

NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATIONS PARTNERSHIP
POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

+ + + + +

MONDAY
DECEMBER 14, 2015

+ + + + +

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., Carol Raphael and Debra Saliba, Co-Chairs, presiding.

PRESENT:

CAROL RAPHAEL, MPA, Co-Chair
DEBRA SALIBA, MD, MPH, Co-Chair
JOSEPH AGOSTINI, MD, Aetna
ROBYN GRANT, MSW, The National Consumer Voice
for Quality Long-Term Care
E. LIZA GREENBERG, RN, MPH, Visiting Nurses
Association of America
ROGER HERR, PT, MPA, American Physical Therapy
Association
BRUCE LEFF, MD, Johns Hopkins University School
of Medicine
JAMES LETT II, MD, National Transitions of Care
Coalition
CARI LEVY, MD, PhD, AMDA -- The Society for Post-
Acute and Long-Term Care Medicine
SANDY MARKWOOD, MA, National Association of Area
Agencies on Aging
SEAN MULDOON, MD, Kindred Healthcare
PAMELA ROBERTS, PhD, American Occupational
Therapy Association

SUZANNE SNYDER KAUSERUD, PT, American Medical
Rehabilitation Providers Association
CAROL SPENCE, PhD, National Hospice and
Palliative Care Organization*

ARTHUR STONE, MD, National Pressure Ulcer
Advisory Panel
JENNIFER THOMAS, PharmD, American Society of
Consultant Pharmacists
LISA WINSTEL, Caregiver Action Network

SUBJECT MATTER EXPERTS (Voting):

KIM ELLIOTT, PhD
GERRI LAMB, PhD
PAUL MULHAUSEN, MD
EUGENE NUCCIO, PhD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

ALAN LEVITT, MD, Centers for Medicare and
Medicaid Services (CMS)
ELIZABETH PALENA HALL, MBA, RN, Office of the
National Coordinator for Health
Information Technology (ONC)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON:

CLARKE ROSS, DPA

NQF STAFF:

CHRISTINE CASSEL, MD, President and CEO
ANN HAMMERSMITH, JD, General Counsel
LAURA IBRAGIMOVA, Project Analyst
ERIN O'ROURKE, Senior Project Manager
KATIE STREETER, Senior Project Manager
MARGARET TERRY, PhD, RN, Senior Director
SARAH SAMPSEL, NQF Consultant

ALSO PRESENT:

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

ANDREW BAIRD, HealthSouth

NICOLE FEDELI-TURIANO, University of Pittsburgh
Medical Center

DAVID GIFFORD, MD, MPH, American Health Care
Association

HOLLY HARMON, American Health Care Association

TROY HILLMAN, Uniform Data System for Medical
Rehabilitation

JAMES MULLER, American Health Care Association

ALYSSA KEEFE, California Hospital Association

LANE KOENIG, PhD, National Association of Long-
Term Care Hospitals

TERESA LEE, MPH, JD, Alliance for Home Health
Quality and Innovation

TARA McMULLEN, MD, PhD, Centers for Medicare and
Medicaid Services (CMS)

D.E.B. POTTER, MS, Office of the Assistant
Secretary for Planning and Evaluation
(ASPE)

* present by teleconference

CONTENTS

Welcome, Disclosures of Interest and Review

Meeting Objectives:

Carol Raphael, Workgroup Co-Chair.	6
Chris Cassel, CEO, NQF	9
Ann Hammersmith, General Counsel, NQF.	21
Debra Saliba, Workgroup Co-Chair	27
Sarah Sampsel, NQF Consultant.	63

Overview of Post-Acute Care Quality Reporting

Programs: Statutory Guidelines:

Alan Levitt, CMS	31
----------------------------	----

MAP Pre-Rulemaking Approach and Voting

Instructions: Erin O'Rourke, Senior Project

Manager, NQF	42
------------------------	----

Opportunity for Public Comment on Measures Under

Consideration for IMPACT Act: Medication

Reconciliation	65
--------------------------	----

Pre-Rulemaking Input on Measures Under

Consideration for IMPACT Act: Medication

Reconciliation:.	68
--------------------------	----

Opportunity for Public Comment on Measures Under

Consideration for IMPACT Act: Discharge to

Community	109
---------------------	-----

Pre-Rulemaking Input on Measures Under

Consideration for IMPACT Act: Discharge to

Community	109
---------------------	-----

Opportunity for Public Comment on Measures Under

Consideration for IMPACT Act: Potentially

Preventable Readmission Rates	146
---	-----

Pre-Rulemaking Input on Measures Under

Consideration for IMPACT Act: Potentially

Preventable Readmission Rates	147
---	-----

Opportunity for Public Comment on Measures Under Consideration for Inpatient Rehabilitation Facility Quality Reporting Program	177
Pre-Rulemaking Input on Measures Under Consideration for Inpatient Rehabilitation Facility Quality Reporting Program	180
Opportunity for Public Comment on Measures Under Consideration for Skilled Nursing Facility Quality Reporting Program	188
Pre-Rulemaking Input on Measures Under Consideration for Skilled Nursing Facility Quality Reporting Program	212
Opportunity for Public Comment on Measures Under Consideration for Skilled Nursing Facility Value- Based Purchasing Program	230
Pre-Rulemaking Input on Measures Under Consideration for Skilled Nursing Facility Value- Based Purchasing Program	231
Opportunity for Public Comment Measures on Under Consideration for Long-Term Care Hospital Reporting Program	252
Pre-Rulemaking Input on Measures Under Consideration for Long-Term Care Hospital Quality Reporting Program	253
Opportunity for Public Comment on Measures Under Consideration for Home Health Quality Reporting Program	266
Pre-Rulemaking Input on Measures Under Consideration for Home Health Quality Reporting Program	269
Opportunity for Public Comment	297
Summary of Day	304

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

2 (9:08 a.m.)

3 CO-CHAIR RAPHAEL: Good morning,
4 everyone. Deb and I want to welcome everyone to
5 this meeting of our --- what we belovedly call
6 our MAP PAC Long-Term Care Workgroup and I want
7 to just make sure that I know who is on the phone
8 as we begin here.

9 So, do we have a roster of who's on
10 the phone? All right. Okay. Great. So, we are
11 going to have a day-and-a-half meeting to
12 accomplish a number of things, to review and
13 provide our input on the measures that are under
14 consideration this round for federal programs
15 that are applicable to our area of post-acute and
16 long-term care.

17 I believe there are 31 measures. So,
18 we have quite a few. A number of them are tied
19 to the IMPACT Act. A number of them are tied to
20 our QRPs. And there are several tied to the
21 nursing home value-based purchasing that is
22 around the bend here.

1 And in addition to reviewing and
2 providing input on those measures, we hope to
3 spend some time just stepping back and looking at
4 the high priority gaps that remain in our area.

5 And then lastly, there are quite a few
6 people on this committee who have been with us
7 from the early stages and we spent a good deal of
8 time trying to come up with a core measure set
9 that was parsimonious and, we thought,
10 consequential, but it's been a number of years.
11 And so, we think that this is a time to just step
12 back and take a look at that core measure set and
13 evaluate what we have done and whether any
14 changes are needed.

15 So, with that, I want to be sure that
16 we introduce six new members of our workgroup
17 starting with --- and I'm just going to ask each
18 person to introduce himself or herself. Kim
19 Elliott.

20 MEMBER ELLIOTT: Hi. I'm Kim Elliott.
21 I'm with the Medicaid program in Arizona.

22 CO-CHAIR RAPHAEL: Okay. Liza

1 Greenberg.

2 MEMBER GREENBERG: Good morning. I'm
3 Liza Greenberg representing the Visiting Nurse
4 Associations of America.

5 CO-CHAIR RAPHAEL: Welcome. Cari
6 Levy.

7 MEMBER LEVY: Okay. I'm representing
8 AMDA, the Society for Post-Acute and Long-Term
9 Care Medicine.

10 CO-CHAIR RAPHAEL: Welcome. Sandra
11 Markwood. I don't see --- she will be late.
12 Okay. Thank you. Paul Mulhausen.

13 MEMBER MULHAUSEN: Good morning. I'm
14 Paul Mulhausen. I am a subject matter expert.
15 And I'm a geriatrician and I work with a quality
16 improvement organization called Telligen.

17 CO-CHAIR RAPHAEL: Thank you. Eugene
18 Nuccio.

19 MEMBER NUCCIO: Good morning. I'm
20 Gene Nuccio, University of Colorado, subject
21 matter expert in home health.

22 CO-CHAIR RAPHAEL: And I also want to

1 welcome Clarke Ross. Clarke, you are our
2 liaison, I believe, to the Duals Workgroup, but
3 why don't you introduce yourself as well.

4 MR. ROSS: Thank you. Clarke Ross.
5 I work for the American Association on Health and
6 Disability, but I represent the Consortium for
7 Citizens with Disabilities, which is a 42-year-
8 old national coalition of public policy, 113
9 national disability organizations and counting.
10 Happy to be here.

11 CO-CHAIR RAPHAEL: Thank you. And
12 now, it's my pleasure to introduce Chris Cassel,
13 who is the president and CEO of the National
14 Quality Forum. And Chris is someone I know from
15 many, many years now and a real leader in trying
16 to reshape our healthcare system. So, Chris,
17 take it away.

18 DR. CASSEL: Well, thank you, Carol.
19 And this is an opportunity for me to thank Deb
20 and Carol for their leadership of this important
21 process. And to thank all of you for the
22 contribution that you have made and will make to

1 our nation and to setting these important quality
2 standards for our most vulnerable patients,
3 really, and on behalf of their families.

4 So, as a geriatrician, I have a
5 personal interest in the work of this particular
6 part of the MAP process. And I always like to
7 remind people that the decisions that are made
8 here and the quality standards for this aspect of
9 our healthcare system actually affect many, many
10 more people than the acute care system. And
11 people actually don't often understand that just
12 in terms of the numbers.

13 So, this is important work. It has
14 increasing attention because of the IMPACT Act,
15 because of the increasing acceleration that the
16 Secretary announced last January about moving
17 more quickly in every aspect of Medicare and of
18 federally-funded healthcare in general and the
19 direction of value-based purchasing. And,
20 therefore, we have to know how to define value if
21 we're going to purchase according to value.

22 And as all of you know, the quality

1 measures that are part of --- and safety measures
2 that are a part of these various systems are key
3 to that. So, I also want to, just in terms of
4 this process, thank our staff, all of whom have
5 worked tirelessly on this.

6 Some people refer to this time of year
7 as the holiday season. At NQF, we refer to it as
8 MAP season, because inevitably the measures under
9 consideration list comes the day before
10 Thanksgiving, happened again this year, and our
11 staff work within this holiday period with the
12 deadlines that are very important, legislatively
13 mandated and rulemaking deadlines so that this
14 process can happen over this holiday period.

15 So, particularly to all of you, thank
16 you for the professionalism that's involved in
17 sometimes long hours.

18 That said, we've gotten much better at
19 making that process more efficient. So the hours
20 aren't quite as long as they used to be and
21 particularly with some of our new staff on board
22 and the leadership of Marcia and Elisa and their

1 teams looking at how we can get the materials
2 that go to you to be more meaningful, more easily
3 accessible and more positive in terms of how
4 efficiently your work for the MAP can go.

5 So, we've seen tremendous progress
6 over the last two years in that area. We got
7 lots of really good feedback last year and I
8 think we're even in better shape this year, but
9 we can always do --- just like healthcare and
10 everything else, we can always get better. So,
11 do give us your feedback, and we will be asking
12 you for that about how the materials worked for
13 you, what we might do differently, et cetera.

14 Just do remember in terms of the
15 timeliness of the process, that we don't have
16 complete control over all of that. So, thank you
17 for that.

18 I wanted to mention two other things
19 that are going on at NQF and that are related to,
20 in some ways, the goals of the IMPACT Act to both
21 standardize and strengthen the accountability
22 framework in post-acute and long-term care. And

1 that has to do with this, with two areas of
2 innovation at NQF. One is measurement science.

3 As you know, Helen Burstin is our
4 chief science officer. And under her leadership,
5 we have really developed a lot of CMS-funded and
6 foundation-funded work asking the questions about
7 how could measurement be better.

8 I was on a political panel last week
9 where Joanne Kenen asked --- the first question
10 she threw my way was, well, Dr. Cassel, is
11 measurement an art or a science? So, you know,
12 that was an interesting question.

13 And my answer is it's definitely a
14 science, but like any science, it's evolving and
15 it doesn't have all the answers. It's an
16 imperfect science, if you want to think of it
17 that way, and it can get better.

18 So, NQF is working on trying to
19 improve methodology as we live in a world of very
20 changing data sources and approaches to
21 measurement.

22 So, you're all familiar with one of

1 the first of the reports in this area, which was
2 our report last year on risk adjustment for
3 socioeconomic and demographic factors, which now
4 is in a trial period for CMS and I suspect will
5 continue to be influential in a lot of important
6 work, including yours, but we just recently got
7 contracts to do a similar study on attribution in
8 healthcare measurement. Another really vexing
9 and complex issue. I see a lot of heads nodding
10 around the table. So, you'll be hearing more
11 about that.

12 We also just had public comment on
13 report on intended use. Can you classify
14 measures according to what they're actually going
15 to be used for, public reporting versus payment,
16 for example, a really interesting question that I
17 think will only become more important, and then
18 another project on variation.

19 In this time when everybody is trying
20 to standardize measures and yet at the state
21 level and institutional levels people use
22 slightly different versions of the same thing to

1 measure the same thing, instead of having this
2 idea that every specification has to be exactly
3 the same in order for the information to be
4 comparable, we're asking the question how close
5 is close enough and is there, as there is with
6 everything else in life, a bell-shaped curve
7 where you can actually say, well, these are close
8 enough and could be used, saving a lot of expense
9 for people having to retool their IT systems, et
10 cetera.

11 I won't prejudge what the answer to
12 that will be, but I think it is, at this point in
13 time, a really important question to ask.

14 The last thing is this issue of the
15 gaps in measures. And as you know, those of you
16 who have worked with us before, NQF has done a
17 lot of really authoritative work with committees
18 like this on what are the important gaps in
19 measurement that are out there.

20 And then we issue these reports. And
21 then we sit back and wait for somebody to send us
22 the measures. And you know what? It often

1 doesn't happen because there is kind of a market
2 failure in the measure development world where
3 the organizations that have the resources and
4 motivation to actually develop measures are fine,
5 but in a lot of these areas such as the area
6 we're here talking about today, mental and
7 behavioral health, care coordination, a whole
8 range of things, we just are not seeing a robust
9 pipeline of measure development.

10 So, we decided to get into trying to
11 help people develop measures more rapidly and
12 more efficiently and hopefully lower cost, too,
13 by creating a measure incubator.

14 So, first thing to say is NQF will not
15 become a measure developer, because that is not
16 our --- part of this world as the standard
17 setter, we are very careful to keep a firewall
18 between the endorsement process and anything that
19 goes on in the development world.

20 On the other hand, we have learned
21 that it can be very helpful for us to give
22 upstream advice to measure developers about what

1 works and what doesn't work and our experience,
2 and we will continue to do that.

3 So, this is taking that next step in
4 being kind of a matchmaker to bring together the
5 people with the idea, the technical expertise,
6 the resources, both financial and human, and
7 probably most important of all, the datasets for
8 testing. That's the thing that very often
9 bedevils this whole process.

10 So, living in the world of big data as
11 we do, we've developed agreements with a number
12 of big data sources. The first one that Carol is
13 familiar with is Optum Labs in Cambridge,
14 Massachusetts. A spinoff of Optum.

15 They have not only a huge database of
16 claims data, but also because of other
17 relationships, millions of clinical data sources
18 as well.

19 And they have data partners that
20 include Mayo Clinic, Johns Hopkins, Yale and AARP
21 and AMGA and a number of other people. So,
22 there's lots of richness of data there. And so,

1 we're working with them on a proof of concept
2 about could this relationship be used to develop
3 measures.

4 AARP, thank you, Carol, has been very
5 supportive of this effort and we are working on
6 ideas about measures for dementia and Alzheimer's
7 disease. We're actually bringing in the
8 international registry consortium, ICHOM,
9 involved in that. So, lots of interesting
10 exploratory work there.

11 We also, as you know, patient-reported
12 outcomes are kind of the really bright star that
13 we all keep looking at, and yet getting that data
14 is often thought to be so expensive.

15 So, we just got a grant from Robert
16 Wood Johnson Foundation to work with Patients
17 Like Me, the cloud-based crowdsourcing
18 organization that brings patients with specific
19 conditions together and to see if that kind of
20 approach could get more quickly to patient-
21 reported outcomes, at least for those kinds of
22 conditions that Patients Like Me represents, and

1 maybe present a model for other things.

2 We're also in discussions with
3 PCORnet, with a number of large delivery systems
4 who could also be clinical test beds as well.
5 So, if you're interested more about that
6 information, just let me know.

7 And there's also a letter that I sent
8 out to our members this month that sort of
9 describes the incubator and we'll be happy to
10 make --- and if any of you are members, just go
11 on the member website and you'll find it there.

12 So, I will --- Carol and Deb, I'll
13 stop there, but I'm happy to take questions, if
14 people have any questions.

15 CO-CHAIR RAPHAEL: Are there any
16 questions from any workgroup members? Okay.
17 Gerri.

18 MEMBER LAMB: Good morning. Gerri
19 Lamb. I co-chair the Standing Committee on Care
20 Coordination, and it's relevant to this group as
21 well just to comment that I am absolutely
22 delighted to hear that, because that has been a

1 real issue in the area of care coordination, and
2 I'm the sitting expert in this committee on that,
3 is that we have not gotten new measures. So,
4 that's very, very promising and it's something
5 that our committee has really talked to Helen a
6 lot.

7 DR. CASSEL: Well, you'll probably be
8 hearing more from Helen about this. And any
9 ideas you have about ways that we could bring the
10 right people together to get this done would be
11 great.

12 CO-CHAIR RAPHAEL: Any other
13 questions? Bruce, did you have a question?

14 MEMBER LEFF: No, not a question, but
15 just a comment to pile on what Chris said about
16 the Optum Lab/NQF partnership. We were at one of
17 those meetings. They got interested in our work.
18 They've been tremendous partners.

19 So, I would encourage people to try
20 and push that forward. It's just been great.

21 CO-CHAIR RAPHAEL: Thank you so much.
22 All right. So, after that update, we're going to

1 go to some of our administrative work and I'm
2 going to introduce Ann Hammersmith who is the NQF
3 general counsel, so that we can review our
4 disclosure of interests. Ann.

5 And can I just ask everyone who's
6 sitting around the table to turn your name plates
7 so that we can be sure to see them? Thanks a
8 lot. Okay. Ann, take it away.

9 MS. HAMMERSMITH: Thank you, Carol.
10 Many of you are veterans of the Committee and of
11 NQF committees. So, you're familiar with this
12 process.

13 We do this every year. If you recall,
14 you received disclosure of interest forms from
15 us. And what we do is at the meeting, the first
16 meeting of the group for the year, we have you
17 disclose anything that you think is relevant,
18 that you do that's relevant to the Committee's
19 work.

20 If you recall, MAP committees are
21 different from standing committees in terms of
22 the disclosures. MAP committees have subject

1 matter experts, we have organizational
2 representatives, and then they have federal
3 representatives who are nonvoting.

4 The disclosures are different for the
5 organizational representatives and the subject
6 matter representatives. This group is mostly
7 organizational representatives. So, that
8 disclosure is easiest. So, we'll do that first.

9 If you are an organizational
10 representative, you've got a very simple form
11 from us where the only thing that you were asked
12 to disclose is if you have an interest of \$10,000
13 or more that is relevant to the Committee's work.

14 The reason that we ask you for such a
15 brief disclosure is because you are
16 organizational representatives. You do represent
17 a particular group. We expect you to come to the
18 table with that viewpoint. So, we only ask you a
19 very limited disclosure of interest question.

20 So, let's start with the
21 organizational representatives. As a reminder, I
22 will read the subject matter experts' names.

1 It's your chairs, Carol Raphael, Debra Saliba,
2 Kim Elliott, Gerri Lamb, Paul Mulhausen, Eugene
3 Nuccio and Thomas von Sternberg.

4 If I called your name, please do not
5 disclose in this round. We'll get to you in a
6 moment. So, if I could start with Dr. Agostini?

7 MEMBER AGOSTINI: Hi. Joe Agostini,
8 National Medical Director at Medicare and full-
9 time Aetna employee.

10 MS. HAMMERSMITH: Do you have anything
11 to disclose?

12 MEMBER AGOSTINI: No further
13 disclosures.

14 MS. HAMMERSMITH: Thank you.

15 MEMBER GRANT: Okay. Robyn Grant,
16 Director of Public Policy and Advocacy, National
17 Consumer Voice for Quality Long-Term Care and
18 nothing to disclose.

19 MEMBER STONE: Art Stone. National
20 Pressure Ulcer Advisory Panel, Advisory Board
21 Member. Nothing to disclose.

22 MEMBER GREENBERG: Liza Greenberg,

1 Interim Vice President of Quality and Performance
2 Improvement with Visiting Nurse Associations of
3 American, and I have nothing to disclose.

4 MEMBER LEVITT: Alan Levitt, Medical
5 Officer for the Division of Chronic and Post-
6 Acute Care at CMS. Nothing to disclose.

7 DR. McMULLEN: Tara McMullen, Measure
8 and Analytic Lead for the Division of Chronic and
9 Post-Acute Care. I have nothing to disclose.
10 I'm with the Centers for Medicare and Medicaid
11 Services.

12 MEMBER LETT: Jim Lett representing
13 the National Transitions of Care Coalition.
14 Nothing to disclose.

15 MEMBER LEFF: Bruce Leff, Johns
16 Hopkins University. I'm on an advisory board to
17 a company called Landmark Health, which deals in
18 home-based primary care.

19 MEMBER KAUSERUD: Suzanne Kauserud,
20 representative of the American Medical
21 Rehabilitation Providers Association. I have an
22 agreement. It's new work for me to be an advisor

1 to RAND on some of the IMPACT Act measure work.

2 MEMBER PALENA HALL: Hi. I'm Liz
3 Palena Hall. I'm a long-term post-acute care
4 coordinator within HHS, the Office of the
5 National Coordinator for Health IT. And I have
6 nothing to disclose.

7 MEMBER THOMAS: I'm Jennifer Thomas.
8 I'm a member of the American Society of
9 Consultant Pharmacists. I have nothing to
10 disclose.

11 MEMBER LEVY: Cari Levy representing
12 AMDA, the Society for Post-Acute and Long-Term
13 Care Medicine, and I have nothing to disclose.

14 MEMBER HERR: Roger Herr, American
15 Physical Therapy Association. Nothing to
16 disclose.

17 MEMBER ROBERTS: Pam Roberts
18 representing American Occupational Therapy
19 Association. Nothing to disclose.

20 MEMBER ELLIOTT: Kim Elliott, the
21 Medicaid program in Arizona. I have nothing to
22 disclose.

1 MEMBER WINSTEL: Lisa Winstel,
2 Caregiver Action Network. Nothing to disclose.

3 MS. HAMMERSMITH: Okay. Thank you.
4 Is Carol Spence on the phone?

5 MEMBER SPENCE: Yes, I am. This is
6 Carol Spence. I am representing the National
7 Hospice and Palliative Care Organization, and I
8 have nothing to disclose.

9 MS. HAMMERSMITH: Thank you. Are
10 there any other organizational members on the
11 phone? Organizational members only.

12 (No response.)

13 MS. HAMMERSMITH: Okay. We'll move to
14 the subject matter experts. Subject matter
15 experts sit as individuals. They are on the
16 Committee because they are experts. They do not
17 represent the views of their employer, any
18 organization with which they're associated, or
19 anyone who may have nominated them to sit on this
20 committee.

21 Because the subject matter experts sit
22 as individuals, they got the long form. And the

1 long form asks a great deal of information about
2 professional activities.

3 We don't expect you in this disclosure
4 to review your CV, but only to disclose things
5 that you believe are relevant to this committee's
6 work.

7 We're especially interested in
8 consulting, grants, research, speaking
9 engagements, but only if it's relevant to the
10 work before the Committee. So, I will start with
11 your chairs.

12 CO-CHAIR RAPHAEL: Okay. So, I'll
13 disclose that I'm a Senior Advisor at Manatt
14 Health Solutions. I'm the Chair of the Board of
15 the Long-Term Quality Alliance.

16 I have been the Chair of the Board and
17 still sit on the Board of the New York eHealth
18 Collaborative, which does a lot of work with ONC.
19 And I am the Chair of the Board of AARP.

20 CO-CHAIR SALIBA: I'm Deb Saliba, and
21 I'm Secretary of the Board of Directors for the
22 American Geriatric Society. As a researcher, I

1 have funding from several different
2 organizations, including the Centers for Medicare
3 and Medicaid Services, AHRQ, NIH, and the State
4 of California, which I have disclosed on my form.

5 I also am on the Board of Directors
6 for the California Association of Long-Term Care
7 and Medicine.

8 MEMBER MULHAUSEN: Paul Mulhausen. I
9 am a Committee Chair at the American Geriatric
10 Society. I am employed by an organization called
11 Telligen, which is a federal contractor with the
12 Centers for Medicare and Medicaid Services,
13 including operational support for the IMPACT Act.

14 I'm a consultant for RAND Corporation.
15 I think that came out since my initial
16 disclosure. So, that would be the only addition.

17 MS. HAMMERSMITH: Okay. I think
18 Eugene Nuccio is the next SME.

19 MEMBER NUCCIO: Yes. Eugene Nuccio
20 from the University of Colorado. We have funding
21 from CMS on --- to develop many of the home
22 health measures, some of which you'll be seeing

1 today, and also with the IMPACT Act with the home
2 health area.

3 MEMBER LAMB: Gerri Lamb, Arizona
4 State University. I am on the advisory groups
5 for measure development for AHRQ and NCQA. I do
6 a lot of public presentations for professional
7 organizations across multiple disciplines on care
8 coordination. And I'm the editor of a book on
9 care coordination.

10 MS. HAMMERSMITH: Kim Elliott, would
11 you like to disclose?

12 MEMBER ELLIOTT: Kim Elliott, the
13 Medicaid program in Arizona. I have nothing to
14 disclose.

15 MS. HAMMERSMITH: Thank you. Is
16 Thomas von Sternberg on the phone?

17 (No response.)

18 MS. HAMMERSMITH: Thomas von Sternberg
19 on the phone?

20 (No response.)

21 MS. HAMMERSMITH: Okay. Thank you for
22 those disclosures. Based on what was disclosed,

1 do you have any questions of each other or of me?
2 Anything you would like to discuss?

3 (No response.)

4 MS. HAMMERSMITH: Okay. Before I
5 leave you today, I just want to remind you that
6 we rely on all of you to make the conflict of
7 interest process really work. So, if you're in
8 the meeting and you think that you have a
9 conflict, or you think someone else has a
10 conflict, please do speak up.

11 We don't want you to sit there and
12 feel uncomfortable and kind of wonder, and then
13 tell us a few months later that you had a
14 conflict or you think somebody else did.

15 So, if you do believe that there is a
16 conflict or someone is behaving in a very biased
17 manner, you're always welcome to bring that up
18 openly in a meeting. If you prefer not to do
19 that, you can go to your chairs, who will go to
20 NQF staff, or you can go directly to NQF staff.
21 Thank you.

22 CO-CHAIR RAPHAEL: Thank you, Ann.

1 (Pause.)

2 CO-CHAIR SALIBA: Thank you, Ann. So,
3 we're going to move on to the next agenda item,
4 which is introducing Alan Levitt and Tara
5 McMullen to talk with us about the post-acute
6 care quality reporting programs and statutory
7 guidelines.

8 MEMBER LEVITT: Okay. Well, thank
9 you. This is Alan Levitt. I first wanted to
10 thank you for allowing me to lead off the meeting
11 here. And from myself, from Doc McMullen, from
12 all my colleagues in the Division of Chronic and
13 Post-Acute Care at CMS, both here and in
14 Baltimore, our contractors who are both here and
15 on the phone, I wanted to thank the workgroup for
16 your continued collaboration and support of our
17 programs.

18 This is my third year here. And one
19 of the more consistent requests or themes that
20 I've heard here is kind of to understand more
21 when measures may be statutory. And if those
22 measures are statutory, what the timelines are

1 for those measures.

2 And so, I thought I'd quickly review
3 the guidelines on those and hopefully bring us
4 back a little bit more towards the schedule that
5 we're supposed to be on.

6 So, if we go to the next slide, this
7 is kind of the history of our program from
8 earliest to the newest. The Home Health Quality
9 Reporting Program, as my wife who's a
10 pediatrician would say, it's in the middle
11 childhood, and the skilled nursing facility at
12 the other end is in the infancy. It just
13 finalized its first rule. And so, we'll be going
14 from beginning to end.

15 If you go to the next slide, the Home
16 Health Quality Reporting Program was established
17 in the Deficit Reduction Act of 2005. And this
18 will be a consistent theme that you will see
19 here.

20 And for any home health agency that
21 was not submitting data, they would be subject to
22 a two percentage point decrease in their market

1 basket increase.

2 And for this year now, there's going
3 to be a 70 percent threshold in the submission of
4 quality assessment. And it will be 80 percent
5 next year, 90 percent the following year.

6 CAHPS surveys have been added to the
7 Quality Reporting Program in 2012. This is our
8 most mature quality reporting program. It has a
9 well-established, publicly-reported website.
10 We've added star ratings in the past year.

11 We have a lot of measures. Probably
12 too many, as Peg would say. And we're looking at
13 always what we should be doing in terms of
14 retiring those measures, adding new measures.

15 It is a quality reporting program.
16 There is also, as you know, there is a value-
17 based purchasing program at CMS that was
18 finalized in this past year's rule. And that's a
19 demonstration, it's a model that's being done
20 through the Innovation Center in nine states.
21 It's using some of our measures, but as of now
22 this is a quality reporting program.

1 Going to the next slide, the Patient
2 Protection of the Affordable Care Act was a game
3 changer, not just from a financial standpoint in
4 terms of marketplace, but also from a quality
5 standpoint.

6 It's probably the reason why we're
7 here, it's certainly the reason why I'm here
8 today, as it expanded the responsibilities of the
9 National Quality Forum.

10 It also established these three
11 quality reporting programs for long-term care
12 hospitals, inpatient rehabilitation
13 hospitals/facilities, and hospice program.

14 And once again these programs needed
15 to submit data. And if they did not submit data,
16 they would be subject to the two percentage point
17 decrease in their market basket.

18 Public reporting was also part of the
19 Affordable Care Act. And in this past year's
20 rule, we've finalized that in the fall of 2016
21 for the long-term care hospitals, the inpatient
22 rehab facilities, we will be public reporting

1 those programs. Hospice we'll be announcing in
2 future rules.

3 Let's go to the next slide. Now,
4 measures come in different shapes and sizes.
5 This is just to show you where measures may show
6 up for us statutorily. This was on Page 40 of
7 the 40-page Bipartisan Budget Act.

8 There was a small, little section
9 added that we needed to establish a functional
10 status quality measure in long-term care
11 hospitals for patients on ventilator support.

12 This was a measure that came up here
13 a couple years ago, as the older committee
14 members may remember. And so, again, Congress
15 told us we need to establish this measure by this
16 certain time.

17 Next slide. PAMA, or the Protecting
18 Access to Medicare Act, in 2014 again had a
19 section that established the skilled nursing
20 facility value-based purchasing program. And
21 within that section there were two measures that
22 needed to be specified.

1 Both measures were to be publicly
2 reported. And one, then the other, would then be
3 used in the value-based purchasing program and
4 again the program had an established date as
5 well.

6 Let's go to the next slide. The
7 IMPACT Act, which probably is now mentioned, I
8 guess, probably the sixth or seventh time today,
9 we can count how many times it will be mentioned
10 today, once again is a game-changer.

11 It's requiring post-acute care
12 providers to report on standardized patient
13 assessment data, to use post-acute care
14 assessment instruments, to report on data and
15 quality measures and measures in those five
16 domains that I have listed on the slide. And
17 then also to report data on resource use and
18 other measures. And those three measures we are
19 going to be discussing later this morning.

20 Let's go to the next slide. We've
21 known that we need standardized patient
22 assessment data in post-acute care for a long,

1 long time. For the sake of today, I'll start
2 with MEDPAC's recommendation that they've
3 recommended that we have a core set of assessment
4 information back in 1999. They have repeated
5 that in their updates up until the present.

6 Congress in 2000, through BIPA,
7 required that CMS report on developing
8 standardized assessment instruments. In 2005, in
9 the Deficient Reduction Act, an impatient
10 Congress once again told now CMS to test a
11 concept of a common standardized assessment tool
12 and that was in the form of the PAC-PRD. CMS
13 developed, as part of that PAC-PRD, the
14 continuity assessment record and evaluation or
15 care item set.

16 In 2011 CMS came back to Congress,
17 reported on the PAC-PRD. They reported on the
18 successful, consensus-based development of this
19 item set, the successful reliability testing of
20 the item set, positive feedback that they got,
21 and also the idea that patient information could
22 actually be used to look at the differences in

1 resource use in post-acute care.

2 In 2013, Congress held a hearing on
3 post-acute care reform. Some of you were there
4 for that hearing. They also sent out a letter to
5 stakeholders requesting feedback on how to best
6 do post-acute care reform.

7 And as I have written on the slide
8 here, this is a direct quote from Congress, the
9 resounding theme across more than the 70 letters
10 was the need for standardized post-acute care
11 assessment data across Medicare post-acute care
12 provider settings.

13 So, we go to the next slide and so
14 came the IMPACT Act of 2014 and standardized
15 patient assessment data by these dates. And it's
16 within these six different categories which I
17 have listed here.

18 And I'm proud to say that it's really
19 been my division which has done a lot of work in
20 this, particularly Dr. McMullen next door and
21 Stella or Stacy Mandl back there. They've done
22 an incredible amount of work bringing Congress'

1 vision to reality. So, we should definitely
2 thank them.

3 As a former post-acute care provider,
4 this is something that really is essential and
5 really is game-changing. So, thank you.

6 We're here today for the next slide,
7 which is actually the measures that are
8 associated with that standardized, interoperable
9 assessment data. These measures are within five
10 domains.

11 Last year we discussed functional
12 status, skin integrity and incidence of major
13 falls. This year we'll be talking about
14 medication reconciliation domain. And those are
15 the application dates. Application date,
16 earliest one would be January 1st of 2017 for
17 that domain.

18 Let's go to the next slide. There
19 were also specified application dates for the
20 resource use measures. And that the post-acute
21 care settings need to report data on these three
22 measures starting in the three facility settings

1 by October 1st of next year, and home health by
2 January 1st of 2017. And we'll be discussing
3 those three measures later today.

4 Go to the next slide. Finally, the
5 IMPACT Act also established the skilled nursing
6 facility Quality Reporting Program. Again, this
7 is a quality reporting program, not a value-based
8 purchasing program like previous slides I
9 mentioned in PAMA.

10 And so, once again, by fiscal year
11 2018, skilled nursing facilities need to submit
12 data, or be subject once again to the two
13 percentage point decrease.

14 Next slide, I guess questions or
15 questions throughout the day we can go to, but
16 thank you. Thank you for the time.

17 CO-CHAIR SALIBA: Thank you, Alan.
18 Did anyone have any questions for Alan? That was
19 a very nice overview. Thank you.

20 (No response.)

21 CO-CHAIR RAPHAEL: Before we turn it
22 over to Erin, I was just thinking, Alan, as you

1 were talking, I guess, from my MEDPAC experience
2 that it's important to keep in mind that post-
3 acute care expenditures continue to rise faster
4 than other sectors of healthcare.

5 I think given the demographics, the
6 changing nature of illness with more chronic
7 illness, I think we can expect that there will be
8 continued increase in need for post-acute care
9 services and pressure on payers, primarily in the
10 public sector.

11 And the other thing that always struck
12 me at MEDPAC, and I don't know, Alan and Tara, if
13 this has changed, but I don't think it has from
14 the latest data that I looked at, there is
15 tremendous variation in the post-acute care
16 sector, in terms of utilization and the little
17 that we know about outcomes at this juncture.

18 So, any other comments that anyone
19 wants to make before we end our little context
20 setting and turn it over to you, Erin, to go
21 through the process with us?

22 (No response.)

1 MS. O'ROURKE: Thanks, Carol. So,
2 we're excited to let you know about some updates
3 that we've made to the pre-rulemaking process
4 this year. We're always working to improve our
5 processes and we've made these changes based on
6 what we've heard from you, the MAP members, as
7 well as members of the public.

8 So, we've reviewed the majority of
9 this during our all-MAP web meeting, but I did
10 want to give you a brief refresher before we get
11 into the nuts and bolts of making our
12 recommendations.

13 First, we use a three-step process for
14 the analysis and selection of measures. We first
15 develop a framework to organize the measures that
16 are currently in the program measure set.

17 This is an attempt to help you see
18 what is currently addressed by those measures,
19 and we include information about what PAC/LTC
20 core concept the measure might address, what
21 IMPACT Act domain might address, as well as what
22 National Quality Strategy priority it relates to.

1 Next, we review each measure under
2 consideration to see what that might add to the
3 program measure set. And finally, we identify
4 and prioritize the gaps for each program and
5 setting.

6 So, a change for this year is that we
7 are asking the workgroups to reach a decision
8 about every measure under consideration and to
9 not leave any, quote/unquote, split decisions.

10 The decisions are standardized for
11 consistency. I'll review those with you in the
12 next few slides. We also developed rationale for
13 each decision that helps explain how that
14 decision was reached and allows us to capture the
15 workgroup's deliberations. So, just to let you
16 know it is not just the decision that goes on to
17 CMS. It is also the workgroup's rationale.

18 So, we have two pathways this year
19 that we're using to review measures under
20 consideration. For a fully developed measure,
21 MAP can make a recommendation to support,
22 conditionally support, or not support the

1 measure. And on this side, you'll also see a few
2 examples of a rationale that we might use to
3 explain why the workgroup made that decision.

4 The next slide shows the pathway for
5 measures that are still under development. As
6 you know, we've been reviewing measures that are
7 earlier in development, increasingly, over the
8 past few years.

9 For these measures, you can make a
10 recommendation to encourage continued
11 development, not encourage further consideration,
12 or that there is insufficient information for the
13 group to come to a decision.

14 And this last category would be
15 discouraged, but we do want to recognize that the
16 group may feel there is not enough information,
17 but again this is something we would try to push
18 you to come to a full recommendation.

19 So, the MAP measure selection criteria
20 were developed to help review the characteristics
21 of a program measure set and help the workgroup
22 to think about what might be an ideal set of

1 measures for a program.

2 They're intended to assist MAP with
3 identifying characteristics that are associated
4 with ideal measure sets used for public reporting
5 and payment programs.

6 They're not absolute rules. Rather,
7 they are meant to give general guidance on
8 measure selection decisions and to complement
9 program-specific statutory and regulatory
10 requirements such as the ones that Alan just
11 reviewed.

12 The central focus should be on the
13 selection of high-quality measures that optimally
14 address the National Quality Strategy's three
15 aims, fill critical measurement gaps and increase
16 alignment across the programs and settings.

17 Although competing priorities are
18 often weighed against one another, the measure
19 selection criteria can be used as a reference
20 when you're evaluating the relative strengths and
21 weaknesses of a program measure set and how the
22 addition of an individual measure might

1 contribute to that set.

2 Measure selection criteria are
3 constantly evolving and they have changed to
4 reflect the input of a wide variety of
5 stakeholders since we implemented these back in
6 the first year of MAP.

7 And to determine whether a measure
8 should be considered for a specified program, the
9 MAP evaluates the measures under consideration
10 against these measure selection criteria. And
11 we'd ask you to take a few minutes and
12 familiarize yourselves with the criteria and to
13 use these to support your decisions when you're
14 reviewing the measures under consideration.

15 A change that we made to the process
16 last year and that we've refined for this year is
17 the addition of a preliminary analysis of each
18 measure under consideration.

19 The preliminary analysis is really
20 staff's attempt to operationalize the measure
21 selection criteria. We answer a series of
22 questions about each measure under consideration

1 to give the workgroup a summary of that measure.
2 And from staff's perspective, what it might add
3 to the program measure set.

4 We ask if the measure addresses the
5 program goals and objectives, if it addresses an
6 important quality issue for that setting, if it
7 fills a gap in the program measure set and if
8 it's tested for the setting and level of analysis
9 of the program.

10 We also pull in any information we can
11 find about how that measure is currently being
12 used and if we can find any results from the
13 field on that measure. We ask if the measure
14 promotes alignment.

15 For the PAC/LTC group, you'll see
16 information if it addresses one of your core
17 concepts or if it addresses a high-priority issue
18 for dual-eligible beneficiaries. And finally, if
19 the measure has been reviewed for NQF
20 endorsement, you'll know we pull in a summary of
21 the results of that review.

22 So, I think I can pause and take any

1 process questions. If not, we can jump into the
2 voting instructions.

3 CO-CHAIR RAPHAEL: Okay. Are there
4 any questions for Erin? Erin, I was just going
5 to ask you if you could talk a little bit more
6 about for the measures under development you can
7 support continued development, you cannot support
8 continued development, and the third was
9 insufficient information.

10 Would you talk a little bit more about
11 the third?

12 MS. O'ROURKE: Of course. So, the
13 third is really a category we are trying to
14 sunset. So ---

15 CO-CHAIR RAPHAEL: That's why you gave
16 a short ---

17 MS. O'ROURKE: That's why it was
18 glossed over. And this is something we've been
19 working with our colleagues at CMS so that they
20 provide as much information as they can about the
21 measures under consideration. And definitely
22 kudos to them because it's changed quite a bit

1 form the early years of MAP, where all we might
2 have received is a title of a measure, and the
3 groups felt they really could not make a good
4 decision, when all that they had to go on was a
5 title.

6 So, now you'll notice there are at
7 least preliminary specifications about each
8 measure. So, we do ask that if you can avoid
9 that insufficient information decision, to do so.
10 But when you really do not feel like you have the
11 right information to make a solid recommendation,
12 that is why that is there.

13 CO-CHAIR RAPHAEL: Thank you. Any
14 other questions for Erin?

15 (No response.)

16 CO-CHAIR RAPHAEL: All right. So, why
17 don't we go on to voting instructions.

18 MS. O'ROURKE: Okay. So, before we
19 get started on the instructions, does everyone
20 who is a voting member of the workgroup have a
21 little blue clicker?

22 If you're a federal liaison or the

1 liaison from the dual eligible groups, you are
2 not a voting member. Sean, you need a clicker?

3 MS. IBRAGIMOVA: So, whoever doesn't
4 have a clicker, can you just put up your tent so
5 I'll walk around and assign you one?

6 MS. O'ROURKE: And while Laura is
7 taking care of that, Sean, if you wouldn't mind
8 introducing yourself and reviewing any
9 disclosures that you have?

10 MEMBER MULDOON: My name is Sean
11 Muldoon. I'm with Kindred Healthcare and I, by
12 disclosure, is that I'm a full-time employee of a
13 provider of post-acute care services.

14 MS. O'ROURKE: Thank you. Was there
15 anyone else who joined us after introductions and
16 needs to introduce themselves?

17 (No response.)

18 MS. O'ROURKE: Okay. So, moving on to
19 some key principles about voting, every measure
20 under consideration is subject to a vote. We'll
21 either vote on that individually, or as part of a
22 consent calendar.

1 As I mentioned, the workgroups will
2 be expected to reach a decision about every
3 measure under consideration this year. This is a
4 request from the Coordinating Committee that we
5 no longer pass things up to them as a split
6 decision.

7 They stress that it's difficult for
8 them to make a solid recommendation when they
9 don't have the benefit of at least a preliminary
10 recommendation on that measure from the experts
11 in post-acute long-term care that are around this
12 table.

13 There's a more diverse group of
14 expertise at the Coordinating Committee. So,
15 they greatly value what the preliminary
16 recommendations from the workgroups are.

17 That being said, the workgroup
18 recommendations are still subject to continued
19 discussion at the Coordinating Committee level,
20 particularly if it addresses an important program
21 policy issue or strategy in the context of a
22 measure for the program.

1 So, after introductory presentations
2 from the staff and the Chair, to give you a
3 little bit of context about the program, we'll
4 start the discussion and voting using the
5 electronic discussion guide.

6 So, I would ask if you have a
7 computer, to please pull up the discussion guide
8 that we sent around. This will be the main
9 document that we'll be going through.

10 We've also assigned a lead discussant
11 to each group of measures. They'll be people
12 that our co-chairs will be turning to when we
13 start conversation about an individual measure.
14 If you have remarks, Carol and Deb will be
15 looking to you to make them to help kick off the
16 workgroup's conversation.

17 You'll notice on the discussion guide
18 the content is organized as follows. The measures
19 under consideration are divided into a series of
20 related groups for the purposes of discussion and
21 voting.

22 Each measure under consideration has

1 a preliminary staff analysis that I just
2 described, and this discussion guide notes the
3 results of that preliminary analysis. For
4 example, if staff would recommend support, do not
5 support or conditional support based on the
6 results of the analysis. And it provides
7 rationale for how that conclusion was reached.

8 So, how we will actually go about this
9 voting. So, the step one is we'll review the
10 preliminary analysis consent calendar. So, we'll
11 present each group of measures as a consent
12 calendar that reflect the results of the
13 preliminary analysis that we came to using the
14 selection criteria and the objectives of the
15 program.

16 For the next step, the co-chairs will
17 ask the workgroup to identify any measures under
18 consideration that you'd like to discuss
19 individually, and not have them be voted on as
20 part of a consent calendar.

21 Any workgroup member can ask for one
22 or more MUCs to be removed from the consent

1 calendar and turned into an individual agenda
2 item.

3 Once we have gone through that and all
4 of the items that you'd like to discuss have been
5 identified, the co-chairs will ask if there's any
6 objections to accepting the preliminary analysis
7 and recommendation for the measures under
8 consideration that remain on the consent
9 calendar.

10 And if no objections are made, what's
11 left on the consent calendar will pass. There
12 will not be a formal vote on accepting the
13 consent calendar. This is something we heard
14 from last year that voting on what you've already
15 agreed to was getting a little bit redundant.
16 So, we removed this vote to try to make it a
17 little smoother for you.

18 Once we're through with the consent
19 calendar, we'll move on to the individual
20 measures that you've pulled for discussion. The
21 person who identified that measure for discussion
22 is asked to be the first to go and to explain why

1 you pulled the measure and what your concerns are
2 with the preliminary analysis.

3 We will then turn to the lead
4 discussants to see if there's something they
5 would like to add to the conversation. They can
6 state their own point of view, either whether
7 they agree with the person who pulled the
8 measure, if they agree with the preliminary
9 analysis, or if they have a completely different
10 opinion. And then we'll open that measure up for
11 discussion by the workgroup.

12 And then once conversation is starting
13 to come to a conclusion, Carol and Deb will move
14 us for a vote. And here is another change that I
15 wanted to draw your attention to for this year.
16 We'll only be taking one vote per measure.

17 Last year, we took it through a series
18 of votes and we received some feedback that was
19 an awful lot of clicking. So, this time we'll
20 take one vote per measure.

21 We do need to get to a 60 percent
22 threshold for consensus. So, you'll be taking

1 one vote per measure. You'll notice you'll have
2 the choice of all three categories for --- if
3 it's either a fully developed measure or a
4 measure under consideration.

5 A change we did want to draw your
6 attention to is if we don't --- we can sum the
7 scores for support and conditional support to get
8 to a recommendation of conditional support. And
9 we'll be clarifying announcing the conditions at
10 the conclusion of the vote.

11 So, basically for this year if
12 anything gets to a 60 percent threshold on its
13 first vote, that stands. So, no further actions
14 are needed.

15
16 If we don't get the 60 percent for any
17 one decision, we'll sum the votes for support and
18 conditional support to see if that gets the 60
19 percent. If that doesn't get the 60 percent
20 together, the recommendation is a do not support.
21 And then finally, abstentions are discouraged.
22 But if there are, they will not count in the

1 denominator.

2 And this is also something -- we've
3 built a few more breaks into the agenda this
4 year. So, we'd ask that you if at all possible,
5 not step away from the voting until a formal
6 break.

7 Another change that we've made for
8 this year are some increased opportunities for
9 public comment. We'll be taking public comment
10 before each consent calendar.

11 We do ask that commenters limit their
12 comments to only the measures under consideration
13 for that consent calendar and that you limit the
14 comments to two minutes to allow everyone a
15 chance to speak.

16 We will have two global public comment
17 periods at the end of each day where commenters
18 can address any topic that the workgroup
19 discussed. We'll also have public comment on the
20 workgroup recommendations that will run from
21 December 23rd through January 12th.

22 This will be the formal written public

1 comment period on the draft recommendations. And
2 those comments will be considered by the
3 Coordinating Committee and submitted to CMS.

4 I also wanted to note if you're
5 looking at your Discussion Guide, you'll see the
6 comments that were generated from the early
7 public comment period, we've been calling it.

8 This is the comment period on the
9 measures under consideration. So, we did want to
10 draw your attention to those comments and to
11 please consider them in your deliberations.

12 So, I think with that we can do a
13 quick -- first I'll take questions, and then
14 we'll do a quick test run of the voting.

15 CO-CHAIR RAPHAEL: Okay. Are there
16 any questions? I think we're going to have to go
17 through this and then we'll see if we really
18 understand what you have shared with us, Erin.

19 Okay. Any preliminary questions? I
20 would say that one of the things that I think is
21 a real improvement is getting public comments
22 before we do our deliberation.

1 We used to do our deliberations and
2 then turn for the public comment. And, you know,
3 I spent a good deal of time yesterday reading the
4 public comments that have come in, as I'm sure
5 many of you did, from many organizations. And
6 they were very thorough and very thoughtful. And
7 there were certain themes that kind of came
8 through to me and we probably will hear them
9 again.

10 One is the compressed time frame that
11 people experienced and wished they had had more
12 time, but I think we all, including the NQF
13 staff, have dealt with that.

14 I think the second question was the
15 degree to which these measures are well
16 correlated with outcomes was raised several
17 times.

18 A third, and this to me is reflective
19 of the fact that, as you said, this is early
20 stage when people asked a lot about testing and
21 validity and reliability.

22 A fourth, and this is a perennial

1 theme that we have heard, and I think it's going
2 to be raised again, and it's an important area
3 for us to think about, which is how do you deal
4 with the areas that are beyond your control.

5 And, you know, we've heard that before
6 and I read that in the home healthcare comments,
7 as well as in some of the nursing home comments
8 where you cannot necessarily control all the
9 variables, nor can you control the behavior of
10 the patient.

11 You make a recommendation, but they
12 may not comply with the recommendation. So, that
13 was another, you know, recurring theme that I
14 heard.

15 Another one which we are grappling
16 with at NQF has to do with risk adjustment and
17 socioeconomic status. That's an important area
18 that a lot of attention is being given to at NQF.

19 And the last one had to do with this
20 whole issue about improvement versus
21 stabilization, because there are some patients
22 where you cannot achieve improvement, where the

1 best that you can get is stabilization and how we
2 are mindful of that as we really deliberate and
3 move these measures along.

4 So, we may hear some of the same
5 things again and we may hear others, but I
6 thought that was a very valuable change that we
7 have made to the process.

8 Okay. Any other comments or questions
9 before we launch here?

10 (No comments.)

11 CO-CHAIR RAPHAEL: Okay. So, we are
12 going to start with the first -- and please
13 interrupt Deb and me if we are not -- yes, go
14 ahead, Sarah.

15 MS. SAMPSEL: If we could do staff
16 introductions?

17 CO-CHAIR RAPHAEL: Oh, thank you.
18 That is really important. So, let us do staff
19 introductions. Thank you, Sarah.

20 MS. IBRAGIMOVA: I'll start. My name
21 is Laura Ibragimova. I'm a project analyst here
22 at NQF. I've been here for about two years and

1 this is the second time I am supporting the MAP
2 PAC/LTC Workgroup.

3 DR. TERRY: Hi. My name is Peg Terry
4 and I know many people here, because I was on
5 this workgroup for many years. And I'm from the
6 Visiting Nurse Association of America. And I'm
7 really delighted to be here.

8 I've been here about five months at
9 NQF and I look forward to this meeting.

10 MS. STREETER: Hi. Good morning. I'm
11 Katie Streeter, Senior Project Manager. I have
12 been with NQF for about five years and this is
13 the first time I'm working with the PAC/LTC
14 workgroup.

15 I've supported MAP in the past, but
16 this is my first time with PAC/LTC.

17 CO-CHAIR RAPHAEL: You'll tell us
18 later how we stack up compared --

19 MS. STREETER: Of course.

20 CO-CHAIR RAPHAEL: -- to the other
21 workgroups. Okay.

22 MS. O'ROURKE: Hello. I'm Erin

1 O'Rourke. I'm also a Senior Project Manager here
2 at NQF. And I've actually been supporting the
3 PAC/LTC Workgroup since the beginning.

4 So, this is my fifth year with you
5 all. So, thank you again for all of your hard
6 work and looking forward to another exciting pre-
7 rulemaking.

8 MS. SAMPSEL: Well, good morning. And
9 I'll introduce myself before I get started with
10 the next -- for the first consent agenda, but I'm
11 Sarah Sampsel. I'm a consultant to NQF. Have
12 been working with NQF actually for a long time
13 since I am a former measure developer from NCQA
14 and also out of the health plan world.

15 And more recently have been working
16 more on endorsement projects, including person
17 and family-centered care, many of those measures
18 we'll be discussing over the next couple of days,
19 or a similar adaptation of some of those
20 measures. And I also work in renal, behavior
21 health and do some musculoskeletal work.

22 But with that, and, again, I do want

1 to recognize all the work that staff do to
2 prepare for this meeting and make sure that if
3 any of you have any logistics questions, that you
4 let us know or if you have any concerns or
5 issues.

6 We do know there was at least one
7 problem with the hotel. So, if you do have
8 issues with the hotel, if you could let one of us
9 know so we could get that solved for you during
10 the day before you go back.

11 But with that, our first -- and,
12 actually, I'm going to turn it back to Carol
13 first to do the public comment.

14 CO-CHAIR RAPHAEL: Okay. All right.
15 So, the first thing, we are going to ask the
16 operator to actually open the lines for public
17 comment. And these are for the group of measures
18 having to do with the IMPACT Act and medication
19 reconciliation.

20 So, let me ask the operator to open
21 the lines for public comment.

22 THE OPERATOR: Okay. If you would

1 like to make a comment, please press * and the
2 number one.

3 CO-CHAIR RAPHAEL: Is there anyone on
4 line?

5 THE OPERATOR: There are no public
6 comments at this time.

7 CO-CHAIR RAPHAEL: Okay. Then I'm
8 going to turn to anyone -- part of the audience
9 in the room who wishes to make public comments.

10 MS. HARMON: Good morning. I'm Holly
11 Harmon. I serve as the Senior Director of
12 Clinical Services at the American Healthcare
13 Association. We do represent 10,000 nursing
14 homes across the country and have been a strong
15 supporter of the IMPACT Act.

16 We also recognize the importance of
17 medication reconciliation upon reducing
18 rehospitalizations and reducing unintended
19 healthcare outcomes, which is a very important
20 part of our National Quality Initiative.

21 For those reasons, it's very important
22 to us that the drug regimen review and/or

1 medication reconciliation measure is an effective
2 and appropriate measure.

3 We do have concerns for this measure
4 which I will briefly outline, and our
5 recommendation is that this measure is not ready
6 for rulemaking. And we recommend encourage
7 continued development for these five reasons:

8 There is no NQF application or
9 endorsements or reliability and validity is
10 unknown. Second, the data elements for this
11 measure do not currently exist in all PAC
12 assessments.

13 Third, the definition of "drug regimen
14 review" is not consistent with other PAC
15 settings. And, in particular, is inadequate in
16 capturing the scope of drug -- medication regimen
17 review and does not address the involvement of
18 interdisciplinary team members.

19 Third, the measure -- or fourth, the
20 measure description does not define what
21 constitutes a potentially significant medication
22 issue, which is a critical part of the measure.

1 And fifth, the measure has not been
2 tested, nor has an examination of feasibility for
3 implementing this measure across PAC settings
4 been completed, nor a pilot has begun yet.

5 So, for all of these reasons, this
6 drug regimen review measure is not ready for
7 rulemaking and should receive a vote of encourage
8 continued development. Thank you for the
9 opportunity to comment.

10 CO-CHAIR RAPHAEL: Are there any other
11 comments from the audience?

12 (No comments.)

13 CO-CHAIR RAPHAEL: Okay. Laura, is
14 there anything that's come in on the chat box?

15 MS. IBRAGIMOVA: No, there are no
16 chats via chat box.

17 CO-CHAIR RAPHAEL: Okay. Thank you.
18 So, I'm going to turn it over to you, Sarah, to
19 provide a brief overview of the IMPACT/med
20 reconciliation measures and also share with us
21 the preliminary analysis from the staff.

22 MS. SAMPSEL: Sure. First, though,

1 Jim, did you have comments before we got started
2 with that part?

3 MEMBER LETT: Just a procedural thing.
4 If those who make a public comment would tell us
5 which specific measure under consideration
6 they're addressing or whether it's for the whole
7 packet. Thanks.

8 MS. SAMPSEL: Okay. So, with that,
9 what we did, and you'll notice on the agenda for
10 the first part of this morning, as well as when
11 we start up tomorrow morning, is for any of those
12 measures that have been identified as IMPACT Act
13 measures and meeting those domains or being put
14 forward as measures under consideration for the
15 IMPACT Act domains, we have pulled those onto
16 their own consent calendars.

17 We really felt that speaking about all
18 of the similar concept measures at once would
19 again help with the rest of the flow of the
20 meeting. And so, we wouldn't have to repeat the
21 conversations through each of the programs. We
22 just pulled them all together.

1 So, the first set of such measures is
2 four measures, and it is -- they are the
3 medication reconciliation measures which are
4 looking for drug regimen review being conducted.

5 The timing of that review is dependent
6 on the setting. So, it could be upon admission,
7 it could be on resumption of care if it's home
8 health, but would be specific to each PAC
9 setting. And you'll find those in the details of
10 the measures that were provided to us.

11 And then the measures also looking for
12 follow-up with a physician on an ongoing basis
13 and any time a clinically important or clinically
14 significant medical issue is identified, these
15 measures are in early development, as reported to
16 us from CMS. So, all of the overall staff
17 recommendations were to encourage continued
18 development.

19 And the preliminary analysis, we felt,
20 supported that encourage continued development
21 due to the fact that these are patient safety
22 issues.

1 As we just heard from public comment,
2 this is an important issue. Falls under the
3 National Quality Strategy not only for patient
4 safety, but also for preventing some downstream
5 events that could happen with improper or not
6 performed medical reconciliation.

7 The other comments that we would make
8 staff-wise is obviously this measure is -- these
9 MUCs, there are four of them, are being presented
10 to you for consideration, because they are
11 promoting that alignment across the program
12 settings, which is one of the goals of the IMPACT
13 Act. And medication reconciliation is one of the
14 IMPACT Act domains.

15 So, with that, I will go ahead and
16 turn it back over to Carol.

17 CO-CHAIR RAPHAEL: Thank you. So, now
18 let me ask Alan and Tara if you want to comment
19 on these.

20 MEMBER LEVITT: Okay. Well, first of
21 all, thank you. Thank you for going through the
22 measure. And also thank you for the public

1 comment as well.

2 The concerns just in terms of public
3 comment are also things that we've really, you
4 know, thought about in the development of the
5 measure itself that these three items in the
6 measure are actually items that are part of the
7 OASIS and have been defined as such. And have
8 been given guidance as such in the home health
9 manual without being totally prescriptive in
10 terms of what it means.

11 Well, certainly after I'm done, I
12 guess, be interested in how the workgroup feels
13 about how prescriptive we really need to be in
14 defining what "clinically significant" means and
15 what "one day" means.

16 I mean, my hope was allowing the
17 settings to define it best for, you know, the way
18 that the settings saw it to be, but have the idea
19 that the drug regimen review is a very serious
20 act and needed to be done and needed to be done
21 well under review by each one of these post-acute
22 care settings, but we are interested in terms of

1 the feedback on that and certainly can further
2 discuss that without changing the specification
3 to the measure itself, just in terms of the
4 guidance that would be given for that measure.

5 In terms of testing and feasibility of
6 the measure, as I said, this is a measure that
7 the components of the measure have been used in
8 the home health setting for several years now and
9 have been used successfully.

10 Testing has begun in the other
11 settings and already getting in terms of
12 preliminarily that this is something that can be
13 done.

14 In those settings, I think if you look
15 at the items themselves and see whether or not
16 you think that they would be items that would be
17 feasible to be done within your own setting, you
18 can make up your own mind as well.

19 I'm trying to think in terms of other
20 comments itself. Certainly validation will be
21 important. It's important in all of the measures
22 that we are presenting here today and are

1 measures in our program. When you're dealing
2 with anything that's particularly on an
3 assessment instrument, validation is going to be
4 important.

5 And we will continue to work with the
6 other components in CMS. And we will work
7 through our rulemaking in terms of trying to best
8 ensure that we are getting the best information
9 that's possible on these measures.

10 As things come up in the workgroup,
11 Carol, if you wish, I can continue to come back
12 and comment on other items that are going on.

13 CO-CHAIR RAPHAEL: I just had one
14 question that came up in some of the comments I
15 read. Is there -- the difference between drug
16 regimen review and medication reconciliation.

17 MEMBER LEVITT: I consider drug
18 regimen review/medication reconciliation on
19 steroids that essentially medication
20 reconciliation is the process of identifying an
21 accurate list of medications that an individual
22 is on.

1 Drug regimen review is more than that.
2 It's really looking at the adverse effects, drug
3 reactions that potentially are there. It's a
4 review that's done initially when somebody is
5 first admitted to your setting and continues,
6 when appropriate, throughout the rest of the
7 setting.

8 And when circumstances come up within
9 that review that's conducted, it's felt that
10 contact needs to be done with the prescriber of
11 interest that that get done in a timely fashion
12 that is appropriate for the patient that you're
13 taking care of.

14 CO-CHAIR RAPHAEL: Right. So, now let
15 me ask the workgroup if you would like to pull
16 any of these four measures from the consent
17 calendar that we're going to be reviewing and
18 discussing and propose a different disposition.
19 Jennifer.

20 MEMBER THOMAS: Can you clarify what
21 you mean by that by pulling that from the consent
22 calendars that you've -- expand on that, please.

1 CO-CHAIR RAPHAEL: Okay. So, Erin,
2 why don't you --

3 MS. O'ROURKE: Of course. So, the
4 consent calendar is based on the result of the
5 staff preliminary analysis, which you can find in
6 your discussion guide. I'm trying to pull that
7 up for these.

8 So, Sarah, correct me if I'm wrong,
9 but I believe all have a preliminary analysis
10 result of encourage continued development. So,
11 if you disagree with that result, please at this
12 time pull the measure for the whole workgroup to
13 discuss.

14 CO-CHAIR RAPHAEL: Okay. Robyn.

15 MEMBER GRANT: So, what if you have a
16 concern about an element within that measure, but
17 you don't disagree with the recommendation?

18 MS. O'ROURKE: You can still pull that
19 and we can have some conversation to work through
20 those concerns, or if there's something you'd
21 like to have captured in the report, that's
22 certainly on the table. We don't want to stop

1 any conversation about any elements.

2 MEMBER GRANT: But if it --

3 CO-CHAIR SALIBA: I think --

4 MEMBER GRANT: Go ahead.

5 CO-CHAIR SALIBA: I think Robyn's
6 question is can she raise a point to -- I think
7 Robyn's question is -- I was starting to yell --
8 can she raise points or issues without pulling
9 something from the consent calendar?

10 Does it have to be pulled from the
11 consent calendar for her to raise some points or
12 discuss it?

13 CO-CHAIR RAPHAEL: I mean, I think
14 that's the part that's not clear. If we leave
15 all of this in the consent calendar, how
16 extensive a discussion can we have?

17 MS. SAMPSEL: So, what I would
18 recommend here is -- and this is almost a
19 function of how this workgroup is different from
20 some of the other workgroups which might have
21 five measures that are all very different where
22 how we group these measures is making them all

1 together.

2 So, what I would encourage is you
3 wouldn't necessarily pull these measures from the
4 consent calendar. You need to indicate to us
5 that you want to discuss these measures further,
6 that -- but what we would ask that you do is as
7 we discuss these, to also if you have specific
8 concerns about a particular setting of care since
9 these are all grouped as predominantly the same
10 measure, but for different settings of care, that
11 you also indicate to us which setting of care or
12 which program you would have the most concerns
13 about.

14 So, I mean, I think if anybody has
15 slight issues about any issue of any one of
16 these, it kind of applies to all of them, which
17 is how we did it in the first place. So, it's
18 going to be a little bit difficult to say pull a
19 measure from the consent calendar, if that makes
20 more sense.

21 CO-CHAIR RAPHAEL: Okay. Bruce.

22 MEMBER LETT: Just another process

1 question. Is there -- so, for instance, let's
2 say as an example we agreed with the public
3 comments. Is there added value to members of the
4 workgroup piling on with similar comments, or is
5 that adequate for discussion? Do we need to
6 repeat? Is there a value in repetition?

7 MS. SAMPSEL: That's a great question.
8 So, while we want to prevent, you know, speaking
9 about the same measure for hours on end if you
10 feel there was something particularly relevant
11 that you feel should be, you know, kind of a I
12 just want to agree with what the public commenter
13 said, that is perfectly acceptable and would be
14 encouraged.

15 At the same time we don't -- or we
16 would appreciate not having the same conversation
17 over and over and over.

18 CO-CHAIR SALIBA: So, Bruce, I would
19 use the word "amplify" as opposed to "pile on."

20 CO-CHAIR RAPHAEL: I think it's part
21 of the role of the chairs to make sure that we
22 don't hear the same thing over and over and over

1 again. So, we can handle that.

2 All right. Jim.

3 MEMBER LETT: Thank you. I just
4 didn't feel we could allow these to go to the
5 consent calendar without emphasizing how
6 important medication reconciliation is. And it
7 seems to not discuss it a little bit would lessen
8 its importance, number one.

9 Number two, I will amplify what I've
10 heard. And I think the real problem for me as a
11 practicing physician and as a medical director
12 and as the other roles I've had, is defining the
13 word "significant."

14 I mean, my world is frail elders and
15 transitions of them. And polypharmacy in this
16 day and age is a very perverse, but new normal in
17 this population. We end up adding on medications
18 many times, because there are multiple guidelines
19 that really aren't validated for this age group.
20 But we feel to meet quality indicators, we should
21 add medications even when we think maybe it's not
22 the best of ideas.

1 So, we need some help out there in,
2 number one, determining what is significant in
3 drug reactions. Because sadly when we're seeing
4 patients in various sites who are on 20, 25,
5 sometimes more medications, their everyday normal
6 is an adverse drug event.

7 I mean, a hundred percent of those
8 people have them. So, what is significant? What
9 will allow us to withdraw medications
10 appropriately? Otherwise, I would say absolutely
11 I'm in favor of measures for medication
12 reconciliation.

13 I don't want perfect to be the enemy
14 of good. They can't be perfect to start with,
15 but we need some help with significance. Thank
16 you.

17 CO-CHAIR RAPHAEL: Just to clarify,
18 we're leaving these on the consent calendar, but
19 we're now going to discuss them.

20 All right. So, Gerri.

21 MEMBER LAMB: A process question after
22 Bruce's in terms of amplification. Is there

1 value in knowing that there is strong support for
2 any particular concern versus an individual
3 saying, yeah, I agree with this?

4 So, if everybody in the group says,
5 yes, this is a significant concern and it needs
6 to be addressed, is there value in knowing that
7 there is consensus that this needs to be
8 addressed?

9 MS. O'ROURKE: Again, I would say
10 that's a little bit of a balancing act and where
11 we'll look to Deb and Carol, but, yes, it's
12 beneficial to know where the concerns are,
13 consensus concern versus one individual person.

14 We do try to reflect all of that in
15 the reports that we'll be generating, but knowing
16 the strength of the concern is valuable, but
17 again without having the same conversation all
18 day.

19 CO-CHAIR SALIBA: Yeah. So, I think,
20 Gerri, there's sort of that idea of saturation.
21 At some point we'll reach saturation. And unless
22 we hear someone say that they think the term

1 "significant" is clear and obvious and there's
2 nothing, you know, I think after we have a few
3 comments from people about it, we start to sort
4 of understand the sentiment.

5 CO-CHAIR RAPHAEL: I mean, I was just
6 going to ask Sarah how you think about this,
7 because on one hand I can argue that we don't
8 want to put people into a straitjacket. I mean,
9 you rely on clinical judgment at the end of the
10 day and you don't want to become too
11 prescriptive, because there's no way we can
12 anticipate all the possible situations.

13 On the other hand, you know, in terms
14 of what Jim is sharing with frail elderly with,
15 you know, where there can be so many medications
16 and, therefore, it's unlikely you can entirely
17 avoid adverse reaction, so how should we think
18 about that?

19 MS. SAMPSEL: I think it's important
20 -- we're always going back to balance, but I
21 think a couple ways. First of all, we heard from
22 Alan that CMS wants to hear some of these

1 concerns as they continue testing the measures
2 and moving them forward for full development and
3 potential implementation and endorsement in the
4 future.

5 So, that's where I think knowing your
6 strong support of a measure and the concept
7 behind the measure is important to convey to us
8 as staff, but do I need every single person in
9 the room to tell me that? No, we're watching you
10 all, you know.

11 If somebody crawls under the table
12 with their hands over their head, we're probably
13 going to understand you don't understand that
14 count or you don't agree with that comment, but
15 at the same time you're right.

16 I mean, some of the issues that Jim
17 brought up and others of you may bring up about
18 each individual measure that maybe those issues,
19 you know, we didn't see in preliminary analysis,
20 but we would want to reflect in the report,
21 that's where we will need you to say, hey, this
22 is something really important and we would want

1 to see this as part of our workgroup
2 recommendation.

3 CO-CHAIR RAPHAEL: Clarke.

4 MR. ROSS: Thank you. I wanted to
5 make an observation from the perspective of your
6 workgroup of persons dually eligible for Medicare
7 or Medicaid. It's a unique entity within the
8 National Quality Forum, because it's focused on
9 the individual maximizing the health and well-
10 being of the individual.

11 And just an observation, I was the
12 liaison to this workgroup last year, the IMPACT
13 Act's purpose is standardization across settings
14 to improve the health and well-being of
15 individual patients or persons or consumers.

16 And I heard last year in the
17 discussion of a number of measure, proposed
18 measures, one provider type saying, well, they
19 may do it in that group, but it doesn't -- we
20 don't do it in this group.

21 Again, just to remind people, the
22 focus is on what is -- how do we maximize the

1 health and well-being of the individual who many
2 of these people will experience two or more of
3 these settings in a short period of time.

4 And so, in my -- my advice is please
5 keep in mind the individual beneficiary. And if
6 something is working in one setting type, working
7 well, then the question would be, what will it
8 take to get us to have it work in all the other
9 settings rather than leave us out because we
10 don't currently do it that way.

11 CO-CHAIR RAPHAEL: Thank you, Clarke.
12 Robyn.

13 MEMBER GRANT: My question then, and
14 I guess concern, relates to the part potentially
15 clinically significant medication issues that are
16 identified during the course of care and followed
17 up with the physician afterwards.

18 I will take Alan's word for it that
19 all three of those elements are in OASIS, because
20 I am not familiar with OASIS. But in terms of
21 Number 4 for skilled nursing facilities, now
22 granted it's been a while since I have dug into

1 the minimum dataset, but I'm just -- it strikes
2 me just from memory that I'm not sure that that's
3 where you would go to find out if there had been
4 a medication issue identified or followed up by
5 the physician.

6 That last one particularly, followed
7 up by the physician, seems to be that's going to
8 be in the medical record and not in the
9 assessment. So, I just wanted to raise that as a
10 question.

11 And then for the other two settings,
12 IRF and long-term care hospital settings, I don't
13 know about the assessment data, but I just wonder
14 if perhaps the same things have applied that some
15 of that information might not be in the
16 assessment, but rather in the medical record.

17 Did you want to say something?

18 MS. O'ROURKE: Let's let CMS -- do you
19 all want to respond to that?

20 MEMBER LEVITT: Just to tell you I do
21 have my coffee-stained copy of OASIS that I carry
22 -- actually carry around everywhere, Robyn, if

1 you want to take a look.

2 MS. O'ROURKE: Thank you. I trust
3 you.

4 (Laughter.)

5 CO-CHAIR RAPHAEL: I hope it was good
6 coffee, Alan. All right. Bruce.

7 MEMBER LEFF: So, I'm going to pile
8 on. So I think, and it may be there already, but
9 I think in terms of the guidance providing a
10 clear definition of "review" versus
11 "reconciliation" would be useful, because quite
12 honestly I was thinking about it.

13 I could totally see your definition
14 and I think it does make sense. But before I
15 heard what you said, I was thinking of it in a
16 very different way. I was thinking of
17 "reconciliation" as you have more than one list
18 and you have to do something to make that one
19 list.

20 I thought of "review" as you have a
21 list and you're reviewing it for clinically
22 significant trouble that could happen for Jim's

1 patient who's on 25 medicines, but I don't
2 necessarily need to go back and forth between two
3 lists between settings. So, having that guidance
4 would be helpful if it's not there.

5 I do think the feasibility issue may
6 be a little bit different for home health
7 compared to some of the other settings just
8 because in these other settings at least in
9 theory of medical provider/physician, MP is maybe
10 on site rather than the physician in home health
11 who is at a distance. So, that's an important
12 feasibility issue to consider along with the
13 continued development.

14 And I think also that clinically
15 significant, you know, identifying that
16 clinically significant event in the settings may
17 vary as well.

18 CO-CHAIR RAPHAEL: Thank you. Let's
19 go to Gene.

20 MEMBER NUCCIO: I wanted to share a
21 couple of things. First, the items or variates
22 of the items have been on the OASIS instrument

1 for several years, as Alan said.

2 The primary discussion among the
3 multi-representative IMPACT team has included
4 people from home health, from skilled nursing,
5 from IRF and from long-term care. And the issues
6 that we are raising here have been discussed at
7 length at those meetings, especially the issue of
8 what's the difference between medication
9 reconciliation versus medication review.

10 And the general definition has been,
11 as Alan suggested, that reconciliation is simply
12 check box. The review is much more in depth
13 looking at potential interactions for care
14 coordination issues. The issue of timely
15 initiation of care has been raised both --
16 because that varies from setting to setting.

17 The other thing that I wanted to point
18 out that's not been pointed out yet is that the
19 measure that's being suggested across these
20 settings is a comprehensive measure in the sense
21 that it looks not just at what happens to the
22 patient as they -- the patient enters care, but

1 looks at the patient throughout the care process
2 for the provider.

3 And that is a major change from many
4 of the process measures where there's simply a
5 check box that happens at the start of care and
6 no reflection on what is the ongoing care that
7 goes on for that patient.

8 CO-CHAIR RAPHAEL: Cari.

9 MEMBER LEVY: Thank you. Just two
10 things I don't think we've talked about yet. One
11 is -- basically two cautions. One is with the
12 reconciliation, maybe I don't have the definition
13 exactly right, so correct me, is to include the
14 home drug regimen, because often the individual
15 is going from home to hospital to one of these
16 settings and we forget the home list.

17 And so, when they go back home,
18 they're very, very confused about what has
19 happened in the interim and often we don't know
20 what they were on at home and a lot has changed
21 in the hospital.

22 And the second is if what's happening

1 right now where I get a list from our clinical
2 pharmacist, that's 17 pages long with all the
3 clinically significant interactions between
4 drugs, if I get that I can't make heads or tails
5 of it.

6 And so, to the extent that we can be
7 mindful about these reviews, that would be great
8 and specific in the recommendations.

9 CO-CHAIR RAPHAEL: Thank you. Deb,
10 did you want to say something?

11 CO-CHAIR SALIBA: I just wanted to ask
12 a question. I mean, I think it's pretty clear
13 that there is questions about significance and
14 defining significance.

15 Do you folks have suggestions for what
16 that might be that we could feed back?

17 CO-CHAIR RAPHAEL: Do you want to
18 respond?

19 MEMBER THOMAS: Yes. And actually in
20 the written comments that ASCP provided, there is
21 in the skilled nursing facility and state DSOM
22 manual, there is description of medication

1 regimen review and the term "clinical
2 significance."

3 So, whether we would adopt that or
4 not, but it does provide a little more
5 elaboration of what that would be.

6 The number, I actually have it. I can
7 send the -- send that to you all, but I think
8 it's 463.60 in the section of the statute, but it
9 is somewhere in there, but if you all find that
10 and pull that up, but so I think that could be
11 helpful.

12 And that actually was in the
13 recommendations from ASCP as far as standardizing
14 the terms, because it's gone from drug regimen
15 review in skilled nursing facilities now to the
16 term "medication regimen review." Are they the
17 same thing, you know, refer to things in the same
18 way across all of these settings?

19 And it's now by statute in, you know,
20 for CMS for long-term care and skilled nursing
21 facilities have the pharmacies provide a review,
22 regimen review every month for every beneficiary

1 or resident.

2 So, I think that that could be helpful
3 to use that. It's two or three sentences,
4 actually. I believe that would help describe
5 that.

6 I have other comments, but I'll wait.
7 Okay. In terms of this issue of medication
8 reconciliation being distinct from the drug
9 regimen review, I think we really need to be very
10 careful and actually do that.

11 I would consider medication
12 reconciliation may be a step in the drug regimen
13 or the medication regimen review that always
14 would follow, you know, periodicity and follow up
15 with depending on what circumstances arise with
16 the disease states and the medication changes.

17 And it's not just a list to check off
18 the box. It implies that there is, as Cari had
19 said, there's several lists. There's a list at
20 the pharmacy. There's a list at the patient's
21 house. There's a list at the hospital where they
22 came from and hopefully, you know, when they

1 transferred they got that list, but maybe that
2 list is not even reconciled.

3 And so, the reconciliation piece is
4 really complex and it's difficult making this
5 whole process very difficult, but I would want to
6 say we need to have a very distinct statement
7 defining that process and maybe it is part of the
8 measure.

9 And then otherwise in comments you
10 made, Carol, as far as how prescriptive, I think
11 we have some guidance from a current MTM TEP
12 panel that's underway as far as some things that
13 we can do to identify what the problems are and
14 issues and they can be categorized so that it's
15 not just a yes or no, there's a problem and then
16 we've addressed it with the physician, but what
17 the problem was.

18 And it can be as simple as a drop-down
19 that could be added to the current perhaps
20 elements, data collection and how we might -- how
21 they might have been addressed as well on the
22 physician, the prescriber side of how we address

1 those. So, I think those are important, too.

2 MEMBER WINSTEL: Thank you. To pile
3 on both with some of the things that Bruce said,
4 and also Cari, I'd like to say that getting the
5 list of medications that are in the home setting
6 is incredibly important.

7 And I'd like to see that home setting
8 list incorporated into all of the other setting
9 measures and to make sure that these measures as
10 a group are harmonized across settings. And that
11 there is something that refers to if the patient
12 is coming to short-term rehab from a hospital
13 setting, that we go all the way upstream in
14 either reconciliation or review so that by the
15 time they get to short-term rehab or skilled
16 nursing, we're looking at both the home list and
17 the hospital list and making sure that there is
18 complete review, not using the word "review"
19 literally in that point, but that we have
20 everything.

21 Also, I would be remiss if I didn't
22 say that sometimes the patient is not the best

1 one to report on what they are taking and that --
2 and to encourage input from the family caregivers
3 if there is not a home health provider at the
4 beginning of that patient's journey.

5 CO-CHAIR RAPHAEL: Liz.

6 MEMBER PALENA HALL: I would just
7 encourage as reading through the comments, there
8 are a couple comments on provider burden. And
9 just thinking about how technology might be able
10 to, you know, address some of the burden, I was
11 considering communication as between, for
12 instance, the home health agency or -- and the
13 physician. There might be an opportunity there
14 also just with the EHR being able to help with
15 the process generally with medication.

16 MEMBER MULDOON: Related to med rec
17 and medical regimen review, it seems to me that
18 we should think about it as two steps. First,
19 give me the list of reconciled medication. It's
20 only when that has done, ask the physician and
21 the PharmD, which is the level of expertise we're
22 going to require on this thing, to say now that

1 you've got the list, think through very hard what
2 could happen, do they need it, is it being
3 effective.

4 Because although we have no debate in
5 this room, I think, about why it's important and
6 what has to be done, the debate will be about how
7 do you do it.

8 And perhaps the experience in short-
9 term hospitals who have gone before us can do
10 that, but, you know, split out what we want for
11 patients and what actually the tasks of the day
12 will be for the pharmacist, the nurse and the
13 physician, because that's where our stumbling
14 block in implementation and rulemaking will be.

15 CO-CHAIR RAPHAEL: Paul.

16 MEMBER MULHAUSEN: So, I think my
17 thoughts flow nicely from what Sean has said and
18 I've been reflecting on Alan's comments about not
19 wanting to be too proscriptive. I've been
20 thinking about the public comments about what's
21 the role of the interdisciplinary team here. And
22 then I've been thinking about the ambiguity and

1 the numerator on measure specifications.

2 And so, my first thought would be that
3 much of what we're looking at in the numerator is
4 not necessarily tied to the drug regimen review,
5 which I don't -- I'm not confused by at all. But
6 one way in my mind to potentially operationalize
7 the drug regimen review is to find who should do
8 it, which gets at Sean's comments about, you
9 know, who can actually take a review of the
10 medications and synthesize that in the spirit of
11 the review that Alan has described to us. So,
12 that would be one way that I would like to try to
13 offer something a little more concrete and
14 potentially helpful to CMS.

15 The ambiguity around identifying
16 significant medication issues during the course
17 of care, in my mind, is not necessarily tied to
18 the drug regimen review. So, we're asking two
19 elements of this.

20 Take care of the problems that are
21 found on the drug regimen review, as well as find
22 the problems over the course of care and take care

1 of those, which, to me, introduces way too much
2 ambiguity and I, quite frankly, think that CMS
3 has struggled in its ability to define what is
4 clinically significant.

5 We spent a lot of time trying to
6 define what drugs aren't friendly to the frail
7 elder. Out in the universe of physicians, that
8 remains controversial. So, I think that
9 simplifying the measure, focusing on the review
10 process and who could do it might be helpful.

11 CO-CHAIR RAPHAEL: Jim.

12 MEMBER LETT: Thank you. Two things.
13 One, I would certainly strongly support defining
14 "drug regimen review" and "medication
15 reconciliation," but an appendage to that is
16 people in the community and, for the most part,
17 post-acute care is a community sport, take a
18 stunning array of things that are non-
19 prescription, over the counter, their neighbor's
20 pills, the dog's antibiotics because they had
21 some left and they got a cold -- a vitamin
22 supplement.

1 So, I would want us to expand our
2 consciousness around that however we define those
3 two entities to include nonprescription
4 medications.

5 Second piece, I just took a wild stab
6 in the dark at Deb's suggestion, what is
7 significant in a drug interaction. And just some
8 things that came to me is, one, they extend post-
9 acute stay. Two, they require transportation to
10 the emergency department or the hospital.

11 Three, they are forced to stop the
12 medication as a result of those symptoms. Four,
13 they caused -- symptoms which caused the patient
14 to call their provider about them or interfered
15 with their normal lifestyle or activities of
16 daily living. And five, last, but not least,
17 death.

18 MEMBER LEFF: Yeah, I just wanted to
19 endorse Paul's comments. I thought those were
20 very compelling. Sort of the compoundness of
21 that numerator I thought that was good to point
22 out.

1 Second, just a caution. Technology
2 may ultimately help with this. But if my initial
3 growing pangs with Epic even within a single
4 system is any indication, right now the
5 technology will in no way solve this.

6 MEMBER LAMB: Two comments. I wanted
7 to elaborate a bit on the does this measure fill
8 a gap in the program measure set? And to frame
9 it just a little bit differently, but similar to
10 Gene, which is in from the care coordination
11 standpoint, and this is an element of important
12 care coordination, is that right now many of our
13 measures are kind of one part of the process.

14 Don Casey, who co-chairs, says it's
15 one side of the handshake. This is, in my view,
16 not only important content, but from a
17 measurement science standpoint is can we really
18 do closed-loop measures in a meaningful and
19 feasible way. Because this measure has, as I
20 think we're all saying, has multiple components
21 that have to come together to get a positive on
22 it. So, from a closed-loop standpoint this is

1 important work.

2 The other is what Paul was saying and
3 I think the public comment, which is attribution.
4 I think we're all saying that this measure
5 doesn't get accomplished without lots of people
6 being involved. And I really think it's time to
7 pay attention to the attribution issue. So, it's
8 very timely with NQF looking at this, because the
9 closed-loop isn't going to happen.

10 And while the physician is a critical
11 piece of it, it's also the appropriate physician
12 for the complication and who else is involved in
13 the process whether it be the pharmacist, the
14 care coordinator, the nurse and so forth.

15 So, this is one that I think is
16 important to pay attention to from closed-loop
17 and attribution.

18 CO-CHAIR RAPHAEL: Two more comments
19 and then move to a vote. Jennifer, did you want
20 to add something? Oh, okay. Gene.

21 MEMBER NUCCIO: If I might share,
22 there's a manual that's being developed,

1 instruction guidance for these particular set of
2 three items.

3 And if I could share the current
4 verbiage regarding clinical -- potentially
5 clinical significant medications are those issues
6 that in the care provider's clinical judgment
7 require action by midnight of the next calendar
8 day as the issues possess an actual or potential
9 threat to the patient's health and safety.

10 Clinically significant medication
11 issues can be the result of drug reactions,
12 ineffective drug therapy, side effects, drug
13 interactions, multiple drug therapy, medication
14 omissions, drug dosage errors or non-adherence to
15 prescribed medication regimen.

16 And then the instructions go on to
17 define each of those kinds of things. So, for
18 example, side effects could be potential bleeding
19 of an anticoagulant, a drug interaction, serious
20 drug-to-drug or food-to-drug interactions.

21 And indeed the point that I think I
22 can remember either Bruce or Jim mentioned about

1 the over-the-counter medications, that would be
2 included.

3 And we had a very long discussion
4 about herbals as part of the medication -- self-
5 medication that patients might do and those were
6 included. And I will make no comment about
7 living in Colorado for herbals.

8 (Laughter.)

9 CO-CHAIR RAPHAEL: You know, I think
10 this set of four measures really kind of very
11 much connects to our attempting to work on
12 function, care coordination, safety and cost. I
13 think it really crosses all of those lines.

14 I would just say that, you know, from
15 having been in the home healthcare field, and
16 this is just something that's going to have to be
17 dealt with, when you go into a home and you see
18 the number of medications from many specialists,
19 plus over-the-counter, and now you have a new set
20 of four medications from the hospital and you're
21 trying to put all of this together, and then you
22 want to call a physician and you have the

1 hospitalist who discharged and you can't get a
2 hold of the hospitalist because you want to
3 change your med, I mean, I think there are some
4 real world issues here that are not
5 insurmountable, but that we just have to be
6 cognizant of.

7 I've seen a lot of issues and it goes
8 back to, I think, Liz, how do we improve
9 communication so it's really easy to problem
10 solve in a coordinated and joint way, which right
11 now it is not.

12 So, I think with that, let us move now
13 to the vote. On all four of these -- oh, Alan,
14 did you have an inspirational concluding comment
15 for us before we go to our vote?

16 MEMBER LEVITT: No, it's not
17 inspirational, first of all. Thank you. No,
18 thank you all for your comments. I mean, this,
19 you know, this is why we, you know, have the
20 workgroup is to get this sort of feedback.

21 As Gene mentioned, this has all been
22 discussed, these sorts of issues. And the

1 wording and the reason we've done what we've done
2 is really to try not to narrow things down or to
3 take so much time.

4 This is why Congress has set timelines
5 for us on these measures, because we'd all be
6 sitting here all the time discussing should we do
7 herbals, should we do, you know. Everyone is
8 going to have a different definition and way and
9 thought about how to do this.

10 And meanwhile, we all know that these
11 sorts of issues and items that I'm talking about
12 here one day should be never events. They should
13 be things that should not be happening.

14 Unfortunately, they do still happen
15 and, you know, we're trying to develop measures
16 that will hopefully help to influence behavior to
17 try to help to make these really never events.

18 And as you understand, we really try
19 to be giving each setting the chance to look at
20 this. And our main reason is not to say, well,
21 you did, you know, one thing and you did the
22 other, but that, you know, you're doing it and

1 that you're really reviewing these records for
2 these type of events and trying to prevent it
3 from happening and not waiting for the perfect
4 measure, which, you know, we will all define
5 differently to come along.

6 But we do -- we really did -- we want
7 to get kind of a consensus from the community,
8 because we do represent what your viewpoint is on
9 these things. And, you know, if the consensus is
10 that you wish for us to continue the measure
11 development, but really want much more or better-
12 defined guidance as to what these things mean,
13 you know, that's what we can take back from the
14 Committee. And we do thank you for that.

15 CO-CHAIR RAPHAEL: We have a staff
16 recommendation, and that is encourage continued
17 development. I believe that's Number 1, if I can
18 see far enough on the voting screen; is that
19 correct?

20 MS. O'ROURKE: So, we actually have
21 that for all of the medication reconciliation
22 measures under consideration.

1 CO-CHAIR RAPHAEL: Right.

2 MS. O'ROURKE: So, we don't need to
3 take a formal vote if no one has an objection.

4 CO-CHAIR RAPHAEL: Oh, okay. So, we
5 don't need to use our little --

6 MS. O'ROURKE: Just pass by consensus.
7 You don't need to use your blue clicker if no one
8 has an issue with --

9 (Laughter.)

10 CO-CHAIR RAPHAEL: All right. Then we
11 have approved encourage continued development for
12 all four. And with that, we're going to take a
13 15-minute break.

14 MEMBER LEVITT: Can I just be sure --
15 I just wanted to be sure, Carol.

16 CO-CHAIR RAPHAEL: Yes.

17 MEMBER LEVITT: And so, the Committee
18 as a whole feels that we should give further
19 guidance. Is that kind of -- I'm getting the
20 nods. Okay. Thank you.

21 (Whereupon, the above-entitled matter
22 went off the record at 10:58 a.m. and resumed at

1 11:18 a.m.)

2 CO-CHAIR RAPHAEL: Before we resume
3 our review of three measures under consideration
4 having to do with discharge to community, during
5 the break, a small group of us had a discussion
6 with someone who is a member of the MAP
7 Coordinating Committee, who raised a question
8 which I wanted him to raise for the entire group.

9 DR. GIFFORD: My name is David
10 Gifford. I work with the American Healthcare
11 Association, but also on the MAP, also a measure
12 steward, so full disclosure. The question that
13 came up was on the MAP, when we develop these
14 criteria, at least I was under the impression
15 that the measures under consideration, when they
16 were not fully specified, were following a
17 different path.

18 It had the equivalent of sort of still
19 being a measure that had to come back to the
20 future to -- that it was not considered on the
21 MUC list. Because once a measure gets
22 considered, with or without consideration by the

1 MAP, it's on the MUC list forever, and CMS can
2 then put it in any future proposed rule, without
3 specifying why they addressed it. But if it's
4 not endorsed -- sorry, not the word endorsed --
5 if it's not recommended through the MAP process,
6 the measures, if CMS decides to put them in a
7 proposed rule, they have to specify in the rule
8 why they are putting a measure in that the MAP
9 did not support.

10 It's sort of the discussion that you
11 were having about why -- the details of the
12 measures, if several committee members said, "If
13 all these are going to be just encouraged further
14 development, why do we really care about what the
15 details are because they'll have to bring them
16 back to us?"

17 I asked the question to Erin, "Does
18 CMS have to bring them back?" The interpretation
19 I got from Erin, and I think it's worth
20 clarifying, is that measures that are not fully
21 specified, that get a vote of consensus that they
22 encourage further development is the equivalent

1 of a fully specified measure being recommended
2 with no conditions.

3 Then CMS is on the MUC list, and CMS
4 can then put it in the rule. I guess I would
5 like to clarify that because I also had heard
6 from several other people that was not the case.
7 I think that would change the nature of the
8 dialogue and the discussion, and certainly it
9 would change how the MAP views the comments that
10 come from this group back to the MAP in January.

11 MS. O'ROURKE: I can start, and then
12 I'll look to Alan, if you could help us clarify
13 how CMS uses some of these recommendations. We
14 had developed the two pathways when we had
15 started getting measures that were earlier and
16 earlier in development.

17 MAP had expressed a desire to not vote
18 down, if you will, innovative measures because
19 they were still going through the development
20 process. We came up with this alternate pathway,
21 the measures under development pathway, where
22 you'll see the recommendation of encourage

1 further consideration or do not encourage further
2 consideration, or encourage further development,
3 do not encourage further consideration.

4 However, we cannot require CMS to put
5 a measure back on the MUC list and bring it back
6 to MAP. The guidance of that pathway is that
7 ideally, they would do that, but our
8 understanding is that we cannot require that of
9 them. So I'd ask if Alan or Tara could clarify
10 that a bit.

11 MEMBER LEVITT: I'll start first.
12 That's true. I do think that the first measure
13 that we just talked about, the issue wasn't the
14 actual measure items and specification of the
15 items, but was the guidance to be given for those
16 items. We certainly will use the MAP's
17 recommendation in our future development of this
18 measure.

19 Certainly, the IMPACT Act and the
20 timelines that Congress has specified for measure
21 development are timelines that are tight, that,
22 as you mentioned, specifications changed even

1 from when they first came in until now. We've
2 done testing on many of the measures already, and
3 we're continuing that and really do value the MAP
4 process and the recommendations and suggestions
5 that the MAP does give us, and we will continue
6 to do that in our measure development.

7 But in addition, we also do have to
8 continue to look at the statutory guidelines that
9 are there, in terms of the measure development,
10 and work within those guidelines, while using all
11 these resources we luckily have.

12 DR. GIFFORD: So that means the
13 answers you don't have to bring them back, you
14 consider them supported by the MAP process when
15 they went through that boat? Because there is a
16 statutory requirement that if it's not supported
17 by this -- and the statutory requirements are
18 that you meet certain timelines and go forward,
19 you can say that in the proposed rule and put it
20 forward and say, "We're putting it forward even
21 though the MAP process didn't support it because
22 it has to meet the time frame and everything

1 else there."

2 DR. MCMULLEN: I think what Alan was
3 delineating was that CMS has our marching orders
4 by Congress to develop quality measures for the
5 IMPACT Act, and to standardize those quality
6 measures by a specified application date. In
7 this case, the specified application date for
8 this quality measure, for IRFs, LTACs, and SNFs
9 is 2016.

10 So we go through the pre-rule making
11 process to be able to receive the input by the
12 MAP, so that we can, in the process of doing
13 that, propose this measure in our NPRMs. If the
14 measure did not receive favorable input by the
15 MAP, of course we'd probably put it back on our
16 MUC list, as we do appreciate this process. It's
17 quintessentially a part of the pre-rule making
18 cycle.

19 DR. GIFFORD: Probably put it back on
20 the list?

21 DR. MCMULLEN: Well, these are
22 discussions that we would have to have with our

1 leadership. That's it.

2 MEMBER LEVITT: As you know, last
3 year, for example, we had an ad hoc MUC list that
4 was done at a certain time because we needed to
5 -- but like I said, we appreciate support.
6 Certainly, the first measure that we just
7 discussed, we heard the support for the
8 specifications and for the idea of the measure
9 and to continue the development with these
10 recommendations for the guidance. We're going to
11 take these recommendations back, in terms of
12 looking at it.

13 DR. MCMULLEN: May I add that this
14 measure is fully specified. We have posted the
15 specifications for this quality measure on our
16 CMS website for public comment. We've had
17 technical expert input. The specifications,
18 actually, as they live, you can go Google our
19 public comment page. They're there. We are in
20 the process of finalizing the summary document
21 and posting -- I believe that summary document
22 was just posted for medication reg. We're moving

1 through the development phase. We're getting
2 ready to pilot the measure to test out the
3 feasibility of the items, in terms of the coding.
4 We're moving through the development as it stands
5 today.

6 Originally, when the measures under
7 consideration list was open, there weren't full
8 specifications for the measures. That was simply
9 because of the timelines in the pre-rule-making
10 cycle, which is a bit out of CMS's hands. We
11 can't really comment to those timelines.

12 Per an agreement with the National
13 Quality Forum, we actually updated the MUC list
14 and put full specifications. Whether those
15 specifications were commented on the NQF public
16 comment is not my job, but we actually -- CMS
17 actually did provide those specifications.

18 DR. GIFFORD: I guess I would
19 encourage the workgroup to maybe go back and look
20 at the voting criteria that you have for measures
21 under consideration because I don't think this
22 fully was laid out. I think it may change the

1 amplification comment discussion that may want to
2 occur given this feedback.

3 CO-CHAIR RAPHAEL: I'm going to ask
4 the operator to open the lines for any public
5 comment.

6 OPERATOR: At this time, if you'd like
7 to make a comment, please press star, then the
8 No. 1. There are no public comments at this
9 time.

10 CO-CHAIR RAPHAEL: Let me turn to
11 members of the audience. Please introduce
12 yourself, and we welcome your comments.

13 MR. BAIRD: Thank you. My name is
14 Andrew Baird. I'm from HealthSouth. We are a
15 large post-acute care provider, primarily in the
16 rehabilitation hospital space and the home health
17 space.

18 My primary comment around this measure
19 -- and I appreciate all your time and
20 consideration of these concepts and, like you
21 said, balance is of the essence in these
22 discussions -- we know that in the law, the term

1 was discharge to community, and that the measure
2 is actually structured so that it said discharge
3 to community plus staying in community for 31
4 days. I'm not necessarily going to speak about
5 that distinction between the law and the
6 specification, but I do note that it is an
7 additional re-admissions measure, essentially.
8 This is a measure that is a discharge to
9 community for people who go home, and then stay
10 home.

11 That is already encapsulated in at
12 least two other measures that rehab hospitals
13 already report on. My ultimate comment is that
14 under public reporting and the discharge planning
15 requirements, the rule that was recently released
16 by CMS, the idea of sharing quality data, in
17 fact, IMPACT Act data, with patients during their
18 discharge process, I'd just like to underscore
19 the fact that the different flavors of
20 essentially the same population that may be
21 delivered to the patient and what efforts are
22 being made to make sure that those numbers are

1 distinct from one another?

2 For example, there is the all-cause
3 unplanned re-admission measure, which captures
4 everyone who comes back. This measures people
5 who come back who went home. There is a
6 potentially preventable re-admissions measure
7 that is being developed that will track certain
8 diagnoses and who those come home. I'd just like
9 to underscore the fact that if these are
10 essentially two or three, or sometimes, even, in
11 some cases, four measures -- for example, in
12 rehab hospitals, we also have a within-stay
13 measure that's being proposed, as do other
14 post-acute care settings -- that there be some
15 effort around the idea of what it means to
16 distribute or indicate to the patients what these
17 different measures about re-admissions mean.

18 Because while it's called discharge to
19 community, I believe the measurement
20 specification that is discharge to community
21 within -- and staying home within 31 days is
22 actually a re-admissions measure. I just want to

1 underscore that. Thank you.

2 MS. KEEFE: Good morning. My name's
3 Alyssa Keefe. I'm with the California Hospital
4 Association. We also represent post-acute
5 providers, including SNF, LTAC, IRFs, and home
6 health agencies. Appreciate the opportunity to
7 comment. I first want to commend NQF staff on
8 the materials for these workgroup meetings. I
9 have been here since the beginning, and we had
10 volumes of paper this thick. This online
11 discussion guide is tremendously helpful because
12 one of the key goals in the MAP process was to
13 engage providers early about what measures CMS
14 was considering, so that they could get an early
15 indicator and begin to prepare for implementation
16 of these measures.

17 I was able to open my screen, click on
18 measure specifications, go to CMS technical
19 expert panel documents, and share these measures
20 with providers on a series of member calls that
21 involved over 100 hospitals and post-acute care
22 providers last week, so I just want to commend

1 the staff for the tremendous work because I think
2 that was one of the key goals of the stakeholder
3 engagement.

4 Second, just to the process point
5 earlier, I would encourage the MAP to continue on
6 measures that have not been fully brought forward
7 through the NQF process and technically, I think,
8 in this process, the ones for the IMPACT Act are
9 still considered under development. We have not
10 seen testing data. We have not had them all
11 piloted yet. And then encourage continued
12 development, I believe is an appropriate
13 recommendation for this group because there are
14 other measures that will be considered in quality
15 reporting programs that don't have the
16 accelerated timeline of the IMPACT Act, where you
17 really do need to assess is it ready for
18 inclusion because there may actually be
19 additional time for that consideration and could
20 be prioritized against additional measures.

21 So I would just offer that the staff
22 recommendations on these measures that were all

1 just put out for public comment over the last few
2 weeks is an appropriate recommendation. Then
3 lastly, just briefly, on the discharge to
4 community measure, this measure is well underway
5 in development. We have providers that stand
6 ready to pilot test some of these measures if CMS
7 would like some additional providers to do so.

8 But one of the things that we learned
9 in the re-admissions measures is that discharge
10 coding -- discharge status codes on claims are a
11 challenge. When we implemented in the hospital
12 re-admissions penalty program, we had to add
13 discharge codes to appropriately account for the
14 planned re-admissions. We believe there are a
15 number of factors that could be considered by
16 NUBC for updated education and refinement of the
17 discharge codes. With that, I'll leave my
18 comments to the comments that have been
19 previously submitted to the TEP that I know CMS
20 has, and appreciate the opportunity to comment.
21 Thank you.

22 DR. KOENIG: Good morning. My name is

1 Lane Koenig. I'm director of policy and research
2 for the National Association of Long-Term Care
3 Hospitals. Thank you for the opportunity to make
4 comments this morning. I should say National
5 Association of Long-Term Care Hospitals
6 represents about 80 long-term care hospitals
7 throughout the nation. We've got some concerns
8 regarding the discharge to the community measure,
9 particularly as intended in the IMPACT Act as a
10 cross-setting measure.

11 Long-term care hospitals are
12 acute-care hospitals, they meet the requirements
13 of an acute-care hospital. For the very sick and
14 ill patients that are treated in long-term care
15 hospital, the goal is not always to send them
16 home because that might not be an appropriate
17 setting for these sick patients, but it's to get
18 them to the next level of care and appropriate
19 level of care. Discharge to community, the way
20 it's currently constructed, if implemented, we
21 have concerns that it would create incentives
22 that won't be in the beneficiaries' interests if

1 really where they should be going is to a
2 lower-level care, they're not quite ready to go
3 home.

4 What makes this a unique problem for
5 long-term care hospitals is, as I said, because
6 they are acute-care hospitals. Therefore, once
7 the patient no longer needs acute level of care,
8 then they need to go to the next appropriate
9 setting. That may not be home. Thank you for
10 the opportunity to comment.

11 DR. GIFFORD: I'm David Gifford from
12 American Healthcare Association. We think this
13 is a very important measure. It actually aligns
14 with our national quality initiative goals, so we
15 would like to see this implemented as soon as
16 possible, but we have some concerns about the
17 measure that should be continued development and
18 probably are not ready for rule making because of
19 the specifications. In particular, our concerns
20 are similar to the previous one, commenting on
21 Measure 462 and 523, by the way, both the home
22 health and the SNF, that the way the measure's

1 currently constructed, it double counts
2 admissions to different providers, so individuals
3 who go to an IRF, and then get discharged later
4 from an IRF to a SNF or home health, are counted
5 in the SNF and home health, as well as counted in
6 the IRF measure, so there's a double counting of
7 admissions.

8 It also disadvantages home health and
9 SNF, in that individuals discharged from IRF and
10 LTAC to a SNF and home health, they couldn't go
11 home because they usually are sicker, regardless
12 of risk adjustment, you're enriching the sample
13 for home health and SNF, who are not going to be
14 able to discharge home. The intent of the IMPACT
15 Act is to do cross-setting comparison, so we
16 think that definition is not dissimilar.

17 I think the other aspect is we don't
18 believe it's fully specified. This is going to
19 be based off of claims, and it's going to require
20 ICD-10 codes, and we don't know what the ICD-10
21 codes are. The risk adjustment models are not
22 specified, just categories of variables are

1 specified out there, so we don't think it's ready
2 for full specification. We think that the
3 exclusion, or not counting individuals who
4 discharge home who die in the next 30 days, is
5 going to create a disadvantage to the care of
6 getting people home, to die at home, but
7 encouraging people to die in an institutional
8 setting. So we would encourage some way to
9 include deaths in the next 30 days as a
10 successful discharge home, if it's within hospice
11 or some other aspect to do it.

12 We also think that individuals who are
13 discharged home, who are re-admitted to a SNF
14 within the next 30 days, should not be counted as
15 successful discharge back to the community.
16 Right now, they are counted as a successful
17 discharge. Risk adjustment, there's no risk
18 adjustments for sociodemographic characteristics,
19 I think something that NQF has said very clearly
20 they need to be identified.

21 Functional status, probably the single
22 most important predictors of being discharged

1 home, and cognitive status, are excluded from the
2 measure because it's a claims-only measure, when
3 that information is available in the new PAC
4 assessments with Section GG and the care tool.
5 We would say that those individuals really need
6 to be included. Last is the risk adjustment
7 variables differ between settings, which makes
8 some sense, but in many areas of the country,
9 there are no LTACs and IRFs, and the SNFs provide
10 the same level of service. Therefore, the risk
11 adjustment for IRF and LTAC should apply to the
12 SNF, as well, and have the same characteristics
13 across them all. Thank you very much for that.

14 CO-CHAIR RAPHAEL: All right, is there
15 anything that's come in on the chat room?

16 MS. IBRAGIMOVA: Not at this time.

17 CO-CHAIR RAPHAEL: Okay, thank you.
18 I'm going to turn it over to Sarah to provide a
19 brief overview of the discharge to community
20 measures and the staff's preliminary analysis and
21 recommendations.

22 MS. SAMPSEL: Certainly, thank you.

1 As with the last set of measures, this is a set
2 of four measures across the different settings of
3 care, home health, inpatient rehab, long-term
4 care hospital, and the skilled nursing
5 facilities. These are outcome measures. All of
6 the staff recommendations are encourage continued
7 development, based on the information that we
8 received as to their current status. They all
9 address the impact domain of discharge to
10 community, and we do know that CMS is in the
11 process of testing and fully specifying the
12 measures, and that they are based on claims data.
13 We find that in one of the criteria for NQF
14 preliminary analysis on determining if the
15 measures would be valuable to any setting have to
16 do with are they outcome measures, and are they
17 really driving us toward improved care?

18 Those ratings were included, as we did
19 find these to be valuable measures not only
20 because of being outcome measures, but because
21 they do address not only the IMPACT Act domains,
22 but also national quality strategy and

1 understanding what the next steps of care are, as
2 well as alignment across settings.

3 CO-CHAIR RAPHAEL: So let me turn to
4 Alan and see if you want to make any comments on
5 this.

6 MEMBER LEVITT: Okay. First of all,
7 once again, thank you for the comments that were
8 made and for the summary of the measure. I think
9 first and foremost, we have to remember who these
10 measures are really for. These are measures that
11 are not just to be implemented at a certain date,
12 but within two years, are to be publicly
13 reported. This is information that consumers,
14 patients and their families, want. When Congress
15 looked at this, it felt that a discharge to
16 community measure was important, the idea of
17 somebody who's entering a certain setting would
18 want to know what percent of patients go home and
19 stay home a month later from that setting.

20 That's very important information.
21 Re-admissions are a part of that. I used to run
22 an IRF. Patients come into my rehab hospital,

1 they don't all go home. They end up going --
2 transferred to acute care. They end up going to
3 a lower level of care. They may not go home.
4 Those patients are still in this measure.

5 Patients who do go home if,
6 unfortunately, they pass away and they are not
7 discharged to hospice, which is an exclusion in
8 this measure, they would also, then, be included
9 in the measure. Re-admissions or potentially
10 preventable re-admissions are very important.
11 They should be reported, but they are different
12 than this measure. This is a measure that, as we
13 mentioned -- I'll now say it for the 24th time, I
14 think, IMPACT Act measure -- IMPACT Act resource
15 and use in other measures are measures that are
16 to be claims based, and may also include
17 standardized patient assessment data. At this
18 point, claims are the information that really is
19 available to use for this type of measure.

20 The claims are being used, and the
21 methodology for this measure is methodology
22 that's been successful in other claims-based

1 measures used in hospital programs and the
2 post-acute care setting. It has been a
3 successful methodology. I'm trying to think.
4 Discharge codes, we're trying to get some other
5 information. I do know that from looking at 2013
6 data, the agreement was 98.8 percent between the
7 claims and the IRF-PAI discharge.

8 We can get the other settings if the
9 workgroup wants. We are, with all of our
10 claims-based measures, looking at the
11 conversation of ICD-9 to 10, trying to work
12 through those, so that we can accurately
13 represent patients as we make that conversion.
14 As what's already been mentioned, SES is really
15 important to us. We are concerned about that.
16 We obviously don't want to report adversely on
17 measures for settings that have their mission to
18 take care of patients with lower socioeconomic
19 status. We are participating in the NQF projects
20 that are going on and looking at other factors
21 that we may be able to use in our measures. Duly
22 eligible we are using for now, and we're looking

1 for better things.

2 We're also looking towards part of the
3 IMPACT Act, mentioned now 30 times, is ASPE.
4 ASPE is doing a project with SES, as well. Those
5 are additions that we look forward to adding to
6 this measure and to all of our measures. I'm not
7 sure if I addressed everything.

8 CO-CHAIR RAPHAEL: All right, thank
9 you. Now let me ask workgroup members if you
10 want to pull any of the measures from the consent
11 calendar that we're reviewing?

12 (No audible response.)

13 CO-CHAIR RAPHAEL: Okay, if not, we're
14 going to begin a discussion. Let me hear any
15 comments or issues that any workgroup member
16 wants to raise in regard to the discharge to
17 community measures. Suzanne.

18 MEMBER KAUSERUD: Thank you. I had
19 the honor of serving on one of the technical
20 expert panels for this measure, so I have a
21 little bit of knowledge of it, as well. One of
22 the things we really struggled with was the

1 definition of discharge to community. One thing
2 that I don't see that has been resolved and did
3 come up in the public comments was that a
4 discharge to home as the residential setting of a
5 skilled nursing facility I don't believe truly
6 meets the intent of discharge to community.

7 Yet with the claims coding, that is
8 something that occurs. If you are in a skilled
9 nursing facility in the residential portion, so I
10 guess not the skilled portion, you go to acute
11 care, then you go to the skilled nursing portion
12 for a little bit of rehab, and then you're
13 discharged back to the residential section,
14 that's considered a discharge to community under
15 the coding there.

16 We discussed in the workgroup that for
17 inpatient rehab, any discharge to a nursing
18 facility, whether it's skilled or residential, we
19 generally code as skilled nursing facility. That
20 was the first time I'd ever heard it discussed
21 and realized that hey, it should maybe be a
22 different code. I think there's some

1 inconsistency in how those codes are applied, as
2 well, that creates some confusion. But I think
3 the main point I'm trying to make is the codes
4 that are available, the discharge codes that are
5 available now, and the way they fall in the
6 measure, someone discharging back to the
7 residential portion of a nursing home would be
8 counted as a discharge to the community. I just
9 don't feel that meets the intent, or that it
10 would be clear to the consumer when they're
11 looking up this information online.

12 MEMBER AGOSTINI: Hi, thanks. I have
13 a couple comments and a question. The first
14 question, maybe to Alan or others, is the measure
15 specifications are not complete, in terms of the
16 risk adjustment, and I'm not sure if they're
17 available, if that was articulated, and we just
18 didn't see them all, in terms of SES and
19 functional status and things that I think are
20 terribly important, or are they not fully
21 developed? So that was my first question.

22 MEMBER LEVITT: Yes, they should be in

1 the public comment documents. I can try to find
2 them for you.

3 MEMBER AGOSTINI: That would be good.
4 Because I do think we need to spend time thinking
5 about making sure they're in alignment with the
6 other re-admission-type models that previously
7 exist.

8 The other comment I would just make is
9 I do share the concern about the previous public
10 comment that I really encourage the continued
11 development of the measures, but I do have the
12 concern for public -- consumers, families and
13 caregivers on differentiating, as someone said,
14 across these measures, planned re-admits, all
15 cause re-admits, and then the discharge to the
16 community measure.

17 I wholeheartedly believe in the
18 concept, but I do think we're going to have a
19 difficult time explaining to people, and I worry
20 that people will cherry-pick measures that they
21 want to emphasize, whether it's a planned
22 re-admit rate or all cause or discharge to the

1 community. I just urge us to think about that on
2 how the transparency of these measures would
3 ultimately be received, and could we provide more
4 clarity to, ultimately, patients and consumers
5 who will be looking at these measures.

6 CO-CHAIR RAPHAEL: Liza.

7 MEMBER GREENBERG: Yes, hi. We had
8 submitted some comments to the contractors, as
9 well, so I'm sure some of these are already in
10 the pipeline. We felt like this is where so many
11 measures coming out at the same time really show
12 that there's a need to make some cross-cutting
13 decisions about how risk adjustment will be
14 applied, how the re-admissions will be
15 considered, I have concerns about the multiple
16 countings of re-admissions, it gets captured in
17 many measures, so the same emergency could
18 potentially be dinged multiple times.

19 With this particular measure, the
20 denominator for home health was different than
21 from the other PAC providers. It included
22 patients who had not had an inpatient stay prior

1 to admission to home health, which does it make
2 it a different measure.

3 It's possible that population behaves
4 just like the population that came from an
5 inpatient facility, but we don't really know, so
6 if we could see some data about that or the
7 measure with the same denominator. If we're
8 going to be using it for comparison, that would
9 be important. Then we had one other concern
10 about potentially having unintended consequence
11 of reducing referrals to hospice because there's
12 more of an emphasis on having people not
13 discharged and bounce back to an inpatient
14 facility. We think that exclusion should be
15 anybody who's admitted to hospice at any time
16 during that 31-day window, even if they go from
17 the community to inpatient and back out to
18 hospice, they should be excluded because we don't
19 want to discourage hospitals from discharging to
20 hospice.

21 MEMBER ROBERTS: Just a little bit of
22 confusion. In looking at discharge to the

1 community, if you add the 31 days, you're really
2 looking at the durability of outcomes of keeping
3 somebody out in the community, which then does
4 have an impact on the re-admission measure.

5 If it's really just a measure of
6 looking at discharge to the community, it might
7 be better to keep it separate than adding those
8 31 days. The other piece that hasn't been
9 mentioned is discharge to the community has a lot
10 to do with social support, and that may need to
11 be considered in that.

12 MEMBER MULDOON: Perhaps the people
13 who worked on the details of this could answer
14 this. All post-acute settings will have, but
15 particularly LTACs because they already have, a
16 highly skewed outlier group. How do we solve the
17 double bind that encourages us to have a high
18 discharge to community rate, which means keep
19 someone longer -- so long that they can go
20 directly home versus the downside of that
21 strategy is that it drives up costs.

22 It increases length of stay in a

1 fairly high-risk setting, and that puts us at
2 some risk from retrospectal denial, instead
3 according to traditional criteria. You didn't
4 need to be there anyway. Why'd you keep them the
5 extra five days?

6 MEMBER LEVITT: I didn't know how you
7 wanted to do this, Carol, in terms of having more
8 comments or whatever. I can go through some of
9 them right now if you want.

10 MEMBER PALENA HALL: My comment was
11 more around the SES conversation. I just wanted
12 to point out that ONC recently published, later
13 in the fall of this year, its updated 2015
14 certification criteria and standards. Part of
15 that includes certification criteria and
16 standards around capturing race and ethnicity
17 data, as well as other social and psychological
18 and behavioral data. That would include items
19 such as financial resource strain, stress,
20 depression, physical activity, alcohol use, and
21 social connection and isolation, which might be
22 relevant to some of the SES conversation, so just

1 wanted to make you aware.

2 CO-CHAIR RAPHAEL: Alan.

3 MEMBER LEVITT: First of all, to
4 start, again, this is a measure that Congress has
5 mandated to be done. It is claims based. We
6 build our house with the Legos we have. I mean
7 Legos because they're all -- some of them are
8 attached to other Legos. You can't take off one
9 Lego without waiting for that Lego to do
10 something else with another Lego. You end up
11 building it the best you can, and we've done
12 that.

13 We've done that with our other
14 measures. In terms of acuity, Sean, obviously we
15 try to handle that, in terms of risk adjustment.
16 We do always worry about unintended consequences
17 of all of our measures, what's going to happen,
18 in terms of behavior. But again, this is
19 information that Congress feels -- and patients'
20 families want to know are they going to be able
21 to go home from a certain setting? Certainly,
22 that setting can also explain why they may be

1 best served not going home right away and to go
2 somewhere else, in order for them to continue to
3 get better.

4 As I'm saying, this is a measure we're
5 using for reporting and reporting to the public.
6 The issue with nursing home, it's true that
7 because we are using claims, and we are using the
8 code, as Suzanne mentioned, patients who are
9 either short or long-stay nursing home residents
10 that are discharged to a hospital, and then they
11 come back as a SNF patient, and then they get
12 discharged from the SNF to the nursing home, will
13 be counted as being discharged to the nursing
14 home.

15 How do we handle that? Well, a couple
16 of things. One is when we report this measure,
17 we can certainly -- our reporting of the measure,
18 as we do with measures, in terms of explaining to
19 patients and families what that means, particular
20 in a nursing home setting, that this does also
21 include nursing home residents who are discharged
22 back to the nursing home. So there's an

1 explanation that's given. Secondly, there are
2 certain nursing homes that do have a higher
3 percentage of patients that tend to get
4 transferred back to the acute-care hospital.

5 This measure indirectly may be able to
6 also recognize that there are certain nursing
7 homes that are doing that because they'll have
8 such a high rate of their residents that don't go
9 home because they're back to their place of
10 original residence. Again, that's a limitation
11 of claims.

12 As we continue to build our measures
13 with the Legos we have, we can continue to look
14 at that with the advice of the entire community
15 as to what we should do. Sorry, Liz, I forgot
16 the issue with home health. What was that again?
17 Very important issue.

18 For those of you not familiar with
19 home health, home health is an unbelievably
20 heterogeneous group, goes anywhere from a couple
21 of patients a year to thousands, tens of
22 thousands of patients. When we're sitting around

1 building our measures, we're trying to figure out
2 how can we include the largest group of home
3 health agencies, so they can be reported upon,
4 and also reported upon fairly? The referral into
5 a home health agency comes two ways. They come
6 from a hospital, and then they also come from the
7 community. I forget the exact stats, but it's
8 about 50 percent or more, actually, are community
9 referrals that come in.

10 If we went ahead and we did not
11 include the community referrals and just used
12 just the home health patients that came from
13 hospitals, we would have probably -- I think it
14 was about 44 percent of the agencies, even if we
15 used three years' of data, that would not be able
16 to report on this measure. By including all the
17 patients and doing the best we possibly can to
18 risk adjust -- because you're absolutely right,
19 Liz.

20 For the most part, they are different
21 types of patients. I do have stats of what the
22 differences are in their discharge rates, and

1 they are different. But what we do, like we
2 always do, is try to account for that difference
3 within our risk adjustment and, therefore, allow
4 to be able to report on as many agencies as we
5 fairly can. I'm not sure if there was anything
6 else.

7 CO-CHAIR RAPHAEL: Tara, did you want
8 to jump in?

9 DR. MCMULLEN: No, just to add to Dr.
10 Levitt's responses, we sent the specifications
11 and the risk adjustment model to Catherine.
12 Catherine, I emailed that to you. In the email,
13 I also listed out the risk adjustment and the
14 adjusters, highlighted the three adjusters for
15 function. LTAC is the only setting that we do
16 not currently have adjuster for function in our
17 risk adjustment model, but we're moving in that
18 direction, undoubtedly. So if anyone's
19 interested, that information, Catherine has that,
20 if she wants to disseminate to the group, or it's
21 on the CMS website.

22 CO-CHAIR RAPHAEL: Okay. I'm going to

1 ask Kim and Gene to be quick in their comments
2 because we need to move to a vote, so Kim first.

3 MEMBER ELLIOTT: I'll be really quick.
4 My only concern, when I look at these measures,
5 is that it might incentivize behavior that we
6 don't want. I know that there's a risk
7 adjustment model, but I haven't seen a lot of the
8 detail of that, so I will go to the CMS site to
9 look at it. I'm concerned that perhaps then we
10 will see facilities perhaps not wanting to accept
11 some of the patients that aren't necessarily
12 ready to discharge home or will be more
13 challenging to discharge home. I guess that
14 would be my comment.

15 CO-CHAIR RAPHAEL: The last comment on
16 this.

17 MEMBER NUCCIO: I'll be quick. I have
18 three psychometric concerns. One is in addition
19 to the risk adjustment model, the rationale for
20 choosing to use a numerator that's a
21 risk-adjusted estimate of performance, and then
22 several other risk adjustment kinds of values in

1 that particular metric.

2 The second has been brought up, the
3 difference in denominators across the multiple
4 settings. The third is sort of an overarching
5 issue. That is one of the goals of these
6 measures is to be publicly reported. I am very
7 concerned that with all the exclusions that are
8 being presented across these measures, we're
9 going to have a very accurate measure on a very
10 small portion of the population. That's my third
11 concern.

12 CO-CHAIR RAPHAEL: All right.

13 (Off mic comment)

14 MS. O'ROURKE: That is correct. If no
15 one has an objection to the staff's preliminary
16 analysis of encourage continued development,
17 there's not a need for a formal vote at this
18 time.

19 CO-CHAIR RAPHAEL: We are going to go
20 on to the next category, which has to do with
21 potentially preventable re-admission rates. I
22 think there are five, if I recall, measures under

1 consideration, so let me turn to the operator to
2 open the lines for public comment.

3 OPERATOR: At this time, if you would
4 like to make a comment, please press star, then
5 the No. 1. No, no public comments at this time.

6 CO-CHAIR RAPHAEL: Thank you. I'm
7 going to turn to the audience. Is there anyone
8 in the audience who wants to make a comment on
9 this? Anything in the chat box?

10 MS. IBRAGIMOVA: No, not at this time.

11 CO-CHAIR RAPHAEL: Okay, so Sarah, I'm
12 turning to you to give us an overview and the
13 recommendation of the staff.

14 MS. SAMPSEL: Sure. There are
15 actually four measures here, and again across the
16 same settings of home health, inpatient rehab,
17 long-term care and the skilled nursing
18 facilities. Again, these four measures were put
19 on a consent calendar for the IMPACT Act. Again,
20 the domain would be the potentially preventable
21 hospital re-admissions.

22 These are all safety measures, as well

1 as kind of overarching measures that address a
2 number of national quality strategy aims that I
3 think the industry has been trying to go towards
4 for some time. These are measures that the staff
5 have recommended, continued, or encouraged
6 continued development, based on where they are in
7 development and getting their specifications
8 finalized and going through the public comment
9 period.

10 These are all outcome measures, and
11 they are similar to currently endorsed measures,
12 so you should have found some notes in your
13 discussion guide based on the endorsement process
14 for those similar measures. I think the other
15 thing that I would just mention, again, is this
16 is part of, with the IMPACT Act, encouraging
17 alignment across the settings and summarize,
18 again, that our recommendation is to encourage
19 continued development and seek additional input
20 from the MAP workgroup on this.

21 CO-CHAIR RAPHAEL: Alan or Tara, do
22 you want to comment on this?

1 MEMBER LEVITT: Well, first of all, I
2 want to introduce Dr. Joel Andress. He used to
3 be here for ESRD, and we've lost ESRD, but we
4 still get to keep Joel, so we're very lucky.
5 He's part of the workgroup. I'm very interested
6 in the committee -- the committee has questions
7 and stuff, certainly Joel and I are both
8 available for it.

9 It's a similar type of description, a
10 similar type of rules of engagement, so to speak,
11 of what we are able to use and how we end up
12 designing these types of measures. Again, we've
13 successfully done these type of measures in other
14 settings for re-admissions, and now we've gone to
15 the potentially preventable. Did you want to add
16 anything, Joel?

17 CO-CHAIR RAPHAEL: Let me turn to the
18 workgroup and ask if any workgroup member would
19 like to pull any of the measures on the consent
20 calendar? All right, then let me open this up
21 for discussion. Suzanne?

22 MEMBER KAUSERUD: A few things that

1 applies to this measure and some other measures.
2 I very much so appreciate, having an 11 year old
3 and a 15 year old, my stepsons, at home, I very
4 much appreciate the Lego analogy. It makes a
5 whole lot of sense.

6 I think there's -- again, looking at
7 just claims data when there's such a rich dataset
8 out there with the other patient assessment
9 instruments, I hope that we will be able to move,
10 in the future, to be able to use some of that
11 information that's also collected off the IRF-PAI
12 or the MDS or the OASIS.

13 Because having additional information
14 about functional status, intended discharge
15 location, admission location, where they come
16 from before the acute-care stay, cognitive
17 function, the different complexities would be
18 valuable in this case and others -- or in this
19 measure and others. Additionally, potentially
20 preventable is kind of problematic just because,
21 again, running off the claims data, if we have a
22 spinal cord injury tetraplegic who is

1 unexpectedly admitted to acute care from
2 inpatient rehab for autonomic dysreflexia, the
3 acute-care claim is unlikely to say autonomic
4 dysreflexia. It might be hypertension or
5 something on the admission there. In this
6 scenario, something that we might not have been
7 able to prevent at all would look like a
8 preventable admission.

9 There are other areas, like -- what's
10 one that we talk about a lot -- the DVTs being
11 linked to inadequate prophylaxis. We're finding
12 -- and I think there's literature out there to
13 support it, as well -- that sometimes even when
14 you give adequate prophylaxis, you end up with a
15 DVT or PE in a certain percentage of the
16 population.

17 So there are some areas that might
18 have small numbers associated with them, but
19 could have an impact, particularly for smaller
20 providers, if they happen to have one case. I
21 think those are the key points that I wanted to
22 make. Oh, actually I did have one more question.

1 I guess just to clarify -- sorry, I'm looking at
2 my notes -- if you could clarify your intent
3 about replacing the existing IRF QRP measure with
4 this one, or will there be two re-admissions
5 measures in the quality reporting program?

6 CO-CHAIR RAPHAEL: Jim.

7 MEMBER LETT: Thank you, a couple of
8 things. You can cut me off and I'll come back
9 later if they get too many. Trust you on that,
10 please -- or trust me on that, that I will. A
11 couple of things. One, I always worry about
12 collateral effects, unintended consequences in a
13 measure like this.

14 We have to think about, No. 1,
15 emergency department and observation state
16 visits. Maybe you drive them up as you drive
17 down 30-day re-admission rates. Secondly, more
18 risk adjustment, particularly socioeconomic
19 status that has such a massive effect on quality
20 indicators. I would anticipate it'll have one on
21 transitions, but I have not seen, personally,
22 data on that.

1 I worry that unless you really, really
2 risk adjust, you're going to see facilities
3 decline complex medical patients coming to their
4 facilities if it's going to look very bad on
5 their re-admission data, particularly in rural
6 and urban areas, where there may not be an IRF or
7 an LTAC available, and they may, generously, to
8 keep people in their communities, take really
9 high-risk, complex patients, and unless they're
10 risk adjusted for that, there may well be a
11 problem. Second thing is, again, the definition
12 of community, and we have to resolve that. The
13 third thing, to me, comes -- and I will speak to
14 the SNF measures, not the home health one,
15 because I don't really feel I'm deep into that,
16 but I feel comfortable in the SNF area.

17 I'm concerned about double jeopardy
18 because when you look at 497, that is a
19 potentially preventable within the stay
20 re-admission measure, but you're also going to be
21 judged -- and forgive me, I don't have the
22 number. You're also going to be judged on 30-day

1 re-admissions, so is there a potential double
2 jeopardy in terms of one re-admission counting
3 against two measures?

4 I'm still unclear about assignation.
5 That is if a patient leaves the acute hospital
6 with a three-day qualifying stay, who then goes
7 to a SNF and stays a relatively short period of
8 time, that patient is discharged to the community
9 with a home health agency, and then that patient
10 is re-admitted to the hospital within a
11 relatively short period of time, is it really the
12 SNF's fault? Should they be assigned "the
13 penalty" because they, in good faith, completed
14 their treatment, handed them off to another
15 member of the post-acute community.

16 I'm not saying there's any fault
17 involved, but when you have let go of the
18 patient, handed them over with a warm handoff,
19 how can you control the re-admission to the
20 hospital if someone has left your facility a week
21 prior? Those were -- socioeconomic status we
22 talked about.

1 I'm sorry; I'm looking at my notes.

2 Oh, on 496, potentially preventable 30-day
3 post-admission re-admission measure, one of the
4 exclusions is patients who are transferred to the
5 same level of care or a hospital at the end of
6 their IRF stay. There is the same exclusion
7 under 498.

8 I didn't just technically understand
9 why they were excluded. Aren't those
10 re-admissions? The last, but not least, is the
11 potentially preventable definition, which I think
12 is really the devil in the details. I assume
13 we're talking about the ambulatory sensitive
14 conditions that MEDPAC came out with a number of
15 years ago. I'd like to hear a little bit more
16 about what's preventable. Thank you.

17 MEMBER ROBERTS: Within that IRF
18 measure, question. If that is a re-admission,
19 now they have a new one for within the IRF
20 measure. The IRFs already have a financial
21 penalty for people that are going back to the
22 hospital, so that would be a double penalty for

1 them, so that should be looked at.

2 CO-CHAIR RAPHAEL: Lisa.

3 MEMBER WINSTEL: Thank you. Just a
4 quick comment. With all due respect to Dr. Leff,
5 the handoff to home health issue, it could also
6 be that perhaps there was a premature discharge,
7 so that needs to be looked at from both sides.

8 I'm also wondering if there is some
9 way, on the home health measure, to take into
10 account the number of contact hours that were
11 part of the home health benefit. A re-admission
12 based on a home health benefit that is just six
13 hours a week that have not occurred yet, and
14 there is a re-admission in that interim time,
15 that home health agency should, perhaps, not
16 receive a penalty if the prescription and
17 recommendation for home health was insufficient.

18 MEMBER MULDOON: In the spirit of QI,
19 I want just everyone to recognize that the
20 providers will not know this rate until we're
21 told by CMS because we have no way of doing that
22 follow up. In order for us to do any QI on this

1 number that you will tell us, we're going to need
2 to know who the patients were, where they went,
3 so that we can then decide did we send them to
4 the right place or the wrong place. Otherwise,
5 we'll just read them and weep, not be able to act
6 on it.

7 CO-CHAIR RAPHAEL: Liza.

8 MEMBER GREENBERG: With this measure,
9 in particular, I feel like we're taking the term
10 potentially preventable to its furthest extreme
11 because we really have gone beyond where the
12 evidence falls on what's preventable,
13 particularly in home health, which is the sector
14 I'm commenting on.

15 There really isn't any strong evidence
16 about what happens 30 days after a discharge from
17 home health, and there could be so many
18 intervening interactions with that patient. To
19 the extent that we do know how to keep people
20 from having re-admissions, it's really condition
21 specific. We've taken a population that we -- or
22 a setting we don't much about, post-discharge

1 from home health, and added it to the conditions
2 of interest very substantially. We know the most
3 about CHF and certain acute conditions, but less
4 about the pretty broad portfolio that are in this
5 measure. I have some concerns about the strength
6 of the evidence for the full continuum of the
7 measure.

8 MEMBER GRANT: I guess I just want to
9 build on this question and concern about
10 potentially preventable. I'd like to know if
11 it's tied to very specific diagnoses and those
12 diagnoses are evidence based, if they are the
13 same diagnosis across all settings.

14 CO-CHAIR RAPHAEL: Building on that,
15 as I sort of thought about this, one of the
16 issues for me is in home health care, you rarely
17 get someone with one diagnosis. Even though they
18 come in because of COPD or CHF, they have three
19 or four other key conditions that they're
20 grappling with. I think one of the challenges
21 will be how do you separate out what's
22 attributable just to that COPD episode and what

1 is not attributable to that COPD episode in the
2 real world. I think that's one thing that I
3 think gets tangled up. The other for me that
4 gets tangled up is that so much care in home
5 health is also provided by caregivers, who are a
6 very broad group these days.

7 And so, if they don't know how to
8 flush a catheter, or they haven't really been
9 prepared well for what can be difficult medical
10 tasks, or they just haven't been instructed on
11 what you can expect as side effects of
12 medications, very often, their default position,
13 they panic, and they just call 911, in our
14 instance, and the person lands back in the
15 emergency room. So it's how to prevent that
16 default from occurring. Not that we can -- any
17 kind of measure can, in fact, deal with all of
18 those, but I think we do need to be mindful of
19 some of those issues as they play out. So now to
20 you, Alan and Joel.

21 MEMBER LEVITT: I'm going to pass it
22 to Joel, and then Joel can pass it back.

1 DR. ANDRESS: Can I do that right now?

2 Actually, I want to kind of address on one very
3 particular issue before we get started. I
4 believe we have RTI on one, and we've got Abt,
5 which is another contractor that worked on the
6 measure. I'll actually begin with discussing the
7 technical specifications on how we define PPR.
8 But we essentially had a list of diagnostic codes
9 that were viewed by our technical expert panel in
10 order to identify what codes were likely to
11 reflect a re-admission that was potentially
12 preventable.

13 To the issue of preventability, in
14 general, I think it's important to note that this
15 was an early and quite vibrant discussion within
16 the TEP. I'll say not necessarily in the
17 direction that I was anticipating, given the
18 feedback I've gotten in other -- among other
19 groups on re-admissions.

20 Also they had some trepidation on the
21 very concept of identifying a potentially
22 preventable re-admission measure, particularly

1 using diagnostic codes since, of course,
2 diagnostic codes are neither designed nor built
3 for the purpose of identifying preventability.
4 Though, if we implement these measures, that
5 thinking would change.

6 I think the issue is that it's not
7 condition specific in all ways. Some things are
8 certainly condition specific, in terms of the
9 clinical care you're providing your patients, but
10 it's also process specific. How is the flow of
11 information being handled as patients are moving
12 from one setting to another? In that case, I
13 think to some extent, you could make an argument
14 that most re-admissions are potentially
15 preventable within that framework.

16 Now does that mean that, from a
17 particular set of diagnostic codes, every
18 re-admission would have been preventable by the
19 facility if only they'd done their job better? I
20 think that the answer's probably no, and that's
21 why we originally developed the all cause
22 re-admission measures, because we recognized

1 there was going to be some fuzz, and they were
2 designed to deal with what we thought was
3 generally distributed noise within the measure.

4 There would always be patients who
5 were unpreventable, to one extent or another. I
6 think the concept of preventability, therefore,
7 has been addressed pretty broadly in the
8 development of the all cause measures. I just
9 wanted to make the point that it's not -- I don't
10 think it's really, and the TEP, I think, was
11 generally supportive of this, it's not about the
12 condition. It's about the processes that occur
13 as you're treating patients with the condition.

14 The fact is that some processes are
15 common across most, if not all, conditions that
16 patients are treated for in your settings. I
17 just wanted to kind of hit on that before I went
18 after the -- I went after, kind of sounds
19 adversarial -- before I address some of the
20 concerns that have been raised here.

21 First of all, the idea, I think, of
22 using just claims data, as Alan has pointed out,

1 we've got what we've got. We'd like to have
2 more, of course. There are some areas in which
3 we anticipate having more available to us
4 shortly. I think the standardized functional
5 data that we're anticipating, again, as part of
6 the IMPACT Act, is something we're certainly
7 interested in.

8 With these measures, where the claims
9 data currently give us access to functional
10 status information about the patients, we've
11 incorporated those in the risk adjustment.
12 They're not standardized. They're not common
13 across all settings, and not all settings have
14 them, but we certainly look forward to having the
15 data that will be collected in the future for
16 consideration in risk adjustment. That was
17 something that was addressed at the TEP, and
18 certainly they were interested in seeing the
19 measure augmented. Also, point out there's some
20 concerns about the timeline, in terms of how this
21 has been rushed.

22 We've already invited the TEP members

1 to continue working with us for further
2 development and modifications of these measures.
3 We anticipate that there will need to be things
4 that we look at that we simply haven't had time
5 to address yet, which is, I think, as close as I
6 can get to saying the timeline was not terribly
7 beneficial to the development of the best measure
8 possible.

9 The other area that is impacted by
10 this is socioeconomic status. As most of you are
11 aware, we've talked about the different process
12 that are ongoing. I'll simply say specifically
13 for the all cause re-admission measures that are
14 already endorsed by NQF, we have submitted
15 analytical plans for addressing socioeconomic
16 status analyses over the course of the next
17 couple of years. Our intention is to mirror
18 those with the potentially preventable
19 re-admissions measures. We have done the
20 analyses that we can currently do with the
21 dataset we have. Unfortunately, most of the
22 analyses we're interested in doing will require

1 additional data sources that we'll need to roll
2 into it, and we haven't had time to address them
3 yet.

4 Which is why we invited the TEP to
5 join us in continuing development work as we look
6 to augment the measure with a variety of areas in
7 SES, not just income, but also area information
8 and other characteristics that we can discuss for
9 some time. I think in terms of clarifying the
10 intent of whether or not we're going to replace
11 the all cause re-admission measures with these
12 measures, I don't know the extent to which we can
13 actually get into the rule-making issue.

14 I think the answer to that is that --
15 the best answer I can give to that is that we're
16 certainly aware of the potential for confusion
17 with the measures. I think there's potentially
18 some value, at least analytically, in having both
19 measures being tracked, because we can finally
20 get into the true value of identifying that
21 potentially preventable measure, versus an all
22 cause measure. Are they truly that different?

1 Do facilities look different in their
2 performance? Does it have a differential impact
3 in the programs where it's implemented? What
4 that's going to mean in terms of what's being
5 publicly reported I can't say, certainly not
6 across four programs in the immediate, but it's
7 certainly something we're aware of.

8 Unintended consequences, observation
9 stays and ED visits, this was something we
10 considered very early on in the process, when we
11 were thinking about these measures and what the
12 statute allowed us to do. The statute very
13 specifically calls out re-admissions, as opposed
14 to hospitalizations. So it was our understanding
15 of the measures, as we had to develop them for
16 the IMPACT Act, that we needed to limit our view
17 to hospital re-admissions.

18 We have been aware of observation
19 stays and ED use issues for some time, and we're
20 continuing to track them analytically, if not in
21 a measure. Although, as I think the home health
22 team will be aware, we are, in fact, tracking

1 them with a home health ED use measure. Those
2 are additional measures that may continue in
3 development in the future. I think they may, in
4 fact, be worthwhile, although the rates of
5 observation stays up until now, in the data we
6 have, remain relatively small, in the order of 1
7 or 2 percent of events. They are, however,
8 increasing within that limited scope.

9 In terms of -- getting back to this
10 issue of the lack of SES adjustment and the
11 potential for facilities to decline complex,
12 high-risk patients, I would point out that -- and
13 this has been raised before, and it'll be raised
14 again, I suspect. There are a lot of facilities
15 that do accept a lot of those patients and
16 perform very well on re-admission measures,
17 hospital mortality measures, and the
18 complications measures that work in a very
19 similar fashion.

20 I think what we're going to end up
21 finding is we're probably going to end up risk
22 adjusting for SES in some fashion someday, and

1 the SES adjustment will have a much more muted
2 impact than people are expecting it to have. The
3 conversation's then going to turn about whether
4 or not we're risk adjusting for the right
5 elements of SES to capture the variation. But I
6 will be honest. I don't know -- I don't know
7 that the risk adjustment for SES is going to have
8 the program impact for facility assessment that's
9 hoped for, but that's why we do the analysis,
10 because my opinion isn't really what matters.

11 To the issue of double jeopardy, I'll
12 note that most of these measures are going to
13 quality reporting. Your performance doesn't
14 actually penalize you on these programs, as far
15 as I'm aware. It's just that if you reported the
16 data which, of course, you're reporting because
17 you like to get paid, and these data require
18 claims data, which you're already submitting, or
19 hospitals are submitting because they like to get
20 paid, too -- in that sense, double jeopardy is
21 not there.

22 For the SNF re-admission measures,

1 there's sort of a special thing going on that
2 we've talked about, with regard to the
3 implementation of the 30-day hybrid measure in a
4 VBP program, as the only measure. If I had my
5 druthers, I think we'd probably do two combined
6 measures, where you had a within the stay, and
7 then a post-discharge measure, and they kind of
8 sat together.

9 Alas, the statute does not allow that.
10 So we built that measure with the intent of
11 making the measure as resistant to potential
12 gaming as possible. If we had used a within the
13 stay definition, which I think has been suggested
14 on multiple occasions, you end up with a measure
15 where the best move for a SNF that wants to avoid
16 a re-admission is to discharge the patient early,
17 which we probably don't want to have happen.

18 MEMBER LEVITT: Joel, is there any way
19 that the workgroup, if they have other questions,
20 they can get them to you?

21 DR. ANDRESS: Sure. I have an email.
22 My name is -- we can do that.

1 MS. O'ROURKE: Sure. If you have
2 remaining questions, send them to the MAP PAC/LTC
3 mailbox, because that way the whole project team
4 can access that, and we'll compile them and work
5 to get them to CMS.

6 MEMBER LEFF: Just a technical
7 question on the risk adjustment. Does the model
8 account for number of transitions that someone
9 has? We had done some work years back on home
10 health transitions, and patterns can be very
11 complicated. So someone who goes from a
12 hospital, to a SNF, to home health in the
13 community is probably someone different who goes
14 from the hospital to SNF, directly home, sort of
15 in the way that if you're flying from here to the
16 West Coast and you have two stops to make versus
17 a non-stop, the odds of you getting screwed up go
18 up exponentially, probably. I was just curious
19 if that's part of the model?

20 DR. ANDRESS: So I'll say at present,
21 it is not. We simply require that there have
22 been an acute-care discharge, in the case of the

1 within the stay measure I think you're -- not the
2 within the stay, the post 30-day discharge. We
3 simply require there have been an acute-care
4 discharge within 30 days prior to the start of
5 the post-acute-care stay.

6 CO-CHAIR RAPHAEL: Erin wanted to make
7 an announcement before we broke for lunch.

8 MS. O'ROURKE: Yes, I just wanted to
9 give a reminder that we have lunch provided for
10 the workgroup members and NQF staff members
11 supporting the meeting. Members of the public,
12 if you need a recommendation for where you can
13 get a quick lunch before we reconvene, please see
14 our meeting staff at the front desk.

15 CO-CHAIR RAPHAEL: We are going to
16 reconvene at 1:00.

17 MS. IBRAGIMOVA: One more announcement
18 is that we have, also, dinner reservations for
19 workgroup members tonight at 6:30 at Mio. That's
20 1110 Vermont Northwest, a few blocks away. So if
21 you do come --

22 CO-CHAIR RAPHAEL: Wait, repeat that

1 again.

2 MS. IBRAGIMOVA: It's Mio.

3 CO-CHAIR RAPHAEL: Spell it.

4 MS. IBRAGIMOVA: M-I-O. We can email
5 the --

6 CO-CHAIR RAPHAEL: 1110 --

7 MS. IBRAGIMOVA: 1110 Vermont
8 Northwest. It's a few blocks away. We can email
9 the address to the workgroup.

10 CO-CHAIR RAPHAEL: What time?

11 MS. IBRAGIMOVA: 6:30. So if you plan
12 on attending, please let us know. We have those
13 reservations set. Thanks.

14 CO-CHAIR RAPHAEL: Okay, thank you.
15 We'll resume at 1:00.

16 (Whereupon, the above-entitled matter
17 went off the record at 12:29 p.m. and resumed at
18 1:00 p.m.)

19 CO-CHAIR RAPHAEL: Okay, we're going to
20 resume our meeting. Can I ask all of the
21 workgroup members to take your seats? First of
22 all, I'd like to thank NQF for a really delicious

1 lunch. A number of workgroup members commented
2 on what they thought was a particularly delicious
3 lunch, so thank you to whoever is responsible for
4 that. Secondly, we've had a new workgroup member
5 join us, Sandy Markwood. Welcome, Sandy. I
6 think we just need you to do disclosure.

7 MEMBER MARKWOOD: Is there something
8 formal you need me to say?

9 MS. O'ROURKE: Basically, what we
10 would need you to do is introduce yourself, the
11 organization you're representing, and then if you
12 have any conflicts of interest or disclosure
13 about anything pertinent to the work of this
14 workgroup.

15 MEMBER MARKWOOD: Sure. Good
16 afternoon, Sandy Markwood. I'm the CEO of the
17 National Association of Area Agencies on Aging,
18 so I'm representing community based
19 organizations. I am pleased to be on the
20 workgroup, and I have nothing to disclose that is
21 a conflict with this meeting or this committee.

22 CO-CHAIR RAPHAEL: Thank you, Sandy.

1 I understand, Pam, you had a modification in your
2 disclosure.

3 MEMBER ROBERTS: Just to be totally
4 transparent, I just wanted to disclose I did
5 pilot the care tool. I was one of the
6 demonstration sites. I've also been a UDS
7 contractor, and I also am on the NQF
8 re-admissions committee.

9 CO-CHAIR RAPHAEL: Thank you. It's
10 been brought to my attention that during the
11 public participation part that involved the
12 potentially preventable re-admissions measure,
13 that there were some people in the audience who
14 wanted to make comments, and for whatever reason,
15 where they were stationed, it wasn't obvious that
16 they wanted to participate.

17 So we need to just backtrack and make
18 sure that anyone in the audience who wants to
19 comment on that IMPACT-related potential
20 preventable re-admissions measure has an
21 opportunity to do so. This time, make sure you
22 come right to the mic, okay?

1 MS. FEDELI-TURIANO: Good afternoon.
2 In the interest of time, I will be very brief.
3 I'm Nicole Fedeli-Turiano from University of
4 Pittsburgh Medical Center. Just in regard and
5 with respect to the PPPR, we would just, again,
6 like to re-affirm and recommend that the measure
7 be narrowed, perhaps, to three or four conditions
8 currently, such as COPD, CHF, pneumonia,
9 diabetes, those chronic-care pieces that were
10 already in the home, as a home health provider,
11 to care for.

12 We believe, in respect to the comment
13 made about the Legos, I'd like to just take that
14 inference -- put a little different twist on it,
15 in terms of looking at the capabilities of the
16 home health agencies, in respect to the current
17 home health PPS and the clinical and functional
18 domain thresholds and just take note that it's a
19 little daunting, with the tools in our current
20 toolbox, to figure out how we're going to expand
21 -- to all of those measures, like adverse drug
22 events, UTI.

1 I'll just take one moment to give a
2 pertinent example with adverse drug events.
3 Perhaps we categorize being held accountable for
4 those re-admissions related to drug events in
5 which the drugs that the patient was on during
6 the time of our service, certainly we would take
7 accountability for that, but extending that -- I
8 could just play out a scene where that patient
9 would go visit their PCP on Day 46 and he or she
10 would prescribe a new med.

11 That patient would then have an
12 adverse event and be re-admitted, and it would
13 somehow reflect on us because there would not be
14 that communication there. So we are very
15 cautionary about that. Again, we also, perhaps,
16 look at what's coming down the pipe with the
17 Senate Primary Care legislation that's due out at
18 this week, at least draft language, and are
19 hopeful that some of the tenets in that will
20 allow us to better, as post-acute providers, be
21 able to broaden our scope and really be
22 patient-centered care, since they're going to

1 extend some payment to chronic care.

2 We're very hopeful about that. But we
3 just would caution that in our current status,
4 and within the parameters that we are covering,
5 the home health piece, we have concerns about
6 being able to be accountable for all of those
7 measures on the PPPR. Thank you.

8 CO-CHAIR RAPHAEL: Is there anyone
9 else in the audience who wanted to comment? All
10 right.

11 CO-CHAIR SALIBA: Next on the agenda
12 for today is measures under consideration for the
13 inpatient rehab facility quality reporting
14 program. We were going to start with public
15 comments, as we've been doing so far today.
16 Operator, is there anyone on the line that wants
17 to make a public comment?

18 OPERATOR: If you'd like to make a
19 public comment at this time, please press Star 1
20 on your telephone keypad. There are no public
21 comments.

22 CO-CHAIR SALIBA: Thank you. Are

1 there members of the audience that want to make a
2 comment?

3 MR. BAIRD: I think I'm the only one.
4 My name is Andrew Baird, again. I'm with
5 HealthSouth. We are a large inpatient rehab
6 facility provider across most of the country.
7 This is just a technical point for consideration
8 about this measure, and it has to do with a
9 unique admission time frame that works within the
10 IRF payment system. The measure specification
11 document states that the IRF within stay measure
12 is intended to capture re-admissions within the
13 stay. However, it does not include precisely
14 when the stay begins.

15 IRFs are relatively unique, in that
16 they have a special three-day period for which
17 clinicians can determine whether or not a patient
18 who has come to their facility actually meets IRF
19 coverage criteria, and then if something between
20 when they arrive and when they are formally
21 admitted, something occurs where the patient may
22 no longer meet such coverage criteria, they are

1 paid at a much reduced rate, and the patient can
2 potentially go to another site of care, sometimes
3 back to the hospital, if necessary.

4 This policy is really intended to help
5 make sure that the people who are going to be
6 admitted to IRFs are correctly admitted to IRFs,
7 because there's a long list of very specific
8 criteria that IRF patients need to meet. Because
9 the measure specification does not indicate
10 precisely when the re-admissions measure should
11 start measuring quote, unquote, within stay
12 measures, we think it would be appropriate to
13 start on Day 4, instead of the day that they show
14 up, in order to account for this pre-existing
15 policy that is already designed to tenor the
16 payment and, therefore, sort of penalize IRFs for
17 bringing in people who potentially do not meet
18 the IRF coverage criteria up front. It's just,
19 again, a technical point, but I think it's
20 something that the way that the measure is
21 specified doesn't account for that very unique
22 IRF admission time frame. Thank you.

1 CO-CHAIR SALIBA: Are there any other
2 comments from the audience? I'm going to hand it
3 over to Katie Streeter to orient us to this
4 section.

5 MS. STREETER: Thank you. There's one
6 measure on this consent calendar. It is the
7 potentially preventable within stay re-admission
8 measure for inpatient rehab facilities. This
9 measure is in early development, so the staff
10 recommendation is encourage continued
11 development. The reason why this measure is by
12 itself is because it is not required under the
13 IMPACT Act and, therefore, did not fit with the
14 other groupings.

15 CO-CHAIR SALIBA: All right. Alan and
16 Tara, any comments for CMS about this?

17 MEMBER LEVITT: I'll play Joel, since
18 Joel's not here. Anyhow, this, again, is within
19 -- oh, Joel.

20 CO-CHAIR SALIBA: Somebody put Joel in
21 the corner.

22 MEMBER LEVITT: Let's see how well I

1 do, Joel. This is a within stay measure.

2 Regarding the three-day period, as former, IRF
3 leader, so to speak, in my unit, the three-day
4 rule is a financial -- is really financial, not
5 quality based. From the patient and the family
6 standpoint, having to bounce back, as we used to
7 call it, due to medical complication, they don't
8 -- they look at it as a medical complication.

9 The IRF does have a responsibility --
10 again, it's all attribution, it's not all or none
11 -- in terms of when accepting a patient, to try
12 to accept patients who are medically stable
13 enough to tolerate the rehab program. Sometimes
14 we make the right decision, and sometimes we
15 don't. But again, it's felt that we really
16 should include that window within a stay because
17 it is potentially preventable. I'll be able to
18 talk about any other comments, or Joel will,
19 coming up from the workgroup.

20 CO-CHAIR SALIBA: Thank you. I'm
21 supposed to ask if anyone wants to pull any
22 measures. We only have one measure. Does anyone

1 want to remove this measure from the consent
2 calendar?

3 (No audible response.)

4 CO-CHAIR SALIBA: Okay, so now the
5 floor's open for discussion. Does anyone have
6 any comments or questions about this measure?

7 MEMBER KAUSERUD: I think, on behalf
8 of the American Medical Rehab Providers
9 Association, we did have the similar concern,
10 which Alan has addressed, about those first three
11 days. Really, in thought about measure, there's
12 kind of two phases. I just kind of provide this
13 for background; we participate in EQUATOR, the
14 exchange data for rehab quality database.

15 They look at this measure in two ways.
16 There's a first three days transfer back to acute
17 care, and then after three days. The theory is
18 that within the first three days, it's more about
19 the admission decision and/or care in acute care,
20 whether that's been wrapped up and completed.
21 But then after three days, it's more result of
22 either things that were maybe not managed in

1 inpatient rehab or that weren't avoidable at all.
2 As a quality view, we kind of look at it as two
3 portions. In that way, also, those first three
4 days, it's just kind of a different reason, one I
5 think is more about the admission and the patient
6 stability at admission, and the other one is more
7 just about ongoing care.

8 We feel like the measure, as it's
9 going -- I know right now it wouldn't be a
10 penalty, but again, just that piece about the
11 double jeopardy, if it's a re-admission quality
12 metric in pay for performance in the future, just
13 worried about that double penalty, as far as
14 taking the reduced payment for the stay, and then
15 also, perhaps, the impact of the quality metric.
16 That's it for me.

17 CO-CHAIR SALIBA: Thank you. Any
18 other questions or comments about this measure?
19 Jim?

20 MEMBER LETT: More a matter of
21 understanding how it's reported out. If I'm
22 reading this correctly, it's not reported out as

1 the traditional percentage of re-admissions. It
2 will be a ratio of what you actually -- how you
3 actually performed to an expected number for the
4 average facility, which seems a little
5 convoluted, and I had to read it several times
6 before it started to make sense. I was curious
7 as to why that was felt to be a more effective
8 way, rather than the traditional percentages
9 we've kind of all grown up with? How is it risk
10 adjusted for an average facility?

11 CO-CHAIR SALIBA: Alan, if you want to
12 go ahead and jump in?

13 MEMBER LEVITT: If you have an hour,
14 we can have Mel Ingber go over the expected
15 versus predicted. Joel, do you want to just
16 respond quickly? This is, again, what --

17 DR. ANDRESS: You know you're in
18 trouble when I'm the succinct one.

19 (Simultaneous speaking.)

20 MEMBER LEVITT: -- we've been doing
21 with all of our re-admission measures, in terms
22 of expected and predicted and ratio of it.

1 DR. ANDRESS: A measure like this can
2 be expressed in one of two ways, and we've done
3 both in different programs. I think we're trying
4 to standardize those going forward. You can have
5 a risk ratio, which is -- as you say, it's a
6 value set about 1.0, where your performance is
7 relative to everyone else. What you can do with
8 that ratio, and what is done for the hospitals in
9 their measures historically, is you standardize
10 against the national raw rate. Sans risk
11 adjustment, you look at the national raw rate,
12 just multiply all the ratios by that, and that
13 gets you the facility rate for that year. It's
14 only good for that year.

15 The next year, you have to recalculate
16 the raw rate and put it forward. You can
17 actually get a rate value out of this. It slips
18 my mind. I don't recall. Alan, did we finalize
19 in the rule that this was going to be reported as
20 a ratio? Because I think it's actually -- if
21 memory serves, we're actually reporting this as
22 -- going to report this as a rate.

1 MEMBER LEVITT: This has not been --

2 DR. ANDRESS: Has not been finalized
3 in the rule?

4 MEMBER LEVITT: Right, has not been
5 proposed.

6 DR. ANDRESS: That would certainly be
7 something to discuss for the rule-making process,
8 but you can report the measures either way. It's
9 equally appropriate, from a statistical
10 perspective, but of course, ratios have some
11 unique difficulties in being interpreted by a
12 broader population.

13 CO-CHAIR SALIBA: Jim, does that get
14 your question?

15 MEMBER LETT: Sort of. Just to be
16 clear, RAR is risk-adjusted ratio? You used the
17 term RAR, I thought. That's risk-adjusted ratio?

18 DR. ANDRESS: Sorry, Alan was holding
19 us up there.

20 (Laughter.)

21 CO-CHAIR SALIBA: I said raw. What
22 you do is you take the --

1 MEMBER LETT: I apologize. It's
2 R-A-W, not R-A-R.

3 DR. ANDRESS: Right. You use the
4 inclusion and exclusion criteria of the measure
5 to define what the raw numerator and denominator
6 is for the country. You calculate that, and
7 that's your raw national rate. You just multiply
8 a facility's ratio by that. If the facility has
9 a ratio of 1.5, and the national rate is 10
10 percent, then the facility's rate is 15 percent.

11 MEMBER LETT: So there is a single
12 risk-adjusted, expected re-admission rate across
13 the country, rather than extrapolated to
14 different size facilities, rural versus urban
15 versus suburban?

16 DR. ANDRESS: The national rate is not
17 risk adjusted because you're not comparing
18 facilities, you're just calculating the raw
19 national rate. It's not -- you don't need to
20 account for differences. You just need to know
21 what the actual rate of re-admission is for the
22 country. Then the risk adjusted portion is

1 embedded within the ratio. The risk adjustment -
2 - keeps effect there, you're just multiplying it
3 by the national rate so that it's easier to
4 interpret.

5 MEMBER LETT: So each facility should
6 be risk adjusted, in order to be compared to the
7 national rate? We've already talked about the
8 difficulty around socioeconomic status may be way
9 off in an urban or a very rural nursing facility.

10 DR. ANDRESS: Right. If you included
11 SES or anything else in the risk adjustment, it
12 would be embedded within the facility risk ratio,
13 and then you're just multiplying it by the
14 national rate. All that does is it makes it
15 easier to interpret what you're looking at. The
16 multiplication of the national rate has no -- it
17 has no consequences for the facility's
18 performance relative to other facilities,
19 because they're all being multiplied by the same
20 thing.

21 CO-CHAIR SALIBA: Any other questions
22 or comments? Hearing none, we'll move on, unless

1 someone had other concerns.

2 (No audible response.)

3 CO-CHAIR SALIBA: The next item on the
4 agenda is the skilled nursing facility quality
5 reporting program. There's several measures in
6 this consent calendar, including functional
7 outcome measure, change in mobility score, a
8 change in self-care score, discharge mobility
9 score, discharge self-care score, facility
10 residents who received an antipsychotic
11 medication, percent of skilled nursing residents
12 who self-reported moderate to severe pain, and
13 SNF residents who were assessed and appropriately
14 given the influenza vaccine. I'd like to ask the
15 operator to open the lines for public comment,
16 measures under consideration for the SNF QRP,
17 quality reporting program.

18 OPERATOR: At this time, if you'd like
19 to make a comment, please press star, then the
20 No. 1. There are no comments at this time.

21 CO-CHAIR SALIBA: Thank you. I'd like
22 to open the floor to the audience for comments,

1 please.

2 MS. POTTER: Hi. I'm D.E.B. Potter.
3 I'm from the Office of the Secretary for Planning
4 and Evaluation. I'm also a member of the MAP
5 duals workgroup. First of all, let me just say
6 I'm here reporting as an individual. You should
7 not take my comments as the official position of
8 the Office of the Secretary, please.

9 I'm here to speak specifically to
10 Measure 1133, which is the use of antipsychotics
11 in the nursing home population. First of all, I
12 think this is a very important concept, and I do
13 not at all disagree with the importance of it. I
14 also do not disagree with continued development
15 of the measure. I recognize the importance of
16 this measure for the dementia population, but I
17 am specifically concerned about the behavioral
18 health population.

19 As this measure is currently
20 specified, it excludes the population with
21 schizophrenia, Tourette's, and Huntington, but it
22 does not exclude the population with bipolar

1 disease. The Food and Drug Administration has
2 approved antipsychotics for the care of people
3 with bipolar disease. Clinical guidelines
4 recommend the treatment of bipolar disease with
5 antipsychotics. NQF has actually endorsed a
6 measure, NQF 211, that's specific to the nursing
7 home population and the use of dementia was a
8 physician quality alliance measure, however, that
9 measure does not exclude the bipolar population.

10 Finally, there's two other NQF
11 endorsed measures, 1932 and 1927, that are
12 specific to the schizophrenia and bipolar
13 population and their use of antipsychotics. So I
14 recommend that CMS continue development of this
15 measure, as well as the two similar measures that
16 are on Nursing Home Compare, and that they
17 include the bipolar population as an exclusion
18 population.

19 I'm concerned that the population with
20 serious mental illness will not necessarily get
21 the treatment they need in a nursing home if they
22 include or exclude, depending upon that

1 population. I want the population with dementia
2 to get good care, but I also want the population
3 with bipolar disease to get good care. Thank
4 you.

5 DR. GIFFORD: My name is David
6 Gifford. I'm going to wear two hats here. I'm
7 going to distinguish them. My first hat is as a
8 MAP member. I'm to exercise my MAP thing and
9 actually pull some of these things off the
10 consent calendar for discussion, Measures 1131,
11 1132, and 1133, pain, influenza, and
12 antipsychotic should be pulled off and voted as
13 fully developed measures.

14 They are fully developed, and they've
15 been approved by NQF in the past. They are in
16 use right now on Nursing Home Compare, so had the
17 discussion there. On the fourth IRF measures,
18 I'd also say -- and this was clarified in the
19 last MAP meeting -- when there's NQF endorsed
20 measures on the same topic, as alluded to in a
21 previous speaker, this workgroup should consider
22 those measures, not just the measures brought

1 forth by CMS in the discussion.

2 There are five other measures that are
3 based off the care tool for functional
4 improvement in self-care and mobility, NQF
5 Measures 2613, 2612, 2286, 2287, and 2232, that
6 should have discussion about the merits. I'll
7 take off my hat and put on my AHCA hat. We
8 strongly support the influenza and pain measure
9 being approved without any conditions. The
10 antipsychotic measure should get support with
11 conditions with the bipolar, as the previous
12 speaker added as an exclusion that measure. Then
13 I think the discussion, we would just support a
14 more robust discussion or some sort of alignment.
15 Because right now, all the functional measures in
16 the PAC setting that have been endorsed by NQF
17 are based off the care tool.

18 Most of them are based off the full
19 complement of the care tool. Last year, CMS
20 added Section GG to all the post-acute assessment
21 measures. They did differing items for the
22 mobility and self-care. They don't match. I

1 mean, when they're the same, they're the same,
2 but they don't have the same full listing.

3 So none of the measures, when they
4 were specified or approved by the NQF panel, they
5 were setting specific endorsed, even though some
6 of the measure developers brought forth that the
7 measure should be elsewhere. So I think there
8 needs to be some harmonization of those measures
9 in the approach going forward. That would be a
10 condition that we would advocate for this group
11 as they vote on those measures.

12 MR. HILLMAN: Hi, my name's Troy
13 Hillman. I'm from the Uniform Data System for
14 Medical Rehabilitation. I echo some of the
15 comments that were made by Mr. Gifford for your
16 consideration, related to the endorsed measures
17 that are already within the portfolio and whether
18 or not competing measure discussions need to
19 continue, such that a best-in-class measure is
20 chosen for functional assessment.

21 I'd also like to further draw some
22 specific attention to the mobility measures.

1 When we were discussing the mobility measures,
2 one of the things we wanted to point out is that
3 there are 15 individual items, care tool-based
4 items or care tool functional items, utilized in
5 this measure. Eight of those measures are
6 specific only to those patients who are walking
7 at the time of their stay.

8 Based on data that's in the Uniform
9 Data System database for inpatient rehab
10 facilities, roughly 20 percent of those patients
11 utilize a locomotion mode of wheelchair, meaning
12 those wheelchair-dependent patients will only be
13 assessed on half of the items utilized in each of
14 these measures, both the discharge measure and
15 the change measure, suggesting that it's possible
16 that those wheelchair-dependent patients are not
17 considered, and the outcomes that these types of
18 patients will come up with, the outcomes that
19 they'll see will be substandard to those patients
20 who are walking during their stay in inpatient
21 rehab and SNF, and if this is an IMPACT Act
22 measure going forward, in home health and LTAC,

1 as well. We definitely want you to consider that
2 as part of the measure calculation discussion and
3 thank you so much for your time.

4 CO-CHAIR SALIBA: Any other comments
5 from the audience?

6 (No audible response.)

7 CO-CHAIR SALIBA: Okay, thank you.
8 We had a couple of suggestions, and I'm going to
9 hand it over to NQF to advise us.

10 MS. O'ROURKE: Yes, just a few
11 procedural points here. Only members of the
12 post-acute-care, long-term care workgroup can
13 pull measures off of the consent calendar for
14 this meeting, so if you agree with the public
15 comments that 1133, 1131, and 1132 should be
16 pulled for discussion, we'd look for a workgroup
17 member to also make that recommendation.
18 Coordinating committee members can consider their
19 measures at their meeting. At this meeting, this
20 is the -- the ability to pull measures lies with
21 post-acute-care, long-term care members, not all
22 MAP members, generally.

1 (Off mic comment.)

2 MS. O'ROURKE: I think there was some
3 misunderstanding. Coordinating committee members
4 can pull at -- every MAP member can pull at their
5 own meeting, to clarify. Coordinating committee
6 members will be able to review all of the
7 measures under consideration at their meeting and
8 pull anything that they have concerns about.

9 However, there's no cross-workgroup
10 pulling, if that makes sense. The chance for
11 coordinating committee members to review would
12 come at their meeting. Similarly, PAC workgroup
13 members can't pull things from the hospital
14 workgroup's consent calendars, and so on and so
15 forth, only your own workgroup meetings can you
16 pull off of the consent calendar.

17 CO-CHAIR SALIBA: Thank you. What I'd
18 like to ask -- we're in the process of discussing
19 the items. Before we talk about the consent
20 calendar, I guess I would ask if there were any
21 comments from CMS?

22 DR. MCMULLEN: Alan and I are both

1 going to handle this. Do you want us just to do
2 global comments on all the measures, or do you
3 want us to --

4 (Simultaneous speaking.)

5 CO-CHAIR SALIBA: Yes, just some
6 global comments to get started before we decide
7 about the consent calendar issue, and then as
8 specific items come up, we'll hand it back over
9 to you to talk about specific responses.

10 DR. MCMULLEN: Okay. This is Tara
11 McMullen. I'm going to start with the function
12 measures, and then I'm going to turn it over to
13 Alan, Dr. Levitt, to talk about the antipsychotic
14 QM. Because I think now we're okay with the last
15 three. I don't know if we're talking about
16 those. I'm going to leave it here. We have four
17 function measures. These measures are developed
18 with the data source of care from the care tool.

19 Alan spoke a little bit about that.
20 The care tool was developed in PAC-PRD, the
21 Deficit Reduction Act of 2005. These measures
22 are setting specific at the current time.

1 However, they do meet a domain of the IMPACT Act
2 to standardize function.

3 But CMS added these measures onto the
4 MUC list for setting specific measures for the
5 SNF Quality Reporting Program. We have submitted
6 other function measures to National Quality Forum
7 for consideration of endorsement, and those have
8 been setting specific quality measures for the
9 IRF quality reporting program, as well as the
10 LTAC quality reporting program. We also have
11 developed and finalized, for SNF Quality
12 Reporting Program, the IRF quality reporting
13 program, and the LTAC quality reporting program,
14 a process measure that assesses function in
15 self-care and mobility using the care data
16 source.

17 That was the measure that was used in
18 the mandate of the IMPACT Act. Just very briefly
19 to address a few comments in opening up, there's
20 been a lot of discussion about how IRF and SNF
21 populations differentiate the case mix. In the
22 development of these measures, these measures

1 really grow from that of the IRF measures that
2 were finalized for the IRF quality reporting
3 program.

4 The one thing that we like to denote
5 as a difference between the IRF and the SNF
6 measures are that for the two models, the
7 self-care and mobility models, we have more than
8 75 risk adjusters for these SNF measures,
9 including age, admission, the admission function,
10 prior functioning, prior device use, primary
11 diagnosis, comorbidities, as well as condition
12 severity markers, such as incontinence and
13 swallowing. We do exclude, at this time, persons
14 under the age of 21 from this quality measure,
15 and that's simply because we don't have enough
16 data at this time to analyze that population.

17 But with the collection of more data,
18 we will consider opening this up to basically
19 dropping that age exclusion. There was a comment
20 about exclusions overall in this quality measure,
21 and if the exclusions in the SNF measure are
22 analogous to that IRF quality measure. The SNF

1 quality measures actually have a few other
2 measure exclusions, including exclusions of
3 individuals in swing bed populations in critical
4 access hospitals, as well as the residents who
5 did not receive rehab therapy services.

6 That lines up with the ACQA measures
7 that are currently endorsed. We also understand
8 that in developing these measures, and if we
9 choose to propose these measures in the future,
10 there needs to be consideration in expanding the
11 currently finalized Section GG, which holds the
12 care items. There were comments about adding
13 more items, so we will take that into
14 consideration, as well as the wheelchair use. If
15 you notice, in the IRF quality reporting program
16 for the measures that were finalized, we do have
17 items that assess wheelchair use and scooter use.
18 Of course, there are always the comments about
19 cognition, and whether CMS is going to begin
20 developing cognitive items.

21 At the current time, the care items
22 look at motor and cognitive function, but they're

1 not a true indicator of a true cognitive measure.
2 CMS is moving in the direction to develop
3 cognition-specific quality measures, and will
4 take into consideration risk adjusting those
5 measures by functional status. I'm going to turn
6 it over to Alan.

7 MEMBER LEVITT: Yes, I guess I'm not
8 sure, if the three measures have been pulled,
9 does that mean that they're not going to --

10 CO-CHAIR SALIBA: They're not pulled
11 yet, Alan.

12 PARTICIPANT: Oh, so we still talk
13 about those.

14 MEMBER LEVITT: So I guess we should
15 wait until a decision's made by the workgroup to
16 talk about that?

17 CO-CHAIR SALIBA: I think whether
18 they're pulled or not, you can still go ahead and
19 give an overview right now. Then the decision
20 will be made by the workgroup whether or not to
21 separate out those items.

22 MEMBER LEVITT: Tara, do you want to

1 just talk a little bit about bipolar exclusion
2 because I think that was the only --

3 DR. MCMULLEN: Yes, let's touch on
4 that for a second. This antipsychotic quality
5 measure, as most of you know, was first
6 introduced in the Measures Application
7 Partnership in 2012. The first year we did it,
8 Catherine was here, or Erin was here. I remember
9 Erin being here the whole time.

10 The measure itself, there is an
11 incidence and prevalence measure, a short stay
12 and a long stay. They're currently used in the
13 nursing home quality initiative, and they were
14 originally developed to back end the National
15 Partnership for Dementia looking at the use of
16 antipsychotics in nursing homes and whether you
17 can decrease the use of antipsychotics.

18 At that time, CMS, we vetted a couple
19 technical expert panels and stakeholders and
20 subject matter experts about that bipolar
21 exclusion, because it can go either way. A lot
22 of people were worried about epidemics. A lot of

1 people were worried about things such as
2 appropriate use in nursing homes and the quality
3 of the beneficiary.

4 At the time that we presented this in
5 2012 to the Measures Application Partnership, and
6 at the time that we presented this quality
7 measure to our technical expert panel, there was
8 a strong consensus to exclude bipolar in the
9 measure.

10 So CMS has moved forward with
11 benchmarking this quality measure in the nursing
12 home quality initiative without the exclusion --
13 or with the exclusion of bipolar. This year, in
14 considering this measure now for our new program,
15 the SNF Quality Reporting Program, we basically
16 took this measure -- it was analogous.

17 We said we're going to take the same
18 exclusions and we're going to move forward. A
19 lot of folks were worried about how bipolar would
20 be coded, whether the coder would be able to
21 differentiate -- what would be appropriate coding
22 and whether you would increase error in your

1 measure. So there are some analytical issues, in
2 terms of the exclusions. We bring this measure
3 forward to the MAP today for discussion about the
4 bipolar exclusion, whether it's appropriate that
5 we maintain excluding that condition, or whether
6 we should consider including it with the
7 Huntington's, or including it in the quality
8 measure, overall.

9 So that's kind of the history. We
10 moved forward in that way, and we have data now
11 to support, that exclusion actually gives us a
12 significant measure no matter what, but I guess
13 we pose this one back to the MAP. Do we want to
14 keep moving in this direction?

15 CO-CHAIR SALIBA: Okay, thank you. My
16 annotated agenda says that I'm supposed to now
17 ask for our lead discussants, Kim and Pamela, to
18 make any comments about this particular set of
19 items and the process. Kim and Pamela, have you
20 all decided how you all were going to divide this
21 up to -- okay, Kim.

22 MEMBER ELLIOTT: I was going to

1 address the three that have been recommended for
2 pulling off the calendar. I do agree that those
3 particular measures have had quite a bit of
4 vetting already, and they're pretty consistent
5 with other measures used by other organizations.
6 The population exclusions are pretty good, but I
7 would say that bipolar should be included in the
8 exclusions for the antipsychotic medication.

9 In addition to the clinical reasons,
10 there's also a lot of concern about the skilled
11 nursing facilities' willingness to accept members
12 that have behavioral health conditions and
13 residents that have behavioral health conditions.
14 Without the exclusion, I think it would be even
15 more challenging for many populations to be
16 admitted into skilled nursing facilities.

17 MEMBER ROBERTS: The only other thing
18 I wanted to bring up, which I think has been
19 discussed in the past, is with the functional
20 measures, that they are -- there will be an
21 increased burden on the skilled nursing team with
22 two different measures with the MDS, as well as

1 the new care-tool measures, although it does go
2 to harmonize with the other areas, as well as the
3 scales are different. So there'll just be some
4 challenges.

5 CO-CHAIR SALIBA: Okay, so now's the
6 time to discuss whether we're going to pull
7 things from the consent calendar or not. I'd
8 like to break it into two questions here because
9 this is sort of a long list. I'm going to first
10 ask if anyone wants to pull from the consent
11 calendar any of the measures that are based on
12 the IRF functional outcome measures?

13 So that would be measure change in
14 mobility score for medical rehab patients, change
15 in self-care score for medical rehab patients,
16 discharge mobility score for medical rehab
17 patients, discharge self-care score for medical
18 rehabilitation patients. Does anyone want to ask
19 that we pull some of those from the consent
20 calendar?

21 (No audible response.)

22 CO-CHAIR SALIBA: Okay, so then the

1 next three on this list are the percent of SNF
2 residents who receive an antipsychotic
3 medication, percent of SNF residents who
4 self-report moderate to severe pain, and percent
5 of SNF residents who were assessed and
6 appropriately given the influenza vaccination.
7 Does anyone want to pull any of those from the
8 consent calendar? Sean.

9 MEMBER MULDOON: After hearing that
10 other comment, is it unusual to have
11 fully-endorsed measurements still under
12 consideration by this group?

13 MS. O'ROURKE: I will look up what --
14 technically, no. If the measure is fully
15 endorsed, it should have been considered for a
16 support, conditional support, or do not support
17 decision. We went off of the information we had
18 on the measures under consideration lists. Tara,
19 Alan, was there a reason that these were marked
20 as early in development?

21 DR. MCMULLEN: Is for function, or is
22 this for the final three?

1 (Simultaneous speaking.)

2 MS. O'ROURKE: I think it's the final
3 three.

4 DR. MCMULLEN: Oh, I understand. CMS
5 was in the notion that -- so the nursing home
6 quality initiative and the SNF Quality Reporting
7 Program are two separate entities. If we are
8 adopting these measures, of course we're going to
9 have to tinker with the measures, in terms of
10 case mix differences, but adopting them into our
11 program, that we should vet them through the
12 pre-rule-making process.

13 If, at some point, we choose to
14 propose these measures in a rule, the nursing
15 home quality initiative does not utilize, at this
16 point in time, the rule-making process. It was
17 more structural, I guess, in our logic. Yes,
18 they're fully cooked, but they're in a new
19 program, and if we do propose to use them, we
20 will have to utilize our rule-making vehicle.

21 MEMBER LEVITT: Exactly, just because
22 -- (Simultaneous speaking)

1 MEMBER LEVITT: Again, we're proposing
2 them for a program now, so NQF endorsed measures
3 --

4 (Simultaneous speaking)

5 CO-CHAIR SALIBA: Yes. I think the
6 issue that was raised in the public comment
7 period wasn't so much up or down on the measures,
8 but whether they should be classified as still in
9 development, versus classified as endorse/not
10 endorse. You're thinking that because it's a
11 different program that's why?

12 DR. MCMULLEN: Yes, that and looking
13 at the way that the measures are defined, some of
14 these are long stay, so you're looking at the mix
15 of your skilled, as well as your nursing home
16 population. As you know, with the SNF Quality
17 Reporting Program, we're looking at that
18 definitive at the time of admission to that Part
19 APPS discharge or your OBRA discharge. You're
20 looking at definitively the skilled stay. You're
21 looking at a shorter stay. That was kind of the
22 thinking of CMS, because we're going to have to

1 rerun these measures, test that stay, and see
2 what the data look like. It might end up looking
3 like a different measure just because of,
4 actually, the population of interest.

5 CO-CHAIR SALIBA: Jim.

6 MEMBER LETT: Thank you. I find
7 myself sufficiently confused to suggest that we
8 withdraw those three and discuss them. If I'm
9 confused, perhaps some others are, also.

10 CO-CHAIR SALIBA: Any other comments?

11 (No audible response.)

12 CO-CHAIR SALIBA: My understanding is
13 if one person requests that it be withdrawn, then
14 it's withdrawn from the consent calendar, so it's
15 now withdrawn from the consent calendar. Not
16 hearing any more discussion about the functional
17 outcome measures, we'll move on from those, but
18 we have pulled from the consent calendar the
19 antipsychotic, moderate to severe pain, and
20 influenza vaccination measures. Is everybody
21 clear at least on that much?

22 MEMBER LEVITT: What does that mean to

1 us at CMS?

2 CO-CHAIR SALIBA: What that means, I
3 think, now is that we have a discussion, and then
4 decide -- then I think once it's been pulled from
5 the consent calendar, then do we vote it? What
6 were your thoughts? I'm looking to Sarah here.

7 MS. SAMPSEL: Yes, I know. What we'll
8 do is we will vote individually on those three
9 measures that were pulled from the consent
10 calendar, so that we'll be able to record and
11 hopefully, get you all to come to consensus on if
12 you support the -- encourage continued
13 development.

14 We'd like to -- this goes back to our
15 conversation this morning -- glean any additional
16 information from you that you would like CMS to
17 consider, as they continue to adapt these
18 measures to go into those specific programs.
19 Then, we would vote en masse for the consent
20 calendar, so for those four items that remain on
21 the consent calendar.

22 MS. O'ROURKE: Yes, I can try to

1 clarify again. Hearing no objections, it sounds
2 like the four functional status will pass on the
3 consent calendar, with a recommendation of
4 encourage further development. These three have
5 now been pulled off, so we're going to take them
6 individually, and we'll go measure by measure,
7 and they will be subject to a vote. So maybe we
8 should start with the antipsychotic measure and
9 go there.

10 CO-CHAIR SALIBA: Let me ask one
11 question, just to clarify what we're going to
12 vote. Will the vote be the choice of the three
13 development categories, or will the choice also
14 include just endorsement as an option?

15 MS. O'ROURKE: It sounds like, from
16 CMS' perspective, while these measures -- there
17 is an NQF endorsed version of these measures,
18 there might be substantial differences in how
19 they would apply to the SNF QRP versus the
20 nursing home quality initiative. So I think we
21 --

22 MEMBER LEVITT: Yes, that's absolutely

1 correct. Again, as Tara said, we have a short
2 stay version and a long stay version, and this is
3 the SNF QRP version. The denominators may not be
4 necessarily the same.

5 DR. MCMULLEN: You have to remember,
6 with the SNF QRP, the providers are also held to
7 a little bit different standards. They have to
8 submit data, or they have the APU applied to
9 them. The program itself is a federally mandated
10 program, so the use of the measure may look a
11 little bit different than it looks right now on
12 Nursing Home Compare. The measure itself, as
13 used in SNF Quality Reporting Program, will not
14 be tied to a star at this time, so it is a
15 different measure. It will be a different
16 measure, maybe not in concept or in construct,
17 but the way that it's identified, the
18 specification, I guess, of the population.

19 CO-CHAIR SALIBA: So what I'm going to
20 do is take each one of these separately, so that
21 we can discuss them more clearly. Let's start
22 with the SNF residents who newly received an

1 antipsychotic medication. Any comments,
2 questions, thoughts? Kim, you look like you're
3 --

4 MEMBER ELLIOTT: I think that because
5 the measure calls for measurement of those that
6 were already on an antipsychotic when they were
7 admitted, and then were -- at each quarter
8 measure to see whether they were on an
9 antipsychotic makes a big difference. I think
10 that will really start to separate out the
11 populations that this would be applicable to. If
12 you're bipolar, unless it's identified during the
13 stay, you would already be coming in with that
14 medication. So if the adjustment is made to
15 include bipolar as an exclusion, I think it would
16 be a better measure, more reliable.

17 CO-CHAIR SALIBA: Thank you. Other
18 comments or questions about newly received
19 antipsychotic medication? Paul.

20 MEMBER MULHAUSEN: So I've
21 historically been very sympathetic to the way CMS
22 has developed similar measures around

1 antipsychotic medication. But in terms of buy in
2 from the provider community, it does seem to me
3 that there might be more face validity if bipolar
4 was excluded.

5 I agree that the measure that we have
6 right now seems to be pretty good, and we can do
7 a lot of work using that measure, but I
8 constantly hear the gripe around colleagues and
9 the people that I share care with in the skilled
10 nursing facilities where they remain perplexed
11 about why an FDA-approved indication for
12 antipsychotics is not excluded.

13 CO-CHAIR SALIBA: I'm seeing some head
14 nods around the table on that. Any other
15 comments? Let's vote on that one. Let's vote on
16 that one, since we just finished discussing it.
17 Our options are up here on the board, and we
18 finally get to use, I think, our fancy clickers,
19 and we'll see if they work. The first vote, if
20 you select 1, then you're encouraging continued
21 development; 2 is do not encourage continued
22 development; and 3 is that category we've been

1 discouraged from using, insufficient information.

2 Cari?

3 MEMBER LEVY: Just a point of
4 clarification. If we agree that the bipolar
5 exclusion needs to be inserted, what do we vote?

6 CO-CHAIR SALIBA: I think you're just
7 -- you would say that you want continued
8 development because the measure as proposed, in
9 part, does currently exclude -- or does not
10 exclude. So you're saying you wanted more work
11 to be done on that measure. Are there any
12 questions about what we're voting on here? Alan?

13 MEMBER LEVITT: Again, just to, again,
14 hopefully clarify a little bit. I would assume
15 that's what it'd be, a continued development, but
16 the workgroup recommends that bipolar is
17 excluded.

18 CO-CHAIR SALIBA: Yes. Okay,
19 everyone's clear on what you're voting on, right?
20 Okay, are you ready for them to start voting?

21 MS. IBRAGIMOVA: Yes, the poll is
22 open. You can vote now.

1 CO-CHAIR SALIBA: You're pointing
2 towards --

3 MS. IBRAGIMOVA: You can point
4 directly toward me.

5 (Voting.)

6 CO-CHAIR SALIBA: I think we're
7 missing a few votes that we were looking for.
8 How many are we expecting?

9 MS. IBRAGIMOVA: We are expecting 21
10 votes. We're missing --

11 CO-CHAIR SALIBA: Okay, so we're
12 missing a couple. Everybody just reclick. You
13 won't get counted twice, just point and click.
14 Do we have anyone on the phone that is --

15 MS. IBRAGIMOVA: I got Carol Spence's
16 vote.

17 CO-CHAIR SALIBA: You got it? Okay,
18 thank you, Carol. Are we good? We're 21? Okay.

19 MS. IBRAGIMOVA: The results for
20 MUC15-1133 are 100 percent encourage continued
21 development.

22 CO-CHAIR SALIBA: Okay, thank you. So

1 now we'll move on to the next item that had been
2 pulled from the consent calendar, percent of
3 skilled nursing facility residents who
4 self-report moderate to severe pain. Comments,
5 questions, thoughts about this particular
6 measure?

7 (No response.)

8 CO-CHAIR SALIBA: Okay, hearing no
9 comments, I think we can go ahead and vote.

10 Let me let everything get set up here,
11 though. It takes a minute to get the system
12 ready to receive your votes, so we'll just wait
13 just a second. It will be the same three options
14 that we had before, to encourage continued
15 development, do not encourage continued
16 development, or insufficient information.

17 MS. IBRAGIMOVA: The voting poll is
18 now open.

19 (Voting.)

20 CO-CHAIR SALIBA: We're still missing
21 a few people's votes.

22 MS. IBRAGIMOVA: The results for

1 MUC15-1131 are 95 percent encourage continued
2 development, 5 percent do not encourage continued
3 development, and 0 percent insufficient
4 information.

5 CO-CHAIR SALIBA: Now I know we've
6 closed the comments and discussion, if you all
7 will indulge me, as the chair, the do not
8 encourage continued development, did any of those
9 folks want to say if they're commenting that they
10 think it's just ready for prime time and there's
11 not any more need for continued development, or
12 if they don't want to see the measure going
13 forward?

14 MEMBER MULDOON: I don't know if I'm
15 a full 5 percent, but I did do it, too. I just
16 don't want it to be messed with anymore. I'm
17 afraid that you'll have two different measures
18 that sound the same, but are actually done
19 differently. It's so convoluted how they do it
20 in the MDS that I just say let's be done with it.

21 CO-CHAIR SALIBA: All right. I just
22 wanted to make sure that we understood the intent

1 of that no vote. Any other thoughts before we
2 move on? Let's move on now to the final one that
3 was pulled from the consent calendar, percent of
4 skilled nursing facility residents who were
5 assessed and appropriately given the influenza
6 vaccine.

7 MEMBER LEVY: That last comment brings
8 up a good point. If we feel similarly that this
9 one shouldn't be messed with and just go for it,
10 should a vote of do not change be the appropriate
11 vote?

12 CO-CHAIR SALIBA: The question here is
13 if someone wants to say no more development is
14 needed because it's ready for prime time, what
15 should they vote, and how do we know that's what
16 they're voting when they vote?

17 MS. O'ROURKE: I think the best way to
18 capture that might be in the rationale. If you
19 could raise those concerns via conversation, and
20 we'll write them down and put them in the
21 rationale section that goes along with the vote
22 to CMS.

1 I don't know that I have guidelines on
2 how you should vote about encouraging further
3 development or not encouraging further
4 consideration, but we do capture that rationale,
5 and we can note that there are concerns that
6 there might be two similar sounding measures now
7 going into play for two different programs, and
8 we'll pass those concerns along to CMS for them
9 to reconcile.

10 DR. MCMULLEN: We take that into
11 consideration, too. So Sean, your comment,
12 that's very important for us. That actually
13 weighs very heavily.

14 CO-CHAIR SALIBA: So it would be
15 helpful to discuss any concerns that people have,
16 either that we should just proceed with what's
17 there, or that they're worried about slightly
18 differing measures on the plate here. Any
19 comments? Cari?

20 MEMBER LEVY: I think the similar
21 concern would be raised here is the measure is
22 reporting the percentage of skilled nursing

1 facility residents who were assessed and
2 appropriately given the seasonal influenza
3 vaccine. Great. That sounds good. I think
4 messing with it probably isn't necessary, but if
5 others disagree, then we should hear that.

6 MEMBER MULHAUSEN: I don't disagree,
7 which makes me confused about why we came up with
8 the original preliminary recommendation and what
9 it was on the part of the group that initially
10 presented us with that preliminary analysis
11 result, what their concern was. What I see here
12 was that it's -- the measure is a little
13 different from the NQF-endorsed measure.
14 Everything else seems fairly consistent with what
15 Cari has already articulated, so I'm curious if
16 I'm just missing something. I guess it's a
17 question for staff or for the key presenters.

18 MS. SAMPSEL: I think this goes back
19 to the original conversation and the way Tara
20 addressed it. When NQF staff get the measure
21 information from CMS, it's almost a translation
22 of if CMS says they're continuing to look at a

1 measure for use in a different program or a
2 different adaptation of the measure, it's
3 considered still in development.

4 For us as staff, our recommendations
5 would then go by is there the potential for any
6 type of changes to that measure specification
7 that would move a material change from the
8 endorsed measure? We would have gone along the
9 line of any of these measures that did come in to
10 us as CMS is still looking at as just the --
11 encourage continued development. It's kind of
12 almost a nuance in the language because you're
13 all correct. These are fully developed measures
14 for use somewhere. It was a programmatic, more
15 than a measure recommendation. We recommend CMS
16 continue to look at this and determine whether it
17 could be used in the program versus kind of that
18 we're asking for changes to the measure
19 specification on the endorsement side.

20 CO-CHAIR SALIBA: I think part of the
21 confusion is that we haven't typically looked at
22 measures in terms of their use. In this case,

1 you're saying that it's the use of the measure.
2 But I think that Tara was also saying that some
3 of the specifications might change because of the
4 different uses.

5 MEMBER LEVITT: Yes, I just want to
6 reiterate, again, that these have been very
7 useful, helpful measures in Nursing Home Compare
8 with the denominators of the short stay and long
9 stay, short stay being less than 100 days, long
10 stay more than 100 days.

11 The denominator for this measure would
12 be patients who are receiving a SNF level of
13 care, which is not necessarily needing the
14 100-day definition. The reason we would really
15 qualify it better as under development, again, is
16 to just go ahead and look at it with that
17 denominator and go ahead. But again, if we get a
18 very strong recommendation that things -- that
19 you agree that once we look at this, if it does
20 look like, through the testing, that things look
21 the same, we would love to get that sort of
22 support from you, if that's what you -- if that's

1 how you feel.

2 CO-CHAIR SALIBA: Okay, Jennifer?

3 MEMBER THOMAS: I'm just wondering,
4 with the specifications that may change, would
5 this be in the area of skilled nursing with short
6 stays, could some of the options include some of
7 those options that are included now in the home
8 health assessment? It's not just that you either
9 receive the vaccine or you refuse. There's
10 things like drug shortages exist, there's no
11 vaccine on the market or whatever, so during that
12 time period, that might also be a consideration.

13 DR. MCMULLEN: The measure on the MUC
14 list is the specs -- the description of what you
15 see here, but I think the world is our oyster.
16 The sky's the limit, in terms of what we can do
17 in this domain. We always, actually, encourage
18 folks -- stakeholders, everyone -- to write in to
19 us and present these ideas to us because you're
20 in the work. Sometimes it's good to get that
21 outside perspective to see where you can align or
22 harmonize. I tend not to use standardization in

1 this sense on purpose. But yes, that's a good
2 idea.

3 MEMBER ELLIOTT: I just wanted to
4 comment on the numerator and denominator, in
5 respect to the October 1st through March 31st. I
6 recognize in all measures, you do have to have
7 hard cutoffs and start dates. However,
8 oftentimes, now, the influenza vaccine is really
9 recommended almost year round, particularly in
10 different parts of the country where the seasons
11 are a little bit different.

12 We do see the flu vaccinations being
13 given, oftentimes, now in September, August time
14 period. If we continue with these hard cutoffs,
15 it would probably exclude some of the people that
16 may be getting those vaccinations appropriately,
17 so some thought could be given to that as that
18 trend continues.

19 CO-CHAIR SALIBA: Jim.

20 MEMBER LETT: As the puller -- maybe
21 I'm the pullee. I'm not sure which one I am, but
22 as the person who suggested that we pull them and

1 look at them, my intent on this one was mainly is
2 there anything special that we need to change or
3 add, and I'm not hearing that at this point in
4 time. I think the second thing is it might be
5 interesting, as an unintended consequence, are
6 these measures basically forcing people to get
7 multiple vaccinations with the same vaccine?

8 That is, if you have this measure at
9 all sites of post-acute care, plus, I might add,
10 in the hospital, which also has the measure for
11 it, particularly elders with dementia or others
12 with dementia or cognitive impairment may not
13 recall, the records may not be clear. Are people
14 ending up with three and four pneumonia vaccines,
15 three and four influenza vaccines?

16 I guess the third thing is it sounds
17 like it might be worth, mechanically, just to see
18 if there's a way to suggest fast tracking some of
19 these measures, rather than just say yes, keep
20 working on them, that we can say we like the way
21 they are, go with it?

22 CO-CHAIR SALIBA: Thank you. Any

1 other comments or thoughts? Oh, Gene, I'm sorry.
2 Go ahead.

3 MEMBER NUCCIO: Sorry. To answer your
4 question, at least for home health, in the home
5 health item, it specifically asks if they've
6 received it from another provider. So if the
7 agency has received it -- if the patient has
8 received it at the nursing home, and then been
9 transferred to home health, then that's recorded
10 as having received.

11 CO-CHAIR SALIBA: Jim, I think your
12 comment would call for making sure that's part of
13 the transfer information that gets transferred
14 with the individual across settings. Other
15 comments, questions? I think we're ready to go
16 for a vote on this one. Again, we've got our
17 three options here. We're going to be voting on
18 percent of skilled nursing facility residents who
19 were assessed and appropriately given the
20 influenza vaccine. We can vote 1, encourage
21 continued development, 2, do not encourage, and
22 3, insufficient information.

1 MS. IBRAGIMOVA: The voting results
2 for MUC15-1132 are now open.

3 (Voting.)

4 MS. IBRAGIMOVA: The results for SNF
5 QRP MUC15-1132 are 95 percent encourage continued
6 development, 5 percent do not encourage continued
7 development, and 0 percent insufficient
8 information.

9 CO-CHAIR SALIBA: Thank you. We're
10 going to move on now to the input on measures
11 under consideration under value-based purchasing
12 program. I'd like to ask the operator to open
13 the line for comments.

14 OPERATOR: At this time, if you would
15 like to make a comment, please press star, then
16 the number 1. There are no comments at this
17 time.

18 CO-CHAIR SALIBA: Thank you. Are
19 there any comments from members of the audience?

20 MR. MULLER: Hi, James Muller from the
21 American Healthcare Association. The SNF
22 value-based purchasing re-admission measure

1 within and without 30-day post-SNF stay
2 re-admission measure, we believe that it should
3 be aligned with the similar IRF measure and kept
4 to be a purely within SNF stay re-admission
5 measure. There's nothing in the PAMA that
6 actually forces this to be a 30-day follow-up
7 period, and the payment theme of the PAMA sort of
8 suggests that it should be kept within the SNF
9 stay. My comment, thank you.

10 CO-CHAIR SALIBA: Thank you. Any
11 other comments from the audience? Laura, are
12 there any comments in the chat box?

13 MS. IBRAGIMOVA: No, not at this time.

14 CO-CHAIR SALIBA: Katie, can you maybe
15 give a brief overview of the value-based
16 purchasing?

17 MS. STREETER: Sure. For the SNF
18 value-based purchasing program, we have this one
19 measure here. We actually -- the workgroup did
20 review and discuss this measure, but not for this
21 specific program. The reason why we have it
22 separated is because this is required by PAMA and

1 not IMPACT Act, but this is the skilled nursing
2 facility 30-day potentially preventable
3 re-admission measure. It is also in early
4 development, and our recommendation was encourage
5 continued development.

6 CO-CHAIR SALIBA: CMS, do you have any
7 comments before we discuss whether or not it
8 stays on the consent calendar?

9 DR. ANDRESS: Sure. The decision to
10 make this a 30-day re-admission measure stems
11 from two issues. One is practical, and the other
12 is an issue of policy. The practical issue is
13 that this is essentially, I guess, a potentially
14 preventable version of the SNF re-admission
15 measure that is already being considered by this
16 committee. It was finalized in rule making for
17 use in the SNF value-based purchasing program. A
18 particular quirk of this program is that there
19 are only ever two measures that are statutorily
20 allowed within it.

21 The first was the SNF re-admission
22 measure, which is an all cause re-admission

1 measure, which is to be replaced by a potentially
2 preventable re-admission measure as soon as is
3 practicable, which I never thought I'd hear used
4 outside of the movie Gettysburg, but there it is.
5 Anyway, the issue with -- so the statute only
6 allows those two measures.

7 That's the basis of the payment
8 determination for SNFs in the VBP program, which
9 puts this measure -- puts a great deal of
10 responsibility on this measure, because a
11 facility can lose up to two percent of its
12 payment based upon its performance on this
13 measure, or it can gain a substantial amount of
14 money in the cost-savings setup that was mandated
15 within the PAMA statute. There seems to us to be
16 a substantial reason why we'd want to prevent
17 issues such as gaming. This is an area where
18 gaming would be fairly straightforward if we were
19 to keep it as a within stay only measure.
20 Because if it is designed as within stay, the
21 only thing you have to do in order to avoid a
22 re-admission for the SNF is to discharge your

1 patient prematurely, before they get re-admitted.

2 You kick them out, and even if they go
3 back to the hospital after that, they die, the
4 measure will not capture it, which means that the
5 value-based purchasing program will not capture
6 it. Now, as has been pointed out by commenters
7 in the rule making, it does not seem that this is
8 something that is likely to occur overmuch, given
9 the ethical considerations in place.

10 But it seems to us that as a policy
11 matter, it is incumbent upon CMS to not design
12 value-based purchasing programs wherein there is,
13 in fact, an incentive for kicking your patients
14 out before they have received the care that they
15 require. For that reason, we decided to retain
16 the SNF re-admission measure's 30-day setup.
17 This created some interesting issues around this
18 measure, particularly with the potentially
19 preventable re-admission definition. We developed
20 this alongside the IMPACT Act measures, as well
21 as the IRF within stay measure. When we did
22 that, it became quickly apparent to us that the

1 definition of what is potentially preventable
2 varies very much, in experts' minds, by whether
3 you are within the facility or outside of the
4 facility.

5 So we actually created two
6 definitions, one which defines a class of codes
7 for which a facility may potentially prevent a
8 re-admission while the patient is within the
9 facility, and another set of codes that is less
10 inclusive, that defines potentially preventable
11 re-admissions for patients who depart from the
12 facility because this measure includes both time
13 windows, potentially.

14 The potentially preventable definition
15 uses the within stay definition for patients who
16 are re-admitted while they were within the SNF
17 and uses the post-discharge definition if they
18 are re-admitted following discharge from the SNF,
19 but still within the 30-day window. That is the
20 rationale there for why we included the 30-day
21 and some of the quirks around the measure as a
22 consequence of our decision to retain that

1 structure.

2 CO-CHAIR SALIBA: Thank you. So now
3 the question before the group is whether you want
4 to keep this on the consent calendar or you want
5 to pull it from the consent calendar? Anyone
6 want to have it pulled from the consent calendar?
7 Okay, Jim?

8 MEMBER LETT: Just a point of
9 clarification. We can discuss it without pulling
10 it, can't we?

11 CO-CHAIR SALIBA: Yes.

12 MEMBER LETT: So if I say no, then we
13 can still discuss it?

14 CO-CHAIR SALIBA: Exactly.

15 MEMBER LETT: Okay, thank you.

16 CO-CHAIR SALIBA: Hearing no requests
17 to take it from the consent calendar, we will
18 move forward with discussion of this item on the
19 consent calendar. Robyn?

20 MEMBER GRANT: From a resident
21 perspective, our concern is one of unintended
22 consequences. There is the possibility that the

1 measure could create a disincentive for nursing
2 homes to send residents to the hospital for the
3 care they need. We are aware of many situations
4 that families have reported to us, and advocates
5 on the ground, where there have been family
6 members in the facility very concerned about the
7 condition of their loved one. They have asked
8 for their loved one to be sent to the hospital.
9 For a variety of reasons, they have gotten
10 pushback from facility staff who said, absolutely
11 not. They've refused to send their loved one to
12 the hospital.

13 Families, out of sheer desperation,
14 have eventually called 911 and had an ambulance
15 come and sent their loved one to the emergency
16 room. What we hear back from family members is
17 the hospital staff said that had we not gotten
18 their loved one to the hospital when they did
19 that they would very likely have died, or there
20 would have been very serious consequences. I
21 just wanted to raise that as a potential adverse
22 consequence.

1 CO-CHAIR SALIBA: Thank you, Robyn.

2 Other comments? Lisa?

3 MEMBER WINSTEL: I just don't want to
4 waste anyone's time, but I really want to amplify
5 what Robyn said. It's not the occasional story.
6 We hear this from family members all the time,
7 and it should be taken seriously. I don't have a
8 recommendation for how CMS can address it in this
9 measure, but it is something that has to be
10 heard.

11 CO-CHAIR SALIBA: Jim?

12 MEMBER LETT: Oh, thank you. Back to
13 the spirit of Sean's earlier comment about how do
14 you do QI with this information? How can you
15 make care better? To me, just somebody went back
16 to the hospital within 30 days doesn't help me a
17 lot.

18 If somebody went back to the hospital
19 within 48 hours of admission to the SNF, then
20 that was a failed hospital discharge. If they go
21 back to the hospital within 48 hours of leaving
22 the skilled nursing facility, I would personally

1 consider that a failed SNF discharge.

2 If you have a re-admission within, for
3 example, the first seven to ten days from the
4 SNF, then that may well be an issue around the
5 quality of care of the SNF, not always, but could
6 well be. How do you make this measure actionable
7 is really what occurs to me. Lord knows too many
8 measures is like having no measures, but it might
9 be more useful were it broken up into time
10 increments where you could say I have a problem
11 with my intake process, as a post-acute provider,
12 or I have a problem with my discharge process, as
13 a post-acute provider. No action intended, but a
14 thought for as we develop.

15 CO-CHAIR SALIBA: Jim, do you think
16 the facility could do its own tracking of these
17 issues within the facility to look at when their
18 re-admissions are occurring?

19 CO-CHAIR RAPHAEL: Can I just say
20 something? Because at the Visiting Nurse Service
21 of New York, where we dealt with 50 hospitals, we
22 actually charted re-admissions by hospitals, and

1 it was a dramatic, dramatic difference. The
2 range was phenomenal between some high-performing
3 hospitals and some where we had really just, I
4 thought, astounding readmission rates.

5 I think there are things that you have
6 to do on your own. You can't wait for this
7 public reporting system to come and give you the
8 information that you need. I think when you then
9 go to the hospital and show them some of the
10 data, then you have to begin to work on what's a
11 combination of issues. It's work on both sides.

12 MEMBER LETT: To answer your question,
13 yes. If you're an active, good post-acute
14 provider, none of these numbers are a surprise to
15 you. We used to, weekly, look at all unplanned
16 transfers from the facility, whether it was to
17 the emergency room or they actually were
18 re-admitted, and we calculated our own
19 re-admission rates.

20 We looked at all the folks who went
21 out, whether they got admitted to the hospital or
22 not, and we would compare our numbers with --

1 because of the hospital re-admission reduction
2 program are almost, in all the urban, and I
3 presume a lot more widespread than that areas, we
4 would monthly, or at least quarterly, sometimes
5 monthly, get the re-admission rates as calculated
6 by the hospital, which we could then look at our
7 re-admission rates.

8 We could look on when they went back
9 and have a constructive, educational dialogue
10 around yes, we had three people we had to send
11 back to you within 24 hours or 48 hours. Where
12 are we missing it? The same thing on the other
13 end, but we don't always get the information when
14 they leave the SNF that they ended up back in the
15 hospital. In fact, we almost never do, unless
16 they cycle back through from the hospital into
17 the SNF. We go, oh, my goodness, you were in the
18 hospital. The data that we get, if we have it
19 timely, then it is absolutely wonderful because
20 we can actually look at those charts, pull them,
21 and see why people were discharged or what the
22 process of care was while they were there.

1 Long answer to your question, yes, if
2 we're doing our own re-admission data, it is
3 absolutely wonderful, and we can figure out what
4 we're doing wrong pretty darn quickly and defend
5 our numbers to any outside entity, a managed care
6 company, a hospital, whatever.

7 CO-CHAIR SALIBA: We started, when we
8 send people home from the hospital, we follow up
9 with them at 48 hours. We follow up with them at
10 two weeks to see how they're doing post
11 discharge. I have this fantasy that we could
12 start doing that with post-acute care patients.
13 Paul, you had your tent up.

14 MEMBER MULHAUSEN: This is part of my
15 disclosure. I work for Telligen, and we are a
16 CMS Quality Innovation Network, quality
17 improvement organization. From my world view,
18 there are numerous resources that CMS provides to
19 providers to support achieving the goals of this
20 kind of a measure. Advancing Excellence is a
21 public/private partnership with a lot of help for
22 skilled nursing facilities, in terms of tools

1 that can be used to do root cause analysis and
2 monitor re-admissions.

3 There's a lot of push for interact
4 through the Quality Innovation Network. From my
5 perspective, we have, actually, an under-utilized
6 resource being provided by CMS through the
7 quality improvement organizations that aligns
8 beautifully with this measure, in terms of
9 supporting the provider community to succeed with
10 this as the value-based purchasing outcome of
11 interest.

12 MEMBER LEVITT: I was going to wait
13 until all the comments were done, but assuming
14 they are, first of all, I want to thank Paul for
15 that lead-in. That was very nice, telling what
16 CMS does do, and it is true. I do think we need
17 to remember that this is a statutory measure. So
18 again, we start off with the fact that Congress
19 felt this is important, and it actually is an
20 important measure. It is a within stay measure.
21 It's not necessarily within stay measure. It's a
22 30-day from the start of stay measure. So for

1 most SNF patients, it would be a within stay
2 measure. So for most of the residents who get
3 transferred out, you would actually have the
4 information on the resident to begin with because
5 they would've been within stay while all this was
6 occurring.

7 Just a general comment before I turn
8 it over to Joel. The point of all these
9 re-admission measures, it's kind of a shared
10 attribution. CMS recognizes that, for example,
11 in home health, how much does a home health
12 agency have in terms of the effect? Is it 100
13 percent? Obviously it isn't.

14 But the point of these measures is
15 that there are things that we can do, whether
16 it's a within stay measure, in terms of the care
17 that we're providing to the resident or the
18 patient, or post-discharge, in terms of the
19 discharge planning of the patient. There are
20 things that we can do to affect the rates that we
21 do have, or that compare to other, similar
22 settings after risk adjustment. Again, that's

1 what we're trying to do here. We accept the fact
2 that patients may come in and be bounced right
3 back or whatever. But there are things we can
4 do, in terms of assessing those patients prior to
5 coming to us, to hopefully keep the patients
6 where they belong until they're ready to come to
7 the right setting. Is it 100 percent effective?
8 Obviously it isn't, but there are pieces that we
9 can do, and that's kind of where the shared
10 accountability comes in. Joel, do you have
11 specifics?

12 CO-CHAIR SALIBA: Before you move on,
13 we had one other member that had a comment.
14 Cari?

15 MEMBER LEVY: I'm sorry. I just
16 wanted to raise one issue, which was we were able
17 to hear Joe -- present recently. The unfortunate
18 news was the interact tool doesn't appear to have
19 an effect in randomized control trial in the
20 community.

21 I worry if we're expecting facilities
22 in the community to use a tool that doesn't have

1 an effect. I don't know if we're setting them up
2 for success. I just wanted to put that out
3 there. Then also, one of the other things that I
4 wonder about is emergency room visits that don't
5 result in admission, if that could be a signal
6 for facilities that are not being mindful about
7 assessing residents, and if there was some way to
8 use that, as opposed to because of this issue
9 that Jim brings up, where we have people who
10 come, and then two days later, they're back in
11 the hospital, and that's probably the hospital's
12 fault, and not the SNF's fault. Anyway, just
13 wanted to bring those two things.

14 DR. ANDRESS: I'm sorry, I'm going to
15 be obnoxious and ask you if you could restate
16 that last one? I missed the first part of it.

17 MEMBER LEVY: There's this percentage
18 of folks who come in and go right back within one
19 or two days, and that's likely not the nursing
20 facility's fault. It's probably the -- it's a
21 shared effort in not doing a good job by the
22 patient.

1 DR. ANDRESS: Right. I think we do
2 make some effort, analytically, at least, to pull
3 apart when people are being re-admitted and so
4 on. There's no clear -- there's not a drop-off
5 point, where everybody's getting -- then all of a
6 sudden, it just stops. There's actually a fairly
7 slow progression down, where people are
8 re-admitted sooner, but other than that, there's
9 not just a clear point to cut it off. I think
10 the shared accountability piece to it gets it
11 right. We want both providers involved in any
12 handoff to be conscientious about what's going
13 on.

14 I think we've started to hit on that
15 with hospitals and post-acute care settings.
16 There are probably other areas where we really
17 haven't. That's probably got to be a discussion,
18 as we consider the proliferation of care provider
19 types and different kinds of handoffs, exactly
20 how you do that without inundating people with
21 re-admission measures for home health to SNF,
22 home health to the IRF, home health -- you can

1 just imagine how that expands rapidly.

2 To this issue of unintended
3 consequences, I think this is an important one.
4 It's something that's been raised and addressed
5 in hospitals, but bears repeating. One of the
6 earlier concerns, right, was that you're reducing
7 re-admissions because they're just letting their
8 patients die. So they die instead of getting
9 re-admitted. That's why re-admission rates would
10 go down. The analyses that we conducted in the
11 hospital certainly have not borne that out. We
12 don't have mortality measures in place in our
13 quality programs for SNFs at this point. I would
14 say that there's actually a pretty good
15 illustration of why you want companion measures
16 within a set, why you don't want to put your eggs
17 in one basket, so to say, with a single measure.

18 We don't have that option with this
19 program, but this program does not exist in a
20 vacuum. You have the Quality Reporting Program.
21 You have the Nursing Home Quality Initiative,
22 where other measures can be implemented and have

1 an effect on the quality efforts of various
2 providers. I think it's important to understand
3 sort of the context in which a quality measure
4 can exist.

5 I don't know that you necessarily get
6 at a single measure that deals with all
7 unintended consequences, but you can develop a
8 suite of measures that make it increasingly
9 difficult to game any one measure by your
10 particular actions. I think that's certainly
11 something we try to bear in mind as we develop
12 not just a single measure, but an entire suite of
13 them.

14 CO-CHAIR SALIBA: One thing I think
15 that Cari raised was the issue of emergency
16 department, of using that as part of the gaming
17 of this measure.

18 DR. ANDRESS: Right. There's some
19 interesting issues in addressing this. On one
20 hand is if it never becomes a re-admission, was
21 it something that rose to the level of being a
22 re-admission in the first place and, therefore,

1 should be captured by the measure?

2 I think the other issue, of course, is
3 do you have enough events -- is it a common
4 enough occurrence that you can actually capture
5 the event and say something meaningful about a
6 facility's performance with it? Right now, we're
7 observing these. We continue to track them,
8 along with observation stays.

9 There is actually a couple of these
10 measures in the home health setting, where we do
11 include those as their own separate indicators.
12 I can't say how that should be addressed. I can
13 say that for measures that are in statute called
14 out for re-admissions, it's probably problematic
15 to include ED use, but that doesn't mean that we
16 couldn't look at it in developing other measures,
17 in the future, that do cover that area. I think
18 it's certainly something worth capturing. Again,
19 one of the advantages of those is they're
20 probably, at least initially, the claims based,
21 so it doesn't expand the reporting burden for the
22 facilities.

1 CO-CHAIR SALIBA: Alan, your tag is
2 still up. Were you going to make another
3 comment?

4 DR. ANDRESS: The other core issue
5 that I think I want to touch before I shut up is
6 the QI because this is something we've heard in
7 the TEP that we convened for this and a number of
8 other settings, which is that a lot of
9 information isn't available to them.

10 The comorbidities that are identified
11 for the patients who got re-admitted outside of
12 the facility setting, who did not -- this is
13 something that we've been looking at how to
14 address, and there have been a number of legal
15 and infrastructural issues. I think we're
16 actually making some headway on this, so I can't
17 make any promises now. I can say, though, that I
18 am optimistic that we will be able to at least
19 expand the depth of information that you're
20 getting on re-admissions. That said, when you're
21 receiving a re-admissions rate, I think it's
22 probably best if you consider it as a signpost.

1 You are doing well on this; you are not doing
2 well on that. But there are a number of efforts
3 that have to be taken at the facility level to
4 track the issues, in particular, that we're
5 simply not going to be able to capture with a
6 claims based measure.

7 CO-CHAIR SALIBA: Thank you. Any
8 other questions or comments about this item?
9 Again, it's on our consent calendar. We didn't
10 take it off the consent calendar, so hearing no
11 more new discussion, we will move on to the next
12 item. We're a little bit ahead of schedule.
13 Consulting over here with NQF folks, we're going
14 to keep moving through, up until the scheduled
15 break.

16 That does mean that if someone's not
17 on the call right now that wants to comment,
18 we'll have an open mic at the end of the day for
19 people to comment, so they'll still have an
20 opportunity.

21 We're moving on to the Long-Term Care
22 Hospital Quality Reporting Program. There are

1 several items on the consent calendar, compliance
2 with spontaneous breathing trial, including trach
3 collar trial or continuous positive airway
4 pressure breathing trial by day two of the LTAC
5 stay, percent of patients who received an
6 antipsychotic medication, and ventilator weaning.
7 Operator, can you open the lines for comment?

8 OPERATOR: Yes, ma'am. At this time,
9 if you would like to make a comment, please press
10 star, then the number 1. There are no comments
11 at this time.

12 CO-CHAIR SALIBA: Thank you. Are
13 there any members of the audience who want to
14 make a comment?

15 MS. POTTER: Similar to the comment I
16 made on the skilled nursing facility
17 antipsychotic, I'll make a similar comment on the
18 antipsychotic in long-term care hospitals, which
19 also excludes the bipolar population. Thank you.

20 CO-CHAIR SALIBA: Are there any other
21 comments? Laura, any comments from the chat box?

22 MS. IBRAGIMOVA: No, there are no

1 comments.

2 CO-CHAIR SALIBA: Kate, do you want to
3 fill us in a little bit on this one?

4 MS. STREETER: These are the three
5 measures that are being considered for the
6 Long-term Care Hospital Quality Reporting
7 Program. They're all in early development, and
8 our preliminary staff recommendation is to
9 encourage continued development.

10 CO-CHAIR SALIBA: Before we ask for
11 workgroup discussion about consent calendar, did
12 CMS have any comments?

13 MEMBER LEVITT: Just, again, that if
14 we are going to continue with measure
15 development, if it's the workgroup's
16 recommendation, again, that bipolar patients be
17 excluded, we would want to hear that. I would
18 point out one thing that may generate workgroup
19 discussion is just to note that we had chosen, in
20 this measure, that this is a prevalence measure,
21 and not an incidence measure.

22 We chose that because the idea that

1 patients coming into the long-term care hospital
2 facility may have been started on antipsychotic
3 medication while they were in the ICU, and that
4 the hope or the idea was that hopefully, they
5 could get weaned while they were in the LTAC
6 setting. Again, maybe that'll generate some
7 workgroup discussion as to whether it's better to
8 have a prevalence versus an incidence measure in
9 this population.

10 CO-CHAIR SALIBA: Thank you. We had
11 two discussants for this set of items, Sean and
12 Bruce. How do you guys want to tag team it?
13 Sean, you want to start?

14 MEMBER MULDOON: I think, maybe I'll
15 do the weaning ones, because they're easier. I
16 was on that TEP. These have been -- anything
17 that this group probably will -- asking
18 themselves what about this, what about that, ask
19 me, I'll tell you. I know that it's come up in
20 the other groups, and we just had to make some
21 choices.

22 One piece of clarification that I

1 either am not reading right or we got mixed up is
2 on the wean rate, one place in the specifications
3 it says it's discharge dead or alive, and in
4 here, it says live discharges. We went round and
5 round on that.

6 I don't actually remember where we
7 landed, but just resolve that apparent
8 discrepancy. The TEP group is reasonably happy
9 with these, in spite of all limitations that
10 we've thought up, and this group may well think
11 up, as well. I think I'll hold it there. If
12 there's anyone that has a question about those
13 two, we can deal with them now. The trickier one
14 is the antipsychotic one, so I want to leave a
15 little bit of time for that.

16 CO-CHAIR SALIBA: Bruce. Okay. I
17 think our next discussion is whether or not we
18 want to pull any of these measures from the
19 consent calendar to have specific voting on.
20 We'll still be able to discuss, whether they're
21 on the consent calendar or not. Any move to pull
22 anything? Okay.

1 So now we'll move on to discussion.
2 I'm going to break it up a little bit, the way
3 Sean did, for discussion, so that we can sort of
4 stay on track with what we're talking about.
5 Let's talk about the two ventilator measures
6 first, the compliance with an SBT weaning trial
7 by day two, or a continuous -- a CPAP trial by
8 day two of the LTAC stay, and ventilator weaning
9 or liberation rates. Any comments, discussion?
10 Roger?

11 MEMBER HERR: I just want to thank
12 Sean for talking about the work on the TEP. This
13 is an area that I've seen variation in practice
14 out there, so the two days, I think, is a great
15 -- how you got there, I don't know, and if that's
16 the right number of days, but I'm glad you're
17 setting something there, and also the exclusion
18 criteria because I see so much variation of what
19 facilities do in this area. It's of great
20 concern to me, so I'm glad this is being put
21 forward, both of them.

22 CO-CHAIR SALIBA: Roger, that was

1 actually my question. Is this a standard of
2 care, or is it still being resolved in the
3 community about who gets trialed? Does everyone
4 get trialed, and is two days -- Sean, can you
5 help with that?

6 MEMBER MULDOON: This reflects two
7 things. One is that by the time you come to an
8 LTAC for weaning, you've long fallen off the care
9 path. That leads to variation, where people say
10 all the usual stuff didn't work. What will we
11 try today?

12 That was the side of the room that
13 said let's not button this down too much. But we
14 could not ignore the fact that the Loyola study
15 found that if you just let people settle down,
16 and then let them breathe on their own, 18
17 percent of them popped off the vent. That is why
18 we said not that you have to wean with
19 spontaneous breathing trials, because that wasn't
20 as clear, but once the patient settles down, how
21 long is that? Forty-eight hours. Could have
22 been 24, could have been longer. Give them a

1 shot at it. Just see what they can do.

2 Then that Loyola study also said if
3 they last a long time, you can go this way. If
4 they don't last a long time, you can go this way.
5 If they've totally got no drive at all, they're
6 probably in that category that means that they
7 may even be an exclusion. There actually was
8 some logic to it, even though we had to draw some
9 bright lines.

10 CO-CHAIR SALIBA: Questions, comments?
11 Thank you, Sean. Questions, comments? We're
12 talking about breathing trial or CPAP trial by
13 Day 2, and ventilator weaning or liberation
14 rates. Okay. I think I've worn you guys out.
15 The next one is percent of patients who received
16 an antipsychotic medication. This is slightly
17 different, as Alan was saying, from the one that
18 we discussed for SNF. Comments, thoughts? Sean?

19 MEMBER MULDOON: I'll go ahead and tee
20 up the debate. In the SNF, the desired behavior
21 is to not use antipsychotics to calm people down.
22 In the LTACs, for the ventilator patient, it is

1 how do you identify and treat delirium quickly?
2 So the concern was the unintended consequence of
3 this, which was -- is fairly loud, is that if you
4 get dinged for using an antipsychotic without one
5 of those exclusions, then you've taken away one
6 of the many imperfect tools for promptly
7 responding to delirium. That would be bad.

8 CO-CHAIR SALIBA: Comments? Jim.

9 MEMBER LETT: Just in looking at
10 harmonization between the measures, it seems to
11 make sense that we would ask the same of LTACs
12 that we ask of SNFs, that is have an incidence
13 rather than prevalence measure. Also, I would
14 assume that we would like to discuss removing
15 bipolar, or adding bipolar to the exclusions.

16 CO-CHAIR SALIBA: Other comments or
17 questions about the antipsychotic?

18 MEMBER KAUSERUD: I will admit I have
19 not reviewed this measure in super great detail,
20 but it seems that you would be able to build in
21 an exclusion for the purposes of identifying
22 delirium, so just a thought.

1 CO-CHAIR SALIBA: Gene. Wait just a
2 second. Gene hasn't -- let him go first.

3 MEMBER NUCCIO: It's just a question
4 of clarification. Is a good outcome higher or
5 lower? I don't know. If you're excluding that
6 which should be excluded --

7 MEMBER LEVITT: Gene, that's always a
8 bad sign when you have to ask a question like
9 that.

10 MEMBER NUCCIO: That's my purpose.

11 CO-CHAIR SALIBA: I think we have
12 started in the hospital, at least, discouraging
13 the use of antipsychotics for the management of
14 delirium. That's sort of -- it's not always
15 appropriate, even in the hospital setting. The
16 first thing is to avoid the development of
17 delirium which, even in the best trials, is not
18 100 percent, but that an antipsychotic doesn't
19 treat delirium. It only masks the symptoms of
20 what's going on. We might not see that as always
21 the right approach with all delirious patients.
22 But it may be different, I guess, in other

1 settings. Other comments? Sean, I'm sorry.

2 Yes, please.

3 MEMBER MULDOON: When we use
4 antipsychotics, we mean typicals and atypical?

5 CO-CHAIR SALIBA: Yes. Oh, I'm sorry.
6 I shouldn't have answered for CMS.

7 (Simultaneous speaking.)

8 CO-CHAIR SALIBA: Alan.

9 MEMBER LEVITT: If I could just
10 comment. I do want to point out that in the LTAC
11 QRP, previous MAP recommendations have been to
12 include a measure such as this, the use of
13 antipsychotic medications. That's come from the
14 workgroup before, and I guess this is our
15 response. We do listen, believe it or not, to
16 workgroup recommendations that this come forward.
17 Again, we are interested in whether or not,
18 assuming you still agree that a measure such as
19 this is useful in this setting, whether or not a
20 prevalence versus incidence measure would be the
21 right way to go.

22 CO-CHAIR SALIBA: Bruce.

1 MEMBER LEFF: Yes, just a
2 clarification. Would using a single dose of an
3 antipsychotic versus having someone started on
4 chronic use of the antipsychotic, those would be
5 judged the same in this context of this measure?
6 I need to give someone a good dose of Haloperidol
7 because they're bucking the vent and I need to
8 calm them down for their safety versus longer
9 term, perhaps inappropriate use.

10 DR. MCMULLEN: It'd be longer term
11 inappropriate use. It begs the question of
12 harmonization, but what would the MAP think?
13 Would that be appropriate for an LTAC, knowing
14 that the stay's a little bit longer than a SNF in
15 the first place?

16 CO-CHAIR SALIBA: So we've been asked
17 to comment on a couple of things, it sounds like,
18 the question of incidence and prevalence and
19 which type of approach you would want for
20 antipsychotic medication. Then I think the other
21 question was given that it's not going to be just
22 a one-time dose, what are we thinking this would

1 be, in terms of the duration of exposure that
2 would meet the numerator? Any thoughts? Cari.

3 MEMBER LEVY: Well, if you want a
4 thought, I was thinking, as Jim was mentioning
5 the incidence issue, that yes, that's good. But
6 the reality is the hospital has started these,
7 often, and then you're stuck with them when they
8 come over. If the LTAC can get rid of them, then
9 that's part of the whole rehab plan. Is there
10 any way to reward facilities for actually getting
11 rid of them? I don't know if that can be part of
12 the concept, as well.

13 CO-CHAIR SALIBA: Thank you. Paul.

14 MEMBER MULHAUSEN: In the spirit of
15 amplification for what Cari just had to say,
16 which is why I like the prevalence measure. I
17 think the prevalence measure, assuming high is
18 not good, then the prevalence measure, there is
19 an incentive to be thinking about gradual dose
20 reductions and gradually taking people off of
21 them after their delirium has been effectively
22 treated. I like the prevalence measure.

1 Although I'm sympathetic to this issue of
2 harmonization, I don't think that's the intent
3 here, so I like the prevalence measure.

4 CO-CHAIR SALIBA: Alan.

5 MEMBER LEVITT: Just to point out, in
6 the nursing home setting, the short stay
7 antipsychotic measure is incidence and the long
8 stay is prevalence. It doesn't necessarily have
9 to be the same measure. We've chosen prevalence
10 because we thought it just made more sense and,
11 again, are interested in what's going on. Again,
12 we are sensitive. Sean, we are sensitive to
13 changes in behavior. It is unfortunate that
14 people sometimes are -- practitioners do things
15 that may be inappropriate for a patient because
16 they're afraid of the measure consequences of it.
17 That's something we have to continue to monitor
18 religiously because that does happen.

19 CO-CHAIR SALIBA: Thank you. Any
20 other comments or questions? Not hearing any
21 movement to take any off the consent calendar,
22 we've discussed and provided feedback, so we're

1 going to consider this section complete, which
2 gets us to almost the break. I think we're going
3 to go ahead -- we were just talking. We're going
4 to go ahead and take the break and come back at
5 3:15, so you're just getting a little bit longer
6 break this time. We are ahead of schedule, as
7 well. When we come back at 3:15, we'll actually
8 be starting with the home health quality
9 reporting program items. Thank you all.

10 (Whereupon, the above-entitled matter
11 went off the record at 2:46 p.m. and resumed at
12 3:17 p.m.)

13 CO-CHAIR SALIBA: Thank you to
14 everybody that came back on time, so let's get
15 started. We're at the 4:15 item, which is the
16 home health quality reporting program. What we
17 have on our consent calendar for the home health
18 quality reporting program is fall risk composite
19 process measure and improvement in dyspnea in
20 patients with a primary diagnosis of heart
21 failure, COPD and/or asthma. I want to first
22 open the lines to see if there are public

1 comments on the line. Operator?

2 OPERATOR: At this time, if you would
3 like to make a comment, please press star, then
4 the No. 1. There are no public comments at this
5 time.

6 CO-CHAIR SALIBA: Thank you. Are
7 there members in the audience who want to make a
8 comment?

9 MS. LEE: Thank you. My name is
10 Teresa Lee. I'm with the Alliance for Home
11 Health Quality and Innovation. I want to thank
12 this group, as well as CMS, for the opportunity
13 to provide comments. Both of these measures that
14 are on the consent calendar are of great interest
15 to the home health community. One thing that we
16 are noticing, and I think this is true for a lot
17 of the other settings, is that many of the
18 measures that are being presented, there are
19 other similar measures that are already in use.
20 In the falls area, there are actually, I want to
21 say, three different measures. This composite
22 might actually represent sort of a bringing

1 together of the three. The improvement in
2 dyspnea measure, there is already an improvement
3 in dyspnea measure that's in home health compare,
4 but it's just not specific to these particular
5 diagnosis groups.

6 One thing that we've been continuing
7 to find is that as we think about these
8 additional measures, it will also be really
9 important to think, going forward, about what
10 measures should be retained, and what might need
11 to be retired down the road. While I'll still be
12 interested to see the more detailed specs
13 relating to each of these measures and maybe we
14 can figure out, over time, what's the most
15 meaningful, the ideal, I think, really, should be
16 that we have a streamlined measure set.

17 Until that time, I think that,
18 actually, education is just so critical for the
19 audiences that are going to be using these
20 measures, and for the audiences that are going to
21 be looking at the data related to these measures.
22 Because it can easily become somewhat confusing

1 as to what all of these many different
2 overlapping measures may mean. In addition, the
3 only other thing that I just wanted to add here
4 is that one of these measures has to do with
5 improvement, the dyspnea measure. We have a
6 number of measures in the home health measure set
7 that are used for various different purposes that
8 involve improvement.

9 We don't really have any measures that
10 go to stabilization. That's something that, as a
11 home health community, we're very, very aware of
12 and sensitized to in the wake of the GMO
13 settlement, which has emphasized and underscored
14 the fact that the benefit is not only for those
15 who are seeking improvement, but also for those
16 for whom stabilization is an appropriate goal.

17 We just want to encourage CMS to
18 continue to look at measures for home health, but
19 to not limit the goal to measuring improvement,
20 but to continue to focus in on both improvement,
21 as well as stabilization of function. Thank you
22 for the opportunity to comment.

1 CO-CHAIR SALIBA: Are there other
2 comments from the audience? Laura, anything in
3 the chat box?

4 MS. IBRAGIMOVA: No, nothing in the
5 chat box.

6 CO-CHAIR SALIBA: Okay, Peg, do you
7 want to give an overview?

8 DR. TERRY: Certainly. I think I had
9 a good head start with Teresa's comments. The
10 first measure is the falls risk composite process
11 measure. What this measure is, it's basically a
12 measure which encompasses three aspects of the
13 falls risk process measure.

14 The first one is the number of
15 patients who were assessed for falls, so they do
16 have to, in home health, have a multifactorial
17 assessment for falls. The second one is was this
18 risk what was determined whose risk was
19 incorporated into the care plan, so was this
20 incorporated into the care plan? The third one
21 was this care plan implemented?

22 So there are three parts to this. I

1 want to say that this is a measure that is
2 clearly under development. We recommended
3 encourage continued development for this measure.
4 We did find a study that we thought was relevant.
5 It was by Dr. Tinetti. People may know Dr.
6 Tinetti's name. She's done a lot of research in
7 falls. Did find that if you actually put in
8 place some strategies for prevention that you can
9 actually reduce the risk of falls in home care
10 patients. I think that's just a quick summary of
11 this composite process measure.

12 CO-CHAIR SALIBA: Thank you. CMS?

13 MEMBER LEVITT: First of all, thank
14 you, Teresa, and thank you, Peggy, both comments.
15 We agree, in terms of, first of all, looking at
16 trying to get a parsimonious set of measures
17 together and really look forward to continuing to
18 work with the home health stakeholder community
19 to try to find that set.

20 Also looking, at the same time,
21 whether some measures may be getting used by the
22 community that we would want to keep reporting on

1 just because they're using them in their own
2 quality efforts. It is a little bit of a
3 balance, but this is an example of what we are
4 looking at now is trying to take existing
5 processes that may be looked at and combining
6 them into a reasonable composite to try to make
7 it into a composite measure that makes sense,
8 that would be something that would be meaningful
9 to the patients and families, would be meaningful
10 to the stakeholder community, would not add
11 burden, and would also hopefully decrease the
12 number of measures that are out there and the
13 confusion that may be associated with those
14 measures.

15 I guess one of the questions that we'd
16 be interested in would be if you agree that this
17 is the way to go, particularly in this case, in
18 this measure group, should we be looking to
19 assign an outcome to it, as well, or should we
20 just keep going the way we are going here, in
21 terms of having three different items combined
22 into one measure. So we would be interested in

1 the workgroup opinion as to whether or not, in
2 our development, we should just continue going
3 this way, or whether there are other ways to look
4 at it.

5 CO-CHAIR SALIBA: We had two
6 discussants from our group on this measure, Liza
7 and Lisa. Who's first? Okay, Lisa.

8 MEMBER WINSTEL: I guess I am. I
9 think, Alan, you might have just answered my
10 first question for the discussion, which was is
11 this meant to replace or add to some of the
12 existing measures out there? I think that
13 bringing clarity and having one comprehensive
14 measure is a terrific goal. I find that one of
15 the fuzziest areas is how to measure that the
16 care plan was actually implemented. Because if
17 it's implemented, and then it continues to have
18 that implementation in the home after the
19 discharge from home health, is not within home
20 health's control. That, I think, becomes a
21 question on how that can be measured.

22 MEMBER GREENBERG: This is Liza. I

1 think my thoughts are along the same lines as
2 others that at the moment, there are a lot of
3 falls measures. I, at first glance, don't really
4 see how much this added to the portfolio. But
5 thinking of it as a composite, I think it gets
6 more valuable, particularly if you do add the
7 outcomes.

8 I think without the outcomes, you're
9 just enhancing emphasis on more process, and
10 there's not always a very strong correlation
11 between having a plan -- although you're going to
12 be trying to measure implementation -- but having
13 a plan doesn't necessarily correlate to all the
14 pieces falling into place, the physician making a
15 referral to PT, a patient using a cane, all the
16 things that have to happen. It makes much more
17 sense to pair that with an outcome measure about
18 the actual rates of falls. I think adding
19 outcomes and adding a component about patient
20 experience, which I guess is already around, but
21 seeing if there's a way to pair it with the
22 information to understand how the patient is

1 engaging in that whole process.

2 CO-CHAIR RAPHAEL: I was just going to
3 jump in on this because I also agree that right
4 now, we have -- this is kind of risk of falls and
5 how to reduce the risk of falls. We've also had,
6 in the past, rates of falls, particularly with
7 injury. To me, I think we have to find the
8 bridge between the risks and the rates in as
9 simple and as streamlined a way as we possibly
10 can.

11 But I think the virtue of this is that
12 if you see a patient in the home for congestive
13 heart failure, this really enlarges your
14 relationship and your frame because you're now
15 thinking about the drug reviewing regimen that we
16 talked about earlier because one of the causes of
17 falls has to do with drugs. You're now thinking
18 about balance and whether or not the person has
19 balance, things that you wouldn't ordinarily
20 think about if you just zoom in and deal with the
21 CHF. I think that is an important change in how
22 we're viewing this benefit and the

1 responsibilities of the post-acute care entity.

2 CO-CHAIR SALIBA: So now's the time
3 that we talk about whether we're going to keep
4 these on the consent calendar or not. Anyone
5 want to remove one of these from the consent
6 calendar?

7 MEMBER LEVITT: Are we done discussing
8 the dyspnea measure?

9 CO-CHAIR SALIBA: I think we do the
10 discussing whether or not we want to put it on
11 the consent calendar first, and then we do the
12 discussion. I'm sort of in a pattern here.
13 Anyone want to remove one of these items from the
14 consent calendar? Okay, now we'll discuss. Any
15 comments, questions, thoughts? Alan, did you
16 have your card up to say something?

17 MEMBER LEVITT: I was going to wait
18 for the discussion. I just did want to mention,
19 for the dyspnea measure, why is this measure
20 here, if we've already got a dyspnea measure out
21 there. This was actually -- when this came up
22 for endorsement in the pulmonary and critical

1 care meeting here at the NQF and it was not
2 recommended for endorsement, the reason from the
3 committee was that they felt that it should be a
4 measure that really, the denominator should be of
5 these diagnoses, that it shouldn't just be of the
6 general home health population.

7 That's why we've brought this measure
8 here to the workgroup, to get your opinion as to
9 whether or not you feel that this measure should
10 be for the general home health population versus
11 this more specific, diagnosis-specific
12 population.

13 Just to point out that this may be a
14 good idea, the down side to it is that it
15 probably is -- about 10 percent of the population
16 would end up being in the denominator, and it
17 would cause reportability to go down to about 30
18 percent of the agencies if we decided to do this.
19 So there is a down side to it. The up side is
20 that was the committee's recommendation, as well,
21 just to generate the discussion.

22 CO-CHAIR SALIBA: Alan, it would help

1 me to understand why they -- clearly these are
2 diagnoses that are associated with shortness of
3 breath, but why did they think that you needed to
4 limit it to these particular conditions? What
5 was their reasoning?

6 MEMBER LEVITT: Unfortunately, in
7 2012, I was still retired, before I decided to
8 come back to do this work. I'm not sure,
9 actually. It would be okay to ask one of our
10 contractors if they know?

11 CO-CHAIR SALIBA: Yes, absolutely.

12 MEMBER LEVITT: Anybody from the ABT
13 contracting team? Can we ask Dr. Nuccio, even
14 though he's the ex-officio for this?

15 CO-CHAIR SALIBA: Yes. Just to
16 explain, Dr. Nuccio has excused himself from
17 discussing this as a panel member because he
18 worked on the measures. But yes, certainly he
19 can comment as a measure developer.

20 MEMBER NUCCIO: I think I'm the only
21 member of the team that was here in 2012, when
22 the NQF group said we should restrict it. Quite

1 frankly, there was a concern that the measure of
2 just improvement in dyspnea was overly broad. It
3 applied to too many people, and should only be
4 applied to those folks with those particular
5 diagnoses. Since then, we've had a technical
6 expert panel come in and review the data from the
7 measure that's reported publicly, which is the
8 improvement in dyspnea measure for all patients,
9 and compare the results with this one.

10 The technical expert panel said that
11 we are treating symptoms of dyspnea, whether or
12 not they have the actual diagnosis on the OASIS
13 instrument. Because there is only a limited
14 number of spaces that you can have for the
15 diagnosis, either as primary or secondary, on the
16 OASIS instrument, we're under-reporting to the
17 point, as Alan pointed out, there's only about 3
18 to 5 percent that have dyspnea as a primary
19 designation.

20 Whereas, we can report the measure of
21 improvement in dyspnea if you have the symptoms
22 related to shortness of breath for more than 50

1 percent of our patients. So it's a much broader
2 measure, and is well risk adjusted, and CMS has
3 requested that we continue to use the measure
4 publicly.

5 CO-CHAIR SALIBA: I asked, in part,
6 because from a patient-centered perspective, if
7 someone's short of breath, it seems like you want
8 to be figuring out what's going on and addressing
9 it, regardless of the etiology. It sounds like
10 your second panel sort of was leaning in that
11 direction, as well.

12 MEMBER NUCCIO: Absolutely.

13 MEMBER LEVITT: Again, obviously, we
14 listened to the recommendations of the NQF
15 workgroups, and we bring that here. Again, we'd
16 like you to discuss it and make a recommendation.
17 If you feel that we should continue going this
18 way, that's a recommendation we would listen to.
19 If you think that we'd be better off being more
20 inclusive with either all diagnoses or other --
21 however you would wish to look at this and think
22 about it.

1 CO-CHAIR SALIBA: Thank you. Cari?

2 MEMBER LEVY: I was just going to
3 comment. Many of the measures have to do with
4 function and medications and that kind of thing.
5 This really does speak to quality of life. I
6 think it's an important measure to consider.
7 Given what Gene is saying, inclusion of a broader
8 population seems very reasonable with the
9 knowledge that we have now. Those would be my
10 comments.

11 CO-CHAIR SALIBA: Jim.

12 MEMBER LETT: Generally, with the two,
13 I personally always have a problem with
14 multi-part measures because if you fail the
15 measure, you don't have actionable information.
16 If you have a three-part process around falls,
17 and you fail it, you don't know which of the
18 three parts you need to work on.

19 Quality improvement wise, it's not
20 actionable to me. The same thing with dyspnea.
21 That is it's a two part. You have to both have
22 dyspnea and also have a very specific diagnosis.

1 Going backwards, being patient centered, I agree
2 with you 100 percent. Patients really don't care
3 why they're short of breath. They're okay with
4 no diagnosis, as long as you do something about
5 their dyspnea.

6 As far as the falls, why not just go
7 to outcomes? How many falls do you have? If you
8 have very few falls, are we truly going to live
9 and die by whether or not they follow the right
10 process? Looking at it from the other way, if
11 you do the right processes and you have a lot of
12 falls, does that mean you pass the measure? Are
13 we going to do this, this three-part falls issue,
14 in all the sites of care, SNF, LTAC, IRFs and
15 home health? If not, we shouldn't do it in one
16 and not do it in the others, unless it offers, to
17 me, humbly, a clear advantage. Also, you're
18 asking for more reporting elements, which is more
19 burdensome on the providers. So for parsimony's
20 sake, maybe less is more sometimes.

21 CO-CHAIR SALIBA: Liza?

22 MEMBER GREENBERG: When I first

1 reviewed this measure, I didn't really understand
2 what it added to the portfolio. It sounds like
3 this group mostly agrees. I think it would be a
4 step backwards to start excluding large
5 components of the population. From a quality
6 improvement point of view, you might look at your
7 most at-risk populations from time to time to see
8 if you're addressing their needs.

9 But I think when you report it to the
10 public, a patient would want to know if I'm short
11 of breath, will I get help, not do I fit in this
12 category. I do think, though, that there needs
13 to be some consideration -- to Teresa's point
14 about stabilization, some people just won't
15 improve. They will stabilize. Maybe a question
16 about did your home health agency help you learn
17 techniques to manage your shortness of breath or
18 something that would help address whether they
19 were trying to address the dyspnea, but not
20 necessarily improving my comments.

21 CO-CHAIR SALIBA: Jim, is your card
22 still up on purpose? Alan?

1 MEMBER LEVITT: A couple of things.
2 First of all, Jim, this would be specifically a
3 measure in home health. The items already exist.
4 There actually have been measures -- singular
5 measures associated with these items that have
6 kind of been legacy measures.

7 That's one of the issues we're talking
8 about is this huge group of measures that are out
9 there, many of which are topped out, some of
10 which may still yet be used by home health
11 agencies in their own quality improvement
12 activities.

13 That's why even if we decided to go
14 ahead and develop composite measures such as this
15 that may be more understandable for patients and
16 families and may be more reportable, and there
17 may be a greater performance gap or difference
18 between agencies, would the agencies, themselves,
19 still like to have those individual components
20 reported on to themselves, which they can in
21 their own files? That's one of the questions
22 that we'll be working on with the stakeholder

1 community if we decide to go this way. We're not
2 really adding anything new. We're just kind of
3 taking what's there and putting it together.

4 I apologize I didn't talk about
5 stabilization because that is important. We
6 successfully were able to develop a star rating
7 for home health compare this past year, and we
8 did it with -- the stakeholder community really
9 helped us a lot in the development of the star
10 rating. Certainly, what we've learned from that
11 is that we need stabilization measures.

12 It is something that is a priority of
13 ours to try to look at that because as you know,
14 the existing stabilization measures that were out
15 there are not meaningful. So it is something we
16 need to develop. They are important. Obviously
17 agencies that take care of such patients as their
18 mission, it's important. We obviously want to be
19 able to show that these agencies are successful
20 at what they do, so it is something we are
21 looking.

22 CO-CHAIR SALIBA: Any other thoughts

1 or comments about either the falls or -- oh, I'm
2 sorry, only looking in one direction. Gerri.

3 MEMBER LAMB: I just would like to
4 follow up Jim's comment about the composite
5 measures. I understand the need for
6 disassociating for quality improvement. Speaking
7 from the experience on the care coordination
8 standing committee, I think there's a really
9 strong need to connect process and outcome.

10 So I, for one, am very supportive of
11 composite measures because it begins to allow us
12 to connect the dots. From what you're saying, we
13 can also take them apart, so that we can look at
14 quality improvement. But I really see a huge
15 need, particularly in the care coordination
16 front, for bringing those pieces together, and
17 then also voicing a vote of support for
18 stabilization.

19 That was one of the things, going back
20 to discharge to the community, when I looked at
21 the rationale for why that was an important
22 measure, it talked about optimization of function

1 and cognitive function. That's not always the
2 case, particularly in home care. So I think the
3 point of looking at stabilization is well taken,
4 as well.

5 MEMBER WINSTEL: Just one quick point
6 about falls assessment in the home. That's for
7 you to recognize that being in the home actually
8 is very different than falls assessment in any of
9 the other settings. It would be really great if
10 this particular home health measure could in some
11 way include in the list of medication, transfers,
12 falls history -- include that there be an
13 assessment of the home for falls risks, whether
14 that's the throw rugs or low lighting, etc., but
15 really taking advantage of having that worker in
16 the home.

17 MEMBER MARKWOOD: Thank you. Just
18 building on Lisa's comment, one of the questions,
19 just as a clarification on the falls prevention,
20 is does this preclude -- because there are a lot
21 of evidence-based, community-based fall
22 prevention programs. What I'm wondering about,

1 is there any restriction or prohibition of a home
2 health agency using other community-based,
3 evidence-based programs for fall prevention?

4 CO-CHAIR SALIBA: I would think that
5 would be a sign of a better organization if they
6 were doing it.

7 MEMBER LEVITT: I'm trying to think of
8 a situation where CMS says don't do more.

9 MEMBER MARKWOOD: But clarification
10 there, I think that sometimes there's also the
11 incentive to say utilizing community-based
12 resources that exist, that will augment and
13 further the goal, rather than just feeling like
14 you have to do it within the context of just your
15 agency.

16 CO-CHAIR SALIBA: Thank you. It's a
17 good point. Erin.

18 MS. O'ROURKE: Thanks, Deb. I did
19 find an old endorsement report about -- that can
20 help clarify the question about where these
21 conditions came from on the dyspnea measure. It
22 looks like during the last endorsement review of

1 the previous NQF 179, the generic improvement in
2 dyspnea measure, the pulmonary and critical care
3 steering committee recommended that this measure
4 was a little overly broad, and it might be more
5 meaningful if restricted to patients with
6 cardiopulmonary conditions. I believe that CMS
7 was building on the recommendation that came from
8 the last endorsement review of the dyspnea
9 measure with this measure, if that can clarify
10 the committee's --

11 CO-CHAIR SALIBA: I think I was asking
12 what were they thinking.

13 CO-CHAIR RAPHAEL: I think they came
14 from a view of looking at this as derived from
15 diagnosis. We're trying to move to a broader
16 patient-centered quality of life, so we're coming
17 at it from a different perspective.

18 MEMBER LEVITT: It didn't have the
19 holistic post-acute care members on that
20 committee.

21 CO-CHAIR SALIBA: You need to implant
22 a geriatrician on every one of these panels.

1 Sean.

2 MEMBER MULDOON: The reductionist view
3 of that would be is it home care's role to
4 recondition/decondition patients, and can you
5 build a care plan around something that's not a
6 medical diagnosis? If that's yes and yes, then
7 broaden it.

8 CO-CHAIR SALIBA: Other thoughts,
9 comments? Paul, you look like you want to say
10 something?

11 MEMBER MULHAUSEN: I've been spending
12 the last ten minutes here just trying to find a
13 counter argument of what I've heard from the
14 people who've been pursuing the more holistic
15 view. I have struggled. I would go back to
16 Deb's observation that when faced with someone
17 with dyspnea, the task is to figure out why,
18 which ultimately leads to a diagnosis, one would
19 hope.

20 There are several elements here that
21 are problematic for my world view. One is the
22 primary diagnosis issue in dealing with a

1 population of people who fundamentally are going
2 to have comorbidities, and highly likely that
3 their primary diagnosis is not one of these
4 conditions. They could live with the primary
5 diagnosis.

6 Then the second would be to drive a
7 diagnostic process that would inform the care
8 plan would be very appropriate to incentivize.
9 The conditioning and reconditioning part, I guess
10 I would argue yes. If my patient was enrolling
11 in a home health program, I would want them to be
12 participating in helping the team, including me,
13 create a program that would help them become
14 better conditioned. Those are my reflections on
15 yours, Sean. Thank you.

16 CO-CHAIR SALIBA: Cari.

17 MEMBER LEVY: Just one quick thing.
18 Under exclusions, I don't see hospice as an
19 exclusion. Is it? It probably should be -- no,
20 I'm sorry, for dyspnea. Maybe for falls, hadn't
21 thought about that. For dyspnea, maybe there's --

22 MEMBER LEVITT: Not for this measure,

1 in particular, because it's congestive heart
2 failure and COPD/asthma in the hospice setting.

3 MEMBER LEVY: They could be getting
4 hospice and home health at the same time.

5 MEMBER LEVITT: We could add that as a
6 suggestion to the workgroup if you want to go
7 forward.

8 MEMBER LEVY: Yes, maybe just for -- I
9 haven't thought through it carefully, and I'm
10 sure there's things I'm not thinking of, but it
11 seems like it probably needs to be thought about
12 --

13 (Simultaneous speaking)

14 CO-CHAIR SALIBA: Cari, would treating
15 shortness of breath be a marker of quality even
16 in hospice?

17 MEMBER LEVY: Well, it would. I'm
18 just -- yes, maybe it's fine to leave it and not
19 exclude it. I'm just thinking of the person who
20 has lung cancer and a horrible pleural effusion,
21 and they're never not going to be dyspneic.

22 CO-CHAIR RAPHAEL: It's hard to get

1 improvement. Dyspnea is very common.

2 CO-CHAIR SALIBA: Other comments,
3 questions? Jim.

4 MEMBER LETT: I wanted to broaden the
5 end of life beyond just being in the hospice
6 program. A lot of times, we say hospice, we're
7 thinking about end of life, when in fact, I would
8 presume in this group, hospice means a specific
9 Medicare designated plan. So end of life should
10 expand way beyond that. Again, treating dyspnea
11 at end of life, usually important, but there's
12 only way it's going to get better.

13 CO-CHAIR SALIBA: Other comments,
14 questions? Again, given that this was on the
15 consent calendar, that means we don't vote, and
16 we didn't take it off the consent calendar.
17 We're not voting, so we're just moving forward to
18 the next item on the agenda. Is everyone okay
19 with that? Liza?

20 MEMBER GREENBERG: Would it be helpful
21 to CMS for us to take it off the consent calendar
22 and vote to do not continue or to discourage

1 continuation, or would that not matter to you?

2 MEMBER LEVITT: We can't tell you what
3 to do and not to do, but again, as I think I had
4 mentioned before, we were interested in which
5 direction that the workgroup felt we should be
6 going with this type of measure, so thank you,
7 Liza.

8 CO-CHAIR SALIBA: Liza, are you
9 suggesting we take it off the consent calendar
10 and just do a quick straw vote?

11 MEMBER GREENBERG: Yes, the dyspnea
12 measure.

13 CO-CHAIR SALIBA: We'll give her time
14 to type in this for voting. We're going to vote
15 on whether or not improvement in dyspnea in
16 patients with a primary diagnosis of heart
17 failure, COPD, and/or asthma should be continued
18 development or do not encourage continued
19 development or insufficient information. Pam.

20 MEMBER ROBERTS: If we want it
21 expanded to other diagnoses, how should we vote?

22 CO-CHAIR SALIBA: I think you would

1 vote not to encourage -- you'd vote 2, do not
2 encourage continued development, because what you
3 want is for it to be the broader, as opposed to
4 working on this specific measure.

5 MEMBER ROBERTS: Thank you.

6 CO-CHAIR SALIBA: Let us know when
7 you're ready.

8 MS. IBRAGIMOVA: The voting for
9 MUC15-207 is now open.

10 CO-CHAIR SALIBA: No, I think we're
11 voting on 15-235. I think we're voting on 235.
12 We're not voting on falls. We're voting on --

13 (Simultaneous speaking)

14 MS. IBRAGIMOVA: Sorry, 235.

15 CO-CHAIR SALIBA: Hold on a second.
16 Wait for her to change it. I think she has to
17 change it before -- oh, you can? Okay, so
18 everybody can vote. I'm sorry. You're voting on
19 235.

20 (Voting.)

21 CO-CHAIR SALIBA: That's everybody
22 because we had one recuse.

1 MS. IBRAGIMOVA: The voting results
2 for MUC15-235 are 25 percent encourage continued
3 development, 75 percent do not encourage
4 continued development, and 0 percent insufficient
5 information.

6 MEMBER LEVITT: Can I just ask would
7 the recommendation of the workgroup be to expand
8 to the general home health population or to other
9 diagnoses or what? General? Thank you.

10 MEMBER GREENBERG: I thought we were
11 discussing not changing it because we're going to
12 continue to use the measure that we're using, not
13 doing anything with this measure.

14 CO-CHAIR SALIBA: Which is general.
15 I think what Alan was asking is would we want
16 them to take this one and just expand the list
17 and come up with more diagnoses, or just continue
18 with general? We are now at sort of the end of
19 the items that were teed up for today for
20 discussion. It's an opportunity for public
21 comment in general, about anything related to the
22 quality measures across these settings, or any of

1 the discussions that we've had today. I'd like
2 to start by asking the operator to open the lines
3 for comment.

4 OPERATOR: At this time, if you would
5 like to make a comment, please press star, then
6 the No. 1. There are no comments at this time.

7 CO-CHAIR SALIBA: Are there any members
8 of the audience that wish to make a comment?

9 MR. HILLMAN: Hi, not to prolong this
10 any longer. I know it's 4:00, and you guys have
11 done an extensive amount of work today. Just
12 wanted to take a moment, from a commentary
13 standpoint, to thank you all for your time.

14 Thanks, CMS, for coming here and
15 answering some very difficult questions about
16 some of these measures. Just in general, I had
17 two main questions. I believe Mr. Gifford had
18 alluded to this before, but if the NQF committee
19 would consider once again defining the
20 differences between continued development -- the
21 continued development category versus last year,
22 we saw a lot of these conditional support with

1 NQF endorsement.

2 One of the biggest questions we have,
3 as a public, as a community, as a whole, is how
4 do these measures -- how do they proceed? How do
5 these measures get implemented, and does this
6 continued development allow the opportunity for
7 implementation of a measure who hasn't gone
8 through the entire NQF endorsement process? Then
9 just a generalized question -- again, I know
10 they're not required to answer any of the
11 questions from a public commentary standpoint,
12 but realistically, will CMS ultimately be seeking
13 NQF endorsement -- the official NQF endorsement
14 for each of the measures that were discussed
15 today and that will potentially be discussed
16 tomorrow?

17 As a measure developer at UDSMR, we
18 went through a full NQF endorsement process. We
19 know the requirements that we were held to, the
20 standards we were held to. Realistically, we
21 just want to know whether each of these measures
22 that we've discussed today, and we'll be

1 discussing tomorrow, will go through that same
2 rigorous and extensive testing process? Thank you
3 so much.

4 MS. LEE: My comment was somewhat
5 similar to his, but I just think, as a practical
6 matter -- this is my first time attending one of
7 these meetings. To me, it just seems like
8 continued development could mean that it's good
9 or it's not good, and discontinuing could mean
10 green light it, go forward, or wow, we've got a
11 major problem with this measure. It just seems
12 to me, from a process standpoint, that it
13 deserves some consideration as to what should the
14 different voting options be? It probably can't
15 be changed for today and tomorrow, obviously, but
16 going forward, it might make sense to really
17 think about what might be more meaningful.
18 Because I can just imagine that the NQF staff
19 probably have a dickens of a time taking notes
20 and making sure you capture it all accurately as
21 to what was actually the feel of the room and
22 what was discussed.

1 That's the only comment that I have,
2 but otherwise, I think this is a really
3 productive exercise because it enables the
4 public, like me, and all of you, as subject
5 matter experts around the room, to really fully
6 think through some of these measures. I look
7 forward to seeing still more information from CMS
8 about each measure. Thank you.

9 MS. IBRAGIMOVA: There are no chats.

10 MEMBER GREENBERG: Can I just make one
11 last comment? We put this in our public comments
12 to our CMS. As the measures get more complex,
13 it's much harder for us and the associations to
14 respond to them intelligently. I just wanted to
15 put a question or a suggestion on the table that
16 maybe as certain models that are embedded in all
17 of the measures come out, like your risk
18 adjustment model or your groupings for
19 potentially preventable re-admissions come out,
20 that those be presented -- when the measure comes
21 out for public comment, there be a slideshow that
22 explains, walks the non-experts through it --

1 just gets better quality of comment back to CMS
2 and helps us really understand what we're in.
3 Then as ICD-10 becomes the thing, that really
4 seeing those as they're mapped to ICD-10 will be
5 important.

6 CO-CHAIR RAPHAEL: Very briefly, I
7 think one comment I would make is that as you
8 listen to all of this, the IMPACT Act is
9 foundational, in terms of at least directionally
10 in trying to move us to tie payments to the
11 patient, not to the setting, to really think
12 about how to align across post-acute care
13 settings, how to ensure that people are getting
14 the right care in the right place at the right
15 time, and how we can work toward that. Something
16 that we've grappled with before in this workgroup
17 is how to deal with the tension between
18 standardization and customization. That is
19 recurring because we're dealing with four
20 different settings with, very often, different
21 patient populations, although there is some
22 considerable overlap. I think the other things

1 that I heard was in regard to our work on
2 medication reconciliation and drug regimen
3 review.

4 I hope we gave CMS some guidance there
5 that we want more guidance in return. I think
6 two other points that were important is to think
7 about the home setting, what medications you find
8 in the home setting, and not to forget
9 non-prescribed, over-the-counter drugs, which
10 also need to be included in any work that we do
11 in that area.

12 I think one point that was made in
13 regard to potentially preventable re-admissions I
14 thought was an interesting point, which is we
15 were thinking very much about conditions, and I
16 think it was Joel who said you also have to think
17 at the process. Because we're trying to look at
18 the process, as well as the conditions. I think
19 the other thing we continue to struggle with is
20 how to move along the spectrum from the process
21 to the outcomes. That continues, from my mind,
22 to be a formidable challenge to get to the

1 outcomes here. We often go back to the processes
2 of care. Then another thing that I think we're
3 grappling with is overlap. Parsimony is
4 something we care deeply about, at least those of
5 us who have been providers and have had to live
6 through this.

7 So how do you not layer new things on?
8 How do you remove, as well as improve? I think
9 that saying if the Edsel had been a public sector
10 program, it still would be in existence today,
11 that sort of occurs to me, which is how do we
12 really step back and think about what is it that
13 we have that we really don't need, that isn't
14 really showing its utility, or that we can
15 replace with composite or other measures that are
16 going to be more impactful?

17 Those are some of the things that
18 occur to me. Then I will make one last comment.
19 As I listen to all of this, we talk a lot about
20 moving toward a value-based system and population
21 health. Then we think about -- we were talking
22 last about falls and breathing issues. We talked

1 about when you go into a home, you ought to
2 examine the home, not just look at the patient.
3 We are, to me, redefining, in a way, post-acute
4 care and what we're responsible for in the
5 post-acute-care sector because we're moving away
6 from just the presenting condition that leads
7 someone to be referred to a post-acute-care
8 setting and saying that we have to look at the
9 whole person and things that just weren't on the
10 referral sheet that we got or on the e-referral
11 that came over online. I think that is something
12 that we need to think more about here, as we
13 continue our work. Deb, I'll turn it over to you.

14 CO-CHAIR SALIBA: I think other ideas,
15 in terms of the parsimony that came up today, was
16 the idea of in our efforts to be responsive to
17 concerns about measures that people have raised,
18 that leads to refining and tweaking measures, and
19 it may lead to slightly different measures.

20 That's something that we want to try
21 to steer clear of. We may need to be willing to
22 take a measure that's sort of a compromise, so

1 that it could be similar with other measures. I
2 think the other thing is that the easy measures
3 have been done. I think now we're at the stuff
4 that's much more difficult and that takes a lot
5 more thought to develop. I really appreciated
6 the comments that people have made today. I
7 think there was a lot of very helpful discussion.
8 CMS was very open, in terms of providing us with
9 background information, and that was much
10 appreciated. I'd like to see if anybody else had
11 some summary thoughts or comments about the day
12 before we adjourn? Alan.

13 MEMBER LEVITT: I just wanted to thank
14 everyone again. This was exactly what I wanted,
15 we wanted at CMS was really to get a workgroup
16 that we've worked with before to get the opinion
17 as to how our measures are, how our programs are,
18 and where we should be going forward and how we
19 should be going forward, so thank you. We got
20 another day ahead tomorrow.

21 (Whereupon, the above-entitled matter
22 adjourned at 4:03 p.m.)

A			
\$10,000 22:12	121:8,16 123:9	165:2 172:9 199:19	142:14
a.m 1:9 6:2 108:22	125:15 128:21 130:14	206:1 238:8 251:14	advise 196:9
109:1	130:14 132:3 147:19	283:18,19	advisor 24:22 27:13
AARP 17:20 18:4 27:19	148:16 157:5 163:6	addressed 42:18 81:6,8	advisory 2:4 23:20,20
ability 99:3 196:20	166:16 180:13 195:21	94:16,21 110:3 132:7	24:16 29:4
able 96:9,14 114:11	198:21 199:1,18	162:7 163:17 182:10	Advocacy 23:16
120:17 125:14 131:21	232:1 234:20 301:8	223:20 248:4 250:12	advocate 194:10
140:20 142:5 143:15	Act's 84:13	addresses 47:4,5,16,17	advocates 237:4
144:4 149:11 150:9	action 2:5 26:2 103:7	51:20	Aetna 1:13 23:9
150:10 151:7 157:5	239:13	addressing 68:6 164:15	affect 10:9 244:20
176:21 177:6 181:17	actionable 239:6	249:19 280:8 283:8	Affordable 34:2,19
197:6 204:20 212:10	281:15,20	adequate 78:5 151:14	afraid 220:17 265:16
245:16 251:18 252:5	actions 56:13 249:10	adjourn 305:12	afternoon 173:16 175:1
256:20 260:20 285:6	active 240:13	adjourned 305:22	age 79:16,19 200:9,14
285:19	activities 27:2 100:15	adjust 143:18 153:2	200:19
above-entitled 108:21	284:12	adjusted 153:10 184:10	agencies 1:20 120:6
172:16 266:10 305:21	activity 139:20	187:17,22 188:6	143:3,14 144:4
absolute 45:6	actual 103:8 112:14	280:2	173:17 175:16 277:18
absolutely 19:21 80:10	187:21 274:18 279:12	adjuster 144:16	284:11,18,18 285:17
143:18 213:22 237:10	acuity 140:14	adjusters 144:14,14	285:19
241:19 242:3 278:11	acute 1:19 10:10 24:6	200:8	agency 32:20 96:12
280:12	41:3 100:9 124:7	adjusting 167:22 168:4	143:5 154:9 156:15
abstentions 56:21	130:2 133:10 151:1	202:4	229:7 244:12 283:16
Abt 160:4 278:12	154:5 158:3 182:16	adjustment 14:2 60:16	288:2,15
accelerated 121:16	182:19	125:12,21 126:17	agenda 31:3 54:1 57:3
acceleration 10:15	acute-care 123:12,13	127:6,11 134:16	63:10 68:9 177:11
accept 145:10 167:15	124:6 142:4 150:16	136:13 140:15 144:3	189:4 205:16 293:18
181:12 206:11 245:1	151:3 170:22 171:3	144:11,13,17 145:7	Aging 1:20 173:17
acceptable 78:13	ad 115:3	145:19,22 152:18	ago 35:13 155:15
accepting 54:6,12	adapt 212:17	163:11,16 167:10	Agostini 1:13 23:6,7,7
181:11	adaptation 63:19 224:2	168:1,7 170:7 185:11	23:12 134:12 135:3
access 35:18 163:9	add 43:2 47:2 55:5	188:1,11 215:14	agree 55:7,8 78:12 81:3
170:4 201:4	79:21 102:20 115:13	244:22 300:18	83:14 196:14 206:2
accessible 12:3	122:12 138:1 144:9	adjustments 126:18	216:5 217:4 225:19
accomplish 6:12	149:15 228:3,9 269:3	Administration 191:1	262:18 271:15 272:16
accomplished 102:5	272:10 273:11 274:6	administrative 21:1	275:3 282:1
account 122:13 144:2	292:5	admission 69:6 137:1	agreed 54:15 78:2
156:10 170:8 179:14	added 33:6,10 35:9	150:15 151:5,8 178:9	agreement 24:22
179:21 187:20	78:3 94:19 158:1	179:22 182:19 183:5	116:12 131:6
accountability 12:21	193:12,20 199:3	183:6 200:9,9 210:18	agreements 17:11
176:7 245:10 247:10	274:4 283:2	238:19 246:5	agrees 283:3
accountable 176:3	adding 33:14 79:17	admissions 125:2,7	AHCA 193:7
177:6	132:5 138:7 201:12	admit 260:18	ahead 61:14 70:15 76:4
accurate 73:21 146:9	260:15 274:18,19	admitted 74:5 137:15	143:10 184:12 202:18
accurately 131:12	285:2	151:1 178:21 179:6,6	219:9 225:16,17
299:20	addition 7:1 28:16	206:16 215:7 240:21	229:2 252:12 259:19
achieve 60:22	45:22 46:17 113:7	adopt 92:3	266:3,4,6 284:14
achieving 242:19	145:18 206:9 269:2	adopting 209:8,10	305:20
ACQA 201:6	additional 118:7 121:19	Advancing 242:20	AHRQ 28:3 29:5
act 4:10,12,14,16,18,20	121:20 122:7 148:19	advantage 282:17	aims 45:15 148:2
6:19 10:14 12:20 25:1	150:13 165:1 167:2	287:15	airway 253:3
28:13 29:1 32:17 34:2	212:15 268:8	advantages 250:19	Alan 2:11 4:7 24:4 31:4
34:19 35:7,18 36:7	Additionally 150:19	adversarial 162:19	31:9 40:17,18,22
37:9 38:14 40:5 42:21	additions 132:5	adverse 74:2 80:6	41:12 45:10 70:18
64:18 65:15 68:12,15	address 42:20,21 45:14	82:17 175:21 176:2	82:22 87:6 89:1,11
70:13,14 71:20 81:10	57:18 66:17 94:22	176:12 237:21	98:11 105:13 111:12
112:19 114:5 118:17	96:10 128:9,21 148:1	adversely 131:16	112:9 114:2 129:4
	160:2 162:19 164:5	advice 16:22 85:4	134:14 140:2 148:21

159:20 162:22 180:15 182:10 184:11 185:18 186:18 197:22 198:13 198:19 202:6,11 208:19 217:12 251:1 259:17 262:8 265:4 273:9 276:15 277:22 279:17 283:22 296:15 305:12 Alan's 85:18 97:18 Alas 169:9 alcohol 139:20 align 226:21 301:12 aligned 231:3 alignment 45:16 47:14 70:11 129:2 135:5 148:17 193:14 aligns 124:13 243:7 alive 256:3 all-cause 119:2 all-MAP 42:9 alliance 3:9 27:15 191:8 267:10 allow 57:14 79:4 80:9 144:3 169:9 176:20 286:11 298:6 allowed 166:12 232:20 allowing 31:10 71:16 allows 43:14 233:6 alluded 192:20 297:18 alongside 234:20 alternate 111:20 Alyssa 3:7 120:3 Alzheimer's 18:6 ambiguity 97:22 98:15 99:2 ambulance 237:14 ambulatory 155:13 AMDA 1:18 8:8 25:12 America 1:15 8:4 62:6 American 1:15,21 2:1,4 3:4,5,7 9:5 24:3,20 25:8,14,18 27:22 28:9 65:12 109:10 124:12 182:8 230:21 AMGA 17:21 amount 38:22 233:13 297:11 amplification 80:22 117:1 264:15 amplify 78:19 79:9 238:4 analogous 200:22 204:16 analogy 150:4 analyses 164:16,20,22 248:10 analysis 42:14 46:17,19	47:8 53:1,3,6,10,13 54:6 55:2,9 67:21 69:19 75:5,9 83:19 127:20 128:14 146:16 168:9 223:10 243:1 analyst 2:18 61:21 Analytic 24:8 analytical 164:15 205:1 analytically 165:18 166:20 247:2 analyze 200:16 and/or 65:22 182:19 266:21 294:17 Address 3:2 149:2 160:1 169:21 170:20 184:17 185:1 186:2,6 186:18 187:3,16 188:10 232:9 246:14 247:1 249:18 251:4 Andrew 3:3 117:14 178:4 Ann 2:17 4:4 21:2,4,8 30:22 31:2 annotated 205:16 announced 10:16 announcement 171:7 171:17 announcing 35:1 56:9 answer 13:13 15:11 46:21 138:13 165:14 165:15 229:3 240:12 242:1 298:10 answer's 161:20 answered 262:6 273:9 answering 297:15 answers 13:15 113:13 antibiotics 99:20 anticipate 82:12 152:20 163:3 164:3 anticipating 160:17 163:5 anticoagulant 103:19 antipsychotic 189:10 192:12 193:10 198:13 203:4 206:8 208:2 211:19 213:8 215:1,6 215:9,19 216:1 253:6 253:17,18 255:2 256:14 259:16 260:4 260:17 261:18 262:13 263:3,4,20 265:7 antipsychotics 190:10 191:2,5,13 203:16,17 216:12 259:21 261:13 262:4 anybody 77:14 137:15 278:12 305:10 anymore 220:16	anyone's 144:18 238:4 anyway 139:4 233:5 246:12 apart 247:3 286:13 apologize 187:1 285:4 apparent 234:22 256:7 appear 245:18 appendage 99:15 applicable 6:15 215:11 application 39:15,15,19 66:8 114:6,7 203:6 204:5 APPLICATIONS 1:3 applied 86:14 134:1 136:14 214:8 279:3,4 applies 77:16 150:1 apply 127:11 213:19 appreciate 78:16 114:16 115:5 117:19 120:6 122:20 150:2,4 appreciated 305:5,10 approach 4:8 18:20 194:9 261:21 263:19 approaches 13:20 appropriate 66:2 74:6 74:12 102:11 121:12 122:2 123:16,18 124:8 179:12 186:9 204:2,21 205:4 221:10 261:15 263:13 269:16 291:8 appropriately 80:10 122:13 189:13 208:6 221:5 223:2 227:16 229:19 approved 108:11 191:2 192:15 193:9 194:4 APPS 210:19 APU 214:8 area 1:19 6:15 7:4 12:6 14:1 16:5 20:1 29:2 60:2,17 153:16 164:9 165:7 173:17 226:5 233:17 250:17 257:13 257:19 267:20 302:11 areas 13:1 16:5 60:4 127:8 151:9,17 153:6 163:2 165:6 207:2 241:3 247:16 273:15 argue 82:7 291:10 argument 161:13 290:13 Arizona 7:21 25:21 29:3 29:13 array 99:18 arrive 178:20 art 13:11 23:19 ARTHUR 2:3	articulated 134:17 223:15 ASCP 91:20 92:13 asked 13:9 22:11 54:22 59:20 110:17 237:7 263:16 280:5 asking 12:11 13:6 15:4 43:7 98:18 224:18 255:17 282:18 289:11 296:15 297:2 asks 27:1 229:5 ASPE 3:12 132:3,4 aspect 10:8,17 125:17 126:11 aspects 270:12 assess 121:17 201:17 assessed 189:13 195:13 208:5 221:5 223:1 229:19 270:15 assesses 199:14 assessing 245:4 246:7 assessment 33:4 36:13 36:14,22 37:3,8,11,14 38:11,15 39:9 73:3 86:9,13,16 130:17 150:8 168:8 193:20 194:20 226:8 270:17 287:6,8,13 assessments 66:12 127:4 assign 50:5 272:19 assignment 154:4 assigned 52:10 154:12 assist 45:2 Assistant 3:11 associated 26:18 39:8 45:3 151:18 272:13 278:2 284:5 Association 1:15,16,19 1:22 2:1 3:5,5,7,7,8 9:5 24:21 25:15,19 28:6 62:6 65:13 109:11 120:4 123:2,5 124:12 173:17 182:9 230:21 associations 8:4 24:2 300:13 assume 155:12 217:14 260:14 assuming 243:13 262:18 264:17 asthma 266:21 294:17 astounding 240:4 at-risk 283:7 attached 140:8 attempt 42:17 46:20 attempting 104:11 attending 172:12 299:6
---	---	--	---

attention 10:14 55:15
56:6 58:10 60:18
102:7,16 174:10
194:22
attributable 158:22
159:1
attribution 14:7 102:3,7
102:17 181:10 244:10
atypicals 262:4
audible 132:12 182:3
189:2 196:6 207:21
211:11
audience 65:8 67:11
117:11 147:7,8
174:13,18 177:9
178:1 180:2 189:22
196:5 230:19 231:11
253:13 267:7 270:2
297:8
audiences 268:19,20
augment 165:6 288:12
augmented 163:19
August 227:13
authoritative 15:17
autonomic 151:2,3
available 127:3 130:19
134:4,5,17 149:8
153:7 163:3 251:9
average 184:4,10
avoid 49:8 82:17
169:15 233:21 261:16
avoidable 183:1
aware 140:1 164:11
165:16 166:7,18,22
168:15 237:3 269:11
awful 55:19

B

back 7:3,12 15:21 32:4
37:4,16 38:21 46:5
64:10,12 70:16 73:11
82:20 88:2 90:17
91:16 105:8 107:13
109:19 110:16,18
111:10 112:5,5
113:13 114:15,19
115:11 116:19 119:4
119:5 126:15 133:13
134:6 137:13,17
141:11,22 142:4,9
152:8 155:21 159:14
159:22 167:9 170:9
179:3 181:6 182:16
198:8 203:14 205:13
212:14 223:18 234:3
237:16 238:12,15,18
238:21 241:8,11,14
241:16 245:3 246:10

246:18 266:4,7,14
278:8 286:19 290:15
301:1 303:1,12
background 182:13
305:9
backtrack 174:17
backwards 282:1 283:4
bad 153:4 260:7 261:8
Baird 3:3 117:13,14
178:3,4
balance 82:20 117:21
272:3 275:18,19
balancing 81:10
Baltimore 31:14
based 5:10,12 29:22
33:17 42:5 53:5 75:4
125:19 128:7,12
130:16 140:5 148:6
148:13 156:12 158:12
173:18 181:5 193:3
193:17,18 195:8
207:11 233:12 250:20
252:6
basically 56:11 90:11
173:9 200:18 204:15
228:6 270:11
basis 69:12 233:7
basket 33:1 34:17
248:17
bear 249:11
bears 248:5
beautifully 243:8
bed 201:3
bedevils 17:9
beds 19:4
beginning 32:14 63:3
96:4 120:9
begins 178:14 286:11
begs 263:11
begun 67:4 72:10
behalf 10:3 182:7
behaves 137:3
behaving 30:16
behavior 60:9 63:20
106:16 140:18 145:5
259:20 265:13
behavioral 16:7 139:18
190:17 206:12,13
believe 6:17 9:2 27:5
30:15 75:9 93:4
107:17 115:21 119:19
121:12 122:14 125:18
133:5 135:17 160:4
175:12 231:2 262:15
289:6 297:17
bell-shaped 15:6
belong 245:6
belovedly 6:5

benchmarking 204:11
bend 6:22
beneficial 81:12 164:7
beneficiaries 47:18
123:22
beneficiary 85:5 92:22
204:3
benefit 51:9 156:11,12
269:14 275:22
best 38:5 61:1 71:17
73:7,8 79:22 95:22
140:11 141:1 143:17
164:7 165:15 169:15
221:17 251:22 261:17
best-in-class 194:19
better 11:18 12:8,10
13:7,17 107:11 132:1
138:7 141:3 161:19
176:20 215:16 225:15
238:15 255:7 280:19
288:5 291:14 293:12
301:1
beyond 60:4 157:11
293:5,10
biased 30:16
big 17:10,12 215:9
biggest 298:2
bind 138:17
BIPA 37:6
Bipartisan 35:7
bipolar 190:22 191:3,4
191:9,12,17 192:3
193:11 203:1,20
204:8,13,19 205:4
206:7 215:12,15
216:3 217:4,16
253:19 254:16 260:15
260:15
bit 32:4 48:5,10,22 52:3
54:15 77:18 79:7
81:10 88:6 101:7,9
112:10 116:10 132:21
133:12 137:21 155:15
198:19 203:1 206:3
214:7,11 217:14
227:11 252:12 254:3
256:15 257:2 263:14
266:5 272:2
bleeding 103:18
block 97:14
blocks 171:20 172:8
blue 49:21 108:7
board 11:21 23:20
24:16 27:14,16,17,19
27:21 28:5 216:17
boat 113:15
bolts 42:11
book 29:8

borne 248:11
bounce 137:13 181:6
bounced 245:2
box 67:14,16 89:12
90:5 93:18 147:9
231:12 253:21 270:3
270:5
break 57:6 108:13
109:5 207:8 252:15
257:2 266:2,4,6
breaks 57:3
breath 278:3 279:22
280:7 282:3 283:11
283:17 292:15
breathe 258:16
breathing 253:2,4
258:19 259:12 303:22
bridge 275:8
brief 22:15 42:10 67:19
127:19 175:2 231:15
briefly 66:4 122:3
199:18 301:6
bright 18:12 259:9
bring 17:4 20:9 30:17
32:3 83:17 110:15,18
112:5 113:13 205:2
206:18 246:13 280:15
bringing 18:7 38:22
179:17 267:22 273:13
286:16
brings 18:18 221:7
246:9
broad 158:4 159:6
279:2 289:4
broaden 176:21 290:7
293:4
broader 186:12 280:1
281:7 289:15 295:3
broadly 162:7
broke 171:7
broken 239:9
brought 83:17 121:6
146:2 174:10 192:22
194:6 277:7
Bruce 1:16 20:13 24:15
77:21 78:18 87:6 95:3
103:22 255:12 256:16
262:22
Bruce's 80:22
bucking 263:7
Budget 35:7
build 140:6 142:12
158:9 260:20 290:5
building 140:11 143:1
158:14 287:18 289:7
built 57:3 161:2 169:10
burden 96:8,10 206:21
250:21 272:11

burdensome 282:19
Burstin 13:3
button 258:13
buy 216:1

C

CAHPS 33:6
calculate 187:6
calculated 240:18
 241:5
calculating 187:18
calculation 196:2
calendar 50:22 53:10
 53:12,20 54:1,9,11,13
 54:19 57:10,13 74:17
 75:4 76:9,11,15 77:4
 77:19 79:5 80:18
 103:7 132:11 147:19
 149:20 180:6 182:2
 189:6 192:10 196:13
 197:16,20 198:7
 206:2 207:7,11,20
 208:8 211:14,15,18
 212:5,10,20,21 213:3
 219:2 221:3 232:8
 236:4,5,6,17,19 252:9
 252:10 253:1 254:11
 256:19,21 265:21
 266:17 267:14 276:4
 276:6,11,14 293:15
 293:16,21 294:9
calendars 68:16 74:22
 197:14
California 3:7 28:4,6
 120:3
call 6:5 100:14 104:22
 159:13 181:7 229:12
 252:17
called 8:16 23:4 24:17
 28:10 119:18 237:14
 250:13
calling 58:7
calls 120:20 166:13
 215:5
calm 259:21 263:8
Cambridge 17:13
cancer 292:20
cane 274:15
capabilities 175:15
capture 43:14 168:5
 178:12 221:18 222:4
 234:4,5 250:4 252:5
 299:20
captured 75:21 136:16
 250:1
captures 119:3
capturing 66:16 139:16
 250:18

card 276:16 283:21
cardiopulmonary 289:6
care 1:3,14,17,19 2:2
 3:4,5,7,8 4:6 5:13,15
 6:6,16 8:9 10:10
 12:22 16:7 19:19 20:1
 23:17 24:6,9,13,18
 25:3,13 26:7 28:6
 29:7,9 31:6,13 34:2
 34:11,19,21 35:10
 36:11,13,22 37:15
 38:1,3,6,10,11 39:3
 39:21 41:3,8,15 50:7
 50:13 51:11 63:17
 69:7 71:22 74:13 77:8
 77:10,11 85:16 86:12
 89:5,13,15,22 90:1,5
 90:6 92:20 98:17,20
 98:22 99:17 101:10
 101:12 102:14 103:6
 104:12 110:14 117:15
 119:14 120:21 123:2
 123:5,6,11,14,18,19
 124:2,5,7 126:5 127:4
 128:3,4,17 129:1
 130:2,3 131:2,18
 133:11 147:17 151:1
 155:5 158:16 159:4
 161:9 174:5 175:11
 176:17,22 177:1
 179:2 182:17,19,19
 183:7 191:2 192:2,3
 193:3,17,19 195:3,4
 196:12,21 198:18,18
 198:20 199:15 201:12
 201:21 216:9 225:13
 228:9 234:14 237:3
 238:15 239:5 241:22
 242:5,12 244:16
 247:15,18 252:21
 253:18 254:6 255:1
 258:2,8 270:19,20,21
 271:9 273:16 276:1
 277:1 282:2,14
 285:17 286:7,15
 287:2 289:2,19 290:5
 291:7 301:12,14
 303:2,4 304:4
care's 290:3
care-tool 207:1
CARE/LONG-TERM 1:3
careful 16:17 93:10
carefully 292:9
Caregiver 2:5 26:2
caregivers 96:2 135:13
 159:5
Cari 1:18 8:5 25:11 90:8
 93:18 95:4 217:2

222:19 223:15 245:14
 249:15 264:2,15
 281:1 291:16 292:14
Carol 1:9,12 2:2 4:3
 9:18,20 17:12 18:4
 19:12 21:9 23:1 26:4
 26:6 42:1 52:14 55:13
 64:12 70:16 73:11
 81:11 94:10 108:15
 139:7 218:15,18
carry 86:21,22
case 111:6 114:7
 150:18 151:20 161:12
 170:22 199:21 209:10
 224:22 272:17 287:2
cases 119:11
Casey 101:14
Cassel 2:17 4:3 9:12,18
 13:10 20:7
categories 38:16 56:2
 125:22 213:13
categorize 176:3
categorized 94:14
category 44:14 48:13
 146:20 216:22 259:6
 283:12 297:21
Catherine 144:11,12,19
 203:8
catheter 159:8
cause 135:15,22 161:21
 162:8 164:13 165:11
 165:22 232:22 243:1
 277:17
caused 100:13,13
causes 275:16
caution 101:1 177:3
cautionary 176:15
cautions 90:11
Center 3:4 33:20 175:4
centered 282:1
Centers 2:11 3:2,10
 24:10 28:2,12
central 45:12
CEO 2:17 4:3 9:13
 173:16
certain 35:16 59:7
 113:18 115:4 119:7
 129:11,17 140:21
 142:2,6 151:15 158:3
 300:16
certainly 34:7 71:11
 72:1,20 75:22 99:13
 111:8 112:16,19
 115:6 127:22 140:21
 141:17 149:7 161:8
 163:6,14,18 165:16
 166:5,7 176:6 186:6
 248:11 249:10 250:18

270:8 278:18 285:10
certification 139:14,15
cetera 12:13 15:10
chair 27:14,16,19 28:9
 52:2 220:7
chairs 23:1 27:11 30:19
 78:21
challenge 122:11
 302:22
challenges 158:20
 207:4
challenging 145:13
 206:15
challenge 57:15 106:19
 197:10
change 43:6 46:15
 55:14 56:5 57:7 61:6
 90:3 105:3 111:7,9
 116:22 161:5 189:7,8
 195:15 207:13,14
 221:10 224:7 225:3
 226:4 228:2 275:21
 295:16,17
changed 41:13 46:3
 48:22 90:20 112:22
 299:15
changer 34:3
changes 7:14 42:5
 93:16 224:6,18
 265:13
changing 13:20 41:6
 72:2 296:11
characteristics 44:20
 45:3 126:18 127:12
 165:8
charted 239:22
charts 241:20
chat 67:14,16 127:15
 147:9 231:12 253:21
 270:3,5
chats 67:16 300:9
check 89:12 90:5 93:17
cherry-pick 135:20
CHF 158:3,18 175:8
 275:21
chief 13:4
childhood 32:11
choice 56:2 213:12,13
choices 255:21
choose 201:9 209:13
choosing 145:20
chose 254:22
chosen 194:20 254:19
 265:9
Chris 4:3 9:12,14,16
 20:15
CHRISTINE 2:17
chronic 24:5,8 31:12

41:6 177:1 263:4
chronic-care 175:9
circumstances 74:8
 93:15
Citizens 9:7
claim 151:3
claims 17:16 122:10
 125:19 128:12 130:16
 130:18,20 131:7
 133:7 140:5 141:7
 142:11 150:7,21
 162:22 163:8 168:18
 250:20 252:6
claims-based 130:22
 131:10
claims-only 127:2
clarification 217:4
 236:9 255:22 261:4
 263:2 287:19 288:9
clarified 192:18
clarify 74:20 80:17
 111:5,12 112:9 152:1
 152:2 197:5 213:1,11
 217:14 288:20 289:9
clarifying 56:9 110:20
 165:9
clarity 136:4 273:13
Clarke 2:15 9:1,4 84:3
 85:11
class 235:6
classified 210:8,9
classify 14:13
clear 76:14 82:1 87:10
 91:12 134:10 186:16
 211:21 217:19 228:13
 247:4,9 258:20
 282:17 304:21
clearly 126:19 214:21
 271:2 278:1
click 120:17 218:13
clicker 49:21 50:2,4
 108:7
clickers 216:18
clicking 55:19
Clinic 17:20
clinical 17:17 19:4
 65:12 82:9 91:1 92:1
 103:4,5,6 161:9
 175:17 191:3 206:9
clinically 69:13,13
 71:14 85:15 87:21
 88:14,16 91:3 99:4
 103:10
clinicians 178:17
close 15:4,5,7 164:5
closed 220:6
closed-loop 101:18,22
 102:9,16

cloud-based 18:17
CMS 2:11 3:2,10 4:7
 14:4 24:6 28:21 31:13
 33:17 37:7,10,12,16
 43:17 48:19 58:3
 69:16 73:6 82:22
 86:18 92:20 98:14
 99:2 110:1,6,18 111:3
 111:3,13 112:4 114:3
 115:16 116:16 118:16
 120:13,18 122:6,19
 128:10 144:21 145:8
 156:21 170:5 180:16
 191:14 193:1,19
 197:21 199:3 201:19
 202:2 203:18 204:10
 209:4 210:22 212:1
 212:16 213:16 215:21
 221:22 222:8 223:21
 223:22 224:10,15
 232:6 234:11 238:8
 242:16,18 243:6,16
 244:10 254:12 262:6
 267:12 269:17 271:12
 280:2 288:8 289:6
 293:21 297:14 298:12
 300:7,12 301:1 302:4
 305:8,15
CMS's 116:10
CMS-funded 13:5
co-chair 1:12,12 4:3,4
 6:3 7:22 8:5,10,17,22
 9:11 19:15,19 20:12
 20:21 27:12,20 30:22
 31:2 40:17,21 48:3,15
 49:13,16 58:15 61:11
 61:17 62:17,20 64:14
 65:3,7 67:10,13,17
 70:17 73:13 74:14
 75:1,14 76:3,5,13
 77:21 78:18,20 80:17
 81:19 82:5 84:3 85:11
 87:5 88:18 90:8 91:9
 91:11,17 96:5 97:15
 99:11 102:18 104:9
 107:15 108:1,4,10,16
 109:2 117:3,10
 127:14,17 129:3
 132:8,13 136:6 140:2
 144:7,22 145:15
 146:12,19 147:6,11
 148:21 149:17 152:6
 156:2 157:7 158:14
 171:6,15,22 172:3,6
 172:10,14,19 173:22
 174:9 177:8,11,22
 180:1,15,20 181:20
 182:4 183:17 184:11

186:13,21 188:21
 189:3,21 196:4,7
 197:17 198:5 202:10
 202:17 205:15 207:5
 207:22 210:5 211:5
 211:10,12 212:2
 213:10 214:19 215:17
 216:13 217:6,18
 218:1,6,11,17,22
 219:8,20 220:5,21
 221:12 222:14 224:20
 226:2 227:19 228:22
 229:11 230:9,18
 231:10,14 232:6
 236:2,11,14,16 238:1
 238:11 239:15,19
 242:7 245:12 249:14
 251:1 252:7 253:12
 253:20 254:2,10
 255:10 256:16 257:22
 259:10 260:8,16
 261:1,11 262:5,8,22
 263:16 264:13 265:4
 265:19 266:13 267:6
 270:1,6 271:12 273:5
 275:2 276:2,9 277:22
 278:11,15 280:5
 281:1,11 282:21
 283:21 285:22 288:4
 288:16 289:11,13,21
 290:8 291:16 292:14
 292:22 293:2,13
 294:8,13,22 295:6,10
 295:15,21 296:14
 297:7 301:6 304:14
co-chairs 1:9 52:12
 53:16 54:5 101:14
coalition 1:18 9:8 24:13
Coast 170:16
code 133:19,22 141:8
coded 204:20
coder 204:20
codes 122:10,13,17
 125:20,21 131:4
 134:1,3,4 160:8,10
 161:1,2,17 235:6,9
coding 116:3 122:10
 133:7,15 204:21
coffee 87:6
coffee-stained 86:21
cognition 201:19
cognition-specific
 202:3
cognitive 127:1 150:16
 201:20,22 202:1
 228:12 287:1
cognizant 105:6
cold 99:21

collaboration 31:16
Collaborative 27:18
collar 253:3
collateral 152:12
colleagues 31:12 48:19
 216:8
collected 150:11
 163:15
collection 94:20 200:17
Colorado 8:20 28:20
 104:7
combination 240:11
combined 169:5 272:21
combining 272:5
come 7:8 22:17 35:4
 44:13,18 55:13 59:4
 67:14 73:10,11 74:8
 101:21 107:5 109:19
 111:10 119:5,8
 127:15 129:22 133:3
 141:11 143:5,6,9
 150:15 152:8 158:18
 171:21 174:22 178:18
 195:18 197:12 198:8
 212:11 224:9 237:15
 240:7 245:2,6 246:10
 246:18 255:19 258:7
 262:13,16 264:8
 266:4,7 278:8 279:6
 296:17 300:17,19
comes 11:9 119:4
 143:5 153:13 245:10
 300:20
comfortable 153:16
coming 95:12 136:11
 153:3 176:16 181:19
 215:13 245:5 255:1
 289:16 297:14
commend 120:7,22
comment 4:10,14,18
 5:1,5,9,13,17,21
 14:12 19:21 20:15
 57:9,16,19 58:1,7,8
 59:2 64:13,17,21 65:1
 67:9 68:4 70:1,18
 71:1,3 73:12 83:14
 102:3 104:6 105:14
 115:16,19 116:11,16
 117:1,5,7,18 118:13
 120:7 122:1,20
 124:10 135:1,8,10
 139:10 145:14,15
 146:13 147:2,4,8
 148:8,22 156:4
 174:19 175:12 177:9
 177:17,19 178:2
 189:15,19 197:1
 200:19 208:10 210:6

221:7 222:11 227:4 229:12 230:15 231:9 238:13 244:7 245:13 251:3 252:17,19 253:7,9,14,15,17 262:10 263:17 267:3 267:8 269:22 278:19 281:3 286:4 287:18 296:21 297:3,5,8 299:4 300:1,11,21 301:1,7 303:18 commentary 297:12 298:11 commented 116:15 173:1 commenter 78:12 commenters 57:11,17 234:6 commenting 124:20 157:14 220:9 comments 41:18 57:12 57:14 58:2,6,10,21 59:4 60:6,7 61:8,10 65:6,9 67:11,12 68:1 70:7 72:20 73:14 78:3 78:4 82:3 91:20 93:6 94:9 96:7,8 97:18,20 98:8 100:19 101:6 102:18 105:18 111:9 117:8,12 122:18,18 123:4 129:4,7 132:15 133:3 134:13 136:8 139:8 145:1 147:5 174:14 177:15,21 180:2,16 181:18 182:6 183:18 188:22 189:20,22 190:7 194:15 196:4,15 197:21 198:2,6 199:19 201:12,18 205:18 211:10 215:1 215:18 216:15 219:4 219:9 220:6 222:19 229:1,15 230:13,16 230:19 231:11,12 232:7 238:2 243:13 252:8 253:10,21,21 254:1,12 257:9 259:10,11,18 260:8 260:16 262:1 265:20 267:1,4,13 270:2,9 271:14 276:15 281:10 283:20 286:1 290:9 293:2,13 297:6 300:11 305:6,11 committee 7:6 19:19 20:2,5 21:10 26:16,20 27:10 28:9 35:13 51:4 51:14,19 58:3 107:14 108:17 109:7 110:12 149:6,6 173:21 174:8 196:18 197:3,5,11 232:16 277:3 286:8 289:3,20 297:18 committee's 21:18 22:13 27:5 277:20 289:10 committees 15:17 21:11,20,21,22 common 37:11 162:15 163:12 250:3 293:1 communication 96:11 105:9 176:14 communities 153:8 community 4:15,17 99:16,17 107:7 109:4 118:1,3,3,9 119:19,20 122:4 123:8,19 126:15 127:19 128:10 129:16 132:17 133:1 133:6,14 134:8 135:16 136:1 137:17 138:1,3,6,9,18 142:14 143:7,8,11 153:12 154:8,15 170:13 173:18 216:2 243:9 245:20,22 258:3 267:15 269:11 271:18 271:22 272:10 285:1 285:8 286:20 298:3 community-based 287:21 288:2,11 comorbidities 200:11 251:10 291:2 companion 248:15 company 24:17 242:6 comparable 15:4 compare 191:16 192:16 214:12 225:7 240:22 244:21 268:3 279:9 285:7 compared 62:18 88:7 188:6 comparing 187:17 comparison 125:15 137:8 compelling 100:20 competing 45:17 194:18 compile 170:4 complement 45:8 193:19 complete 12:16 95:18 134:15 266:1 completed 67:4 154:13 182:20 completely 55:9 complex 14:9 94:4 153:3,9 167:11 300:12 complexities 150:17 compliance 253:1 257:6 complicated 170:11 complication 102:12 181:7,8 complications 167:18 comply 60:12 component 274:19 components 72:7 73:6 101:20 283:5 284:19 composite 266:18 267:21 270:10 271:11 272:6,7 274:5 284:14 286:4,11 303:15 compoundness 100:20 comprehensive 89:20 273:13 compressed 59:10 compromise 304:22 computer 52:7 concept 18:1 37:11 42:20 68:18 83:6 135:18 160:21 162:6 190:12 214:16 264:12 concepts 47:17 117:20 concern 75:16 81:2,5 81:13,16 85:14 135:9 135:12 137:9 145:4 146:11 158:9 182:9 206:10 222:21 223:11 236:21 257:20 260:2 279:1 concerned 131:15 145:9 146:7 153:17 190:17 191:19 237:6 concerns 55:1 64:4 66:3 71:2 75:20 77:8 77:12 81:12 83:1 123:7,21 124:16,19 136:15 145:18 158:5 162:20 163:20 177:5 189:1 197:8 221:19 222:5,8,15 248:6 304:17 concluding 105:14 conclusion 53:7 55:13 56:10 concrete 98:13 condition 157:20 161:7 161:8 162:12,13 194:10 200:11 205:5 237:7 304:6 conditional 53:5 56:7,8 56:18 208:16 297:22 conditionally 43:22 conditioned 291:14 conditioning 291:9 conditions 18:19,22 56:9 111:2 155:14 158:1,3,19 162:15 175:7 193:9,11 206:12,13 278:4 288:21 289:6 291:4 302:15,18 conducted 69:4 74:9 248:10 Conference 1:8 conflict 30:6,9,10,14,16 173:21 conflicts 173:12 confused 90:18 98:5 211:7,9 223:7 confusing 268:22 confusion 134:2 137:22 165:16 224:21 272:13 congestive 275:12 292:1 Congress 35:14 37:6 37:10,16 38:2,8,22 106:4 112:20 114:4 129:14 140:4,19 243:18 connect 286:9,12 connection 139:21 connects 104:11 conscientious 247:12 consciousness 100:2 consensus 55:22 81:7 81:13 107:7,9 108:6 110:21 204:8 212:11 consensus-based 37:18 consent 50:22 53:10,11 53:20,22 54:8,11,13 54:18 57:10,13 63:10 68:16 74:16,21 75:4 76:9,11,15 77:4,19 79:5 80:18 132:10 147:19 149:19 180:6 182:1 189:6 192:10 196:13 197:14,16,19 198:7 207:7,10,19 208:8 211:14,15,18 212:5,9,19,21 213:3 219:2 221:3 232:8 236:4,5,6,17,19 252:9 252:10 253:1 254:11 256:19,21 265:21 266:17 267:14 276:4 276:5,11,14 293:15 293:16,21 294:9

consequence 137:10
228:5 235:22 237:22
260:2
consequences 140:16
152:12 166:8 188:17
236:22 237:20 248:3
249:7 265:16
consequential 7:10
consider 58:11 73:17
88:12 93:11 113:14
192:21 196:1,18
200:18 205:6 212:17
239:1 247:18 251:22
266:1 281:6 297:19
considerable 301:22
consideration 4:10,12
4:14,16,18,20 5:1,3,5
5:7,9,11,13,15,17,19
6:14 11:9 43:2,8,20
44:11 46:9,14,18,22
48:21 50:20 51:3
52:19,22 53:18 54:8
56:4 57:12 58:9 68:5
68:14 70:10 107:22
109:3,15,22 112:1,2,3
116:7,21 117:20
121:19 147:1 163:16
177:12 178:7 189:16
194:16 197:7 199:7
201:10,14 202:4
208:12,18 222:4,11
226:12 230:11 283:13
299:13
considerations 234:9
considered 46:8 58:2
109:20,22 121:9,14
122:15 133:14 136:15
138:11 166:10 195:17
208:15 224:3 232:15
254:5
considering 96:11
120:14 204:14
consistency 43:11
consistent 31:19 32:18
66:14 206:4 223:14
consortium 9:6 18:8
constantly 46:3 216:8
constitutes 66:21
construct 214:16
constructed 123:20
125:1
constructive 241:9
consultant 2:5,20 4:5
25:9 28:14 63:11
consulting 27:8 252:13
consumer 1:13 23:17
134:10
consumers 84:15

129:13 135:12 136:4
contact 74:10 156:10
content 52:18 101:16
CONTENTS 4:1
context 41:19 51:21
52:3 249:3 263:5
288:14
continuation 294:1
continue 14:5 17:2 41:3
73:5,11 83:1 107:10
113:5,8 115:9 121:5
141:2 142:12,13
164:1 167:2 191:14
194:19 212:17 224:16
227:14 250:7 254:14
265:17 269:18,20
273:2 280:3,17
293:22 296:12,17
302:19 304:13
continued 31:16 41:8
44:10 48:7,8 51:18
66:7 67:8 69:17,20
75:10 88:13 107:16
108:11 121:11 124:17
128:6 135:10 146:16
148:5,6,19 180:10
190:14 212:12 216:20
216:21 217:7,15
218:20 219:14,15
220:1,2,8,11 224:11
229:21 230:5,6 232:5
254:9 271:3 294:17
294:18 295:2 296:2,4
297:20,21 298:6
299:8
continues 74:5 227:18
273:17 302:21
continuing 113:3 165:5
166:20 223:22 268:6
271:17
continuity 37:14
continuous 253:3
257:7
continuum 158:6
contracting 278:13
contractor 28:11 160:5
174:7
contractors 31:14
136:8 278:10
contracts 14:7
contribute 46:1
contribution 9:22
control 12:16 60:4,8,9
154:19 245:19 273:20
controversial 99:8
convened 251:7
conversation 52:13,16
55:5,12 75:19 76:1

78:16 81:17 131:11
139:11,22 212:15
221:19 223:19
conversation's 168:3
conversations 68:21
conversion 131:13
convey 83:7
convoluted 184:5
220:19
cooked 209:18
coordinated 105:10
coordinating 51:4,14
51:19 58:3 109:7
196:18 197:3,5,11
coordination 16:7
19:20 20:1 29:8,9
89:14 101:10,12
104:12 286:7,15
coordinator 2:12 25:4,5
102:14
COPD 158:18,22 159:1
175:8 266:21 294:17
COPD/asthma 292:2
copy 86:21
cord 150:22
core 7:8,12 37:3 42:20
47:16 251:4
corner 180:21
Corporation 28:14
correct 75:8 90:13
107:19 146:14 214:1
224:13
correctly 179:6 183:22
correlate 274:13
correlated 59:16
correlation 274:10
cost 16:12 104:12
cost-savings 233:14
costs 138:21
counsel 2:17 4:4 21:3
count 36:9 56:22 83:14
counted 125:4,5 126:14
126:16 134:8 141:13
218:13
counter 99:19 290:13
counting 9:9 125:6
126:3 154:2
countings 136:16
country 65:14 127:8
178:6 187:6,13,22
227:10
counts 125:1
couple 35:13 63:18
82:21 88:21 96:8
134:13 141:15 142:20
152:7,11 164:17
196:8 203:18 218:12
250:9 263:17 284:1

course 48:12 62:19
75:3 85:16 98:16,22
114:15 161:1 163:2
164:16 168:16 186:10
201:18 209:8 250:2
cover 250:17
coverage 178:19,22
179:18
covering 177:4
CPAP 257:7 259:12
crawls 83:11
create 123:21 126:5
237:1 291:13
created 234:17 235:5
creates 134:2
creating 16:13
criteria 44:19 45:19
46:2,10,12,21 53:14
109:14 116:20 128:13
139:3,14,15 178:19
178:22 179:8,18
187:4 257:18
critical 45:15 66:22
102:10 201:3 268:18
276:22 289:2
cross-cutting 136:12
cross-setting 123:10
125:15
cross-workgroup
197:9
crosses 104:13
crowdsourcing 18:17
curious 170:18 184:6
223:15
current 94:11,19 103:3
128:8 175:16,19
177:3 198:22 201:21
currently 42:16,18
47:11 66:11 85:10
123:20 125:1 144:16
148:11 163:9 164:20
175:8 190:19 201:7
201:11 203:12 217:9
curve 15:6
customization 301:18
cut 152:8 247:9
cutoffs 227:7,14
CV 27:4
cycle 114:18 116:10
241:16

D

D.C 1:9
D.E.B 3:11 190:2
daily 100:16
dark 100:6
darn 242:4
data 3:6 13:20 17:10,12

17:16,17,19,22 18:13
32:21 34:15,15 36:13
36:14,17,22 38:11,15
39:9,21 40:12 41:14
66:10 86:13 94:20
118:16,17 121:10
128:12 130:17 131:6
137:6 139:17,18
143:15 150:7,21
152:22 153:5 162:22
163:5,9,15 165:1
167:5 168:16,17,18
182:14 194:13 195:8
195:9 198:18 199:15
200:16,17 205:10
211:2 214:8 240:10
241:18 242:2 268:21
279:6
database 17:15 182:14
195:9
dataset 86:1 150:7
164:21
datasets 17:7
date 36:4 39:15 114:6,7
129:11
dates 38:15 39:15,19
227:7
daunting 175:19
David 3:4 109:9 124:11
192:5
day 5:22 11:9 40:15
57:17 64:10 71:15
79:16 81:18 82:10
97:11 103:8 106:12
176:9 179:13,13
252:18 253:4 257:7,8
259:13 305:11,20
day-and-a-half 6:11
days 63:18 118:4
119:21 126:4,9,14
138:1,8 139:5 157:16
159:6 171:4 182:11
182:16,17,18,21
183:4 225:9,10
238:16 239:3 246:10
246:19 257:14,16
258:4
dead 256:3
deadlines 11:12,13
deal 7:7 27:1 59:3 60:3
159:17 162:2 233:9
256:13 275:20 301:17
dealing 73:1 290:22
301:19
deals 24:17 249:6
dealt 59:13 104:17
239:21
death 100:17

deaths 126:9
Deb 6:4 9:19 19:12
27:20 52:14 55:13
61:13 81:11 91:9
288:18 304:13
Deb's 100:6 290:16
debate 97:4,6 259:20
Debra 1:9,12 4:4 23:1
December 1:6 57:21
decide 157:3 198:6
212:4 285:1
decided 16:10 205:20
234:15 277:18 278:7
284:13
decides 110:6
decision 43:7,13,14,16
44:3,13 49:4,9 51:2,6
56:17 181:14 182:19
202:19 208:17 232:9
235:22
decision's 202:15
decisions 10:7 43:9,10
45:8 46:13 136:13
decline 153:3 167:11
decrease 32:22 34:17
40:13 203:17 272:11
deep 153:15
deeply 303:4
default 159:12,16
defend 242:4
Deficient 37:9
Deficit 32:17 198:21
define 10:20 66:20
71:17 99:3,6 100:2
103:17 107:4 160:7
187:5
defined 71:7 107:12
210:13
defines 235:6,10
defining 71:14 79:12
91:14 94:7 99:13
297:19
definitely 13:13 39:1
48:21 196:1
definition 66:13 87:10
87:13 89:10 90:12
106:8 125:16 133:1
153:11 155:11 169:13
225:14 234:19 235:1
235:14,15,17
definitions 235:6
definitive 210:18
definitively 210:20
degree 59:15
deliberate 61:2
deliberation 58:22
deliberations 43:15
58:11 59:1

delicious 172:22 173:2
delighted 19:22 62:7
delineating 114:3
delirious 261:21
delirium 260:1,7,22
261:14,17,19 264:21
delivered 118:21
delivery 19:3
dementia 18:6 190:16
191:7 192:1 203:15
228:11,12
demographic 14:3
demographics 41:5
demonstration 33:19
174:6
denial 139:2
denominator 57:1
136:20 137:7 187:5
225:11,17 227:4
277:4,16
denominators 146:3
214:3 225:8
denote 200:4
depart 235:11
department 100:10
152:15 249:16
dependent 69:5
depending 93:15
191:22
depression 139:20
depth 89:12 251:19
derived 289:14
describe 93:4
described 53:2 98:11
describes 19:9
description 66:20
91:22 149:9 226:14
deserves 299:13
design 234:11
designated 293:9
designation 279:19
designed 161:2 162:2
179:15 233:20
designing 149:12
desire 111:17
desired 259:20
desk 171:14
desperation 237:13
detail 145:8 260:19
detailed 268:12
details 69:9 110:11,15
138:13 155:12
determination 233:8
determine 46:7 178:17
224:16
determined 270:18
determining 80:2
128:14

develop 16:4,11 18:2
28:21 42:15 106:15
109:13 114:4 166:15
202:2 239:14 249:7
249:11 284:14 285:6
285:16 305:5
developed 13:5 17:11
37:13 43:12,20 44:20
56:3 102:22 111:14
119:7 134:21 161:21
192:13,14 198:17,20
199:11 203:14 215:22
224:13 234:19
developer 16:15 63:13
278:19 298:17
developers 16:22 194:6
developing 37:7 201:8
201:20 250:16
development 16:2,9,19
29:5 37:18 44:5,7,11
48:6,7,8 66:7 67:8
69:15,18,20 71:4
75:10 83:2 88:13
107:11,17 108:11
110:14,22 111:16,19
111:21 112:2,17,21
113:6,9 115:9 116:1,4
121:9,12 122:5
124:17 128:7 135:11
146:16 148:6,7,19
162:8 164:2,7 165:5
167:3 180:9,11
190:14 191:14 199:22
208:20 210:9 212:13
213:4,13 216:21,22
217:8,15 218:21
219:15,16 220:2,3,8
220:11 221:13 222:3
224:3,11 225:15
229:21 230:6,7 232:4
232:5 254:7,9,15
261:16 271:2,3 273:2
285:9 294:18,19
295:2 296:3,4 297:20
297:21 298:6 299:8
device 200:10
devil 155:12
diabetes 175:9
diagnoses 119:8
158:11,12 277:5
278:2 279:5 280:20
294:21 296:9,17
diagnosis 158:13,17
200:11 266:20 268:5
279:12,15 281:22
282:4 289:15 290:6
290:18,22 291:3,5
294:16

diagnosis-specific 277:11	65:11 79:11 123:1	discuss 30:2 53:18	Doc 31:11
diagnostic 160:8 161:1	Directors 27:21 28:5	54:4 72:2 75:13 76:12	document 52:9 115:20
161:2,17 291:7	Disabilities 9:7	77:5,7 79:7 80:19	115:21 178:11
dialogue 111:8 241:9	disability 9:6,9	165:8 186:7 207:6	documents 120:19
dickens 299:19	disadvantage 126:5	211:8 214:21 222:15	135:1
die 126:4,6,7 234:3	disadvantages 125:8	231:20 232:7 236:9	dog's 99:20
248:8,8 282:9	disagree 75:11,17	236:13 256:20 260:14	doing 33:13 106:22
died 237:19	190:13,14 223:5,6	276:14 280:16	114:12 132:4 142:7
differ 127:7	disassociating 286:6	discussant 52:10	143:17 156:21 164:22
difference 73:15 89:8	discharge 4:14,16	discussants 55:4	177:15 184:20 242:2
144:2 146:3 200:5	109:4 118:1,2,8,14,18	205:17 255:11 273:6	242:4,10,12 246:21
215:9 240:1 284:17	119:18,20 122:3,9,10	discussed 39:11 57:19	252:1,1 288:6 296:13
differences 37:22	122:13,17 123:8,19	89:6 105:22 115:7	domain 39:14,17 42:21
143:22 187:20 209:10	125:14 126:4,10,15	133:16,20 206:19	128:9 147:20 175:18
213:18 297:20	126:17 127:19 128:9	259:18 265:22 298:14	199:1 226:17
different 14:22 21:21	129:15 131:4,7	298:15,22 299:22	domains 36:16 39:10
22:4 28:1 35:4 38:16	132:16 133:1,4,6,14	discussing 36:19 40:2	68:13,15 70:14
55:9 74:18 76:19,21	133:17 134:4,8	63:18 74:18 106:6	128:21
77:10 87:16 88:6	135:15,22 137:22	160:6 195:1 197:18	Don 101:14
106:8 109:17 118:19	138:6,9,18 143:22	216:16 276:7,10	door 38:20
119:17 125:2 128:2	145:12,13 150:14	278:17 296:11 299:1	dosage 103:14
130:11 133:22 136:20	156:6 157:16 169:16	discussion 51:19 52:4	dose 263:2,6,22 264:19
137:2 143:20 144:1	170:22 171:2,4 189:8	52:5,7,17,20 53:2	dots 286:12
150:17 164:11 165:22	189:9 195:14 207:16	54:20,21 55:11 58:5	double 125:1,6 138:17
166:1 170:13 175:14	207:17 210:19,19	75:6 76:16 78:5 84:17	153:17 154:1 155:22
183:4 185:3 187:14	233:22 235:18 238:20	89:2 104:3 109:5	168:11,20 183:11,13
206:22 207:3 210:11	239:1,12 242:11	110:10 111:8 117:1	downside 138:20
211:3 214:7,11,15,15	244:19 256:3 273:19	120:11 132:14 148:13	downstream 70:4
220:17 222:7 223:13	286:20	149:21 160:15 182:5	DPA 2:15
224:1,2 225:4 227:10	discharged 105:1 125:3	192:10,17 193:1,6,13	Dr 9:18 13:10 20:7 23:6
227:11 247:19 259:17	125:9 126:13,22	193:14 196:2,16	24:7 38:20 62:3 109:9
261:22 267:21 269:1	130:7 133:13 137:13	199:20 205:3 211:16	113:12 114:2,19,21
269:7 272:21 287:8	141:10,12,13,21	212:3 220:6 236:18	115:13 116:18 122:22
289:17 299:14 301:20	154:8 241:21	247:17 252:11 254:11	124:11 144:9,9 149:2
differential 166:2	discharges 256:4	254:19 255:7 256:17	156:4 160:1 169:21
differentiate 199:21	discharging 134:6	257:1,3,9 273:10	170:20 184:17 185:1
204:21	137:19	276:12,18 277:21	186:2,6,18 187:3,16
differentiating 135:13	disciplines 29:7	296:20 305:7	188:10 192:5 197:22
differently 12:13 101:9	disclose 21:17 22:12	discussions 19:2	198:10,13 203:3
107:5 220:19	23:5,11,18,21 24:3,6	114:22 117:22 194:18	208:21 209:4 210:12
differing 193:21 222:18	24:9,14 25:6,10,13,16	297:1	214:5 222:10 226:13
difficult 51:7 77:18 94:4	25:19,22 26:2,8 27:4	disease 18:7 93:16	232:9 246:14 247:1
94:5 135:19 159:9	27:13 29:11,14	191:1,3,4 192:3	249:18 251:4 263:10
249:9 297:15 305:4	173:20 174:4	disincentive 237:1	270:8 271:5,5 278:13
difficulties 186:11	disclosed 28:4 29:22	disposition 74:18	278:16
difficulty 188:8	disclosure 21:4,14 22:8	disseminate 144:20	draft 58:1 176:18
dinged 136:18 260:4	22:15,19 27:3 28:16	dissimilar 125:16	dramatic 240:1,1
dinner 171:18	50:12 109:12 173:6	distance 88:11	draw 55:15 56:5 58:10
direct 38:8	173:12 174:2 242:15	distinct 93:8 94:6 119:1	194:21 259:8
direction 10:19 144:18	disclosures 4:2 21:22	distinction 118:5	drive 152:16,16 259:5
160:17 202:2 205:14	22:4 23:13 29:22 50:9	distinguish 192:7	291:6
280:11 286:2 294:5	discontinuing 299:9	distribute 119:16	drives 138:21
directionally 301:9	discourage 137:19	distributed 162:3	driving 128:17
directly 30:20 138:20	293:22	diverse 51:13	drop-down 94:18
170:14 218:4	discouraged 44:15	divide 205:20	drop-off 247:4
director 2:19 23:8,16	56:21 217:1	divided 52:19	dropping 200:19
	discouraging 261:12	division 24:5,8 31:12	drug 65:22 66:13,16
	discrepancy 256:8	38:19	67:6 69:4 71:19 73:15

73:17 74:1,2 80:3,6
90:14 92:14 93:8,12
98:4,7,18,21 99:14
100:7 103:11,12,12
103:13,14,19 175:21
176:2,4 191:1 226:10
275:15 302:2
drug-to-drug 103:20
drugs 91:4 99:6 176:5
275:17 302:9
druthers 169:5
DSOM 91:21
dual 2:14 50:1
dual-eligible 47:18
dually 84:6
duals 9:2 190:5
due 69:21 156:4 176:17
181:7
dug 85:22
Duly 131:21
durability 138:2
duration 264:1
DVT 151:15
DVTs 151:10
dyspnea 266:19 268:2
268:3 269:5 276:8,19
276:20 279:2,8,11,18
279:21 281:20,22
282:5 283:19 288:21
289:2,8 290:17
291:20,21 293:1,10
294:11,15
dyspneic 292:21
dysreflexia 151:2,4

E

E 1:14
e-referral 304:10
earlier 44:7 111:15,16
121:5 238:13 248:6
275:16
earliest 32:8 39:16
early 7:7 49:1 58:6
59:19 69:15 120:13
120:14 160:15 166:10
169:16 180:9 208:20
232:3 254:7
easier 188:3,15 255:15
easiest 22:8
easily 12:2 268:22
easy 105:9 305:2
echo 194:14
ED 166:9,19 167:1
250:15
editor 29:8
Edsel 303:9
education 122:16
268:18

educational 241:9
effect 152:19 188:2
244:12 245:19 246:1
249:1
effective 66:1 97:3
184:7 245:7
effectively 264:21
effects 74:2 103:12,18
152:12 159:11
efficient 11:19
efficiently 12:4 16:12
effort 18:5 119:15
246:21 247:2
efforts 118:21 249:1
252:2 272:2 304:16
effusion 292:20
eggs 248:16
eHealth 27:17
EHR 96:14
Eight 195:5
either 50:21 55:6 56:3
95:14 103:22 141:9
182:22 186:8 203:21
222:16 226:8 256:1
279:15 280:20 286:1
elaborate 101:7
elaboration 92:5
elder 99:7
elderly 82:14
elders 79:14 228:11
electronic 52:5
element 75:16 101:11
elements 66:10 76:1
85:19 94:20 98:19
168:5 282:18 290:20
ELIGIBILITIES 2:14
eligible 50:1 84:6
131:22
Elisa 11:22
ELIZABETH 2:12
Elliott 2:7 7:19,20,20
23:2 25:20,20 29:10
29:12,12 145:3
205:22 215:4 227:3
email 144:12 169:21
172:4,8
emailed 144:12
embedded 188:1,12
300:16
emergency 100:10
136:17 152:15 159:15
237:15 240:17 246:4
249:15
emphasis 137:12 274:9
emphasize 135:21
emphasized 269:13
emphasizing 79:5
employed 28:10

employee 23:9 50:12
employer 26:17
en 212:19
enables 300:3
encapsulated 118:11
encompasses 270:12
encourage 20:19 44:10
44:11 66:6 67:7 69:17
69:20 75:10 77:2 96:2
96:7 107:16 108:11
110:22 111:22 112:1
112:2,3 116:19 121:5
121:11 126:8 128:6
135:10 146:16 148:18
180:10 212:12 213:4
216:21 218:20 219:14
219:15 220:1,2,8
224:11 226:17 229:20
229:21 230:5,6 232:4
254:9 269:17 271:3
294:18 295:1,2 296:2
296:3
encouraged 78:14
110:13 148:5
encourages 138:17
encouraging 126:7
148:16 216:20 222:2
222:3
ended 241:14
endorse 100:19 210:10
endorse/not 210:9
endorsed 110:4,4
148:11 164:14 191:5
191:11 192:19 193:16
194:5,16 201:7
208:15 210:2 213:17
224:8
endorsement 16:18
47:20 63:16 83:3
148:13 199:7 213:14
224:19 276:22 277:2
288:19,22 289:8
298:1,8,13,13,18
endorsements 66:9
enemy 80:13
engage 120:13
engagement 121:3
149:10
engagements 27:9
engaging 275:1
enhancing 274:9
enlarges 275:13
enriching 125:12
enrolling 291:10
ensure 73:8 301:13
entering 129:17
enters 89:22
entire 109:8 142:14

249:12 298:8
entirely 82:16
entities 100:3 209:7
entity 84:7 242:5 276:1
Epic 101:3
epidemics 203:22
episode 158:22 159:1
equally 186:9
EQUATOR 182:13
equivalent 109:18
110:22
Erin 2:18 4:8 40:22
41:20 48:4,4 49:14
58:18 62:22 75:1
110:17,19 171:6
203:8,9 288:17
error 204:22
errors 103:14
especially 27:7 89:7
ESRD 149:3,3
essence 117:21
essential 39:4
essentially 73:19 118:7
118:20 119:10 160:8
232:13
establish 35:9,15
established 32:16
34:10 35:19 36:4 40:5
estimate 145:21
et 12:13 15:9
ethical 234:9
ethnicity 139:16
etiology 280:9
Eugene 2:9 8:17 23:2
28:18,19
evaluate 7:13
evaluates 46:9
evaluating 45:20
evaluation 3:11 37:14
190:4
event 80:6 88:16
176:12 250:5
events 70:5 106:12,17
107:2 167:7 175:22
176:2,4 250:3
eventually 237:14
everybody 14:19 81:4
211:20 218:12 266:14
295:18,21
everybody's 247:5
everyday 80:5
everyone's 217:19
evidence 157:12,15
158:6,12
evidence-based 287:21
288:3
evolving 13:14 46:3
ex-officio 278:14

exact 143:7
exactly 15:2 90:13
 209:21 236:14 247:19
 305:14
examination 67:2
examine 304:2
example 14:16 53:4
 78:2 103:18 115:3
 119:2,11 176:2 239:3
 244:10 272:3
examples 44:2
Excellence 242:20
exchange 182:14
excited 42:2
exciting 63:6
exclude 190:22 191:9
 191:22 200:13 204:8
 217:9,10 227:15
 292:19
excluded 127:1 137:18
 155:9 216:4,12
 217:17 254:17 261:6
excludes 190:20
 253:19
excluding 205:5 261:5
 283:4
exclusion 126:3 130:7
 137:14 155:6 187:4
 191:17 193:12 200:19
 203:1,21 204:12,13
 205:4,11 206:14
 215:15 217:5 257:17
 259:7 260:21 291:19
exclusions 146:7 155:4
 200:20,21 201:2,2
 204:18 205:2 206:6,8
 260:5,15 291:18
excused 278:16
exercise 192:8 300:3
exist 66:11 135:7
 226:10 248:19 249:4
 284:3 288:12
existence 303:10
existing 152:3 272:4
 273:12 285:14
expand 74:22 100:1
 175:20 250:21 251:19
 293:10 296:7,16
expanded 34:8 294:21
expanding 201:10
expands 248:1
expect 22:17 27:3 41:7
 159:11
expected 51:2 184:3,14
 184:22 187:12
expecting 168:2 218:8
 218:9 245:21
expenditures 41:3

expense 15:8
expensive 18:14
experience 17:1 41:1
 85:2 97:8 274:20
 286:7
experienced 59:11
expert 8:14,21 20:2
 115:17 120:19 132:20
 160:9 203:19 204:7
 279:6,10
expertise 17:5 51:14
 96:21
experts 2:6 22:1,22
 26:14,15,16,21 51:10
 203:20 235:2 300:5
explain 43:13 44:3
 54:22 140:22 278:16
explaining 135:19
 141:18
explains 300:22
explanation 142:1
exploratory 18:10
exponentially 170:18
exposure 264:1
expressed 111:17
 185:2
extend 100:8 177:1
extending 176:7
extensive 76:16 297:11
 299:2
extent 91:6 157:19
 161:13 162:5 165:12
extra 139:5
extrapolated 187:13
extreme 157:10

F

face 216:3
faced 290:16
facilities 34:22 40:11
 85:21 92:15,21 128:5
 145:10 147:18 153:2
 153:4 166:1 167:11
 167:14 180:8 187:14
 187:18 188:18 195:10
 206:11,16 216:10
 242:22 245:21 246:6
 250:22 257:19 264:10
facility 5:2,4,5,7,9,11
 32:11 35:20 39:22
 40:6 91:21 133:5,9,18
 133:19 137:5,14
 154:20 161:19 168:8
 177:13 178:6,18
 184:4,10 185:13
 187:8 188:5,9,12
 189:4,9 219:3 221:4
 223:1 229:18 232:2

233:11 235:3,4,7,9,12
 237:6,10 238:22
 239:16,17 240:16
 251:12 252:3 253:16
 255:2
facility's 187:8,10
 188:17 246:20 250:6
fact 59:19 69:21 118:17
 118:19 119:9 159:17
 162:14 166:22 167:4
 234:13 241:15 243:18
 245:1 258:14 269:14
 293:7
factors 14:3 122:15
 131:20
fail 281:14,17
failed 238:20 239:1
failure 16:2 266:21
 275:13 292:2 294:17
fairly 139:1 143:4 144:5
 223:14 233:18 247:6
 260:3
faith 154:13
fall 34:20 134:5 139:13
 266:18 287:21 288:3
fallen 258:8
falling 274:14
falls 39:13 70:2 157:12
 267:20 270:10,13,15
 270:17 271:7,9 274:3
 274:18 275:4,5,6,17
 281:16 282:6,7,8,12
 282:13 286:1 287:6,8
 287:12,13,19 291:20
 295:12 303:22
familiar 13:22 17:13
 21:11 85:20 142:18
familiarize 46:12
families 10:3 129:14
 135:12 140:20 141:19
 237:4,13 272:9
 284:16
family 96:2 181:5 237:5
 237:16 238:6
family-centered 63:17
fancy 216:18
fantasy 242:11
far 92:13 94:10,12
 107:18 168:14 177:15
 183:13 282:6
fashion 74:11 167:19
 167:22
fast 228:18
faster 41:3
fault 154:12,16 246:12
 246:12,20
favor 80:11
favorable 114:14

FDA-approved 216:11
feasibility 67:2 72:5
 88:5,12 116:3
feasible 72:17 101:19
Fedeli-Turiano 3:3
 175:1,3
federal 2:10 6:14 22:2
 28:11 49:22
federally 214:9
federally-funded 10:18
feed 91:16
feedback 12:7,11 37:20
 38:5 55:18 72:1
 105:20 117:2 160:18
 265:22
feel 30:12 44:16 49:10
 78:10,11 79:4,20
 134:9 153:15,16
 157:9 183:8 221:8
 226:1 277:9 280:17
 299:21
feeling 288:13
feels 71:12 108:18
 140:19
felt 49:3 68:17 69:19
 74:9 129:15 136:10
 181:15 184:7 243:19
 277:3 294:5
field 47:13 104:15
fifth 63:4 67:1
figure 143:1 175:20
 242:3 268:14 290:17
figuring 280:8
files 284:21
fill 45:15 101:7 254:3
fills 47:7
final 208:22 209:2
 221:2
finalize 185:18
finalized 32:13 33:18
 34:20 148:8 186:2
 199:11 200:2 201:11
 201:16 232:16
finalizing 115:20
finally 40:4 43:3 47:18
 56:21 165:19 191:10
 216:18
financial 17:6 34:3
 139:19 155:20 181:4
 181:4
find 19:11 47:11,12
 69:9 75:5 86:3 92:9
 98:7,21 128:13,19
 135:1 211:6 268:7
 271:4,7,19 273:14
 275:7 288:19 290:12
 302:7
finding 151:11 167:21

fine 16:4 292:18
finished 216:16
firewall 16:17
first 13:9 14:1 16:14
 17:12 21:15 22:8 31:9
 32:13 42:13,14 46:6
 54:22 56:13 58:13
 61:12 62:13,16 63:10
 64:11,13,15 67:22
 68:10 69:1 70:20 74:5
 77:17 82:21 88:21
 96:18 98:2 105:17
 112:11,12 113:1
 115:6 120:7 129:6,9
 133:20 134:13,21
 140:3 145:2 149:1
 162:21 172:21 182:10
 182:16,18 183:3
 190:5,11 192:7 203:5
 203:7 207:9 216:19
 232:21 239:3 243:14
 246:16 249:22 257:6
 261:2,16 263:15
 266:21 270:10,14
 271:13,15 273:7,10
 274:3 276:11 282:22
 284:2 299:6
fiscal 40:10
fit 180:13 283:11
five 36:15 39:9 62:8,12
 66:7 76:21 100:16
 139:5 146:22 193:2
flavors 118:19
floor 1:8 189:22
floor's 182:5
flow 68:19 97:17 161:10
flu 227:12
flush 159:8
flying 170:15
focus 45:12 84:22
 269:20
focused 84:8
focusing 99:9
folks 91:15 204:19
 220:9 226:18 240:20
 246:18 252:13 279:4
follow 93:14,14 156:22
 242:8,9 282:9 286:4
follow-up 69:12 231:6
followed 85:16 86:4,6
following 33:5 109:16
 235:18
follows 52:18
Food 191:1
food-to-drug 103:20
forced 100:11
forces 231:6
forcing 228:6

foremost 129:9
forever 110:1
forget 90:16 143:7
 302:8
forgive 153:21
forgot 142:15
form 22:10 26:22 27:1
 28:4 37:12 49:1
formal 54:12 57:5,22
 108:3 146:17 173:8
formally 178:20
former 39:3 63:13
 181:2
formidable 302:22
forms 21:14
forth 88:2 102:14 193:1
 194:6 197:15
Forty-eight 258:21
Forum 1:1,8 9:14 34:9
 84:8 116:13 199:6
forward 20:20 62:9 63:6
 68:14 83:2 113:18,20
 113:20 121:6 132:5
 163:14 185:4,16
 194:9 195:22 204:10
 204:18 205:3,10
 220:13 236:18 257:21
 262:16 268:9 271:17
 292:7 293:17 299:10
 299:16 300:7 305:18
 305:19
found 98:21 148:12
 258:15
Foundation 18:16
foundation-funded
 13:6
foundational 301:9
four 69:2 70:9 74:16
 100:12 104:10,20
 105:13 108:12 119:11
 128:2 147:15,18
 158:19 166:6 175:7
 198:16 212:20 213:2
 228:14,15 301:19
fourth 59:22 66:19
 192:17
frail 79:14 82:14 99:6
frame 59:10 101:8
 113:22 178:9 179:22
 275:14
framework 12:22 42:15
 161:15
frankly 99:2 279:1
friendly 99:6
front 171:14 179:18
 286:16
full 23:8 44:18 83:2
 109:12 116:7,14

126:2 158:6 193:18
 194:2 220:15 298:18
full-time 50:12
fully 43:20 56:3 109:16
 110:20 111:1 115:14
 116:22 121:6 125:18
 128:11 134:20 192:13
 192:14 208:14 209:18
 224:13 300:5
fully-endorsed 208:11
function 76:19 104:12
 144:15,16 150:17
 198:11,17 199:2,6,14
 200:9 201:22 208:21
 269:21 281:4 286:22
 287:1
functional 35:9 39:11
 126:21 134:19 150:14
 163:4,9 175:17 189:6
 193:3,15 194:20
 195:4 202:5 206:19
 207:12 211:16 213:2
functioning 200:10
fundamentally 291:1
funding 28:1,20
further 23:12 44:11
 56:13 72:1 77:5
 108:18 110:13,22
 112:1,1,2,3 164:1
 194:21 213:4 222:2,3
 288:13
furthest 157:10
future 35:2 83:4 109:20
 110:2 112:17 150:10
 163:15 167:3 183:12
 201:9 250:17
fuzz 162:1
fuzziest 273:15

G

gain 233:13
game 34:2 249:9
game-changer 36:10
game-changing 39:5
gaming 169:12 233:17
 233:18 249:16
gap 47:7 101:8 284:17
gaps 7:4 15:15,18 43:4
 45:15
Gene 8:20 88:19 101:10
 102:20 105:21 145:1
 229:1 261:1,2,7 281:7
general 2:17 4:4 10:18
 21:3 45:7 89:10
 160:14 244:7 277:6
 277:10 296:8,9,14,18
 296:21 297:16
generalized 298:9

generally 96:15 133:19
 162:3,11 196:22
 281:12
generate 254:18 255:6
 277:21
generated 58:6
generating 81:15
generic 289:1
generously 153:7
Geriatric 27:22 28:9
geriatrician 8:15 10:4
 289:22
Gerri 2:8 19:17,18 23:2
 29:3 80:20 81:20
 286:2
getting 18:13 54:15
 58:21 72:11 73:8 95:4
 108:19 111:15 116:1
 126:6 148:7 167:9
 170:17 227:16 247:5
 248:8 251:20 264:10
 266:5 271:21 292:3
 301:13
Gettysburg 233:4
GG 127:4 193:20
 201:11
Gifford 3:4 109:9,10
 113:12 114:19 116:18
 124:11,11 192:5,6
 194:15 297:17
give 12:11 16:21 42:10
 45:7 47:1 52:2 96:19
 108:18 113:5 147:12
 151:14 163:9 165:15
 171:9 176:1 202:19
 231:15 240:7 258:22
 263:6 270:7 294:13
given 41:5 60:18 71:8
 72:4 112:15 117:2
 142:1 160:17 189:14
 208:6 221:5 223:2
 227:13,17 229:19
 234:8 263:21 281:7
 293:14
gives 205:11
giving 106:19
glad 257:16,20
glance 274:3
glean 212:15
global 57:16 198:2,6
glossed 48:18
GMO 269:12
go 12:2,4 19:10 21:1
 30:19,19,20 32:6,15
 35:3 36:6,20 38:13
 39:18 40:4,15 41:20
 49:4,17 53:8 54:22
 58:16 61:13 64:10

70:15 76:4 79:4 86:3
 88:2,19 90:17 95:13
 103:16 104:17 105:15
 113:18 114:10 115:18
 116:19 118:9 120:18
 124:2,8 125:3,10
 129:18 130:1,3,5
 133:10,11 137:16
 138:19 139:8 140:21
 141:1 142:8 145:8
 146:19 148:3 154:17
 170:17 176:9 179:2
 184:12,14 202:18
 203:21 207:1 212:18
 213:6,9 219:9 221:9
 224:5 225:16,17
 228:21 229:2,15
 234:2 238:20 240:9
 241:17 246:18 248:10
 259:3,4,19 261:2
 262:21 266:3,4
 269:10 272:17 277:17
 282:6 284:13 285:1
 290:15 292:6 299:1
 299:10 303:1 304:1
goal 123:15 269:16,19
 273:14 288:13
goals 12:20 47:5 70:12
 120:12 121:2 124:14
 146:5 242:19
goes 16:19 43:16 90:7
 105:7 142:20 154:6
 170:11,13 212:14
 221:21 223:18
going 6:11 7:17 10:21
 12:19 14:14 20:22
 21:2 31:3 32:13 33:2
 34:1 36:19 48:4 52:9
 58:16 60:1 61:12
 64:12,15 65:8 67:18
 70:21 73:3,12 74:17
 77:18 80:19 82:6,20
 83:13 86:7 87:7 90:15
 96:22 102:9 104:16
 106:8 108:12 110:13
 111:19 115:10 117:3
 118:4 124:1 125:13
 125:18,19 126:5
 127:18 130:1,2
 131:20 132:14 135:18
 137:8 140:17,20
 141:1 144:22 146:9
 146:19 147:7 148:8
 153:2,4,20,22 155:21
 157:1 159:21 162:1
 165:10 166:4 167:20
 167:21 168:3,7,12
 169:1 171:15 172:19

175:20 176:22 177:14
 179:5 180:2 183:9
 185:4,19,22 192:6,7
 194:9 195:22 196:8
 198:1,11,12,16
 201:19 202:5,9
 204:17,18 205:20,22
 207:6,9 209:8 210:22
 213:5,11 214:19
 220:12 222:7 229:17
 230:10 243:12 246:14
 247:12 251:2 252:5
 252:13 254:14 257:2
 261:20 263:21 265:11
 266:1,2,3 268:9,19,20
 272:20,20 273:2
 274:11 275:2 276:3
 276:17 280:8,17
 281:2 282:1,8,13
 286:19 291:1 292:21
 293:12 294:6,14
 296:11 299:16 303:16
 305:18,19
good 6:3 7:7 8:2,13,19
 12:7 19:18 49:3 59:3
 62:10 63:8 65:10
 80:14 87:5 100:21
 120:2 122:22 135:3
 154:13 173:15 175:1
 185:14 192:2,3 206:6
 216:6 218:18 221:8
 223:3 226:20 227:1
 240:13 246:21 248:14
 261:4 263:6 264:5,18
 270:9 277:14 288:17
 299:8,9
goodness 241:17
Google 115:18
gotten 11:18 20:3
 160:18 237:9,17
GOVERNMENT 2:10
gradual 264:19
gradually 264:20
grant 1:13 18:15 23:15
 23:15 75:15 76:2,4
 85:13 158:8 236:20
granted 85:22
grants 27:8
grappled 301:16
grappling 60:15 158:20
 303:3
great 6:10 20:11,20
 27:1 78:7 91:7 223:3
 233:9 257:14,19
 260:19 267:14 287:9
greater 284:17
greatly 51:15
green 299:10

Greenberg 1:14 8:1,2,3
 23:22,22 136:7 157:8
 273:22 282:22 293:20
 294:11 296:10 300:10
gripe 216:8
ground 237:5
group 19:20 21:16 22:6
 22:17 44:13,16 47:15
 51:13 52:11 53:11
 64:17 76:22 79:19
 81:4 84:19,20 95:10
 109:5,8 111:10
 121:13 138:16 142:20
 143:2 144:20 159:6
 194:10 208:12 223:9
 236:3 255:17 256:8
 256:10 267:12 272:18
 273:6 278:22 283:3
 284:8 293:8
grouped 77:9
groupings 180:14
 300:18
groups 29:4 49:3 50:1
 52:20 160:19 255:20
 268:5
grow 200:1
growing 101:3
grown 184:9
guess 36:8 40:14 41:1
 71:12 85:14 111:4
 116:18 133:10 145:13
 152:1 158:8 197:20
 202:7,14 205:12
 209:17 214:18 223:16
 228:16 232:13 261:22
 262:14 272:15 273:8
 274:20 291:9
guidance 45:7 71:8
 72:4 87:9 88:3 94:11
 103:1 107:12 108:19
 112:6,15 115:10
 302:4,5
guide 52:5,7,17 53:2
 58:5 75:6 120:11
 148:13
guidelines 4:6 31:7
 32:3 79:18 113:8,10
 191:3 222:1
guys 255:12 259:14
 297:10

H

half 195:13
Hall 2:12 25:2,3 96:6
 139:10
Haloperidol 263:6
Hammersmith 2:17 4:4
 21:2,9 23:10,14 26:3

26:9,13 28:17 29:10
 29:15,18,21 30:4
hand 16:20 82:7,13
 180:2 196:9 198:8
 249:20
handed 154:14,18
handle 79:1 140:15
 141:15 198:1
handled 161:11
handoff 154:18 156:5
 247:12
handoffs 247:19
hands 83:12 116:10
handshake 101:15
happen 11:14 16:1 70:5
 87:22 97:2 102:9
 106:14 140:17 151:20
 169:17 265:18 274:16
happened 11:10 90:19
happening 90:22
 106:13 107:3
happens 89:21 90:5
 157:16
happy 9:10 19:9,13
 256:8
hard 63:5 97:1 227:7,14
 292:22
harder 300:13
Harmon 3:5 65:10,11
harmonization 194:8
 260:10 263:12 265:2
harmonize 207:2
 226:22
harmonized 95:10
hat 192:7 193:7,7
hats 192:6
head 83:12 216:13
 270:9
heads 14:9 91:4
headway 251:16
health 2:12 3:4,5,7,9
 5:17,19 8:21 9:5 16:7
 24:17 25:5 27:14
 28:22 29:2 32:8,16,20
 40:1 63:14,21 69:8
 71:8 72:8 84:9,14
 85:1 88:6,10 89:4
 96:3,12 103:9 117:16
 120:6 124:22 125:4,5
 125:8,10,13 128:3
 136:20 137:1 142:16
 142:19,19 143:3,5,12
 147:16 153:14 154:9
 156:5,9,11,12,15,17
 157:13,17 158:1,16
 159:5 166:21 167:1
 170:10,12 175:10,16
 175:17 177:5 190:18

195:22 206:12,13
 226:8 229:4,5,9
 244:11,11 247:21,22
 247:22 250:10 266:8
 266:16,17 267:11,15
 268:3 269:6,11,18
 270:16 271:18 273:19
 277:6,10 282:15
 283:16 284:3,10
 285:7 287:10 288:2
 291:11 292:4 296:8
 303:21
health's 273:20
healthcare 1:20 9:16
 10:9,18 12:9 14:8
 41:4 50:11 60:6 65:12
 65:19 104:15 109:10
 124:12 230:21
HealthSouth 3:3 117:14
 178:5
hear 19:22 59:8 61:4,5
 78:22 81:22 82:22
 132:14 155:15 216:8
 223:5 233:3 237:16
 238:6 245:17 254:17
heard 31:20 42:6 54:13
 60:1,5,14 70:1 79:10
 82:21 84:16 87:15
 111:5 115:7 133:20
 238:10 251:6 290:13
 302:1
hearing 14:10 20:8 38:2
 38:4 188:22 208:9
 211:16 213:1 219:8
 228:3 236:16 252:10
 265:20
heart 266:20 275:13
 292:1 294:16
heavily 222:13
held 38:2 176:3 214:6
 298:19,20
Helen 13:3 20:5,8
Hello 62:22
help 16:11 42:17 44:20
 44:21 52:15 68:19
 80:1,15 93:4 96:14
 101:2 106:16,17
 111:12 179:4 238:16
 242:21 258:5 277:22
 283:11,16,18 288:20
 291:13
helped 285:9
helpful 16:21 88:4
 92:11 93:2 98:14
 99:10 120:11 222:15
 225:7 293:20 305:7
helping 291:12
helps 43:13 301:2

herbals 104:4,7 106:7
Herr 1:15 25:14,14
 257:11
heterogeneous 142:20
hey 83:21 133:21
HHS 25:4
hi 7:20 23:7 25:2 62:3
 62:10 134:12 136:7
 190:2 194:12 230:20
 297:9
high 7:4 138:17 142:8
 264:17
high-performing 240:2
high-priority 47:17
high-quality 45:13
high-risk 139:1 153:9
 167:12
higher 142:2 261:4
highlighted 144:14
highly 138:16 291:2
Hillman 3:6 194:12,13
 297:9
historically 185:9
 215:21
history 32:7 205:9
 287:12
hit 162:17 247:14
hoc 115:3
hold 105:2 256:11
 295:15
holding 186:18
holds 201:11
holiday 11:7,11,14
holistic 289:19 290:14
Holly 3:5 65:10
home 3:9 5:17,19 6:21
 8:21 28:21 29:1 32:8
 32:15,20 40:1 60:6,7
 69:7 71:8 72:8 88:6
 88:10 89:4 90:14,15
 90:16,17,20 95:5,7,16
 96:3,12 104:15,17
 117:16 118:9,10
 119:5,8,21 120:5
 123:16 124:3,9,21
 125:4,5,8,10,11,13,14
 126:4,6,6,10,13 127:1
 128:3 129:18,19
 130:1,3,5 133:4 134:7
 136:20 137:1 138:20
 140:21 141:1,6,9,12
 141:14,20,21,22
 142:9,16,19,19 143:2
 143:5,12 145:12,13
 147:16 150:3 153:14
 154:9 156:5,9,11,12
 156:15,17 157:13,17
 158:1,16 159:4

166:21 167:1 170:9
 170:12,14 175:10,10
 175:16,17 177:5
 190:11 191:7,16,21
 192:16 195:22 203:13
 204:12 209:5,15
 210:15 213:20 214:12
 225:7 226:7 229:4,4,8
 229:9 242:8 244:11
 244:11 247:21,22,22
 248:21 250:10 265:6
 266:8,16,17 267:10
 267:15 268:3 269:6
 269:11,18 270:16
 271:9,18 273:18,19
 273:19 275:12 277:6
 277:10 282:15 283:16
 284:3,10 285:7 287:2
 287:6,7,10,13,16
 288:1 290:3 291:11
 292:4 296:8 302:7,8
 304:1,2
home-based 24:18
homes 65:14 142:2,7
 203:16 204:2 237:2
honest 168:6
honestly 87:12
honor 132:19
hope 7:2 71:16 87:5
 150:9 255:4 290:19
 302:4
hoped 168:9
hopeful 176:19 177:2
hopefully 16:12 32:3
 93:22 106:16 212:11
 217:14 245:5 255:4
 272:11
Hopkins 1:16 17:20
 24:16
horrible 292:20
hospice 2:2 26:7 34:13
 35:1 126:10 130:7
 137:11,15,18,20
 291:18 292:2,4,16
 293:5,6,8
hospital 3:7 5:13,15
 86:12 90:15,21 93:21
 95:12,17 100:10
 104:20 117:16 120:3
 122:11 123:13,15
 128:4 129:22 131:1
 141:10 142:4 143:6
 147:21 154:5,10,20
 155:5,22 166:17
 167:17 170:12,14
 179:3 197:13 228:10
 234:3 237:2,8,12,17
 237:18 238:16,18,20

238:21 240:9,21
 241:1,6,15,16,18
 242:6,8 246:11
 248:11 252:22 254:6
 255:1 261:12,15
 264:6
hospital's 246:11
hospitalist 105:1,2
hospitalizations 166:14
hospitals 3:8 34:12,21
 35:11 97:9 118:12
 119:12 120:21 123:3
 123:5,6,11,12 124:5,6
 137:19 143:13 168:19
 185:8 201:4 239:21
 239:22 240:3 247:15
 248:5 253:18
hospitals/facilities
 34:13
hotel 64:7,8
hour 184:13
hours 11:17,19 78:9
 156:10,13 238:19,21
 241:11,11 242:9
 258:21
house 93:21 140:6
huge 17:15 284:8
 286:14
human 17:6
humbly 282:17
hundred 80:7
Huntington 190:21
Huntington's 205:7
hybrid 169:3
hypertension 151:4

I

Ibragimova 2:18 50:3
 61:20,21 67:15
 127:16 147:10 171:17
 172:2,4,7,11 217:21
 218:3,9,15,19 219:17
 219:22 230:1,4
 231:13 253:22 270:4
 295:8,14 296:1 300:9
ICD-10 125:20,20 301:3
 301:4
ICD-9 131:11
ICHOM 18:8
ICU 255:3
idea 15:2 17:5 37:21
 71:18 81:20 115:8
 118:16 119:15 129:16
 162:21 227:2 254:22
 255:4 277:14 304:16
ideal 44:22 45:4 268:15
ideally 112:7
ideas 18:6 20:9 79:22

226:19 304:14
identified 54:5,21 68:12
 69:14 85:16 86:4
 126:20 214:17 215:12
 251:10
identify 43:3 53:17
 94:13 160:10 260:1
identifying 45:3 73:20
 88:15 98:15 160:21
 161:3 165:20 260:21
ignore 258:14
il 1:17
ill 123:14
illness 41:6,7 191:20
illustration 248:15
imagine 248:1 299:18
immediate 166:6
impact 4:10,12,14,16
 4:18,20 6:19 10:14
 12:20 25:1 28:13 29:1
 36:7 38:14 40:5 42:21
 64:18 65:15 68:12,15
 70:12,14 84:12 89:3
 112:19 114:5 118:17
 121:8,16 123:9
 125:14 128:9,21
 130:14,14 132:3
 138:4 147:19 148:16
 151:19 163:6 166:2
 166:16 168:2,8
 180:13 183:15 195:21
 199:1,18 232:1
 234:20 301:8
IMPACT-related 174:19
IMPACT/med 67:19
impacted 164:9
impactful 303:16
impairment 228:12
impatient 37:9
imperfect 13:16 260:6
implant 289:21
implement 161:4
implementation 83:3
 97:14 120:15 169:3
 273:18 274:12 298:7
implemented 46:5
 122:11 123:20 124:15
 129:11 166:3 248:22
 270:21 273:16,17
 298:5
implementing 67:3
implies 93:18
importance 65:16 79:8
 190:13,15
important 9:20 10:1,13
 11:12 14:5,17 15:13
 15:18 17:7 41:2 47:6
 51:20 60:2,17 61:18

65:19,21 69:13 70:2
 72:21,21 73:4 79:6
 82:19 83:7,22 88:11
 95:1,6 97:5 101:11,16
 102:1,16 124:13
 126:22 129:16,20
 130:10 131:15 134:20
 137:9 142:17 160:14
 190:12 222:12 243:19
 243:20 248:3 249:2
 268:9 275:21 281:6
 285:5,16,18 286:21
 293:11 301:5 302:6
impression 109:14
improper 70:5
improve 13:19 42:4
 84:14 105:8 283:15
 303:8
improved 128:17
improvement 8:16 24:2
 58:21 60:20,22 193:4
 242:17 243:7 266:19
 268:1,2 269:5,8,15,19
 269:20 279:2,8,21
 281:19 283:6 284:11
 286:6,14 289:1 293:1
 294:15
improving 283:20
inadequate 66:15
 151:11
inappropriate 263:9,11
 265:15
incentive 234:13
 264:19 288:11
incentives 123:21
incentivize 145:5 291:8
incidence 39:12 203:11
 254:21 255:8 260:12
 262:20 263:18 264:5
 265:7
include 17:20 42:19
 90:13 100:3 126:9
 130:16 139:18 141:21
 143:2,11 178:13
 181:16 191:17,22
 213:14 215:15 226:6
 250:11,15 262:12
 287:11,12
included 89:3 104:2,6
 127:6 128:18 130:8
 136:21 188:10 206:7
 226:7 235:20 302:10
includes 139:15 235:12
including 14:6 28:2,13
 59:12 63:16 120:5
 143:16 189:6 200:9
 201:2 205:6,7 253:2
 291:12

inclusion 121:18 187:4
 281:7
inclusive 235:10
 280:20
income 165:7
inconsistency 134:1
incontinence 200:12
incorporated 95:8
 163:11 270:19,20
increase 33:1 41:8
 45:15 204:22
increased 57:8 206:21
increases 138:22
increasing 10:14,15
 167:8
increasingly 44:7 249:8
incredible 38:22
incredibly 95:6
increments 239:10
incubator 16:13 19:9
incumbent 234:11
indicate 77:4,11 119:16
 179:9
indication 101:4 216:11
indicator 120:15 202:1
indicators 79:20 152:20
 250:11
indirectly 142:5
individual 45:22 52:13
 54:1,19 73:21 81:2,13
 83:18 84:9,10,15 85:1
 85:5 90:14 190:6
 195:3 229:14 284:19
individually 50:21
 53:19 212:8 213:6
individuals 26:15,22
 125:2,9 126:3,12
 127:5 201:3
indulge 220:7
industry 148:3
ineffective 103:12
inevitably 11:8
infancy 32:12
inference 175:14
influence 106:16
influential 14:5
influenza 189:14
 192:11 193:8 208:6
 211:20 221:5 223:2
 227:8 228:15 229:20
inform 291:7
information 2:13 15:3
 19:6 27:1 37:4,21
 42:19 44:12,16 47:10
 47:16 48:9,20 49:9,11
 73:8 86:15 127:3
 128:7 129:13,20
 130:18 131:5 134:11

140:19 144:19 150:11
 150:13 161:11 163:10
 165:7 208:17 212:16
 217:1 219:16 220:4
 223:21 229:13,22
 230:8 238:14 240:8
 241:13 244:4 251:9
 251:19 274:22 281:15
 294:19 296:5 300:7
 305:9
infrastructural 251:15
Ingber 184:14
initial 28:15 101:2
initially 74:4 223:9
 250:20
initiation 89:15
initiative 65:20 124:14
 203:13 204:12 209:6
 209:15 213:20 248:21
injury 150:22 275:7
innovation 3:9 13:2
 33:20 242:16 243:4
 267:11
innovative 111:18
inpatient 5:1,3 34:12,21
 128:3 133:17 136:22
 137:5,13,17 147:16
 151:2 177:13 178:5
 180:8 183:1 195:9,20
input 4:12,16,20 5:3,7
 5:11,15,19 6:13 7:2
 46:4 96:2 114:11,14
 115:17 148:19 230:10
inserted 217:5
inspirational 105:14,17
instance 78:1 96:12
 159:14
institutional 14:21
 126:7
instructed 159:10
instruction 103:1
instructions 4:8 48:2
 49:17,19 103:16
instrument 73:3 88:22
 279:13,16
instruments 36:14 37:8
 150:9
insufficient 44:12 48:9
 49:9 156:17 217:1
 219:16 220:3 229:22
 230:7 294:19 296:4
insurmountable 105:5
intake 239:11
integrity 39:12
intelligently 300:14
intended 14:13 45:2
 123:9 150:14 178:12
 179:4 239:13

intent 125:14 133:6
 134:9 152:2 165:10
 169:10 220:22 228:1
 265:2
intention 164:17
interact 243:3 245:18
interaction 100:7
 103:19
interactions 89:13 91:3
 103:13,20 157:18
interdisciplinary 66:18
 97:21
interest 4:2 10:5 21:14
 22:12,19 30:7 74:11
 158:2 173:12 175:2
 211:4 243:11 267:14
interested 19:5 20:17
 27:7 71:12,22 144:19
 149:5 163:7,18
 164:22 262:17 265:11
 268:12 272:16,22
 294:4
interesting 13:12 14:16
 18:9 228:5 234:17
 249:19 302:14
interests 21:4 123:22
interfered 100:14
interim 24:1 90:19
 156:14
international 18:8
interoperable 39:8
interpret 188:4,15
interpretation 110:18
interpreted 186:11
interrupt 61:13
intervening 157:18
introduce 7:16,18 9:3
 9:12 21:2 50:16 63:9
 117:11 149:2 173:10
introduced 203:6
introduces 99:1
introducing 31:4 50:8
introductions 50:15
 61:16,19
introductory 52:1
inundating 247:20
invited 163:22 165:4
involve 269:8
involved 11:16 18:9
 102:6,12 120:21
 154:17 174:11 247:11
involvement 66:17
IRF 86:12 89:5 125:3,4
 125:6,9 127:11
 129:22 152:3 153:6
 155:6,17,19 178:10
 178:11,18 179:8,18
 179:22 181:2,9

192:17 199:9,12,20
 200:1,2,5,22 201:15
 207:12 231:3 234:21
 247:22
IRF-PAI 131:7 150:11
IRFs 114:8 120:5 127:9
 155:20 178:15 179:6
 179:6,16 282:14
isolation 139:21
issue 14:9 15:14,20
 20:1 47:6,17 51:21
 60:20 66:22 69:14
 70:2 77:15 86:4 88:5
 88:12 89:7,14 93:7
 102:7 108:8 112:13
 141:6 142:16,17
 146:5 156:5 160:3,13
 161:6 165:13 167:10
 168:11 198:7 210:6
 232:12,12 233:5
 239:4 245:16 246:8
 248:2 249:15 250:2
 251:4 264:5 265:1
 282:13 290:22
issues 64:5,8 69:22
 76:8 77:15 83:16,18
 85:15 89:5,14 94:14
 98:16 103:5,8,11
 105:4,7,22 106:11
 132:15 158:16 159:19
 166:19 205:1 232:11
 233:17 234:17 239:17
 240:11 249:19 251:15
 252:4 284:7 303:22
it'd 217:15 263:10
it'll 152:20 167:13
item 31:3 37:15,19,20
 54:2 189:3 219:1
 229:5 236:18 252:8
 252:12 266:15 293:18
items 54:4 71:5,6 72:15
 72:16 73:12 88:21,22
 103:2 106:11 112:14
 112:15,16 116:3
 139:18 193:21 195:3
 195:4,4,13 197:19
 198:8 201:12,13,17
 201:20,21 202:21
 205:19 212:20 253:1
 255:11 266:9 272:21
 276:13 284:3,5
 296:19

J

James 1:17 3:7 230:20
January 10:16 39:16
 40:2 57:21 111:10
JD 2:17 3:9

Jennifer 2:4 25:7 74:19
 102:19 226:2
jeopardy 153:17 154:2
 168:11,20 183:11
Jim 24:12 68:1 79:2
 82:14 83:16 99:11
 103:22 152:6 183:19
 186:13 211:5 227:19
 229:11 236:7 238:11
 239:15 246:9 260:8
 264:4 281:11 283:21
 284:2 293:3
Jim's 87:22 286:4
Joanne 13:9
job 116:16 161:19
 246:21
Joe 23:7 245:17
Joel 3:2 149:2,4,7,16
 159:20,22,22 169:18
 180:17,19,20 181:1
 181:18 184:15 244:8
 245:10 302:16
Joel's 180:18
Johns 1:16 17:20 24:15
Johnson 18:16
join 165:5 173:5
joined 50:15
joint 105:10
JOSEPH 1:13
journey 96:4
judged 153:21,22 263:5
judgment 82:9 103:6
jump 48:1 144:8 184:12
 275:3
juncture 41:17

K

Kate 254:2
Katie 2:19 62:11 180:3
 231:14
Kauserud 2:1 24:19,19
 132:18 149:22 182:7
 260:18
Keefe 3:7 120:2,3
keep 16:17 18:13 41:2
 85:5 138:7,18 139:4
 149:4 153:8 157:19
 205:14 228:19 233:19
 236:4 245:5 252:14
 271:22 272:20 276:3
keeping 138:2
keeps 188:2
Kenen 13:9
kept 231:3,8
key 11:2 50:19 120:12
 121:2 151:21 158:19
 223:17
keypad 177:20

kick 52:15 234:2
kicking 234:13
Kim 2:7 7:18,20 23:2
 25:20 29:10,12 145:1
 145:2 205:17,19,21
 215:2
kind 16:1 17:4 18:12,19
 30:12 31:20 32:7 59:7
 77:16 78:11 101:13
 104:10 107:7 108:19
 148:1 150:20 159:17
 160:2 162:17,18
 169:7 182:12,12
 183:2,4 184:9 205:9
 210:21 224:11,17
 242:20 244:9 245:9
 275:4 281:4 284:6
 285:2
Kindred 1:20 50:11
kinds 18:21 103:17
 145:22 247:19
know 6:7 9:14 10:20,22
 13:3,11 15:15,22
 18:11 19:6 33:16
 41:12,17 42:2 43:16
 44:6 47:20 59:2 60:5
 60:13 62:4 64:4,6,9
 71:4,17 78:8,11 81:12
 82:2,13,15 83:10,19
 86:13 88:15 90:19
 92:17,19 93:14,22
 96:10 97:10 98:9
 104:9,14 105:19,19
 106:7,10,15,21,22
 107:4,9,13 115:2
 117:22 122:19 125:20
 128:10 129:18 131:5
 137:5 139:6 140:20
 145:6 156:20 157:2
 157:19 158:2,10
 159:7 165:12 168:6,6
 172:12 183:9 184:17
 187:20 198:15 203:5
 210:16 212:7 220:5
 220:14 221:15 222:1
 246:1 249:5 255:19
 257:15 261:5 264:11
 271:5 278:10 281:17
 283:10 285:13 295:6
 297:10 298:9,19,21
knowing 81:1,6,15 83:5
 263:13
knowledge 132:21
 281:9
known 36:21
knows 239:7
Koenig 3:8 122:22
 123:1

kudos 48:22

L

Lab/NQF 20:16

Labs 17:13

lack 167:10

laid 116:22

Lamb 2:8 19:18,19 23:2

29:3,3 80:21 101:6

286:3

landed 256:7

Landmark 24:17

lands 159:14

Lane 3:8 123:1

language 176:18

224:12

large 19:3 117:15 178:5

283:4

largest 143:2

lastly 7:5 122:3

late 8:11

latest 41:14

Laughter 87:4 104:8

108:9 186:20

launch 61:9

Laura 2:18 50:6 61:21

67:13 231:11 253:21

270:2

law 117:22 118:5

layer 303:7

lead 24:8 31:10 52:10

55:3 205:17 304:19

lead-in 243:15

leader 9:15 181:3

leadership 9:20 11:22

13:4 115:1

leads 258:9 290:18

304:6,18

leaning 280:10

learn 283:16

learned 16:20 122:8

285:10

leave 30:5 43:9 76:14

85:9 122:17 198:16

241:14 256:14 292:18

leaves 154:5

leaving 80:18 238:21

Lee 3:9 267:9,10 299:4

Leff 1:16 20:14 24:15

24:15 87:7 100:18

156:4 170:6 263:1

left 54:11 99:21 154:20

legacy 284:6

legal 251:14

legislation 176:17

legislatively 11:12

Lego 140:9,9,10 150:4

Legos 140:6,7,8 142:13

175:13

length 89:7 138:22

lessen 79:7

let's 22:20 35:3 36:6,20

39:18 78:1 86:18

88:18 180:22 203:3

214:21 216:15,15

220:20 221:2 257:5

258:13 266:14

Lett 1:17 24:12,12 68:3

77:22 79:3 99:12

152:7 183:20 186:15

187:1,11 188:5 211:6

227:20 236:8,12,15

238:12 240:12 260:9

281:12 293:4

letter 19:7 38:4

letters 38:9

letting 248:7

level 14:21 47:8 51:19

96:21 123:18,19

124:7 127:10 130:3

155:5 225:12 249:21

252:3

levels 14:21

Levitt 2:11 4:7 24:4,4

31:4,8,9 70:20 73:17

86:20 105:16 108:14

108:17 112:11 115:2

129:6 134:22 139:6

140:3 149:1 159:21

169:18 180:17,22

184:13,20 186:1,4

198:13 202:7,14,22

209:21 210:1 211:22

213:22 217:13 225:5

243:12 254:13 261:7

262:9 265:5 271:13

276:7,17 278:6,12

280:13 284:1 288:7

289:18 291:22 292:5

294:2 296:6 305:13

Levitt's 144:10

Levy 1:18 8:6,7 25:11

25:11 90:9 217:3

221:7 222:20 245:15

246:17 264:3 281:2

291:17 292:3,8,17

liaison 2:14 9:2 49:22

50:1 84:12

LIAISONS 2:10

liberation 257:9 259:13

lies 196:20

life 15:6 281:5 289:16

293:5,7,9,11

lifestyle 100:15

light 299:10

lighting 287:14

limit 57:11,13 166:16

226:16 269:19 278:4

limitation 142:10

limitations 256:9

limited 22:19 167:8

279:13

line 65:4 177:16 224:9

230:13 267:1

lines 64:16,21 104:13

117:4 147:2 189:15

201:6 253:7 259:9

266:22 274:1 297:2

linked 151:11

Lisa 2:5 26:1 156:2

238:2 273:7,7

Lisa's 287:18

list 11:9 73:21 87:17,19

87:21 90:16 91:1

93:17,19,20,21 94:1,2

95:5,8,16,17 96:19

97:1 109:21 110:1

111:3 112:5 114:16

114:20 115:3 116:7

116:13 160:8 179:7

199:4 207:9 208:1

226:14 287:11 296:16

listed 36:16 38:17

144:13

listen 262:15 280:18

301:8 303:19

listened 280:14

listing 194:2

lists 88:3 93:19 208:18

literally 95:19

literature 151:12

little 32:4 35:8 41:16,19

48:5,10 49:21 52:3

54:15,17 77:18 79:7

81:10 88:6 92:4 98:13

101:9 108:5 132:21

133:12 137:21 155:15

175:14,19 184:4

198:19 203:1 214:7

214:11 217:14 223:12

227:11 252:12 254:3

256:15 257:2 263:14

266:5 272:2 289:4

live 13:19 115:18 256:4

282:8 291:4 303:5

living 17:10 100:16

104:7

Liz 25:2 96:5 105:8

142:15 143:19

Liza 1:14 7:22 8:3 23:22

136:6 157:7 273:6,22

282:21 293:19 294:7

294:8

location 150:15,15

locomotion 195:11

logic 209:17 259:8

logistics 64:3

long 3:8 11:17,20 26:22

27:1 36:22 37:1 63:12

91:2 104:3 138:19

179:7 203:12 207:9

210:14 214:2 225:8,9

242:1 258:8,21 259:3

259:4 265:7 282:4

long-stay 141:9

long-term 1:14,19 5:13

5:15 6:6,16 8:8 12:22

23:17 25:3,12 27:15

28:6 34:11,21 35:10

51:11 86:12 89:5

92:20 123:2,5,6,11,14

124:5 128:3 147:17

196:12,21 252:21

253:18 254:6 255:1

longer 51:5 124:7

138:19 178:22 258:22

263:8,10,14 266:5

297:10

look 7:12 37:22 62:9

72:14 81:11 87:1

106:19 111:12 113:8

116:19 132:5 142:13

145:4,9 151:7 153:4

153:18 163:14 164:4

165:5 166:1 176:16

181:8 182:15 183:2

185:11 196:16 201:22

208:13 211:2 214:10

215:2 223:22 224:16

225:16,19,20,20

228:1 239:17 240:15

241:6,8,20 250:16

269:18 271:17 273:3

280:21 283:6 285:13

286:13 290:9 300:6

302:17 304:2,8

looked 41:14 129:15

156:1,7 224:21

240:20 272:5 286:20

looking 7:3 12:1 18:13

33:12 52:15 58:5 63:6

69:4,11 74:2 89:13

95:16 98:3 102:8

115:12 131:5,10,20

131:22 132:2 134:11

136:5 137:22 138:2,6

150:6 152:1 155:1

175:15 188:15 203:15

210:12,14,17,20,21

211:2 212:6 218:7

272:4,18 282:10
 285:21 286:2 287:3
 289:14
looks 89:21 90:1
 214:11 288:22
Lord 239:7
lose 233:11
lost 149:3
lot 13:5 14:5,9 15:8,17
 16:5 20:6 21:8 27:18
 29:6 33:11 38:19
 55:19 59:20 60:18
 90:20 99:5 105:7
 138:9 145:7 150:5
 151:10 167:14,15
 199:20 203:21,22
 204:19 206:10 216:7
 238:17 241:3 242:21
 243:3 251:8 267:16
 271:6 274:2 282:11
 285:9 287:20 293:6
 297:22 303:19 305:4
 305:7
lots 12:7 17:22 18:9
 102:5
loud 260:3
love 225:21
loved 237:7,8,11,15,18
low 287:14
lower 16:12 130:3
 131:18 261:5
lower-level 124:2
Loyola 258:14 259:2
LTAC 120:5 125:10
 127:11 144:15 153:7
 195:22 199:10,13
 253:4 255:5 257:8
 258:8 262:10 263:13
 264:8 282:14
LTACs 114:8 127:9
 138:15 259:22 260:11
luckily 113:11
lucky 149:4
lunch 171:7,9,13 173:1
 173:3
lung 292:20

M

M-I-O 172:4
MA 1:19
ma'am 253:8
mailbox 170:3
main 52:8 106:20 134:3
 297:17
maintain 205:5
major 39:12 90:3
 299:11
majority 42:8

making 11:19 42:11
 76:22 94:4 95:17
 114:10,17 124:18
 135:5 169:11 229:12
 232:16 234:7 251:16
 274:14 299:20
manage 283:17
managed 182:22 242:5
management 261:13
Manager 2:18,19 4:9
 62:11 63:1
Manatt 27:13
mandate 199:18
mandated 11:13 140:5
 214:9 233:14
Mandl 38:21
manner 30:17
manual 71:9 91:22
 102:22
MAP 2:14 4:8 6:6 10:6
 11:8 12:4 21:20,22
 42:6 43:21 44:19 45:2
 46:6,9 49:1 62:1,15
 109:6,11,13 110:1,5,8
 111:9,10,17 112:6
 113:3,5,14,21 114:12
 114:15 120:12 121:5
 148:20 170:2 190:4
 192:8,8,19 196:22
 197:4 205:3,13
 262:11 263:12
MAP's 112:16
mapped 301:4
March 227:5
marching 114:3
Marcia 11:22
MARGARET 2:19
marked 208:19
marker 292:15
markers 200:12
market 16:1 32:22
 34:17 226:11
marketplace 34:4
Markwood 1:19 8:11
 173:5,7,15,16 287:17
 288:9
masks 261:19
Massachusetts 17:14
masse 212:19
massive 152:19
match 193:22
matchmaker 17:4
material 224:7
materials 12:1,12 120:8
matter 2:6 8:14,21 22:1
 22:6,22 26:14,14,21
 108:21 172:16 183:20
 203:20 205:12 234:11

266:10 294:1 299:6
 300:5 305:21
matters 168:10
mature 33:8
maximize 84:22
maximizing 84:9
Mayo 17:20
MBA 2:12
McMULLEN 3:10 24:7,7
 31:5,11 38:20 114:2
 114:21 115:13 144:9
 197:22 198:10,11
 203:3 208:21 209:4
 210:12 214:5 222:10
 226:13 263:10
MD 1:12,13,16,17,18,20
 2:3,8,11,17 3:4,10
MDS 150:12 206:22
 220:20
mean 71:16 74:21
 76:13 77:14 79:14
 80:7 82:5,8 83:16
 91:12 105:3,18
 107:12 119:17 140:6
 161:16 166:4 194:1
 202:9 211:22 250:15
 252:16 262:4 269:2
 282:12 299:8,9
meaning 195:11
meaningful 12:2 101:18
 250:5 268:15 272:8,9
 285:15 289:5 299:17
means 71:10,14,15
 113:12 119:15 138:18
 141:19 212:2 234:4
 259:6 293:8,15
meant 45:7 273:11
measure 1:3 7:8,12
 15:1 16:2,9,13,15,22
 24:7 25:1 29:5 35:10
 35:12,15 42:16,20
 43:1,3,8,20 44:1,19
 44:21 45:4,8,18,21,22
 46:2,7,10,18,20,22
 47:1,3,4,7,11,13,13
 47:19 49:2,8 50:19
 51:3,10,22 52:13,22
 54:21 55:1,8,10,16,20
 56:1,3,4 63:13 66:1,2
 66:3,5,11,19,20,22
 67:1,3,6 68:5 70:8,22
 71:5,6 72:3,4,6,6,7
 75:12,16 77:10,19
 78:9 83:6,7,18 84:17
 89:19,20 94:8 98:1
 99:9 101:7,8,19 102:4
 107:4,10 109:11,19
 109:21 110:8 111:1

112:5,12,14,18,20
 113:6,9 114:8,13,14
 115:6,8,14,15 116:2
 117:18 118:1,7,8
 119:3,6,13,22 120:18
 122:4,4 123:8,10
 124:13,17,21 125:6
 127:2,2 129:8,16
 130:4,8,9,12,12,14,19
 130:21 132:6,20
 134:6,14 135:16
 136:19 137:2,7 138:4
 138:5 140:4 141:4,16
 141:17 142:5 143:16
 146:9 150:1,19 152:3
 152:13 153:20 155:3
 155:18,20 156:9
 157:8 158:5,7 159:17
 160:6,22 162:3
 163:19 164:7 165:6
 165:21,22 166:21
 167:1 169:3,4,7,10,11
 169:14 171:1 174:12
 174:20 175:6 178:8
 178:10,11 179:9,10
 179:20 180:6,8,9,11
 181:1,22 182:1,6,11
 182:15 183:8,18
 185:1 187:4 189:7
 190:10,15,16,19
 191:6,8,9,15 193:8,10
 193:12 194:6,7,18,19
 195:5,14,15,22 196:2
 199:14,17 200:14,20
 200:21,22 201:2
 202:1 203:5,10,11
 204:7,9,11,14,16
 205:1,2,8,12 207:13
 208:14 211:3 213:6,6
 213:8 214:10,12,15
 214:16 215:5,8,16
 216:5,7 217:8,11
 219:6 220:12 222:21
 223:12,13,20 224:1,2
 224:6,8,15,18 225:1
 225:11 226:13 228:8
 228:10 230:22 231:2
 231:3,5,19,20 232:3
 232:10,15,22 233:1,2
 233:9,10,13,19 234:4
 234:18,21 235:12,21
 237:1 238:9 239:6
 242:20 243:8,17,20
 243:20,21,22 244:2
 244:16 248:17 249:3
 249:6,9,12,17 250:1
 252:6 254:14,20,20
 254:21 255:8 260:13

260:19 262:12,18,20
 263:5 264:16,17,18
 264:22 265:3,7,9,16
 266:19 268:2,3,16
 269:5,6 270:10,11,11
 270:12,13 271:1,3,11
 272:7,18,22 273:6,14
 273:15 274:12,17
 276:8,19,19,20 277:4
 277:7,9 278:19 279:1
 279:7,8,20 280:2,3
 281:6,15 282:12
 283:1 284:3 286:22
 287:10 288:21 289:2
 289:3,9,9 291:22
 294:6,12 295:4
 296:12,13 298:7,17
 299:11 300:8,20
 304:22
measure's 124:22
 234:16
measured 273:21
measurement 13:2,7
 13:11,21 14:8 15:19
 45:15 101:17 119:19
 215:5
measurements 208:11
measures 4:10,12,14
 4:16,18,20 5:1,3,5,7,9
 5:11,13,15,17,19 6:13
 6:17 7:2 11:1,1,8
 14:14,20 15:15,22
 16:4,11 18:3,6 20:3
 28:22 31:21,22 32:1
 33:11,14,14,21 35:4,5
 35:21 36:1,15,15,18
 36:18 39:7,9,20,22
 40:3 42:14,15,18
 43:19 44:5,6,9 45:1
 45:13 46:9,14 48:6,21
 52:11,18 53:11,17
 54:7,20 57:12 58:9
 59:15 61:3 63:17,20
 64:17 67:20 68:12,13
 68:14,18 69:1,2,3,10
 69:11,15 72:21 73:1,9
 74:16 76:21,22 77:3,5
 80:11 83:1 84:18 90:4
 95:9,9 101:13,18
 104:10 106:5,15
 107:22 109:3,15
 110:6,12,20 111:15
 111:18,21 113:2
 114:4,6 116:6,8,20
 118:12 119:4,11,17
 120:13,16,19 121:6
 121:14,20,22 122:6,9
 127:20 128:1,2,5,12

128:15,16,19,20
 129:10,10 130:15,15
 131:1,10,17,21 132:6
 132:10,17 135:11,14
 135:20 136:2,5,11,17
 140:14,17 141:18
 142:12 143:1 145:4
 146:6,8,22 147:15,18
 147:22 148:1,4,10,11
 148:14 149:12,13,19
 150:1 152:5 153:14
 154:3 161:4,22 162:8
 163:8 164:2,13,19
 165:11,12,17,19
 166:11,15 167:2,16
 167:17,18 168:12,22
 169:6 175:21 177:7
 177:12 179:12 181:22
 184:21 185:9 186:8
 189:5,16 191:11,15
 192:10,13,17,20,22
 192:22 193:2,5,15,21
 194:3,8,11,16,22
 195:1,5,14 196:13,19
 196:20 197:7 198:2
 198:12,17,17,21
 199:3,4,6,8,22,22
 200:1,6,8 201:1,6,8,9
 201:16 202:3,5,8
 203:6 204:5 206:3,5
 206:20,22 207:1,11
 207:12 208:18 209:8
 209:9,14 210:2,7,13
 211:1,17,20 212:9,18
 213:16,17 215:22
 220:17 222:6,18
 224:9,13,22 225:7
 227:6 228:6,19
 230:10 232:19 233:6
 234:20 239:8,8 244:9
 244:14 247:21 248:12
 248:15,22 249:8
 250:10,13,16 254:5
 256:18 257:5 260:10
 267:13,18,19,21
 268:8,10,13,20,21
 269:2,4,6,9,18 271:16
 271:21 272:12,14
 273:12 274:3 278:18
 281:3,14 284:4,5,6,8
 284:14 285:11,14
 286:5,11 296:22
 297:16 298:4,5,14,21
 300:6,12,17 303:15
 304:17,18,19 305:1,2
 305:17
measuring 179:11
 269:19

mechanically 228:17
med 96:16 105:3
 176:10
Medicaid 2:11 3:2,10
 7:21 24:10 25:21 28:3
 28:12 29:13 84:7
medical 2:1 3:4,6 23:8
 24:4,20 69:14 70:6
 79:11 86:8,16 88:9
 96:17 153:3 159:9
 175:4 181:7,8 182:8
 194:14 207:14,15,16
 207:17 290:6
medically 181:12
Medicare 2:11 3:2,10
 10:17 23:8 24:10 28:2
 28:12 35:18 38:11
 84:6 293:9
medication 4:10,12
 39:14 64:18 65:17
 66:1,16,21 69:3 70:13
 73:16,19 79:6 80:11
 85:15 86:4 89:8,9
 91:22 92:16 93:7,11
 93:13,16 96:15,19
 98:16 99:14 100:12
 103:10,13,15 104:4,5
 107:21 115:22 189:11
 206:8 208:3 215:1,14
 215:19 216:1 253:6
 255:3 259:16 263:20
 287:11 302:2
medications 73:21
 79:17,21 80:5,9 82:15
 95:5 98:10 100:4
 103:5 104:1,18,20
 159:12 262:13 281:4
 302:7
Medicine 1:17,19 8:9
 25:13 28:7
medicines 88:1
MEDPAC 41:1,12
 155:14
MEDPAC's 37:2
meet 79:20 113:18,22
 123:12 178:22 179:8
 179:17 199:1 264:2
meeting 4:2 6:5,11
 21:15,16 30:8,18
 31:10 42:9 62:9 64:2
 68:13,20 171:11,14
 172:20 173:21 192:19
 196:14,19,19 197:5,7
 197:12 277:1
meetings 20:17 89:7
 120:8 197:15 299:7
meets 133:6 134:9
 178:18

Mel 184:14
member 7:20 8:2,7,13
 8:19 19:11,18 20:14
 23:7,12,15,19,21,22
 24:4,12,15,19 25:2,7
 25:8,11,14,17,20 26:1
 26:5 28:8,19 29:3,12
 31:8 49:20 50:2,10
 53:21 68:3 70:20
 73:17 74:20 75:15
 76:2,4 77:22 79:3
 80:21 85:13 86:20
 87:7 88:20 90:9 91:19
 95:2 96:6,16 97:16
 99:12 100:18 101:6
 102:21 105:16 108:14
 108:17 109:6 112:11
 115:2 120:20 129:6
 132:15,18 134:12,22
 135:3 136:7 137:21
 138:12 139:6,10
 140:3 145:3,17 149:1
 149:18,22 152:7
 154:15 155:17 156:3
 156:18 157:8 158:8
 159:21 169:18 170:6
 173:4,7,15 174:3
 180:17,22 182:7
 183:20 184:13,20
 186:1,4,15 187:1,11
 188:5 190:4 192:8
 196:17 197:4 202:7
 202:14,22 205:22
 206:17 208:9 209:21
 210:1 211:6,22
 213:22 215:4,20
 217:3,13 220:14
 221:7 222:20 223:6
 225:5 226:3 227:3,20
 229:3 236:8,12,15,20
 238:3,12 240:12
 242:14 243:12 245:13
 245:15 246:17 254:13
 255:14 257:11 258:6
 259:19 260:9,18
 261:3,7,10 262:3,9
 263:1 264:3,14 265:5
 271:13 273:8,22
 276:7,17 278:6,12,17
 278:20,21 280:12,13
 281:2,12 282:22
 284:1 286:3 287:5,17
 288:7,9 289:18 290:2
 290:11 291:17,22
 292:3,5,8,17 293:4,20
 294:2,11,20 295:5
 296:6,10 300:10
 305:13

members 7:16 19:8,10
19:16 26:10,11 35:14
42:6,7 66:18 78:3
110:12 117:11 132:9
163:22 171:10,10,11
171:19 172:21 173:1
178:1 196:11,18,21
196:22 197:3,6,11,13
206:11 230:19 237:6
237:16 238:6 253:13
267:7 289:19 297:7
memory 86:2 185:21
mental 16:6 191:20
mention 12:18 148:15
276:18
mentioned 36:7,9 40:9
51:1 103:22 105:21
112:22 130:13 131:14
132:3 138:9 141:8
294:4
mentioning 264:4
merits 193:6
messed 220:16 221:9
messing 223:4
met 1:8
methodology 13:19
130:21,21 131:3
metric 146:1 183:12,15
mic 146:13 174:22
197:1 252:18
middle 32:10
midnight 103:7
millions 17:17
mind 41:2 50:7 72:18
85:5 98:6,17 185:18
249:11 302:21
mindful 61:2 91:7
159:18 246:6
minds 235:2
minimum 86:1
minute 219:11
minutes 46:11 57:14
290:12
Mio 171:19 172:2
mirror 164:17
missed 246:16
missing 218:7,10,12
219:20 223:16 241:12
mission 131:17 285:18
misunderstanding
197:3
mix 199:21 209:10
210:14
mixed 256:1
mobility 189:7,8 193:4
193:22 194:22 195:1
199:15 200:7 207:14
207:16

mode 195:11
model 19:1 33:19
144:11,17 145:7,19
170:7,19 300:18
models 125:21 135:6
200:6,7 300:16
moderate 189:12 208:4
211:19 219:4
modification 174:1
modifications 164:2
moment 23:6 176:1
274:2 297:12
MONDAY 1:5
money 233:14
monitor 243:2 265:17
month 19:8 92:22
129:19
monthly 241:4,5
months 30:13 62:8
morning 6:3 8:2,13,19
19:18 36:19 62:10
63:8 65:10 68:10,11
120:2 122:22 123:4
212:15
mortality 167:17 248:12
motivation 16:4
motor 201:22
move 26:13 31:3 54:19
55:13 61:3 102:19
105:12 145:2 150:9
169:15 188:22 204:18
211:17 219:1 221:2,2
224:7 230:10 236:18
245:12 252:11 256:21
257:1 289:15 301:10
302:20
moved 204:10 205:10
movement 265:21
movie 233:4
moving 10:16 50:18
83:2 115:22 116:4
144:17 161:11 202:2
205:14 252:14,21
293:17 303:20 304:5
MP 88:9
MPA 1:12,15
MPH 1:12,14 3:4,9
MSW 1:13
MTM 94:11
MUC 109:21 110:1
111:3 112:5 114:16
115:3 116:13 199:4
226:13
MUC15-1131 220:1
MUC15-1132 230:2,5
MUC15-1133 218:20
MUC15-207 295:9
MUC15-235 296:2

MUCs 53:22 70:9
Muldoon 1:20 50:10,11
96:16 138:12 156:18
208:9 220:14 255:14
258:6 259:19 262:3
290:2
Mulhausen 2:8 8:12,13
8:14 23:2 28:8,8
97:16 215:20 223:6
242:14 264:14 290:11
Muller 3:7 230:20,20
multi-part 281:14
multi-representative
89:3
multifactorial 270:16
multiple 29:7 79:18
101:20 103:13 136:15
136:18 146:3 169:14
228:7
multiplication 188:16
multiplied 188:19
multiply 185:12 187:7
multiplying 188:2,13
musculoskeletal 63:21
muted 168:1

N

N.W 1:9
name 21:6 23:4 50:10
61:20 62:3 109:9
117:13 122:22 169:22
178:4 192:5 267:9
271:6
name's 120:2 194:12
names 22:22
narrow 106:2
narrowed 175:7
nation 10:1 123:7
national 1:1,8,13,17,19
2:2,3,12 3:8 9:8,9,13
23:8,16,19 24:13 25:5
26:6 34:9 42:22 45:14
65:20 70:3 84:8
116:12 123:2,4
124:14 128:22 148:2
173:17 185:10,11
187:7,9,16,19 188:3,7
188:14,16 199:6
203:14
nature 41:6 111:7
NCQA 29:5 63:13
necessarily 60:8 77:3
88:2 98:4,17 118:4
145:11 160:16 191:20
214:4 225:13 243:21
249:5 265:8 274:13
283:20
necessary 179:3 223:4

need 35:15 36:21 38:10
39:21 40:11 41:8 50:2
55:21 71:13 77:4 78:5
80:1,15 83:8,21 88:2
93:9 94:6 97:2 108:2
108:5,7 121:17 124:8
126:20 127:5 135:4
136:12 138:10 139:4
145:2 146:17 157:1
159:18 164:3 165:1
171:12 173:6,8,10
174:17 179:8 187:19
187:20 191:21 194:18
220:11 228:2 237:3
240:8 243:16 263:6,7
268:10 281:18 285:11
285:16 286:5,9,15
289:21 302:10 303:13
304:12,21
needed 7:14 34:14 35:9
35:22 56:14 71:20,20
115:4 166:16 221:14
278:3
needing 225:13
needs 50:16 74:10 81:5
81:7 124:7 156:7
194:8 201:10 217:5
283:8,12 292:11
neighbor's 99:19
neither 161:2
Network 2:5 26:2
242:16 243:4
never 106:12,17 233:3
241:15 249:20 292:21
new 7:16 11:21 20:3
24:22 27:17 33:14
79:16 104:19 127:3
155:19 173:4 176:10
204:14 207:1 209:18
239:21 252:11 285:2
303:7
newest 32:8
newly 214:22 215:18
news 245:18
nice 40:19 243:15
nicely 97:17
Nicole 3:3 175:3
NIH 28:3
nine 33:20
nodding 14:9
nods 108:20 216:14
noise 162:3
nominated 26:19
non 99:18
non-adherence 103:14
non-experts 300:22
non-prescribed 302:9
non-stop 170:17

Non-voting 2:10
nonprescription 100:3
nonvoting 22:3
normal 79:16 80:5
 100:15
Northwest 171:20
 172:8
note 58:4 118:6 160:14
 168:12 175:18 222:5
 254:19
notes 53:2 148:12
 152:2 155:1 299:19
notice 49:6 52:17 56:1
 68:9 201:15
noticing 267:16
notion 209:5
now's 207:5 276:2
NPRMs 114:13
NQF 2:16,20 4:3,4,5,9
 11:7 12:19 13:2,18
 15:16 16:14 21:2,11
 30:20,20 47:19 59:12
 60:16,18 61:22 62:9
 62:12 63:2,11,12 66:8
 102:8 116:15 120:7
 121:7 126:19 128:13
 131:19 164:14 171:10
 172:22 174:7 191:5,6
 191:10 192:15,19
 193:4,16 194:4 196:9
 210:2 213:17 223:20
 252:13 277:1 278:22
 280:14 289:1 297:18
 298:1,8,13,13,18
 299:18
NQF-endorsed 223:13
nuance 224:12
NUBC 122:16
Nuccio 2:9 8:18,19,20
 23:3 28:18,19,19
 88:20 102:21 145:17
 229:3 261:3,10
 278:13,16,20 280:12
number 6:12,18,19 7:10
 17:11,21 19:3 65:2
 79:8,9 80:2 84:17
 85:21 92:6 104:18
 107:17 122:15 148:2
 153:22 155:14 156:10
 157:1 170:8 173:1
 184:3 230:16 251:7
 251:14 252:2 253:10
 257:16 269:6 270:14
 272:12 279:14
numbers 10:12 118:22
 151:18 240:14,22
 242:5
numerator 98:1,3

100:21 145:20 187:5
 227:4 264:2
numerous 242:18
nurse 8:3 24:2 62:6
 97:12 102:14 239:20
Nurses 1:14
nursing 5:5,7,9,11 6:21
 32:11 35:19 40:5,11
 60:7 65:13 85:21 89:4
 91:21 92:15,20 95:16
 128:4 133:5,9,11,17
 133:19 134:7 141:6,9
 141:12,13,20,21,22
 142:2,6 147:17 188:9
 189:4,11 190:11
 191:6,16,21 192:16
 203:13,16 204:2,11
 206:11,16,21 209:5
 209:14 210:15 213:20
 214:12 216:10 219:3
 221:4 222:22 225:7
 226:5 229:8,18 232:1
 237:1 238:22 242:22
 246:19 248:21 253:16
 265:6
nuts 42:11

O

O'Rourke 2:18 4:8 42:1
 48:12,17 49:18 50:6
 50:14,18 62:22 63:1
 75:3,18 81:9 86:18
 87:2 107:20 108:2,6
 111:11 146:14 170:1
 171:8 173:9 196:10
 197:2 208:13 209:2
 212:22 213:15 221:17
 288:18
OASIS 71:7 85:19,20
 86:21 88:22 150:12
 279:12,16
objection 108:3 146:15
objections 54:6,10
 213:1
objectives 4:2 47:5
 53:14
obnoxious 246:15
OBRA 210:19
observation 84:5,11
 152:15 166:8,18
 167:5 250:8 290:16
observing 250:7
obvious 82:1 174:15
obviously 70:8 131:16
 140:14 244:13 245:8
 280:13 285:16,18
 299:15
occasional 238:5

occasions 169:14
Occupational 1:21
 25:18
occur 117:2 162:12
 234:8 303:18
occurred 156:13
occurrence 250:4
occurring 159:16
 239:18 244:6
occurs 133:8 178:21
 239:7 303:11
October 40:1 227:5
odds 170:17
offer 98:13 121:21
offers 282:16
Office 2:12 3:11 25:4
 190:3,8
officer 13:4 24:5
official 190:7 298:13
oftentimes 227:8,13
oh 61:17 102:20 105:13
 108:4 151:22 155:2
 180:19 202:12 209:4
 229:1 238:12 241:17
 262:5 286:1 295:17
okay 6:10 7:22 8:7,12
 19:16 21:8 23:15 26:3
 26:13 27:12 28:17
 29:21 30:4 31:8 48:3
 49:18 50:18 58:15,19
 61:8,11 62:21 64:14
 64:22 65:7 67:13,17
 68:8 70:20 75:1,14
 77:21 93:7 102:20
 108:4,20 127:17
 129:6 132:13 144:22
 147:11 172:14,19
 174:22 182:4 196:7
 198:10,14 205:15,21
 207:5,22 217:18,20
 218:11,17,18,22
 219:8 226:2 236:7,15
 256:16,22 259:14
 270:6 273:7 276:14
 278:9 282:3 293:18
 295:17
old 9:8 150:2,3 288:19
older 35:13
omissions 103:14
ONC 2:13 27:18 139:12
once 34:14 36:10 37:10
 40:10,12 54:3,18
 55:12 68:18 109:21
 124:6 129:7 212:4
 225:19 258:20 297:19
one-time 263:22
ones 45:10 121:8
 255:15

ongoing 69:12 90:6
 164:12 183:7
online 120:10 134:11
 304:11
open 55:10 64:16,20
 116:7 117:4 120:17
 147:2 149:20 182:5
 189:15,22 217:22
 219:18 230:2,12
 252:18 253:7 266:22
 295:9 297:2 305:8
opening 199:19 200:18
openly 30:18
operational 28:13
operationalize 46:20
 98:6
operator 64:16,20,22
 65:5 117:4,6 147:1,3
 177:16,18 189:15,18
 230:12,14 253:7,8
 267:1,2 297:2,4
opinion 55:10 168:10
 273:1 277:8 305:16
opportunities 57:8
opportunity 4:10,14,18
 5:1,5,9,13,17,21 9:19
 67:9 96:13 120:6
 122:20 123:3 124:10
 174:21 252:20 267:12
 269:22 296:20 298:6
opposed 78:19 166:13
 246:8 295:3
optimally 45:13
optimistic 251:18
optimization 286:22
option 213:14 248:18
options 216:17 219:13
 226:6,7 229:17
 299:14
Optum 17:13,14 20:16
order 15:3 141:2 156:22
 160:10 167:6 179:14
 188:6 233:21
orders 114:3
ordinarily 275:19
organization 2:2 8:16
 18:18 26:7,18 28:10
 173:11 242:17 288:5
organizational 22:1,5,7
 22:9,16,21 26:10,11
organizations 9:9 16:3
 28:2 29:7 59:5 173:19
 206:5 243:7
organize 42:15
organized 52:18
orient 180:3
original 142:10 223:8
 223:19

originally 116:6 161:21
203:14
ought 304:1
outcome 128:5,16,20
148:10 189:7 207:12
211:17 243:10 261:4
272:19 274:17 286:9
outcomes 18:12,21
41:17 59:16 65:19
138:2 195:17,18
274:7,8,19 282:7
302:21 303:1
outlier 138:16
outline 66:4
outside 226:21 233:4
235:3 242:5 251:11
over-the-counter 104:1
104:19 302:9
overall 69:16 200:20
205:8
overarching 146:4
148:1
overlap 301:22 303:3
overlapping 269:2
overly 279:2 289:4
overmuch 234:8
overview 4:6 40:19
67:19 127:19 147:12
202:19 231:15 270:7
oyster 226:15

P

P-R-O-C-E-E-D-I-N-G-S
6:1
p.m 172:17,18 266:11
266:12 305:22
PAC 6:6 66:11,14 67:3
69:8 127:3 136:21
193:16 197:12
PAC-PRD 37:12,13,17
198:20
PAC/LTC 42:19 47:15
62:2,13,16 63:3 170:2
packet 68:7
page 35:6 115:19
pages 91:2
paid 168:17,20 179:1
pain 189:12 192:11
193:8 208:4 211:19
219:4
pair 274:17,21
Palena 2:12 25:2,3 96:6
139:10
Palliative 2:2 26:7
Pam 25:17 174:1
294:19
PAMA 35:17 40:9 231:5
231:7,22 233:15

Pamela 1:21 205:17,19
panel 2:4 13:8 23:20
94:12 120:19 160:9
194:4 204:7 278:17
279:6,10 280:10
panels 132:20 203:19
289:22
pangs 101:3
panic 159:13
paper 120:10
parameters 177:4
parsimonious 7:9
271:16
parsimony 303:3
304:15
parsimony's 282:19
part 10:6 11:1,2 16:16
34:18 37:13 50:21
53:20 65:8,20 66:22
68:2,10 71:6 76:14
78:20 84:1 85:14 94:7
99:16 101:13 104:4
114:17 129:21 132:2
139:14 143:20 148:16
149:5 156:11 163:5
170:19 174:11 196:2
210:18 217:9 223:9
224:20 229:12 242:14
246:16 249:16 264:9
264:11 280:5 281:21
291:9
PARTICIPANT 202:12
participate 174:16
182:13
participating 131:19
291:12
participation 174:11
particular 10:5 22:17
66:15 77:8 81:2 103:1
124:19 136:19 141:19
146:1 157:9 160:3
161:17 205:18 206:3
219:5 232:18 249:10
252:4 268:4 278:4
279:4 287:10 292:1
particularly 11:15,21
38:20 51:20 73:2
78:10 86:6 123:9
138:15 151:19 152:18
153:5 157:13 160:22
173:2 227:9 228:11
234:18 272:17 274:6
275:6 286:15 287:2
partners 17:19 20:18
partnership 1:3 20:16
203:7,15 204:5
242:21
parts 227:10 270:22

281:18
pass 51:5 54:11 108:6
130:6 159:21,22
213:2 222:8 282:12
path 109:17 258:9
pathway 44:4 111:20
111:21 112:6
pathways 43:18 111:14
patient 18:20 34:1
36:12,21 37:21 38:15
60:10 69:21 70:3
74:12 88:1 89:22,22
90:1,7 95:11,22
100:13 118:21 124:7
130:17 141:11 150:8
154:5,8,9,18 157:18
169:16 176:5,8,11
178:17,21 179:1
181:5,11 183:5 229:7
234:1 235:8 244:18
244:19 246:22 258:20
259:22 265:15 274:15
274:19,22 275:12
282:1 283:10 291:10
301:11,21 304:2
patient's 93:20 96:4
103:9
patient-centered
176:22 280:6 289:16
patient-reported 18:11
patients 10:2 18:16,18
18:22 35:11 60:21
80:4 84:15 97:11
104:5 118:17 119:16
123:14,17 129:14,18
129:22 130:4,5
131:13,18 136:4,22
140:19 141:8,19
142:3,21,22 143:12
143:17,21 145:11
153:3,9 155:4 157:2
161:9,11 162:4,13,16
163:10 167:12,15
179:8 181:12 195:6
195:10,12,16,18,19
207:14,15,17,18
225:12 234:13 235:11
235:15 242:12 244:1
245:2,4,5 248:8
251:11 253:5 254:16
255:1 259:15 261:21
266:20 270:15 271:10
272:9 279:8 280:1
282:2 284:15 285:17
289:5 290:4 294:16
pattern 276:12
patterns 170:10
Paul 2:8 8:12,14 23:2

28:8 97:15 102:2
215:19 242:13 243:14
264:13 290:9
Paul's 100:19
pause 31:1 47:22
pay 102:7,16 183:12
payers 41:9
payment 14:15 45:5
177:1 178:10 179:16
183:14 231:7 233:7
233:12
payments 301:10
PCORnet 19:3
PCP 176:9
PE 151:15
pediatrician 32:10
Peg 33:12 62:3 270:6
Peggy 271:14
penalize 168:14 179:16
penalty 122:12 154:13
155:21,22 156:16
183:10,13
people 7:6 10:7,10,11
11:6 14:21 15:9 16:11
17:5,21 19:14 20:10
20:19 52:11 59:11,20
62:4 80:8 82:3,8
84:21 85:2 89:4 99:16
102:5 111:6 118:9
119:4 126:6,7 135:19
135:20 137:12 138:12
153:8 155:21 157:19
168:2 174:13 179:5
179:17 191:2 203:22
204:1 216:9 222:15
227:15 228:6,13
241:10,21 242:8
246:9 247:3,7,20
252:19 258:9,15
259:21 264:20 265:14
271:5 279:3 283:14
290:14 291:1 301:13
304:17 305:6
people's 219:21
percent 33:3,4,5 55:21
56:12,16,19,19 80:7
129:18 131:6 143:8
143:14 167:7 187:10
187:10 189:11 195:10
208:1,3,4 218:20
219:2 220:1,2,3,15
221:3 229:18 230:5,6
230:7 233:11 244:13
245:7 253:5 258:17
259:15 261:18 277:15
277:18 279:18 280:1
282:2 296:2,3,4
percentage 32:22 34:16

40:13 142:3 151:15
184:1 222:22 246:17
percentages 184:8
perennial 59:22
perfect 80:13,14 107:3
perfectly 78:13
perform 167:16
performance 24:1
145:21 166:2 168:13
183:12 185:6 188:18
233:12 250:6 284:17
performed 70:6 184:3
period 11:11,14 14:4
58:1,7,8 85:3 148:9
154:7,11 178:16
181:2 210:7 226:12
227:14 231:7
periodicity 93:14
periods 57:17
perplexed 216:10
person 7:18 54:21 55:7
63:16 81:13 83:8
159:14 211:13 227:22
275:18 292:19 304:9
personal 10:5
personally 152:21
238:22 281:13
persons 84:6,15 200:13
perspective 47:2 84:5
186:10 213:16 226:21
236:21 243:5 280:6
289:17
pertinent 173:13 176:2
perverse 79:16
pharmacies 92:21
pharmacist 91:2 97:12
102:13
Pharmacists 2:5 25:9
pharmacy 93:20
PharmD 2:4 96:21
phase 116:1
phases 182:12
PhD 1:18,21 2:2,7,8,9
2:19 3:2,8,10
phenomenal 240:2
phone 6:7,10 26:4,11
29:16,19 31:15
218:14
physical 1:15 25:15
139:20
physician 69:12 79:11
85:17 86:5,7 88:10
94:16,22 96:13,20
97:13 102:10,11
104:22 191:8 274:14
physicians 99:7
piece 94:3 100:5 102:11
138:8 177:5 183:10

247:10 255:22
pieces 175:9 245:8
274:14 286:16
pile 20:15 78:19 87:7
95:2
piling 78:4
pills 99:20
pilot 67:4 116:2 122:6
174:5
piloted 121:11
pipe 176:16
pipeline 16:9 136:10
Pittsburgh 3:3 175:4
place 77:17 142:9 157:4
157:4 234:9 248:12
249:22 256:2 263:15
271:8 274:14 301:14
plan 63:14 172:11
264:9 270:19,20,21
273:16 274:11,13
290:5 291:8 293:9
planned 122:14 135:14
135:21
planning 3:11 118:14
190:3 244:19
plans 164:15
plate 222:18
plates 21:6
play 159:19 176:8
180:17 222:7
please 23:4 30:10 52:7
58:11 61:12 65:1
74:22 75:11 85:4
117:7,11 147:4
152:10 171:13 172:12
177:19 189:19 190:1
190:8 230:15 253:9
262:2 267:3 297:5
pleased 173:19
pleasure 9:12
pleural 292:20
plus 104:19 118:3
228:9
pneumonia 175:8
228:14
point 15:12 32:22 34:16
40:13 55:6 76:6 81:21
89:17 95:19 100:21
103:21 121:4 130:18
134:3 139:12 162:9
163:19 167:12 178:7
179:19 195:2 209:13
209:16 217:3 218:3
218:13 221:8 228:3
236:8 244:8,14 247:5
247:9 248:13 254:18
262:10 265:5 277:13
279:17 283:6,13

287:3,5 288:17
302:12,14
pointed 89:18 162:22
234:6 279:17
pointing 218:1
points 76:8,11 151:21
196:11 302:6
policy 9:8 23:16 51:21
123:1 179:4,15
232:12 234:10
political 13:8
poll 217:21 219:17
polypharmacy 79:15
popped 258:17
population 79:17
118:20 137:3,4
146:10 151:16 157:21
186:12 190:11,16,18
190:20,22 191:7,9,13
191:17,18,19 192:1,1
192:2 200:16 206:6
210:16 211:4 214:18
253:19 255:9 277:6
277:10,12,15 281:8
283:5 291:1 296:8
303:20
populations 199:21
201:3 206:15 215:11
283:7 301:21
portfolio 158:4 194:17
274:4 283:2
portion 133:9,10,11
134:7 146:10 187:22
portions 183:3
pose 205:13
position 159:12 190:7
positive 12:3 37:20
101:21 253:3
possess 103:8
possibility 236:22
possible 57:4 73:9
82:12 124:16 137:3
164:8 169:12 195:15
possibly 143:17 275:9
post 1:18 24:5 41:2
100:8 171:2 242:10
post-acute 1:3 4:6 6:15
8:8 12:22 24:9 25:3
25:12 31:5,13 36:11
36:13,22 38:1,3,6,10
38:11 39:3,20 41:8,15
50:13 51:11 71:21
99:17 117:15 119:14
120:4,21 131:2
138:14 154:15 176:20
193:20 228:9 239:11
239:13 240:13 242:12
247:15 276:1 289:19

301:12 304:3
post-acute-care 171:5
196:12,21 304:5,7
post-admission 155:3
post-discharge 157:22
169:7 235:17 244:18
post-SNF 231:1
posted 115:14,22
posting 115:21
potential 83:3 89:13
103:8,18 154:1
165:16 167:11 169:11
174:19 224:5 237:21
potentially 4:18,20
66:21 74:3 85:14 98:6
98:14 103:4 119:6
130:9 136:18 137:10
146:21 147:20 149:15
150:19 153:19 155:2
155:11 157:10 158:10
160:11,21 161:14
164:18 165:17,21
174:12 179:2,17
180:7 181:17 232:2
232:13 233:1 234:18
235:1,7,10,13,14
298:15 300:19 302:13
Potter 3:11 190:2,2
253:15
PPPR 175:5 177:7
PPPS 175:17
PPR 160:7
practicable 233:3
practical 232:11,12
299:5
practice 257:13
practicing 79:11
practitioners 265:14
pre 63:6
pre-existing 179:14
pre-rule 114:10,17
pre-rule-making 116:9
209:12
pre-rulemaking 4:8,12
4:16,20 5:3,7,11,15
5:19 42:3
precisely 178:13
179:10
preclude 287:20
predicted 184:15,22
predictors 126:22
predominantly 77:9
prefer 30:18
prejudge 15:11
preliminarily 72:12
preliminary 46:17,19
49:7 51:9,15 53:1,3
53:10,13 54:6 55:2,8

58:19 67:21 69:19
 75:5,9 83:19 127:20
 128:14 146:15 223:8
 223:10 254:8
premature 156:6
prematurely 234:1
prepare 64:2 120:15
prepared 159:9
prescribe 176:10
prescribed 103:15
prescriber 74:10 94:22
prescription 99:19
 156:16
prescriptive 71:9,13
 82:11 94:10
present 1:11 3:1,15
 19:1 37:5 53:11
 170:20 226:19 245:17
presentations 29:6
 52:1
presented 70:9 146:8
 204:4,6 223:10
 267:18 300:20
presenters 223:17
presenting 72:22 304:6
president 2:17 9:13
 24:1
presiding 1:10
press 65:1 117:7 147:4
 177:19 189:19 230:15
 253:9 267:3 297:5
pressure 2:3 23:20 41:9
 253:4
presume 241:3 293:8
pretty 91:12 158:4
 162:7 206:4,6 216:6
 242:4 248:14
prevalence 203:11
 254:20 255:8 260:13
 262:20 263:18 264:16
 264:17,18,22 265:3,8
 265:9
prevent 78:8 107:2
 151:7 159:15 233:16
 235:7
preventability 160:13
 161:3 162:6
preventable 4:19,21
 119:6 130:10 146:21
 147:20 149:15 150:20
 151:8 153:19 155:2
 155:11,16 157:10,12
 158:10 160:12,22
 161:15,18 164:18
 165:21 174:12,20
 180:7 181:17 232:2
 232:14 233:2 234:19
 235:1,10,14 300:19

302:13
preventing 70:4
prevention 271:8
 287:19,22 288:3
previous 40:8 124:20
 135:9 192:21 193:11
 262:11 289:1
previously 122:19
 135:6
primarily 41:9 117:15
primary 24:18 89:2
 117:18 176:17 200:10
 266:20 279:15,18
 290:22 291:3,4
 294:16
prime 220:10 221:14
principles 50:19
prior 136:22 154:21
 171:4 200:10,10
 245:4
priorities 45:17
prioritize 43:4
prioritized 121:20
priority 7:4 42:22
 285:12
probably 17:7 20:7
 33:11 34:6 36:7,8
 59:8 83:12 114:15,19
 124:18 126:21 143:13
 161:20 167:21 169:5
 169:17 170:13,18
 223:4 227:15 246:11
 246:20 247:16,17
 250:14,20 251:22
 255:17 259:6 277:15
 291:19 292:11 299:14
 299:19
problem 64:7 79:10
 94:15,17 105:9 124:4
 153:11 239:10,12
 281:13 299:11
problematic 150:20
 250:14 290:21
problems 94:13 98:20
 98:22
procedural 68:3 196:11
proceed 222:16 298:4
process 9:21 10:6 11:4
 11:14,19 12:15 16:18
 17:9 21:12 30:7 41:21
 42:3,13 46:15 48:1
 61:7 73:20 77:22
 80:21 90:1,4 94:5,7
 96:15 99:10 101:13
 102:13 110:5 111:20
 113:4,14,21 114:11
 114:12,16 115:20
 118:18 120:12 121:4

121:7,8 128:11
 148:13 161:10 164:11
 166:10 186:7 197:18
 199:14 205:19 209:12
 209:16 239:11,12
 241:22 266:19 270:10
 270:13 271:11 274:9
 275:1 281:16 282:10
 286:9 291:7 298:8,18
 299:2,12 302:17,18
 302:20
processes 42:5 162:12
 162:14 272:5 282:11
 303:1
productive 300:3
professional 27:2 29:6
professionalism 11:16
program 5:2,4,6,8,10
 5:12,14,16,18,20 7:21
 25:21 29:13 32:7,9,16
 33:7,8,15,17,22 34:13
 35:20 36:3,4 40:6,7,8
 42:16 43:3,4 44:21
 45:1,21 46:8 47:3,5,7
 47:9 51:20,22 52:3
 53:15 70:11 73:1
 77:12 101:8 122:12
 152:5 168:8 169:4
 177:14 181:13 189:5
 189:17 199:5,9,10,12
 199:13,13 200:3
 201:15 204:14,15
 209:7,11,19 210:2,11
 210:17 214:9,10,13
 224:1,17 230:12
 231:18,21 232:17,18
 233:8 234:5 241:2
 248:19,19,20 252:22
 254:7 266:9,16,18
 291:11,13 293:6
 303:10
program-specific 45:9
programmatic 224:14
programs 4:6 6:14 31:6
 31:17 34:11,14 35:1
 45:5,16 68:21 121:15
 131:1 166:3,6 168:14
 185:3 212:18 222:7
 234:12 248:13 287:22
 288:3 305:17
progress 12:5
progression 247:7
prohibition 288:1
project 2:18,18,19 4:8
 14:18 61:21 62:11
 63:1 132:4 170:3
projects 63:16 131:19
proliferation 247:18

prolong 297:9
promises 251:17
promising 20:4
promotes 47:14
promoting 70:11
promptly 260:6
proof 18:1
prophylaxis 151:11,14
propose 74:18 114:13
 201:9 209:14,19
proposed 84:17 110:2
 110:7 113:19 119:13
 186:5 217:8
proposing 210:1
proscriptive 97:19
Protecting 35:17
Protection 34:2
proud 38:18
provide 6:13 48:20
 67:19 92:4,21 116:17
 127:9,18 136:3
 182:12 267:13
provided 69:10 91:20
 159:5 171:9 243:6
 265:22
provider 38:12 39:3
 50:13 84:18 90:2 96:3
 96:8 100:14 117:15
 175:10 178:6 216:2
 229:6 239:11,13
 240:14 243:9 247:18
provider's 103:6
provider/physician
 88:9
providers 2:1 24:21
 36:12 120:5,13,20,22
 122:5,7 125:2 136:21
 151:20 156:20 176:20
 182:8 214:6 242:19
 247:11 249:2 282:19
 303:5
provides 53:6 242:18
providing 7:2 87:9
 161:9 244:17 305:8
psychological 139:17
psychometric 145:18
PT 1:15 2:1 274:15
public 4:10,14,18 5:1,5
 5:9,13,17,21 9:8
 14:12,15 23:16 29:6
 34:18,22 41:10 42:7
 45:4 57:9,9,16,19,22
 58:7,21 59:2,4 64:13
 64:16,21 65:5,9 68:4
 70:1,22 71:2 78:2,12
 97:20 102:3 115:16
 115:19 116:15 117:4
 117:8 118:14 122:1

133:3 135:1,9,12
 141:5 147:2,5 148:8
 171:11 174:11 177:14
 177:17,19,20 189:15
 196:14 210:6 240:7
 266:22 267:4 283:10
 296:20 298:3,11
 300:4,11,21 303:9
public/private 242:21
publicly 36:1 129:12
 146:6 166:5 279:7
 280:4
publicly-reported 33:9
published 139:12
pull 47:10,20 52:7
 74:15 75:6,12,18 77:3
 77:18 92:10 132:10
 149:19 181:21 192:9
 196:13,20 197:4,4,8
 197:13,16 207:6,10
 207:19 208:7 227:22
 236:5 241:20 247:2
 256:18,21
pulled 54:20 55:1,7
 68:15,22 76:10
 192:12 196:16 202:8
 202:10,18 211:18
 212:4,9 213:5 219:2
 221:3 236:6
pullee 227:21
puller 227:20
pulling 74:21 76:8
 197:10 206:2 236:9
pulmonary 276:22
 289:2
purchase 10:21
purchasing 5:10,12
 6:21 10:19 33:17
 35:20 36:3 40:8
 230:11,22 231:16,18
 232:17 234:5,12
 243:10
purely 231:4
purpose 84:13 161:3
 227:1 261:10 283:22
purposes 52:20 260:21
 269:7
pursuing 290:14
push 20:20 44:17 243:3
pushback 237:10
put 50:4 68:13 82:8
 104:21 110:2,6 111:4
 112:4 113:19 114:15
 114:19 116:14 122:1
 147:18 175:14 180:20
 185:16 193:7 221:20
 246:2 248:16 257:20
 271:7 276:10 300:11

300:15
puts 139:1 233:9,9
putting 110:8 113:20
 285:3

Q
QI 156:18,22 238:14
 251:6
QM 198:14
QRP 152:3 189:16
 213:19 214:3,6 230:5
 262:11
QRPs 6:20
qualify 225:15
qualifying 154:6
quality 1:1,8,14 3:9 4:6
 5:2,4,6,8,15,17,19
 8:15 9:14 10:1,8,22
 23:17 24:1 27:15 31:6
 32:8,16 33:4,7,8,15
 33:22 34:4,9,11 35:10
 36:15 40:6,7 42:22
 45:14 47:6 65:20 70:3
 79:20 84:8 114:4,5,8
 115:15 116:13 118:16
 121:14 124:14 128:22
 148:2 152:5,19
 168:13 177:13 181:5
 182:14 183:2,11,15
 189:4,17 191:8 199:5
 199:6,8,9,10,11,12,13
 200:2,14,20,22 201:1
 201:15 202:3 203:4
 203:13 204:2,6,11,12
 204:15 205:7 209:6,6
 209:15 210:16 213:20
 214:13 239:5 242:16
 242:16 243:4,7
 248:13,20,21 249:1,3
 252:22 254:6 266:8
 266:16,18 267:11
 272:2 281:5,19 283:5
 284:11 286:6,14
 289:16 292:15 296:22
 301:1
quarter 215:7
quarterly 241:4
question 13:9,12 14:16
 15:4,13 20:13,14
 22:19 59:14 73:14
 76:6,7 78:1,7 80:21
 85:7,13 86:10 91:12
 109:7,12 110:17
 134:13,14,21 151:22
 155:18 158:9 170:7
 186:14 213:11 221:12
 223:17 229:4 236:3
 240:12 242:1 256:12

258:1 261:3,8 263:11
 263:18,21 273:10,21
 283:15 288:20 298:9
 300:15
questions 13:6 19:13
 19:14,16 20:13 30:1
 40:14,15,18 46:22
 48:1,4 49:14 58:13,16
 58:19 61:8 64:3 91:13
 149:6 169:19 170:2
 182:6 183:18 188:21
 207:8 215:2,18
 217:12 219:5 229:15
 252:8 259:10,11
 260:17 265:20 272:15
 276:15 284:21 287:18
 293:3,14 297:15,17
 298:2,11
quick 58:13,14 145:1,3
 145:17 156:4 171:13
 271:10 287:5 291:17
 294:10
quickly 10:17 18:20
 32:2 184:16 234:22
 242:4 260:1
quintessentially 114:17
quirk 232:18
quirks 235:21
quite 6:18 7:5 11:20
 48:22 87:11 99:2
 124:2 160:15 206:3
 278:22
quote 38:8 179:11
quote/unquote 43:9

R
R-A-R 187:2
R-A-W 187:2
race 139:16
raise 76:6,8,11 86:9
 109:8 132:16 221:19
 237:21 245:16
raised 59:16 60:2 89:15
 109:7 162:20 167:13
 167:13 210:6 222:21
 248:4 249:15 304:17
raising 89:6
RAND 25:1 28:14
randomized 245:19
range 16:8 240:2
Raphael 1:9,12 4:3 6:3
 7:22 8:5,10,17,22
 9:11 19:15 20:12,21
 23:1 27:12 30:22
 40:21 48:3,15 49:13
 49:16 58:15 61:11,17
 62:17,20 64:14 65:3,7
 67:10,13,17 70:17

73:13 74:14 75:1,14
 76:13 77:21 78:20
 80:17 82:5 84:3 85:11
 87:5 88:18 90:8 91:9
 91:17 96:5 97:15
 99:11 102:18 104:9
 107:15 108:1,4,10,16
 109:2 117:3,10
 127:14,17 129:3
 132:8,13 136:6 140:2
 144:7,22 145:15
 146:12,19 147:6,11
 148:21 149:17 152:6
 156:2 157:7 158:14
 171:6,15,22 172:3,6
 172:10,14,19 173:22
 174:9 177:8 239:19
 275:2 289:13 292:22
 301:6
rapidly 16:11 248:1
RAR 186:16,17
rarely 158:16
rate 135:22 138:18
 142:8 156:20 179:1
 185:10,11,13,16,17
 185:22 187:7,9,10,12
 187:16,19,21 188:3,7
 188:14,16 251:21
 256:2
rates 4:19,21 143:22
 146:21 152:17 167:4
 240:4,19 241:5,7
 244:20 248:9 257:9
 259:14 274:18 275:6
 275:8
rating 285:6,10
ratings 33:10 128:18
ratio 184:2,22 185:5,8
 185:20 186:16,17
 187:8,9 188:1,12
rationale 43:12,17 44:2
 53:7 145:19 221:18
 221:21 222:4 235:20
 286:21
ratios 185:12 186:10
raw 185:10,11,16
 186:21 187:5,7,18
re-admission 119:3
 138:4 146:21 152:17
 153:5,20 154:2,19
 155:3,18 156:11,14
 160:11,22 161:18,22
 164:13 165:11 167:16
 168:22 169:16 180:7
 183:11 184:21 187:12
 187:21 230:22 231:2
 231:4 232:3,10,14,21
 232:22 233:2,22

234:16,19 235:8
 239:2 240:19 241:1,5
 241:7 242:2 244:9
 247:21 248:9 249:20
 249:22
re-admission-type
 135:6
re-admissions 118:7
 119:6,17,22 122:9,12
 122:14 129:21 130:9
 130:10 136:14,16
 147:21 149:14 152:4
 154:1 155:10 157:20
 160:19 161:14 164:19
 166:13,17 174:8,12
 174:20 176:4 178:12
 179:10 184:1 235:11
 239:18,22 243:2
 248:7 250:14 251:20
 251:21 300:19 302:13
re-admit 135:22
re-admits 135:14,15
re-admitted 126:13
 154:10 176:12 234:1
 235:16,18 240:18
 247:3,8 248:9 251:11
re-affirm 175:6
reach 43:7 51:2 81:21
reached 43:14 53:7
reaction 82:17
reactions 74:3 80:3
 103:11
read 22:22 60:6 73:15
 157:5 184:5
reading 59:3 96:7
 183:22 256:1
readmission 4:19,21
 240:4
ready 66:5 67:6 116:2
 121:17 122:6 124:2
 124:18 126:1 145:12
 217:20 219:12 220:10
 221:14 229:15 245:6
 295:7
real 9:15 20:1 58:21
 79:10 105:4 159:2
realistically 298:12,20
reality 39:1 264:6
realized 133:21
really 10:3 12:7 13:5
 14:8,16 15:13,17
 18:12 20:5 30:7 38:18
 39:4,5 46:19 48:13
 49:3,10 58:17 61:2,18
 62:7 68:17 71:3,13
 74:2 79:19 83:22 93:9
 94:4 101:17 102:6
 104:10,13 105:9

106:2,17,18 107:1,6
 107:11 110:14 113:3
 116:11 121:17 124:1
 127:5 128:17 129:10
 130:18 131:14 132:22
 135:10 136:11 137:5
 138:1,5 145:3 153:1,1
 153:8,15 154:11
 155:12 157:11,15,20
 159:8 162:10 168:10
 172:22 176:21 179:4
 181:4,15 182:11
 200:1 215:10 225:14
 227:8 238:4 239:7
 240:3 247:16 268:8
 268:15 269:9 271:17
 274:3 275:13 277:4
 281:5 282:2 283:1
 285:2,8 286:8,14
 287:9,15 299:16
 300:2,5 301:2,3,11
 303:12,13,14 305:5
 305:15
reason 22:14 34:6,7
 106:1,20 174:14
 180:11 183:4 208:19
 225:14 231:21 233:16
 234:15 277:2
reasonable 272:6 281:8
reasonably 256:8
reasoning 278:5
reasons 65:21 66:7
 67:5 206:9 237:9
rec 96:16
recalculate 185:15
recall 21:13,20 146:22
 185:18 228:13
receive 67:7 114:11,14
 156:16 201:5 208:2
 219:12 226:9
received 21:14 49:2
 55:18 128:8 136:3
 189:10 214:22 215:18
 229:6,7,8,10 234:14
 253:5 259:15
receiving 225:12
 251:21
reclick 218:12
recognize 44:15 64:1
 65:16 142:6 156:19
 190:15 227:6 287:7
recognized 161:22
recognizes 244:10
recommend 53:4 66:6
 76:18 175:6 191:4,14
 224:15
recommendation 37:2
 43:21 44:10,18 49:11

51:8,10 54:7 56:8,20
 60:11,12 66:5 75:17
 84:2 107:16 111:22
 112:17 121:13 122:2
 147:13 148:18 156:17
 171:12 180:10 196:17
 213:3 223:8 224:15
 225:18 232:4 238:8
 254:8,16 277:20
 280:16,18 289:7
 296:7
recommendations
 42:12 51:16,18 57:20
 58:1 69:17 91:8 92:13
 111:13 113:4 115:10
 115:11 121:22 127:21
 128:6 224:4 262:11
 262:16 280:14
recommended 37:3
 110:5 111:1 148:5
 206:1 227:9 271:2
 277:2 289:3
recommends 217:16
reconcile 222:9
reconciled 94:2 96:19
reconciliation 4:11,13
 39:14 64:19 65:17
 66:1 67:20 69:3 70:6
 70:13 73:16,18,20
 79:6 80:12 87:11,17
 89:9,11 90:12 93:8,12
 94:3 95:14 99:15
 107:21 302:2
recondition/decondit...
 290:4
reconditioning 291:9
reconvene 171:13,16
record 37:14 86:8,16
 108:22 172:17 212:10
 266:11
recorded 229:9
records 107:1 228:13
recurring 60:13 301:19
recuse 295:22
redefining 304:3
reduce 271:9 275:5
reduced 179:1 183:14
reducing 65:17,18
 137:11 248:6
reduction 32:17 37:9
 198:21 241:1
reductionist 290:2
reductions 264:20
redundant 54:15
refer 11:6,7 92:17
reference 45:19
referral 143:4 274:15
 304:10

referrals 137:11 143:9
 143:11
referred 304:7
refers 95:11
refined 46:16
refinement 122:16
refining 304:18
reflect 46:4 53:12 81:14
 83:20 160:11 176:13
reflecting 97:18
reflection 90:6
reflections 291:14
reflective 59:18
reflects 258:6
reform 38:3,6
refresher 42:10
refuse 226:9
refused 237:11
reg 115:22
regard 132:16 169:2
 175:4 302:1,13
regarding 103:4 123:8
 181:2
regardless 125:11
 280:9
regimen 65:22 66:13,16
 67:6 69:4 71:19 73:16
 73:18 74:1 90:14 92:1
 92:14,16,22 93:9,12
 93:13 96:17 98:4,7,18
 98:21 99:14 103:15
 275:15 302:2
registry 18:8
regulatory 45:9
rehab 34:22 95:12,15
 118:12 119:12 128:3
 129:22 133:12,17
 147:16 151:2 177:13
 178:5 180:8 181:13
 182:8,14 183:1 195:9
 195:21 201:5 207:14
 207:15,16 264:9
rehabilitation 2:1 3:6
 5:1,3 24:21 34:12
 117:16 194:14 207:18
rehospitalizations
 65:18
reiterate 225:6
related 12:19 52:20
 96:16 176:4 194:16
 268:21 279:22 296:21
relates 42:22 85:14
relating 268:13
relationship 18:2
 275:14
relationships 17:17
relative 45:20 185:7
 188:18

relatively 154:7,11 167:6 178:15 released 118:15 relevant 19:20 21:17,18 22:13 27:5,9 78:10 139:22 271:4 reliability 37:19 59:21 66:9 reliable 215:16 religiously 265:18 rely 30:6 82:9 remain 7:4 54:8 167:6 212:20 216:10 remaining 170:2 remains 99:8 remarks 52:14 remember 12:14 35:14 103:22 129:9 203:8 214:5 243:17 256:6 remind 10:7 30:5 84:21 reminder 22:21 171:9 remiss 95:21 remove 182:1 276:5,13 303:8 removed 53:22 54:16 removing 260:14 renal 63:20 repeat 68:20 78:6 171:22 repeated 37:4 repeating 248:5 repetition 78:6 replace 165:10 273:11 303:15 replaced 233:1 replacing 152:3 report 14:2,13 36:12,14 36:17 37:7 39:21 75:21 83:20 96:1 118:13 131:16 141:16 143:16 144:4 185:22 186:8 279:20 283:9 288:19 reportability 277:17 reportable 284:16 reported 18:21 36:2 37:17,17 69:15 129:13 130:11 143:3 143:4 146:6 166:5 168:15 183:21,22 185:19 237:4 279:7 284:20 reporting 4:6 5:2,4,6,8 5:14,16,17,19 14:15 31:6 32:9,16 33:7,8 33:15,22 34:11,18,22 40:6,7 45:4 118:14 121:15 141:5,5,17	152:5 168:13,16 177:13 185:21 189:5 189:17 190:6 199:5,9 199:10,12,12,13 200:2 201:15 204:15 209:6 210:17 214:13 222:22 240:7 248:20 250:21 252:22 254:6 266:9,16,18 271:22 282:18 reports 14:1 15:20 81:15 represent 9:6 22:16 26:17 65:13 107:8 120:4 131:13 267:22 representative 22:10 24:20 representatives 22:2,3 22:5,6,7,16,21 representing 8:3,7 24:12 25:11,18 26:6 173:11,18 represents 18:22 123:6 request 51:4 requested 280:3 requesting 38:5 requests 31:19 211:13 236:16 require 96:22 100:9 103:7 112:4,8 125:19 164:22 168:17 170:21 171:3 234:15 required 37:7 180:12 231:22 298:10 requirement 113:16 requirements 45:10 113:17 118:15 123:12 298:19 requiring 36:11 rerun 211:1 research 27:8 123:1 271:6 researcher 27:22 reservations 171:18 172:13 reshape 9:16 residence 142:10 resident 93:1 236:20 244:4,17 residential 133:4,9,13 133:18 134:7 residents 141:9,21 142:8 189:10,11,13 201:4 206:13 208:2,3 208:5 214:22 219:3 221:4 223:1 229:18 237:2 244:2 246:7 resistant 169:11	resolve 153:12 256:7 resolved 133:2 258:2 resounding 38:9 resource 36:17 38:1 39:20 130:14 139:19 243:6 resources 16:3 17:6 113:11 242:18 288:12 respect 156:4 175:5,12 175:16 227:5 respond 86:19 91:18 184:16 300:14 responding 260:7 response 26:12 29:17 29:20 30:3 40:20 41:22 49:15 50:17 132:12 182:3 189:2 196:6 207:21 211:11 219:7 262:15 responses 144:10 198:9 responsibilities 34:8 276:1 responsibility 181:9 233:10 responsible 173:3 304:4 responsive 304:16 rest 68:19 74:6 restate 246:15 restrict 278:22 restricted 289:5 restriction 288:1 result 75:4,10,11 100:12 103:11 182:21 223:11 246:5 results 47:12,21 53:3,6 53:12 218:19 219:22 230:1,4 279:9 296:1 resume 109:2 172:15 172:20 resumed 108:22 172:17 266:11 resumption 69:7 retain 234:15 235:22 retained 268:10 retired 268:11 278:7 retiring 33:14 retool 15:9 retrospectal 139:2 return 302:5 review 4:2 6:12 21:3 27:4 32:2 43:1,11,19 44:20 47:21 53:9 65:22 66:14,17 67:6 69:4,5 71:19,21 73:16 74:1,4,9 87:10,20 89:9,12 92:1,15,16,21	92:22 93:9,13 95:14 95:18,18 96:17 98:4,7 98:9,11,18,21 99:9,14 109:3 197:6,11 231:20 279:6 288:22 289:8 302:3 review/medication 73:18 reviewed 42:8 45:11 47:19 260:19 283:1 reviewing 7:1 44:6 46:14 50:8 74:17 87:21 107:1 132:11 275:15 reviews 91:7 reward 264:10 rich 150:7 richness 17:22 rid 264:8,11 right 6:10 20:10,22 49:11,16 64:14 74:14 79:2 80:20 83:15 87:6 90:13 91:1 101:4,12 105:10 108:1,10 126:16 127:14 132:8 139:9 141:1 143:18 146:12 149:20 157:4 160:1 168:4 174:22 177:10 180:15 181:14 183:9 186:4 187:3 188:10 192:16 193:15 202:19 214:11 216:6 217:19 220:21 245:2 245:7 246:18 247:1 247:11 248:6 249:18 250:6 252:17 256:1 257:16 261:21 262:21 275:3 282:9,11 301:14,14,14 rigorous 299:2 rise 41:3 risk 14:2 60:16 125:12 125:21 126:17,17 127:6,10 134:16 136:13 139:2 140:15 143:18 144:3,11,13 144:17 145:6,19,22 152:18 153:2,10 163:11,16 167:21 168:4,7 170:7 184:9 185:5,10 187:17,22 188:1,6,11,12 200:8 202:4 244:22 266:18 270:10,13,18,18 271:9 275:4,5 280:2 300:17 risk-adjusted 145:21 186:16,17 187:12
---	--	---	---

risks 275:8 287:13
RN 1:14 2:12,19
road 268:11
Robert 18:15
Roberts 1:21 25:17,17
 137:21 155:17 174:3
 206:17 294:20 295:5
robust 16:8 193:14
Robyn 1:13 23:15 75:14
 85:12 86:22 236:19
 238:1,5
Robyn's 76:5,7
Roger 1:15 25:14
 257:10,22
role 78:21 97:21 290:3
roles 79:12
roll 165:1
room 1:8 65:9 83:9 97:5
 127:15 159:15 237:16
 240:17 246:4 258:12
 299:21 300:5
root 243:1
rose 249:21
Ross 2:15 9:1,4,4 84:4
roster 6:9
roughly 195:10
round 6:14 23:5 227:9
 256:4,5
RTI 160:4
rugs 287:14
rule 32:13 33:18 34:20
 110:2,7,7 111:4
 113:19 118:15 124:18
 181:4 185:19 186:3
 209:14 232:16 234:7
rule-making 165:13
 186:7 209:16,20
rulemaking 11:13 63:7
 66:6 67:7 73:7 97:14
rules 35:2 45:6 149:10
run 57:20 58:14 129:21
running 150:21
rural 153:5 187:14
 188:9
rushed 163:21

S

sadly 80:3
safety 11:1 69:21 70:4
 103:9 104:12 147:22
 263:8
sake 37:1 282:20
Saliba 1:9,12 4:4 23:1
 27:20,20 31:2 40:17
 76:3,5 78:18 81:19
 91:11 177:11,22
 180:1,15,20 181:20
 182:4 183:17 184:11

186:13,21 188:21
 189:3,21 196:4,7
 197:17 198:5 202:10
 202:17 205:15 207:5
 207:22 210:5 211:5
 211:10,12 212:2
 213:10 214:19 215:17
 216:13 217:6,18
 218:1,6,11,17,22
 219:8,20 220:5,21
 221:12 222:14 224:20
 226:2 227:19 228:22
 229:11 230:9,18
 231:10,14 232:6
 236:2,11,14,16 238:1
 238:11 239:15 242:7
 245:12 249:14 251:1
 252:7 253:12,20
 254:2,10 255:10
 256:16 257:22 259:10
 260:8,16 261:1,11
 262:5,8,22 263:16
 264:13 265:4,19
 266:13 267:6 270:1,6
 271:12 273:5 276:2,9
 277:22 278:11,15
 280:5 281:1,11
 282:21 283:21 285:22
 288:4,16 289:11,21
 290:8 291:16 292:14
 293:2,13 294:8,13,22
 295:6,10,15,21
 296:14 297:7 304:14
sample 125:12
Sampsel 2:20 4:5 61:15
 63:8,11 67:22 68:8
 76:17 78:7 82:19
 127:22 147:14 212:7
 223:18
Sandra 8:10
Sandy 1:19 173:5,5,16
 173:22
Sans 185:10
Sarah 2:20 4:5 61:14,19
 63:11 67:18 75:8 82:6
 127:18 147:11 212:6
sat 169:8
saturation 81:20,21
saving 15:8
saw 71:18 297:22
saying 81:3 84:18
 101:20 102:2,4 141:4
 154:16 164:6 217:10
 225:1,2 259:17 281:7
 286:12 303:9 304:8
says 81:4 101:14
 205:16 223:22 256:3
 256:4 288:8

SBT 257:6
scales 207:3
scenario 151:6
scene 176:8
schedule 32:4 252:12
 266:6
scheduled 252:14
schizophrenia 190:21
 191:12
School 1:16
science 13:2,4,11,14,14
 13:16 101:17
scooter 201:17
scope 66:16 167:8
 176:21
score 189:7,8,9,9
 207:14,15,16,17
scores 56:7
screen 107:18 120:17
screwed 170:17
Sean 1:20 50:2,7,10
 97:17 140:14 208:8
 222:11 255:11,13
 257:3,12 258:4
 259:11,18 262:1
 265:12 290:1 291:15
Sean's 98:8 238:13
season 11:7,8
seasonal 223:2
seasons 227:10
seats 172:21
second 59:14 62:1
 66:10 90:22 100:5
 101:1 121:4 146:2
 153:11 203:4 219:13
 228:4 261:2 270:17
 280:10 291:6 295:15
secondary 279:15
Secondly 142:1 152:17
 173:4
Secretary 3:11 10:16
 27:21 190:3,8
section 35:8,19,21 92:8
 127:4 133:13 180:4
 193:20 201:11 221:21
 266:1
sector 41:10,16 157:13
 303:9 304:5
sectors 41:4
see 8:11 14:9 18:19
 21:7 32:18 42:17 43:2
 44:1 47:15 55:4 56:18
 58:5,17 72:15 83:19
 84:1 87:13 95:7
 104:17 107:18 111:22
 124:15 129:4 133:2
 134:18 137:6 145:10
 153:2 171:13 180:22

195:19 211:1 215:8
 216:19 220:12 223:11
 226:15,21 227:12
 228:17 241:21 242:10
 257:18 259:1 261:20
 266:22 268:12 274:4
 275:12 283:7 286:14
 291:18 305:10
seeing 16:8 28:22 80:3
 163:18 216:13 274:21
 300:7 301:4
seek 148:19
seeking 269:15 298:12
seen 12:5 105:7 121:10
 145:7 152:21 257:13
select 216:20
selection 42:14 44:19
 45:8,13,19 46:2,10,21
 53:14
self 104:4
self-care 189:8,9 193:4
 193:22 199:15 200:7
 207:15,17
self-report 208:4 219:4
self-reported 189:12
Senate 176:17
send 15:21 92:7,7
 123:15 157:3 170:2
 237:2,11 241:10
 242:8
Senior 2:18,19,19 4:8
 27:13 62:11 63:1
 65:11
sense 77:20 87:14
 89:20 127:8 150:5
 168:20 184:6 197:10
 227:1 260:11 265:10
 272:7 274:17 299:16
sensitive 155:13
 265:12,12
sensitized 269:12
sent 19:7 38:4 52:8
 144:10 237:8,15
sentences 93:3
sentiment 82:4
separate 138:7 158:21
 202:21 209:7 215:10
 250:11
separated 231:22
separately 214:20
September 227:13
series 46:21 52:19
 55:17 120:20
serious 71:19 103:19
 191:20 237:20
seriously 238:7
serve 65:11
served 141:1

- serves** 185:21
service 127:10 176:6
 239:20
services 2:11 3:2,10
 24:11 28:3,12 41:9
 50:13 65:12 201:5
serving 132:19
SES 131:14 132:4
 134:18 139:11,22
 165:7 167:10,22
 168:1,5,7 188:11
set 7:8,12 37:3,15,19,20
 42:16 43:3 44:21,22
 45:21 46:1 47:3,7
 69:1 101:8 103:1
 104:10,19 106:4
 128:1,1 161:17
 172:13 185:6 205:18
 219:10 235:9 248:16
 255:11 268:16 269:6
 271:16,19
sets 45:4
setter 16:17
setting 10:1 41:20 43:5
 47:6,8 69:6,9 72:8,17
 74:5,7 77:8,11 85:6
 89:16,16 95:5,7,8,13
 106:19 123:17 124:9
 126:8 128:15 129:17
 129:19 131:2 133:4
 139:1 140:21,22
 141:20 144:15 157:22
 161:12 193:16 194:5
 198:22 199:4,8 245:7
 246:1 250:10 251:12
 255:6 257:17 261:15
 262:19 265:6 292:2
 301:11 302:7,8 304:8
settings 38:12 39:21,22
 45:16 66:15 67:3
 70:12 71:17,18,22
 72:11,14 77:10 84:13
 85:3,9 86:11,12 88:3
 88:7,8,16 89:20 90:16
 92:18 95:10 119:14
 127:7 128:2 129:2
 131:8,17 138:14
 146:4 147:16 148:17
 149:14 158:13 162:16
 163:13,13 229:14
 244:22 247:15 251:8
 262:1 267:17 287:9
 296:22 301:13,20
settle 258:15
settlement 269:13
settles 258:20
setup 233:14 234:16
seven 239:3
- seventh** 36:8
severe 189:12 208:4
 211:19 219:4
severity 200:12
shape 12:8
shapes 35:4
share 67:20 88:20
 102:21 103:3 120:19
 135:9 216:9
shared 58:18 244:9
 245:9 246:21 247:10
sharing 82:14 118:16
sheer 237:13
sheet 304:10
short 48:16 85:3 97:8
 141:9 154:7,11
 203:11 214:1 225:8,9
 226:5 265:6 280:7
 282:3 283:10
short-term 95:12,15
shortages 226:10
shorter 210:21
shortly 163:4
shortness 278:2 279:22
 283:17 292:15
shot 259:1
show 35:5,5 136:11
 179:13 240:9 285:19
showing 303:14
shows 44:4
shut 251:5
sick 123:13,17
sicker 125:11
side 44:1 94:22 101:15
 103:12,18 159:11
 224:19 258:12 277:14
 277:19,19
sides 156:7 240:11
sign 261:8 288:5
signal 246:5
significance 80:15
 91:13,14 92:2
significant 66:21 69:14
 71:14 79:13 80:2,8
 81:5 82:1 85:15 87:22
 88:15,16 91:3 98:16
 99:4 100:7 103:5,10
 205:12
signpost 251:22
similar 14:7 63:19
 68:18 78:4 101:9
 124:20 148:11,14
 149:9,10 167:19
 182:9 191:15 215:22
 222:6,20 231:3
 244:21 253:15,17
 267:19 299:5 305:1
similarly 197:12 221:8
- simple** 22:10 94:18
 275:9
simplifying 99:9
simply 89:11 90:4
 116:8 164:4,12
 170:21 171:3 200:15
 252:5
Simultaneous 184:19
 198:4 209:1,22 210:4
 262:7 292:13 295:13
single 83:8 101:3
 126:21 187:11 248:17
 249:6,12 263:2
singular 284:4
sit 15:21 26:15,19,21
 27:17 30:11
site 88:10 145:8 179:2
sites 80:4 174:6 228:9
 282:14
sitting 20:2 21:6 106:6
 142:22
situation 288:8
situations 82:12 237:3
six 7:16 38:16 156:12
sixth 36:8
size 187:14
sizes 35:4
skewed 138:16
skilled 5:5,7,9,11 32:11
 35:19 40:5,11 85:21
 89:4 91:21 92:15,20
 95:15 128:4 133:5,8
 133:10,11,18,19
 147:17 189:4,11
 206:10,16,21 210:15
 210:20 216:9 219:3
 221:4 222:22 226:5
 229:18 232:1 238:22
 242:22 253:16
skin 39:12
sky's 226:16
slide 32:6,15 34:1 35:3
 35:17 36:6,16,20 38:7
 38:13 39:6,18 40:4,14
 44:4
slides 40:8 43:12
slideshow 300:21
slight 77:15
slightly 14:22 222:17
 259:16 304:19
slips 185:17
slow 247:7
small 35:8 109:5 146:10
 151:18 167:6
smaller 151:19
SME 28:18
smoother 54:17
SNF 120:5 124:22 125:4
 125:5,9,10,13 126:13
 127:12 141:11,12
 153:14,16 154:7
 168:22 169:15 170:12
 170:14 189:13,16
 195:21 199:5,11,20
 200:5,8,21,22 204:15
 208:1,3,5 209:6
 210:16 213:19 214:3
 214:6,13,22 225:12
 230:4,21 231:4,8,17
 232:14,17,21 233:22
 234:16 235:16,18
 238:19 239:1,4,5
 241:14,17 244:1
 247:21 259:18,20
 263:14 282:14
SNF's 154:12 246:12
SNFs 114:8 127:9 233:8
 248:13 260:12
SNYDER 2:1
social 138:10 139:17,21
Society 1:18 2:4 8:8
 25:8,12 27:22 28:10
sociodemographic
 126:18
socioeconomic 14:3
 60:17 131:18 152:18
 154:21 164:10,15
 188:8
solid 49:11 51:8
Solutions 27:14
solve 101:5 105:10
 138:16
solved 64:9
somebody 15:21 30:14
 74:4 83:11 129:17
 138:3 180:20 238:15
 238:18
someday 167:22
someone's 252:16
 280:7
somewhat 268:22
 299:4
soon 124:15 233:2
sooner 247:8
sorry 110:4 142:15
 152:1 155:1 186:18
 229:1,3 245:15
 246:14 262:1,5 286:2
 291:20 295:14,18
sort 19:8 81:20 82:3
 100:20 105:20 109:18
 110:10 146:4 158:15
 169:1 170:14 179:16
 186:15 193:14 207:9
 225:21 231:7 249:3
 257:3 261:14 267:22

276:12 280:10 296:18 303:11 304:22 sorts 105:22 106:11 sound 220:18 sounding 222:6 sounds 162:18 213:1 213:15 223:3 228:16 263:17 280:9 283:2 source 198:18 199:16 sources 13:20 17:12,17 165:1 space 117:16,17 spaces 279:14 speak 30:10 57:15 118:4 149:10 153:13 181:3 190:9 281:5 speaker 192:21 193:12 speaking 27:8 68:17 78:8 184:19 198:4 209:1,22 210:4 262:7 286:6 292:13 295:13 special 169:1 178:16 228:2 specialists 104:18 specific 18:18 68:5 69:8 77:7 91:8 157:21 158:11 161:7,8,10 179:7 191:6,12 194:5 194:22 195:6 198:8,9 198:22 199:4,8 212:18 231:21 256:19 268:4 277:11 281:22 293:8 295:4 specifically 164:12 166:13 190:9,17 229:5 284:2 specification 15:2 72:2 112:14 118:6 119:20 126:2 178:10 179:9 214:18 224:6,19 specifications 49:7 98:1 112:22 115:8,15 115:17 116:8,14,15 116:17 120:18 124:19 134:15 144:10 148:7 160:7 225:3 226:4 256:2 specifics 245:11 specified 35:22 39:19 46:8 109:16 110:21 111:1 112:20 114:6,7 115:14 125:18,22 126:1 179:21 190:20 194:4 specify 110:7 specifying 110:3 128:11 specs 226:14 268:12	spectrum 302:20 Spell 172:3 Spence 2:2 26:4,5,6 Spence's 218:15 spend 7:3 135:4 spending 290:11 spent 7:7 59:3 99:5 spinal 150:22 spinoff 17:14 spirit 98:10 156:18 238:13 264:14 spite 256:9 split 43:9 51:5 97:10 spoke 198:19 spontaneous 253:2 258:19 sport 99:17 stab 100:5 stability 183:6 stabilization 60:21 61:1 269:10,16,21 283:14 285:5,11,14 286:18 287:3 stabilize 283:15 stable 181:12 stack 62:18 Stacy 38:21 staff 2:16 11:4,11,21 30:20,20 52:2 53:1,4 59:13 61:15,18 64:1 67:21 69:16 75:5 83:8 107:15 120:7 121:1 121:21 128:6 147:13 148:4 171:10,14 180:9 223:17,20 224:4 237:10,17 254:8 299:18 staff's 46:20 47:2 127:20 146:15 staff-wise 70:8 stage 59:20 stages 7:7 stakeholder 121:2 271:18 272:10 284:22 285:8 stakeholders 38:5 46:5 203:19 226:18 stand 122:5 standard 16:16 258:1 standardization 84:13 226:22 301:18 standardize 12:21 14:20 114:5 185:4,9 199:2 standardized 36:12,21 37:8,11 38:10,14 39:8 43:10 130:17 163:4 163:12	standardizing 92:13 standards 10:2,8 139:14,16 214:7 298:20 standing 19:19 21:21 286:8 standpoint 34:3,5 101:11,17,22 181:6 297:13 298:11 299:12 stands 56:13 116:4 star 18:12 33:10 117:7 147:4 177:19 189:19 214:14 230:15 253:10 267:3 285:6,9 297:5 start 22:20 23:6 27:10 37:1 52:4,13 61:12,20 68:11 80:14 82:3 90:5 111:11 112:11 140:4 171:4 177:14 179:11 179:13 198:11 213:8 214:21 215:10 217:20 227:7 242:12 243:18 243:22 255:13 270:9 283:4 297:2 started 49:19 63:9 68:1 111:15 160:3 184:6 198:6 242:7 247:14 255:2 261:12 263:3 264:6 266:15 starting 7:17 39:22 55:12 76:7 266:8 state 14:20 28:3 29:4 55:6 91:21 152:15 statement 94:6 states 33:20 93:16 178:11 stationed 174:15 statistical 186:9 stats 143:7,21 status 35:10 39:12 60:17 122:10 126:21 127:1 128:8 131:19 134:19 150:14 152:19 154:21 163:10 164:10 164:16 177:3 188:8 202:5 213:2 statute 92:8,19 166:12 166:12 169:9 233:5 233:15 250:13 statutorily 35:6 232:19 statutory 4:6 31:6,21 31:22 45:9 113:8,16 113:17 243:17 stay 100:9 118:9 129:19 136:22 138:22 150:16 153:19 154:6 155:6 169:6,13 171:1,2,5 178:11,13,14 179:11	180:7 181:1,16 183:14 195:7,20 203:11,12 210:14,20 210:21 211:1 214:2,2 215:13 225:8,9,9,10 231:1,4,9 233:19,20 234:21 235:15 243:20 243:21,22 244:1,5,16 253:5 257:4,8 265:6,8 stay's 263:14 staying 118:3 119:21 stays 154:7 166:9,19 167:5 226:6 232:8 250:8 steer 304:21 steering 289:3 Stella 38:21 stems 232:10 step 7:11 17:3 53:9,16 57:5 93:12 283:4 303:12 stepping 7:3 steps 96:18 129:1 stepsons 150:3 Sternberg 23:3 29:16 29:18 steroids 73:19 steward 109:12 Stone 2:3 23:19,19 stop 19:13 75:22 100:11 stops 170:16 247:6 story 238:5 straightforward 233:18 strain 139:19 straitjacket 82:8 strategies 271:8 strategy 42:22 51:21 70:3 128:22 138:21 148:2 Strategy's 45:14 straw 294:10 streamlined 268:16 275:9 Street 1:9 Streeter 2:19 62:10,11 62:19 180:3,5 231:17 254:4 strength 81:16 158:5 strengthen 12:21 strengths 45:20 stress 51:7 139:19 strikes 86:1 strong 65:14 81:1 83:6 157:15 204:8 225:18 274:10 286:9 strongly 99:13 193:8 struck 41:11
---	--	--	--

structural 209:17
structure 236:1
structured 118:2
struggle 302:19
struggled 99:3 132:22
 290:15
stuck 264:7
study 14:7 258:14
 259:2 271:4
stuff 149:7 258:10
 305:3
stumbling 97:13
stunning 99:18
subject 2:6 8:14,20
 21:22 22:5,22 26:14
 26:14,21 32:21 34:16
 40:12 50:20 51:18
 203:20 213:7 300:4
submission 33:3
submit 34:15,15 40:11
 214:8
submitted 58:3 122:19
 136:8 164:14 199:5
submitting 32:21
 168:18,19
substandard 195:19
substantial 213:18
 233:13,16
substantially 158:2
suburban 187:15
succeed 243:9
success 246:2
successful 37:18,19
 126:10,15,16 130:22
 131:3 285:19
successfully 72:9
 149:13 285:6
succinct 184:18
sudden 247:6
sufficiently 211:7
suggest 211:7 228:18
suggested 89:11,19
 169:13 227:22
suggesting 195:15
 294:9
suggestion 100:6 292:6
 300:15
suggestions 91:15
 113:4 196:8
suggests 231:8
suite 249:8,12
sum 56:6,17
summarize 148:17
summary 5:22 47:1,20
 115:20,21 129:8
 271:10 305:11
sunset 48:14
super 260:19

supplement 99:22
support 28:13 31:16
 35:11 43:21,22,22
 46:13 48:7,7 53:4,5,5
 56:7,7,8,17,18,20
 81:1 83:6 99:13 110:9
 113:21 115:5,7
 138:10 151:13 193:8
 193:10,13 205:11
 208:16,16,16 212:12
 225:22 242:19 286:17
 297:22
supported 62:15 69:20
 113:14,16
supporter 65:15
supporting 62:1 63:2
 171:11 243:9
supportive 18:5 162:11
 286:10
supposed 32:5 181:21
 205:16
sure 6:7 7:15 21:7 59:4
 64:2 67:22 78:21 86:2
 95:9,17 108:14,15
 118:22 132:7 134:16
 135:5 136:9 144:5
 147:14 169:21 170:1
 173:15 174:18,21
 179:5 202:8 220:22
 227:21 229:12 231:17
 232:9 278:8 292:10
 299:20
surprise 240:14
surveys 33:6
suspect 14:4 167:14
Suzanne 2:1 24:19
 132:17 141:8 149:21
swallowing 200:13
swing 201:3
sympathetic 215:21
 265:1
symptoms 100:12,13
 261:19 279:11,21
synthesize 98:10
system 3:6 9:16 10:9
 10:10 101:4 178:10
 194:13 195:9 219:11
 240:7 303:20
systems 11:2 15:9 19:3

T

table 14:10 21:6 22:18
 51:12 75:22 83:11
 216:14 300:15
tag 251:1 255:12
tails 91:4
take 7:12 9:17 19:13
 21:8 46:11 47:22

55:20 58:13 85:8,18
 87:1 98:9,20,22 99:17
 106:3 107:13 108:3
 108:12 115:11 131:18
 140:8 153:8 156:9
 172:21 175:13,18
 176:1,6 186:22 190:7
 193:7 201:13 202:4
 204:17 213:5 214:20
 222:10 236:17 252:10
 265:21 266:4 272:4
 285:17 286:13 293:16
 293:21 294:9 296:16
 297:12 304:22
taken 157:21 238:7
 252:3 260:5 287:3
takes 219:11 305:4
talk 31:5 48:5,10 151:10
 181:18 197:19 198:9
 198:13 202:12,16
 203:1 257:5 276:3
 285:4 303:19
talked 20:5 90:10
 112:13 154:22 164:11
 169:2 188:7 275:16
 286:22 303:22
talking 16:6 39:13 41:1
 106:11 155:13 198:15
 257:4,12 259:12
 266:3 284:7 303:21
tangled 159:3,4
Tara 3:10 24:7 31:4
 41:12 70:18 112:9
 144:7 148:21 180:16
 198:10 202:22 208:18
 214:1 223:19 225:2
task 290:17
tasks 97:11 159:10
team 66:18 89:3 97:21
 166:22 170:3 206:21
 255:12 278:13,21
 291:12
teams 12:1
technical 17:5 115:17
 120:18 132:19 160:7
 160:9 170:6 178:7
 179:19 203:19 204:7
 279:5,10
technically 121:7 155:8
 208:14
techniques 283:17
technology 2:13 96:9
 101:1,5
tee 259:19
teed 296:19
teleconference 3:15
telephone 177:20
tell 30:13 62:17 68:4

83:9 86:20 157:1
 255:19 294:2
Telligen 8:16 28:11
 242:15
telling 243:15
ten 239:3 290:12
tend 142:3 226:22
tenets 176:19
tenor 179:15
tens 142:21
tension 301:17
tent 50:4 242:13
TEP 94:11 122:19
 160:16 162:10 163:17
 163:22 165:4 251:7
 255:16 256:8 257:12
Teresa 3:9 267:10
 271:14
Teresa's 270:9 283:13
term 3:8 81:22 92:1,16
 97:9 117:22 157:9
 186:17 263:9,10
terms 10:12 11:3 12:3
 12:14 21:21 33:13
 34:4 41:16 71:2,10,22
 72:3,5,11,19 73:7
 80:22 82:13 85:20
 87:9 92:14 93:7 113:9
 115:11 116:3 134:15
 134:18 139:7 140:14
 140:15,18 141:18
 154:2 161:8 163:20
 165:9 166:4 167:9
 175:15 181:11 184:21
 205:2 209:9 216:1
 224:22 226:16 242:22
 243:8 244:12,16,18
 245:4 264:1 271:15
 272:21 301:9 304:15
 305:8
terribly 134:20 164:6
terrific 273:14
Terry 2:19 62:3,3 270:8
test 19:4 37:10 58:14
 116:2 122:6 211:1
tested 47:8 67:2
testing 17:8 37:19
 59:20 72:5,10 83:1
 113:2 121:10 128:11
 225:20 299:2
tetraplegic 150:22
thank 8:12,17 9:4,11,18
 9:19,21 11:4,15 12:16
 18:4 20:21 21:9 23:14
 26:3,9 29:15,21 30:21
 30:22 31:2,8,10,15
 39:2,5 40:16,16,17,19
 49:13 50:14 61:17,19

63:5 67:8,17 70:17,21
 70:21,22 79:3 80:15
 84:4 85:11 87:2 88:18
 90:9 91:9 95:2 99:12
 105:17,18 107:14
 108:20 117:13 120:1
 122:21 123:3 124:9
 127:13,17,22 129:7
 132:8,18 147:6 152:7
 155:16 156:3 172:14
 172:22 173:3,22
 174:9 177:7,22
 179:22 180:5 181:20
 183:17 189:21 192:3
 196:3,7 197:17
 205:15 211:6 215:17
 218:18,22 228:22
 230:9,18 231:9,10
 236:2,15 238:1,12
 243:14 252:7 253:12
 253:19 255:10 257:11
 259:11 264:13 265:19
 266:9,13 267:6,9,11
 269:21 271:12,13,14
 281:1 287:17 288:16
 291:15 294:6 295:5
 296:9 297:13 299:2
 300:8 305:13,19
thanks 21:7 42:1 68:7
 134:12 172:13 288:18
 297:14
Thanksgiving 11:10
theme 32:18 38:9 60:1
 60:13 231:7
themes 31:19 59:7
theory 88:9 182:17
therapy 1:15,22 25:15
 25:18 103:12,13
 201:5
they'd 161:19
thick 120:10
thing 14:22 15:1,14
 16:14 17:8 22:11
 41:11 64:15 68:3
 78:22 89:17 92:17
 96:22 106:21 133:1
 148:15 153:11,13
 159:2 169:1 188:20
 192:8 200:4 206:17
 228:4,16 233:21
 241:12 249:14 254:18
 261:16 267:15 268:6
 269:3 281:4,20
 291:17 301:3 302:19
 303:2 305:2
things 6:12 12:18 16:8
 19:1 27:4 51:5 58:20
 61:5 71:3 73:10 86:14

88:21 90:10 92:17
 94:12 95:3 99:12,18
 100:8 103:17 106:2
 106:13 107:9,12
 122:8 132:1,22
 134:19 141:16 149:22
 152:8,11 161:7 164:3
 182:22 192:9 195:2
 197:13 204:1 207:7
 225:18,20 226:10
 240:5 244:15,20
 245:3 246:3,13 258:7
 263:17 265:14 274:16
 275:19 284:1 286:19
 292:10 301:22 303:7
 303:17 304:9
think 7:11 12:8 13:16
 14:17 15:12 21:17
 28:15,17 30:8,9,14
 41:5,7,13 44:22 47:22
 58:12,16,20 59:12,14
 60:1,3 72:14,16,19
 76:3,5,6,13 77:14
 78:20 79:10,21 81:19
 81:22 82:2,6,17,19,21
 83:5 87:8,9,14 88:5
 88:14 90:10 91:12
 92:7,10 93:2,9 94:10
 95:1 96:18 97:1,5,16
 99:2,8 101:20 102:3,4
 102:6,15 103:21
 104:9,13 105:3,8,12
 110:19 111:7 112:12
 114:2 116:21,22
 121:1,7 124:12
 125:16,17 126:1,2,12
 126:19 129:8 130:14
 131:3 133:22 134:2
 134:19 135:4,18
 136:1 137:14 143:13
 146:22 148:3,14
 150:6 151:12,21
 152:14 155:11 158:20
 159:2,3,18 160:14
 161:6,13,20 162:6,10
 162:10,21 163:4
 164:5 165:9,14,17
 166:21 167:3,20
 169:5,13 171:1 173:6
 178:3 179:12,19
 182:7 183:5 185:3,20
 190:12 193:13 194:7
 197:2 198:14 202:17
 203:2 206:14,18
 209:2 210:5 212:3,4
 213:20 215:4,9,15
 216:18 217:6 218:6
 219:9 220:10 221:17

222:20 223:3,18
 224:20 225:2 226:15
 228:4 229:11,15
 239:15 240:5,8
 243:16 247:1,9,14
 248:3 249:2,10,14
 250:2,17 251:5,15,21
 255:14 256:10,11,17
 257:14 259:14 261:11
 263:12,20 264:17
 265:2 266:2 267:16
 268:7,9,15,17 270:8
 271:10 273:9,12,20
 274:1,5,8,18 275:7,11
 275:20,21 276:9
 278:3,20 280:19,21
 281:6 283:3,9,12
 286:8 287:2 288:4,7
 288:10 289:11,13
 294:3,22 295:10,11
 295:16 296:15 299:5
 299:17 300:2,6 301:7
 301:11,22 302:5,6,12
 302:16,16,18 303:2,8
 303:12,21 304:11,12
 304:14 305:2,3,7
thinking 40:22 87:12,15
 87:16 96:9 97:20,22
 135:4 161:5 166:11
 210:10,22 263:22
 264:4,19 274:5
 275:15,17 289:12
 292:10,19 293:7
 302:15
third 31:18 48:8,11,13
 59:18 66:13,19 146:4
 146:10 153:13 228:16
 270:20
Thomas 2:4 23:3 25:7,7
 29:16,18 74:20 91:19
 226:3
thorough 59:6
thought 7:9 18:14 32:2
 61:6 71:4 87:20 98:2
 100:19,21 106:9
 158:15 162:2 173:2
 182:11 186:17 227:17
 233:3 239:14 240:4
 256:10 260:22 264:4
 265:10 271:4 291:21
 292:9,11 296:10
 302:14 305:5
thoughtful 59:6
thoughts 97:17 212:6
 215:2 219:5 221:1
 229:1 259:18 264:2
 274:1 276:15 285:22
 290:8 305:11

thousands 142:21,22
threat 103:9
three 34:10 36:18 39:21
 39:22 40:3 45:14 56:2
 71:5 85:19 93:3
 100:11 103:2 109:3
 119:10 143:15 144:14
 145:18 158:18 175:7
 182:10,16,17,18,21
 183:3 198:15 202:8
 206:1 208:1,22 209:3
 211:8 212:8 213:4,12
 219:13 228:14,15
 229:17 241:10 254:4
 267:21 268:1 270:12
 270:22 272:21 281:18
three-day 154:6 178:16
 181:2,3
three-part 281:16
 282:13
three-step 42:13
threshold 33:3 55:22
 56:12
thresholds 175:18
threw 13:10
throw 287:14
tie 301:10
tied 6:18,19,20 98:4,17
 158:11 214:14
tight 112:21
time 7:3,8,11 11:6
 14:19 15:13 23:9
 35:16 36:8 37:1 40:16
 55:19 59:3,10,12 62:1
 62:13,16 63:12 65:6
 69:13 75:12 78:15
 83:15 85:3 95:15 99:5
 102:6 106:3,6 113:22
 115:4 117:6,9,19
 121:19 127:16 130:13
 133:20 135:4,19
 136:11 137:15 146:18
 147:3,5,10 148:4
 154:8,11 156:14
 164:4 165:2,9 166:19
 172:10 174:21 175:2
 176:6 177:19 178:9
 179:22 189:18,20
 195:7 196:3 198:22
 200:13,16 201:21
 203:9,18 204:4,6
 207:6 209:16 210:18
 214:14 220:10 221:14
 226:12 227:13 228:4
 230:14,17 231:13
 235:12 238:4,6 239:9
 253:8,11 256:15
 258:7 259:3,4 266:6

266:14 267:2,5
 268:14,17 271:20
 276:2 283:7,7 292:4
 294:13 297:4,6,13
 299:6,19 301:15
timeline 121:16 163:20
 164:6
timelines 31:22 106:4
 112:20,21 113:18
 116:9,11
timeliness 12:15
timely 74:11 89:14
 102:8 241:19
times 36:9 59:17 79:18
 132:3 136:18 184:5
 293:6
timing 69:5
Tinetti 271:5
Tinetti's 271:6
tinker 209:9
tirelessly 11:5
title 49:2,5
today 16:6 29:1 30:5
 34:8 36:8,10 37:1
 39:6 40:3 72:22 116:5
 177:12,15 205:3
 258:11 296:19 297:1
 297:11 298:15,22
 299:15 303:10 304:15
 305:6
told 35:15 37:10 156:21
tolerate 181:13
tomorrow 68:11 298:16
 299:1,15 305:20
tonight 171:19
tool 37:11 127:4 174:5
 193:3,17,19 195:4
 198:18,20 245:18,22
tool-based 195:3
toolbox 175:20
tools 175:19 242:22
 260:6
topic 57:18 192:20
topped 284:9
totally 71:9 87:13 174:3
 259:5
touch 203:3 251:5
Tourette's 190:21
trach 253:2
track 119:7 166:20
 250:7 252:4 257:4
tracked 165:19
tracking 166:22 228:18
 239:16
traditional 139:3 184:1
 184:8
transfer 182:16 229:13
transferred 94:1 130:2

142:4 155:4 229:9,13
 244:3
transfers 240:16
 287:11
transitions 1:17 24:13
 79:15 152:21 170:8
 170:10
translation 223:21
transparency 136:2
transparent 174:4
transportation 100:9
treat 260:1 261:19
treated 123:14 162:16
 264:22
treating 162:13 279:11
 292:14 293:10
treatment 154:14 191:4
 191:21
tremendous 12:5 20:18
 41:15 121:1
tremendously 120:11
trend 227:18
trepidation 160:20
trial 14:4 245:19 253:2
 253:3,4 257:6,7
 259:12,12
trialed 258:3,4
trials 258:19 261:17
trickier 256:13
trouble 87:22 184:18
Troy 3:6 194:12
true 112:12 141:6
 165:20 202:1,1
 243:16 267:16
truly 133:5 165:22
 282:8
trust 87:2 152:9,10
try 20:19 44:17 54:16
 81:14 98:12 106:2,17
 106:18 135:1 140:15
 144:2 181:11 212:22
 249:11 258:11 271:19
 272:6 285:13 304:20
trying 7:8 9:15 13:18
 14:19 16:10 48:13
 72:19 73:7 75:6 99:5
 104:21 106:15 107:2
 131:3,4,11 134:3
 143:1 148:3 185:3
 245:1 271:16 272:4
 274:12 283:19 288:7
 289:15 290:12 301:10
 302:17
turn 21:6 40:21 41:20
 55:3 59:2 64:12 65:8
 67:18 70:16 117:10
 127:18 129:3 147:1,7
 149:17 168:3 198:12

202:5 244:7 304:13
turned 54:1
turning 52:12 147:12
tweaking 304:18
twice 218:13
twist 175:14
two 12:6,18 13:1 32:22
 34:16 35:21 40:12
 43:18 57:14,16 61:22
 79:9 85:2 86:11 88:2
 90:9,11 93:3 96:18
 98:18 99:12 100:3,9
 101:6 102:18 111:14
 118:12 119:10 129:12
 143:5 152:4 154:3
 169:5 170:16 182:12
 182:15 183:2 185:2
 191:10,15 192:6
 200:6 206:22 207:8
 209:7 220:17 222:6,7
 232:11,19 233:6,11
 235:5 242:10 246:10
 246:13,19 253:4
 255:11 256:13 257:5
 257:7,8,14 258:4,6
 273:5 281:12,21
 297:17 302:6
type 84:18 85:6 107:2
 130:19 149:9,10,13
 224:6 263:19 294:6
 294:14
types 143:21 149:12
 195:17 247:19
typically 224:21
typicals 262:4

U

UDS 174:6
UDSMR 298:17
Ulcer 2:3 23:20
ultimate 118:13
ultimately 101:2 136:3
 136:4 290:18 298:12
unbelievably 142:19
unclear 154:4
uncomfortable 30:12
under-reporting 279:16
under-utilized 243:5
underscore 118:18
 119:9 120:1
underscored 269:13
understand 10:11
 31:20 58:18 82:4
 83:13,13 106:18
 155:8 174:1 201:7
 209:4 249:2 274:22
 278:1 283:1 286:5
 301:2

understandable 284:15
understanding 112:8
 129:1 166:14 183:21
 211:12
understood 220:22
underway 94:12 122:4
undoubtedly 144:18
unexpectedly 151:1
unfortunate 245:17
 265:13
unfortunately 106:14
 130:6 164:21 278:6
Uniform 3:6 194:13
 195:8
unintended 65:18
 137:10 140:16 152:12
 166:8 228:5 236:21
 248:2 249:7 260:2
unique 84:7 124:4
 178:9,15 179:21
 186:11
unit 181:3
universe 99:7
University 1:16 3:3
 8:20 24:16 28:20 29:4
 175:3
unknown 66:10
unplanned 119:3
 240:15
unpreventable 162:5
unquote 179:11
unusual 208:10
update 20:22
updated 116:13 122:16
 139:13
updates 37:5 42:2
upstream 16:22 95:13
urban 153:6 187:14
 188:9 241:2
urge 136:1
use 14:13,21 36:13,17
 38:1 39:20 42:13 44:2
 46:13 78:19 93:3
 108:5,7 112:16
 130:15,19 131:21
 139:20 145:20 149:11
 150:10 166:19 167:1
 187:3 190:10 191:7
 191:13 192:16 200:10
 201:14,17,17 203:15
 203:17 204:2 209:19
 214:10 216:18 224:1
 224:14,22 225:1
 226:22 232:17 245:22
 246:8 250:15 259:21
 261:13 262:3,12
 263:4,9,11 267:19
 280:3 296:12

useful 87:11 225:7
239:9 262:19
uses 111:13 225:4
235:15,17
usual 258:10
usually 125:11 293:11
UTI 175:22
utility 303:14
utilization 41:16
utilize 195:11 209:15,20
utilized 195:4,13
utilizing 288:11

V

vaccination 208:6
211:20
vaccinations 227:12,16
228:7
vaccine 189:14 221:6
223:3 226:9,11 227:8
228:7 229:20
vaccines 228:14,15
vacuum 248:20
validated 79:19
validation 72:20 73:3
validity 59:21 66:9
216:3
valuable 61:6 81:16
128:15,19 150:18
274:6
value 5:9,11 10:20,21
33:16 51:15 78:3,6
81:1,6 113:3 165:18
165:20 185:6,17
value-based 6:21 10:19
35:20 36:3 40:7
230:11,22 231:15,18
232:17 234:5,12
243:10 303:20
values 145:22
variables 60:9 125:22
127:7
variates 88:21
variation 14:18 41:15
168:5 257:13,18
258:9
varies 89:16 235:2
variety 46:4 165:6
237:9
various 11:2 80:4 249:1
269:7
vary 88:17
VBP 169:4 233:8
vehicle 209:20
vent 258:17 263:7
ventilator 35:11 253:6
257:5,8 259:13,22
verbiage 103:4

Vermont 171:20 172:7
version 213:17 214:2,2
214:3 232:14
versions 14:22
versus 14:15 60:20
81:2,13 87:10 89:9
138:20 165:21 170:16
184:15 187:14,15
210:9 213:19 224:17
255:8 262:20 263:3,8
277:10 297:21
vet 209:11
veterans 21:10
vett 203:18
vetting 206:4
vexing 14:8
vibrant 160:15
Vice 24:1
view 55:6 101:15
166:16 183:2 242:17
283:6 289:14 290:2
290:15,21
viewed 160:9
viewing 275:22
viewpoint 22:18 107:8
views 26:17 111:9
virtue 275:11
vision 39:1
visit 176:9
Visiting 1:14 8:3 24:2
62:6 239:20
visits 152:16 166:9
246:4
vitamin 99:21
Voice 1:13 23:17
voicing 286:17
volumes 120:10
von 23:3 29:16,18
vote 50:20,21 54:12,16
55:14,16,20 56:1,10
56:13 67:7 102:19
105:13,15 108:3
110:21 111:17 145:2
146:17 194:11 212:5
212:8,19 213:7,12,12
216:15,15,19 217:5
217:22 218:16 219:9
221:1,10,11,15,16,21
222:2 229:16,20
286:17 293:15,22
294:10,14,21 295:1,1
295:18
voted 53:19 192:12
votes 55:18 56:17
218:7,10 219:12,21
voting 2:6 4:8 48:2
49:17,20 50:2,19 52:4
52:21 53:9 54:14 57:5

58:14 107:18 116:20
217:12,19,20 218:5
219:17,19 221:16
229:17 230:1,3
256:19 293:17 294:14
295:8,11,11,12,12,18
295:20 296:1 299:14
vulnerable 10:2

W

wait 15:21 93:6 171:22
202:15 219:12 240:6
243:12 261:1 276:17
295:16
waiting 107:3 140:9
wake 269:12
walk 50:5
walking 195:6,20
walks 300:22
want 6:4,6 7:15 8:22
11:3 13:16 30:5,11
42:10 44:15 56:5 58:9
63:22 70:18 75:22
77:5 78:8,12 80:13
82:8,10 83:20,22
86:17,19 87:1 91:10
91:17 94:5 97:10
100:1 102:19 104:22
105:2 107:6,11 117:1
119:22 120:7,22
129:4,14,18 131:16
132:10 135:21 137:19
139:9 140:20 144:7
145:6 148:22 149:2
149:15 156:19 158:8
160:2 169:17 178:1
182:1 184:11,15
192:1,2 196:1 198:1,3
202:22 205:13 207:18
208:7 217:7 220:9,12
220:16 225:5 233:16
236:3,4,6 238:3,4
243:14 247:11 248:15
248:16 251:5 253:13
254:2,17 255:12,13
256:14,18 257:11
262:10 263:19 264:3
266:21 267:7,11,20
269:17 270:7 271:1
271:22 276:5,10,13
276:18 280:7 283:10
285:18 290:9 291:11
292:6 294:20 295:3
296:15 298:21 302:5
304:20
wanted 12:18 31:9,15
55:15 58:4 84:4 86:9
88:20 89:17 91:11

100:18 101:6 108:15
109:8 139:7,11 140:1
151:21 162:9,17
171:6,8 174:4,14,16
177:9 195:2 206:18
217:10 220:22 227:3
237:21 245:16 246:2
246:13 269:3 293:4
297:12 300:14 305:13
305:14,15
wanting 97:19 145:10
wants 41:19 82:22
131:9 132:16 144:20
147:8 169:15 174:18
177:16 181:21 207:10
221:13 252:17
warm 154:18
Washington 1:9
wasn't 112:13 174:15
210:7 258:19
waste 238:4
watching 83:9
way 13:10,17 71:17
82:11 85:10 87:16
92:18 95:13 98:6,12
99:1 101:5,19 105:10
106:8 123:19 124:21
124:22 126:8 134:5
156:9,21 169:18
170:3,15 179:20
183:3 184:8 186:8
188:8 203:21 205:10
210:13 214:17 215:21
221:17 223:19 228:18
228:20 246:7 257:2
259:3,4 262:21
264:10 272:17,20
273:3 274:21 275:9
280:18 282:10 285:1
287:11 293:10,12
304:3
ways 12:20 20:9 82:21
143:5 161:7 182:15
185:2 273:3
we'll 19:9 22:8 23:5
26:13 32:13 35:1
39:13 40:2 50:20 52:3
52:9 53:9,10 54:19
55:10,16,19 56:9,17
57:9,19 58:14,17
63:18 81:11,15,21
157:5 165:1 170:4
172:15 188:22 198:8
211:17 212:7,10
213:6 216:19 219:1
219:12 221:20 222:8
252:18 256:20 257:1
266:7 276:14 284:22

294:13 298:22
we're 10:21 12:8 15:4
 16:6 18:1,7 19:2
 20:22 27:7 31:3 32:5
 33:12 34:6 39:6 42:2
 42:4 43:19 54:18
 58:16 74:17 80:3,18
 80:19 82:20 83:9,12
 95:16 96:21 98:3,18
 101:20 102:4 106:15
 108:12 113:3,20
 115:10,22 116:1,4
 131:4,22 132:2,11,13
 135:18 137:7 141:4
 142:22 143:1 144:17
 146:8 149:4 151:11
 155:13 156:20 157:1
 157:9 163:5,6 164:22
 165:10,15 166:7,19
 167:20,21 168:4
 172:19 175:20 177:2
 185:3,21 197:18
 198:14,15 204:17,18
 207:6 209:8 210:1,17
 210:22 213:5,11
 217:12 218:6,10,11
 218:18 219:20 224:18
 229:15,17 230:9
 242:2,4 244:17 245:1
 245:21 246:1 250:6
 251:15 252:4,12,13
 252:21 257:4 259:11
 265:22 266:2,3,15
 269:11 275:22 276:3
 279:16 284:7 285:1,2
 289:15,16 293:6,17
 293:17 294:14 295:10
 295:11,12,12 296:11
 296:12 301:2,19
 302:17 303:2 304:4,5
 305:3
we've 11:18 12:5 17:11
 33:10 34:20 36:20
 42:3,5,6,8 44:6 46:16
 48:18 52:10 57:2,7
 58:7 60:5 71:3 90:10
 94:16 106:1,1 113:1
 115:16 123:7 140:11
 140:13 149:3,12,14
 157:21 160:4 163:1,1
 163:10,22 164:11
 169:2 173:4 177:15
 184:9,20 185:2 188:7
 216:22 220:5 229:16
 247:14 251:6,13
 256:10 263:16 265:9
 265:22 268:6 275:5
 276:20 277:7 279:5

285:10 297:1 298:22
 299:10 301:16 305:16
weaknesses 45:21
wean 256:2 258:18
weaned 255:5
weaning 253:6 255:15
 257:6,8 258:8 259:13
wear 192:6
web 42:9
website 19:11 33:9
 115:16 144:21
week 13:8 120:22
 154:20 156:13 176:18
weekly 240:15
weeks 122:2 242:10
weep 157:5
weighed 45:18
weighs 222:13
welcome 4:2 6:4 8:5,10
 9:1 30:17 117:12
 173:5
well-being 84:14 85:1
well-established 33:9
went 108:22 113:15
 119:5 143:10 157:2
 162:17,18 172:17
 208:17 238:15,18
 240:20 241:8 256:4
 266:11 298:18
weren't 116:7 183:1
 304:9
West 170:16
wheelchair 195:11
 201:14,17
wheelchair-dependent
 195:12,16
who've 290:14
wholeheartedly 135:17
Why'd 139:4
wide 46:4
widespread 241:3
wife 32:9
wild 100:5
willing 304:21
willingness 206:11
window 137:16 181:16
 235:19
windows 235:13
Winstel 2:5 26:1,1 95:2
 156:3 238:3 273:8
 287:5
wise 281:19
wish 73:11 107:10
 280:21 297:8
wished 59:11
wishes 65:9
withdraw 80:9 211:8
withdrawn 211:13,14

211:15
within-stay 119:12
wonder 30:12 86:13
 246:4
wonderful 241:19 242:3
wondering 156:8 226:3
 287:22
Wood 18:16
word 78:19 79:13 85:18
 95:18 110:4
wording 106:1
work 8:15 9:5 10:5,13
 11:11 12:4 13:6 14:6
 15:17 17:1 18:10,16
 20:17 21:1,19 22:13
 24:22 25:1 27:6,10,18
 30:7 38:19,22 63:6,20
 63:21 64:1 73:5,6
 75:19 85:8 102:1
 104:11 109:10 113:10
 121:1 131:11 165:5
 167:18 170:4,9
 173:13 216:7,19
 217:10 226:20 240:10
 240:11 242:15 257:12
 258:10 271:18 278:8
 281:18 297:11 301:15
 302:1,10 304:13
worked 11:5 12:12
 15:16 138:13 160:5
 278:18 305:16
worker 287:15
workgroup 1:3,8 2:14
 4:3,4 6:6 7:16 9:2
 19:16 31:15 44:3,21
 47:1 49:20 51:17
 53:17,21 55:11 57:18
 57:20 62:2,5,14 63:3
 71:12 73:10 74:15
 75:12 76:19 78:4 84:1
 84:6,12 105:20
 116:19 120:8 131:9
 132:9,15 133:16
 148:20 149:5,18,18
 169:19 171:10,19
 172:9,21 173:1,4,14
 173:20 181:19 190:5
 192:21 196:12,16
 197:12,15 202:15,20
 217:16 231:19 254:11
 254:18 255:7 262:14
 262:16 273:1 277:8
 292:6 294:5 296:7
 301:16 305:15
workgroup's 43:15,17
 52:16 197:14 254:15
workgroups 43:7 51:1
 51:16 62:21 76:20

280:15
working 13:18 18:1,5
 42:4 48:19 62:13
 63:12,15 85:6,6 164:1
 228:20 284:22 295:4
works 17:1 178:9
world 13:19 16:2,16,19
 17:10 63:14 79:14
 105:4 159:2 226:15
 242:17 290:21
worn 259:14
worried 183:13 203:22
 204:1,19 222:17
worry 135:19 140:16
 152:11 153:1 245:21
worth 110:19 228:17
 250:18
worthwhile 167:4
would've 244:5
wouldn't 50:7 68:20
 77:3 183:9 275:19
wow 299:10
wrapped 182:20
write 221:20 226:18
written 38:7 57:22
 91:20
wrong 75:8 157:4 242:4

X

Y

Yale 17:20
yeah 81:3,19 100:18
year 11:6,10 12:7,8
 14:2 21:13,16 31:18
 33:2,5,5,10 39:11,13
 40:1,10 42:4 43:6,18
 46:6,16,16 51:3 54:14
 55:15,17 56:11 57:4,8
 63:4 84:12,16 115:3
 139:13 142:21 150:2
 150:3 185:13,14,15
 193:19 203:7 204:13
 227:9 285:7 297:21
year's 33:18 34:19
years 7:10 9:15 12:6
 35:13 44:8 49:1 61:22
 62:5,12 72:8 89:1
 129:12 143:15 155:15
 164:17 170:9
yell 76:7
yesterday 59:3
York 27:17 239:21

Z

zoom 275:20

0

0 220:3 230:7 296:4	2013 38:2 131:5	463.60 92:8
<hr/>	2014 35:18 38:14	48 238:19,21 241:11
1	2015 1:6 139:13	242:9
1 107:17 117:8 147:5	2016 34:20 114:9	496 155:2
152:14 167:6 177:19	2017 39:16 40:2	497 153:18
189:20 216:20 229:20	2018 40:11	498 155:7
230:16 253:10 267:4	21 4:4 200:14 218:9,18	<hr/>
297:6	211 191:6	5
1.0 185:6	212 5:8	5 220:2,15 230:6 279:18
1.5 187:9	2232 193:5	50 143:8 239:21 279:22
1:00 171:16 172:15,18	2286 193:5	523 124:21
10 131:11 187:9 277:15	2287 193:5	<hr/>
10,000 65:13	230 5:10	6
10:58 108:22	231 5:12	6 4:3
100 120:21 218:20	235 295:11,14,19	6:30 171:19 172:11
225:9,10 244:12	23rd 57:21	60 55:21 56:12,16,18,19
245:7 261:18 282:2	24 241:11 258:22	63 4:5
100-day 225:14	24th 130:13	65 4:11
1030 1:8	25 80:4 88:1 296:2	68 4:13
109 4:15,17	252 5:14	<hr/>
11 150:2	253 5:16	7
11:18 109:1	2612 193:5	70 33:3 38:9
1110 171:20 172:6,7	2613 193:5	75 200:8 296:3
113 9:8	266 5:18	<hr/>
1131 192:10 196:15	269 5:20	8
1132 192:11 196:15	27 4:4	80 33:4 123:6
1133 190:10 192:11	297 5:21	<hr/>
196:15	<hr/>	9
12:29 172:17	3	
12th 57:21	3 216:22 229:22 279:17	
14 1:6	3:15 266:5,7	
146 4:19	3:17 266:12	
147 4:21	30 126:4,9,14 132:3	
15 150:3 187:10 195:3	157:16 171:4 238:16	
15-235 295:11	277:17	
15-minute 108:13	30-day 152:17 153:22	
15th 1:8	155:2 169:3 171:2	
17 91:2	231:1,6 232:2,10	
177 5:2	234:16 235:19,20	
179 289:1	243:22	
18 258:16	304 5:22	
180 5:4	31 4:7 6:17 118:3	
188 5:6	119:21 138:1,8	
1927 191:11	31-day 137:16	
1932 191:11	31st 227:5	
1999 37:4	<hr/>	
1st 39:16 40:1,2 227:5	4	
<hr/>	4 85:21 179:13	
2	4:00 297:10	
2 167:7 216:21 229:21	4:03 305:22	
259:13 295:1	4:15 266:15	
2:46 266:11	40 35:6	
20 80:4 195:10	40-page 35:7	
2000 37:6	42 4:9	
2005 32:17 37:8 198:21	42-year 9:7	
2011 37:16	44 143:14	
2012 33:7 203:7 204:5	46 176:9	
278:7,21	462 124:21	

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Post-Acute Care/Long-Term Care

Before: NQF

Date: 12-14-15

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.



Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com