has his card up.

DR. LEVITT: I just had a question. I wasn't sure whether -- since I dominated the discussion, and whether we even can do it at this point. As chairs, you need to tell me whether it's -- or chair -- whether it's a yes or no -- whether or not -- I didn't know if there were any comments from -- RTI was the measure developer with us, as well.

CO-CHAIR MULHAUSEN: Any objection to asking the measure developers to make additional reflections?

DR. LEVITT: They may not have any, but I just didn't know.

CO-CHAIR MULHAUSEN: Anybody from RTI on the line right now? Would they be muted?

MS. QUINNONEZ: Operator, can you please open up the line for any representatives from RTI, if they're raising their hand or using the chat function, please?

OPERATOR: Those lines are open.

MS. QUINNONEZ: Thank you.

CO-CHAIR MULHAUSEN: Just to reiterate, we're looking for any additional input from RTI regarding this measure and the deliberations of the workgroup.

DR. LEVITT: If not, I apologize.

CO-CHAIR MULHAUSEN: No, we appreciate it. Okay, Alan, anything else?

DR. LEVITT: No.

CO-CHAIR MULHAUSEN: Anybody else have additional input? We'll start the process. Essentially, we'll work down the series of choices until we achieve a six -- yes. Is somebody trying to speak?

MS. QUINNONEZ: Operator, we have a

measure developer, was it Ila, trying to speak on the line. Could you make sure they have an open line, please?

OPERATOR: That line is open.

MS. QUINNONEZ: Ila, maybe you're muted on your phone. We're not hearing --

MS. BROYLES: Hi, this is Ila Broyles. Are you all able to hear me now?

MS. QUINNONEZ: Yes, thank you.

CO-CHAIR MULHAUSEN: We can.

MS. BROYLES: Great, thank you so much. I was trying to speak. I appreciate the help. I think we had a few points, and we definitely hear all the members, and these are, as Alan mentioned, things that we thought about really carefully.

With regard to the questions about patient preferences and how the measure can adequately incorporate those, I think one element that we thought about as we were developing this measure and the trade-off between requesting additional information from hospices about

patient preferences is that what we heard from the TEP is often that patient preferences tended to change throughout the hospice stay, so getting real-time information about how the patients' preferences might be informing their decisions about end of life care could be very burdensome. Also, soliciting that information in a standardized format is challenging.

I think as we thought about -- as we develop a measure to capture patients that are live discharge for a variety of reasons, in those trade-offs, we ultimately decided that using claims-based information would provide us at least an outcome, without overly burdening providers to provide that kind of real-time information, which would ultimately be the most meaningful way to reflect patient preferences at end of life.

Because of that one, that took us down a road where we wanted to strongly consider our risk-adjusted measure. As Alan mentioned, in some cases, these negative outcomes are part of

the patients' choices and the families' choices.

So we did incorporate a risk adjustment approach that is a ratio. It would never be that this happened, but whether this happened at a much higher rate, compared to national peers. The negative outcomes that are reflected are not simply live discharge, but acute care and death within 30 days of live discharge. When we were thinking about the intent of this measure, if a hospice has a particularly higher rate of those outcomes, it could reflect patients who leave hospice for a variety of reasons, one of which could include poor quality of care.

That might drive a hospice's relative rate higher, and also patients who are live discharge without comprehensive discharge planning and access to resources in the community to support them, regardless of their choices about end of life care.

There was also some discussion at the end about how smaller hospices might perform on

this measure. Certainly, smaller hospices would have a smaller sample size and could be subject to noise. This actually connects to some of the other workgroup, the MAP members' questions regarding the predicted to expected ratio.

One reason we ultimately chose that methodology was because it incorporates a shrinkage estimator, which actually allows us to account for some of the additional noise in the statistical estimate for smaller providers. Those providers predicted numbers would be essentially brought closer to the average, so we could more adequately address concerns about how -- the vulnerabilities that smaller providers could face. That was one of the advantages, for example, of doing a predicted over an observed.

I wanted to bring up that point, in particular. I think one question that, of course, as CMS thinks about moving forward, for the concerns that were raised about patients that are live discharge and who are currently not reflected in the HQRP's outcomes measures --

because CAHPS measures don't assess patients that are live discharge.

What's the best path forward for this measure, and more broadly for these patients, to make sure that experiences of care and poor quality of care, in particular during the hospice phase, that lead to live discharge with these negative outcomes after the hospice stay, how we can make sure that the experiences of those patients and families are reflected in the HQRP in a way that can inform patients and families who are selecting hospice providers. Those are my comments. I appreciate the chance to speak, and I'm sorry for the delay in getting my line unmuted. Thanks.

DR. LEVITT: Thank you, Paul, and thank you, Committee, for allowing her to speak.

CO-CHAIR MULHAUSEN: All right, any additional comment? What we thought we would do is follow process, which includes starting with support, and then work through, simply because, in my mind, this is important feedback to CMS. I

feel we should just follow the process that has been outlined for us. We lost quorum with the departure of Gene.

If the workgroup is okay with this, he's given proxy vote to Raj. If there are no objections to that, I'm willing to respect the vote, the proxy vote on behalf of Gene, given by Raj. If there is an objection, we'll go collar Gene before he goes and hope -- nobody objects to that.

Let's move to the voting. Again, we're still on -- I've got to put my glasses back on -- MUC2018-101. Our initial vote is whether or not to support including the measure in the hospice quality reporting program.

MS. QUINNONEZ: Okay, voting is now open for MUC2018-101. Do you vote support? If you vote support, please -- Option 1 is A. Option 2 is no. Option 1 is yes, and Option 2 is no.

(Voting.)

MS. O'ROURKE: Hold off on the quorum

issue. Deb is rejoining us and voting, so re-bringing us to our quorum.

CO-CHAIR MULHAUSEN: With a dramatic entrance, no less.

MS. O'ROURKE: While we're collecting votes, support is the highest category. This is essentially you support this measure used as currently specified, no additional caveats. The next would be conditional support, saying you -- it would be NQF endorsement. Then we go down to the do not support with mitigation.

That's conceptually, you think this measure is important, but there's some details with how exactly it's specified, such as the exclusions, the risk adjustment model. Do not support would be conceptually, you're not sure this is a path that should be pursued.

CO-CHAIR MULHAUSEN: What we're looking for is 60 percent of the quorum for consensus. It fails, in terms of the vote for support, so let's reset the voting. Oh --

MS. QUINNONEZ: Voting, 12 percent

voted yes, and 88 percent voted no. To get your total numbers, the count for that, we have 2 individuals voted yes, and 15 individuals voted no. We'll move to our next vote. This is voting for MUC2018-101, do you vote for conditional support? Voting is now open. You may submit your responses.

(Voting.)

MS. QUINNONEZ: Looking for a few more votes. We're at 15. We need one more for quorum.

PARTICIPANT: Apologies. We're going to go get Deb.

CO-CHAIR MULHAUSEN: Deb, this is conditionally support.

MS. QUINNONEZ: Okay, voting is now closed, with 44 percent of individuals voted yes, and 56 individuals voted no. The count for that is 6 individuals voted yes, and 9 individuals voted no.

MS. O'ROURKE: I think someone cleared out the vote.

MS. QUINNONEZ: Would you like to revote?

CO-CHAIR MULHAUSEN: I don't. I think it's pretty clear to me that -- I know you guys probably want the gradient, but it's pretty clear to me it's not passing. Then let's move to support -- what is that?

MS. QUINNONEZ: Do not support.

MS. O'ROURKE: Do not support with the potential for mitigation.

CO-CHAIR MULHAUSEN: Which is basically it's a good concept, but needs to be worked on. Do not support means it just a bad measure, bad idea, bad concept.

PARTICIPANT: Yes, give me one second.

MS. O'ROURKE: We're making one more slide.

CO-CHAIR MULHAUSEN: Now I understand what your concern is. We're not all the way at the bottom yet.

MS. O'ROURKE: While we're queuing that up, this category was designed to capture

some of the concerns around detailed specifications of the measure. We'll pass along all the conversation about appropriate exclusion criteria and risk adjustment as part of this conversation. I'm obviously not telling anyone how to vote, but to make sure those points -- this category does allow for consideration of those concerns.

(Off-mic comment.)

MS. O'ROURKE: Correct. This was intended to say just that, you support the concept, but would like to see changes made to the specifications before it's implemented. We're still queuing up the slide to allow people to vote.

We apologize for the technical delay. On that note, please don't clear it, because we're likely to have to go get Deb from the hallway to cast the quorum-making vote, so please don't hit the clear, so that we can calculate everything and get the accurate number.

MS. QUINNONEZ: It is not allowing me

to save it in that way, however, this slide, on the back side, does say do not support with mitigation. There we go. It updated. Now we are ready to vote on MUC2018-101, do you vote do not support with mitigation? Option 1 is yes; and Option 2 is no.

(Voting.)

CO-CHAIR MULHAUSEN: Does everybody understand this conceptually?

(Off-mic comment.)

CO-CHAIR MULHAUSEN: You're asking too late in the game. The category is do not support with mitigation.

MS. O'ROURKE: To be honest, the full category is do not support for rulemaking with potential for mitigation. The idea here was to delineate between the refine and resubmit and the conditional support.

This is that you're saying it should not be proposed for a rule as currently specified, rather than the conceptual support. You don't support the use of this measure at the

time, but the potential for mitigation -- I think, to address your second point of yes, conceptually support.

CO-CHAIR MULHAUSEN: Remember, if you're voting yes, you're voting to say this should not be used currently for rulemaking, do not support, but has the potential to be mitigated for future use. That's what you're voting for if you say yes. Then the last category is throw this out, don't even use it for anything. You can't even mitigate it. The voting is still open, right?

MS. QUINNONEZ: It's still open. We're at 11-12 votes. We're at 13 votes, 14.

MS. O'ROURKE: Did everyone on the phone -- are you still participating and able to cast your votes?

MS. QUINNONEZ: We're at 15.

MS. MANGRUM: This is Rikki, and yes, I think -- it seems to be taking my vote.

MEMBER HOPPE: Yes for me, as well.

MS. QUINNONEZ: We're at 15 votes.

MS. O'ROURKE: I think we might be having technical difficulty.

MS. QUINNONEZ: We're 16 votes now. All votes are entered. All 16 votes are entered as A, for yes.

CO-CHAIR MULHAUSEN: There appears to be unanimity around this particular categorization, is that correct? So we're not going to take a vote on the last category. The voting is closed on this, but I see Alan wants to make some comments, or maybe ask some questions.

DR. LEVITT: It was a question. First of all, I appreciate all the thought that the workgroup had on this. I guess what I'd be interested in, or we'd be interested, really, as we move further with this measure concept is what the Committee feels, in terms of the mitigating factors that they would wish us to work on.

CO-CHAIR MULHAUSEN: Lori, you look like you're ready.

DR. LEVITT: With some consensus. Obviously, I know everybody has their own

opinion.

MEMBER BISHOP: I just want to choose my words carefully. I think breaking down by the discharge categories and the ability to drill down into understanding the reasons for those, rather than -- I know that death is a negative outcome. Right?

If I didn't die within hospice and I was discharged alive, we're basically making an assumption that's a negative outcome. However, if I revoked and I made an informed decision and I realize my terminal condition isn't going away -- again, I think we need to break down the types of discharge, and we need to look at this in correlation with other measures of quality, rather than make assumptions that claims data, in and of itself, is an indicator of quality. For me, there's just not enough there, so that is my struggle and the struggle of NHPCO.

MEMBER RICHARDSON: If I may -- you okay? I didn't raise my card; I'm sorry. I jumped the queue.

PARTICIPANT: I'm learning.

MEMBER RICHARDSON: Queue jumper, terrible. I'm not sure whether this is a condition because I haven't done the analysis that I'm about to ask you to do, focusing on the shortening of the periods and seeing the effect that would have on the rates.

DR. LEVITT: Is that similar, in terms of the period suggestions in the comments that came forward?

MEMBER RICHARDSON: Yes.

DR. LEVITT: Okay.

MS. MASSUDA: I just want to -- when you talk about breakdowns in the types of discharges, if -- are you looking to expect the data to be reliable? Because there's definite variation of what's going on. That's why I'm asking -- that's part of what we looked at, when we were debating about how we handled this discharge issue versus revocation versus --

MEMBER BISHOP: Are you saying, Cindy, even the way the revocation code is being used or

how hospices are practicing when they use that code?

MS. MASSUDA: Hospices practicing and how they use revocation.

MEMBER BISHOP: How do you get that from the claims data? What other pieces of information are making you aware that there's a variation in practice? Is it because of the volume of revocations for some versus others? Is that --

MS. MASSUDA: There's that, and then you can also see where the patients -- where it happens to the patient, following the claims, so that it wasn't necessarily a revocation. You wouldn't necessarily have categorized it as a revocation.

MEMBER BISHOP: Can you tell me just a little bit more about that?

MS. MASSUDA: A patient revokes on paper, but they end up -- you see them ending up in the -- it's, again, looking at these patterns. They end up having care, getting other aggressive

care, which might be why they took revocation, or they may have just transferred to another -- took a revocation, but just transferred to another hospice.

When you look at revocation, you're not necessarily seeing them going for curative services or other care. A lot of times, you see them going to other hospices, and a lot of times even in the same service area.

MEMBER BISHOP: With a break between providers then?

MS. MASSUDA: Can be.

MEMBER BISHOP: Okay.

CO-CHAIR MULHAUSEN: Any other -- Jen? Any other Jens? No Jens. You have the floor.

MEMBER HALE: I think I'm the only Jen. From our perspective, I think that you have adequately identified that the data is what it is. I appreciate, from the provider perspective, that you want to ensure that there is a reduced burden on the provider for getting the information. I still feel uncomfortable with the

use of claims data as a specific measure of quality, especially in this population where the ability for the hospice to support a patient in their autonomous and self-directed care is really the underpinning of what we do. I think that a dry run of utilization for this particular measure would go a long way perhaps to assuaging some of the concerns in the community.

I also think that additional conversation around correlating the outcomes that you find with CAHPS measures, with even HIS measures, with looking at diagnosis and so on. Because there, I think, is a rich potential for assisting the consumer and the public in looking at what that means when they choose hospice care and services, that they are choosing non-curative support.

As hospice providers, we can say that so many times, but oftentimes, until the situation presents itself as a choice of I'm going to seek curative or aggressive intervention versus I'm going to continue down the hospice

support path. Until that decision point is available, sometimes patients and families aren't really cognizant of the choice that they're making.

CO-CHAIR MULHAUSEN: Alan.

DR. LEVITT: Sorry, since we're braving new territory here, since I think we're probably the first group that's had this category assigned, I guess what I'd be interested in is -- obviously, we got good comments and suggestions from the workgroup members.

I guess what we'd be interested in, is there going to be some sort of consensus opinion of the workgroup that comes back to us on the mitigating factors, so we know which way to go with further measure development?

MS. O'ROURKE: I think we could certainly do that, if the workgroup is willing. Perhaps we could draft something up and circulate it to the workgroup members for your review and input and it'd be a rather quick turnaround. Hopefully, people would be willing to do a little

homework after the meeting to put a concrete list of mitigating factors.

MEMBER LETT: Thank you. I'd like to just speak of my perceptions as a non-hospice person, non-measures wonk. When you all spoke about this measure, I had a very difficult time understanding what you wanted to get out of this measure. I didn't get an elevator speech as to what you hoped to accomplish. As I listened more and more and more to all the great comments, what I have decided is -- and I would appreciate further comments about how inappropriate or appropriate it is -- is you may be asking too many things in this measure.

That is, you're asking death, acute and ER utilization. You're also, I think, looking for inappropriate enrollment, inappropriate discharge, and poor transition planning. I am absolutely in favor of this.

We all want a hospice plan/program that works well and provides services in an excellent fashion to the people who need it, but

not providing services to people who don't need it.

I really think you may have asked five things in this measure, in my poor man's teasing apart. I absolutely support the concept; I just didn't understand what you wanted and how you were going to get there, for what it's worth. Thanks.

CO-CHAIR MULHAUSEN: John, I saw you fiddling with your card. Did you want to --

MEMBER RICHARDSON: Just to endorse what Erin was saying. I'm certainly -- if I may speak on behalf of everybody, I think that makes sense, for us to have a consensus. I totally understand where Alan's coming from. Could you just give us one set of conditions? I think I'd certainly be willing to do that, to work with the staff there to give you one set that combines everybody's feelings and opinions.

CO-CHAIR MULHAUSEN: Lori, your card's up.

MEMBER BISHOP: I want to just thank

Jim because this has been my angst, and he just named it. I didn't do as good a job of naming it. I think that is my angst is you are asking for all of those different things.

They feel more like assumptions based on the data, rather than definite measurement of those things, based on the data. So thank you, Jim. I think that you summarized the issue that NHPCO has with it the way it sits today.

CO-CHAIR MULHAUSEN: Okay, so we're going to need everybody to pitch in when Erin and her team reach back out to us to efficiently and quickly get some kind of a consensus back to our CMS colleagues.

MS. GORHAM: Okay, should we move on?

CO-CHAIR MULHAUSEN: Yes, let's move on. Erin and I decided that we would skip over the conversation around promoting alignment and measurement of post-acute care/long-term care at this point, that we would open it up now for public comment regarding our deliberations today. After that's complete, just summarize the day and

adjourn.

MS. QUINNONEZ: Operator, could you please open up the line for public comment?

OPERATOR: Yes, ma'am. At this time, if you would like to make a comment, please press star, then the No. 1.

CO-CHAIR MULHAUSEN: Last call for public comment.

OPERATOR: There are no public comments from the phone lines at this time.

CO-CHAIR MULHAUSEN: Okay. A, I want to thank everybody. I know we've gone a half hour longer than you had anticipated. Thank you very much for sticking around and helping us with all the voting and the reflections and the input that you've been able to give to the NQF team, as well as to our colleagues at CMS. Gerri's not here to say thank you, but I know she also would have wanted to very much thank you for all of the work you've put in today. I want to wish you all safe travel home, and watch for the information that we'll be getting from NQF to try to clarify

some consensus recommendations for mitigation regarding the hospice measures. Alan.

DR. LEVITT: I'm sorry. I hate following you when you had such a great closing. Again, on behalf of the agency and behalf of myself, I want to thank the Committee, the workgroup, again, for all the thoughtfulness that you put together this year and every year, in terms of our programs and the measures that we are bringing to you for our programs. We appreciate this year and future years together, so thank you.

DR. SCHREIBER: Thank you. I'd like to do the same, on behalf of CMS, to say thank you. I thought your comments, all of them, were really extremely thoughtful, extremely meaningful, and we will take this back and try and make changes accordingly, so thank you.

CO-CHAIR MULHAUSEN: Thanks, Michelle. All right, guys, thanks for all your help.

MS. O'ROURKE: I do have just one thank you from the staff perspective. Apologies,

I won't belabor it. Thank you so much to Paul and Gerri and to all of you for staying late and bearing with us. Just for next steps, again, please keep your eyes out for the summation of the hospice measure. We want to make sure we get Alan an accurate list.

We are going to open for public comments on your recommendations December 21st to January 10th. The workgroup recommendations and the public comments get passed along to the coordinating committee, which finalizes all MAP input, so please submit comments and feel free to participate and listen to the coordinating committee meeting January 22nd and 23rd. Thank you, everyone, and have safe travels home.

(Whereupon, the above-entitled matter went off the record at 3:02 p.m.)

A

a.m 1:18 5:2
ability 30:15 62:2 124:21 132:9,16 146:5,11 170:19 184:13 236:11 237:3 278:4 282:3
able 31:3 39:10,10,11 39:20 40:1,3,5 41:22 42:14 43:3,7 44:3,9 56:21 64:5 65:1 84:4 100:13,22 101:16 108:2 117:8 134:13 134:17 140:16 145:17 157:7 196:3 202:18 226:22 247:19 265:8 276:16 287:16
above-entitled 179:7 289:16
absolute 28:20
absolutely 113:7 183:12,17 284:19 285:5
abstention 102:8
abstentions 101:13 102:5
Abt 81:9,10
academic 72:8
Academy 2:5 78:13 79:11
accept 32:22 99:19 100:1 151:2,11 214:13 262:12
acceptability 157:12
acceptable 104:4 154:12 178:8 233:21 238:15
accepting 32:20 122:8
access 92:5 111:10 129:6 130:10,18 133:7 162:3 170:18 241:2 242:17 267:18
accompanied 27:21
accomplish 284:9
account 161:7 210:19 268:9
accounting 82:17 103:8
accreditation 194:15
accurate 274:21 289:6
accurately 102:14
achieve 67:8 101:4,22 102:10 190:16 229:17 264:20
achievement 49:20
ACHPN 2:18
acknowledge 116:10 117:3
acknowledged 111:19 116:14
acknowledging 257:3
acknowledgment 112:2
act 4:5,8,13 9:19 19:15 44:12 45:6 49:13 55:21 69:22 91:18 92:18 106:15 112:10 124:7 135:5 139:3 181:6 218:2
acted 66:21 111:19
acting 18:2
actionable 61:7,21 66:20,21 202:19
actions 66:18 132:9
activate 39:8
active 140:3 185:11 195:20
activities 11:16 48:6 54:21 55:5 72:22
activity 158:1
ActiVote 39:15
actual 44:6 59:4 118:11 135:21 196:13 251:18
acute 81:14 82:9 124:20 134:18 149:3 155:15,16 157:4,10 157:15 158:5,10 159:19,21 201:4 207:6 209:15 242:14 242:19 244:18,20 267:8 284:15
add 6:8,21 27:15 44:22 115:1 161:4,15 167:3 173:9 177:11 183:22 184:18 185:16 199:2 200:4
added 58:14 186:13
adding 47:11 142:15
addition 14:9 128:13 184:21
additional 6:17 16:9 34:14 42:3 47:11 48:5 54:1 55:2,12 79:19 89:2 114:20 116:1,15 143:20 157:1 168:3 169:10,11 171:14 189:8 211:15 262:10 262:13,17 263:9,19 264:10,18 265:22 268:9 269:19 271:8 282:9
additionally 21:18 85:19
address 30:10 48:5 49:18 76:6 106:14 152:3 170:21 176:6 201:20 236:20 268:13 276:2
addressed 29:20 121:18 167:16 257:2
addresses 144:9 181:6
addressing 25:4 48:7 209:11
adequately 265:19 268:13 281:18
adhere 212:14 243:9
adherence 156:15
adjourn 4:22 287:1
adjust 228:17,21
adjusted 232:2
adjustment 228:20 229:14 230:10 233:19 234:8 248:3 258:12 267:3 271:15 274:4
ADLs 48:7
administer 116:2
administered 139:22
administration 191:21
admission 87:21 88:1 136:9,12 207:22 243:6 247:17
admission/during 96:3
admitted 170:6,7 205:7 213:9
admitting 84:18
adopt 135:9 221:22
adopted 90:16 149:5 229:21
adoption 64:22 65:2 117:7 134:6,13
adults 205:18
advance 5:11 53:8 128:2
advanced 78:21 125:17 238:18
advancing 26:1
advantage 222:13 225:15 241:18 256:21 258:7
advantages 222:11,12 268:15
adverse 83:9 85:9,22 86:3
advice 113:1 159:1 170:1 173:9
Advisor 14:16
Advisory 11:7
Affect 221:7
affordable 24:4 49:13 218:2
afforded 248:9
African-American 229:9
agencies 46:10 65:9 91:15 92:5 140:18 146:2,7,10 150:8 252:8
agency 17:8 61:21 80:2 112:14 122:1,2 130:15 138:13,15 145:13 174:2 186:16 191:4 202:6,15 203:2 203:5 206:20 229:16 251:20 260:7 288:5
agenda 6:19 45:3 179:13
aggregate 61:3
aggressive 235:6 280:22 282:21
aging 74:17 199:6
ago 141:22 142:1 145:22 162:9 177:21
agonizing 71:9
agree 33:4 37:10 115:3 151:9 172:5 184:9 198:7 199:11 206:17 244:5
agreement 90:7 102:15
agrees 30:3 32:19
ahead 5:4 39:14 45:21 67:1 69:9 113:14 115:22 182:19 198:17 201:7 206:14
AHIP 24:17
AHRQ 194:16 195:17
aid 86:6
Alan 3:2 15:11,12,18 21:7 24:5 37:10 44:17 44:21 53:15 71:18 73:19 75:1,13 102:18 141:21 142:10 143:15 154:17 219:11 232:8 233:6,18 253:17 254:12 257:2 260:10 263:9 264:15 265:15 266:21 277:10 283:5 288:2 289:6
Alan's 285:15
albeit 12:9
algorithm 28:12
align 23:10 24:13,19 25:20 161:6
aligned 47:14 160:20
alignment 68:16 181:8 218:19 219:3 286:18
aligns 92:14
alive 278:9
allergies 95:19
Alliance 2:6 78:12 79:2 79:5
allow 35:1 82:4 106:15 140:18 165:18 234:19 274:7,14
allowing 269:17 274:22

allows 268:8
alluded 131:10
alpha 87:1
alternative 25:19
AMA 138:20 172:19 175:15
amazed 163:11
amazing 22:20
ambiguity 155:22
AMDA 2:7 9:8
amend 84:20
amended 87:14 89:11
America 2:9 11:2
America's 24:17
American 2:5,11,11,12 3:17,19 9:11,14,17 17:5 78:13 79:11 94:18
amount 70:8 121:2 157:12 256:4
analogous 193:6
analysis 28:9,10,13 32:5,9,20 58:17 59:15 60:17 69:13 99:19 100:1 105:22 106:14 107:1,3 122:9 143:21 150:19 151:3 152:20 153:2 166:6 167:5 168:16 177:4 214:18 214:22 215:14 216:7 216:22 217:3 220:4 226:18 233:3 247:3 256:2 260:22 262:13 279:4
and/or 198:19 202:3
Andrew 2:3 3:1 10:2 16:3 60:4,6 79:22 107:22 118:5 132:4 145:18,19 146:17 155:6,7 156:20 157:1 164:6 168:5 171:17 185:4 188:5 200:17
Andrew's 76:8
anecdotal 209:10
anecdotes 249:8 254:14
angst 286:1,3
annual 19:2 46:13,13 51:5 52:10 218:5 220:13
ANP-BC 2:18
Anschutz 12:6
answer 36:1 110:21 116:20 130:22 198:1
answered 119:4 159:14 159:17 171:10
answering 72:16,22
antibiotic 128:16
antibiotics 189:15
anticipated 287:13
anxiety 95:19
anybody 38:7 93:13,17 93:19 94:5 98:12 129:6 168:8 180:4 191:12 211:14 260:16 262:14 264:1,17
anymore 239:22
anyway 7:4 40:2
AOCN 2:8
apart 113:3 285:5
apartment 192:10 207:10
aphorism 111:20
apologies 77:18 79:18 272:12 288:22
apologize 79:13 109:4 160:12 174:15 257:12 264:13 274:16
app 40:17,18
appear 245:21
appeared 123:20
appears 277:6
applause 217:16
applicability 193:13
applicable 51:5 96:1 144:17 194:6 225:13
application 7:2 105:2 147:19
Applications 1:5 19:1
applied 185:3
applies 110:7
appointment 172:9
appreciably 120:10
appreciate 48:15 76:17 103:9 109:14 118:18 150:4 164:10 222:7 225:21 234:10,12 246:20 247:1,3 248:21 251:21 252:19 257:12 259:22 264:14 265:12 269:13 277:13 281:19 284:11 288:11
appreciation 121:2
appreciative 73:22 74:6 75:9 206:16
approach 4:4 17:21 26:22 27:10 121:12 123:2 222:19 267:3
approaches 226:16 251:20
appropriate 32:14 50:18 116:3 144:19 238:15 254:5 274:3 284:13
appropriately 206:22 242:1
approval 36:10 181:12 211:19
approved 200:20
APPS 175:10
area 25:4,15 66:8,8 93:13 110:3 135:13 142:8,18 150:7,10 159:8 211:21,22 212:3,4,6,17 224:9 227:1 235:20 236:1,5 236:10 237:21 242:15 244:19 247:3,20 281:9
areas 25:2 46:17 64:14 64:16 74:22 90:12 97:7 189:21 242:16 242:17
argued 207:8
arguments 71:6
Arizona 2:1
arrangements 58:22 77:2
arrivals 77:19
arrived 58:17
Arthur 11:6,8,11
article 69:11
Ash 9:2 13:7,13,14 107:22 108:5,12 114:22 139:15 155:6 159:11 167:11 169:15 169:19
ASHISH 2:22
Asian 229:11
asked 27:17 38:1 58:2 89:4 103:11,17 146:1 146:4 156:1 213:13 285:3
asking 56:16 109:4 127:19,21 135:21 138:3 202:22 263:19 275:11 279:18 284:13 284:15 286:3
asks 130:2
aspect 90:4
aspects 117:15
assess 52:11 91:5 136:8 137:2 142:4 180:22 269:1
assessed 84:22 141:5
assessing 74:21 95:11 140:13 192:9 218:18
assessive 219:3
assessment 33:5,9 34:7 46:19 50:3 55:18 64:8 72:9 89:4 107:5 107:13 137:13 140:14 140:15 141:3 143:10 145:7,12 150:19 151:3,10,11,16 167:5 181:19 233:3
assessments 104:13
assigned 107:21 283:9
assist 7:16 28:17
assistance 38:20,22
assisted 186:15,18 187:3 192:10,16 207:9
assisting 282:14
associated 28:18 84:17 85:22 86:3,4 88:11 147:7 223:1,21 225:3 229:8
Associates 81:10,10
association 2:11,13 9:15,18 182:1
Associations 2:9 11:2
assuaging 282:7
assume 145:2
assuming 39:22 70:20
assumption 278:10
assumptions 278:16 286:5
assure 135:12
attachments 139:9
attainment 68:15,16
attempt 189:6 228:18 253:3
attention 75:15 84:1 86:10 176:4 185:1
attentive 263:8
attorney 187:21
attributable 90:3
attributing 136:13
attribution 74:7,9 84:17 88:1 116:6 136:11
Australian 255:22
automatic 213:10
autonomous 282:4
autonomy 68:15
availability 52:3
available 7:3 55:7 65:7 94:12 147:6 152:15 225:13 255:11 258:11 283:2
average 90:17,21,22 220:13 268:12
avoid 108:7 120:21 121:11 186:2 190:9 228:19
avoids 121:13
aware 75:17 76:8,9 79:22 103:12 138:13 142:12 182:11 212:2 280:7

B

B 39:21 261:1
back 11:11 15:17,21 26:9 30:8 35:22 36:19 37:3,8,21 42:1 43:10 47:17,19,21,21 49:8 54:7,9,13 55:1 67:22 70:17 73:20 77:11 83:15 86:13 95:7 112:5 116:20 120:19 121:12 124:7 128:9 133:11,12 134:15 141:11 147:1 148:14 148:21 154:1 162:8 162:11,21 174:21 179:3 182:8 184:14 188:10 189:3 192:21 194:1,5 204:13 207:4 210:12 212:2,7 217:19 218:3,22 219:16 220:8 222:7 227:4 232:6 236:2,10 237:18 246:3 249:1 249:20 250:7 254:11 259:4,6 261:11 270:12 275:2 283:14 286:12,13 288:17
back-end 73:14 196:19 196:20
back-ending 197:2
backed 136:21
backend 91:6,14 92:1 140:18 142:7 143:2,6 149:16
background 20:12
backwards 155:5
bad 66:3 71:2 198:9 273:13,14,14
Baird 2:3 10:2,2 60:5,6 118:6 132:5 146:18 147:5,12 149:21 155:12 163:17 164:7 168:6 171:18 185:5 188:6 200:18
ballot 255:22
bar 41:11,12
barrier 70:7 210:5
barriers 58:4
based 28:11 33:17 37:17 60:22 80:9 101:7 220:4 225:12 226:4 235:19 251:10 257:18,20 259:11 286:5,7
basically 89:18 96:7 273:12 278:9
basis 63:7
basket 46:13
baton 234:4
be/could 165:6
bearing 5:7 43:21 289:3
bed 162:1 174:21
beg 74:22
began 174:22
beginning 79:14
begs 75:1
behalf 18:12 26:7 78:21 94:17 270:7 285:13 288:5,5,14
behavior 65:22 66:6,20
behaviors 66:18 243:19 244:3
belabor 289:1
believe 18:1 143:14 196:8 224:8,8 234:8 236:14 251:15 255:14
believes 104:4
beneficiaries 82:9 213:13 221:10,15 229:18
beneficiary 61:1 220:13 247:2
benefit 59:20 221:16,18 242:21
benefits 257:5
best 24:2 71:10 163:13 247:8 262:3 269:3
Beth 64:4 92:17
better 18:19,20,22 25:8 55:3 71:8 75:3 191:14 210:15 228:13 229:4 240:5 243:13 249:17 249:17 261:18
beyond 57:11 58:1 84:16 160:3 161:14 195:9 206:19 236:6 240:22
biased 18:2
bidirectional 53:5 112:7 116:5 122:15 122:17 127:10,21 129:4 136:10,18 141:17 171:5
bidirectionality 121:15 136:6,8
big 67:5 111:6 120:1 241:2
bigger 190:17
biggest 69:19 158:15
Bishop 2:3 67:2,3 78:15 78:19,19 204:11 234:6 252:14 254:19 278:2 279:21 280:5 280:17 281:10,13 285:22
bit 15:3 26:22 44:14 53:21 54:5 59:22 70:15 93:4 97:8,12 98:19 105:5 118:4 131:13 140:8,15 148:19 151:7 155:5 155:21 199:3 207:11 236:3 237:21 239:12 240:6 241:4 255:21 256:2,12 280:18
bless 187:20,20
blocking 69:20
blood 201:2,6
blows 251:20
blurry 207:20
board 9:11 70:6 79:6
boarder 192:10
boat 160:14
bold 200:15 223:17
bonding 49:6
bonus 70:12
Bossley 3:17 94:17,17
bottle 209:22 210:4,8
bottles 199:8
bottom 273:20
boy 111:6
brain 200:5
brand 210:2 213:7
braving 283:7
break 109:5 177:21 178:4 179:3 249:18 278:13 281:10
breakdowns 279:14
breaking 278:3
breaks 7:10 31:15 54:8
bridge 242:7
brief 39:1 51:16 64:21 145:21 158:21 233:2
briefly 27:13 78:3 181:17
bright 211:7
bring 57:16 63:17 84:8 86:12 99:14 100:13 120:19 141:21 218:22 249:20 250:6 259:20 268:17
bringing 212:11 252:20 254:14 260:11 288:10
brings 49:3
broadly 269:4
brought 37:3 86:16 87:19 88:6,22 91:18 139:8 150:5 185:1 197:11 246:22 248:22 249:19 268:12
browser 40:21
Broyles 3:18 219:18 265:7,7,11
BSN 2:3 3:3
BSW 3:3
build 137:4 141:15 142:7 208:21
building 73:18
built-in 31:15
bullet 72:5 91:22
bunch 124:1
burden 21:19 23:7 24:7 25:11,12 86:11 88:11 90:3 117:19 210:20 210:21 211:3 222:14 231:19 233:13 253:5 281:21
burdening 266:14
burdens 22:1 150:12
burdensome 85:6 266:6
busy 6:10 66:4
buy 199:9
Byrne 81:12

C

C- 229:12
C-statistic 230:9
CAHPS 46:20 184:16 218:9 230:21,21 269:1 282:11
calculate 107:14 137:22 274:20
calculated 42:21,22 104:7 106:20 161:18
calculates 143:8
calculating 141:3
calculation 75:21 95:11 101:20 148:17
calculus 62:1
calendar 51:13
call 5:12 7:12 72:12 94:4 96:14 97:14 121:16 148:4 158:9 159:6,6 206:5 256:4 287:7
called 13:21 24:18 123:22 147:19 195:18 203:14 221:6 223:4 240:6
calling 66:3
calls 24:7 200:8 211:6
Campus 12:7
canvased 245:15
cap 220:12
capability 132:18 146:7 146:9,12
capable 125:2
capitalized 57:14
capped 149:14
caps 226:16
capture 35:12 153:17 266:10 273:22

capturing 42:5
card 7:11 204:6 263:9 278:21 285:10
card's 285:20
cardiac 244:2
care/long-term 1:6 100:20 286:19
career 56:3
careful 45:14 241:5,22
carefully 5:21 265:16 278:3
caregiver 81:4 88:19 141:14 193:11 194:12 194:20 195:11 196:2 202:3,14,15 203:17 208:20
caregivers 21:15 25:5 57:22 195:22 202:4 214:4,6 221:11
Caregiving 2:6 78:13 79:3,5
Carol 234:3
Carolina 131:6
Caroline 2:19 9:2 12:14 12:16 69:9 91:18 93:2 128:21 133:8 209:17
Caroline's 132:6
case 192:17
cases 190:9 266:22
cast 39:20 42:14 274:19 276:17
catch 238:22 262:7
categories 6:1 19:17 27:19 29:7,10 88:8 102:12 151:17 203:22 261:14 278:4
categorization 277:8
categorized 280:15
category 33:16,22 34:5 34:6 205:4 209:6 271:6 273:22 274:7 275:12,15 276:10 277:9 283:8
Cathy 178:16
Caucasian 238:3
caught 119:14
cause 60:17 83:6
causes 184:7
causing 68:22
caveats 271:8
CDC 16:3 50:5 80:2
CDP 98:22 99:1 100:10 103:15,21 104:22
CDS 64:16
celebrate 49:1
CENP 2:8
census 251:4,9
Centene 2:4 10:9
center 3:8 14:2 15:8
centered 190:22
Centers 3:1,2,3,4,5,9 80:1
central 29:4 61:12
Century 69:22 91:18
certain 19:17 29:19 65:6 157:12 189:12 189:15 221:17 223:20 225:9 238:12 244:1 258:9
certainly 54:14 67:20 110:5 111:9 120:12 178:19 201:9 203:16 253:3,12 268:1 283:18 285:12,17
certification 51:14
certified 203:11,15
cetera 110:18
chair 9:11 263:14
chairs 7:12 26:9 32:13 42:2 263:13
challenge 206:3 238:16 240:13 249:20
challenges 41:4 58:11 77:5 106:12 222:11 222:12,15 233:18 257:3
challenging 39:5 105:6 219:20 256:15 266:8
chance 70:18 111:4 153:22 221:4 269:13
change 36:17 56:19 68:17 116:7 156:7 176:15 199:10,10 209:3 217:10 242:4 244:6 266:3
changed 37:2 79:15 147:16 244:3
changes 26:16 38:8 67:12 89:14 149:17 149:18 235:4 274:12 288:18
channel 94:12
chaotic 173:6
characteristics 28:18 96:21 141:10
chart 171:8 187:17 188:2 210:21
chat 40:12 94:12 178:15 232:13 264:6
chatting 41:1
check 43:15 103:9 110:11 177:20 227:3 234:3
checkbox 96:13 122:19 148:20
checking 38:6
checklist 110:11 121:11
cherry 228:19 229:22 231:8 232:3
Chief 12:18 13:20 20:16
chime 36:14 63:12
CHIP 3:8 15:8
choice 68:12,14 234:20 245:2 282:20 283:3
choices 264:20 267:1,1 267:19
chomping 118:4
Chong 219:18
choose 278:2 282:15
choosing 101:11 282:16
chose 22:12 140:9 268:6
chosen 179:18 262:11
CHPN 2:3,8
Christine 2:4 10:8
chronic 14:17,20 15:19 24:1 81:14
churn 59:22
CIC 2:7
Cindy 3:4 279:21
circulate 283:19
circumstances 194:11 246:2 250:6
citation 62:14
cited 83:6
cities 251:2
claim 57:3 61:11 222:17 226:5 227:6 259:6
claim-based 61:11
claimed 227:4
claims 46:21 50:4 52:13 60:22 68:1,2,6 69:2 222:13,14 225:12 226:20 227:3 230:7 234:11,13 241:16 243:14 247:5 248:13 256:19 258:5,8,9,16 278:16 280:6,13 282:1
claims-based 61:17 222:1,3 231:20 245:21 258:8 259:1 266:13
clarification 173:17 186:5,14 197:20
clarifies 152:16
clarify 30:16 32:17 44:7 77:13 80:11 127:15 151:6 203:21 263:2 287:22
clarifying 32:11 37:5 99:13 164:10 219:9
clarity 159:3 167:17 170:8
classes 83:4
clear 42:7,11 127:20 128:4 142:17 144:14 144:20 159:7 190:21 193:10 200:2 208:18 273:4,5 274:17,20
cleared 272:21
clearly 199:15
clever 69:16
clicker 23:15
clinic 170:16,17
clinical 12:20 194:14 195:7
clinically 51:9
clinician 57:5 65:17,22 74:20 149:8
clinician-based 74:13
clinicians 21:20 57:21 60:12 61:6,14 63:15 66:6,10,19 74:7,8,10 136:13
close 28:5 35:8 49:3 73:15 86:9 142:13
closed 165:1 166:16 168:22 177:8 215:3 217:6,11 261:4 272:17 277:10
closely 164:2
closer 268:12
closest 59:5
closing 288:4
CMA 202:11
CMD 2:6,7
CMS 4:3 10:16 13:22 14:12,17 18:7,8,13 22:21,22 23:14,19 24:17,19 26:7,11 36:14,15 37:4 45:11 45:15,19 47:9,12 50:14 51:4,14,20 52:20 54:4 60:15 63:16,21 64:2 76:11 77:5 82:4 87:6 99:16 102:18,20 116:22 117:1,18,21 118:18 120:10,20 127:1 137:22 142:16 150:4 150:6 152:3 153:13 154:4 156:3 181:18 185:1 193:2 196:21 211:22 212:7 213:2 218:15 219:8 221:19 221:22 268:19 269:22 286:14 287:17 288:14
CMS' 55:17 92:9
CMS's 246:20

co- 7:11 32:12
co-chairs 1:19 5:9 13:17 17:22 31:20 32:11,16 33:15,19
Coalition 2:7 10:13 112:7
code 226:19,21 227:2,9 227:12,16 244:18 259:6 279:22 280:2
coded 226:11 227:20
codes 226:5,8,9 247:4
coding 234:16
coffee 41:15
cognitive 19:19 90:4
cognizant 163:10 250:18 283:3
cohort 203:12
coincides 110:16
Coleman 110:22
Colene 81:12
collaboration 81:17 87:5
Collaborative 24:18
collar 270:8
colleague 64:4 163:18
colleagues 17:18 18:2 22:22 58:3 64:20 87:6 102:20 134:21 211:20 245:8 255:20 286:14 287:17
collect 136:20 137:20 138:3 149:8
collected 80:22 87:21 87:22 88:4 137:8,12 137:13 141:16 142:2 145:10 175:5,11
collecting 72:8,11 90:5 138:2 271:5
collection 9:20 72:16 83:21 145:16
collectively 180:3
Colorado 12:6
combine 8:6
combined 179:19
combines 285:18
come 8:15 11:11 17:21 22:19 36:19 37:8,21 65:19 66:10 78:6 93:13 123:7,10 153:19 178:13 179:3 212:2,19 213:3 220:5 236:1 249:1,10
comes 75:1 114:6 199:20 203:11 212:21 250:7 283:14
comfortable 6:18 38:2 128:8 256:13 259:19
coming 5:5 7:4 54:4 59:18 60:1 66:11 183:1 201:3 246:14 285:15
comment 4:6,11,18 19:10 34:18,20,22 35:1 73:22 74:7 77:9 87:2 93:1,6,11,14,18 93:20 94:2,6,12,19 95:3 97:14 107:15,18 115:18 123:17 125:4 128:21 133:4 136:3 139:7,15 140:11,12 140:20 148:13 153:8 163:7,21 171:15 178:2,3,11,17,20,22 181:22 184:1 186:7 189:8 206:16 208:8 222:6 231:11 232:8 232:15,17 238:18 245:16 246:9 251:1 251:14 254:9 262:21 263:3,5 269:19 274:9 275:10 286:21 287:3 287:5,8
commented 116:17 213:6
commenters 34:16 107:11
commenting 34:10,11 35:7
comments/discussion 248:17
comments/questions 143:20 150:1 173:13
commission 96:19
Commissions 194:17
commitment 6:11
committed 23:1,12
committee 2:1 11:18,20 13:17 14:12 15:21 16:12,16 26:9 28:5 34:8 35:11 36:10 37:13 53:14 78:10 102:17 104:3,16,22 259:20 269:17 277:17 288:6 289:11,14
committees 21:2 24:19 98:21 105:14
common 63:18 83:16
communicate 67:18
communicating 183:10 183:11
communication 23:22 50:14 51:22 53:8 83:5 127:4 141:12 144:8 199:13 208:19
communities 24:2
community 49:21 61:1 162:18 170:12 267:18 282:8
companies 251:4,8
company 10:15 12:19 13:21
comparable 46:6,10 50:1 51:8 123:4
comparative 249:3,16
compare 165:11 235:18
compared 39:4 98:8 224:17 227:20 267:5
comparing 251:15
Compassus 9:22
competency 133:2
compile 32:13
complement 29:1 84:10
complementary 108:20
complete 35:4 62:15 77:22 84:9 90:17,22 115:14 214:3,6 286:22
completely 160:19 198:6 213:1 251:8
completion 90:2
complex 51:9 83:18 85:8 121:3 141:8 208:22
complexity 58:14 141:7
compliance 189:20 235:13 236:14,22 253:12 255:1
compliant 253:8
component 247:15,17
composites 75:3
comprehensive 248:16 267:17
comprehensively 248:20
computation 251:19 252:12
computationally 89:3
computer 31:13 111:10 212:22
concept 30:4,16 62:15 87:18 107:11 118:17 120:10 121:3 246:6 273:12,14 274:12 277:16 285:5
concepts 62:8 181:7 193:13
conceptual 275:21
conceptually 271:12,16 275:9 276:3
concern 84:16 103:5 188:9 234:12 235:17 254:17 273:19
concerned 117:7 131:13 170:19 226:8
concerning 240:20
concerns 30:11 72:1 102:16 127:7 154:11 168:8 171:21 234:10 236:16 254:19,21 255:7,20 259:13,14 268:13,20 274:1,8 282:8
concise 190:21
conciseness 187:16
concludes 33:8
conclusion 32:6
concrete 137:10 139:18 284:1
concur 160:20 161:3 255:6
condemnation 184:12
condition 36:20 250:2 278:12 279:4
conditional 29:10,17 30:13 34:5 36:8 37:6 100:6 104:14 107:5 122:9 151:4,12,18,22 153:2 166:10 167:6 176:21 181:12 215:1 215:18 216:11 217:3 260:18 271:9 272:5 275:18
conditionally 233:4,16 272:15
conditions 29:16,19 249:6 285:16
conduct 149:6
conducted 28:8
conducting 76:6
Conference 1:17
confident 57:18,19,22
confirm 100:15 127:18 127:19 172:4
confirmed 127:20 135:16
confirming 215:17 216:11
conflict 11:22 14:3 17:19 101:8 150:14
conflicts 14:7
conforms 92:12
confuse 23:18
confused 147:13
confuses 213:15
confusing 104:18 185:15 199:11 211:2
confusion 185:16 210:1
congratulate 127:1 211:22
congratulations 35:3
Congress 209:8
congruency 157:10

158:10 160:19
connection 66:19 234:21
connects 268:3
Connie 9:2 13:8,8,10 206:15 208:6 237:17 241:14 242:2
Connor 64:4 92:17
consensus 31:16 33:17 33:20 86:15 98:18 100:16 101:17,22 102:10 103:14 271:20 277:21 283:13 285:14 286:13 288:1
consequence 25:12
consider 17:10 46:4 115:16 138:20 142:15 142:18 157:17 220:20 220:21 247:9 260:5 266:20
consideration 4:8,13 7:4 13:2 26:13 27:19 28:9 34:9 44:20 45:14 47:16 50:13 51:21 52:6,21 77:10 93:16 93:22 122:4 145:11 149:17 154:5 164:17 171:2 176:9,14 179:15 194:4,10 196:7 219:7 274:7
considered 201:8 214:7 239:3
considering 22:6 162:10 165:11 195:20
consistency 27:20
consistent 230:10
CONSTANCE 2:18
constituted 152:11
constitutes 182:4
construct 138:1 165:2
constructed 224:2,4,7 242:22 253:14
construction 224:14
constructs 73:18
consult 170:5
consumer 208:10 282:14
consumer-friendly 186:11
consumer-sensitive 186:19
consumers 67:18 86:6 87:4 208:9 213:12
contains 32:4
content 70:15
CONTENTS 4:1
context 31:21 145:6,9 154:1 191:18,21
continue 8:3 56:4 117:6 183:19 229:16 261:12 282:22
continued 120:1 140:5 220:16,18 221:21
continues 70:1 209:22 210:5 213:11 240:14
continuing 23:9 24:13
continuum 74:10 161:1 240:19 243:20
contract 10:16 244:21 244:22 247:19 253:2 253:3
contracting 245:17 246:1
contractor 219:16
contractors 81:8
contracts 59:14 244:17 257:5
contradiction 150:15
control 3:1 80:1 84:22 257:5
controversies 238:1
conundrum 252:22
conundrums 253:9
convened 222:4
convenes 19:2 103:14
convenient 241:3
convening 18:21
conversation 26:12 44:15 59:2 60:3 101:12 102:20 130:14 144:3,16 249:21 274:3,5 282:10 286:18
conversations 240:13
cool 100:3
cooperation 77:1
coordinating 28:4 34:8 35:10 102:17 289:11 289:13
coordination 14:6 23:22 50:15 51:22 73:16 82:7 106:12 121:16 150:8 218:19
Coordinator 3:7 10:6 16:7
copay 130:7
COPs 155:17 161:7,12
copy 184:5
core 24:18 58:18 92:15 95:10 97:10 140:22 144:8 148:16 181:7 249:20,22
corner 7:8
Corporation 2:4 10:9
correct 20:9 99:2,3 145:6 210:14,16 274:10 277:8
correctly 117:2 151:2
correlate 230:20 243:12
correlating 242:1 282:10
correlation 230:12 278:15
cost 50:10 52:17 226:15 233:12 253:5 253:9
cost-setting 72:11
costly 85:8
councils 57:19
count 100:21 166:20 169:3 177:12 215:6 215:22 216:15 217:8 261:7 272:2,18
counter 139:20
country 22:21 63:5 115:8 212:12 241:8 245:13
countrywide 117:6
couple 55:14 56:1 75:14 98:3 126:22 144:3 172:1 177:7 181:15 207:21 211:19 222:4 234:15 247:8
course 24:3 30:19 45:17,19 51:7 153:9 180:22 193:3 268:19
cover 6:20 253:8
coverage 221:17
covered 114:16,17 156:17 159:18 248:19
CPHQ 2:10
crack 212:18
create 24:21
created 30:15
creating 118:2
CRED 2:4
credibility 210:20 211:5
credit 70:8
crisis 205:10
criteria 28:13,16 87:16 227:4 233:20 240:4 274:4
critical 29:6 92:5 95:10 97:10 140:22 148:16 162:3 183:10,12 199:4,14
cross- 44:14
cross-setting 54:6
cross-walked 69:4
crossed 39:6
crosswalk 68:7
crucial 221:12
cultural 56:9 58:4 243:18 257:1
culturally 238:15
culture 56:13 238:11 241:7
cumbersome 71:8
curative 281:6 282:21
Cures 69:22 91:18
curious 202:2 254:7
current 27:13 50:7 52:14 96:21 106:12 110:9 139:19 140:2 161:5,6 181:3 183:13 183:18 185:13 193:22 201:9 218:7,11 243:1
currently 30:18 60:19 64:17 92:6 129:17 139:1 141:22 142:1 145:10 181:7 192:7 193:1 233:15 268:21 271:8 275:20 276:6
cut 95:18 97:6
cutting 44:15
CWS 2:19
cycling 56:19

D

D.C 1:18
Dahlin 2:18 13:10,10 204:22 205:13 206:1 207:12,16 237:18
daily 48:6
Danielle 2:8 10:22 58:9 60:11 143:22 145:6 182:13 183:6 185:22 199:1 248:20
Danielle's 184:1 185:6 186:7 256:7
dataset 241:17
date 36:11 51:14
day 4:20 6:4 31:15 34:19 51:13 66:2,3 110:4 201:3,3 211:2 239:20 286:22
days 22:7 51:13 111:5 158:13 223:6,9 227:10 237:14 247:12 247:13 257:6 267:8
DCPAC 64:5 75:18 81:13
dealing 256:21,22
death 223:6 224:10 227:20 239:3 247:14 267:8 278:6 284:15
Deb 9:10 75:17 126:21 171:4,22 173:15 175:12 182:13 184:8 198:4,4 210:18 271:1 272:13,14 274:18
Deb's 170:12 199:3

DeBARDELEBEN 17:14,15 163:20 164:5,8
debating 279:19
DEBRA 2:11
decades 72:17
decedents 223:13
December 1:12 35:8 289:8
decide 59:13 71:2 241:4
decided 266:12 284:11 286:17
decision 27:19,20 29:7 29:9 30:12,13 31:20 33:16,22 34:4 101:19 102:12 103:6,18 246:12 278:11 283:1
decision-making 86:7 165:9
decisions 21:17 26:18 27:2 28:22 38:10 103:16 221:13 245:19 266:5
deck 217:20
decode 186:9
dedication 26:6
deemed 140:6
deep 66:8 242:16 254:3
deeper 66:7 68:9 104:5 104:16 152:9
default 179:22
defer 37:4 163:18 164:1
define 63:10 108:16 172:2 189:21 202:21
defined 31:16 145:2 236:4
defining 249:22 250:9
definite 279:16 286:6
definitely 90:12 126:14 136:4 142:14 176:8 176:13 194:5 265:14
definition 95:1,6 107:16 113:4 119:4 123:15 137:8 140:10 142:16 144:22 147:5 148:22 157:16 170:14 183:9 183:17 185:20 186:5 191:17 250:8 251:14
degree 107:2
delay 16:21 61:5 269:14 274:16
deliberation 28:15
deliberations 37:15 93:3 103:22 104:10 264:12 286:21
delighted 23:4
delineate 199:15 275:17
deliverables 153:18
delivered 219:3 240:22
delivery 110:4 242:12
deluged 213:19
demonstrate 107:2
demonstrations 14:2
Denise 81:12
denominator 101:10 102:6 112:15 135:19 159:2 161:18 174:1 176:11 186:6 192:7 192:17 207:5
denominators 174:7
department 159:5
departure 270:3
dependent 65:21
depending 131:11 212:22
described 118:11
description 119:10 131:14 135:18 143:7 180:19
Desi 152:17 166:2,22 168:13 177:1 260:19
design 57:18
designate 203:17
designed 129:16 273:22
desire 102:22
despite 163:12 258:15 258:16
detail 75:5,5 96:5 119:17 140:8 187:7 195:13,14
detailed 274:1
details 271:13
determination 258:13
determine 33:16 104:3 156:12
determined 233:21
determining 69:3
develop 48:4 149:4 221:22 266:10
developed 28:11,12 37:7 92:17,18 134:8 134:15 141:8 197:4 222:10 231:12,21
developer 263:16 265:1
developers 32:17 99:15 115:9,16 117:21 120:20 263:19
developing 20:5 91:10 194:9 219:22 220:1 222:3,19 265:20
development 22:16 37:12 81:8 82:1 85:19 86:11 103:15 147:18 147:21 149:2,15 193:2 219:19 283:16
developmental 165:1
develops 12:21
DHEERAJ 2:7
diagnosis 128:5,11 239:22 240:12 282:12
dictate 200:21
die 227:10 235:3 238:12 239:2 242:19 278:8
died 223:14
diet 190:13
dietary 189:13,22 190:7 190:15 191:22
difference 30:11 98:22 111:17 138:10 229:1 252:11
differences 98:20 103:12 105:7 154:15
different 19:13 54:5,19 57:8 63:3,3 81:1 101:14 103:21 104:11 118:13 123:21,21 134:7,10 145:15,16 146:22 157:15 159:13 165:4 176:11,12 194:11 203:9 213:1 230:1 241:15 255:2 258:20 286:4
differentiate 251:10
differently 25:10
difficult 56:17 59:3 61:22 97:8 110:1 117:10 136:11 145:14 170:16 211:21 212:4 212:16 284:6
difficulty 212:13 277:2
dig 249:4
direct 80:16
direction 19:8 65:12 132:22 153:15
directives 53:8
directly 257:1
director 3:13,14 10:15 12:19 14:19 15:1,10 20:1 132:15 163:20
disagree 210:18
discharged 82:9,10,12 82:13,20,21 162:17 170:11 172:22 174:21 181:2 186:21 190:19 191:3 192:3,15 197:11 227:1,9,12 239:6 242:9 248:8 249:14 252:17 278:9
discharges 68:11 82:18 82:18 161:19 220:7 220:11 223:18,20 225:2 226:11 227:19 228:2 229:7,8 235:14 236:17 237:3 258:2 279:15
discharging 85:1 186:16 193:16 195:4 199:18
disclose 8:17 9:5,15,18 10:1,3,7,10,14,21 11:21 13:12 78:8 79:8
disclosed 77:20
disclosure 7:19 78:1
disclosures 4:2 8:6 9:9 9:12 11:13 12:13 13:15,18 15:4,22 16:11 17:3,11,17 79:16
disconnects 209:20
discontinued 140:3 185:12 188:19
discourse 45:13 182:7
discrepancies 83:3,16 85:10 110:20 142:5
discrepancy 83:1 111:3 120:2
discretion 32:16
discuss 33:3 37:15 83:22 98:5 180:1 252:9 261:13
discussant 182:22 183:2
discussants 32:10 99:10 120:16 121:2 167:8 169:14 182:10 182:16 234:2 254:8
discussed 14:4 182:18 184:22 215:10
discussing 54:7 165:7
discussion 6:5 31:7,22 32:1,12,14 33:8,11,13 33:14,18 34:13 36:10 45:18,20 53:10,17 54:10,13 68:1 80:20 99:20 107:9 108:10 108:11 120:18 135:15 139:12 143:4 151:15 153:11 154:1 162:10 163:9 165:17 175:18 176:8 179:19 192:6 204:7,13 231:12 232:21 261:10 262:10 263:12 267:21
discussions 116:5 133:10 135:11 164:21
disease 3:1 24:2 80:1 242:8 244:1,2,3
disincentives 51:3
disjointed 62:9

disparities 229:19
displayed 164:15,18
disproportionate 220:10 248:4
dissenting 28:3
distal 48:8
distinction 206:17
distort 248:12
distracted 58:15
distribution 228:4,10
dive 44:15 45:21 68:10 104:5,16
diversity 238:4
divide 228:6
divides 32:2
Division 14:16,19,19 15:9,19 81:14
DNR 238:19
DNR/DNI 238:21
Doctor 211:7
doctors 61:7 127:13
document 64:13 171:8
documentation 176:10 187:5,6
doggone 66:4
doing 21:5 23:17 26:17 53:19 62:13 66:12 72:2 89:10 118:18 120:21 125:2 126:3 134:22 141:11 144:10 147:21 167:9 187:17 211:3 232:22 239:2 239:21 247:8 251:21 256:19 268:16
dollars 62:21
domain 196:13 209:7
domains 19:18 47:9 50:13 51:20 52:20 85:5 218:16
dominated 263:11
dominating 59:2
DON's 111:10
dosages 199:10
dose 117:17 195:2
doses 116:11
double 43:14 111:3 176:10
downloadable 75:22
downloaded 40:17
downloads 139:10
dozens 210:22
Dr 14:21 15:12,18 16:3 18:10 37:9 53:12,20 53:22 70:20 71:20 79:22 80:3,5 197:9 219:10 257:10 263:10 263:21 264:13,16 269:16 277:12,21 279:8,12 283:6 288:3 288:13
draft 147:1 283:19
dramatic 271:3
draw 75:15 84:1 188:9
Drew 118:5 163:16
drill 278:4
drive 188:11 267:15
driven 220:15 246:1
driving 246:12 249:6
drug 129:7 141:20
drugs 110:2 116:2
dry 260:3,11 282:6
due 28:1 179:12 223:2 223:19 226:12,14 227:1 231:9 235:14 236:18 257:5
duplicated 110:17
duplicating 108:7
duplicative 155:18 233:14
duration 128:16

E

e- 129:22
e-prescribing 129:2,4,6 129:15 130:18 133:3
earlier 31:19 34:12 35:8 101:9 107:17 120:9 127:6 163:19 221:5 222:18 245:16
early 80:10 147:20,20 147:20 148:10 234:8
ears 142:11
easier 256:12
easy 167:14 168:10
eat 190:1,16
eating 239:19
echo 60:10 208:7 241:14
echoes 62:8
echoing 190:7
economical 213:13
ED 67:15
edition 100:14
educated 191:7
educating 149:13
effect 85:21 279:6
effective 23:21 24:1
efficient 91:8 136:19
efficiently 286:12
effort 23:6 58:16 60:2 247:7
efforts 76:17 84:9,10 91:16 147:21 163:13
EHR 53:7 64:21 65:1,3 65:9 69:13 126:11,13 126:13,17 127:3,7,7 129:4 130:1 146:3 157:11 212:18
EHRs 117:7,12 125:1 146:5,7
Eighty-three 146:8
either 82:11 99:15 101:6 125:13 180:5 184:21 197:3 221:19
elaborate 71:12
elderly 205:6
electing 221:18
electronic 20:20,22 26:3 84:5 89:5 91:20 111:8 112:19 124:21 125:19 126:11 170:17 170:18 172:18 212:6
electronically 126:7,19 134:14 137:21 170:15 170:20
element 55:8 64:3,6 89:12 91:11 92:16 95:10 97:10 106:5 134:16 140:22 148:16 148:16 149:9 202:18 265:19
elements 63:10 137:19 137:21 243:2
Elevating 11:1
elevator 284:8
eligible 101:2
Elisa 3:11 7:18 18:6 101:8 105:9
ELIZABETH 3:6
Ellen 163:19 164:3
email 170:20
emailed 147:10
embarrass 71:1
embarrassment 70:19
emergency 113:5 159:4 167:19 170:7 205:2,5 205:7 207:21
emerging 33:18
empathy 65:17
emphasis 85:15 116:7
emphasize 33:2 85:19 120:8 131:10 149:16 154:16
emphasized 219:2
emphasizing 106:3 115:2
empowered 191:6
empowering 21:16 204:14 205:17 206:4
empowerment 53:6
EMS 243:21
enable 91:19
Encompass 2:3 10:3 17:15 60:6
encounter 58:3
encourage 5:21 25:22 27:5 104:19 128:10 128:18 172:20
encouraging 57:20
ended 83:15 87:15
endorse 245:8 285:11
endorsed 51:19 52:18 52:19 135:1 152:2
endorsement 47:6,7 50:11 103:16 104:15 105:10 107:6 151:5 151:13 152:1,5,13 153:3 166:11 167:6 176:22 181:13 215:1 215:18 216:12 217:4 233:5,17 260:19 271:10
ends 34:22 253:6
engagement 23:21 47:13 57:2,10,16,17
England 69:11
English 188:2,3
enhance 153:16
enjoy 26:11 71:6
enrollment 224:12 284:17
ensure 28:2 31:11 84:20 85:1 87:9 144:7 161:13 193:18 231:8 281:20
ensuring 190:13
enter 39:11 152:22 166:8 177:6 253:1
entered 277:4,4
entirety 126:5
entities 65:18,21
entity 78:9
entrance 271:4
environment 144:7
environmental 134:21
episode 67:14 140:4
episodes 143:9 220:11
equal 31:17 33:7 34:1 101:18
equally 102:21 212:20
equip 196:3
equipment 116:1
equity 26:1 229:18
ER 223:8 284:16
Eric 110:22
Erin 3:13 5:14 7:21 27:9 37:9,20 43:19 45:3,11 98:17 99:2,9 100:10 105:19 107:19 135:16 169:10 219:11 223:10 232:21 234:1 285:12 286:11,17

error 186:2
errors 191:8
especially 95:2 158:4 162:16 180:7 191:18 198:12 236:17 244:1 244:16 245:9 251:2 282:2
essential 186:1 189:19 233:12
essentially 201:5 202:8 256:9 264:19 268:12 271:7
establish 31:10 100:15
established 31:5 49:12 218:2
estimate 268:10
estimated 83:8
estimates 90:2
estimator 268:8
et 110:17
ethic 20:18
ethically 113:7
ethnicity 228:22 229:12 230:2
EUGENE 2:21
evaluate 27:14 82:4 84:21 249:5
event 251:20 259:15
events 83:7,9 85:22 86:3,5 224:1 227:21
eventually 164:14,18
everybody 10:19 18:11 18:20 38:9,10 41:16 42:6 63:17 72:1 98:1 100:3 111:16 154:12 178:8 179:2 262:3 275:8 277:22 285:13 286:11 287:12
everybody's 285:19
evidence 104:1,20 191:6
evolved 144:4
exacerbation 244:1
exact 100:18 107:8,10 107:13 261:7
exactly 71:21 117:4 120:5 152:7 155:22 158:5,11,13 184:4 200:18 271:14
examine 233:18
example 55:9 68:11 121:8 123:15 157:19 201:1,15 202:6 260:3 268:16
examples 249:5,5
exceeded 220:12
excellent 100:11 177:16,16 284:22
exception 9:2
exchange 91:7,20 92:14 129:5
excited 8:1 24:15 131:8 133:21
exciting 22:14 57:9
exclude 226:4 231:22 232:1,1 241:18 259:9
excluded 225:11,16,17
excludes 231:21
excluding 241:19 255:10
exclusion 136:5 169:22 171:1 172:20 173:10 175:22 233:20 248:3 274:3
exclusions 112:12,22 121:20 158:22 226:2 256:19 258:10 259:13 271:15
exclusive 255:8
excuse 61:8 125:3 252:3
expand 95:16
expanding 138:18
expect 8:15 36:9 37:8 78:5 235:2 279:15
expectation 258:1
expected 224:19,20 251:15,19 252:10 254:10 268:5
expediency 182:17
expensive 205:22 206:1
experience 20:19 56:7 68:8 83:1 90:4 110:10 127:12 132:17 208:2 223:12 231:18 237:5 237:8,12,13 241:7 246:11
experienced 205:18
experiences 231:4 269:5,9
experiencing 16:21
expert 12:4,7,17 14:6 57:4 70:16 87:3,3 139:7 208:7 222:5
experts 2:15 8:11 9:1 11:14 13:17 14:10
explain 100:14 151:21 195:5
explained 101:9
explaining 27:21 195:13
explanation 130:21
explicit 189:12
explore 235:10,12
express 235:17
expressed 130:16 248:7
expressing 250:9
extended 51:8
extension 124:22
extracting 210:21
extremely 18:16 143:17 170:15 212:16 288:16 288:16
eye 73:21 142:13
eyes 142:11 289:4

F

FAAN 2:18
face 90:2 268:15
facilitate 28:10 45:18
facilities 65:17 66:7 77:2 115:20 125:12 131:12 140:18 141:12 245:18
facility 45:8,9 49:9 50:3 52:7 61:3,4 84:18,19 107:1 109:18,19 110:3 126:18 131:22 141:10,12 145:13 159:4,5 162:2,3,5 170:12 174:1,17,20 175:9 186:15,19 206:20 244:20,22 245:4 253:1 259:2
facility-based 74:11 76:3
facility/institutional 65:20
fact 124:12 126:7 132:7 139:8 157:3 160:20 173:5 175:20 213:6 227:14
factor 228:20 252:18
factors 107:4 228:20 229:1 230:1 277:18 283:15 284:2
fail 70:19 122:21
failed 83:7 218:3
fails 271:20
failure 46:7 49:11,14 51:2 52:8,9 217:22 238:13,14
fair 256:4
fairly 37:7 46:10 175:16 260:9
faith 256:4
fall 192:19
falling 194:13
falls 19:20 111:21
familial 202:14
familiar 56:6
families 221:11 244:8 250:10 269:10,11 283:2
families' 267:1
family 23:21 47:13 53:6 57:2,10,16 81:5 88:19 141:13 183:12 184:7 190:11 191:1,5,7,19 193:10 194:13,19,22 195:11 200:10 202:3 202:7 204:14 208:19 213:20 223:19 236:18 237:10
FAOTA 2:10
far 41:17 100:2 106:18 121:1
fascinated 254:9
fascinating 22:14 208:1
fashion 66:12 284:22
father 75:7 193:14
fault 242:20
favor 284:19
fax 127:12,13
faxing 130:12
feasibility 90:3 104:6
feasible 136:20
feasibly 106:19
features 45:4
February 35:13
federal 3:1 14:10 16:5 19:4 80:2 91:14 92:7 100:21 101:1,20 150:8 213:3
federally- 92:12
Federation 3:17 94:18
fee 222:16
fee-for-service 46:21
feedback 23:5 26:19 28:1 29:9 44:18 45:12 53:18 55:10,20 57:21 75:13 269:22
feel 33:19 38:2 41:15 60:14 65:17 80:4 81:19,20 84:9 99:6 101:7 128:8 151:7,14 205:19 226:13 231:22 250:17 259:18 270:1 281:22 286:5 289:12
feelings 285:19
feels 201:11 277:17
fell 195:12
felt 37:22 220:14
fentanyl 205:8
FHIR 64:16
fiddling 285:10
field 86:22 89:7 124:18 228:18 232:3
fiercely 207:18
Fife 2:19 12:16,16

69:10 128:22 133:7 209:19
fifth 139:9
fighting 173:16
figure 158:4 210:3 239:13
figured 35:21
figuring 59:16 129:20
fill 29:5 52:4 223:11,12 223:16
filled 145:12
filling 24:8
fills 231:16
final 34:22 84:8 193:3
finalize 35:11
finalized 181:20 197:5
finalizes 289:11
finally 19:9 25:22 27:13 34:19 125:21 127:22 128:9 131:7 228:3 259:14
financial 12:13 13:15 59:9
find 13:5 26:21 42:13 63:11,18 66:17 155:3 157:15 158:14 164:11 170:20 213:4 226:19 227:20 244:15 282:11
finding 66:9
findings 221:10,13
finds 244:13
fine 23:19 47:20,22 48:3 105:5
fingers 39:6
finished 204:8 217:11
fire 112:13
fires 122:1
firm 213:16
firmly 214:2
first 9:3 12:4 27:11 32:8 32:18 33:17 39:15 46:3,18 51:12 54:2 64:9 65:14 71:20 78:18 81:6 84:13 86:16 89:20 96:10 97:19 98:5,13 99:8,18 114:7 122:7 145:19 150:1,18 160:18 174:12 197:21 198:1 198:5 201:3 204:4 219:12 220:2 234:7 241:16 246:19 254:8 277:12 283:8
fit 25:18 163:9 212:15
fits 26:2
five 19:18 25:14 215:21 215:21 285:3
fix 144:20
flag 104:22
flagged 34:9
flaw 255:7
flawed 254:13,20
flexibility 23:13 140:16
flexible 239:7
flog 66:10
floor 1:17 210:10 281:15
flow 64:12
fluid 149:15
flushes 200:8
flying 207:16
focus 29:4 53:3 73:6 74:16 80:18 81:1 82:6 83:12 84:20 85:10 88:15,17 95:13 103:21,22 104:10 105:2 107:12 141:18
focuses 206:18
focusing 24:9 85:2 137:14 279:5
foggy 162:12
folks 59:12 63:15 96:16 101:15 127:10 138:3 138:8 162:16 178:11
follow 23:16 46:5 48:20 49:22 182:7 269:20 270:1
follow-up 172:9
followed 123:20 227:2
following 23:13 48:18 148:2 186:6 208:1 223:6 280:13 288:4
follows 231:13,19
font 199:15
food 198:18
foods 189:17
Ford 20:17
forest 111:21
forget 81:9,19 162:12
forgiving 66:16
form 11:14 40:6 139:12 148:20 149:13 199:13
formal 187:2 202:12
formalize 208:12
formalizing 208:15
formally 147:7
format 117:5 125:19 164:18 187:13 266:8
formulary 213:8,10
formulate 45:15
formulated 164:12
forth 34:5 132:1 134:15 154:2 156:16
Forum 1:1,17 24:16 135:2
forward 18:17 19:11 26:7 38:3 47:20 64:14 65:12 71:5,8 102:14 120:7 151:22 181:12 237:2 240:8 259:20 268:19 269:3 279:10
found 90:6 220:10 229:9,10
foundation 254:17
founder 79:4
four 25:11 29:9 45:4 87:1 90:11 98:14 99:8 99:12 100:4 102:8 107:21 108:8 109:15 114:7 123:4 135:5 138:11 150:21 151:17 154:11 176:14 182:10 192:8 212:10
fourth 139:9
FPCN 2:18
frail 72:20
frailty 239:14,21 242:5
frame 21:10 26:11 56:8 257:7
framed 32:22
framework 91:19
frameworks 89:10
framing 18:7 45:19 219:8
frankly 22:15,21 252:1
fraught 237:22
Frederick 108:1,2
free 41:15 80:4 99:6 151:7 170:17 289:12
frequencies 199:10
frequent 83:6
frequently 110:19
friend 130:15 132:19
friends 60:15 93:8
front 8:18 11:17 17:22 50:8 93:12 101:19 103:3 137:11 139:18 173:14 246:16
frustrates 70:5
frustration 130:16
frustrations 56:7
FUHM 2:19
fulfilled 89:19
full 55:22 129:3 225:16 248:9 261:10 275:14
fully 57:14 125:2,19 231:12
function 88:10 141:8 239:19 264:6
functional 19:18 49:20 72:10
functionality 69:13
functions 19:19 146:4
fundamental 198:21 243:17 254:16
fundamentally 254:13 254:20
funding 17:7 134:3,4
furnishing 51:8
further 36:10 37:12 54:9,12 91:22 99:20 151:15 202:20 260:6 260:14 277:16 283:16 284:12
future 19:8 30:6 47:16 50:12 51:21 52:20 64:17 142:17 153:15 205:21 218:16 276:8 288:11

G

Gail 2:6 78:12 79:2 182:12,14,19 183:4 201:17 202:9
galaxies 134:10
gambit 90:11
game 250:14 275:12
gap 52:4 170:3 184:11 184:18 198:19,19 219:1 223:11,12,16 231:16 242:12
gaps 19:8 24:8 29:6 48:1 50:21 53:2 76:7 113:2 223:10
gather 246:11
gathering 68:9
gear 62:3
Geller 3:1 16:3,3 79:22 80:4,5
Gene 9:2 12:3,5 122:11 173:13 176:9 186:3 224:18 251:12 258:22 270:3,7,9
Gene's 254:9
general 20:14 28:21 37:21 55:20 109:5,15 113:15 114:11,12 115:6 119:10,16 123:3 125:8,10 154:10,13 155:8 157:2 161:19 199:11 220:6 221:3 229:4 247:19
generally 38:2 44:19 62:14 132:17
generated 190:22
generic 124:11 210:1 213:7
geographic 235:21
geographical 63:3
geography 236:5,12
Geriatric 9:11

geriatrician 56:2
Geriatrics 2:11
germane 171:5
gerontologist 74:18
Gerri 1:19 2:1 5:9 6:18 7:22 13:19 26:15 36:6 97:17 100:12 103:11 105:8 109:3 122:13 151:7 153:7 160:12 217:17 232:6 261:11 261:17,19 289:2
Gerri's 6:6 261:15 287:17
getting 59:9 62:21 69:13 76:21 77:5 133:13 170:6 174:2 185:22 190:10,12 200:8 204:12 237:8 266:3 269:14 280:22 281:21 287:22
giant 118:17 120:10
GIP 247:22
give 31:21 35:22 39:1 45:19 53:12 64:3,19 71:18 76:15 138:16 139:4 148:15 166:19 179:20 181:9 193:11 195:10 210:10 212:22 261:6 262:18 273:15 285:16,18 287:16
given 84:13 93:9 96:3,8 101:15 102:22 106:10 115:14 119:15,15,21 128:12,14 152:1 184:15 187:12,22 188:1,9 190:11 191:1 192:21,22 193:7 194:11 195:22 201:15 212:5 213:7 252:7 270:5,7
giver 237:9
gives 34:6 68:2 141:9 153:22 184:20 214:4
giving 55:1 183:15 186:10 198:13 213:18
glad 172:2 245:9
glasses 270:12
global 34:18
goal 21:14 26:12 49:18 51:8 68:15,16
goals 23:14,19 47:14 61:12 219:4
God 187:20
gold 195:8
Gorham 27:4,9 35:21 38:12 40:10,16,22 41:5,9 42:9 43:5,11 48:16 286:15
gotten 67:6,8 129:17
governed 155:16
government 3:1 14:11 101:2
gradient 273:5
granted 196:6
granularity 159:15
graph 41:11,12
grateful 13:6
gratifying 247:6
gray 159:8
greater 31:16 33:7 34:1 34:6 75:5 101:18 123:8 185:21
green 70:20 255:6
group 5:9 8:8,14,21 15:2 20:3,4 22:20 23:18 27:14,17 28:1 31:12,17 32:12,19,21 33:3,21 34:2 35:2 37:22 53:14 98:6,8,9 98:12 109:4 119:9 174:7 179:5,22 180:5 180:11 184:21 189:5 192:11 197:10 214:19 215:14 216:7,22 219:2 228:9 245:11 283:8
group's 27:22 33:10,14
groups 67:7 87:4,7 244:2
grow 74:15,22
guess 72:11 87:15 122:20 126:6 134:4 156:10,12 188:6 201:14 245:7 248:2 277:14 283:9,12
guessing 126:2
guidance 19:7 28:22 37:5 73:20 84:14 95:10,15,16 96:1,6 97:9 109:14 117:1 139:16 140:9,11,13 140:22 148:9,15,19 148:21 149:2,6,7,10 149:11 184:2 192:20 192:22 193:5,7,12 196:9
guide 32:1 34:13 38:10 45:20 107:9 109:7 135:16 139:13 143:4 161:9 192:7
guideline 195:8
guidelines 34:10 190:15 194:14,15,16 194:18
guiding 204:18
gusto 134:5

H

Hale 9:21,21 241:13 255:5 281:16
half 59:18 82:8 162:9 211:5 287:12
Hall 3:6 10:4,5 16:6,7 63:20 145:20
hallmarks 60:16
hallway 7:8 274:19
hand 38:20 40:3 53:9 98:14 115:13 136:16 144:6 180:10 264:5
handful 46:22
handle 257:8
handled 131:21 170:9 279:19
handoff 144:19
handoffs 83:8
hands 212:4
handshake 121:16 123:2
hang 40:11 146:18
happen 39:2 174:17 208:4 223:18,19 224:6 225:8,8 236:3 247:13
happened 87:18 138:9 138:15 200:7 220:11 226:21 267:4,5
happening 126:2 208:13 228:15
happens 112:14 175:3 175:16 205:4 209:1 227:18 235:4 242:4 280:13
happy 136:1 202:11 208:11
hard 56:11,17 63:22 71:6 119:1,8 120:6 240:2
harder 244:16,16
harmonize 63:18
hate 288:3
hats 64:4,19
hawing 256:8
Hawkins 2:4 10:8,8
hazardous 85:9
HCAHPS 50:4
head 42:1 142:13
heads 203:13
headway 76:10
health-specific 133:4
healthcare 12:8 17:8 20:15 21:20 22:13 91:8 174:12 243:20
healthy 24:3
hear 11:8 15:3 16:22 17:1 73:13 98:2 132:19 142:9 164:4,6 193:9 265:8,14
heard 16:10 17:17 18:11 21:22 60:15 74:2 85:4 86:19 88:10 88:14 89:7 102:19 112:6 117:2 136:10 136:21 137:6 156:7 190:4 208:8,9 214:11 256:20 266:1
hearing 19:11 97:16 121:1 156:10 263:8 265:6
hearts 187:20
Heather 2:12 9:13 76:14
heavily 102:19
heck 66:9 70:11
Heidi 3:17 94:17
held 87:3 89:18 119:22 140:4 159:19 175:19 185:13
help 6:18 18:18 21:17 26:11 28:10 38:9,15 40:11 45:20 54:20 68:21 80:11,16 85:6 97:11 112:3 123:12 123:14 165:8 184:7 196:6 202:19 207:11 228:19 259:8 262:18 265:13 288:20
helped 6:15
helpful 67:9 94:22 95:4 117:2 184:11 188:4 201:12
helping 59:12 189:2 287:14
helps 19:7 40:2 143:2 242:7
hemming 256:8
Henry 20:17
heparin 200:8
herbal 139:21 185:10
HES 74:9
Hey 17:14 118:6 163:17
hi 9:13 12:16 13:10 14:15 15:12,18 16:17 16:18 75:11 78:19 79:10 80:19 178:16 265:7
HIEs 89:6
high 25:4 29:5 47:9 51:19 52:20 62:3 90:15,21 207:16 211:4 218:15 225:6 228:11 229:18
high-risk 189:21
higher 224:10 226:14

229:7,10 267:5,11,16
highest 47:11 228:7,9 271:6
highlight 28:4 105:6 122:15 152:12 154:3
highlighted 106:13 233:6
HIOs 89:5
hired 202:6
Hispanic 229:11
history 40:9 83:20 129:11 159:21
hit 274:20
hitting 39:22
hold 42:12 113:17,19 125:5 204:7 205:20 270:22
holding 57:19 90:21
holidays 111:12
holistic 48:12
home 11:1,3 12:7,9 45:6 46:2,10,13 49:8 58:20 60:8 65:8,18 67:14 74:4 82:13,20 83:3 92:4 105:19 106:20,22 111:2 112:12,13 113:16 114:15 121:21 122:1 122:1 123:6,7 124:19 126:11 130:15 132:7 132:11,12,16 133:4 137:14 138:6,11,15 142:3 144:16 146:2,6 146:10 150:21,22 161:20,21 173:3,3,22 174:1,8 186:22 190:20 191:4 192:10 192:11,11,12 194:15 196:2,5 199:20,20 201:13 202:6,15 203:1,4,9,11,14,22 205:9,14 206:19 207:10 213:12 214:4 238:12 251:3 287:21 289:15
home-like 190:20 192:3
homecare 58:12 61:21
homeopathic 139:21 185:10
homes 199:6
homework 284:1
hone 119:18
honest 275:14
Honestly 252:15 256:3
honing 124:12
honors 248:9
hope 26:21 83:21 143:2 191:14 270:9
hoped 284:9
hopefully 5:5,17 6:2 24:22 38:9 39:6 44:1 44:8 74:4 76:5 134:16 137:4 142:6 152:16 187:10 188:3 206:22 283:22
hoping 208:20
Hoppe 2:5 41:6 43:8 78:13 79:9,10,10 115:1 116:21 150:3,3 156:22 163:6 168:2 171:14 189:7,7 211:18,19 276:21
horribly 71:2
horrifies 67:12
hospice's 267:15
hospices 218:3 221:14 224:17 225:4,4,9 228:8,11 229:4,15 230:5,19 231:1,3,15 232:5 233:8 236:15 238:7 244:17 245:12 247:18 257:8 265:22 267:22 268:1 280:1,3 281:8
hospital 20:7 45:9 51:1 54:19,21 60:20 61:20 82:10,17 83:3 109:19 111:2,4 123:5,6,10 125:1 134:9,20 135:3 155:13,16,17 158:5 158:10 162:4 170:6,7 174:19 197:12 198:11 201:4,5 207:4 210:22 213:9 235:22 248:8
hospitalization 223:8 224:11 243:4,7
hospitals 3:17 51:11 60:7 67:7 92:4,5 94:18 123:8 125:1 126:2 127:13 156:18 157:4,10,15 158:4 161:20 191:9 244:17 248:6
hour 177:21 287:13
hours 6:16,17 8:2 201:6 207:22
housekeeping 7:7 77:16
HQRP 269:10
HQRP's 268:22
huge 58:4 210:5
humbling 22:15
hundreds 72:14
Hunt 2:6 78:12 79:2,4 182:12,20 201:19 202:2,22 203:7
hurt 71:1
hybrid 200:1

I

ICC 230:14
idea 71:3 186:12 207:2 273:14 275:16
ideal 28:18 160:21 161:3
ideally 29:20
ideas 153:14
identified 29:16,19 47:12 48:1 50:20 51:20 53:2 218:15 281:18
identifies 19:8
identify 99:13 229:17
identifying 24:8 28:17 243:9
IDG 250:4
ignoring 56:15
II 2:6
IIa 3:18 219:17 265:1,5 265:7
ill 174:19 227:21
immediate 244:10,11
impact 4:5,8,13 5:6 9:19 19:15 25:4 44:12 45:6 55:21 92:18 106:15 124:7 135:5 139:3 181:6 196:11 229:14 249:7
impacts 251:6
impair 190:1
implement 56:22 193:4
implementation 20:18 29:15,17,18,21 30:2 30:18
implemented 198:17 241:11 274:13
implicit 187:10 188:3
importance 30:4 82:6 84:2 85:15 195:5,13
important 5:18 7:1 19:2 21:9 24:9 33:5 64:8 73:15 75:16 87:16 89:13,14 102:21 106:4,8,10 111:7 127:5,11 141:10 164:13 170:14 175:18 184:10 198:15 202:17 205:5 211:22 212:3 212:20 219:15 223:18 231:15 242:22 256:16 269:22 271:13
importantly 92:16 230:15
improve 21:15 23:3 62:2 73:16 76:6 84:10 84:14 85:17 95:22 141:16 231:16
improved 49:20 50:19 53:3,7,8 82:7 224:11 229:13
improvement 10:17 13:22 20:3 23:2 25:15 48:5 56:6,12,21 57:4 57:7,12,17 60:17 63:7 76:2 90:13
improvements 224:12
Improving 19:16
in-home 186:2
in-patient 45:7 50:2
in-person 35:5
inaccurate 221:15
inappropriate 284:12 284:17,18
incentive 249:4
incentives 15:2 51:3 67:7 88:14 89:9 134:12
incentivize 57:15
inch 71:4
incidence 229:7,10
incidentally 182:21
include 25:6 52:13,21 140:1 156:4 183:14 196:15 197:17 207:6 210:13 218:8 225:14 229:12 267:13
included 46:22 51:17 101:13 113:1 120:2,3 173:22 181:7 186:8 235:16
includes 28:3 128:4,11 135:17 195:18 197:13 223:6,15 269:20
including 21:2 24:11 25:13 49:19 53:4 60:8 72:19 82:19 96:2 140:3 156:13 172:20 185:7,8,11 197:19 218:16 221:10,16 230:1 270:14
inclusive 96:7 205:3
incomplete 83:10 221:15 241:20
incorporate 56:11,18 265:19 267:2
incorporated 34:11,13 57:10,11
incorporates 268:7
increase 84:4 85:18 134:12
increased 69:16
increases 83:13

increments 199:9
independent 174:9 207:18
indicate 129:8,9,12
indicated 116:22
indicating 143:11
indication 116:2,13 214:1
indicator 239:15 278:17
individual 2:15 61:22 173:21 177:13 184:14 192:18 193:10,14 196:16 203:16 215:7 216:2,17 217:13 248:22 253:3
individually 98:6 179:21 180:7
individuals 49:19 51:9 75:20 154:7,8 166:20 166:21 169:1,4,5 177:13 215:6,21,22 216:1,16 217:7,8,12 261:5,6,7,8 272:3,3 272:17,18,19,19
industry 59:4 65:7
ineffective 83:7
inform 123:12 165:8 234:14 269:11
informal 202:12
informational 262:6
informationally 36:7
informative 65:11
informed 204:16 221:12 278:11
informing 266:5
infrastructure 65:7
infusing 23:12
inhabiting 183:16
initial 22:4 42:4 270:13
initiate 132:10
initiated 45:5
initiates 234:18
initiative 21:9
initiatives 91:15 139:3
innovation 2:10 10:20 14:2 23:13
inpatient 20:10 49:9 82:16 162:3 245:18 247:16,19
input 4:7,12 19:3 35:11 39:19 42:13 45:19 48:15 53:13 85:7 86:8 118:21 179:14 182:17 183:4 262:18 263:9 264:10,18 283:21 287:15 289:12
input's 18:16
inside 51:17 191:8 219:21
Inspector 220:6 221:2
instance 64:12 157:20 245:10,14
Institute 79:7
Institutes 3:19 17:6
institution 66:18
institutional 162:1,18
institutions 66:9
instructions 31:2 187:18,22 188:1 189:12 190:12 206:8 214:5
instrument 50:4
instrumental 48:7
instruments 137:14 145:7
Insurance 24:17
integrate 66:5
integrated 126:17
integrity 19:19 221:8 243:15 245:22 254:22 255:15
intend 86:5 141:15
intended 28:17 129:20 132:8 274:11
intent 85:20 92:9,18 134:11 135:3 204:19 267:10
intentions 71:11
inter- 20:8
inter-rater 90:1,7,20
interaction 61:13
interactions 129:7 130:5
interest 4:2 7:20 8:6,17 11:22 14:3,7 16:11 78:4,8 101:8 233:2 248:18
interested 20:21 45:11 53:16 54:14,17,22 229:3 277:15,15 283:9,12
interesting 205:15 206:9 228:22 239:11
interests 78:6
interfaced 130:1
intermediate 161:20
internal 20:14 226:17
internally 76:11
International 3:18 81:9 81:12
internet 111:10 170:18 213:19
interoperability 26:2 50:16 52:1 53:1,7 64:1,18 65:3,10 67:5 67:8,21 69:20 91:4,17 92:15 111:15 112:17 112:20 117:8 212:21
interoperable 91:20
interoperably 64:10
interpretation 236:8
interrelated 104:12
intersection 20:21
intervention 282:21
interventions 243:8,22
intimately 105:10
introduce 5:8 7:17 14:14 16:18 17:1 18:6 54:3 77:11 78:2,16
introduced 163:18
introduction 15:16 20:12
introductions 4:2 7:19 8:7 16:10
invite 45:13 77:9
inviting 70:17
involved 22:12 105:10
IRF 49:12,15 50:2 113:2 113:10,17 115:20 125:4 137:15 138:20 155:1,8,11,19 157:8 158:11,17 160:7 161:10,11 162:1,16 166:1
IRF-PAI 137:16
IRF-specific 163:22
IRFs 90:10 112:21 124:22 157:3
irregularities 103:2
isolating 109:17
issue 59:10 67:11 111:8 121:15 122:16 127:10 146:19 150:5 159:16 167:17 184:11 187:15 199:4 201:21 210:7 231:15 233:7,9 234:14 235:13 237:19 243:16,17 246:5 247:1 248:2,3,3 253:11,12,13 256:18 271:1 279:20 286:8
issued 221:3,5
issues 7:14 41:7 48:13 48:17,21 49:1 67:6 69:6 72:1 79:18,20 104:20 122:6 127:7 158:7,15 168:9 176:3 185:2 191:20 198:14 198:15 211:11 213:8 236:14 249:19 256:6 257:1
it'd 283:21
item 77:16 89:4 96:12 135:22 139:11 179:14 218:8 230:7 243:1
items 32:12,14 44:17 89:2 107:13 139:1 143:1 144:8 145:10 152:7 156:3,11 174:3 181:20
iteration 96:13 119:19
iterations 60:16 80:17 87:12 88:3 94:22 120:11
iterative 149:15
IV 115:18,21

J

jack 59:18
JAMES 2:6
January 34:22 35:8,10 289:9,14
JCAHO 194:14 195:7
JD 2:3
Jen 9:21 241:12 245:9 255:3 281:14,17
Jennifer 81:10
Jens 281:15,15
Jim 10:11 36:5 65:15,15 75:9 107:22 109:2 113:9 114:10,22 115:21 116:4 138:16 155:6 158:19 167:15 167:22 169:20 171:12 174:14 187:8 204:3 210:9 286:1,8
Jim's 73:6 189:3
job 70:12 238:4,5 286:2
John 2:9 10:19 252:22 285:9
join 42:4 80:4 101:16 108:3
joined 17:13 41:21
joint 66:17 96:19 194:17
Journal 69:11
judged 66:1
judgments 65:20
July 221:5
jump 49:7 151:8 203:6 263:4
jumped 171:20 278:22
jumper 279:2
juncture 262:11
June 64:3

K

keep 21:11 70:16,16 73:21 181:4 233:1 240:3 289:4
keeping 23:17 58:15
keeps 240:17

kept 191:14 258:19
key 46:17 61:17 107:10 179:11
keypad 178:21 262:22
kicks 19:5
kinds 129:13 203:9 213:21
kit 195:18
knew 193:14 261:17
knowing 61:9 120:5
knowledge 83:19
known 20:8 64:2
knows 111:16
Kurt 2:5 41:6 43:6 78:13 79:9,10,17 107:22 114:19,20 116:16,16 150:3,17 155:6 156:21 168:1,4 171:13,16 189:7 190:3 211:18 214:10

L

l.65 230:13
label 209:21
labeling 210:4
labyrinthine 175:3
lack 24:9 85:22 88:13 182:1
lag 16:21
lagging 62:22
Lamb 1:19 2:1 5:9,13 14:5 36:4 38:5 41:14 97:18 99:4 105:12 107:19 108:4 109:2,9 113:9,15 114:2,6,14 114:19 116:16 118:1 120:15 124:15 125:3 125:8 126:20 128:20 131:1 132:3 133:5,8 143:18 145:17 146:16 149:22 150:17 152:17 153:1,9 154:9 156:20 158:18 159:10 160:4 160:13 162:22 163:4 163:16 165:20 166:9 166:22 167:7,14,21 168:4,7 169:6,13,19 171:12,16,19 173:12 174:14 175:12 176:2 176:17 177:15 179:1 232:7,20 234:1 237:17 241:12 248:15 250:22 251:12 252:13 253:16,21 256:10 260:10
language 57:6 187:12 190:21 191:19 193:12 193:18,21 196:6
large 68:19 170:4 241:19 255:8
larger 245:12
lastly 46:20 70:14 116:4 216:18
late 77:19 100:13 110:6 275:12 289:2
Laughter 209:9 211:9 219:14
launch 160:22
launched 21:13
lead 6:9 32:9 53:10 99:10 110:2 182:10 182:16 234:2 254:7 269:7
leadership 5:11 18:21 261:22
leading 80:20
leads 54:3,3,13
leaning 255:21 256:1
learn 123:14
learned 127:11 261:21
learning 279:1
leave 35:19 115:19 159:1 163:14 169:22 170:1 173:5 254:4 255:12 261:16 267:12
leaves 101:2 112:22
leaving 145:13 247:2
led 20:17 81:10,12
left 144:21 158:12 175:20
legal 124:6
legislation 118:12
legislative 91:16
lengthier 11:15
lengthy 71:9 196:14
lens 241:15
let's 40:10 42:18 45:21 47:8,17 49:4,7,9 50:5 58:3 98:11 99:4 105:16 118:5 119:1 120:7 122:5 125:5 133:9,11 156:21 169:14 176:4 177:19 178:10 179:2 198:1 201:22 215:10 248:16 260:13 270:11 271:21 273:6 286:16
Lett 2:6 10:11,12 36:6 38:4 65:16 109:3,13 113:13,19 114:12,17 158:20 167:16 169:21 174:15 187:9 204:5 210:11 284:3
letter 51:15 112:9
letting 239:1
level 58:14 59:19 60:13 61:3,4,10 65:6,20 89:9 107:1,3 187:4,6 228:18 232:2 247:22 247:22
levels 65:5,10
leverage 63:6 68:6
Levitt 3:2 15:12,12,18 15:18 37:9 53:13,20 71:20 219:10,11 257:10 263:10,21 264:13,16 269:16 277:12,21 279:8,12 283:6 288:3
liable 175:20
liaison 80:3
liaisons 3:1 14:11 16:5 100:21 101:20
library 55:9 64:3,6 91:11 92:17 134:16
licensed 128:7 203:18
lies 238:21
life 74:2 202:10 233:9 237:21 242:9 243:7 266:6,18 267:20
life- 83:14
life-saving 243:22
lifecycle 85:15
light 180:7 199:16
light/green 199:16
likelihood 83:13
Likewise 18:1
limit 34:16,17 182:17 220:12
limitations 73:15 76:9 258:15,16
limited 186:21 222:17
line 80:1 102:8 104:18 105:5 123:18 147:17 178:15 194:13 195:12 201:12 220:4 264:2,4 265:2,3,4 269:14 287:3
linear 231:1
lines 93:19 94:8 178:17 232:15,19 264:7 287:10
link 117:3 139:4
lip 58:1
listed 29:3 222:6 227:8 228:19
listen 5:21 23:4 57:6 289:13
listened 86:8 118:20 284:9
listening 21:5 54:8,14 262:17
lists 83:12 85:13 91:13 108:17 139:17 159:16
literacy 184:13 186:21 187:14 191:19 193:8 199:13
little 26:22 31:19 39:5 44:14 54:5 59:22 70:15 77:11 80:15 83:19 93:4 97:8,11 98:19 118:12 131:13 140:8,15 151:7 155:5 155:21 199:2,17 207:11,19 239:7,12 240:6 241:4 246:19 255:21 256:2,12 280:18 283:22
live 220:7,10,22 223:2,6 223:15,18,20 226:11 226:15 227:1,9,10,19 228:7,8,9,11 229:7,8 236:17,17 237:3,14 237:15,19 249:14 250:15 254:21 255:17 258:2 266:11 267:7,8 267:16 268:21 269:2 269:7
lives 6:10
living 24:3 48:6 186:15 186:19 187:3 192:11 192:11,16 207:9
Liz 10:5 16:6 63:8 69:20 81:19,20,21 133:22 145:18,18,19 146:16
local 244:17 245:18 246:1 248:6
location 162:14 235:22
locations 60:8,9 63:3
locked 111:11
locus 84:21
log 38:16
logged 38:17
Logging 39:4
logic 255:7
logical 130:9,20,21
LOINC 64:7
long 44:2 70:11 88:9 118:10,14 128:14 131:22 183:17 250:14 282:7
long- 51:10 56:3
long-stay 174:18
long-term 2:8 9:9 26:14 45:8 51:1 74:15 106:16 134:5 157:4
longer 129:10 188:21 227:21 242:8 250:11 287:13
longitudinal 72:15 161:2
look 16:9 19:10 26:7

41:5 48:11 51:16 68:13,21 72:10 75:3 88:4 92:8 93:17 95:20 102:7 108:14 116:6 127:17 129:7 136:4 136:15 150:4 161:12 162:8,11,21 165:11 190:1,18 198:20 213:1 220:2 221:4 222:21 224:6 226:20 230:12,16,19 237:4 237:13 238:1 240:4 241:6 243:14 247:11 257:19 277:19 278:14 281:5
looked 55:8 88:22 90:1 96:20 117:14 206:5 222:2 225:21 227:18 234:10 259:11 260:12 279:18
looking 18:17 38:1 43:1 47:16 48:4 61:7 64:15 72:13 75:2 76:4 81:1 81:3,20 95:18 102:9 103:4 118:9 141:3,4 161:1,2,12 162:5,13 165:2,5 166:12 168:19,20 177:6 200:11 207:2,7,9,9 208:2 215:2 220:7 222:20 235:1 236:16 239:18 241:8,8,9 247:2 255:10 257:18 259:16 263:3 264:10 271:19 272:9 279:15 280:21 282:12,14 284:17
looks 39:17 43:17,18 44:8 90:15 135:22 153:4 215:4,20 216:14 217:6
Lori 2:3 65:15 67:1,2 73:5 75:8 78:14,17,19 83:15 204:10 222:18 234:3 237:17 242:3 252:13 255:6 277:19 285:20
Lori's 205:16 241:7,14 246:9
lose 35:20 242:10
losing 179:11
loss 239:18,19
lost 109:21 154:4 270:2
lot 11:15 20:19 21:5 25:9 38:15 39:3 56:20 57:20 58:15,16 59:6 59:11,15 71:15 72:2 73:13 74:12,14,18 81:15 87:22 88:11 89:8 91:3 96:16,17 118:20 125:14 127:6 134:3 135:13 137:7 142:9 147:21 156:13 156:17 160:18 163:8 175:16 187:17 189:9 203:14 208:9 221:3 225:20 235:4 240:3 242:10 245:17 247:12 248:21 250:5 251:3 263:8 281:7,8
lots 6:4 57:7 110:21 133:9
love 20:6 68:5 77:3 81:20 202:10 237:1
loved 199:7
low 190:13 225:7 230:22
lower 65:4,10 228:12 231:2
lowest 228:8
LTAC 113:3,10,17 191:3
LTCH 137:16,17,17 138:19 158:11 161:10 161:11 162:2 167:2,9 167:10,13 168:3,9
lunch 178:4,5,6 179:3 179:13

M

MA 255:10
ma'am 232:16 287:4
magic 102:9 103:3 129:19
Mahajan 2:7 9:7,7 62:6 124:16 125:6,10 175:15 183:22 200:1 251:1
mail 112:9
main 21:14 26:12 217:20
maintain 190:12
major 103:8 153:18 158:7
majority 8:14 102:16 133:1 170:10
making 5:15 23:14,20 24:4 26:18 27:2 58:22 63:22 71:12,14 103:16 168:10 173:10 193:20 213:16 221:12 234:21 247:7 258:12 273:16 278:9 280:7 283:4
man's 285:4
manage 199:19 245:3
managed 252:6
management 77:8 146:3 218:17
Manager 27:4
managing 195:6
mandates 19:17
MANDI 196:12 209:5
Mandl 3:3 14:18,18,19 75:11,11 143:16 196:10
Mangrum 2:20 3:19 16:14,17,20 17:4,5 40:7,15,20 41:2 43:4 131:5 190:6 276:19
manner 18:2 204:17
mantra 112:5
manual 149:7
manuals 95:16 149:2,7
MAP 18:13 19:13 21:4 26:19 27:10 28:17 29:9,14,18 30:1,3,17 35:10 36:19 37:3,8,17 37:22 81:6 86:9 87:20 103:2,13,17 141:21 152:3,10 268:4 289:11
MAP's 30:15 35:11
maps 64:6
March 35:13 147:2,9 156:2
margin 35:19 254:15
markers 58:21
market 46:13
Mary 73:20,20 142:10 163:19 164:3 171:9
Maryellen 17:15,16
mask 229:19
MASSUDA 3:4 279:13 280:3,11,19 281:12
master 6:7
match 206:2
material 6:19
materials 28:7 32:2 48:19 147:7
math 103:5,9
matrix 123:20
matter 2:15 8:10 9:1 11:14 12:4,7 13:17 14:5,10 87:3 110:22 112:1 120:14 179:7 208:17 289:16
maybes 249:12
MBA 3:6
McMULLEN 3:5 14:15 14:15 53:22,22 73:4 80:13,14,19 95:6 133:20 145:5 147:4 147:10,14 160:11,15 162:20 163:2 164:19 175:4 176:7 192:4 196:19 202:9 206:15 207:15 208:6
MD 2:2,5,6,7,11,19 3:1 3:2,9
MDS 52:13 137:17 175:7
mean 11:22 36:9 60:1 113:7 119:7 121:5,8 124:16 125:22 132:17 145:15 160:12 172:10 188:7 189:1 202:20 207:12 209:10 225:3
meaningful 20:8 21:9 21:13,17,18 23:7,11 24:5 25:5 30:11 56:11 62:21 75:6 134:8 135:8 246:5 266:17 288:17
means 40:1 56:15,16 59:15 62:18 74:19 111:11 144:11 145:2 149:9 160:2 183:19 190:14 195:2 273:13 282:15
meant 28:13,21 86:21
measure's 85:20 233:14
measure-by-measure 98:13
measured 66:14 237:12
measurement 3:12 15:10 22:2,8 29:6 50:8 73:17 74:11,16 81:8 106:16 116:18 121:4 142:8,18 153:16 286:6,19
measurements 74:13
measuring 257:18
mechanism 134:17 208:12 243:8 253:7
mechanisms 242:11 243:10
med 109:22 112:8 121:5,9 125:2 126:3 126:14,19 128:1 129:11,21 130:17 159:16
Medicaid 3:3,4,4,6,8,9 15:8 162:2 196:22
medical 10:14 12:6,18 13:21 15:13,19 19:20 20:20,22 51:8 67:7 87:6 113:1 132:15 159:1 170:1 173:9,20 174:1 203:18
Medicare 3:2,4,4,5,9

19:16 46:21 61:1 82:8 196:22 221:7,17 222:16 225:14,15 240:4 241:18 256:20 258:6
medicated 189:10
medications 67:13 83:4 88:10 95:18 96:4,4,6 96:8 108:19,20 110:1 110:14 115:19,21 116:11 117:9,15,16 119:15,21 124:1,3 129:12,16 132:13 139:20 140:2 141:18 146:13 150:13 157:20 158:6,12 159:19 185:8,17 188:21 189:11,13,16 193:15 193:22 195:1,15 197:1,12,13,14,18 200:3,6,9 204:15 205:14 211:1 213:14
medicine 2:5,8 20:14 78:14 79:12 129:10 130:5 210:3,16 211:8
medicines 108:20 129:20 198:8,10 210:16
MedPAC 220:5,8,9,16 224:9 226:10 231:14 233:6
meds 95:19 146:6,8,11 173:4,5 183:13,19 200:16
meet 87:17
meeting 1:7 4:2 18:4 28:7 31:8 32:2 48:2 48:10,19 50:17 52:2 53:3 79:14 101:11,16 263:6 284:1 289:14
meetings 19:14 35:5
meets 181:6
members 2:1 8:9 26:19 27:14 31:3,4,12 34:2 41:21 42:4 53:14 77:22 78:4 100:19 101:4 116:22 191:2,7 200:11 202:7 208:7 213:21 245:15 247:18 248:4 263:4 265:14 283:11,20
members' 268:4
mentioned 27:10 45:11 110:19 116:4 230:8 231:5 237:2 242:3 245:10 265:15 266:21
mentioning 26:15 222:18
mercy 237:7
merits 104:17
merry-go-round 174:22
mess 115:14 199:16
met 1:16 29:16 37:13 37:22 84:13 87:4,5 219:1 227:3 261:20
metabolism 190:2
methodology 69:15 268:7
Methods 12:12 122:22
metric 25:15
metrics 65:4
MHA 2:3
MHS 2:2
mic 256:11 257:11
Michelle 3:9 14:22 18:6 54:17 288:19
microgram 205:8
microphone 9:6 93:12 93:14 232:11 255:5
middle 59:12
mike 178:13
military 248:9
million 23:9 82:16
millions 72:15
mind 21:11 22:3 75:2 78:11 107:4 181:5 204:10 206:11 235:5 242:4 254:3 269:22
mindful 85:8 86:11 237:19
mindless 110:11
minds 68:18
mine 109:19
minimal 70:19 222:13 229:14 231:19
minimizes 232:3
minimizing 228:14
minimum 31:11
minority 28:6
minus 176:15
minute 35:22 41:20,22
minutes 34:17 53:18 71:18 90:17 91:1 178:6
MIPS 12:22 20:7 70:7 135:9
MIS 3:6
misses 158:8 208:4
missing 41:11 43:14 47:19 83:11
misuses 235:10,10
mitigate 276:11
mitigated 276:8
mitigating 277:17 283:15 284:2
mitigation 29:12 30:1,8 30:9,15 100:7 151:19 271:11 273:10 275:3 275:5,13,16 276:1 288:1
mix 47:6 50:9 51:17,18 52:16 185:15 206:2
mixed 50:11 52:18 58:21
MLS 2:20
modalities 172:17
model 25:20 56:19 230:10 233:19 252:11 257:16 271:15
models 141:8 231:20
moderate 231:1
modifications 29:20 30:5 189:22
modules 129:4
moment 56:10
MONDAY 1:11
money 70:12
monitor 31:10 86:2 229:22 231:8
monitoring 231:6
month 14:22
months 225:15,17
morning 5:13 10:4,11 10:18 12:5 14:21 18:11 27:9 38:16 58:10 101:9
mortality 85:21 86:3
move 16:14 22:12 34:4 41:22 59:17 64:10 73:17 77:8 97:18 105:16 107:20 108:5 150:1 154:19 155:4 157:7 165:21 167:1 169:7 178:1,10 181:11 212:1 215:8 216:3 217:20 232:7 232:21 234:2 235:20 236:1 237:2,20 260:15 270:11 272:4 273:6 277:16 286:15 286:16
moved 58:1 84:19 88:2 227:1 235:15 244:19
movement 74:19
moving 50:22 65:12 137:1 159:4 178:5 218:14 261:13 268:19
MPH 2:11,12 3:5
MSC 28:17,20
MSN 2:18
MUC 22:5 27:15 28:6 31:19 33:12,12 36:17 97:19 100:2 121:21 146:21 147:8,18,22 176:19 214:17 215:13 216:4,6,19,21
MUC2018-101 260:21 270:13,17 272:5 275:4
MUC2018-131 4:9 105:17 150:20 152:19
MUC2018-132 4:9 154:20 165:22 166:4
MUC2018-133 4:10 168:15
MUC2018-135 4:14
MUC2018-136 4:10 169:8 177:3
MUC2018-138 4:15
MUC2018-139 4:14
MUC2018-141 4:15
MUCs 32:2 34:15
muddle 261:18
Mulhausen 1:19 2:2 5:10 6:6 13:20 35:16 41:19 48:14 49:5 53:11 55:13 60:4 62:5 65:14 67:1 69:8 71:17 76:14 77:7,14,17 92:22 94:4,9 97:13 179:10 182:9 183:3 183:21 184:8,19 186:3 187:8 188:5 189:4 190:3 191:11 197:6,21 199:1,22 200:17 201:17,22 204:2,9,21 206:13 209:4,17 210:9 211:13 214:9,21 215:8,16 216:3,10,18 217:2,14 253:19 254:1 261:15 263:7 263:18 264:1,9,14,17 265:10 269:18 271:3 271:18 272:14 273:3 273:11,18 275:8,11 276:4 277:6,19 281:14 283:5 285:9 285:20 286:10,16 287:7,11 288:19
multiple 19:3 21:1 23:10 59:7 77:2 85:5 87:12 88:3 91:14,15 115:7 118:19 120:11 127:2 131:20 150:11 172:16 212:2
Munthali 3:11 7:18,21 11:4,10 12:14 13:7,13 13:16 14:8 15:5,11,15 16:1,4,8,15,18,22 17:12,16
murky 36:21

mushy 203:10
mute 11:11
muted 264:2 265:6

N

N 101:14 102:8 251:22
N.W 1:18
N/A 138:12
nail 145:14
name 60:5 70:3 94:16 96:22 123:21 148:4,6 149:18,19 163:19 195:3 210:1,2
named 286:2
names 70:3 200:4,11 213:7,7
naming 286:2
narrowed 22:4 85:10
Natalie 219:18
national 1:1,16 2:3,6,6 2:9 3:7 10:5,12,19 11:7 16:7 21:2 24:16 67:3 76:21 77:3,4 78:12,15 79:2,5 84:1 112:6 115:14 135:1 149:6 163:20 267:6
nationalized 213:3
nationally 149:12
navigate 58:13
near 158:8 208:4
nearly 82:8
necessarily 25:8 68:3 163:14 173:9 201:11 280:14,15 281:6
necessary 258:10
need 6:22 10:13 31:2 36:19 68:20 73:15 81:7 98:6 101:3,7 109:12,22 110:1 114:21 115:2 123:1 131:18 133:14 140:15 151:14 152:12 154:13 173:4,6 175:8 185:14 186:2 187:1,2 193:9 196:4 203:21 205:21 212:7 215:11 219:2 236:14 247:22 256:17 263:13 272:10 278:13 278:14 284:22 285:1 286:11
needed 115:22 156:4 201:2
needs 38:19 49:19 69:4 115:4 121:10 184:1 184:22 186:9 191:19 212:18 213:2 273:12
negative 222:22 223:4 223:21,22 224:10,20 224:21 225:2 228:14 229:8 242:1 257:20 258:3 266:22 267:6 269:8 278:6,10
network 213:8
networks 59:13
never 70:10 211:8 223:22 240:18 259:15 267:4
new 6:1,2 14:6,22 18:12 20:1,13 26:21 30:1 38:10,11 39:5 43:22 51:10 57:3 69:10 83:18 96:4 110:17 118:7 129:12 167:3,4 209:18 283:7
news 56:15 240:11
NHPCO 78:21,22 234:9 236:16 278:19 286:9
night 111:11
nine 146:10
Ninety- 146:9 215:20
Ninety-eight 146:6
nobody's 111:21
nodding 203:13
noise 111:22 268:3,9
nominated 11:20
non- 52:18
non-curative 282:16
non-endorsed 51:19
non-hospice 284:4
non-measures 284:5
non-voting 3:1 14:11
nonprofit 13:3
nonvoting 100:21
nope 121:14
normally 54:4
North 131:6
not-for-profit 245:12
note 44:4 46:4 47:2 50:12 52:16 92:1 106:19 181:14,19,21 219:1 227:7 258:6 274:17
noted 52:3 104:13 107:15 187:18 223:3 224:14 226:14 229:7 233:14
notes 191:14
notice 40:2 41:9 42:16 46:7,14
noticed 72:3 201:18 202:3
notification 51:15
noting 233:6
Novartis 13:15
November 48:2,10 50:17 52:2 53:3 219:1
nowadays 244:16
NPE 175:9
NPHI 245:10
NQF 3:10 6:3,15 12:11 17:22 18:20 19:2 21:3 38:9 47:6 50:11 51:19 52:18 103:13,16 104:15 107:5 120:20 122:9 151:5,12,22 152:12 153:3 166:11 167:6 176:22 180:12 180:17 181:9,13 212:1 214:14 215:1 215:18 216:11 217:4 233:4,17 256:5 260:17,19 271:10 287:16,22
NQF- 152:1
nuance 199:3 257:4
nuanced 256:16
nuances 236:13
Nuccio 2:21 12:5,6 122:13 173:15 186:4 251:13 252:3,5
number 12:8 14:1 31:11 40:6 41:12 42:19 51:14 53:2 62:18 66:13,15 79:13 92:7 94:3 102:9 106:2 107:7 115:19 123:17 123:18 125:17,18 128:3 170:4 195:19 208:3 213:15 224:19 224:20 241:19 248:5 274:21
numbers 38:13 44:6 98:18 100:10,14,18 102:12 103:3 268:11 272:2
numerator 135:18 186:6
nurse 2:9 11:2 125:13 128:3,7 144:5 199:21 203:12 206:6
nurses 61:6 70:10,11 74:20 125:15 129:8 129:22
nursing 45:9 52:6 109:18 126:11 162:2 170:11 175:8
nutritional 139:20 185:9

O

O'ROURKE 3:13 5:3 7:6 18:5 26:10 36:13 41:3 43:6,9,20 77:12,15,18 79:1,9,17 80:6 99:3 100:11 105:21 108:2 151:6 153:7,10 165:13 167:4 169:11 217:19 233:1 261:9 263:2 270:22 271:5 272:21 273:9,16,21 274:10 275:14 276:15 277:1 283:17 288:21
OASIS 46:19 106:20 130:12 137:15 145:1 145:2,9,9
objectify 62:17
objection 263:18 270:8
objections 270:6
Objectives 4:2
objects 270:9
obligation 144:10
observation 57:1
Observations 223:8
observe 243:2
observed 251:16 252:10 268:16
obtain 244:17
obviously 62:20 233:11 257:14 260:7 274:5 277:22 283:10
Occupational 2:11 9:17
occupied 147:19 175:8
occur 76:7 83:3 208:16 228:2 231:9 244:7 257:21
Off-mic 274:9 275:10
offer 28:14 145:21 146:14
office 3:6 10:5 16:7 111:11 126:13 220:6 221:2
Officer 12:18 13:21 15:13,19 20:16
officers 87:6
oftentimes 244:8,15 248:5 253:7 282:19
OIG 221:8,9,13 224:9 231:14
old 111:20 199:7
older 205:18
ONC 10:6 14:12 63:21 64:20,21 81:17,19 84:7 87:5 91:9 145:21 212:7,17 213:2
once 36:17 39:8 40:14 110:4 118:3 126:6 164:11 181:5 205:19 227:15 262:5
oncologist 193:17
one's 25:8
one-by-one 98:9
one-by-one-by- 98:8

one-by-one-by-one-b... 98:10 120:21
ones 109:6 113:16 114:11,13 118:13,15 119:22 157:2 173:18 181:17 197:19 199:7 249:6,7
ongoing 23:2
online 41:7 48:18 114:20 131:2 135:17 139:2 149:11 232:13
Oops 15:6
op 60:3
open 33:11 35:7 53:17 93:19 108:11 112:10 122:5 142:11 160:6 168:7 177:3 178:3,14 178:17 184:20 201:22 215:13 216:5,20 232:15 241:2 248:17 260:14 261:10 264:4 264:7 265:2,4 270:17 272:6 276:12,13 286:20 287:3 289:7
opened 93:5
Opening 4:3
openness 12:1
operability 20:9
operate 60:7 155:15 191:10
operational 14:1 157:17
operationalize 193:1 198:19
operationalizing 200:19
operationally 121:5
Operator 94:1,7 178:16 178:19 232:14,16 262:20 264:3,7,22 265:4 287:2,4,9
operators 63:16
opiates 115:8,10,13 150:4,11
opine 58:8
opined 96:16,19
opinion 28:6 102:16 254:16 278:1 283:13
opinions 28:4 285:19
opioid 129:13
opioids 50:18 122:4 129:14 142:9,15
opportunities 34:12
opportunity 19:10 22:10,15 25:15 35:1 54:10 55:19 57:14 58:4,7 65:12 85:18 93:1,6,9 112:11 152:5 184:20 237:12 249:3
opposed 60:2 69:1 118:14 162:18 198:20 251:16
optimism 56:9
option 39:10,21,21 138:13 151:20 152:21 152:21 179:20 200:1 214:19,20 215:15,15 216:8,8 217:1,1 261:1 261:1 270:18,19,19 270:19 275:5,6
options 100:4,5 152:14
order 5:12 22:20 77:21 109:22 110:1,2 156:5 243:2 258:10
organization 2:4 8:16 11:19 67:4 76:5 78:5 78:16 161:22 165:19 192:12 212:9 245:11
organizational 8:9,13 11:5,12 14:9 77:22 78:4
organizations 10:17 14:14 21:20 55:15 165:15
organize 99:14 108:10 179:18
organized 161:21 192:12
oriented 190:22
originally 87:19 235:7
OTC 108:20 159:16
OTCs 139:16
OTR/L 2:10
outcome 25:7,9 46:18 47:4 50:9 51:18 52:16 61:10 75:4 85:18 106:8 141:17 142:19 218:13,17 220:20,21 242:21 266:14 278:7 278:10
outcomes 15:9 21:15 24:10 48:8 60:19 79:7 84:11 85:9 106:10 222:22,22 223:4,5,21 223:22 224:10,20,21 225:3 228:15 229:8 242:2 243:3,12 257:21 258:4 266:22 267:6,11 268:22 269:8 282:10
outcry 62:20
outlier 68:20
outlined 270:2
outside 110:16 158:5 170:5
over-the- 139:19
over-the-counter 110:14 185:9
overall 85:21 90:4 92:9 134:11
overlap 13:1
overly 266:14
overnight 244:4
oversee 10:16
oversight 86:1
overview 4:4,5 5:22 27:11 45:16 232:9
overwhelm 189:18
oxygen 140:2 185:11

P

P-R-O-C-E-E-D-I-N-G-S 5:1
p.m 171:9 179:8,9 289:17
PA 33:5,9 34:7
PAC 92:11 119:16 185:13 207:3
PAC/LTC 1:6 5:9 181:7
packagings 156:15
page 27:8 98:2 103:1 199:14
pages 187:19
paid 11:16 13:4 86:9 202:5,14 203:1
pain 205:10
Palena 3:6 10:4,5 16:6 16:6 63:20 145:20
palliative 2:4 9:22 13:11 52:3 67:3 78:15 78:20 238:2 239:6,17 240:10,17
Pam 2:10 9:16
panel 11:7 12:12 84:14 122:22 139:7 208:7 222:5
panels 87:3
paper 125:20 127:3 280:20
paper-based 89:5
paperwork 21:21
paradigm 137:3,4 208:21 209:2
paragraphs 118:14
parameters 96:9 200:22
paramount 189:14
pared 148:10
parenthetically 95:17
parents 189:10
parsimonious 22:5
part 19:5 21:3,4 22:11 23:6 28:7 32:1 56:3 56:13 82:16 90:14 112:15 113:8 119:7 126:11 144:22 163:14 174:4,5,11 175:10 203:2 205:15 208:5 223:5 225:14 234:15 238:17 239:11 240:7 260:4 266:22 274:4 279:18
participant 15:14 165:18 205:12,22 272:12 273:15 279:1
participants 241:18 255:10
participate 9:19 25:1 101:4,11 289:13
participating 101:5 276:16
participation 18:14 35:19
particular 78:5 101:12 119:16 128:6 131:11 145:1 150:7 157:9 158:15 163:10 201:10 209:12 213:5 243:10 244:6 248:11 252:19 261:17 262:11 268:18 269:6 277:7 282:6
particularly 58:20 64:1 64:10 71:5 72:7,9 128:15 142:18 233:10 267:11
parties 32:15
partners 84:7
partnership 1:5 2:9 10:20 19:1 24:16
parts 8:8
PAs 125:14
pass 132:1 153:12 183:2 248:8 274:2
passed 34:8 289:10
passing 102:13 273:6
password 7:15
patch 205:8,10
paternalistic 204:12
path 269:3 271:17 283:1
patient's 83:20 96:21 131:11 140:6 174:8 203:20 219:4 234:17 237:10 246:13 250:11
patient- 24:10 190:21
patient-adhered 188:20
patient-by-patient 60:13 61:10
Patient-Centered 79:6
patient-family 226:12
patient-level 61:16
Patient-Post-Acute

4:13
patient-specific 62:1
patient/family 187:12
patients 6:11,13 18:19 21:15,21 25:5 57:22 59:20,20 72:19,20 82:22 106:1,5,21 112:13 115:19 123:6 123:7 155:15 156:16 157:5 169:22 170:4 184:3 185:22 186:9 189:9 190:11,19 191:1,7 192:3 195:22 197:11 200:13 211:6 213:5,9,16,20,21 214:4,6 222:16 223:14,15 225:11,14 225:15,17 226:4,22 227:9,11,15 229:9 233:13 235:3 237:6 238:8,10 241:19 242:4,7,13 243:5 244:5,8 250:10 266:10 267:12,16 268:20 269:1,4,10,11 280:12 283:2
patients' 266:4 267:1
pattern 50:1
patterns 280:21
Paul 1:19 2:2 5:10,20 6:2 7:8,22 13:18 26:15 35:17 36:2 38:8 45:18 53:10 75:16 99:12 180:14 182:8 211:18 261:11 269:16 289:1
pause 41:18 103:7
pay 44:1 176:4
payers 24:14 25:21 58:22
payment 25:19,20 28:20 46:13 49:16,16 51:5,6 52:10 218:6 220:13
PCORI 79:6
PCP 160:10 162:6 163:9,11 172:8,13,15 173:20 174:11 186:7 186:9,10
PCP/PMP 176:7
PCPs 161:17
PDSA 56:19
Pearson 230:12
peeled 142:11
peers 267:6
penalty 46:7 49:11 52:7 217:22
pending 104:14 107:5 151:5,12,22 153:3 166:11 167:6 176:22 215:1,18 216:11 217:4 233:4,16 260:19
people 22:21 23:1 25:9 39:18 41:10 42:20 56:10 57:18 58:15 59:8 60:18 62:16 68:17 70:2 71:1 74:1 75:6 93:7 96:18 101:5 101:21 102:1 109:10 119:5 129:8 137:20 144:14 159:5 163:11 170:10 178:15 179:12 197:22 198:15 199:12 202:8 207:13,19 213:5,6,18 232:10,13 238:3 239:5,13,14,15 239:19 240:3,11 241:1,4 249:13 250:20,21 255:12 261:12 274:14 283:22 284:22 285:1
perceive 14:3 190:10
percent 31:2,17 33:8,11 34:2,7 42:17 51:4 65:2,9 74:2,3,5 82:17 82:19,20,22 83:9 90:6 90:9,10,20 101:3,18 123:7,10 146:2,6,8,10 146:11 153:5,6 166:17,17 169:1,2 177:10,10 194:6 215:4,5,21,22 216:14 216:15 217:6,7 225:2 225:4,5,6 227:3,4,8 227:11,15 228:1 230:4,8 261:5,6 271:19,22 272:1,17
percentage 42:17 46:12 49:15 52:10 123:9 218:5 223:20 235:1
percentages 40:3
percentile 225:7
perceptions 284:4
perfect 22:9 43:5
perform 6:12 233:8 267:22
performance 15:10 85:20 165:6 224:16 230:11 231:15 239:18 259:17
performance-based 142:19
period 34:19,20,22 35:7 70:21 222:6 227:22 251:22 252:6 257:6 279:9
periods 87:2 139:7 145:16 247:10 279:6
person 23:20 31:4 73:7 73:21 97:4 102:2 108:7 138:15 145:12 165:16 195:15 196:3 197:1 201:5 202:5 203:17 247:21 250:3 284:5
person's 195:3
person-centered 57:11 102:2
personalized 47:14 91:8
personnel 203:16
perspective 8:16 18:9 49:15 76:19,20 123:5 169:12 237:9 243:18 245:21 281:17,19 288:22
pharmacist 128:2 132:14
PharmD 2:22
phase 82:1 165:1 193:2 242:8 269:7
PhD 2:1,8,10,21 3:5
phenomena 121:17
PHN 3:3
phone 7:2 8:22 11:8 15:15,17 16:2,16,20 17:13 31:4,13,14 40:19 43:3,6 48:18 93:7 94:8 101:6 139:8 163:19 190:4 211:20 219:17 232:19 265:6 276:16 287:10
phones 79:15
phrase 118:15 119:14 249:22
Physical 2:5,12 9:14 78:14 79:12
physician 20:14 125:13 125:16 128:1 132:15 193:16 194:3
physicians 12:22 70:6 70:9
physiology 190:2
pick 131:22 134:6
picked 212:10
picking 228:19 229:22 231:8 232:3
pickup 134:13
picture 241:21
pie 50:2
piece 49:17 62:22 68:2 69:3 109:16 145:3 202:19 211:4 239:4 258:19
pieces 69:5 239:4 240:20 280:6
Pierotti 2:8 10:22 11:1 58:10 144:1 183:7 199:2 203:6,8 248:21
piggyback 75:12
pile 199:7
pill 129:19
pills 115:11
pilot 89:16
pitch 286:11
pithy 118:15
placard 198:3 201:18
place 70:2 85:15 126:5 173:1 203:10 206:9 242:11
places 191:9
plain 190:21 193:12,18 193:21 196:6
plan 86:2 110:7 202:20 236:7 245:4
plan/program 284:20
plane 262:7
planned 128:16 140:5
planning 73:16 87:8 92:2,4 161:13 165:10 173:1 224:12 238:18 267:18 284:19
plans 24:17,20 231:6
platform 38:18
play 7:5 83:8 246:14
playing 228:18 232:3
plea 150:6
please 7:13 17:20 25:2 27:7 31:12 39:19 41:17 42:13 48:20 70:4 79:19 80:4 94:2 98:14 103:6 109:7 151:7 171:3 178:13 178:18,21 232:15,17 262:8,21 263:4 264:4 264:6 265:3 270:18 274:17,19 287:3,5 289:4,12
pleasure 21:3
plug 199:18 243:10
POH 77:13
point 28:15 33:2 35:18 46:12 49:15 51:4,10 56:10 59:17 62:19 63:14 76:3,8,12 77:6 99:12 101:22 102:4 102:11 103:6 108:18 115:20 120:4 132:6 136:2,12 144:2 145:21 146:15 156:13 162:7 165:10,14

170:13 171:5 178:3 183:8 188:7,12 189:3 193:19 195:16 196:16 196:17 197:17 205:16 209:15 218:5 238:12 243:21 254:6 256:7 259:10 263:13 268:17 276:2 283:1 286:20
pointed 115:21
pointing 73:6
points 36:22 52:10 62:16 136:5 154:1 212:12 230:3 265:13 274:6
policy 22:13,16 65:11 101:8 229:17
poll 38:7 39:9,15 40:9
PollEverywhere 38:18 39:20 40:8 42:15
poor 250:16 267:14 269:5 284:18 285:4
poorly 208:14
population 176:16 192:19 229:11 231:17 231:17 241:9 248:11 255:9 282:2
population-based 25:19
populations 81:1 238:16 239:1
Portfolio 221:8
portion 45:3 88:5 174:20
pose 185:21
position 33:20 83:18 171:6 243:14
positive 74:16,17,17,19 231:3
positivity 137:5
possible 31:14 68:8 88:8
Post 81:14
post- 49:21 134:17 149:2
post-acute 1:6 2:8 9:8 14:17,20 15:20 19:12 19:16 26:14 55:16 56:4,5 67:6,10 72:7 73:13 74:14 75:16 82:10,12,18 83:17 88:12,14 89:8 93:16 93:22 95:15 97:21 100:19 106:1,16 126:9 134:2,5,12 139:2 148:5 154:21 157:8 159:21 166:1 179:16 201:10 209:14 286:19
post-regulation 62:11
posted 48:18 92:6 135:17 139:2
potassium 190:13
potential 29:12 30:1,5,8 30:9,14 32:13 33:17 33:21 51:21 52:4 100:7 151:19 152:12 233:7 273:10 275:16 276:1,7 282:13
potentially 47:10 48:4 48:11 85:8 185:16,21 235:3
practical 157:16
practice 128:2 194:14 200:12 220:15 242:6 244:7 257:22 280:8
practices 24:3 140:17 140:19 165:5 242:13
practicing 144:4 280:1 280:3
practitioner 125:14 126:12,17 206:6
practitioners 125:17
Pratt's 73:20
pre-rulemaking 4:4,7 4:12 35:4
precise 246:19
precisely 129:16
predicted 224:19,19 251:14 252:10,11 254:10 268:5,11,16
predominantly 218:12
prefer 98:9,12
preference 197:16 223:19 226:13,14
preferences 84:3 156:14 243:3,6 246:13 248:7 256:1 265:18 266:1,2,5,17
prefers 180:6
preliminary 28:8,10 32:5,9,20 99:19 100:1 105:22 106:13 122:8 143:21 150:19 151:3 151:12 152:20 153:2 163:5 165:21 166:6 166:10 167:5 168:16 176:19 177:4 214:14 214:18,22 215:14 216:7,22 217:3 233:3 256:2 260:15,17,22 262:12
prepare 55:3 201:6
prepared 151:11 234:5
prescribe 130:4 132:13
prescribed 128:6 139:19 185:8
prescribers 129:9
prescribing 50:18 115:15 130:1
prescription 199:8
present 2:1,16 3:1,16 3:21 31:3 80:14 93:11 101:10
presentation 92:20 148:8
presentations 21:8
presented 21:8 219:13
presenting 219:12
presently 180:5
presents 282:20
preserve 30:15
president 3:11 7:18 78:20 79:11
presiding 1:20
press 94:2 178:21 232:17 262:21 287:5
pressure 11:7 88:10 169:15 262:7
presume 123:8 251:22
pretty 47:3 66:3 90:15 96:7 108:15 121:10 155:10 215:17 252:8 273:4,5
prevent 198:16
preventable 83:9
prevention 3:2 24:1
previous 122:14 181:11 203:3
previously 211:21
primarily 12:21 64:7 203:15
primary 20:13 170:13 176:15 182:5 183:7 194:3 237:9 242:18
principle 84:16 204:18
principles 23:12,14 68:14
print 200:12
printing 184:4
prior 29:17,21 31:5 159:19,21 204:6 227:13
priority 47:9,12 50:13 51:20 52:20 218:16
private 10:15 192:9
privileges 227:13
proactive 62:12
probably 18:22 74:8 175:22 207:3 208:13 229:2 241:16 255:21 273:5 283:8
problem 66:7 69:19 70:1 111:13,16,16 170:22 190:11 198:21 245:22
problematic 213:4 245:18
problems 51:10 79:15 111:9 115:7
procedural 120:4 146:19
procedure 118:22 180:2
procedures 5:22
proceed 31:6 33:15
proceeding 38:3
process 7:20 19:2 21:4 25:7 26:16 28:11 32:7 36:15 38:8,11 39:3 47:4 50:9 51:18 52:16 63:2,4,8 71:13 75:4 85:16 98:1,17,20 99:1 99:5 103:13,15 105:15 106:11 142:6 143:8 165:14 180:7 180:12 212:11 218:12 224:13 233:17 242:8 243:11,13 256:5,5 261:9,17 264:18 269:20 270:1
processes 6:2 71:9 87:9 104:12 105:7 228:14
produces 104:8
producing 230:10
productive 6:4
products 139:21 185:10
professional 144:5 203:18
profile 28:14 96:14,15 96:17,20 107:17 148:2 149:19 156:5,6 156:8
profiles 96:18
profound 254:4
prognosis 239:12,16 242:3
program 4:16 23:8,11 25:14 27:12,15 29:1 32:3 34:15,17 45:7,8 46:3,3,4,6 49:10,17 50:7,22 51:2,7,17 52:5,7,8,15 54:3,3,13 60:20 90:16 103:20 135:9,10 137:17 142:4 145:7 149:5 164:13 181:8 193:5 217:21 218:1 219:7 220:19 221:7,8,21 223:11 229:22 230:18 243:15 245:21 254:22

255:15 270:15
programmatic 31:21
programs 4:5 19:4 20:6 20:7,10 22:2 23:3,10 24:14 25:21 26:14 28:20 44:12,18 45:5 45:10,12,14 46:5,8 53:19 54:12,18 55:16 55:21 59:1 61:15 71:22 74:12 84:12 134:22 142:2 181:9 231:21 236:8 239:6 240:14,17 288:9,10
progress 63:22 64:15
project 27:4 195:17
promise 86:14 89:19
promising 65:5
promote 21:21
promotes 181:8
promoting 20:8 23:21 23:22 286:18
proper 110:6
properly 157:18 200:10
proportion 143:8
proposal 92:6 149:13
proposals 37:14
propose 193:4
proposed 92:3 98:4 149:5 197:4 198:21 249:2 275:20
prototypical 149:1 206:20
provide 18:7 19:3,7 24:2 27:11 28:21 38:22 48:11 53:18 55:19 75:18 91:19 105:9 115:9 117:3,11 149:6 150:12 152:5 155:14 188:19,20 191:4 221:14 249:4 262:14 266:13,15
provided 106:7 115:12 116:8 117:1 131:15 143:12 155:19 157:2 194:22
provider 56:13 81:3 84:22 85:1 88:18 90:8 93:15,21 97:20 98:5 105:18 113:22 114:2 114:3,8 116:8,9 117:17 131:16 132:7 138:12 140:17 143:12 148:5 150:12 154:21 154:22 166:1 169:8 171:8 172:22 173:18 173:20 174:4,5,12 176:10,20 179:18 183:11 184:5,6 187:4 188:17,17 198:13 203:2,4,20 207:2 208:20 214:3 281:19 281:21
Provider-Post-Acute 4:8
providers 6:12 57:21 61:2 75:19 76:1 83:17 86:21 88:13,18 89:8 92:12 96:15 116:14 117:4,20 127:6 131:21 132:12,16 133:1 136:3 141:14 175:17,19 184:2 188:11,22 196:9 200:22 260:9 266:15 268:10,11,14 269:12 281:11 282:18
providers' 132:9 201:16
provides 14:1 32:5 284:21
providing 117:16 139:16 144:11,18 155:18 190:14 231:3 285:1
provisions 91:17 196:21,22
proxy 194:12 270:5,7
psych 20:10
psychiatric 162:3
PT 2:12
public 4:6,11,18 19:10 19:11 28:19 34:11,12 34:18,20,22 35:1,7 73:18 77:9 80:9,10 87:2 93:1,6,10,13,14 93:18,20 94:2,6,7,11 97:14 107:7,15,18 115:4 139:6 152:3 164:15 178:2,3,10,17 178:20,22 181:15 222:5,6 231:11 232:8 232:15,18 245:16 259:21,22 260:12 262:21 263:1,5,5 282:14 286:21 287:3 287:8,9 289:7,10
publicly 86:5
publish 64:5 65:1
published 64:21 145:22
publishing 64:2
pull 131:9 139:14
pulmonary 244:2
pump 109:22,22 115:22
pun 129:19
purchase 213:14
purchasing 59:1
purely 125:20 192:2
purpose 139:16 180:22 195:2
pursued 271:17
push 212:7 240:8,9
put 6:9,15 7:11 8:2,3 33:16 36:16 50:14 51:4 62:3,7,10 69:21 70:19 76:20 78:17 80:17 81:16 97:13 102:14 103:3 112:8 113:2 120:18 123:19 131:17 134:6 147:22 151:21 153:17 169:15 174:10,11 183:5 193:2 199:17 204:6 211:10 245:16 256:10 261:20 270:12 284:1 287:20 288:8
puts 256:4
putting 6:17 118:18 133:2 211:12 238:7

Q

QCDR 70:17
QM 90:9,14,21
QMs 90:6
QMVIG 15:1 20:2
QRP 49:12 52:12 105:19 150:21 155:1 166:1 176:20 218:1 220:20
qualified 12:20
quality 1:1,16 3:11 4:16 10:16 12:21 13:22 15:1,9 17:9,9 18:19 20:2,16,22 22:8 23:14 23:19 24:16,18 29:5 45:5,7,8,9 46:2,11 49:10 51:1,12 52:7 54:18,20 55:4,21 56:6 56:12,21 57:4,7,12,17 60:16 61:14 63:7 68:2 68:4,6 69:3,6 70:9 72:22 73:9,17 74:13 75:4 76:1,6 84:11 89:18 135:2 139:2 142:3 143:9 149:1 163:21 182:2 209:7 209:12 217:21 221:1 221:7,20 222:1,22 233:7 234:11,14 235:11 236:21 240:22 245:22 250:16 253:11 254:20 255:1,15,17 256:16 257:20 267:14 269:6 270:15 278:15 278:17 282:2
quantity 116:11 213:15
quarter 51:13 179:4
quartile 228:9
quartiles 228:6
question 8:15 12:17 35:17 36:5 39:19 40:17 72:4 78:7 93:3 94:15,19 106:18 108:15 128:22 129:1 144:21 160:8 163:22 164:20 165:14,14,17 166:5 187:5 190:17 192:14 196:9 197:10 197:15 198:2,3 201:2 202:10 210:13 214:17 246:6 253:20 260:12 263:10 268:18 277:12
questioning 145:4
questions 27:6 30:21 30:22 32:11,13,18 35:15 38:7 55:14 72:17 73:1 91:3 92:20 99:6,14 103:10 105:12 107:13 108:10 112:3,11 116:15 119:5 120:22 123:3 124:18 127:9 133:18 137:7 142:21 143:3,3 146:1 152:6 154:11 156:2 159:13 168:8 171:10,22 191:12 227:5 232:11 258:6 265:17 268:4 277:11
questions/comments 160:7
queue 278:22 279:2
queuing 273:21 274:14
quick 40:16 89:16 97:22 209:19 251:1 283:21
quickly 39:9 87:11 99:5 121:10 175:15 247:9 286:13
quietly 262:17
QUINNONEZ 152:18 153:4 154:6 166:3,12 168:14 177:2 178:16 214:16 215:2,12,19 216:5,13,20 217:5 232:14 260:20 261:4 264:3,8,22 265:5,9 270:16 271:22 272:9 272:16 273:1,8 274:22 276:13,18,22 277:3 287:2
quite 12:8 57:18,19 69:15 122:12 236:3
quorum 5:18 31:2,5,6 31:10 35:18,20 38:6

38:13 44:5,8 100:16 100:22 101:4,5 270:2 270:22 271:2,19 272:11
quorum-making 274:19
quote 74:2

R

race 161:15 228:21 229:12 230:1
race/ethnicity 247:1
Rainey 15:7,7
raise 27:7 98:14 104:21 107:12 278:21
raised 127:10 198:15 233:18 260:13 268:20
raising 180:9 264:5
Raj 9:6,6,7 62:5 63:20 74:8 124:15 125:3 175:14 182:13 183:21 199:22 250:22 251:19 270:5,8
Raj's 185:6
rally 59:4
RANEY 3:8
range 90:9
ranged 46:17
rapid 175:17
rare 112:22
rarely 210:18
rate 220:22 225:3,8 228:8,12,12 252:7 267:5,11,16
rate-based 224:15
rates 85:21 134:6 224:10 226:15 228:7 231:2 279:7
rating 62:15 181:10
ratio 224:17 251:14 267:3 268:5
rationale 27:22 28:2 32:5 128:5
re-admission 250:19
re-admissions 233:11
re-admit 236:9
re-admitted 250:20
re-bringing 271:2
re-engineered 195:17
re-enlist 236:2
re-institution 24:15
reach 61:13 286:12
reached 32:6
reaction 132:21
read 29:3 39:16 112:10 119:4 147:6 151:2 188:3 259:21
readable 200:12
reading 207:6 225:5
readmission 111:4 141:6 224:4,5 228:5
readmissions 60:22 76:9 224:5
readmitted 61:8,9
reads 143:7 166:5 214:17
ready 30:17 38:18 40:13,13 41:7,14 42:10 117:12 133:13 150:18 152:17,18 160:5 165:20 168:12 176:18 275:4 277:20
real 16:12 17:20 39:12 54:18 60:2 65:17 74:1 238:16
real- 75:21 90:15
real-time 75:18 89:11 266:4,15
realistically 76:21 104:7
realize 22:19 34:21 70:22 116:6 163:8 257:11 278:12
reason 123:1 128:12 140:9 149:11 156:1 158:13 160:10 202:22 209:6 226:4,11 231:9 234:16 268:6
reasons 228:1 250:20 250:21 255:12 256:21 266:11 267:13 278:5
reassurance 161:16
reassuring 258:19
rec 126:3 128:1 159:16
receipt 17:7 116:14 127:20
receive 31:20 61:15 134:2 140:12 186:19 220:14 221:12 244:5
received 26:19 32:1 75:13 85:3 86:17 88:5 107:7 111:19 116:11 121:17 122:18 127:14 142:22 171:10 182:2 201:5,9 225:20
receiver 127:17 172:7
receives 209:21
receiving 22:17 84:19 111:14 116:9,13 136:14,15 203:19
recognition 73:4,5 124:10
recognize 19:15 22:8 85:14 104:11 238:14
recognized 92:13
recognizing 117:19 152:2
recommendation 27:18 31:18 32:21 33:10 34:3 151:4 152:21 153:21 166:7,10 168:17 176:20 177:5 181:10 194:1 197:16 214:13,14,19 215:15 216:8 217:1 261:1 262:12,13
recommendations 25:3 35:2 37:16,18 220:5 221:22 231:13 288:1 289:8,9
recommended 234:9 259:12 260:18
recommending 127:16
reconcile 117:8 137:9 146:5,8 189:10
reconciled 83:12 84:6 85:12 88:16 91:13 95:1,7,9,14 96:4 97:2 110:9 119:6,11 121:5 121:9 122:4 123:16 139:17 140:10 142:16 143:11 148:3,9,12 149:19 156:8 157:18 182:4 183:9,18 185:20 191:17 194:8 200:10
reconciliation 19:20 106:4,9 108:16 110:12 129:22 142:6 157:14 158:1 195:21 209:8 210:15
reconciliations 141:19
reconciling 126:19
reconvene 41:19
record 67:16 124:21 146:11,12 179:8 182:2 289:17
records 20:20,22 212:6
recs 125:2
recuperating 158:2
recurring 102:19
recusals 101:9 102:5
recuse 101:7
red 195:18 199:16 200:2
reduce 23:6 233:12,12
reduced 281:20
reducing 21:19 233:10
reduction 24:7 46:12 49:15 51:5 52:9 218:5
reference 124:4
refine 30:9,12 36:22 275:17
refined 86:18
refinement 22:10
reflect 205:6 246:10 266:17 267:12
reflected 67:15 177:9 267:7 268:22 269:10
reflecting 247:5
reflection 55:20 191:20 209:18,19
reflections 32:10 56:1 189:5 190:5 191:13 198:1 211:15 254:2 254:11 263:20 287:15
reflects 224:16
refuse 112:15
refused 253:5
refuses 121:22
refusing 70:3
regard 265:17
regarding 115:10 158:17 163:9 167:17 185:2 220:19 258:5 264:11 268:5 286:21 288:2
regardless 144:9 191:2 267:19
regards 115:18 234:11
regimen 141:20 201:7
regimens 83:19
regionally 241:10
regions 241:8
Register 92:7
registered 40:18 144:5 203:12
registering 41:6
registers 200:5
registries 70:18
registry 12:20 13:3 70:1
regroup 108:9
regs 238:20
regular 232:21
regulation 87:7 235:19
regulations 197:2
regulatory 29:2 134:4 234:12 235:13 236:13 253:12 254:22 256:5 256:17
rehab 45:7 132:13 155:18 156:18
rehabilitation 2:5 49:9 49:19 50:3 60:7,20 78:14 79:12 155:13 158:3 201:4,7
reinforced 243:20 244:11
reinforcing 82:5 155:9
reiterate 185:6 196:13 264:10
reiterating 201:14
rejoining 271:1

related 45:12 50:14 78:10 106:9 168:9 181:22 209:13 243:3 250:1,5,8 255:15 256:18
related/unrelated 252:15,18
relation 68:1
relationship 91:9 136:11 231:1
relationships 240:15 245:17 248:6
relative 61:20 224:16 249:2,16 255:12,17 259:17 267:15
relatively 61:4 82:3
relatives 205:6
released 35:13 61:2 107:18 146:21 156:3
relevance 188:14
relevant 8:18 11:17 28:3 34:16 140:6
reliability 90:1,20 104:2 105:4 107:2 152:10 226:9 230:5
reliability/validity 104:21
reliable 230:11 233:22 279:16
relieve 116:8
remarkably 180:20
remarks 4:3 7:7 18:8 45:20 105:9
remember 17:19 33:6 88:9 184:17,17 276:4
remembering 210:12
remind 78:3 99:17,21 153:1
reminded 24:6
reminder 72:6 99:17 214:22 257:17
removal 24:7
removed 23:8 101:10 102:5 112:17 159:2
renders 63:16
rep 11:12
repeat 109:12 114:21 248:18
repeated 69:18
replaces 30:9
report 12:22 46:7 49:11 51:2 52:8 86:6 153:21 181:1,20 184:14 218:1 220:9 221:6
reportability 252:7
reportable 230:4
reported 24:11 84:11 106:19 125:22 218:13 232:4
reporting 4:16 18:19 19:18,21 21:19 22:9 28:19 45:5,7,8,10 46:2 49:10 51:1,12 52:7 55:21 60:20 68:7 73:19 84:12 126:1 142:3 164:15 192:19 217:21 221:20 270:15
reports 35:13 66:12 75:18 220:16 221:3,9 231:13
represent 9:8 10:12 11:3 78:4 245:11
representation 47:3
representatives 8:10 8:13 11:5 14:9,13 101:1 264:4
representing 9:14,17 11:19 78:6 165:16 221:1 257:16
request 124:8
requesting 265:21
requests 181:18
require 129:3 196:14
required 30:5 36:16 37:21 51:11 116:1 117:5 121:13 155:13 157:11 186:17 188:18 189:1 218:4 235:19
requirement 37:3 106:15 123:11 124:6 125:15 163:15
requirements 29:2 92:2 92:3 157:8 161:13 181:6 190:8 191:22
requires 19:21 157:12
requiring 148:11
research 3:19 17:6,7,8 76:19 77:6 79:7 202:11 224:9 251:5
researcher 17:5 161:2
researchers 55:17 72:12
reset 271:21
resident 57:17,19 73:7 83:14 139:22 143:9 174:18
residential 174:18
residents 169:22 192:2
resolve 152:6
resolved 48:21
resource 19:22 47:5 50:10 52:17
resourced 238:6
resources 59:6 267:18
respect 270:6
respond 32:15,17 71:19 118:4 132:6 133:14 176:3 200:22 202:11 206:14 244:8 253:18
responding 260:13
response 11:9 26:18 29:8 40:9 41:8 42:8 147:15 156:7 198:2 201:16
responses 272:7
responsibility 113:6 116:9 144:7 171:6,7 203:4
responsible 20:4 84:19 173:20 250:1
responsiveness 218:18 246:21
rest 193:15
restriction 192:1
restrictions 189:13 190:8 191:22
restrooms 7:7
resubmit 30:10,12 37:1 86:18 275:17
result 33:1 214:22 217:3 258:3
results 32:4,8,20 34:7 40:5 42:11 52:9 60:18 104:2 105:4 151:3 152:9 164:14 230:10
resumed 140:5 179:8 185:14
retrieve 97:8
return 36:9 49:21 236:10
returns 174:19
reveal 75:19 256:1
revert 242:13
review 4:2 5:19 26:13 27:13 31:1 32:8 97:22 99:1,9 103:14,17 107:10 122:21 133:14 141:21 156:12 179:19 179:20 180:11,13 217:18 232:22 283:20
reviewed 100:5 102:17 148:14 152:4 180:21 207:1
reviewers 99:16 107:20 155:2
reviewing 12:10 44:13 45:4 103:22 104:2 105:1
reviews 100:9 187:17
revise 36:22
revised 86:18 148:1,2
revisions 92:3 212:3
revisit 182:6
revocation 68:20 227:10 234:16,22 246:12 255:17 279:20 279:22 280:4,14,16 281:1,3,5
revocations 68:12 280:9
revoke 227:15 235:3 245:1 253:6
revoked 227:13 278:11
revokes 280:19
revote 273:2
RF 134:3
rich 282:13
Richardson 2:9 10:18 10:19 245:6 255:3,19 278:20 279:2,11 285:11
rid 69:13 241:4
ridiculous 70:13
Riggs 81:11
right- 40:2
rigorous 187:4
Rikki 2:20 3:19 16:13 16:16 17:4 40:7,10,16 43:3 131:2,4 132:3 190:4 276:19
risk 58:22 83:14 185:21 188:12 228:17,20,21 229:1,14 230:1,9 232:2 233:19 234:8 248:3 258:12 267:2 271:15 274:4
risk-adjusted 224:15 266:21
RN 2:3,8 3:3,6
road 198:20 203:20,20 266:20
Roberts 2:10 9:16,16
robust 86:15 87:5 134:20 142:7 148:6 148:20
rock 41:15
role 15:1 18:12 31:9 83:8
roll 41:15
room 1:17 8:21 11:5 12:4 15:16 39:13 42:16 48:20 74:14 81:11 93:9,11,18 94:14 97:15 101:6,21 107:15 113:5 167:20 178:12 180:9 183:16 205:2,5,7 207:21 232:10
root 60:17 83:6
rote 61:3
round 217:16
rounded 102:1

route 139:22 181:21 182:1 195:2
routes 89:1 141:4
routinely 58:3 155:14
row 87:16 88:21
RTI 3:18 81:9,11 219:16 219:18 263:16 264:1 264:5,11
rule 275:20
rulemaking 19:5 29:10 29:11,12,13,14,22 30:7,20 37:15 275:15 276:6
rules 28:21 71:15
run 7:18 44:2,22 75:19 147:17 213:8 238:9 247:18 260:3,11 282:6
running 54:18 90:10 93:4 161:15
rural 66:8 110:3 229:3,4 241:9 242:15

S

sad 261:16
sadly 13:3
safe 207:17 287:21 289:15
safeguards 191:8
safely 116:1
safer 23:15,20
safety 53:6 67:11 73:8 74:1 83:14 96:1 106:4 106:10 144:8 199:4 206:11
sake 87:15
Saliba 2:11 9:10,10 113:21 114:3 126:22 160:8 162:15 172:1 184:9 198:6
salient 45:4
saline 200:8
Sam 3:14 44:11,21 180:16
SAMHSA 14:13
sample 230:14 268:2
satisfaction 69:17
satisfying 156:5
sauce 57:3
save 275:1
saved 23:9
saw 65:8 69:12 80:10 228:1 285:9
saying 5:15 25:7 69:1 72:13 102:18 125:7 132:21 140:14 170:22 200:19 206:8 211:6 235:9 236:15 240:21 271:9 275:19 279:21 285:12
says 40:8 109:16 132:19 188:2 200:5 202:3
scan 134:21
scenario 174:16
scenarios 248:22
schedule 117:17
scheduled 7:10 172:10 172:12
schedules 116:12
Schreiber 3:9 14:21,22 18:10 197:9 288:13
science 22:9
scientific 12:12 104:17 122:21
scientifically 104:4 233:21
scope 236:6
score 90:14
scores 90:9,22 229:15 230:20
scot-free 221:19
screen 43:15 55:13 126:4 177:10
SCRES 2:10
scrutiny 115:14
se 124:20
seamless 24:22
seamlessly 39:7
seats 42:13 177:22
second 40:12 42:12 57:1 64:22 72:5 88:21 89:17,20,21 95:21 96:13 135:14 139:9 148:7 174:7 182:22 191:20 246:4 254:2 273:15 276:2
secondary 58:21
seconds 76:15
secret 57:3
section 77:9 198:10
sector 62:11
secure 84:5
seeing 40:9 105:16 232:12 248:12 279:6 281:6
seek 235:6 244:10 282:21
seeking 236:5
seen 118:20 172:12 195:8 228:5 242:6 259:21
selecting 269:12
selection 28:13,16,22 29:5
self-directed 282:4
self-reported 126:1 226:8 259:5,8
semi 125:19
send 131:22 132:11 134:14 138:4 148:12 163:12 188:17 199:20
sender 127:19
sending 88:13 171:8 172:3 173:21 187:6
sends 123:6 214:3
Senior 3:11,13,14 7:18 17:5 27:4
sense 70:10 80:8 96:17 136:19 176:1 230:17 240:2 241:1 285:14
senses 241:2
sensitive 132:6 254:8 256:7
sensitivities 188:20
sent 85:3 112:18 113:5 121:17 124:7 157:14 167:19 170:6 174:5 194:19,21 197:1 202:17 205:9 207:4
sentinel 83:7
separate 198:10 212:10 212:10
sequence 262:19
series 35:13 182:15 264:19
serious 83:9
seriously 21:22 37:11 37:19 49:6
serve 6:12 28:15 236:11 248:4
served 6:11 21:1 248:11
serves 80:2
service 58:1 67:10 161:21 222:16 223:1 227:1 235:20 236:1,4 236:10 244:19 245:1 247:3,20 281:9
services 3:3,4,5,6,8,9 15:8 52:4 67:6 136:13 203:14 205:9 221:18 281:7 282:16 284:21 285:1
set 24:19,22 27:16 41:16 43:22 46:19 47:8 52:21 61:18 80:21 86:15 98:5 101:17 103:17 107:21 110:6 117:12 137:3 137:16,17 142:8 169:7 173:18,22 174:3,7 181:8,11 197:3 198:22 203:3 216:19 218:8,8 233:15 243:1 285:16 285:18
sets 28:19 92:22 176:16
setting 82:11,13 90:13 106:22 107:3 108:19 132:12,14 134:9,20 135:3 138:6,16 145:13 154:14 155:18 162:1,19 175:9 181:3 187:3,3 190:20 192:3 196:5 206:19 207:4 209:1
setting-specific 35:5
settings 56:4,5 82:19 90:12,14 106:2,6,17 123:9 135:6 144:17 156:19 157:6 160:21 161:6,8 176:12 185:2 192:2,8,15 207:7
setup 46:9
seven 29:3 107:8 223:9 237:14 249:10
Shaconna 27:4 35:16 100:5
shape 188:16 201:16
share 32:10 44:11 45:15 220:10 255:20
shared 86:7 165:9
sharing 91:20
Sheila's 38:21 43:11
short 22:20
short-term 161:19 172:8
shortcut 59:10,14 178:5
shortening 247:10 279:6
shorter 257:7
shorthand 172:14
shortly 41:1
shots 200:9
show 25:9 30:16 44:6 46:15 52:14 67:15 89:19 136:1
showing 43:13 223:10
shown 49:2 226:18
shows 65:6 111:2
Shreiber 18:7
shrinkage 268:8
sicker 157:5
sickest 72:19
side 22:13,16,17 40:3 130:10 275:2
significant 25:14 61:4 225:8 230:22
silly 129:1
silos 63:14

similar 49:13 180:20 181:17 213:11 224:3 228:4 251:13 279:8
similarly 146:9
simple 39:3 82:3
simplistic 186:22 190:12
simply 187:19 242:12 267:7 269:21
Simultaneous 252:2,4
sincerely 18:14 23:1
single 61:12 179:22
sister 74:12
sit 11:18 12:11 98:21 105:14
site 40:8 112:20 121:10 164:15 165:12
sites 89:21,22 115:17
sits 286:9
sitting 63:13 177:22
situation 131:12 145:1 237:13 282:20
six 25:18 177:10 183:20 219:13 249:10 264:20
sixth 15:20
size 268:2
skilled 45:9 52:6 109:18 170:11 174:17,20,21 175:8
skimming 58:18
skin 19:19
skip 286:17
skipped 13:8
skirt 5:16
slapped 205:8
slide 29:4 30:8 34:21 44:5 46:21 47:1,8,17 47:17,18 50:5 52:14 81:18,22 86:13 87:10 88:20 89:15,16 91:1,2 100:14 148:7 217:20 218:10,14,21 219:1,5 220:2,2 224:15 225:10,19 228:16 273:17 274:14 275:1
slides 23:16 46:16 47:19 48:3,17 77:13 80:8,15 87:11
slightly 19:13 101:14 103:21 123:21 241:15
small 200:12 251:3 252:9 257:7,8
smaller 111:9 259:2 267:22 268:1,2,10,14
Smith 2:12 9:13,13 76:16 171:9
smoke 187:22
smokers 188:1
smoother 26:22
SNF 52:12 82:21 90:13 113:11,17 124:19 169:9,16 170:4 175:6 176:20
SNFs 64:22 65:2,3 90:10 111:9 123:9 137:18 146:2,9,12 161:20
SNOMED 64:7
snowing 131:7
social 228:22 243:18
society 2:7,12 9:8,11 67:17
software 7:15 43:22
solely 88:4
soliciting 266:7
solution 130:21
solutions 229:17
solve 210:8
solvent 87:10
somebody 61:8 94:14 112:9 264:21
someday 208:21
someplace 251:16
somewhat 246:4
sorry 9:6 15:6,6,15 47:17 50:6 66:20 113:13,20 137:9 139:18 160:11 163:3 168:11 173:13 176:21 181:12 269:14 278:21 283:6 288:3
sort 47:5 55:14 56:9 58:4 59:10,11 61:3,12 61:18 72:21 75:12,14 117:13 120:4 121:16 148:6 159:15,20 172:10,14 174:9 179:19 186:22 187:6 196:17 206:2,20 237:4 239:17 241:3 259:4 283:13
sorts 161:7 257:20
sound 85:18
sounds 185:15 215:19 234:22
source 209:22
sources 46:16 49:22 52:12 127:2 218:7
South 5:6 187:21
Southeast 5:17
SOWs 161:8
space 20:15 132:8
speak 7:11 17:20 18:3 48:2 73:10 74:8 79:13 95:21 134:1 156:19 188:2 250:3 264:21 265:1,12 269:13,17 284:4 285:13
speaking 79:20 252:2,4
speaks 122:16 239:21
special 122:4
specialist 13:11 170:5
specific 36:19 44:16,17 44:19 78:7 96:6 97:7 103:17,19,19 104:1 105:3 108:14 109:1,6 113:10,16,17 114:15 115:17 116:18 117:15 125:4 144:16 147:17 154:14 155:1,8,11 156:3 157:1 158:17 163:22 166:1 167:10 167:12 168:3,8 169:16,17 185:2 193:11 198:2 209:7 238:16 242:2 245:14 246:3 282:1
specifically 48:7 50:15 53:16 85:12 88:15,17 88:21 91:13 97:9 115:12 117:18 119:2 119:20 121:21 123:22 124:3,11 136:12 146:4 150:20 153:13 156:18 161:17 194:17 195:2 223:11 256:18 256:22
specification 119:8 147:1 185:18,19
specifications 32:18 115:3 117:13 119:3 119:20 120:13,14 121:4 128:10 135:7 135:15 137:6 138:22 139:5,11 143:5 150:13 152:7 159:3 164:9,10 167:18 170:8 171:2 175:2 187:11 188:8,10 190:18 192:6 193:3 200:20 246:18 259:10 274:2,13
specificity 160:2 181:19
specifics 29:1 114:10 115:10 124:19
specified 29:15,19 30:3 30:18 106:21 135:4 147:1 148:18 182:4 188:14,15 271:8,14 275:21
specifying 146:20 191:16
specs 116:18 121:12 128:17
spectrum 237:1
speech 284:8
speed 86:14
spell 154:6
spelled 115:4
spending 57:20 61:1
spent 6:16 56:2,20 59:7 59:16
spirit 12:1 56:8 77:8
split 230:14
spoke 171:8 284:5
spot 78:17 183:5 238:8
spouse 202:16
spreadsheet 153:20
squeeze 240:6
stabilization 48:6
stabilized 82:15
stable 139:6
Stace 14:18 75:11 133:22 141:22 142:10 143:15 196:10,12,20 209:4
Stace's 73:19
staff 3:10 6:3,15 17:22 27:11 28:2,8 31:20 32:8 33:13 35:12 38:15 98:4 99:9,15 100:9 104:13 107:4 120:20 151:10,11,16 151:21 169:12 180:12 181:9 214:14 233:2 260:17 285:18 288:22
staff's 105:22
staffing 74:21
stage 93:1
stakeholder 85:7 140:11,20 148:13 208:8
stakeholders 19:3 22:1 26:20 85:4 86:9 96:16
stand 61:20 155:9
standard 63:7,10 172:11 195:9 212:15 213:3
standardization 73:14 76:18 212:19
standardize 63:1
standardized 27:20 55:17 63:5 72:9 135:5 266:8
standards 64:6 84:7 92:13
standing 98:21 105:14
standpoint 157:17 224:5,22
stands 183:20
star 58:16,17 59:18,18

62:15 232:18 262:21 262:22 287:6
stars 58:13,14,20 59:9 59:10,14 62:17
start 9:6 12:3 13:8,18 31:9,10 40:14 56:18 72:13,16,20 81:7 97:19 98:11 100:8 105:17 108:5 116:3 126:15 136:18 155:7 167:11 178:11 179:4 180:12,18 182:13 190:6 198:4 208:1 232:9 240:12 249:15 250:13,13,17 256:8 256:17 257:9 261:13 264:18
started 5:4 87:4 91:9 129:13 142:3 179:13
starting 28:15 33:22 83:18 218:3 269:20
starts 183:13
state 2:1 21:1 63:16 94:15 160:21 161:3,5 174:9
state-by-state 63:4
stated 214:2
statement 27:21 28:3 142:14 213:17
states 24:21 150:9,14 194:18 241:10
statistic 229:13 259:3
statistical 224:22 268:10
statistically 225:22 230:22
statistics 82:14 251:2
stats 225:5
status 19:19 47:6,7 49:20 50:11 51:19 52:18 64:21 96:21 124:20 239:18
statutorily 36:15 37:20
statutory 29:1
stay 7:5,9 31:12 47:21 96:3,8 113:15 119:15 119:16,21,22 133:9 138:10 155:10 185:13 201:3,10 210:22 223:8 227:14,16 238:11 252:16 262:3 266:3 269:8
stayed 139:5
staying 289:2
stays 82:16 143:9 227:17
Stella 3:3 14:18 196:10
step 64:9 99:18 148:14
stepped 148:21
steps 4:20 59:7 289:3
stewarding 20:5
stick 114:10 133:6 262:8,8
sticking 287:14
Stolpe 3:14 45:2 48:22 49:7 180:14,17
stone 11:6 197:3
stop 30:21 35:14 69:11 116:3 128:13 197:14 197:19 199:4,12
stopped 131:7
stories 209:10
storm 5:6
storms 5:16
story 75:5
straight 185:7 204:10
strange 16:21
strategies 156:16 188:21 195:20
stream 196:1
Street 1:18
strengthening 23:20
stressing 181:22
strict 240:4
strikes 57:9 204:11
strong 28:5 63:9,22 91:19 200:15
strongly 266:20
struck 252:21
structure 46:6,9 51:3
structured 27:12
struggle 158:4 278:19 278:19
struggling 56:14 254:4
stuck 59:9
student 6:7
studied 223:3
studies 49:2 229:6
study 17:9 77:4
stuff 69:12 111:6 129:14 145:16 160:18 164:2 187:19
stupid 69:11
subject 2:15 8:10,12 9:1 11:14 12:4,7 13:17 14:5,10 16:13 46:11 49:14 87:3 204:6 268:2
subjected 218:4
submission 104:14
submit 46:11 49:14 52:9 135:22 137:21 150:6 166:4 168:18 218:4 261:2 272:6 289:12
submitted 22:5 39:18 42:20 43:16 94:20 222:15 246:17
submitting 66:12 90:5 152:4 166:15 217:11
subsection 209:12
subsequent 46:15 47:1 51:13 82:12 88:18 108:6 131:16 143:12 207:2 226:20
substantial 56:3
substantially 36:18 37:2
substitutions 213:10
subtracted 112:16
suburban 242:16
success 82:6 156:12
successful 49:21 82:4 82:6 196:5
successfully 41:10 156:6 231:20
succinct 28:14
sufficient 186:18
suggest 124:11
suggested 30:5 195:7 226:10
suggesting 250:15
suggestion 195:19
suggestions 279:9 283:10
suggests 191:6
sum 249:2 250:14 256:15
summaries 156:18
summarize 33:14 102:14 131:3 181:16 231:10 245:8 253:17 286:22
summarized 233:5 286:8
summary 4:20 133:11 155:14,20 157:13 191:15 221:6,9
summation 289:4
summed 143:17
supplements 139:20 185:9 213:22 214:7
supply 188:11
support 14:1 29:10,11 29:11,13,14,17,22 30:2,6,7,13,14,16,20 32:6 34:1,3,5 36:8 37:6 64:11,18 67:20 91:7,14 92:2 98:7 100:5,6,6,7 103:19 104:1,14 107:5 122:9 122:14 151:4,12,18 151:18,18,20,22 152:19 153:3 166:5 166:11 167:6 168:15 176:21 177:4 214:18 215:1,13,18 216:6,11 216:21 217:4 233:4 242:10 260:18,21 267:19 269:21 270:14 270:17,18 271:6,7,9 271:11,16,21 272:6 272:15 273:7,8,9,13 274:11 275:2,5,12,15 275:18,21,22 276:3,7 282:3,17 283:1 285:5
supported 224:8 233:16
supporting 106:1,8
supportive 107:11 236:16
supports 29:14,18 92:13
supposed 70:15 177:20 178:1 183:19 234:4
Surely 117:21
surface 256:6
surgery 157:21,21
surprised 132:19
surrounding 191:20
surveillance 85:17
survey 31:7 63:2 237:5 237:15
surveys 46:20
swing 162:1
switch 244:7
symptom 218:17 243:22
synopsis 39:1
system 20:17 38:14 42:3 49:16 62:19 117:9 126:5 212:12 249:18 251:17

T

table 7:1,5,9 31:13 54:4 78:6 93:2 122:7,10 131:18 176:21 180:6
tagged 36:19
taken 157:21 158:6 239:14
takes 217:17
tale 68:4
talk 53:21 54:9,11 58:15 98:18 108:9 109:11 110:9 121:21 134:7 204:5 260:2 279:14
talked 226:10 240:15 242:3,5 258:17 259:16
talking 76:2 97:19 98:7 124:3 127:16 131:13

134:9 173:19 194:12 202:4,5,7 204:1 205:2 205:16 212:5 222:15 225:1 230:13 241:21 250:12 252:22 254:15
Tara 3:5 14:15 44:17 53:21 55:11 71:18 73:2,5 75:12 77:12 80:8,13,19 110:19 118:9 119:4 123:19 132:10 133:13 143:16 143:18 152:8 160:4 160:13 162:22 164:10 164:19 168:10 171:19 176:2,17 177:17 191:14 202:9 206:13
Tara's 76:3 80:11 133:16,17
targeted 156:11
task 188:10
tasked 103:15 105:1
teaching 195:21
team 36:14 37:4 53:13 63:9 70:21 208:11 219:8,18 254:12 286:12 287:16
teams 76:2,2
teasing 48:15 113:3 285:4
technical 7:14 14:16 15:10 48:12,17,21 49:1 79:14,18 87:2 139:7 165:17 208:7 222:5 274:16 277:2
technicalities 77:21
technically 37:1 175:7
technology 3:7 12:19 26:3 62:22 63:6,15
tee 133:22
teeth 69:21
teleconference 3:21
telephone 93:19 94:5 94:11 97:15 127:4 136:3 178:21 180:5 180:10 191:12 211:14 262:16,22
tell 8:22 9:4 73:12 118:12 130:6 131:7 149:7 199:12 213:20 263:13 280:17
Telligen 2:2 13:21
telling 193:17 274:5
tells 68:3
temporarily 227:19
Ten 225:6
tend 157:4
tended 266:2
tensions 257:2
tent 7:11
TEP 85:7 259:11,12 266:2
term 51:11 56:4 148:2,3 210:15 242:9
terminal 242:8 250:2 278:12
terminally 227:21
terms 37:12 38:1 54:20 54:22 55:10 72:15,18 72:21,22 74:15 86:19 97:5 98:18 111:13 118:7 121:7 122:8 141:7 145:6 156:14 162:6 172:6 186:5 193:8 198:12,18 219:22 222:3 226:1,9 227:19 228:14 230:9 231:1 247:14,16 248:11 252:11 254:22 255:1 257:2,15 259:8 260:6 271:20 277:17 279:8 288:9
terrible 279:3
territory 283:7
test 36:2 38:14 41:21 42:2,4 89:17,21,22 258:18,21 259:3
tested 107:1 228:21
testing 84:16 86:10,16 86:20 87:1 104:3 105:4 152:10 208:10 229:2 230:6,7 258:20 259:2
tests 89:17 106:22 232:4
thanks 5:7,15 6:15 7:4 40:16 43:19 45:22 60:5 62:4 63:20 66:22 76:13 98:2 109:13 116:16 118:6 132:3,5 150:17 156:20 164:5 166:22 168:4,6 171:12,16 176:17 180:14,16 185:5 190:3 234:1 237:17 241:11 250:22 253:16 260:10 269:15 285:8 288:19,20
theme 60:10 61:19 102:19 250:3
themes 63:18 80:10 107:10
theoretical 208:3
therapeutic 83:4
therapy 2:11,12 9:14,17 128:17
they'd 44:18
things 21:10 54:16 55:7 57:13 63:2 66:13 69:14 70:14 71:5 75:14 80:11,18 98:4 102:13 114:21 116:12 127:1 128:4 130:13 144:14 145:16 154:15 156:13 169:21 170:15 170:21 172:2 185:7 185:15 187:14 188:19 189:22 192:5 193:9 198:19 199:5,9 200:9 200:14,15 207:10 211:12 227:7 230:17 234:15 236:20 238:5 239:8 240:7 246:14 247:9,12 253:14 257:13 261:12 265:15 284:14 285:4 286:4,7
thinks 268:19
thinner 201:2,6
third 80:2 83:6 121:11
third-party 59:12
Thirty 247:12
thought 81:15 94:19 105:13 113:14 117:22 124:8 135:13 136:19 183:15 196:1 198:18 252:15 255:21 265:15 265:20 266:9 269:19 277:13 288:15
thoughtful 248:16 288:16
thoughtfully 248:19
thoughtfulness 288:7
thoughts 45:15 108:22 249:9 260:14
thousands 72:14 251:9
threatening 83:15
three 25:6 35:5 46:17 77:19,22 81:15 82:2 87:2 90:11 100:20 101:20 118:14 142:1 162:9 166:21 212:9
three-step 27:10
threshold 100:16 101:17
throw 151:15 213:21 276:10
tie 189:2 239:7
tied 126:16
tight 40:11
tighten 181:18
time-sucking 69:14
timeline 35:4
timeliness 109:15 121:7 141:1 218:18
timely 66:11 84:2,5 87:10 91:5 138:14 144:22 145:3 160:2 181:1
times 24:6 73:17 79:13 109:21 110:21 116:3 125:14 138:7 163:8 175:16 189:9 200:7 204:16 212:2 213:20 235:4 240:3 245:17 281:7,8 282:19
timing 191:22
tipping 56:10 63:13
title 123:21 124:6
today 5:5 8:5 12:10 14:4 17:10 18:18 21:6 21:12 22:11 23:1 25:3 26:12 35:6 36:8 44:13 52:6 67:19 83:22 84:8 85:11 86:12 89:12 102:7 152:8 163:19 222:9 261:19,20 286:9,21 287:20
toggle 40:5
told 205:9
tolerate 67:17
Tom 175:9
tomorrow 35:6
tongues 57:8
tool 134:16 195:18
tooled 102:12
top 63:5
top-down 60:2
topic 133:9 209:18 225:18
topics 120:18
topped 25:16
torn 246:5
total 150:15 166:20 169:4 177:9 215:5,22 216:15 217:8 272:2
totally 161:3 206:17 234:13 285:14
totals 154:7 166:19 215:5 216:14
touch 21:10
touched 160:1
tough 238:8 256:3,3
TPN 140:2 185:10
trade-off 265:21
trade-offs 266:12
traditionally 56:13
traffic 80:16
train 262:7
training 149:6
transfer 4:8,13 19:20 50:15,19 51:22 52:22 53:5 80:20 81:2,3 82:2,4 84:2,5 85:5,6

88:7 89:5 90:7,18,19 91:5,12 93:15,21 95:12 96:12 97:11,16 97:20 105:18 113:21 113:22 124:9 132:10 134:14 138:14 140:1 141:1 143:10,13 148:4,17 154:20 159:7 160:2 165:22 167:19 170:4,18,20 171:6 172:17 179:15 179:17 180:19 181:1 192:9 194:20 208:15 209:13 211:16 235:15
transferred 85:12 92:11 119:13 281:2,3
transferring 156:5 160:9 170:14 201:13
transfers 82:7 86:4 235:14 256:22
transition 64:13 83:2 87:13 106:5,11 110:21 228:12 231:2 240:16 284:18
transitional 192:11
transitioning 206:21
transitions 2:6 10:12 19:16 53:4,6 64:11 83:2 84:3 86:1,4 106:3 111:1 112:7 233:9 240:16 258:3
transmission 181:22 186:8 208:15
transmit 70:3 126:7
transmitted 109:17 111:18 158:1 173:7 173:10
transmitting 111:13,22
transparency 12:2
traumatic 233:10
travel 5:7 287:21
traveling 261:21
travels 289:15
traverses 160:22
treat 145:8
treated 260:9
treatment 24:1 235:6 236:6 250:2
treatments 67:14 236:1
tree 111:21
tremendous 70:8 130:16
tremendously 69:16
trial 49:3
tried 79:13 206:5 211:5 212:13 226:19
trigger 55:14
triggered 192:18
triggering 75:20
Trivedi 2:22 13:14,14 108:13 159:12 167:12 169:17
trouble 7:14 184:7
troubles 70:15
troubling 236:21 253:13
true 70:6 223:22 249:13
truly 62:10,17 90:3 174:8
try 7:9 40:10 42:2 151:21 163:13 183:13 219:21 225:22 229:17 230:15 262:3,8 287:22 288:17
trying 6:18 56:10,17 58:12 59:7 62:6 63:10 64:9 144:19 152:8 170:20 175:2 192:22 206:10 212:1 240:9 241:1,2 246:17 257:19 264:21 265:1 265:12
turn 26:8 27:3 44:11,21 53:21 133:12 142:13 173:14 182:7 198:3 219:8 232:6 256:11 261:11
turnaround 283:21
turned 219:20 234:4
turning 45:17
twice 86:22
two 8:7,8 17:7 25:4 34:17 43:14 46:12 49:14 51:4 52:10 80:21,22 82:1,2 83:22 84:8 87:2,11,20 88:3 89:17 105:7 115:6 121:7 123:3,18 125:18 134:10 135:2 136:7 139:6 141:22 145:22 149:18,19 153:18 154:8 158:21 160:15 162:9 169:4 174:13 176:16 201:8 210:19 211:11 223:4 225:2 227:2,16 230:3 251:15
two-tenths 59:17
Tyler 81:13
type 46:6 52:8 97:3 115:11 165:4 200:22 202:13 223:1
types 8:8 54:20 96:5,6 97:1 141:18 156:14 170:21 242:2 258:20 278:13 279:14
typical 155:19
typically 135:22 186:9
typo 34:21

U

U.S 92:15
ulcer 11:7 88:10
ultimately 26:4 86:2 188:16 266:12,16 268:6
unaccounted 43:2
unanimity 277:7
uncomfortable 281:22
undergo 106:2
undergoing 158:3
underpinning 282:5
underscored 196:17
underscoring 209:6
understand 8:21 11:6 59:7 67:16,18 68:21 69:5 91:7 95:1,3 116:10 124:5 129:1 184:15 185:18 187:13 187:14 189:19 190:14 204:17 206:7 210:8 214:7 234:20 240:19 250:10,11 258:5 273:18 275:9 285:6 285:15
understandable 193:9
understanding 36:18 55:6 60:18 87:17 89:9 120:12 125:11 157:3 188:8 278:5 284:7
understands 27:1
understood 193:13,21
undertake 262:19
unfortunate 242:21
unfortunately 236:3
uniform 241:17
unintended 25:12
unique 138:6
unite 49:4
United 24:21 241:10
universal 193:20
universe 136:22 255:11
university 2:1 12:6 235:22
unlicensed 203:15
unmuted 269:15
unnecessary 233:11
unpaid 11:16 202:8,8
unrelated 252:16
unusual 158:22 174:16
update 46:14 49:16 51:6 52:11 218:6
updated 29:8 32:7 130:17 275:3
updating 193:21
upside 219:20 225:22
upstream 237:21 240:10
urban 66:8 229:3 242:16
USCDI 92:16
use 19:4 20:8 25:1 33:20 50:10,18 52:17 55:4,10 68:8 69:2 70:21 72:21 76:1 96:18 97:1 103:19 105:3 134:8,13 135:8 137:22 142:15 156:15 172:8,13 195:11 210:19 226:22 239:17 239:22 242:19 275:22 276:8,10 280:1,4 282:1
useful 60:12 94:20 104:8 105:13 138:18
usefulness 252:9
useless 183:16,17
users 63:11
uses 27:10
usually 213:14
utilization 19:22 47:5 220:15 222:21 223:2 241:22 242:14 257:19 282:6 284:16
utilize 243:1,21
utilizers 255:9

V

VA 248:6,8
vagueness 137:10
valid 122:20 233:22 250:19,21
validation 122:18 226:19 230:16
validity 90:2 104:3 105:4 107:3 122:16 152:10 230:5
valuable 18:17 129:13
value 23:13 251:16,19
value-based 15:2 20:2 20:7 23:3 25:13 59:1
values 251:16
variation 233:7 279:17 280:8
variations 250:3
variety 59:1,11 266:11 267:13
vast 133:1 170:10
venders 117:12
vendor 213:1
vendors 212:8,10,14,18
verbal 127:4

verbiage 55:22 187:21
verify 247:4
version 107:17 186:11 186:12,20
versions 186:10
versus 58:13 107:16 167:18 170:3 213:7 230:8 236:22 246:14 251:8 252:10 257:6 279:20,20 280:9 282:22
veteran 248:7
veterans 248:5
vetting 86:16
vice 3:11 7:18 78:20
videos 139:10
view 48:12 77:13 120:5
Virginia 3:8 15:7
vis-a-vis 61:15
visceral 244:9
visit 223:8
Visiting 2:9 11:2
vital 82:5
vitamins 139:21 185:10
vocabulary 146:22
voice 25:6
volume 68:19 249:13 251:11 257:8,8 280:9
vote 6:22 7:3 31:3,5,7 32:18,21,22 33:4,8,15 33:17,21 34:2 36:3 38:18 39:10,11,16,17 39:18,20 40:1,14 41:7 41:22 42:8,10,12,14 43:3,7,16 44:3,9 71:15 98:6 99:21 100:22 114:4,8 122:8 122:22 143:21 150:2 150:18,19 151:9,13 151:16 152:15,18,19 163:5 165:21 166:5 168:12,15,21 176:18 176:19 177:4,11 214:18 215:11 216:6 216:19,21 217:10 254:6,18 260:16,17 260:21 270:5,7,7,13 270:17,18 271:20 272:4,5,22 274:6,15 274:19 275:4,4 276:20 277:9
voted 41:10 154:7,8 166:17,17,20,21 169:2,2,4,5 200:21 215:4,5,6,7,21,22 216:1,2,15,15,16,17 217:7,8,12,13 261:5,6 261:8,8 272:1,1,3,3 272:17,18,19,20
voters 101:2
votes 28:5 31:11 39:12 42:5,20,21,22 43:1,13 43:14 44:6 152:22 153:5 166:4,8,13,14 168:18,20 177:6,7,9 215:3,20 216:13 217:12 261:2 271:6 272:10 276:14,14,17 276:22 277:3,4,4
voting 2:1,15 5:22 6:22 7:2,15 28:11 31:1,3 31:17,22 32:7 33:9,11 33:20 34:1,14 36:2 38:14,17 39:8,15,19 40:4,18 41:20 42:2,6 71:13,15 100:17 101:18 102:2,4,8,21 103:2 119:9 150:22 165:18 166:16 168:14 168:21 177:3,8,10,11 177:13,13,22 214:12 214:17 215:3,12 216:5,20 217:5,10 260:21 261:3,4,14 262:4,5,19 270:11,16 270:21 271:1,21,22 272:4,6,8,16 275:7 276:5,5,9,12 277:10 287:15
vulnerabilities 221:6 268:14
vulnerability 106:11

W

wait 93:8 113:11 180:15 237:6
waiting 237:7
waiving 221:17
walk 27:5 38:21 44:6 100:17 103:7
walking 38:15
Walmart 130:8
wander 179:3
wanted 8:16 11:15,21 38:13 44:22 53:12 54:2 57:5 75:12 76:12 76:16 93:5 103:3 105:6 131:9,17 132:5 144:2 145:20 146:14 150:5 152:12 163:6 164:1,9,11,16 172:3 181:4 196:10,13,16 201:20 205:1 230:19 235:5,7 259:20 266:20 268:17 284:7 285:6 287:19
wants 33:3 105:9 117:18 180:1 211:14 260:16 277:10
Warfarin 189:14
warning 200:2
Washington 1:18
wasn't 263:11 280:14
watch 229:20 287:21
water 251:21
way 13:5 20:12 36:14 62:9 63:8 66:5,15,17 71:4,8 74:16 76:22 98:11 118:11 124:7 126:6,18 129:2 133:7 134:7 136:20 137:1 138:16 140:16 141:9 145:2 184:3 224:6,7 233:12 235:12 237:11 242:21 244:9,10 246:10,18 249:16 251:10 253:8,14 255:2,22 259:12 266:17 269:11 273:19 275:1 279:22 282:7 283:15 286:9
ways 55:3 71:7 75:3 153:16 224:3 255:16
web 40:20 48:2,10 50:17 52:2 53:3
webpage 139:3,10
websites 117:1
Wednesday 35:6
week 19:14 146:21 147:11
weekends 111:12
weeks 145:22 201:8 227:2
weighs 102:18
Weiland 75:17
welcome 4:2 6:5,7 15:5 16:8 18:13 209:2 237:16
welcoming 18:8
well-informed 236:19
well-resourced 238:3
went 86:22 154:10 179:8 180:8 217:15 260:5 289:17
weren't 101:15
what-ifs 249:11
whatnot 141:19
who've 6:15
whoops 176:21
Wi-Fi 7:15
wide 228:4,10
willing 178:1,2 270:6 283:18,22 285:17
willingness 183:4
window 172:13
winds 33:13
wish 7:10 99:20 235:6 245:1 277:18 287:20
wishes 93:13,20 94:5 94:15
wonder 190:22
wonderful 45:2 61:19 177:17
wondering 70:16 184:16 252:6
wonk 284:5
word 20:9 156:8 182:21
wording 96:17
words 5:12 115:10 146:22 210:19 254:18 278:3
wordy 196:14
work 5:9 6:12 8:3,4,8 8:14,18,21 10:14,16 11:17 13:4,15,22 18:21 23:5 26:6,17 27:14,17,21 28:1 31:12,17 32:12,19,21 33:3,10,14,21 34:2 35:2 37:22 53:14 56:5 60:1 63:9,19,19 64:17 70:9 74:9 78:10 80:18 88:5 90:5 92:8 97:17 105:11 111:1 118:19 120:11 121:3 144:11 152:2 164:2 179:22 180:5 184:21 202:14 204:3 212:15 213:2 214:19 215:14 216:7 216:22 229:16 236:15 262:2,18 264:19 269:21 277:18 285:17 287:20
worked 12:8 63:21 87:7 96:15 273:13
workflow 126:12,17
workgroup 1:7,16 54:11 80:3 100:20 152:15,20 153:15,19 166:6 168:16 177:5 260:22 261:10,22 262:15 263:4,4 264:12 268:4 270:4 277:14 283:11,14,18 283:20 288:7 289:9
working 24:2 26:7 43:11,18 56:3 62:16 87:8 91:10 179:13
works 36:15 130:15 197:4 284:21
world 54:18 58:2 67:10 70:18 72:7,8,13 73:18

109:18 155:13 193:16
worried 179:11
worry 130:12
worse 259:2
worth 285:7
wouldn't 37:7 96:17 173:8 191:1 201:11 252:17 280:15
wound 12:21 48:12
wraps 261:13
write 153:22 171:1
writing 72:2
written 131:14 195:1
wrote 80:15 209:8

X

Y

Yay 76:11
year 15:20 21:14 23:7 26:16 28:2 29:8 30:1 32:8 37:8 44:1 54:5 63:22 64:3 65:1 71:2 129:12 139:6 221:5 227:14,17 245:16 249:17 288:8,8,11
years 17:7 20:15 22:18 76:22 81:16 82:2 86:15 141:22 142:1 144:3,5 162:9 219:13 221:10 222:4 230:4 243:21 288:11
yesterday 5:6
yield 85:17 145:8
yields 165:4
yup 121:14

Z

zero 202:13 249:2 250:14,18 251:20

0

1

1.72 225:7
1.8 90:22
1/10 34:20
10 1:12 34:22 35:9 53:17 153:6 221:10 225:4,6 261:7
10,000 8:17 78:9
100 23:9 42:17 194:5 230:8
100-day 213:15
1030 1:17
10th 289:9
11 41:10 82:19 88:8 169:2
11-12 276:14
12 102:9 130:7 205:8 225:15,16 271:22
12-month 251:22
12/10/18 171:9
12/21 34:20
12:31 179:8
12:48 179:9
13 276:14
130 60:7
131 121:21
133 167:1
136 176:19
14 4:3 230:13 276:14
14.4 102:1
15 53:17 101:21 166:17 178:6 205:7 227:3 272:3,10 276:18,22
15-minute 179:2
155 4:9
15th 1:17
16 42:19 101:3 166:20 221:9 230:13 277:3,4
167 4:10
169 4:10
17 42:21 168:20 169:4 177:12 215:6 217:9 217:12
178 4:11
18 42:22 43:13 154:7 166:14 177:9 216:1 216:16 225:17
18.42 225:5
184 22:4
19 43:17 177:9

2

2 90:17 152:21 209:12 214:20 215:15 216:8 217:1 261:1 270:19 270:19 272:2 275:6
2.0 218:5
20 83:8 101:5 102:8 153:5
2010 220:9
2013 82:14 230:12
2014 218:3
2015 230:13
2015-2016 225:1
2016 81:6 84:13,16 86:17 87:20 88:7,21 96:11 136:7
2017 64:22 65:2,9 82:16
2018 1:12 89:16 147:20 147:21 148:11 220:17
2018-135 214:17
2018-138 216:19,21
2018-139 215:13
2018-141 216:4,6
2018/2019 29:8
21 35:8
214 4:14
215 4:14
216 4:15,15
217 4:16
21st 69:22 91:17 289:8
22 43:1 238:22
22-23 35:10
22.3 82:17
22nd 289:14
23rd 289:14
24 89:21 101:2,15,21 156:11 201:5 227:8
24-month 252:5
25 144:5 156:3,10 251:22
250 60:8
27 4:4 100:19 227:4
286 4:18
288 4:20
289 4:22

3

3 90:17
3:02 289:17
30 51:13 76:15 89:21 111:4 158:13 223:6 227:10 247:13 257:6 267:8
30-day 227:22
30s 251:4
32 22:5

4

4:00 171:9
40 187:18 228:1
40s 251:4
44 261:5 272:17
45 4:5 227:11
45-page 221:5
47 90:9

5

5 4:2 216:15 219:1
5.5 227:14
5.6 225:1
50 123:7,9 187:19
501(c)(3) 13:3
56 261:5 272:18

6

6 215:4 217:7 272:19
60 31:17 33:7,11 34:2,6 60:8 101:18 271:19
65 230:14 243:20
66 31:2 65:2 101:3

7

7 261:8
70 229:13 230:9
70s 90:21
71 229:13
78 65:9
79 23:8

8

8 82:16
8.86 225:4
85 166:17
86 230:4 252:7
87 90:6 146:11
88 272:1
89 169:1

9

9 82:20 272:19
9:00 1:18
9:14 5:2
90 82:22 153:5
90- 213:14
90-day 199:9
93 90:20
94 4:6 90:10 177:10 217:6
95 215:4 216:14
97 4:9
99 74:3
9th 1:17

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Post-Acute Care/Long-Term Care

Before: NQF

Date: 12-10-18

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter