

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP

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POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

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WEDNESDAY

DECEMBER 13, 2017

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Gerri Lamb and Paul Mulhausen, Workgroup Co-Chairs, presiding.

MEMBERS PRESENT:

GERRI LAMB, RN, PhD, Co-Chair

PAUL MULHAUSEN, MD, MHS, Co-Chair

MARY ELLEN DEBARDELEBEN, MBA, MPH, HealthSouth Corporation \*

AMY GOTWALS, National Association of Area Agencies on Aging \*

ROBYN GRANT, MSW, National Consumer Voice for Quality Long-Term Care

KURT HOPPE, MD, American Academy of Physical Medicine and Rehabilitation

FREDERICK ISASI, JD, MPH, Families USA

JAMES LETT, II, MD, CMD, National Transitions of Care Coalition

DHEERAJ MAHAJAN, MD, CMD, The Society for Post-Acute and Long-Term Care Medicine

KURT MERKELZ, MD, Compassus

SEAN MULDOON, MD, Kindred Healthcare

PAMELA ROBERTS, PhD, OTR/L, SCFES, CPHQ, FAOTA, American Occupational Therapy Association

DEB SALIBA, MD, MPH, American Geriatric Society  
 THERESA SCHMIDT, National Partnership for  
 Hospice Innovation  
 HEATHER SMITH, PT, MPH, American Physical  
 Therapy Association  
 CAROL SPENCE, PhD, RN, National Hospice and  
 Palliative Care Organization  
 ARTHUR STONE, MD, National Pressure Ulcer  
 Advisory Panel  
 KATHLEEN UNROE, MD, MHA, American Geriatric  
 Society \*

SUBJECT MATTER EXPERTS (VOTING):

CONSTANCE DAHLIN, MSN, ANP-BC, ACHPN, FPCN, FAAN  
 KIM ELLIOTT, PhD, CPH  
 CAROLINE FIFE, MD, CWS, FUHM  
 EUGENE NUCCIO, PhD  
 ASHISH TRIVEDI, Pharm.D.

FEDERAL GOVERNMENT MEMBERS (NON-VOTING):

ALAN LEVITT, MD, Centers for Medicare and  
 Medicaid Service  
 ELIZABETH PALENA HALL, MIS, MBA, RN, Office of  
 the National Coordinator for Health  
 Information Technology

MAP MEDICAID ADULT CORE SET TASK FORCE LIAISON:

MARISSA SCHLEIFER, Rph, MS, Medicaid Adult Core  
 Set Task Force Chair

NQF STAFF:

ELISA MUNTHALI, MPH, Acting Senior Vice  
 President  
 ERIN O'ROURKE, Senior Director  
 KAREN JOHNSON, Senior Director  
 TAROON AMIN, NQF Contractor  
 MIRANDA KUWAHARA, Project Analyst  
 JEAN-LUC TILLY, Senior Project Manager

ALSO PRESENT:

NICHOLAS CASTLE, PhD, University of Pittsburgh \*

DAVID GIFFORD, MD, MPH, American Health Care  
Association

THEODORE LONG, MD, MHS, Centers for Medicare &  
Medicaid Services

STACE MANDL, RN, BSN, BSW, PHN, Centers for  
Medicare & Medicaid Services

TARA MCMULLEN, PhD, MPH, Centers for Medicare &  
Medicaid Services

MARY ELLEN PRATT, Centers for Medicare &  
Medicaid Services

CAROL SCHWARTZ, Centers for Medicare &  
Medicaid Services

PIERRE YONG, MD, MPH, MS, Centers for Medicare &  
Medicaid Services

\* present by teleconference

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

WELCOME, DISCLOSURES OF INTEREST, AND REVIEW OF MEETING OBJECTIVES . . . . .	5
CMS OPENING REMARKS AND REVIEW OF MEANINGFUL MEASURES FRAMEWORK . . . . .	.19
MAP RURAL HEALTH INTRODUCTION AND PRESENTATION . . . . .	.69
UPDATE ON THE PROMIS TOOL. . . . .	150
SKILLED NURSING QUALITY REPORTING PROGRAM. . . . .	221
PUBLIC COMMENT . . . . .	248
HOSPICE QUALITY REPORTING PROGRAM. . . . .	309
LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM. . . . .	325
INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM	
HOME HEALTH QUALITY REPORTING PROGRAM. . . . .	337
INPUT ON MEASURE REMOVAL CRITERIA. . . . .	347
UPDATE ON IMPLEMENTATION OF THE IMPACT ACT . . . . .	349
REVIEW OF NQF'S ATTRIBUTION WORK AND GUIDANCE ON ATTRIBUTION CHALLENGES IN PAC/LTC. . . . .	379
UPDATE ON EQUITY PROGRAM	
PUBLIC COMMENT . . . . .	397
SUMMARY OF DAY . . . . .	397
ADJOURN. . . . .	401

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

9:12 a.m.

MS. O'ROURKE: Okay, so I think we are ready to get started. Thank you all for making the trip into an unseasonably cold Washington D.C., and especially given that we only had one measure under consideration this year. However, we are excited you all still came to join us. This is actually a meeting we are pretty excited about.

Since we started convening this group -- was it seven years ago, now? We have seen such changes in the post-acute, long-term care world. And, you know, from those early days where the PAC/LTC Group put together their coordination strategy. And then we saw so much of what the group had said carried over into the IMPACT Act and the changes that have come from what the Affordable Care Act put in and then IMPACT built on. And we have a little bit of a pause this year where we can actually step back and think about some of the long-term issues

1 facing quality measurement in this setting. And  
2 we're excited to have all of you and to take  
3 advantage of your expertise to help us think  
4 through where we want to go from here and tackle  
5 some of these outstanding thorny measurement  
6 science issues, if you will.

7 We have teed up conversations on risk  
8 adjustment and attribution that we want to get  
9 your input in. We also want to make sure that  
10 we're thinking about improving quality for the  
11 most vulnerable so we have invited Karen Johnson,  
12 who is heading up our new Rural Workgroup. We  
13 also have Marissa representing the new MAP  
14 Medicaid Workgroup just to make sure that as we  
15 think about these things we are keeping an eye on  
16 the populations that tend to get left behind and  
17 thinking about improving quality for everyone.  
18 So we're excited to have you, and thank you for  
19 joining us. With that I think I will turn it  
20 over to our co-chairs, Gerri and Paul, to welcome  
21 and see if they have any reflections on our goals  
22 for today.

1 CO-CHAIR LAMB: Well welcome everyone.  
2 Really glad to see everyone here and I would like  
3 to echo a couple of things that Erin just shared.  
4 First I would like to say I am absolutely  
5 delighted to be co-chairing with Paul this year.  
6 So we are all ready to facilitate a really  
7 dynamic, lively conversation. And in talking to  
8 many of you we know you are up for it.

9 So going to what Erin was saying, I  
10 hope you have noticed that the agenda has been  
11 crafted for us to have a rich dialogue -- to  
12 really situate our discussion about post-acute,  
13 long-term care in the context of what is  
14 happening, the strategic directions that -- that  
15 are happening in performance measurement. And it  
16 is a time for all of us to, as Erin was saying,  
17 step back and really reflect on the current state  
18 of PAC/Long-Term Care measures -- where we hope  
19 it will go. And we're really fortunate to have  
20 many folks from CMS here with us to be part of  
21 that conversation with us. So we are just going  
22 to launch a really, I think, robust, meaningful

1 conversation that we can kind of go forward with  
2 PAC/Long-Term Care in the future. So, Paul?

3 CO-CHAIR MULHAUSEN: Thanks, Gerri.

4 So I have to say my thank-yous, first. So, Gerri  
5 in my view has been a terrific mentor as we have  
6 been preparing for this meeting and I thank you  
7 for that and am deeply appreciative. And then  
8 the NQF staff, Miranda and Jean-Luc and Erin have  
9 been just terrific in terms of helping us to put  
10 together the agenda for this meeting and bringing  
11 us all together. So -- and then thank you to all  
12 of you for getting out here for this meeting.

13 It is an exciting time in my opinion  
14 -- certainly an interesting time, in my opinion,  
15 to be thinking about quality, to be thinking  
16 about value, to be thinking through how we  
17 measure quality. And with all of the activity  
18 that's taking place in the world of healthcare  
19 quality measurement, how to most effectively  
20 measure quality and bring some of that energy  
21 into the post-acute care environment is really  
22 our task today. So thanks for being here. I too



1 am looking forward to a very exciting dialogue  
2 and I thank you for the privilege to join you as  
3 a co-chair.

4 MS. O'ROURKE: Thank you both. And  
5 thank you for taking on the co-chair role. We  
6 appreciate your leadership so far and throughout  
7 the day. So I would like to introduce Elisa  
8 Munthali, our acting Senior Vice President, to  
9 lead everyone through introductions and  
10 disclosures of interest.

11 MS. MUNTHALI: Thanks, Erin. And I  
12 wanted to thank all of you for being on this  
13 workgroup. And so what we are going to do today  
14 is to combine our introductions with disclosures  
15 of interest. We are doing it in two parts  
16 because there are two types of members that serve  
17 on this workgroup. The first is organizational  
18 members, and many of you are organizational  
19 members, and the second is subject matter  
20 experts. And I will start with the  
21 organizational members. You represent -- I just  
22 wanted to remind you -- you represent the

1 interests of a particular organization and we  
2 expect you to bring those interests to the table  
3 and to your discussions. Because of your status  
4 as an organizational representative, we ask you  
5 only one question that's specific to you as an  
6 individual. And this is if you have any  
7 interests that are in excess of \$10,000 that are  
8 related to the work in front of you.

9 And so what we will ask you to do is  
10 I will ask --- we'll start clock-wise, and we  
11 will go around the room. We will ask you to tell  
12 us who you're with and to orally disclose what  
13 you did on the form. So we'll start after Allen,  
14 I think. We'll start over here on this side --  
15 to my left. Raj.

16 MEMBER MAHAJAN: I am Raj Mahajan. I  
17 am from Chicago and I am representing AMDA, the  
18 Society for Post-Acute and Long-Term Care  
19 Medicine. I do not have any disclosures.

20 MEMBER NUCCIO: Gene Nuccio from the  
21 University of Colorado Anschutz Medical Campus.  
22 I am the SME on Home Healthcare and have no

1 conflicts.

2 MEMBER ELLIOTT: Did you want the  
3 subject matter experts?

4 MS. MUNTHALI: Not yet. So that's a  
5 lengthier process. That's okay, we have that  
6 recorded.

7 MEMBER ROBERTS: Pam Roberts, I  
8 represent American Occupational Therapy  
9 Association and I am from Los Angeles, California  
10 so the cold is a bit chilly today. But I have no  
11 disclosures.

12 MEMBER MULDOON: My name is Sean  
13 Muldoon. I am a full-time employee of Kindred  
14 Healthcare, a provider of post-acute care  
15 services.

16 MEMBER SMITH: Hello, Heather Smith.  
17 I represent the American Physical Therapy  
18 Association and I have no disclosures.

19 MEMBER SALIBA: Hello, I am Deb Saliba  
20 and I am President of the American Geriatric  
21 Society.

22 MEMBER SPENCE: Carol Spence, I

1 represent the National Hospice and Palliative  
2 Care Organization and I have no disclosures.

3 MEMBER HALL: Hello, I am Liz Palena  
4 Hall. I am an ex officio member from the Office  
5 of the National Coordinator.

6 MEMBER TRIVEDI: Hi, I'm Ash Trivedi  
7 from Novartis Pharmaceuticals, I have no  
8 disclosures.

9 MEMBER GRANT: I am Robyn Grant with  
10 the National Consumer Voice for Quality Long-Term  
11 Care and I have no disclosures.

12 MEMBER MERKELZ: Good morning, I am  
13 Kurt Merkelz, I represent hospice with Compassus  
14 and I have no disclosures.

15 MEMBER LETT: Good morning, I am Jim  
16 Lett. I represent the National Transitions of  
17 Care Coalition. I am president of their Board of  
18 Directors and have nothing to declare.

19 MEMBER STONE: Morning, Art Stone. I  
20 am the representative from the National Pressure  
21 Ulcer Advisory Panel and I have nothing to  
22 disclose.

1                   MEMBER HOPPE: Good morning, Kurt  
2 Hoppe. I represent the American Academy of  
3 Physical Medicine and Rehabilitation. I have  
4 nothing further to disclose.

5                   MEMBER SCHMIDT: Hello, my name is  
6 Theresa Schmidt. I represent the National  
7 Partnership for Hospice Innovation and I have  
8 nothing to disclose.

9                   MS. MUNTHALI: And I don't know if we  
10 have any organizational representatives on the  
11 phone. I think we were thinking that the  
12 National Association of Area Agencies on Aging  
13 may be on the phone, but intermittently during  
14 the day.

15                  MEMBER UNROE: Hello, this is Kathleen  
16 Unroe. I am on the phone.

17                  MS. MUNTHALI: Hello, Kathleen.

18                  MEMBER UNROE: Hello, so I am also  
19 American Geriatrics Society. I am sorry to be  
20 here in Indiana, but nothing to disclose.

21                  MS. MUNTHALI: Thank you. So thank  
22 you so much for the organizations that disclosed

1 and now we will be going into the disclosures of  
2 interests for subject matter experts. This was a  
3 lengthier form that you received and the reason  
4 why is you sit here not representing your  
5 organization, but we put you here based on the  
6 experience and activities that are related to  
7 this work for which you can help us, you know, to  
8 complete.

9           So we wanted to give you a couple of  
10 reminders. We want you to be able to disclose  
11 any of -- any grants, consulting, speaking  
12 arrangements that are relevant to this work. So  
13 only those that are relevant to this work -- not  
14 just those that you were paid for, but also those  
15 that you may have volunteered for or that you  
16 were not paid for.

17           And there are a couple of other  
18 additional reminders that are really important  
19 for you to remember. Just because you disclose  
20 does not mean you have a conflict of interest.  
21 We do this in the spirit of transparency and  
22 openness. And so I think we have gone through

1 all of the reminders. And so we will go around  
2 the room for those that haven't yet disclosed  
3 that are subject matter experts. And again, we  
4 will start clockwise, so to my left. And Eugene,  
5 I think we got your disclosure.

6 MEMBER ELLIOTT: Kim Elliott and I  
7 work for Health Services Advisory Group, and I  
8 have nothing to disclose.

9 MEMBER DAHLIN: Hello, I am Connie  
10 Dahlin. I work for the Hospice and Palliative  
11 Nurses Association, but I am representing the  
12 Coalition for Hospice and Palliative Care and I  
13 have nothing to disclose.

14 MEMBER FIFE: I am Caroline Fife, I am  
15 a physician in Houston and just to make sure that  
16 I am thorough, I am the Executive Director of a  
17 qualified clinical data registry called the U.S.  
18 Wound Registry, which I don't think is a  
19 conflict, but I will let you know that I do that  
20 anyway.

21 MS. MUNTHALI: Yes, and Co-Chairs.

22 CO-CHAIR LAMB: I didn't think we were

1 exempt.

2 (Laughter.)

3 CO-CHAIR LAMB: I am Gerri Lamb and I  
4 direct the Interprofessional Center at Arizona  
5 State University. And, Elisa, do we share any --  
6 or does it need to be over \$10,000?

7 MS. MUNTHALI: Over \$10,000.

8 CO-CHAIR LAMB: Okay. I have no  
9 conflicts.

10 CO-CHAIR MULHAUSEN: So this is Paul  
11 Mulhausen. I am the Chief Medical Officer for  
12 Telligen, which is a health management firm that  
13 supports CMS and a number of its quality  
14 reporting initiatives. And that's my one  
15 conflict.

16 MS. MUNTHALI: Thank you. And we also  
17 have some federal members that are with us. They  
18 are non-voting members of this workgroup. And so  
19 I will start with Pierre.

20 DR. YONG: Hello, Pierre Yong from  
21 CMS.

22 MEMBER LEVITT: Alan Levitt from CMS.



1 I have nothing to disclose except this is my  
2 fifth year at the Committee, so I think I deserve  
3 a pin.

4 (Laughter.)

5 MS. MUNTHALI: Any other federal  
6 members? On the phone? Perhaps from ONC?

7 MEMBER HALL: Oh, this is Liz Palena  
8 Hall. I had introduced myself in the first go-  
9 around.

10 MS. MUNTHALI: Thank you. So now that  
11 you've heard all of the disclosures, I am going  
12 to ask the group if you have any questions of  
13 each other?

14 (No audible response.)

15 MS. MUNTHALI: It doesn't look like  
16 you do. I just wanted to remind you, if at any  
17 time you remember that you have a conflict,  
18 please speak up. You can do so in real time or  
19 you can approach your co-chairs. Or you can  
20 approach any one of us on the NQF staff. So I  
21 just want to ask before I leave again, if you  
22 have anything you would like to ask your

1 colleagues?

2 (No audible response.)

3 MS. MUNTHALI: Great, thank you.

4 MS. O'ROURKE: So I think I would also  
5 like to ask the NQF team to introduce themselves.  
6 I am Erin O'Rourke. I am the Senior Director  
7 supporting the Workgroup.

8 MR. TILLY: I am Jean-Luc Tilly, a  
9 Senior Project Manager supporting the Workgroup.

10 MS. KUWAHARA: Good morning everyone,  
11 my name is Miranda Kuwahara. I am the Project  
12 Analyst for this work.

13 MR. AMIN: Hello everyone, I am Taroon  
14 Amin. I am a consultant to NQF supporting the  
15 MAP Coordinating Committee.

16 MS. O'ROURKE: Great, so if we could  
17 just move on to our agenda slide. One more.  
18 Just want to do our few housekeeping comments  
19 before we start with the agenda.

20 If you could, please, make sure you  
21 turn on your microphone before you speak so the  
22 transcriptionist can capture it. Also, for the

1 folks on the phone, to do so you just push the  
2 red speak button once and then to push it again  
3 to turn it off. We can only have three of them  
4 on at a time, so apologies if we have to remind  
5 you to turn the microphone off. Otherwise, if  
6 you want to speak in the room, please lift your  
7 tent card up so the co-chairs know you want to  
8 get in the queue and can call on you. Let us  
9 know if you can't get on the wifi and we can send  
10 you the log-in and the passwords. And the  
11 restrooms are right past the elevator to your  
12 right.

13           So with that, just to cover our agenda  
14 briefly. We are going to turn it over to Pierre  
15 to share some opening remarks and review the new  
16 Meaningful Measures Framework. After that we  
17 will be providing you with an overview of the new  
18 MAP Rural Health Group -- to cover what that  
19 group is charged with doing. We will also have  
20 an update on the implementation of the IMPACT Act  
21 and some updates on the work around the PROMIS  
22 tool.

1                   After that we are going to have a  
2                   conversation about the application of the Merit-  
3                   based Incentive Payment System in post-acute care  
4                   and long-term care. This was actually suggested  
5                   by our co-chairs as a potential discussion when  
6                   they saw the list of measures under consideration  
7                   and to think about what input this group could  
8                   provide to the Clinician Workgroup who is  
9                   primarily charged with reviewing measures for  
10                  that group and the Coordinating Committee to  
11                  overcome some of the challenges that clinicians  
12                  practicing post-acute care and long-term care may  
13                  experience participating in that challenge -- or,  
14                  in that program -- and what guidance the group  
15                  may have to overcome some of those challenges.  
16                  If there's any particular measurement gaps or  
17                  input the group would like to share with CMS.  
18                  After that we will cover the pre-rulemaking  
19                  approach as we get into our main task at hand.  
20                  And then go through each of the programs the  
21                  group is tasked with reviewing.

22                   Obviously we only have our one measure

1       that's under consideration for the Skilled  
2       Nursing Facility Quality Reporting Program.  
3       However, we will ask you to spend a bit of time  
4       thinking about potential gaps in the Hospice,  
5       LTCH, IRF and Home Health programs -- in  
6       particular, thinking about the work that Pierre  
7       will share and Stace and Tara will share about  
8       the update of the IMPACT Act and how we can  
9       continue to foster alignment across the settings,  
10      are there any gaps that the workgroup would like  
11      to name across all of the settings.

12               I think we also want to think about  
13      how we can overcome some of the challenges to get  
14      to the next generations of measures, if you will.  
15      There's been quite a few gaps the group has named  
16      for years, but we're having challenges actually  
17      developing those measures. Obviously, NQF is not  
18      a measure developer, but what input the group may  
19      have for measure developers on where to focus and  
20      how to get to some of the concepts around care  
21      coordination and patient engagement that you've  
22      named previously. After that we will provide an

1 overview of NQF's attribution work and ask the  
2 group for some input on any special  
3 considerations that panel should take into  
4 account for post-acute and long-term care  
5 settings.

6 We then want to provide you with an  
7 overview of NQF's new Equity Program. And then  
8 finally end the day with an overview from CMS on  
9 the criteria they are considering for measure  
10 removal and to get input from this group on what  
11 you think about them all. So it is a pretty full  
12 agenda and we are excited to have you join us and  
13 help us think through some of these cross-cutting  
14 more -- longer-facing issues while we have a  
15 break from reviewing measures under  
16 consideration. So I think with that, was there  
17 anything else? Oh, yes.

18 CO-CHAIR MULHAUSEN: So when I hear  
19 Erin review the agenda it reinforces a thought  
20 that Gerri brought to the table which was, this  
21 is really an opportunity for us to collectively  
22 think strategically around the future of quality

1 measurement and post-acute care and long-term  
2 care and to share those strategic thinking --  
3 that strategic thinking with CMS.

4 So although we have a single action  
5 item on the agenda, this is -- the team here has  
6 really put together a very unique opportunity for  
7 us to think about what's missing, what can we do,  
8 how can we make the programs that aren't  
9 necessarily focused on post-acute and long-term  
10 care work better for those who are dedicated to  
11 post-acute and long-term care. And as I heard  
12 you review the agenda, I got more excited about  
13 this strategic opportunity.

14 MS. O'ROURKE: Excellent, so I think  
15 with that why don't I turn it over to Pierre for  
16 some welcoming comments and to review the  
17 Meaningful Measures Framework?

18 DR. YONG: Great, thank you to Erin,  
19 Gerri and Paul, and the rest of the NQF staff.  
20 So, very nice to see many familiar faces around  
21 the table and see some new faces as well. My  
22 name is Pierre Yong, I am the Director of the

1       Quality Measurement and Value-Based Incentives  
2       Group at CMS. And we have primary responsibility  
3       for the programs that you are talking about  
4       today.

5               And so, very happy to see you all. We  
6       weren't sure last week if we were going to be  
7       here. There's discussion, obviously, with the  
8       shutdown about, like, what would happen with MAP  
9       if we didn't actually get the continuing  
10      resolution. But luckily there was the CR that  
11      was passed, so we have a two-week reprieve. So  
12      we don't know what's going to happen at the 22nd,  
13      but, you know, wish us well.

14             But really excited about today. I  
15      think that like Paul was just saying -- and Gerri  
16      was saying earlier -- there's really a  
17      tremendous, I think, opportunity today with you  
18      in the room to really gather your thoughts about,  
19      you know, sort of, bigger picture strategic  
20      thinking relative to the PAC programs. And so,  
21      you know, there are a number of CMS staff here in  
22      the room as well as on the phone and we will be



1 here all day. So really want to take advantage  
2 of, you know, your presence here to sort of get  
3 your insightful thoughts about a variety of  
4 topics.

5 So, I apologize in advance, because I  
6 am sure many of you have actually heard this  
7 presentation before. I think by tomorrow I am  
8 going to nominate Erin to do this because I think  
9 Erin has heard this particular presentation  
10 probably like eight or nine times at this point.  
11 So, we are doing it across all the workgroups.

12 So you may have heard our  
13 administrator, Seema Verma, talk a little bit  
14 about some of the priorities that they have set  
15 forth for our work at CMS. And in particular one  
16 initiative is called Patients Over Paperwork,  
17 which really relates to sort of thinking about  
18 how we can at CMS be really supportive of the  
19 work that -- and the clinical care that is  
20 happening out across the country in a supportive  
21 way. And really sort of trying to minimize the  
22 burden as well as the -- any sort of -- how to

1 support the workflow so that we are not, sort of,  
2 interfering or getting in the way of clinical  
3 care. Because that's, I think, why we all  
4 entered healthcare in the first place, really,  
5 right? To really improve patient care.

6 So if we move to the next slide, the  
7 Meaningful Measures Framework is really a  
8 framework that we developed to really help us and  
9 think through at a strategic level, across all of  
10 our quality reporting and accountability  
11 programs, what really would be the most  
12 Meaningful Measures to focus on and include in  
13 our programs. One of the things that we've heard  
14 at prior MAPs -- but also in other settings, too  
15 -- is that we've had a proliferation of measures  
16 to be included in our program. So one, is that  
17 really helpful? Two, are those the right  
18 measures? And three, it seems like with all of  
19 those measures it is hard then to tell what  
20 really is the most important topics that we  
21 should be focusing on. What are the biggest  
22 opportunities to improve and target quality

1 improvement efforts, really, to drive quality  
2 improvement.

3 So the Meaningful Measures Framework  
4 sort of came out of all of that feedback as a way  
5 for us to think about how to focus our work. And  
6 so on this slide -- I am not going to go through  
7 everything -- are some of the sort of larger  
8 goals that we are working towards at CMS. And if  
9 you move to the next slide, please? The  
10 framework itself really has an initial set of 18  
11 Meaningful Measure areas. They are topical  
12 areas. And we will quickly go through those and  
13 welcome your feedback to see if there are any  
14 gaps or if these are the right areas and make  
15 sure they resonate with you.

16 But underpinning that there's --  
17 because those are just topical areas, there are  
18 other things we -- elements of measures that we  
19 also want to consider when we think about what  
20 are the right measures. We want to think about  
21 measures that really address high-impact areas,  
22 that safeguard public health -- which I think is

1        what the 18 initial Meaningful Measure areas  
2        really target. But we want to make sure that  
3        actual measures themselves -- because the 18  
4        areas are just topical areas, they're not the  
5        actual measures, right? So we want to make sure  
6        that the measures themselves are patient-centered  
7        and meaningful to patients and to providers, and  
8        are relevant to their care practice.

9                We have long preferred outcome  
10       measures. We've heard this, I think, from -- in  
11       many of our discussions both at the MAP and in  
12       other conversations as well. That doesn't mean  
13       that there isn't a role for process measures. It  
14       just means -- because often times there's not an  
15       outcome measure available for a particular  
16       quality area. But it means that if there are  
17       outcome measures, that those probably are the  
18       preference. Burden is something we talked a  
19       little bit about earlier, but particularly  
20       looking at the level of burden associated with  
21       collecting data, reporting data, reviewing data -  
22       - all of that is -- is another factor that we are

1 considering.

2 We want to look for opportunities for  
3 improvement, so you know if a measure is topped  
4 out, if everybody is performing it at 100  
5 percent, then is there really a point to  
6 including it? Not to say it may not be important  
7 -- we had a whole discussion yesterday about,  
8 like, the role of -- at the Clinician Workgroup,  
9 the role of safe surgery checklists --- where  
10 most everybody is doing it already.

11 But is there still opportunity for  
12 improvement, particularly in programs which are  
13 really supposed to drive quality. And in  
14 particular when you're moving to value-based  
15 purchasing programs where you're then trying to  
16 determine payments based on performance, if  
17 everybody is performing the same, I think it  
18 becomes very much harder to then differentiate  
19 between performance amongst providers.

20 We want to address measure needs that  
21 really help sort of move towards population-based  
22 payment through alternative payment models. And

1       then alignment is really another key  
2       consideration -- not just within and across our  
3       PAC programs, for example, with the IMPACT  
4       measures -- but really within CMS programs, for  
5       example with Medicaid. And then a lot of the  
6       work we are doing with commercial payers through  
7       the Core Measures Collaborative. Can we move to  
8       the next slide, please?

9               This just identifies some of the  
10       sources -- key sources -- that we drew upon when  
11       we were developing this initial framework and  
12       included the NQF work, of course, so -- if you  
13       move to the next slide. This graphic for those  
14       familiar with it is from the LAN, the Learning  
15       and Action Network, white paper -- population  
16       health white paper on measurement. If you look  
17       on the right side, what they have conceptualized  
18       nicely are these atomistic performance measures  
19       on the bottom of the slide. And you can think of  
20       those as any of the individual measures that we  
21       have in our programs, what they've termed little  
22       dots, or level-three dots. And really encouraged

1 us to really move towards really level-one and  
2 level-two dots -- or, big dots, excuse me, level  
3 one and level two -- which really are these  
4 larger sort of performance measures.

5 And so what we thought -- we thought  
6 this was really helpful and helped us think about  
7 how to develop the framework as we think the  
8 Meaningful Measure areas are really more of these  
9 level-one, level-two areas that we want to focus  
10 on. They're not actual measures, as I mentioned  
11 before. So if you move to the next slide.

12 This is -- these are the initial set  
13 of the 18 that I mentioned. I will quickly  
14 review them. They are grouped into six domains  
15 and they are supported by these sort of cross-  
16 cutting considerations that we think are really  
17 important to consider regardless of whether,  
18 which domain you are in and which specific  
19 Meaningful Measure area. So, elimination of  
20 disparities, tracked and measurable outcomes,  
21 safeguarding public health, achieving cost  
22 savings, improving access for rural communities

1 and reducing burden.

2           So if you move to the next slide, the  
3 first domain is about safety. And here we have  
4 two Meaningful Measure areas -- the first being  
5 healthcare-associated infections and the second  
6 being preventable healthcare harm. On the right  
7 side of the slide -- and I know it's a little bit  
8 busy and we won't go through all the details,  
9 though I am happy to answer any questions if  
10 folks have them -- are these more level-three  
11 dots. And we've been starting to think about how  
12 we can use this in our program. So one way is  
13 sort of looking across our measures in our  
14 programs and seeing, do we already have measures  
15 in -- associated that track to this particular  
16 Meaningful Measure area.

17           For the first example, healthcare-  
18 associated infections, where we have the CLABSI  
19 measure, the central line-associated bloodstream  
20 infection measure which we have in several of our  
21 programs including some of the PAC programs. So  
22 you can see how we already have measures that



1 track to each individual Meaningful Measure area.  
2 If you move to the next slide.

3 The next domain is strengthening  
4 person and family engagement. Here we have  
5 Meaningful Measure areas including care that is  
6 personalized and aligned with the patient's  
7 goals, end-of-life care according to preferences  
8 and patient's experience and functional outcomes.  
9 And I am not going to go through the details of  
10 each slide in the interest of time, so we can  
11 maximize time for feedback and discussion. So if  
12 you move to the next slide, please.

13 The third area is promoting effective  
14 communication and coordination of care. And here  
15 we have medication management, admission and re-  
16 admissions to hospitals, and seamless transfer of  
17 health information. If you move to the next  
18 slide is -- the next domain is promoting  
19 effective prevention and treatment of chronic  
20 disease. And here we have a large number of  
21 Meaningful Measure areas given the scope of the  
22 larger domain. But here we have preventive care,

1 management of chronic conditions, prevention,  
2 treatment and management of mental health,  
3 prevention and treatment of opioid and substance  
4 use disorders, and risk-adjusted mortality.

5 If you move to the next slide, here  
6 this next domain is around working with  
7 communities to promote best practices of healthy  
8 living. And here we have equity of care as well  
9 as community engagement. And I wanted to pause a  
10 second on equity of care because I think you can  
11 think about it in a couple of different ways.  
12 But equity of care in particular, I think, could  
13 be measures around equity of care. But we've  
14 been thinking about it a little bit more broadly  
15 than that, as not just measures, because I think  
16 at CMS in particular we have several policy  
17 levers that we can use, for example.

18 So the folks that are familiar with  
19 the Hospital Readmissions Reduction Program may  
20 have -- know that this past year we have  
21 restructured the program moving forward so that  
22 we are actually assessing performance based on a

1 stratification model. So we are comparing  
2 hospitals to other hospitals based on proportions  
3 of dual-eligibles that they care for. So there  
4 is a stratification approach, which is more on  
5 the payment side as opposed to an actual measure.  
6 So we think of this as -- the equity of care  
7 Meaningful Measure areas as broader than  
8 measures, per se, is I think the larger point.

9 So if you move to the next slide --  
10 making care affordable is the next domain. And  
11 here we have appropriate use of healthcare,  
12 patient-focused episode of care, and risk-  
13 adjusted total cost of care. Move to the next  
14 slide. I think -- as we've been doing and had  
15 the opportunity to do a number of presentations  
16 about this, which -- in particular, I think the  
17 feedback and the questions have been particularly  
18 helpful. I think a couple of common questions  
19 have come up that I just wanted to address  
20 quickly.

21 One, I think there's -- folks have  
22 asked if this is new sort of quality reporting

1 program, and I think folks hopefully understand  
2 it's not a quality reporting program. It's  
3 really an overarching strategy for how we think  
4 about quality and quality measures and quality  
5 improvement at CMS. It doesn't by itself impose  
6 any new reporting requirements or new measures  
7 that people have to report. That's not -- it  
8 really is a strategy -- an overarching umbrella  
9 strategy for us to think about quality  
10 measurement and improvement at CMS.

11 One question is sort of -- or, two  
12 related questions, maybe, are one, how will it be  
13 used? And two, how will it actually reduce  
14 burden for me as, you know, either clinician or  
15 facility? And I think those are related  
16 questions. So we've been really trying to get a  
17 lot of stakeholder input, and so welcome that  
18 discussion today. I think we've already started  
19 to think about how this could apply to the  
20 various quality-related activities at CMS. So  
21 we've applied it, for example, to the MUC list.  
22 And you can -- you've noticed that you have only

1 one measure on the MUC list and that is, I think  
2 can be traced to sort of application of the  
3 framework as we review the MUC list.

4 And that's been true across the  
5 workgroups. I mean, we've -- on the MUC list we  
6 took less than a quarter of actually the total  
7 submissions for this past year. So we've really  
8 tried to focus on what we really think would be  
9 the most Meaningful Measures to potentially  
10 include in our programs, to include on the MUC  
11 list.

12 We've also started to think about how  
13 we can apply this as we look at the existing  
14 measures in our programs. So -- and this means  
15 across all of our programs. It's all the PAC  
16 programs, clinician program, the hospital  
17 programs -- I mean, there's 17 programs in total  
18 that we're working on. So later on the agenda we  
19 will have a discussion which we are hoping to get  
20 your feedback on, and we're having across the  
21 workgroups as well, about getting your thoughts  
22 on the criteria we should be using to think about

1       measure removals as we continue to evaluate these  
2       measure sets across the program. So, I think  
3       that's another way we've been thinking about  
4       using the framework.

5               And I think a third is sort of -- as  
6       we've been thinking and looking through the  
7       measure sets, obviously gaps appear. And I know  
8       that's a big point of discussion that we will  
9       talk about today. So I think this also then  
10      feeds into measure development work, right? So  
11      what are the right measures we should be working  
12      on. And so I think those are some key areas. I  
13      will say, it's not being only applied on the  
14      quality measure space of the quality reporting  
15      programs. We've also been working really closely  
16      with our colleagues who work in the quality  
17      improvement space, for example, so those of you  
18      who know Dennis Wagner and Jeneen Iwugo, Paul  
19      McGann who head our quality improvement work in  
20      the QIN-QIO work, for example, partnership with  
21      patients. So they have also been working really  
22      closely with us on thinking through how we apply

1       this framework in terms of their work because  
2       they really go hand in hand. We've also been  
3       working with our colleagues in the Medicaid space  
4       as well, for example.

5               And I think through that as we sort of  
6       review the measure sets and then think through  
7       measure development, I think that's where  
8       hopefully we will see -- and where providers will  
9       then see how -- where the implications for burden  
10      will take place. Because as we potentially make  
11      changes to program requirements, those will go  
12      through our normal rulemaking cycle. So it will  
13      be proposed and then we will seek public comment  
14      and finalize in the next rule cycle. So I think  
15      that's where folks will see some proposals  
16      relating to this in next year's rule cycle.

17             So if you move to the next slide,  
18      that's, I think, all I have in terms of the  
19      presentation. So I am going to stop here, but  
20      really do welcome any sort of feedback or  
21      questions, clarifications, from folks here.

22             CO-CHAIR LAMB: Thanks, Pierre.

1 Pierre, you're going to be with us the whole day?

2 DR. YONG: Yes, I will be at the  
3 table, in and out, yes.

4 CO-CHAIR LAMB: Okay, great. So,  
5 thank you for a wonderful foundation for our  
6 discussion. I think Meaningful Measures gives us  
7 a frame to move forward. So, comments?  
8 Recommendations? Caroline?

9 MEMBER FIFE: Caroline Fife. If you  
10 want to know why this won't work under MIPS for  
11 clinicians, I will be glad to tell you. Probably  
12 not so relevant to the organization here, but if  
13 you want to see my scars from running a QCDR, I  
14 will be glad to show you outside.

15 CO-CHAIR LAMB: Raj?

16 MEMBER MAHAJAN: So, I have a very  
17 foundational question, and it's really three  
18 words here. I understand why those came up, but  
19 who and how was this done? Because almost -- it  
20 looked like came out of nowhere -- the whole  
21 Meaningful -- because we were working on adding  
22 more measures and making it more burdensome,



1 again -- I'm just -- as I said, I am being a  
2 little cynical here, too. But is there more? I  
3 mean, and you're right, this is the ninth time I  
4 am hearing this presentation. But is there more  
5 material on the granularity of how this work was  
6 developed? What feedback? Whose feedback went  
7 there? Was there some evidence used, or --

8 I just want to see -- it just looks  
9 like it came out of nowhere and then maybe with  
10 change of leadership will go away and we'll go  
11 back to where we were. I'm just kind of --  
12 little concerned, or just raising this question.

13 DR. YONG: Yes, thank you, Raj. So I  
14 don't think it came out of nowhere. So if you go  
15 back to a couple -- I didn't go into details, so  
16 if you go back a couple slides. Keep on going.  
17 There's been a lot of work done out by a number  
18 of a bodies -- keep on going, one more. One  
19 more. Thank you. Both -- across sort of -- in  
20 different sort of bodies of work. So there's  
21 been a lot of work done by the Health Care  
22 Payment Learning and Action Network. I

1 referenced that diagram that came from the  
2 Population Health white paper that talked about  
3 this and had some suggestions. National Quality  
4 Forum is actually doing a lot of strategic work  
5 around sort of, you know, a similar concept. So  
6 that sort of came into play. The National  
7 Academy of Medicine last year put out the Vital  
8 Signs Core Metrics Report. So we drew on that.  
9 There's been a lot of work at the Core Measures  
10 Collaborative.

11 So there's been a lot of work at  
12 different bodies of work that sort of -- and  
13 there have been a lot of discussions. We've had  
14 this discussion at various MAP Workgroup  
15 meetings, too. So we reviewed all of that  
16 material and certainly took that material in  
17 order to develop this. So I don't -- so we drew  
18 on a lot of sources to come up to this. So I  
19 don't -- hopefully it's -- while it is a -- new  
20 for CMS, or at least -- framework per se, it  
21 draws on a lot of existing sources which I think  
22 overlap pretty well.

1                   MEMBER MAHAJAN: You know, I just --  
2                   thank you for that. And as I said, I completely  
3                   understand why and we welcome this.

4                   CO-CHAIR LAMB: A thought here is, you  
5                   know, as we look at the six domains, okay, it  
6                   doesn't seem in my mind that there's any question  
7                   about their relevance to PAC long-term care. So  
8                   I am thinking to kind of use this foundationally  
9                   and keep looping back as we go through each of  
10                  our areas to take a look at how can we inform the  
11                  play-out of the Meaningful Measures? My  
12                  understanding is that from what Pierre is saying  
13                  where, you know, the focus is on the level one  
14                  and two. And I think we have the expertise in  
15                  the room to take a look at what is meaningful  
16                  level one and two for PAC long-term care? And  
17                  get that into the dialogue.

18                  The other question I would have for  
19                  Pierre is as -- and he has heard me say this  
20                  before on some of the webinars -- is as we move  
21                  to a healthcare system that reflects all of our  
22                  perspectives, all of the diverse perspectives of

1 all of the professionals, all the community  
2 workers, all the lay workers in healthcare, how  
3 do we bring them into this dialogue? It strikes  
4 me that the framework -- and it may just be an  
5 initial choice of words -- but it focuses on a  
6 particular component -- physician payment,  
7 physician practice -- which is, my guess, is not  
8 the full intent of the framework. But as we move  
9 towards representing that the healthcare system  
10 is pretty complex, has lots of players -- we now  
11 have a National Center on Interprofessional  
12 Practice and Education that's looking at that.  
13 Pierre, is -- has there been any thought about  
14 how to get all of these voices into this and  
15 engaged?

16 DR. YONG: Thanks, Gerri, and I think  
17 that's a great question. I mean, I think we are  
18 -- we've gotten many, many requests to sort of  
19 talk about the framework, to -- so that people  
20 can one, understand it, but two, also to get  
21 feedback on it. I think you have a great point  
22 that, you know, the healthcare system is very

1 complex. And there's many folks who may not be  
2 represented on the MAP, for example, that, you  
3 know, may have relevant input to provide. And so  
4 we are doing our best to sort of reach out to  
5 folks. Like, we had a national webinar. We had  
6 over 4,000 people on this webinar. And maybe  
7 some of you had attended -- it was the same  
8 presentation. There was nothing new on that.

9 But -- so we've been doing a lot of  
10 work trying to get that input. And I think it's  
11 an initial draft, right? I mean, it's not final  
12 and it -- we haven't -- I hope you didn't hear  
13 from me that it was final. It is an initial sort  
14 of stake in the sand, if you will. And so we are  
15 taking this input and we have been discussing  
16 internally about, you know, potential changes  
17 that we might want to make to tweak and improve  
18 the framework. But we do hope that folks can see  
19 that there's utility to the framework. And I  
20 think it's something that as we move forward,  
21 particularly with, you know, rulemaking next  
22 year, I think you'll see some -- how we start to

1       apply the framework in much more concrete ways.

2                   CO-CHAIR MULHAUSEN:   So, this is my  
3       third time through this, Pierre, and I actually -  
4       - it's starting to fall together for me.   And  
5       when I look at the infographics, I can see how it  
6       supports the National Quality Strategy.   It makes  
7       sense to me.   There are a couple of things that I  
8       react to.   And I honestly am not sure how  
9       constructive this reaction is.   But I spend a lot  
10      of time with physician colleagues and I have  
11      listened for years to them complain about the  
12      Meaningful Use Program.   And that was always our  
13      example of high burden, low meaning reporting  
14      requirements.

15                   And when I look at this I go, this is  
16      a response to the Meaningful Use reaction.   And I  
17      -- and that reaction to that reaction -- which is  
18      all in my head, I have no idea if it was driven  
19      centrally at all -- is that it strikes me as -- I  
20      view it optically as a move to push things back.  
21      And I am not sure I mind if you want -- if CMS  
22      wants to push things back on the issues about

1       advancing care information -- whatever that  
2       category is in MIPS -- but I get concerned, I  
3       think, to some extent that it's part of a broader  
4       agenda to role back quality measure -- and I am  
5       not sure the problems we had as a practitioner  
6       community with the Meaningful Use Program are the  
7       same issues in the other domains of quality. And  
8       I just want to reflect on that reaction that I  
9       have, and it comes from the language. And I  
10      don't -- the language is where it is, but that is  
11      how I react to it.

12               And then the second challenge I am  
13      faced with -- so, if we can go to the slide that  
14      shows the healthcare-acquired infections. So I  
15      really love this idea of rolling -- not useless -  
16      - measures that may feel less valuable into  
17      something that feels more valuable. But I think  
18      one of the goals is to reduce reporting burden,  
19      right? And I love the idea of using this  
20      framework to winnow out measures.

21               But when I look at this one,  
22      healthcare-acquired infections, and the granular

1 examples that are provided there, they are all  
2 healthcare-acquired infections that I've still  
3 got to keep track of. Now, if the intent is to  
4 roll that up into one consolidated measure, then  
5 I don't see how this works well for reducing  
6 reporting burden. If however the framework is  
7 used to create level three, level two measures  
8 that you look at in the whole list of the  
9 reporting program and go, this doesn't fit  
10 anywhere in our priority scheme and so let's  
11 winnow them, then I think I can see how this  
12 potentially works well.

13           And then a third thing I had -- I also  
14 react to this a little bit. I think CMS has been  
15 very conscientious about trying to produce  
16 measures that are meaningful. So I had the  
17 privilege of being very involved in the Physician  
18 Quality Reporting initiative and the generation  
19 of measures. And literally the way those  
20 measures were generated was to go to each  
21 specialty society and say what are measures that  
22 we should be doing for your specialty area? Now



1       admittedly, you go to every specialty area and  
2       end up with way too many measures. But it was  
3       each discipline said this is meaningful to us,  
4       this is where we would like to go.

5               And I'm -- to some extent I want to  
6       support that from my world view, CMS has been  
7       working very hard even before this initiative to  
8       try to create something that's relatively  
9       important, of value, and to me there's a lot of  
10      potential traction here for harmonization across  
11      payers as opposed to redefining the quality  
12      strategy. So, observations that I hope are  
13      helpful and maybe even an opportunity for you to  
14      reflect.

15             DR. YONG: Thanks, really appreciate  
16      those comments Paul and I think there are some  
17      great thoughts in there. So I will sort of give  
18      you some initial reactions and then Alan may have  
19      some additional thoughts to add on.

20             So I think the issue that you are  
21      bringing up about sort of how are we going to  
22      roll up into, like, single measures? I think the

1 goal here really is to use this framework to  
2 really get to, for each of our programs really  
3 the most parsimonious, most meaningful if you  
4 will, measure set for that particular program  
5 that meets the needs of that particular provider  
6 or clinician group that -- with -- that has the  
7 most minimal burden that seems -- you know, most  
8 minimal burden. So each program will still  
9 exist.

10 So each program will still have its  
11 own measure sets and needs to have measures that  
12 are applicable and specified for that particular  
13 facility, so whether it's an IRF or an acute care  
14 hospital, right, they're not going to -- the  
15 specs won't be exactly the same because they're  
16 different patient populations. So each measure  
17 still needs to be applicable to that individual  
18 program. So -- because there has been some  
19 thought, you know, if you look at the LAN white  
20 paper, for example, that they want -- they would  
21 like to move to really broad population health-  
22 based measures, which is sort of I think what you

1       were asking about. I think there is some -- you  
2       know, that's something worth discussing.

3               I think in the construct of the way  
4       our programs are constructed, that's a little bit  
5       hard to do right now, right? Because again, we  
6       have individual programs that have individual  
7       measures and so -- and those measures -- those  
8       facilities need to know which measures they need  
9       to report. So I think that's sort of -- right  
10      now we are looking at this in terms of our  
11      existing measure sets and really trying to focus  
12      on what is -- what should we be keeping versus  
13      what potentially might not be really helpful in  
14      driving improvement, right.

15             So hopefully that helps provide a  
16      little bit more context. I think the comment  
17      about sort of meaningful use -- I think we've  
18      gotten a little bit of this reaction. I think  
19      probably because of the meaningful term is where  
20      people reacting to. I do think we've -- we've -  
21      - we've tied a lot of talk with, you know, our  
22      colleagues around sort of meaningful use, having

1 a lot of conversations with providers and  
2 facilities as well. You know, today there's  
3 actually a -- a meeting between CMS leadership  
4 and ONC leadership to talk about sort of, you  
5 know, directions around meaningful use. And you  
6 know, we also think -- do think there's like, you  
7 know -- there's a Meaningful Measurement area  
8 around sort of transfer of health -- seamless  
9 transfer of health information. So it really  
10 does sort of address that.

11 But -- so we are thinking about this.  
12 But you're right, I think the framework itself is  
13 much broader than Meaningful Use, per se, itself.  
14 And finally, completely agree about sort of the  
15 opportunity for harmonization of pairs. It's  
16 something we hear a lot about, sort of, you know,  
17 as people are reporting not just to CMS and we  
18 realize we are not the only sort of pair with  
19 reporting requirements -- that folks are also  
20 reporting to other private pairs and to their  
21 states and to other initiatives. And so that  
22 there's a real opportunity for us to continue the

1 work that we've started with the Core Measures  
2 Collaborative around trying to sort of align  
3 measures for use across quality reporting  
4 programs -- across pairs. So hopefully that's  
5 helpful.

6 MEMBER LEVITT: Thank you -- thank  
7 you, Pierre. And again, these are really great  
8 comments that are being made -- and things that  
9 we have been thinking about ourselves. You know,  
10 we are all quality people. I guess that's why  
11 you're all thinking in your head of the  
12 unintended consequences of, you know, what would  
13 be done. And we think of those unintended  
14 consequences as well.

15 You're quality people, we're quality  
16 people. We need to look at the quality of our  
17 programs and the measures within our programs.  
18 We should always, you know, be doing this. This  
19 is a -- you know, a -- a certainly a strategy  
20 that every program should be doing as they  
21 continue to grow and develop. We -- to give you  
22 an example of, you know, what has been done again

1 with kind of this idea in mind, you remember what  
2 happened in Home Health two years ago where we  
3 reviewed the measure set and we moved 34 total  
4 measures -- six from the Home Health Quality  
5 Reporting Program.

6 Again, with some of this criteria. I  
7 mean, we're trying to develop measures that are  
8 meaningful for a particular program. They may be  
9 meaningful in one program, they may not be as  
10 Meaningful in other programs. Infection idea,  
11 you know, again the -- the devil is always in the  
12 details in terms of, you know, what the  
13 specifications are in the measure and then what  
14 is the goal of that measure? And how is it  
15 turned out in terms of how easy it is for the  
16 data to come in.

17 And so there are so many factors that  
18 are really involved in deciding about a measure  
19 that we -- we should be thinking about. So from  
20 the program standpoint, when we hear these things  
21 -- we actually embrace this because, you know, we  
22 are quality people, and we need to really look at

1 the quality of our measures and our programs.

2 CO-CHAIR LAMB: Gene?

3 MEMBER NUCCIO: Yes, thank you. Could  
4 you put the -- the big wheel slide on there, I  
5 think? Yes, right there.

6 First, when I hear the term meaningful  
7 use I -- I want to add that the next two words  
8 which is, to whom? Meaningful use to whom?  
9 Patients have one set of meaningful uses. Payers  
10 have a different set of meaningful uses.  
11 Providers have a third set of meaningful uses.  
12 And I think, if we don't take into consideration  
13 those three primary recipients of our -- of our  
14 work, we are missing what we're trying to do in  
15 terms of either selecting new measures for  
16 inclusion, be it at level two -- or I don't think  
17 anyone argues with level one -- better health.  
18 How could one really argue with better health?  
19 But it's certainly at the level two.

20 And then I -- Pierre, I wanted to  
21 thank you guys for creating what I want to call  
22 the de-MUC list.

1 (Laughter.)

2 MEMBER NUCCIO: That -- that maybe  
3 next year we'll have a list of, you know, 30 or  
4 40 items that we de-MUC. The -- the other thing  
5 that -- that strikes me from the list that -- and  
6 it perhaps is a different slide that we had over  
7 here -- that you presented. But it has to do  
8 with the types of measures that we're  
9 considering. As we move to this level two kind  
10 of measure, it seems quite clear that process  
11 measures are not very effective because they're  
12 virtually all topped out. You know, which --  
13 it's rewarding everybody for doing what they  
14 should be doing anyway. And -- and -- and so,  
15 you know, the emphasis on outcomes.

16 But the -- the -- implicit in that,  
17 and you use the word in some of the slides, is  
18 the word improvement. And clearly I know in the  
19 world of home health we've heard the word  
20 maintenance. That is, it's important to keep  
21 patients from requiring more extensive and  
22 expensive care. And so we should begin thinking



1 about maintenance kind of measures. You also  
2 mention in the -- in the framework here that the  
3 voice of the patient needs to be heard. And that  
4 patients before -- paperwork. The idea of  
5 promise measures would -- is obviously -- I know  
6 something that we will be talking about later on.  
7 But how you incorporate that into this issue.

8           And then finally within this framework  
9 I am finding it hard to find a content area that  
10 -- that I think is of growing interest and demand  
11 in the post-acute world. And that is dealing  
12 with psychological or mental, behavioral kinds of  
13 issues. It -- certainly Ellen knows that we've  
14 struggled to measure that effectively. And  
15 again, taking into consideration what a provider  
16 community can do to support that with limited  
17 resources. And certainly the next presentation  
18 on rural health and the dearth of support for  
19 that is something -- it's a macro issue that  
20 needs to be taken into consideration. I am sorry  
21 to sort of ramble through several things, but if  
22 you would like to comment we would be delighted

1 to hear.

2 DR. YONG: Yes, thanks Gene, I  
3 appreciate all those comments. I think you bring  
4 up some great points. I think in particular let  
5 me just address the last one in terms of the  
6 psychological, behavioral sort of quality issue,  
7 which I -- I think we agree is really important.  
8 So I think -- hopefully we -- I will point out  
9 how we thought about it in the current framework,  
10 but you can let us know and give us specific  
11 feedback if you think there are ways to make it  
12 clearer or better.

13 But you mentioned in particular sort  
14 of, you know, these macro issues and sort of,  
15 like, more community resources and stuff like  
16 that. And I think one of the cross-cutting, if  
17 you look on the slide itself on the lower left-  
18 hand side, one of the cross-cutting issues is  
19 improved access for rural communities. So I do -  
20 - so that's one way we have thought about that.

21 One of the other Meaningful Measure  
22 areas if you move forward -- two I will call out

1 in particular. Keep on going. One more. And  
2 one more. Here under the domain of the promotion  
3 of effective prevention and treatment of chronic  
4 illnesses, if you look at the third one we've  
5 called out in particular mental health. And in  
6 the fourth one we've called out in particular  
7 opioid and substance use disorders. So would ask  
8 if that sort of -- how that -- if that sort of  
9 addresses what you were pointing out or if you  
10 think there are ways we can do that differently.  
11 And if you move to the next slide, I'd point out  
12 the last one was the equity of care issue, which  
13 again is related to more of a macro issue as  
14 well, so.

15 MEMBER NUCCIO: That -- I will defer.

16 CO-CHAIR LAMB: Okay. And then we  
17 will come back to that. But let's hold that  
18 thought in terms of representing key areas back  
19 as we go through the different areas. Okay.  
20 Robyn, I noticed that you had your card up. Did  
21 you want to say anything or you want to keep  
22 moving, or -- keep moving? Okay. And Caroline?

1                   MEMBER FIFE: So the problem is that  
2                   under MIPS physicians pick any six measures that  
3                   they wish to report. I've been running a  
4                   qualified clinical data registry or -- before  
5                   that a PQRI -- PQRS, before that a PQRI registry  
6                   -- since 2008. And so physicians pick the six  
7                   measures that give them the highest score. That  
8                   means that I can report BMI and follow-up, or I  
9                   could do a promise measure, which costs me money.  
10                  And I could also report a QCDR measures, which  
11                  are very specific to my specialty -- which are  
12                  expensive and have a very high burden, but would  
13                  give you a very clear window on whether I  
14                  actually do things that are relevant to the needs  
15                  of my patients.

16                  The more work I do in order to show  
17                  you how good of a job I actually do, the more  
18                  burden and cost I have on myself and the lower my  
19                  score will be. Because I can actually get  
20                  through MIPS very well with a high score by using  
21                  topped-out, old PQRS, now MIPS, measures creating  
22                  zero incentive for me to do any of those things.

1 As a result, I game the system by reporting  
2 measures that are easy, that have no relevance  
3 whatsoever to my practice -- and so does  
4 everybody else. And that's the reason it doesn't  
5 work under MIPS.

6 It can work in these other sites of  
7 care where there is a defined group of measures  
8 that they all have to report. But under MIPS it  
9 cannot work. And then to make it more bizarre,  
10 under the QCDR system, if you do have a group of  
11 clinicians who are ridiculous enough to want to  
12 report measures that are very specific to their  
13 specialty, then they are reporting the measures  
14 they do well at and then next year CMS rejects  
15 those measures because their passing rate is too  
16 high. They are then, those measures, topped out.

17 When the docs who are -- did poorly on  
18 them didn't report them, which means there's a  
19 huge gap in practice for the non-reporters, and  
20 the only ones that don't have a gap in practice  
21 are the ones who did report. But you just lost  
22 measure because the ones who did report are of

1 course the ones who did well. So you lose the  
2 process or outcomes measures that you're  
3 successful at, which means, there's actually no  
4 reason to run a QCDR at all because the system is  
5 entirely designed so that only people who do well  
6 at a measure will actually pass it. Besides  
7 which, you have to report the measure for three  
8 years before you can get a decile score for it,  
9 which actually helps you with your outcome  
10 anyway.

11 So the whole thing is designed in  
12 order to use measures that are irrelevant to your  
13 practice, which you do really well at, which have  
14 no relevance whatsoever to anything that you  
15 actually do. So, if you want the rest of the  
16 story about why this is not working under MIPS,  
17 please see me after class.

18 (Laughter.)

19 DR. YONG: There's more, Caroline?

20 (Laughter.)

21 DR. YONG: No -- but, yes. I think  
22 yet, MIPS has unique challenges that are

1 different because of the way MIPS is structured.

2 And so totally ---

3 (Simultaneous speaking.)

4 MEMBER FIFE: Yes, and those of us who  
5 really want to drive quality forward would -- we  
6 really want to see changes.

7 DR. YONG: Yes.

8 MEMBER FIFE: But, you know ---

9 DR. YONG: Of course, there's the  
10 other extreme which MedPAC is considering, right,  
11 which is just complete -- no choice at all and  
12 just moving towards ---

13 MEMBER FIFE: Yes.

14 DR. YONG: Like, root-based, you know,  
15 reporting on -- or actually, no reporting  
16 actually, right?

17 MEMBER FIFE: Yes.

18 DR. YONG: For population health based  
19 -- claims-based measures. So that's another  
20 extreme that they're probably --

21 (Simultaneous speaking.)

22 MEMBER FIFE: But I think

1 philosophically, the other thing that troubles me  
2 -- and everyone else has touched on this -- is  
3 that I -- I get it that everybody wants one ring  
4 to rule them all. But there must be somehow,  
5 some quality thing that is just going to be so  
6 fabulous that it's going to tell us whether  
7 you're a good orthopedist or a good cardiologist or  
8 a good obstetrician, but it doesn't work that way  
9 because what is quality for a cardiologist is  
10 truly going to be different for orthopedic. So  
11 the concept somehow that we're going to have  
12 these massive, overarching measures -- you know,  
13 I take care of people that have non-healing  
14 chronic wounds. I just want to do a shout-out  
15 for some process measures because they're not  
16 tic-box measures.

17           When we -- some of our process  
18 measures, like nutritional screening, we have to  
19 do follow-up on that. And we just evaluated the  
20 Medicare five-percent data set and found that CMS  
21 in 2014 spent \$96 billion on non-healing wounds.  
22 And most of them are related to poor nutrition.



1 And yet this year CMS decided to reject our  
2 nutritional screening measure. Well, what am I  
3 supposed to do with that?

4 So, you know, it is a tremendous  
5 problem trying to raise the bar on practice when  
6 you know that a specific thing is linked to a  
7 certain problem and you can't get paid for doing  
8 a better job, and nobody seems to like your way  
9 to target specific things you know would do  
10 better. It's just damnably frustrating.

11 CO-CHAIR LAMB: Thanks. Jim?

12 MEMBER LETT: Oh, thank you. Would  
13 you run it back to the large Meaningful Measures  
14 slide, please? What -- as I look at -- and this  
15 is a wonderful graphic. As I look at all the  
16 areas that are meaningful -- and I agree, they  
17 are, what I am -- I am really not seeing there  
18 and I would like you to consider -- and maybe  
19 this is a gap discussion -- at the top of the  
20 blue centered wheel it says improved CMS customer  
21 satisfaction. I would like to see that expanded  
22 to not just patients. And I -- just patients

1 sounds a little pejorative. Didn't mean it that  
2 way.

3 But your customers also include  
4 bedside nurses, CNAs at the nursing home,  
5 physician, NPs, PAs. And I would love to see a  
6 Meaningful Measure by CMS that actually measures  
7 their relevance and their utilization to the  
8 actual bedside caregivers. Because if we -- if  
9 you -- all of us are going to create a meaningful  
10 healthcare system, everybody has to be included.  
11 And everybody needs to feel that they can impact  
12 the system and that the system works for them.

13 At this point we are facing a huge  
14 workforce issue in post-acute care in geriatrics.  
15 And why is that? I am not smart enough to know  
16 it all. I know AGS has done some terrific work  
17 on it and AMDA is as well. But there's a lot of  
18 dissatisfaction by caregivers all the way from  
19 the top of the chain through everybody that  
20 touches the patient. And I would encourage CMS  
21 to seek out the satisfaction from those people --  
22 if they are not satisfied, try to discern why

1       that is and make some meaningful changes in an  
2       attempt to get everybody engaged into the system.  
3       Thank you.

4               MEMBER MAHAJAN: I just want to echo  
5       Caroline and -- so, for us -- for -- and you --  
6       you guys have heard us speak. For over four  
7       years we've been talking about having Meaningful  
8       Measures and how practitioners in post-acute,  
9       long-term care struggles with the way things  
10      stand with MIPS. We have it broken down from our  
11      users data, and the most commonly used measure by  
12      a nursing home doctor is sinusitis measure and --  
13      because that's how you score the most.

14             So -- so we are extremely excited for  
15      this opportunity to have Meaningful Measures  
16      developed that -- that align between different  
17      system, different pairs and health care setup.  
18      So thank you.

19             MEMBER FIFE: You could lose your hair  
20      over QCDR measures. They're terrible.

21             MEMBER MAHAJAN: I mean, I don't have  
22      any more opportunity, but ---

1 (Laughter.)

2 MEMBER MAHAJAN: But thank you for --  
3 for bringing that up. Anybody has Zoloft, I will  
4 take that. And -- and just on -- on being  
5 comical, Meaningful Use became Advanced Care --  
6 Advanced Care Planning for us. So most other  
7 people still confuse with Advancing Care  
8 Information to Advanced Care Planning, which is  
9 really relevant for us and -- and it's just -- I  
10 think terminology and word selection has been  
11 such a confusing alphabet soup. So it just --  
12 it's getting -- yes.

13 CO-CHAIR LAMB: Thanks for all the  
14 questions and -- and the comments. This is just  
15 the start. I think that Erin and the NQF team  
16 here are keeping notes about everybody's  
17 comments. I am going to invite that those of you  
18 who have not felt the need to comment yet -- we  
19 know that nobody in this room is shy. So when  
20 the spirit moves you, please do. We are going to  
21 move on and we will use the same process of, you  
22 know, having the presentation and then

1       commenting. I think we are beginning to gather  
2       information about how to bring together PAC Long-  
3       Term Care into the current strategic environment.  
4       So, Erin, you want to move on?

5               MS. O'ROURKE: Excellent, so I think  
6       with that I am going to turn it over to Karen to  
7       share a bit about our new rural health work.

8               (Pause.)

9               MS. JOHNSON: Good morning, everyone.  
10       My name is Karen Johnson. I am one of the senior  
11       directors here at NQF and I am really excited to  
12       present our new work on rural MAP to you guys.  
13       So I have quite a bit -- quite a few slides that  
14       are giving some background. I am going to try to  
15       kind of go through those really quickly because  
16       it sounds like you guys have a lot to talk about,  
17       and I would rather get to the discussion points.  
18       So let me just start with background.

19               So we got into the rural health world,  
20       if you will, a couple years ago when we were  
21       funded by CMS with help from HRSA to do a project  
22       looking at challenges and hopefully

1 recommendations on performance measurement issues  
2 for rural providers. So they wanted us to talk  
3 about the challenges of measurement for these  
4 folks and put forward some recommendations on how  
5 to address those challenges.

6 And it was -- we stoked this project  
7 in a few ways. First of all to really think  
8 about CMS P4P type programs. We included a lot  
9 of rural providers who do not actually  
10 participate in these programs. So rural health  
11 centers, often critical-access hospitals -- they  
12 can do some of the work in a voluntary basis --  
13 also FQHCs. So those guys are paid differently  
14 and therefore are not mandated to participate in  
15 a lot of those programs. Finally, we also had  
16 scoped it mainly for primary care look at mostly  
17 hospital and out-patient.

18 So some of the issues regarding  
19 measurement challenges -- these -- first of all,  
20 you know, they're kind of obvious. But they  
21 really actually make a huge impact on  
22 measurement. And they do not -- they are very

1 much inter-related. So geographic isolation can  
2 impact measurement in a lot of ways -- things  
3 like transportation problems and how does that  
4 reflect on measures? IT capability, shortage of  
5 staff -- all of these kinds of things are  
6 problems if you are isolated.

7 Small practice -- often people who are  
8 isolated have small practices, but other people  
9 do too. And it doesn't always work both ways.  
10 But when you're -- when you're a small practice  
11 you have fewer resources for things like  
12 reporting measures, right? For things like doing  
13 QI even if you are reporting measures. So you  
14 have that going on. So that is a real problem.  
15 You also have the -- kind of also the possibility  
16 that some services just aren't offered. So some  
17 of the measures just don't even apply, right? So  
18 small practice size -- definitely a challenge.

19 Heterogeneity -- to that we're -- it's  
20 in settings as well as patient populations. So  
21 people who are older in general live in rural  
22 areas. But not always, right? People often are

1 more socially disadvantaged, but not always. So  
2 all of these things really can make measurement  
3 challenging, particularly when you start thinking  
4 about risk adjustment and things like that. How  
5 do you do that and make things fair? Finally,  
6 low-case volume speaks to reliability and  
7 validity of measurement and even being able to  
8 participate and use the measures that are  
9 included in certain programs.

10 So those are the challenges. So what  
11 did this group do about it? Well, they actually  
12 made a quite surprising overarching  
13 recommendation, and that is that they would like  
14 to see all rural providers brought into the CMS  
15 fold and be included in these programs. So they  
16 -- they were looking for mandatory participation  
17 in programs. A lot of that had to do with this  
18 idea of they don't want to be left behind. Many  
19 rural providers are very proud of what they do.  
20 They feel like they do a really good job. And  
21 they want to be able to demonstrate that to, you  
22 know, their residents as well as others.



1                   But along with this mandatory  
2 participation, a realization that many of these  
3 folks have never participated in these kinds of  
4 programs, so there needs to be some kind of  
5 phased approach, and you really need to make sure  
6 that you're considering low case volume. There  
7 were many supporting recommendations for --  
8 that, you know, kind of support that overarching  
9 recommendation. And the ones listed on this  
10 slide are the ones that were specifically  
11 recommendations about measure selection. So you  
12 will notice that last bullet there is create a  
13 Measure Applications Partnership workgroup to  
14 advise CMS on this selection of measures.

15                   So we are extremely excited that CMS  
16 has taken that committee's recommendation and has  
17 formed a Rural Health Workgroup. So -- and  
18 that's what I will be talking to you about today.  
19 But other things that they did as part of their  
20 recommendations a couple years ago was provide  
21 some guiding principles for selecting measures  
22 into programs and a couple other guiding

1 principles were really to utilize -- or,  
2 identify, really, core sets of measures and then  
3 also have a menu of optional measures for rural  
4 providers.

5           So the idea is the core sets should be  
6 used -- they should be measures that really work  
7 for most providers and most patients. And then  
8 you have optional ones that work, you know, maybe  
9 if you are a hospital that, you know, doesn't  
10 have an ICU, well there should be measures that  
11 you -- you know, you shouldn't be forced to do  
12 the ICU measures because they don't work for you.  
13 But there should be other things that -- that  
14 would work. And then of course, don't forget  
15 patients in a medical home models when -- when  
16 you're thinking about those things.

17           So that brings us to now, again. We  
18 have just been funded for this work. So we are a  
19 new workgroup. Again, very excited. And this  
20 year -- and we hope that we will be funded in  
21 future years -- but we are working on this year  
22 right now. We are actually going to develop a

1 set of criteria for selecting the measures. So  
2 two years ago we had guiding principles for  
3 selection. This time we are actually going to go  
4 a little further and say here are our actual  
5 criteria. And then we are going to identify core  
6 sets of the best -- what we think are the best  
7 available measures. And do the other MAP stuff  
8 that you guys are very used to -- rural relevant  
9 gaps, recommendations around alignment.

10 And then finally, we're also going to  
11 spend a little bit of time addressing some kind  
12 of a measurement topic that's relevant to rural  
13 residents. So that topic has not been decided on  
14 yet. So you guys might have some input for us on  
15 that. There will be interaction with other  
16 committees. So I get to be here today kind of  
17 introducing us. So we are going to do that for  
18 all the other workgroups. We are going to give a  
19 little bit of input to the Coordinating Committee  
20 on the measures that are on the MUC list this  
21 year -- very high-level input. And then finally  
22 in August of 2018 hopefully the Coordinating

1 Committee will take a look at what we come up  
2 with and bless that. So we will see how that  
3 goes.

4 So progress to date -- we have seated  
5 our workgroup. We have I think 25 members --  
6 well, 28 if you count our federal liaisons. Very  
7 excited -- some of the usual suspects are around  
8 the table. We also have some other folks who  
9 aren't the usual folks that show up around these  
10 tables and -- including a mail carriers  
11 association -- a rural mail carriers association,  
12 which we thought was just great. So I can give  
13 you the roster if you're interested.

14 We had our first meeting a couple  
15 weeks ago. We have another one at 1:00 today.  
16 So we are moving fast on this project. So in our  
17 November 29th call we got some initial guidance  
18 from the workgroup. Okay, we have -- we know of  
19 at least probably 1,200 measures that are out  
20 there, right? So how do you -- how do you get a  
21 core set out of 1,200 measures. I mean, this is  
22 crazy. So our first foray into is to -- let's

1 look at NQF-endorsed measures. That gives us  
2 evidence-based, which we feel is very important.  
3 And when I say we, I mean the people who are on  
4 the workgroup now as well as the folks who are on  
5 the panel from a couple years ago. So having  
6 opportunity for improvement, having a strong  
7 evidence base were very important. Those are  
8 criteria that we look at for endorsement. So NQF  
9 endorsement they thought was a reasonable first  
10 cut.

11 Addressing low case volume and being  
12 cross cutting -- those work together, but they  
13 may not be completely overlapping. So that's --  
14 we're looking at that now. And then finally  
15 there are probably going to be a few must-have  
16 topic areas. And a couple of the ones that have  
17 come up potentially -- we haven't definitively  
18 settled on these yet -- things like diabetes.  
19 That might be something that is particularly  
20 relevant to rural residents. The other one -- a  
21 couple of other ones that have definitely come up  
22 are transitions in care, hand-offs, that sort of

1        thing, and access to care has come up quite a  
2        bit. So that's where we are right now.

3                    And that leads me to our discussion  
4        points. So I came up with a few questions here -  
5        - we don't actually have to do any of these  
6        questions. But let me just throw them out there  
7        and then let's just have a discussion. What are  
8        some of the key issues for PAC-LTC programs that  
9        you want us to keep in mind? Now, realize again  
10       that we are going to be focusing this year's work  
11       on in-patient, really, and out-patient settings.  
12       So not so much on post-acute settings. Again,  
13       hopefully in the future we can do that. But  
14       still, you guys don't work in a vacuum, so I know  
15       you have -- you could give us some advice there.

16                   Does the initial guidance concerning  
17       the -- cross-cutting NQF endorsement -- certain  
18       conditions, does that ring true to you? Would  
19       there be other things that you might suggest?  
20       Going forward, what could we do to help you? Is  
21       there anything that we could tell you or think  
22       about for you guys? Finally, what advice could

1       you give this new workgroup about serving on that  
2       group? I am -- Alan, you said you've been here  
3       for five years, so you probably have some nuggets  
4       that you could share.

5               And I didn't have it on here, but I  
6       was thinking about it. That measurement topic  
7       area -- the -- some of the things that we  
8       floated, again, we're going to decide on this.  
9       But we floated several topic areas for this  
10      little measurement science project that we're  
11      going to do as part of the work. And a couple of  
12      them I thought I would specifically mention just  
13      to see if you had any flavor of that. One is to  
14      look at quality of care specific to swing beds --  
15      so that might be something that you guys would  
16      really say, hey, that's really interesting to us.  
17      Maybe, you know, we'd love for you guys to look  
18      into that.

19              The other one that has come up -- we  
20      actually floated it as advanced care planning.  
21      But maybe thinking about it a little bit more  
22      broadly, this idea of community-based palliative

1 care. And I know you guys are really -- and  
2 Theresa is nodding -- so I know there would be a  
3 lot of interaction there, even, you know, with  
4 our focus on in-patient and out-patient. So that  
5 might be something.

6 And then another idea that we floated,  
7 actually, was post-acute care in rural areas. So  
8 what are the challenges in terms of data  
9 collection? Of implementation, QI efforts? So  
10 that's something that we could potentially take  
11 on at this time. So let me stop there and hand  
12 it over.

13 CO-CHAIR LAMB: Thanks, Karen. Kim?

14 MEMBER ELLIOTT: When I'm hearing you  
15 talk a lot about this, it really -- one of the  
16 things with access to care that I think we really  
17 need to keep in mind is all of the different  
18 opportunities that are available in the rural  
19 areas and for coordination of care, for  
20 transitions in care. And that may have to do  
21 with a telemedicine opportunities and perhaps  
22 some of the community worker opportunities that



1 really could make those connections happen much  
2 more easily for people in the rural areas. So I  
3 think those are really important factors that we  
4 keep at the forefront when we're thinking about  
5 access to care sorts of measures for rural  
6 health.

7 CO-CHAIR LAMB: Sean?

8 MEMBER MULDOON: My -- my comment will  
9 end with a -- with an inquiry that I'd like the  
10 workgroup to either tell me you're already taking  
11 care of or consider it. But I should start by  
12 saying I am a city boy, so this is all new to me.  
13 But I do get a -- it's sort of a weird reaction  
14 to the idea of rural relevant. And when I look  
15 at your list of things that say, sort of, you  
16 don't understand, we don't apply to this because  
17 we're different in these ways. And I -- and I  
18 certainly get the small case volume because this  
19 is fundamentally a measurement problem.

20 But, you know, an inner-city hospital  
21 could give you their five lists, why we should  
22 benefit from a carve-out, essentially. And --

1 and yet we're trying to establish national  
2 standards. And you don't get a buy in an inner-  
3 city hospital because you've got low SES. You  
4 know, because the answer is well, fix it. That's  
5 where you live. Go ahead and fix it.

6 And -- and so I would -- I would just  
7 ask, if it hasn't been already done, that there  
8 be a robust discussion about the down side of  
9 carving out rural health and to the degree it  
10 would prevent answering the question, what do we  
11 got to do in this subgroup to bring it up to a  
12 national standard? That is not any different  
13 than we say what do we got to do about the inner-  
14 city academic medical center that tends to  
15 underperform and bring it up to a national  
16 standard?

17 MS. JOHNSON: And let me just respond  
18 very quickly. As part of our work a couple years  
19 ago we kept trying to say what's really different  
20 about rural? And it turns out there really  
21 wasn't a whole lot totally different about rural,  
22 except maybe the geographic isolation. We just

1       felt that some of the problems that we mentioned  
2       were particularly salient to rural providers.  
3       But it is a little bit of a -- a difficult  
4       question. In terms of the downside, you know, I  
5       don't think that we've really hit that one. I  
6       think what -- where we're coming from is that,  
7       you know, 20 percent of the population lives in  
8       rural areas and they pretty much have been  
9       excluded -- to some extent because of the way  
10      payments work.

11                   So, yes, I think that's probably part  
12      of -- of why there's been a focus on rural. But  
13      we can certainly, you know, put that on the list.  
14      Thank you.

15                   CO-CHAIR LAMB: Theresa?

16                   MEMBER SCHMIDT: Well, first of all,  
17      I applaud this work. I think the questions that  
18      you're asking are very critical. Many of our  
19      members at the National Partnership for Hospice  
20      Innovation are community-integrated providers who  
21      are safety nets in their communities. And  
22      they're oftentimes chafing under the burden of

1 regulatory requirements. Much less about quality  
2 measures and more about additional documentation  
3 requests and the financial scrutiny that they  
4 tend to be under.

5 And one of the -- the things that  
6 they're dealing with is sometimes changing  
7 regulations such as the removal of certificate of  
8 need in their states. So as you are considering  
9 these rural measures and focusing on access, I  
10 wonder if you would consider thinking about  
11 measures where the -- sorry, accountability level  
12 is more systemic so that states or communities  
13 could use to measure the impact of policy changes  
14 on the access to different provider types.

15 And the second comment I had is really  
16 a question about how this workgroup would  
17 interact in a little bit more detail with the  
18 other measure applications partnerships groups?  
19 So for example, you're beginning with in-patient  
20 and out-patient, if you identify some great  
21 measures that might be used in CMS programs for  
22 those areas, do they then go back through those

1 workgroups and be evaluated for inclusion or  
2 removal from those programs? Or does your work  
3 kind of happen along the side? So the cross-  
4 setting, cross-cutting and access measures I  
5 think for us are very much of interest. Thank  
6 you.

7 MS. JOHNSON: Well, thanks for that.  
8 I am not exactly sure what we would do going  
9 forward. We are so brand new that we don't have  
10 -- unlike I think the Medicaid liaison here -- at  
11 some point we would like to have one or two folks  
12 from our group actually sitting around your table  
13 and the other tables so that we definitely have  
14 that rural input as you're discussing the MUC  
15 list. What we have this year is pretty much me.  
16 And -- so it will be better hopefully in the  
17 future.

18 In terms of, you know, where we land  
19 how that might inform work in future, I don't  
20 know. I think that's probably more of a CMS  
21 question of how they would want to direct our  
22 interaction there. But it would be great if we

1       could say, hey, you know, we really like these.  
2       And that might -- I don't know if that would  
3       impact what they would consider taking off or  
4       putting on.

5               MEMBER HOPPE: I appreciate all the  
6       comments from my colleagues because I think they  
7       are -- they represent pretty much what rural  
8       patients that I have really talk about in rural  
9       health systems. I think one thing that you have  
10      to understand is the mindset is a little bit  
11      different in rural areas. They would rather have  
12      access to healthcare. And that probably ranks  
13      higher than quality.

14             One particular area of concern to most  
15      rural providers and to patients is  
16      transportation. So trying to aggregate services  
17      when patients don't have transportation, or  
18      providers don't have transportation in that area  
19      can be pretty profound. It can lead to a great  
20      deal of sort of islands of poverty and islands of  
21      poor care. And I think that your former comment  
22      about having Medicaid involved is very important

1       because a number of these patients are dual-  
2       eligible. And they suffer not only from chronic  
3       diseases, but also the poverty that reinforces  
4       the complications of those -- of those chronic  
5       diseases. So I think it's a good idea to include  
6       those other agencies as well.

7                   CO-CHAIR LAMB:   Deb?

8                   MEMBER SALIBA:   I want to start by  
9       saying that several year -- if you had asked me  
10      this question several years ago, I would have  
11      definitely agreed with Sean that it felt like the  
12      rural was always brought up as a reason that  
13      quality measures shouldn't be applied. But I've  
14      had, you know, several experiences over the last  
15      few years that have sort of changed -- shifted my  
16      perspective a bit that I want to share. One is  
17      that we did an analysis looking at who -- who is  
18      the population in rural communities? And you  
19      brought this up on your slide. It is a  
20      significant -- a much larger proportion of older  
21      adults in these communities with high levels of  
22      needs for long-term services and supports, for

1 chronic and advanced medical illness care.

2 So as you look at your measures, I  
3 think it will be really important to bear in mind  
4 that those are the populations that are really  
5 dominant. And I realize there are other  
6 populations there as well, but -- but these are  
7 the ones that have really faced considerable  
8 difficulty in accessing fundamental services. I  
9 have had the privilege of doing some trainings in  
10 rural communities, and the providers are hungry  
11 for this type of training. They really want --  
12 they -- they feel, as you mentioned, isolated.  
13 They really want this training. But it really is  
14 that's an important area.

15 I think the other thing is to think  
16 about -- I don't know what federal partners you  
17 have at the table, but the VA does have an Office  
18 of Rural Health with a huge emphasis on trying to  
19 reach out to the rural communities and to provide  
20 access to services. So they could at least  
21 possibly be a resource to you.

22 In addition, another group that you



1 might want to think about is the Indian Health  
2 Service. So, I have done a series of projects  
3 with them over the years, and they are really  
4 trying to improve access and care coordination  
5 and use partners, both partners outside of IHS --  
6 including the Veterans Administration -- to try  
7 to improve those things. You may already have  
8 them at the table, but if not, that's a good  
9 group to think about.

10 CO-CHAIR LAMB: Alan?

11 MEMBER LEVITT: Thank you. Thank you,  
12 Karen. This is really -- to me a very important  
13 topic and to us at CMS it is a very important  
14 topic. Just to add first to Kurt and Deb what  
15 they said is access is extremely important issue  
16 for our patient population because of functional  
17 impairment. So they even have an extra level of  
18 issues that access could be involved in.

19 Stace was sitting next to me -- this  
20 is something we talk about all the time --  
21 looking at our programs. The question is, is how  
22 is it affecting rural providers? I do think in

1 particular for post-acute care, home health and  
2 hospice come up. Nineteen percent of home health  
3 agencies are qualified as rural. And, you know,  
4 what keeps me up at night -- for things -- are  
5 things like, you know, are what we are measuring  
6 first of all being measured by them? And  
7 secondly, are they scoring as well?

8 And Gene knows that, you know, even  
9 with our star ratings in home health, we -- you  
10 know, we look at every factor in it to try to,  
11 you know, make sure that we're doing the right  
12 thing. And one of them is urban versus rural.  
13 And we want to continue to -- to look at such  
14 things. So I would just continue to support  
15 what's going on. And certainly, I -- I --  
16 occasionally disagree with Sean. But I do think  
17 that this is an extremely important topic in our  
18 area.

19 CO-CHAIR LAMB: Robyn?

20 MEMBER GRANT: Just another thing to  
21 just keep in mind is that from a consumer  
22 perspective -- particularly when it comes to

1 long-term care -- one of the things that we hear  
2 a lot about is lack of choice. So there may be  
3 one nursing home in town, and it is the only  
4 nursing home in town. And so, regardless of its  
5 measures, if I want to have nursing home care in  
6 my community, I have to go to that nursing home.  
7 And so that's -- that weighs heavily on people in  
8 terms of access and choice.

9 The other thing I was just going to  
10 ask is a question. So how does this effort in  
11 this workgroup jive with the Meaningful Measures  
12 Framework so that you don't go down the road and  
13 end up on the de-MUC list down the road?

14 MS. JOHNSON: That's really a good  
15 question and we've already brought in the  
16 framework to some extent as a way to help us  
17 decide on our criteria -- our selection criteria.  
18 So we -- we made sure that that -- people  
19 understood that, and then we'll kind of work our  
20 way down. It may go the other way, too. I think  
21 probably what we'll end up doing -- and who  
22 knows, this might blow up and we have to do it a

1 different way.

2 But I think we will probably end up  
3 taking a list of measures this big, getting it  
4 down to something reasonable that you can put  
5 your head around, and then start bringing in  
6 other concepts as alignment and this measurement  
7 that matters -- the prioritization kinds of  
8 things -- and look at it kind of -- once we get  
9 something, you know, that we can work with and  
10 look at it that way. I hope that answers your  
11 question.

12 MEMBER MAHAJAN: And I -- I completely  
13 agree. Anecdotally, especially behavior health,  
14 is such a huge access issue in rural areas. And  
15 the might -- I have a question for post-acute and  
16 long-term care side. Do we know what degree of  
17 risk-based models have penetrated into rural  
18 areas? Like the ACOs or bundle payments when it  
19 comes to -- because that -- they get a lot of  
20 waivers when it comes to the three-day stay and  
21 use of swing beds. And so -- I think that  
22 definitely becomes important if there is -- their

1 people who have that kind of agreements. And --  
2 and that would also, you know, it would be good  
3 idea for people to start working on some kind of  
4 alternate payment model for physicians in that  
5 area so they have an incentive to -- to work. So  
6 yes, a question and a comment. Yes.

7 MS. JOHNSON: I am afraid I don't  
8 really know the answer to your question,  
9 unfortunately. I do know that there is -- and I  
10 don't know much about it. I guess I will learn  
11 over the next year. There is a -- kind of a -- a  
12 rural ACO that's going on that's kind of a -- I  
13 think a test case. But that's about what I know  
14 right now.

15 CO-CHAIR MULHAUSEN: Alan, did you  
16 want to reflect on the --

17 MEMBER LEVITT: Yes, just one comment  
18 on the Meaningful Measures and rural. I think  
19 it's very important in this area -- because one  
20 of the problems is because of the heterogeneity  
21 and the low volume is making this meaningful to  
22 rural providers, including them in our program.

1 You know, we have minimum number of patients for  
2 -- for our measures to be reported upon. And so  
3 that's one of the -- you know, I think that's a -  
4 - working with kind of looking at this idea of  
5 core with optional, maybe we could somehow  
6 integrate that within our PAC programs to include  
7 more of these providers because right now a lot  
8 of them aren't having measures publically  
9 reported.

10 CO-CHAIR MULHAUSEN: Connie?

11 MEMBER DAHLIN: So a couple things,  
12 thank you. I think one of the things that, you  
13 know, there may -- issues have been brought up,  
14 but I think to remember that this is also -- the  
15 care providers here are really diverse. There's  
16 a workforce shortage. There's a lot of access --  
17 so it's not -- you don't have a lot of physicians  
18 a lot of times. You're really using advanced  
19 practice providers, CNAs, rehab.

20 And I think the other part of this  
21 coordination that has to happen in those  
22 communities between clinical providers and social

1 providers. And -- and so we don't really pick up  
2 that, right? Because there's lack of resources  
3 where you can say urban, you know, inner-city  
4 hospital. Yes, but they still get different  
5 amounts of money and access. And these smaller  
6 programs just don't have the resources to be even  
7 putting in for the personnel to do this  
8 measurement. And I think we forget about that.  
9 Because this is, as you've said, sometimes  
10 costly.

11 I think the other part that we need to  
12 think about is, you know, in -- within palliative  
13 care -- this home-based palliative care is really  
14 our next frontier. And what we noticed when we  
15 looked at the consensus project -- and you know,  
16 NQF had monitored those when we first developed  
17 the NCP Clinical Practice Guidelines -- and then  
18 I helped edit the Second and Third Edition --  
19 what we've done in terms of moving this out is  
20 really understand that the providers in there are  
21 really also community and clinical.

22 And so, like, you have chaplains

1 acting as clinical. Or you have social workers.  
2 And that we can sort of talk about constructs of  
3 quality. But they have so much more of a  
4 challenge of trying to meet this  
5 interdisciplinary component, really thinking  
6 about, you know, what is it like for patients to  
7 die at home? Because yes, a lot of these people  
8 are geriatric patients and they are not sick  
9 enough for hospice, so they don't qualify for  
10 hospice. They don't qualify for home health  
11 because they don't have enough skilled need. I  
12 mean, so this is a population with huge needs.

13 And then I think the other part is  
14 we're looking to help programs across the country  
15 in these rural areas is yes, the pockets of the  
16 different diversity groups, I would say, or the  
17 underserved --- so how do we do that? Because  
18 there are such differences when you're working  
19 with the Indian health population versus the  
20 African-American population in the south --  
21 southeast, which is the lowest palliative care  
22 content versus when you go, you know, across to



1 the Northwest.

2 And so I think the -- these are really  
3 important, so I am really applauding this. And I  
4 think we forget, being from community and urban  
5 and academic and well-resourced organizations,  
6 they don't have what we make basic assumptions  
7 for. So thank you for that.

8 CO-CHAIR MULHAUSEN: Jim, I think  
9 you're next.

10 MEMBER LETT: Thank you, the -- the  
11 one thing -- I am from a small state, from a  
12 small town -- one of the things I would ask is  
13 burden, burden, burden -- don't. You're talking  
14 about individual or very small numbers of doctor  
15 groups. Or, as pointed out, nurse practitioners,  
16 PAs out there, small hospitals, mom and pop  
17 nursing homes, which means they're really not  
18 going to have a lot of resources. The big groups  
19 will have coders and in some of the groups now  
20 even have attendants following physicians and  
21 nurse practitioners, checking off quality  
22 measures. Those resources are not there.

1           The other part about that is you will  
2       likely have the same providers going to all sites  
3       of care. So when you're thinking about office,  
4       hospital, post-acute -- it may be the same person  
5       doing all three. So the burden of reporting is  
6       going to be enormous. And also, CMS to their  
7       credit put out a great paper about what does the  
8       Medicare enrollee look like across the country?  
9       And one of the things that really struck me was  
10      that in the most unexpected places you will come  
11      up with remarkable ethnic immigrant populations -  
12      - even in very rural areas. So you may find some  
13      very interesting and -- what are they doing here  
14      questions come up.

15                   CO-CHAIR MULHAUSEN: Liz?

16           MEMBER HALL: Thank you, I just wanted  
17      echo some support from a -- a prior comment  
18      around the opportunity for telehealth to increase  
19      access. But wanted to just mention consideration  
20      for the technical infrastructure that exists in  
21      the rural communities, particularly around  
22      broadband. We know that still continues to be a

1 challenge. And just to point out as well that  
2 recent opportunities at FCC has enabled through  
3 some of their broadband initiatives particularly  
4 for skilled nursing facilities. So there are  
5 increasing opportunities, but just to consider  
6 those infrastructure issues.

7 CO-CHAIR MULHAUSEN: Kim, you've had  
8 your -- whatever this -- name tag up for a while.  
9 Are -- did you still? You're done. So -- so  
10 since -- so what I am going to do is prioritize  
11 and we'll have Gerri go and since, Theresa,  
12 you've already spoken, we'll do you last and then  
13 we'll take a break. So, Gerri.

14 CO-CHAIR LAMB: Thank you. In  
15 listening to all the comments I was just kind of  
16 resonating with what Theresa was asking before in  
17 terms of how this work integrates with the other  
18 MAPs. And some of the issues that this MAP is  
19 going to be dealing with are really thorny issues  
20 for all the MAPs, related to do you go condition-  
21 specific? Or do you go population-based? Or the  
22 -- the issues related to the same providers

1     seeing people or multiple teams. So I would just  
2     encourage that group to really embrace the thorny  
3     issues so it can come back to all of us for that  
4     dialogue.

5             Because, you know, like Alan was  
6     saying, what keeps him up at night -- I have been  
7     on a lot of committees where we are really  
8     struggling with do we move down the condition-  
9     specific avenue? Or do we keep it general?  
10    Particularly in care coordination and in  
11    transitions of care. And if they can help really  
12    address that, then I think we can advance PAC  
13    Long-Term Care together rather than all these  
14    siloed efforts.

15            CO-CHAIR MULHAUSEN: And -- and  
16    Theresa, we're going to give you the final word.  
17    And then we'll take a ten-minute break.

18            MEMBER SCHMIDT: I will keep it quick.  
19    I just wanted to bring together a couple of the  
20    comments of the colleagues across the table.  
21    Alan, I think you're absolutely right that this  
22    does present unique challenges for providers like

1 Hospice, like home health, like home-based  
2 palliative care who provide care in the home.  
3 And transportation is paramount among those. Our  
4 hospices will travel hours to visit patients in  
5 rural areas.

6 In -- in Kim's neck of the woods  
7 Hospice of the Valley serves the -- the  
8 reservation. And they drive three hours to meet  
9 patients at a community store who have come down  
10 from the reservation. And they don't even make  
11 it all the way to their houses. And cell phone  
12 use -- technology is also a challenge in these  
13 communities. They'll call before they enter the  
14 service area, say hey, I am going in. I will  
15 call when I get back. If you don't hear from me,  
16 send somebody.

17 So these are all challenges for the  
18 providers in access in addition to the patients  
19 in access. And I think that -- I wonder if any  
20 of the measures and any of the work that you're  
21 doing might consider, are there risk adjustments  
22 that would be needed for current measures in

1 place in relation to rural? And I'm not -- I am  
2 honestly not sure if -- if any of that work has  
3 been done -- any of those numbers have been  
4 crunched.

5 MS. JOHNSON: And to answer your  
6 question, yes, risk adjustment definitely came  
7 up. One that came up, obviously, is distance.  
8 Although, even distance may not be quite the  
9 right risk adjuster. It might be more like time  
10 to whatever. So -- yes.

11 CO-CHAIR MULHAUSEN: All right, Karen,  
12 any other reflections or observations after all  
13 that?

14 MS. JOHNSON: I am excited. Thank you  
15 guys for all your input. I will bring this back  
16 at some point and let you know where we -- where  
17 we've landed.

18 CO-CHAIR MULHAUSEN: As an Iowan who  
19 used to drive hours to do in-home Hospice visits,  
20 I think it's a terrific initiative. So we're  
21 going to take ten minutes. The clock up there  
22 says -- let's just reconvene at ten after 11:00.

1 Okay?

2 (Whereupon, the above-entitled matter  
3 went off the record at 10:56 a.m. and resumed at  
4 11:08 a.m.)

5 MS. O'ROURKE: All right, everyone, if  
6 we could have you rejoin us at the table? We  
7 have a few new Workgroup members who have joined  
8 us since Elisa did the disclosures.

9 So, we have Mary Ellen from  
10 HealthSouth and Frederick from Families USA. If  
11 you could just introduce yourselves and let us  
12 know if you have anything to disclose.

13 MEMBER ISASI: Hi there. My name's  
14 Fred Isasi. I'm the Executive Director at  
15 Families USA. We are one of the oldest  
16 organizations in the country that's been  
17 representing consumer interests in healthcare.

18 It's a joy to be here. I've worked on  
19 a lot of these sort of bodies before. And we are  
20 deeply interested in ensuring that the future  
21 direction of long-term care is serving the  
22 interests of consumers. And thanks for having

1 us.

2 MS. O'ROURKE: Thank you.

3 MEMBER ISASI: And I have no conflicts  
4 to disclose.

5 MS. O'ROURKE: Excellent. Thank you.  
6 Mary Ellen, are you on the line?

7 MEMBER DEBARDELEBEN: Yes, I am. My  
8 name is Mary Ellen Debardeleben. I'm the  
9 Director of Quality for HealthSouth. We have 128  
10 inpatient rehabilitation hospitals in over 30  
11 states, and almost 200 home health locations.

12 And we are very interested in quality  
13 measurement in the post-acute care space. And  
14 I'm grateful to be representing Dr. Charbonneau,  
15 our Chief Medical Officer, on this MAP Committee  
16 meeting today. And I have no conflicts to  
17 disclose.

18 MS. O'ROURKE: Excellent. Thank you.  
19 Thank you both, and welcome. So, I think with  
20 that I can turn it back to Paul and Gerri for our  
21 next conversation.

22 CO-CHAIR LAMB: Okay. We're going to



1 continue to talk about background. We've just  
2 gone through the Meaningful Measures, had an  
3 opportunity to hear about rural health.

4 We're going to move now into the  
5 IMPACT Act. And Stace Mandl and Tara McMullen  
6 are here with us to give us an overview. And  
7 just as we've been doing, let's continue the  
8 dialogue, the recommendations.

9 You know, we were just reflecting  
10 during the break, what a wonderful opportunity.  
11 We're usually so packed at these meetings  
12 reviewing measures to really have a sense of, how  
13 can we influence the field for the future?

14 So I think Paul and I feel really  
15 strongly, let's really maximize that opportunity  
16 to get, today, together. So, Tara, Stace, thank  
17 you.

18 MS. MANDL: So, thank you for having  
19 us here to present on the IMPACT Act and the  
20 updates. We have historically joined you to go  
21 through the quality measures. It's with a lot of  
22 enthusiasm that today we're going to actually

1 present on the standardized patient assessment  
2 data elements.

3 As you are probably aware, the IMPACT  
4 Act required not just quality measures that  
5 satisfied certain domains, but it also requires a  
6 standardization of patient assessment data  
7 elements.

8 So, we're going to give you sort of an  
9 update, a little bit of background, and a little  
10 bit of an update on this work.

11 So, the Improving Medicare Post-Acute  
12 Care Transformation Act of 2014, which we were  
13 very excited about -- we're still excited about;  
14 we're a little tired, but we are excited -- was  
15 passed by Congress in September of 2014 and  
16 signed into law in October of 2014.

17 And I think we were quick, fast, and  
18 in a hurry here at the MAP with our first of the  
19 evolution of measures to satisfy the IMPACT Act  
20 domains.

21 So, the IMPACT Act requires that long-  
22 term acute care hospitals and skilled nursing

1 facilities and home health agencies and inpatient  
2 rehab facilities all submit standardized patient  
3 assessment data using the assessment instruments  
4 that we already require that they submit data on  
5 into CMS.

6 And just to kind of orient you, the  
7 long-term acute care hospitals submit the long-  
8 term acute care data set, or the LCDS. And the  
9 skilled nursing facilities, as you are probably  
10 very aware, submit the MDS. The home health  
11 agencies submit the OASIS. And the inpatient  
12 rehab facilities submit the IRF-PAI.

13 But the law requires that these  
14 providers submit standardized assessment data for  
15 various purposes. One is to ensure quality care  
16 and improve outcomes. That's both in the quality  
17 measures that are associated with the IMPACT Act,  
18 but also with the standardized assessment data  
19 itself.

20 It allows for data element uniformity,  
21 which, sort of long story sort, really allows  
22 both written, verbal, and electronic

1 communication to be more feasible and easily  
2 understood to allow for the ability of quality  
3 comparisons, and the transmission of data across  
4 post-acute care settings. And, actually, into  
5 and out of other provider types.

6 To improve discharge planning,  
7 exchangeability of the data. To enable  
8 coordinated care during transitions of care,  
9 which I heard a lot about today. And then to  
10 inform payment models.

11 As you are probably aware, except for  
12 the LTACs, the other providers submit  
13 standardized assessment data not just for quality  
14 measure calculation, but for other purposes as  
15 well, including payment.

16 So, the Act requires, as I said, that  
17 they report the standardized data, patient  
18 assessment data, and standardized patient  
19 assessment data specifically on quality measures.

20 And then also other data sources can  
21 be used for the measures that pertain to resource  
22 use. And the other measures that you're probably

1       aware of, discharge to community, and the  
2       potentially preventable readmission measures, as  
3       well as the MSBP measure, those all are based on  
4       claims data.

5               But the data, in the law it requires  
6       specifically that the standardized patient  
7       assessment data be also made interoperable. And  
8       we're joined by our colleague, Liz Palena Hall  
9       from ONC. And to enable for the exchange of  
10      information using common standards and  
11      definitions. And that's actually specifically  
12      spelled out in the Act. And to facilitate care  
13      coordination and the improvement of Medicare  
14      beneficiary outcomes.

15             And it does spell out the exchange of  
16      information, but also to look at longitudinal  
17      outcomes. And that PAC assessment instruments be  
18      modified. The law requires that the assessment  
19      instruments be modified to include that  
20      standardized patient assessment data. And that  
21      will allow for the comparability of data.

22             So, the Act does not require that each

1 assessment instrument be wholly, exactly the  
2 same. And that was one sort of misunderstanding  
3 that we've spent several years, even time before  
4 the IMPACT Act passed.

5 We are aware that there are core data  
6 elements in the assessment instruments that are  
7 necessary for those specific provider types. For  
8 example, long-term acute care hospitals and home  
9 health agencies may have specific needs of their  
10 own.

11 But ultimately there's sort of this  
12 Venn diagram where the standardized data sits in  
13 the center. And actually, we're working closely  
14 together with our partners and Medicaid with  
15 their work in public community-based services and  
16 long-term services and support to also apply  
17 standardized assessment data there. Because it  
18 doesn't really do us much good if -- I should  
19 actually say beneficiaries -- if the information  
20 is only sort of exchangeable and usable and  
21 uniform up until a point and ultimately they go  
22 on to their homes.

1                   But the IMPACT Act, and I think you've  
2                   probably seen this slide before, does enable us  
3                   to sort of crack the code in three very complex  
4                   areas.

5                   One is strengthening person and family  
6                   engagement as partners in their care. Promoting  
7                   effective communication and coordination of care.  
8                   And promoting effective prevention and treatment  
9                   of chronic disease.

10                  And that's what having that  
11                  standardized assessment data that can be used  
12                  across provider types, with measures that look at  
13                  sort of long-term outcomes, and being able to  
14                  really look at long-term outcomes, and having  
15                  data that's usable in realtime, can provide for  
16                  informing clinical care, decision support, care  
17                  planning, and so on and so forth.

18                  So, these are very unique, a little  
19                  bit more difficult areas to address with quality  
20                  measures and use of data. And so these are some  
21                  of the areas that we think that the IMPACT Act  
22                  helps to address.

1                   So, the IMPACT Act specifically  
2                   requires that the assessment instruments be  
3                   modified by particular dates to include data  
4                   elements on the following five categories:  
5                   functional status; cognitive function and mental  
6                   status; special services, treatments and  
7                   interventions; medical conditions and  
8                   comorbidities, impairments; and other categories  
9                   as required by the Secretary.

10                  Now, I'm a nurse by background. I can  
11                  tell you that this is all very classic nursing  
12                  healthcare types of categories. There's nothing  
13                  arbitrary or odd about any of these.

14                  If you're not familiar with what our  
15                  assessment instruments look like, this is sort of  
16                  a sample of a functional status question and  
17                  response codes where the assessor is looking at  
18                  the individual's usual performance related to  
19                  functional mobility.

20                  The assessment questions are on the  
21                  right-hand side. The response codes that are  
22                  allowable are on the left. And that data can be



1 used by the provider in realtime. And it's also  
2 used by CMS.

3 In realtime, the assessment  
4 information -- and those of you who are familiar  
5 with how this is done, particularly in home  
6 health agencies and in nursing facilities, is  
7 that they use the data for care planning. And  
8 we'll take that a step further: hopefully for  
9 clinical decision support. Because as we saw,  
10 those are categories that are also already in  
11 existence within the assessment instruments, to  
12 some extent. They're just not standardized  
13 across them.

14 So, the standardized data can really  
15 support local care planning and decision support,  
16 quality improvement. It's used by CMS for  
17 payments, for the calculation of quality  
18 measures. And now, sort of the gift of the  
19 IMPACT Act is to also support care transitions.

20 And one unique opportunity that exists  
21 with post-acute care is that the quality measure  
22 data is provided, we can calculate the data on

1 our end. But also, the reports that we provide  
2 to the providers, they can run on demand by them.

3 So, in realtime, or in very close to  
4 realtime, with I think a week or so of the data  
5 being submitted, we work with our support  
6 contractor to develop the technical requirements  
7 so that they can run and generate their own  
8 quality improvement reports by looking at the  
9 quality measure calculation at the facility  
10 level, and actually also at the patient level on  
11 the assessment quality measures.

12 So, really, turning the tide and  
13 looking at quality improvement is a joint effort,  
14 right? And we know, you know, that the quality  
15 measures, the assessment instruments, they can  
16 only drive quality improvement just so far. But  
17 the standardized assessment data, and really  
18 shining a light on specific types of categories,  
19 is a part of the solution.

20 If you think of an individual who has  
21 severe functional and cognitive impairments,  
22 let's say they were in a motor vehicle accident.

1 And the assessment instrument is capturing their  
2 functional cognitive abilities. And then the  
3 treatments and interventions that are used, let's  
4 say they're on a ventilator, they're receiving  
5 tube feeding. They are, you know, requiring  
6 suctioning or oxygen. Those kinds of things can  
7 be captured in a uniform way, which most  
8 facilities do within the facility already.

9 And then you look at the quality of  
10 care by the provider. The patient services and  
11 clinical care, their use of not only the  
12 standardized assessment data, but also the rest  
13 of the medical record for clinical decision  
14 support, and their care planning, and then  
15 communications and continuity.

16 And all of that taken together will  
17 help inform the outcome and drive the outcomes  
18 that that individual has.

19 So, we've done a lot of work in this  
20 space over the last, I guess, couple of years in  
21 looking at standardized assessment data elements.  
22 As you're aware, we went forward with proposals.

1 We heard the public comments loud and clear, that  
2 it was too much, too fast. We understand.

3 And we are back, you know, in the  
4 field working. And really working through a lot  
5 of consensus work, as well as the testing. It's  
6 all really been an important aspect of this work.

7 And with that, I'm going to turn it  
8 over to Tara to describe and provide an update on  
9 that work.

10 DR. MCMULLEN: Yeah, just focusing on  
11 this slide for a second. So, I know many of you  
12 in here are well, very knowledgeable about the  
13 Post-Acute Care Payment Reform Demonstration, the  
14 PAC-PRD. And the PAC-PRD is really the paradigm  
15 to everything we're doing now with the data  
16 element standardization work.

17 And one thing I like about this slide  
18 a lot is, what the PAC-PRD brought CMS was a  
19 greater understanding that a data element is very  
20 powerful, and that it could tell you about  
21 acuity, severity, illness, and characteristic.

22 So, if you're looking at the clinical

1 characteristic of a person, you want to look at  
2 resource intensity. You want to track their  
3 trajectory across care settings. You want to see  
4 case mix. You want to look at if that item's  
5 useful for quality purposes in the risk  
6 adjustment model, or for a quality measure. That  
7 certain items are useful in that way when tested,  
8 proven reliable and valid. And that was PAC-PRD.

9 And as you know, the care tool was  
10 built from that testing and from that knowledge.  
11 And from there, we have this work. And it is the  
12 standardized data element assessment work under  
13 the IMPACT Act.

14 So, specifically under the IMPACT Act,  
15 Section 2A, the Act mandates that CMS develop  
16 standardized data assessment elements. And these  
17 are in the categories that Stace delineated:  
18 function; self-care and mobility, as an example.

19 Cognitive function; for example,  
20 expressing and understanding ideas, mental  
21 status. And then there's depression and  
22 dementia. So, mental health is nested in there.

1 Special services, treatments and  
2 interventions. For example, need for a  
3 ventilator, chemotherapy, and nutritional items.  
4 We heard nutrition earlier.

5 Medical conditions and comorbidities.  
6 For example, pressure ulcers. We heard that  
7 link, pressure ulcers and malnutrition, diabetes,  
8 heart failure.

9 And then impairments. So, you're  
10 looking at the ability to see, hear, swallow,  
11 sensory, moving above and beyond.

12 So, CMS, with our colleagues from the  
13 RAND Corporation, moved a couple of years ago now  
14 to begin to assess candidate items for  
15 standardization purposes. And we have moved in  
16 this selection and this exploration in a phased  
17 approach.

18 So, as you see here, we conducted the  
19 first phase, which was information gathering,  
20 through 2015 into 2016. We piloted our data  
21 elements. And as you know, and I'll touch on,  
22 within that time we also had a rule proposal.

1 And we called that piloting Alpha 1 and Alpha 2.

2 And we are now in the next phase, and  
3 that is the national testing. And that's what  
4 I'm going to focus a lot of this discussion on  
5 today, to give you an update and to gather your  
6 input.

7 Sorry, I'm following along, because  
8 since we had these slides last week, I have all  
9 sorts of updates. Because we're actually in the  
10 field right now and it's like daily updates. But  
11 here is a basic graphic -- and we will provide  
12 these slides -- of basically the general  
13 timeline. And on this slide we really break it  
14 down.

15 What we're trying to delineate here is  
16 that, from the start of this project, we have  
17 embarked on a robust process of consensus  
18 vetting, public comment, technical expert panel  
19 processes, focus groups, into testing, into  
20 developing and piloting from de novo work, to  
21 looking at work that CMS already had done on data  
22 elements, such as the PAC-PRD work.

1                   So, what we're showing here is, going  
2                   into 2018, we're about to hit a point where there  
3                   is a lot of activities going on. And I'm going  
4                   to discuss some of these activities.

5                   So, again, these are the categories  
6                   which are outlined in IMPACT Act, Section 2A.  
7                   So, in our first phase and into our second phase,  
8                   CMS said, well, okay, how do we get to a point  
9                   where we know what are the best candidate items?  
10                  How do we know what are best in class?

11                  As you know, individuals are not the  
12                  same. Older adults are not the same for each  
13                  setting. And care services in each setting vary,  
14                  right. So, what do we do?

15                  So, this slide shows you that CMS,  
16                  with RAND Corporation, went on a fact finding  
17                  mission. We started with developing an  
18                  organizational framework, which I won't discuss  
19                  today, but if you have questions I'm happy to  
20                  speak to.

21                  But this framework kind of set the  
22                  paradigm for us in how we would go about



1 selecting candidate items. We did an environment  
2 scan, a literature review, of all the PAC  
3 settings. And really beyond the PAC settings.  
4 The universality of items and information, and  
5 things like that.

6 We had focus groups. We solicited for  
7 and conducted -- RAND conducted a technical  
8 expert panel. And I'd like to thank Dr. Deb  
9 Saliba for her work on that.

10 We had clinical expert advisor input.  
11 And we continue to have that input, many clinical  
12 and expert advisors on each domain. And we  
13 consulted within CMS, across HHS, with our sister  
14 agencies, on what items are useful, say, for the  
15 idea of care coordination, interoperability.  
16 Where do we need to target? Where do we need to  
17 go? What are the gaps? We know there are many  
18 gaps.

19 So we developed this list of candidate  
20 data elements. And kind of this paradigm guided  
21 us in our fact finding mission in choosing items  
22 to test.

1           We focused in on an item's potential  
2   for improving quality. It's very important to  
3   maintain that person-centeredness. The validity,  
4   and the reliability of the item. Going into the  
5   feasibility of the item for use in PAC settings,  
6   and really for the intent of standardization.  
7   And the utility of that item for describing case  
8   mix. And that's very, very important if you're  
9   talking about things such as payment modeling.

10           So, as we were going into this work in  
11   more depth and we were in the pilot testing, what  
12   we noticed is, now we have two tracks of work.

13           Track 1 is data elements that we were  
14   assessing, that were tested in prior efforts,  
15   such as the Payment Reform Demonstration, the  
16   PAC-PRD. And Track 2 encompassed new items that  
17   we were using for feasibility testing.

18           So, you see here, Track 1 was PAC-PRD.  
19   We were looking at items that were previously  
20   tested, and chosen, and proven to be reliable and  
21   valid in PAC settings, sensory impairments, items  
22   and special services and treatments, impairments

1 and interventions, cognitive function and mental  
2 status.

3 Track 2 encompassed de novo work, new  
4 items that we reviewed and assessed from an  
5 environmental scan. Items that were taken from  
6 public comments that we received from many folks  
7 in this room and beyond, our stakeholders.

8 And that feasibility testing really  
9 focused on a lot of items in cognition, looking  
10 at executive functioning, pain, continence, care  
11 preferences, and medication reconciliation.

12 So, I'm going to touch a bit on Track  
13 1, which was the work that was taken from the  
14 PAC-PRD. So, there were many items that we put  
15 forward in a rule proposal in the Fiscal Year and  
16 Calendar Year 2018 proposed rules.

17 Those items run the gamut of the  
18 domains within the IMPACT Act. And beyond the  
19 domains of functional status and pressure injury,  
20 or ulcer, we chose not to finalize items that  
21 were in the following domains: cognitive function  
22 and mental status; special services, treatments

1 and interventions; impairments.

2 And the reason that we chose not to  
3 adopt those proposals is, as Stace delineated  
4 before, the stakeholders, and everyone who really  
5 read into the rule, caregivers, real people, were  
6 saying, hey, CMS, this is too much too soon.  
7 It's good that the items are reliable. It's good  
8 that you found them valid. But this is a lot.  
9 These items are a lot. They're a lot for our  
10 systems. We need to think this through.

11 As you see in bullet 2, we need to  
12 enable greater recovery for providers between  
13 major releases. As you know, we have release  
14 every two years in our PAC settings. We need  
15 additional testing on items, because if these  
16 items are going to be the gold standard we want  
17 to prove that there's a gold standard. And CMS  
18 agrees with that.

19 And that we need more time to build  
20 the consensus, you know, the collaboration to  
21 ensure that all parties, including CMS, are  
22 onboard with this so that we can move forward in

1 the collaborative effort.

2 So, CMS chose not to finalize our  
3 proposal. And in moving forward and not adopting  
4 what was proposed we said, okay, let's go back to  
5 the drawing board and let's think through, for  
6 our national testing, what items we can take that  
7 might be useful in all PAC settings. And let's  
8 go out and work with the stakeholder community.

9 So, Track 2, Status 2, was occurring  
10 at the same time as that proposal. And we were  
11 looking at elements in Alpha 1 and Alpha 2. And  
12 there are elements from that pilot test that now  
13 we're taking into our national test.

14 And basically what we learned, or what  
15 we gleaned from that pilot test, is that certain  
16 elements performed well, but we need to do  
17 additional testing. They may be feasible, but  
18 we're not exactly sure that they're 100 percent  
19 reliable or valid, or their use can be 100  
20 percent valid in all PAC settings.

21 We received qualitative feedback in  
22 many focus groups and interviews saying we need

1 improved training and instructions on the items.  
2 I know what this item means, but when I go and I  
3 have my gold standard nurse, you know, collect  
4 this item, she may not know, or he may not know  
5 what that means. So, we're not sure if the  
6 inter-rater reliability is of a standard that CMS  
7 would want to move forward with this item.

8 And that there is just other  
9 information that was problematic. Some items  
10 were overly burdensome. We took that to heart.  
11 And in our new initiative looking at Meaningful  
12 Measurement and measures and patients over  
13 paperwork, we are now in our current state. And  
14 that's the next step. This is the national test.

15 So, in our national test we like to  
16 point out that we went back to the drawing board.  
17 And we thought, okay, how do we get to the ideal  
18 state of what could be "best in class"? And we  
19 zeroed in on candidate items and a few facets.  
20 We're now looking at the timing of assessments,  
21 and how those items fit into that timing, so that  
22 if we're collecting on an assessment we're

1 ensuring that we're collecting for an item in the  
2 least burdensome way, but in the most effective  
3 and valuable way, that it's feasible.

4 We're focusing in on data elements  
5 that are key to the overall assessment of a  
6 person, such as malnutrition. We heard that  
7 earlier. We're looking at nutritional status.  
8 We're looking at items for medication  
9 reconciliation. I like to say, items that help  
10 us tell a story, items that are meaningful, items  
11 that are useful in that clinical assessment.

12 We're looking at data elements that  
13 are useful not just for standardization, but for  
14 quality measurement, that detail clinical  
15 complexity, that look at patient characteristic.  
16 Again, that tell that entire story. Items that  
17 can be used and reused many times, not just by  
18 CMS, but to the entire world in our data element  
19 library.

20 At this time, I'd like to note that  
21 we're currently testing items for the sake of  
22 standardization purposes. But we want items that

1 are universal, if there were such a thing. And  
2 we believe that there will be such a thing.

3 So, here we are in the national beta  
4 test. So, the national beta test begins now.  
5 We're preparing for it. We're training. We're  
6 educating our gold standard nurses who are in the  
7 field.

8 We'll be in the field until May of  
9 2018. We are looking at a sampling of 14  
10 geographic and metropolitan areas. These were  
11 randomly selected. And I'm sorry, we have a  
12 really great graphic that shows where we are. I  
13 like to show it. I didn't put it in here and I'm  
14 kicking myself for that now. But it's really  
15 great. And it's online.

16 There are eligible providers. We  
17 invited them to participate. Participation is  
18 voluntary.

19 This slide has been updated since we  
20 finalized this last week. At this point in time,  
21 today, we have successfully recruited 172  
22 agencies and facilities. Our goal is to recruit



1 an N of 210. So, 210 facilities and agencies.

2 We are in the last phase of conducting  
3 recruitment across all markets. And this is  
4 taking place now to offset early dropouts. So,  
5 as we see here -- and I'm sorry, this slide has  
6 also been updated. The target number of patients  
7 per facility and agency, you have that at 30 for  
8 LTACHs, and a 30 for LTCHs, 30 for IRFs, 25 and  
9 25 for home health agencies. These are targeted  
10 assessments so that we can reach a level above  
11 and beyond generalized ability for data outcomes.

12 So, we will be in these markets, in  
13 these facilities and agencies collecting data  
14 with our gold standard nurses electronically on  
15 handheld tablets. So, folks, we can look at the  
16 timing of assessments, and the usability and  
17 feasibility of collection of data through  
18 multiple modes.

19 The protocol includes patient  
20 interviews, patient observation, and record  
21 review items. Testing includes admission and  
22 discharge assessment protocols for assessing

1 communicative patients and residents. And we  
2 also have a protocol for patients and residents  
3 who are unable or unwilling to communicate.

4 So, we have three different protocols,  
5 one at admission, one at discharge, and I think  
6 we did a knowing communicative -- I forget how  
7 it's listed or labeled online. But we have one  
8 for unwilling or unable to communicate.

9 I'd like to say that these protocols  
10 are now posted on our CMS website, on our IMPACT  
11 Act web page, in an effort to be 100 percent  
12 transparent in what we're testing, so that we can  
13 begin this dialogue with everyone, the outside  
14 world, our stakeholders.

15 And if we're going down the right road  
16 in terms of our testing, our methodology, our  
17 mode for collection of the items that we're  
18 assessing.

19 Also, and we announced this yesterday  
20 on our special open door forum. We are walking  
21 into a robust consensus vetting process now for  
22 2018.

1                   We have a three to four pronged  
2                   approach for reaching out to stakeholders,  
3                   caregivers, family members, real people in the  
4                   community, real people in these facilities and  
5                   agencies.

6                   We are going to be speaking at  
7                   conferences, holding webinars and focus groups.  
8                   And these will be targeted on specific  
9                   populations. We're calling them special  
10                  populations.

11                  But we want to hear from, like for  
12                  example, representatives of pediatric  
13                  organizations, so we can get that input for  
14                  future efforts in testing.

15                  We are talking with our beta  
16                  assessors, or the folks who are testing these  
17                  items in the field, to get their feedback. We're  
18                  conducting follow-up interviews.

19                  And in October of 2018 CMS will be  
20                  holding, we call it a forum or a conference at  
21                  CMS to talk about the results that we're finding  
22                  in the field. That forum or conference is open

1 to anyone who would like to attend. And we hope  
2 to have that streaming via webinar.

3 So, again, what I'm calling gold  
4 standard nurses, our research nurses will also  
5 conduct repeat assessments on subsets of patients  
6 to identify optimal look backs. So, that's the  
7 timing of assessments.

8 We heard this in our public comment.  
9 We've heard it for many years. And we've come to  
10 a point where we're able to now test what is an  
11 optimal look back, what is an optimal time to be  
12 able to collect, so that we're able to collect  
13 the most reliable information on the person in  
14 our facility and agency settings.

15 The next slide shows you the domains  
16 in which we're focusing on for the beta  
17 assessment. You'll see the domains align with  
18 the IMPACT Act, but we're going a little bit  
19 above and beyond.

20 We're looking at data elements that  
21 fit in the domains of cognitive status, mental  
22 status, pain, impairments. Special services,

1 treatments and interventions, including  
2 nutritional approaches, care preferences. We're  
3 focusing in on PROMIS, the PROMIS item set. And  
4 items for medication reconciliation.

5 And the next couple of slides, and  
6 this will end the presentation on this data  
7 element work, and love to hear your thoughts.  
8 The next couple of slides give you a qualitative  
9 look on what we're collecting in the  
10 consideration of the beta test.

11 The protocols are online. I don't  
12 know if there's internet access via this. But if  
13 you go online on your computers and you go to the  
14 IMPACT Act web page, and you go to the tab  
15 National Beta Testing, you could pull of the  
16 protocols and you can see how we are testing  
17 those items.

18 Some items are on a one, three, five,  
19 seven day look-back timing assessment. Some  
20 items are split into two different subsets of  
21 collection, we're doing a split half reliability  
22 testing. So there's different processes and

1 different means for different items. And there's  
2 a whole line of thinking behind that approach  
3 stemming from our Alpha 1 and Alpha 2 testing.  
4 And I'd be happy to discuss that.

5 But as you see here, we have data  
6 elements under the mode of expression and  
7 understanding. We have the bins, we have the  
8 CAM. We have the behavioral signs and symptoms  
9 items, staff assessment for mental status, one of  
10 my favorites. PHQ-2 to PHQ-9, that's a gateway,  
11 PROMIS depression, PROMIS anxiety, PHQ-9  
12 observational. That's the staff assessment mode.

13 We have items for pain interview, pain  
14 presence, severity, effect on sleep, interference  
15 with therapy and non-therapy related activities  
16 and related staff assessment on pain or distress.

17 Ability to see, hear, swallow,  
18 continence, patient/resident perceived problems  
19 of such, continence appliance use, frequency of  
20 events. Service and treatments for cancer,  
21 respiratory, or other nutritional approaches, IV  
22 or feeding tube diet.

1 Care preferences, decisionmaking  
2 preferences, designated healthcare agent. We  
3 have PROMIS Global Health. That's the PROMIS 10  
4 I'll discuss in a second. It's one of my  
5 favorites. Medication reconciliation. And  
6 that's it. I say that's it. That's a whole  
7 world of work. That's it.

8 And, you know, like I said, based on  
9 the item we are collecting by different -- you  
10 know, it's the same item but some of the items  
11 may have been altered based on what we found in  
12 our cognitive interview. And again, based on the  
13 timing of assessment.

14 So, happy to answer any questions.  
15 And thank you for your time.

16 MEMBER LEVITT: I just need to say one  
17 thing. First of all, I need to publicly thank  
18 Stace and Tara. Because it's been three years.  
19 I remember watching the bill. We all watched it  
20 trying to be passed. And we thought the vote was  
21 going to go down but was just a voice thing, just  
22 saying yea.

1                   And literally, like, the next day we  
2                   were starting to think about this and how we were  
3                   going to make it work and make it start right.  
4                   And they've carried it for these three years, and  
5                   continue to carry it. And, you know, it's been  
6                   extraordinary.

7                   And also, I know I've said this  
8                   before, I want to thank you. And "you" is the  
9                   post-acute care community, which I still feel  
10                  part of, since that was my life.

11                  When Congress asked for comments  
12                  initially as to how to improve post-acute care,  
13                  it was a universal, "we need to have this type of  
14                  standardized assessment." That was the message  
15                  they got back from you.

16                  And when Congress decided to do this,  
17                  it's being done first with us. You know, this  
18                  doesn't stop with our patients when they're in  
19                  doctors' offices, or in hospitals, particularly  
20                  hospitals that have all the resources that a lot  
21                  of times PAC settings don't necessarily have.

22                  And yet we are the ones who are



1 carrying the ball on this. And, sure, there,  
2 this is a "we," because it is a partnership. And  
3 we've got to look at, you know, the burden of  
4 trying to do this, to get this transition, to  
5 keep all the other things that this is important  
6 for besides quality measures. To be able to be  
7 better. To show the importance of the resource  
8 uses that we need to effectively manage our care  
9 planning and hopefully one day expand this beyond  
10 our settings because the other areas will see how  
11 important this is. And this is just the start.

12 And so, thank you. There's going to  
13 be a lot more to come on this. And we really  
14 appreciate the efforts you've done.

15 CO-CHAIR MULHAUSEN: Jim.

16 MEMBER LETT: Oh, thank you. Could I  
17 ask a couple of process questions about this? I  
18 don't have any problems with seeking for the  
19 right data elements and I love the fact that we  
20 will now be able to compare apples to apples  
21 across the post-acute continuum.

22 My question is about the data elements

1       that you all have spoken about here. Did you  
2       pull these from existing assessment instruments  
3       across the post-acute continuum that are -- these  
4       are questions that are currently in those  
5       instruments? Or you went outside those  
6       instruments in order to gather this data?

7                 That's my first question. I have a  
8       couple.

9                 DR. MCMULLEN: Yes. Hi. That's a  
10       really good question. I don't know if I have to  
11       say my name. I did two years ago for  
12       transcribing. But it's Tara. Yes, that's a very  
13       good question. I'm sorry I left out that detail.  
14       It's very important.

15                For the beta test it's a mixture of  
16       items. Some of them are de novo, you know, from  
17       scratch development. Some of the items, you  
18       know, medication reconciliation, are new items.

19                The PROMIS items, for example, are not  
20       items that are used by CMS in our repository or  
21       data item bank for post-acute care. Those are  
22       developed and held with our sister agency, NIH.

1       So we're testing out what has been developed from  
2       scratch by NIH and their contractors.

3               And then some of the items, such as  
4       the pain items, they're mixed. Some of them are  
5       pain items that have been updated and revised  
6       based on what we know from their current use.

7               So, it just depends on the item. And  
8       let me go back. I'm sorry about this. I should  
9       have detailed this. I skipped over the middle  
10      column. But you'll see a lot of the trajectory  
11      for development of the item, based on where they  
12      came from. And I could speak to each one, if  
13      you're interested.

14              We also have this information online,  
15      where we talk about this item's existing, this  
16      item's new, this item's changing because it's  
17      topped out. The item level testing has shown us  
18      that it's no longer functional in the way that it  
19      should be, things like that.

20              So, it's a mix. We were shooting to  
21      expand upon what we have to see what else is  
22      needed, because there are gaps.

1                   MEMBER LETT: My question goes to  
2     burden. What I'm hearing is that you will find  
3     data elements outside of the current assessment  
4     instruments, which means we will have to expand  
5     the current instrument for each site of post-  
6     acute care.

7                   Are you going to decrease any elements  
8     within those instruments so that we can decrease  
9     the burden of reporting? Would be one of my  
10    questions. Because that is a concern. We  
11    laughingly call the minimum data set in long-term  
12    care, we worry you'll come up with a maximum data  
13    set. And that keeps us up at night. So I would  
14    like us to think about burden as we do this.

15                  And you're going to then have the same  
16    set of questions or similar questions across all  
17    four instruments, post-acute-care instruments?  
18    You'll have a core dataset, and it will be the  
19    same questions across all four so they are  
20    reproduced all across those sites?

21                  MS. MANDL: This is Stace Mandl. So,  
22    if I could just jump in. So, I think you raise

1 questions that we have dealt with since the  
2 beginning. And if you're familiar with the MDS,  
3 some of the questions, you know, assessment areas  
4 that Tara touched on should look familiar.

5 When this work began, we began also  
6 with some basic principles. That we look at  
7 burden, and we also look at clinical relevance.

8 And so I think the PhQ is an excellent  
9 example of an assessment that's used not only in  
10 nursing facilities, but also in physician  
11 practices and hospital practices. But really  
12 looking at sort of guiding principles around  
13 clinical relevance. You know, what would be  
14 assessments that would be important or already  
15 done?

16 We certainly looked at what already in  
17 sort of the wheelhouse of the assessment  
18 instruments, beginning with the MDS and looking  
19 at the assessment questions that related to  
20 interventions, you know, or treatments.

21 And as a clinician, you know, looking  
22 across all of the assessment instruments, what's

1 relevant in transitions in care? Well, I need to  
2 know if they're on a vent. If that information's  
3 supposed to be made interoperable, it's important  
4 to know whether they have, you know, a central  
5 line, if they are on oxygen, if they're being  
6 suctioned. You know, those basic clinical care  
7 to help sort of tell the story quickly.

8 And those are consistent with some of  
9 the state-mandated transitions in care documents  
10 that are required as well. So, we sort of looked  
11 at all of this taken together, but with the  
12 charge of knowing that the information needs to  
13 be meaningful to other providers, you know, back  
14 and forth for those transitions in care.

15 MEMBER LETT: Okay.

16 DR. MCMULLEN: I think, taking from  
17 Dr. Levitt's work with the OASIS and the team  
18 there, our contractors and PAC associates,  
19 they've done a nice job of looking at that  
20 assessment instrument for home health agencies,  
21 and saying, where do we need to cut? What is  
22 most useful for our population? They are really

1 populations of people.

2 I think this sets the tone for what  
3 will happen in post-acute care. It has to. We  
4 can't keep adding, because what we know is, we  
5 have individuals who are more complex, and there  
6 are more of these individuals.

7 And we don't have more physicians.  
8 You brought up workforce shortage. So, I mean, I  
9 think ultimately, yeah, we will have to look at  
10 what's useful, what's not, then cut.

11 MEMBER LEVITT: Thank you, Tara. And  
12 just in the example in home health. So, we  
13 removed measures two years ago. And then it gave  
14 us an opportunity to really look at the OASIS,  
15 and work with our partners in the agency, because  
16 the OASIS is not just used by us. It's used by  
17 survey and certification groups for certain  
18 needs. It's used by Centers for Medicare for  
19 payment. It's used by the home health value-  
20 based purchasing program.

21 So, all these needs on our end for the  
22 instrument. So, looking at it item by item and

1       figuring out what we can remove, because we want  
2       to be able to add items as well. But we were  
3       able to. I mean, it took a lot of work. We  
4       removed over, I'd say, probably two million hours  
5       worth of time. It sounds like a lot, but I know  
6       there are lots of hours that a lot of agencies.

7               But it's something, you know, it's a  
8       model that we'll continue to do, both in home  
9       health and in the other programs.

10              And one thing, I didn't mention this  
11       before, I have to say hospice, you know,  
12       separately we have been looking at and assessment  
13       instrument too, in hospice that's called the  
14       HEART. And, again, it's separate from all of  
15       this. But, again, you know, this idea of  
16       developing assessment items, standardizing it,  
17       really needs to be done, both for a statutory  
18       reason, and then really for all other clinical  
19       reasons that we know.

20              DR. MCMULLEN: And you had one more  
21       question, and that was the use of the item. The  
22       items that we're testing, we'll be testing in the



1 four PAC settings that are, you know, delineated  
2 by the IMPACT Act.

3 So, we love hospice. But the IMPACT  
4 Act said home health, IRFs, LTACHs, SNFs. We're  
5 testing the same item in the same manner with the  
6 same instructions to be used in the same way  
7 across -- to analytically be able to make  
8 associations.

9 And so while that item may be used  
10 differently, say in a quality measure, based on  
11 the model, you know, the model that supersedes  
12 that or balances that out, it will be the same  
13 item. That's the intent, that is.

14 MEMBER LETT: Okay. Thank you. Just  
15 one more comment, if I may. I would encourage  
16 the thought process to move away from medication  
17 reconciliation, because I think that's become a  
18 checklist item. "Did you do med rec?" "Oh,  
19 yeah, yeah, we did." To a concept of a correct  
20 medication list.

21 So, thanks for your indulgence.  
22 Appreciate it. And you all from CMS, appreciate

1 it.

2 CO-CHAIR MULHAUSEN: So, we'll take  
3 one more reflection from Gene on this particular  
4 topic. And then I want to engage you around the  
5 agenda management.

6 MEMBER NUCCIO: Thanks. Real quick,  
7 and I will look at the protocol, but one feature  
8 of the items is a goal box or goal component.  
9 And I was wondering what your vision was for  
10 using that, perhaps to capture something about  
11 patient preference, which is one of your items.

12 And, second, in the protocol you  
13 mentioned that you were doing RN expert gold  
14 standard nurses and you were doing nurse/nurse  
15 assessment. Were you thinking at all of  
16 including PTs in that assessment process?

17 DR. MCMULLEN: So, in the collection  
18 of the items, CMS does not dictate who can  
19 collect items. They just need to be clinicians  
20 that are licensed.

21 And what we were building off, for the  
22 methodology, we were building off the Post-Acute

1       Payment Care Payment Reform Demonstration and the  
2       MDS 3.0. I keep pointing to Deb Saliba. This is  
3       all her down there.

4               But what we found was that testing for  
5       even quality measure reliability by gold standard  
6       nurses is a reliable method to be able to  
7       retrieve results that are usable and feasible for  
8       CMS. So, we went along that method, knowing that  
9       the nurse will be with that person or that  
10      resident most of the time.

11             I don't think that we're limited in  
12      who we can test for collecting in the future.  
13      And I think that we welcome looking at other  
14      individuals who are in different professions for  
15      that reason.

16             And one thing I do want to add is, in  
17      the RAND work, we did speak to many professions  
18      about the use of the item PTs, OTs. We have them  
19      as subject matter experts in the item development  
20      work. We have geriatricians, internists, you  
21      name it. And it doesn't even stop there.

22             So, we're trying to run the gamut of

1       who will be assessing, who's using this item?

2       And we also focus in on caregivers, their

3       proxies, those types of individuals, so that

4       we're hearing everyone's consensus. We're

5       attempting to gain a consensus on those items.

6               Goals are very important to us,

7       obviously. We have Section GG, functional

8       abilities and goals. And one of the main

9       highlights of that section is the goals column.

10      We love that.

11             For the care preference items, we are

12      focusing in on decisionmaking. It was in an

13      effort to be able to illuminate what items could

14      be most useful in the ocean of care preferences.

15      I mean, there's so much you can focus on. And we

16      know that we're building from work that's already

17      in our assessment instruments.

18             The goals items, I think we didn't

19      focus specifically on goals. But the intent

20      always of the assessment instrument is to have

21      items and assessment that's built off the goals,

22      the wants and needs of the person.

1 I mean, that's our overall intent  
2 always. And I hope that answers. I think Stace  
3 wants to add a little bit.

4 MS. MANDL: I was just going to say  
5 that the consensus work doesn't involve, you  
6 know, all of the various specialties. But also  
7 that in the PAC-PRD, I believe that the testing  
8 for function also included physical therapy, so  
9 OTs and PTs. So, just a little background on  
10 that.

11 MEMBER NUCCIO: Yes, thanks. We  
12 should chat about some data that I have  
13 differences between the things, which I'm sure  
14 you're aware of. Okay.

15 CO-CHAIR MULHAUSEN: Okay. So, we've  
16 covered a lot. It's been a lot of terrific  
17 effort. We're running about an hour behind. And  
18 I want to discuss time management with you. And  
19 there are a couple of things that I'd like to  
20 propose at this point around the agenda.

21 So, one is a working lunch, where we  
22 would take a very short break, just to get some

1 food, a bio-break, come back, reconvene, and keep  
2 moving. Is there any disagreement with that?

3 And we would introduce that into the  
4 agenda after the update on the PROMIS tool that  
5 we're about to embark on. Any problem with that?  
6 Okay.

7 And then the other thing I'd like to  
8 propose is that we keep the discussion around the  
9 PROMIS tool update to 30 minutes. And if we  
10 can't achieve that just in the presentation, then  
11 perhaps there would be opportunity to discuss  
12 with the CMS team offline questions you have.

13 So, is everybody okay with that?  
14 Okay. Terrific. So, the next item on the agenda  
15 will be Stace and Tara talking about the PROMIS  
16 tool.

17 DR. MCMULLEN: Okay. I've got 30  
18 minutes. I can do this. I'll get this down to  
19 ten or 15. Okay. I was going to give you some  
20 findings from what we've been doing in PROMIS.  
21 There's two discussions here.

22 Our contractor, Abt Associates, had a

1 pilot looking at the PROMIS Global 10 in home  
2 health agencies. And we found some really good  
3 work from that with their efforts. We also have  
4 a PROMIS that's going into our national test with  
5 RAND that I just discussed.

6 Behind both of those pieces of work I  
7 was going to talk about the findings that we  
8 found from our technical expert panel, from our  
9 public comment periods, and from testing.

10 I'm going to limit that. If you guys  
11 have questions, or if you'd like me to present at  
12 a time when we have more time, I can do that.  
13 So, I'm going to go through this. And I hope  
14 that this is comprehensive enough for today.

15 So, I'm going to start with the  
16 current state of PROMIS. And that's in our RAND  
17 national test work. So, building back to, I  
18 believe, last year -- I was on maternity leave,  
19 so I think that was last year, right, Alan? I  
20 don't remember.

21 We had our colleagues from NIH come in  
22 and give some background about when a new

1 collaboration at CMS and NIH and really the FDA  
2 were embarking on. And that's the use of PROMIS  
3 across our quality reporting programs. And the  
4 focus of this work started in post-acute care.  
5 And there are many reasons for that. As you know  
6 well by now, post-acute care, we use instruments,  
7 their surveys. Looking at item use and the  
8 collection of items for feasibility purposes is a  
9 good reality. So we said, let's bring PROMIS in  
10 here and let's see what we can do.

11 So, we were looking at the following  
12 domains for the use of collecting PROMs -- or  
13 PROMIS, and making, you know, PROMs or PROM-QMs  
14 impact in the following domains: cognitive  
15 function, anxiety, physical function, mobility,  
16 fatigue, sleep disturbance, social role  
17 functioning, depression, and pain.

18 At this point I was going to give you  
19 some background, a lot of results that we found,  
20 but moving into the next slide. So, quickly, we  
21 held a technical expert panel and a public  
22 comment period. And we also had some survey



1 development go out for this PROMIS work.

2 First, our technical expert panel was  
3 held in January 2017. And we assessed the idea  
4 of having PROMIS items, PROMs, to develop PROM-  
5 QMs for cognitive function, anxiety, PROMIS  
6 quality of life profile score, a general one.

7 And then in November and December of  
8 2016 we solicited feedback on cognitive function,  
9 anxiety, physical function, mobility, fatigue,  
10 and sleep disturbance.

11 Overall, there was a lot of  
12 discussion. And I guess mixed discussion.  
13 Quickly, a lot of people are concerned about  
14 burden, about item collection and burden. A lot  
15 of people were concerned about difficulty for  
16 patients to accurately self-report some of the  
17 items, say, for function or cognition.

18 A lot of individuals were thinking  
19 that profiles or protocols such as anxiety are  
20 very important, but some of the items aren't  
21 suitable for PAC populations.

22 People also raised concerns about

1 redundancy and whether items can really be seen  
2 as patient-centered or person-centered care. Or  
3 whether the items would be useful guiding care.

4 From our technical expert panel we  
5 said, okay, this was really good input. We got  
6 mixed results. Let's go solicit some feedback  
7 from individuals on these PROMIS protocols and  
8 see what we find.

9 We sent to 285 providers and 61  
10 consumers a list of the PROMIS items. We asked  
11 these providers and consumers to indicate whether  
12 they believe the items, the PROMIS items, were  
13 suitable or not suitable across PAC settings. We  
14 asked them to provide written comment, just their  
15 overall thoughts.

16 We used these results to reduce the  
17 full item bank of PROMIS items for beta testing.  
18 And what we found was that agreement between  
19 stakeholders was varied, but there were a few  
20 areas that people agreed upon that PROMIS was  
21 useful.

22 And at that time CMS was also

1        assessing for burden. And CMS, with the  
2        stakeholder comments, said let's focus in on the  
3        key areas. And this is where we are now, PROMIS  
4        in the national beta test.

5                So, as I just discussed with this work  
6        that we're in now through May of 2018, CMS, with  
7        our colleagues from RAND, are assessing the  
8        usefulness overall, reliability, and validity of  
9        the -- well, really, the usefulness and  
10       efficiency of the PROMIS Global 10, the PROMIS  
11       Depression, and the PROMIS Anxiety protocols for  
12       use for standardization in post-acute care  
13       settings.

14               So, there are some caveats to this.  
15       And I'm going to explain this right here. But  
16       for PROMIS Global 10 and PROMIS Depression and  
17       Anxiety we have two versions of those protocols  
18       that we're assessing to look at the specific  
19       timing of assessments.

20               And for specifically Global 10, we  
21       looked at the items, how they were being asked.  
22       And through cognitive interviews we found that we

1 had to actually reformat some of the items, not  
2 to take away from the concept of the item, but  
3 the usefulness of the item, how it's being asked  
4 and if the person would be able to understand  
5 what's being asked of them.

6 So, again, these protocols are online.  
7 We've posted them if you want to take a look.  
8 But half of the national sample of assessment  
9 protocols for our national testing will be Global  
10 10 collected at three days. And that's a  
11 modified version. And the other half will be  
12 Global 10 collected in the version that was  
13 finalized by NIH at the seven day timeframe.

14 The same for Depression and Anxiety.  
15 Half of our sample of assessment protocols will  
16 be collected in the three-day timeframe. And the  
17 other half will be asked over the past seven days  
18 for mood.

19 Again, I'd like to remind everyone  
20 that today we have recruited 172 facilities and  
21 agencies. Again, our goal is 210. And we're  
22 looking at a target of 20 or 30 individuals from

1 each setting. So, we're doing a split half  
2 reliability test there.

3 The second part of the discussion's on  
4 the Abt work. So, preceding this work was work  
5 that we did in the home health agency setting.  
6 And that's with the work of the OASIS. And,  
7 really, I'd like to think that this is a proof of  
8 concept for what we did with our RAND colleagues,  
9 and now in our national beta sample.

10 So, when NIH and CMS met about a year  
11 and a half, two years ago, CMS turned to our  
12 colleagues in our home health setting and said,  
13 can we conduct a pilot where we're looking at  
14 Global 10? Let's see how feasible it is in a  
15 home health agency setting.

16 And this is what we have here. We  
17 conducted a small pilot. We looked at 12  
18 Medicare-certified home health agencies, with a  
19 total N of 213 enrolled. We looked at Global 10,  
20 and 56 individuals completed the PROMIS survey on  
21 both start and resumption of care.

22 We have a lot of robust data from this

1 pilot that helped inform where we are in the  
2 national test now. But overall we found that  
3 patient-reported outcomes PROs are feasible to  
4 collect among intact home health patients. And  
5 that clinicians in these settings appreciated the  
6 value of the patient self-reporting their status  
7 overall. So, that's really good.

8 The sample of patients reported worse  
9 overall physical and mental health in comparison  
10 to the U.S. reference population. And Gene, he  
11 was a part of this work. So, thank you, Gene.  
12 And this falls in line with what we know.  
13 Because we know home health patients have more  
14 chronic conditions and worse functional status  
15 than those individuals who are not receiving home  
16 health care. So, this finding we thought was  
17 very reliable.

18 Additional testing in home health is  
19 needed and warranted. And that's why we're in  
20 the national test now, to go back into home  
21 health and test the revised and the stable PROMIS  
22 10 -- stable's not statistical, but the PROMIS 10

1       that was originally developed.

2               We want to take into consideration  
3 participation, how that could be achieved and  
4 integrated for cognitively impaired patients.  
5 And we're doing that.

6               We did assess for feasibility.  
7 Clinicians were evenly divided pertaining to  
8 feasibility in concluding that their patients did  
9 or did not find the survey difficult or  
10 confusing. So, it was an important finding, and  
11 we found that in our data element standardization  
12 work with RAND as well.

13              Some clinicians reported patients  
14 found the response scale, the seven point  
15 response scale in Global 10, confusing. Some  
16 clinicians reported patients had difficulty  
17 distinguishing between some items, like overall  
18 health and physical health.

19              However, just as many clinicians  
20 reported that their patients had no difficulty  
21 completing the survey, the Global 10. And that  
22 they didn't have any questions. They found it

1       useful.

2                       So, overall, these findings were  
3       wonderful. And thank you to our colleagues at  
4       the Abt team, and our CMS home health team.  
5       These colleagues built and solidified why we're  
6       in the field now testing Global 10 in the  
7       hundreds of residents, patients that we're about  
8       to test that on.

9                       I think I got that down to 11 minutes.  
10       I was a doctoral student at one time. There's  
11       not many times you can talk to your stars in your  
12       field.

13                      CO-CHAIR LAMB: Heather, go ahead.

14                      MEMBER SMITH: So, thank you so much  
15       for presenting this information. The American  
16       Physical Therapy Association actually has been  
17       strongly encouraging our providers across all  
18       settings to use this tool. Because, for us, to  
19       be able to look at patient function really across  
20       the care continuum is critically important. And  
21       we also have seen strong adoption with other care  
22       providers.



1                   So, we really think that this is  
2                   potentially a tool that may harmonize the  
3                   discussion around a lot of the domains that are  
4                   really critically important to our patients.

5                   So, just thank you for pursuing this  
6                   and starting to go down this road, because I  
7                   think it will be critically helpful in the  
8                   future.

9                   Just a couple of thoughts. You know,  
10                  again, I think in linking our patients across the  
11                  care continuum, getting to a place where we can  
12                  at least start to incorporate some of these  
13                  items, would be really helpful. And I think just  
14                  sharing that as we move forward and looking how  
15                  we might use that in other quality reporting  
16                  programs across CMS would be really helpful.

17                  The other thing I would say, I mean,  
18                  obviously there are definitely some limitations  
19                  to these tools because they are patient self-  
20                  report. But, you know, I'm always hesitant to  
21                  say, oh, we shouldn't use it. I think we should  
22                  try to use it.

1                   One thing I think we might be able to  
2                   balance this out with, certainly from our  
3                   standpoint in looking at function, are measures  
4                   of performance. So, also looking at something  
5                   like a six minute walk test, for instance, to see  
6                   how a patient self-report might line up with  
7                   actual walking abilities.

8                   That is something that doesn't exist,  
9                   really, in a standardized fashion in any of the  
10                  quality reporting programs. But it's something  
11                  that we're starting to think about, you know,  
12                  both just to lend credibility to, you know,  
13                  what's the patient's perception and what's truly  
14                  happening, as opposed to just having either the  
15                  clinician or the patient self-report.

16                  And because there are normative  
17                  standards for some of those tests, again, I think  
18                  that this would be something else that might go  
19                  hand-in-hand with some of the existing measures.

20                  And, you know, I hate to suggest  
21                  additional measures, because I recognize there's  
22                  always a component of burden, but in really

1       trying to paint that full picture, I do think  
2       some of those performance measures would also  
3       cross multiple care settings as we're trying to  
4       get a full picture of our patients. So, thank  
5       you so much for your work in this area.

6                   CO-CHAIR LAMB: Theresa.

7                   MEMBER SCHMIDT: Just a quick  
8       question. Have you given any thought, or has any  
9       work been done, about the applicability of the  
10      PROMIS tool for caregivers or families?

11                  DR. MCMULLEN: Yeah, that's a very  
12      good question. We have given that thought. I  
13      hate to mix quality work that I'm involved in.  
14      But in our quality measure work that I'm also  
15      involved in under the IMPACT Act, specifically in  
16      our transfer of health information quality  
17      measure work, we are bringing in caregivers,  
18      patients, families, talking about the  
19      applicability of that and that sort of metric.

20                  With PROMIS we have discussed  
21      patients, family, caregivers. And it's  
22      definitely a future direction that we would want

1 to explore. At this time, just bringing in the  
2 person's voice, I think, is the focus. We can't  
3 state how important that is.

4 Plus, the development of our PROM-QM  
5 is something, I mean, I'm very interested in.  
6 It's something that we do not have in post-acute  
7 care. And across HHS, committees are talking  
8 about the feasibility of developing a PROM-QM  
9 that could be used across settings.

10 So, in the future I guarantee there  
11 will probably be a patient, family, proxy,  
12 caregiver voice brought into something. I don't  
13 see how you couldn't do that.

14 MEMBER SCHMIDT: Just to be clear, I  
15 wasn't referring to a proxy or a surrogate voice.  
16 I was referring to capturing health outcomes for  
17 caregivers and families.

18 CO-CHAIR LAMB: Pam.

19 MEMBER ROBERTS: I also applaud your  
20 work in starting to look at measures across the  
21 continuum with PROMIS items. And I echo  
22 Heather's comments about looking at the PROs with

1 performance measures.

2 In addition, are you looking at,  
3 especially with some of the PROMIS measures, in  
4 individuals that have communication and cognitive  
5 problems that may not be able to do it in one  
6 setting, but maybe further down the line they  
7 will be able to do it, and being able to capture  
8 that?

9 DR. MCMULLEN: Yeah, that was the  
10 intent, to add it into the protocols for the four  
11 settings, is to see any type of variation in that  
12 coding and collection.

13 So, if you look at the protocol for  
14 the non communicative folks, and that's applied  
15 to all four. And right now this is just for the  
16 four PAC settings. So I can't talk to home,  
17 community-based, or acute.

18 The point is to be able to see if  
19 there is any variation, if there's a change, and  
20 when that marked change occurred in the services  
21 applied to that person.

22 MEMBER ROBERTS: My understanding of

1 the non-communicative one is different than when  
2 you wouldn't do it at all but there are some  
3 people that you can get some of the information,  
4 but you won't be able to get all of it. And  
5 that's kind of gap that's not captured.

6 DR. MCMULLEN: Right. We agree. And  
7 in that protocol we knew that there might be some  
8 limitations. We added in folks who were  
9 unwilling. But we still understand that we might  
10 have some dropout there. And within that, I  
11 think that's a significant finding. And I think  
12 we've just got to fill that out. But we  
13 understand that. We concur.

14 CO-CHAIR LAMB: Tara, I have a  
15 question about the development of it. When you  
16 were talking about the consensus development,  
17 we've been talking this morning about multiple  
18 stakeholder groups, and I think the question  
19 about the alignment between those groups.

20 So, my understanding of what you said  
21 with PROMIS is that there was a process that  
22 consumers identified what was important, and

1 stakeholders did, and there was an attempt to  
2 look at the intersection of that.

3 Did you have any impressions? Were  
4 there, you know, substantive differences between  
5 what consumers and patients thought was important  
6 and providers, and how that played into it if  
7 there weren't intersections?

8 DR. MCMULLEN: Yeah. So, what I was  
9 going to detail in that work was, between the  
10 consumers and the stakeholders, we asked them to  
11 organize from the protocols what items were most  
12 useful to them.

13 I'd have to go back in and work with  
14 our RAND team on this, but we believe that there  
15 were consistent ideas. Like, for example, I was  
16 going to talk to the most preferred item between  
17 all the folks that we assessed or asked them to  
18 give their input was, "I had difficulty  
19 sleeping." The second preferred was, "I felt  
20 worried." And this was for anxiety.

21 And so I believe that was a universal  
22 agreement for the most part. But I'd have to go

1 look into that. Yeah, I would have to figure out  
2 what weighed heavily on that. I'm looking  
3 through my feedback.

4 Overall, what we found in the PROMIS  
5 work was dependent on who you talked to. There  
6 weren't consistencies. There wasn't an overall  
7 "we have to do this," other than "we have to  
8 assess and have patient-reported outcomes  
9 assessed." But between the protocols there  
10 wasn't a consistent response. So, we relied on  
11 the cognitive testing for that.

12 CO-CHAIR LAMB: Well, I was just going  
13 to also echo what Heather was saying, is the  
14 importance of aligning those different  
15 assessments.

16 And the, obviously, the link to  
17 outcomes, which is, if there is a divergence, how  
18 do we understand if a patient feels something is  
19 critically important, but it's not in alignment  
20 with how the professional is evaluating it? What  
21 difference does it make? Because it may make a  
22 huge difference in terms of what I believe is



1 important, either as an individual, or what  
2 Theresa was saying, is a family member may have  
3 huge insights into the outcomes.

4 I'm really struck, in the latest  
5 report of the National Quality Strategy, that the  
6 care coordination changes are lagging behind the  
7 other key priority areas. And I'm wondering if  
8 understanding this difference may give us some  
9 insights into why they're lagging.

10 DR. MCMULLEN: I would imagine that,  
11 the outcome of testing in beta, we would be able  
12 to make some of those links. And we should be  
13 able to make some of those links. I mean, we're  
14 going into the field collecting on multitudes of  
15 individuals.

16 Ultimately, I think everything you  
17 said is very important. We're just not to the  
18 point yet where we can make those associations.  
19 But we agree with you. And that's why we're  
20 moving forward with looking at PROMIS.

21 CO-CHAIR LAMB: Any other comments,  
22 recommendations? Alan.

1                   MEMBER LEVITT: Yeah. Just one. This  
2                   is a great discussion. It's the reason we're all  
3                   here. And we need to hear these ideas about, you  
4                   know, where this should go, continue to go.

5                   This is step one, you know. We're  
6                   trying to do this. And once again, who's doing  
7                   it? It's post-acute care. We're doing this.  
8                   And we need to build on this.

9                   So, please, you know, we're going to  
10                  give you answers sometimes where we're not doing  
11                  that. But it's we're not doing that yet. But  
12                  the "yet" is going to be, you know, based on the  
13                  partnership that we have together. So, thank you  
14                  very much.

15                 CO-CHAIR LAMB: Ready for lunch? How  
16                  long should we take, Paul? Ten minutes, 15, to  
17                  get the food?

18                 CO-CHAIR MULHAUSEN: That would need,  
19                  I think, at least 15.

20                 CO-CHAIR LAMB: Take 15. And then  
21                  we'll regroup. At 12:35 we'll regroup.

22                 (Whereupon, the above-entitled matter

1       went off the record at 12:18 p.m. and resumed at  
2       12:40 p.m.)

3                   CO-CHAIR MULHAUSEN: All right. If we  
4       get everybody to bring their lunch to the table,  
5       so that they're present at the table, then we can  
6       move on to the next agenda item.

7                   I think we probably have a quorum at  
8       the table, so we're going to just launch right  
9       into our next agenda item that Erin is going to  
10      lead us through.

11                  MS. O'ROURKE: Excellent. Thank you.

12                  So, this is actually something we've  
13      already begun touching on this morning, and I  
14      think we can continue to weave these themes  
15      throughout our conversations throughout the  
16      afternoon. So, I do want to acknowledge that  
17      points that have already been made and that we  
18      will have an opportunity to continue this  
19      conversation.

20                  We did want to briefly have a  
21      conversation about some of the specific  
22      challenges that post-acute providers may face

1 when trying to participate in the Merit-Based  
2 Incentive Payment System. Just to make sure  
3 we're all on the same page, I have a few very  
4 brief overview slides, so that everyone's aware  
5 of what the program is.

6 It was created by MACRA in 2015. It  
7 required CMS to implement an incentive payment,  
8 now referred to as the Quality Payment Program,  
9 that has two participation checks, the MIPS  
10 program as well as the Advanced Alternative  
11 Payment Models.

12 MIPS combined four legacy programs  
13 into a single program, PQRS, the Value-Based  
14 Payment Modifier, as well as the Medicare EHR  
15 Incentive Program for Eligible Professionals.

16 MIPS is comprised of four performance  
17 categories for 2018, quality, cost, improvement  
18 activities, and advancing care information. So,  
19 this program addresses physicians, physician  
20 assistants, nurse practitioners, clinical nurse  
21 specialists, certified registered nurse  
22 anesthetists.

1                   There was a change to the low-volume  
2                   threshold in 2018. It includes MIPS-eligible  
3                   clinicians billing more than \$90,000 a year in  
4                   Medicare Part B allowed charges and providing  
5                   care for more than 200 Medicare patients a year.

6                   So, with that, I want to introduce Dr.  
7                   Ted Long from CMS to say a few words and, then,  
8                   turn it back to our Workgroup for thinking a  
9                   little bit about if there's any MIPS-specific  
10                  gaps you want to highlight or any feedback we  
11                  should pass along to the Clinician Workgroup and  
12                  Coordinating Committee.

13                  MR. LONG: So, first off, thank you,  
14                  everybody, for taking a few minutes to talk about  
15                  this today. We've been excited to come in and  
16                  talk to you all about MIPS, in particular,  
17                  because there are a few key areas where we would  
18                  really love to hear your insight and feedback.  
19                  So, I will be very brief, because I was excited  
20                  to hear from you. So, I will not belabor the  
21                  point.

22                  But I just wanted to lay out three

1 sort of key areas that we see that we would love  
2 to your feedback on, just to sort of set the  
3 stage for the conversation today. Don't feel  
4 limited to these three. Just consider this is a  
5 place to start, and then, wherever the  
6 conversation goes, we would love to hear, because  
7 wherever you think it should go is the most  
8 important direction.

9 Three of the areas we think about are,  
10 first, we have measures in the MIPS program.  
11 There are measures in the post-acute care and  
12 long-term care setting. Do we have the right  
13 measures in the MIPS program and, if we don't,  
14 what would your suggestion be about how we could  
15 get there?

16 Second, in the post-acute care and  
17 long-term care setting you do have measures that  
18 are important to patients, family members,  
19 caregivers, and clinicians in those settings, but  
20 oftentimes those measures are not currently  
21 specified for use on the individual clinician  
22 level or for how we could otherwise use them in

1 the MIPS program.

2 We would love any insider thoughts  
3 into the priority you would give to the idea of  
4 respecifying measures, taking what you think is  
5 of highest priority and most important in the  
6 long-term care and post-acute care setting, and  
7 potentially bridging them over to MIPS, and how  
8 that would look. What would go into that and how  
9 we might deal with some of the thorny issues such  
10 as attribution. If we have a clinician that sees  
11 patients at multiple different facilities, how do  
12 we approach that?

13 And then, finally, we were fortunate  
14 to have several public comments in our proposed  
15 rule this last year for the MIPS program, but a  
16 new concept called facility-based MIPS Score. In  
17 a nutshell, what this is, facility-based scoring  
18 is where the MIPS program would take a facility  
19 program score and translate that into what the  
20 clinician or group score would be for the MIPS  
21 program.

22 To give an example, we laid out what

1       could be a proposed plan for thinking about this  
2       on the hospital side. We, then, received a lot  
3       of comments back about the priority for thinking  
4       about this and some initial thoughts on how this  
5       could look on the post-acute care and long-term  
6       care side.

7               But I was curious, we are curious, if  
8       (a) this sounds like something that we should be  
9       pursuing and thinking about, and (b), if so, what  
10      are your thoughts on how we could begin to  
11      approach that?

12             So, I know my three areas here are  
13      pretty broad, pretty open-ended. Please, again,  
14      don't feel restricted to these, but, overall,  
15      we're looking forward to hearing your thoughts  
16      and feedback today. So, thank you.

17             One more comment and, then, I'll turn  
18      it over to you all. In terms of other upcoming  
19      activities, milestones, and timelines we have at  
20      CMS, our rulemaking cycle will, again, start this  
21      next spring. That is where we can begin to  
22      include some of the ideas we may be discussing



1       today. That would be an important milestone.

2               Another important milestone is that we  
3       have put out, or we will put out, we have put out  
4       a forecast and we will be putting out a funding  
5       opportunity announcement soon where we want to  
6       lay out an opportunity to collaborate with  
7       cooperative agreements for future measure  
8       development. So, we just wanted to put that on  
9       people's radar as well.

10              With that, thank you. Looking forward  
11       to the discussion. I will be quiet.

12              (Laughter.)

13              CO-CHAIR LAMB: Thank you for inviting  
14       the feedback, and thank you so much for being  
15       here today. I know we were all excited about  
16       having this dialog.

17              Heather?

18              MEMBER SMITH: As currently a non-  
19       MIPS-eligible participant, I figured I would just  
20       start it off. As you know, physical therapists  
21       are not part of the program currently. We hope  
22       that we are included in 2019, because, obviously,

1 at this point in time, for a number of reasons,  
2 we think it sends a terrible message to our  
3 providers about not moving forward with value.  
4 And I think it doesn't create a full picture of  
5 what's going on with the care team to have  
6 certain providers being withheld from the  
7 program.

8 I do want to point out some concerns  
9 that we have, and we did express these in  
10 comments, about our post-acute care providers.  
11 Physical therapists independently bill in private  
12 practice. However, we do not independently bill  
13 in Medicare Part B facility settings. And so,  
14 even if we were to be added to the program, if it  
15 was carried out as the old PQRS program was, we  
16 essentially would not be able to participate  
17 because of the fact we don't independently bill  
18 in the Part B post-acute care settings and other  
19 facility Part B settings.

20 We would strongly encourage you to  
21 think about how you might be able to apply the  
22 facility scoring to our providers and potentially

1 create opportunities for them to participate as  
2 groups. We do believe that this would allow CMS  
3 to include our providers in this program. And as  
4 we discussed, obviously, in the last section, I  
5 think measures of function would be easy  
6 potentially to start to think about across the  
7 care continuum. Certainly, some of the measures  
8 for the post-acute care settings moving into  
9 traditional outpatient spaces, where patients are  
10 independent, I think would be a great area to  
11 look at for function and really meaningful to our  
12 patients as well.

13 We're happy to have more detailed  
14 discussions about that, and certainly, we will be  
15 proactively going to the agency to discuss that  
16 in the next couple of months. But I just wanted  
17 to put those comments forward for consideration.

18 Thank you.

19 MR. LONG: Yes. No, those are all  
20 very important comments and points. Thank you.  
21 Yes, this is exactly the type of feedback we  
22 would love to hear. So, thank you.

1 CO-CHAIR LAMB: Caroline?

2 MEMBER FIFE: Yes, Caroline Fife.

3 So, one of the challenges -- I am the  
4 Executive Director of a QCDR -- one of the  
5 challenges that we discussed before you got here  
6 this morning is that, under MIPS, as you know,  
7 physicians pick any measures that they wish to  
8 select and they're monetarily incentivized to  
9 pick their highest-scoring measures, which may or  
10 may not be a natural fact relevant to their  
11 practice.

12 So, as a result, even if you have the  
13 perfect group of measures, as long as I can pick  
14 the measures that I've scored the best at, I can  
15 select the measures where my nurses have  
16 effectively done all of the work for me, and I  
17 have participated really not at all in the actual  
18 work involved. And if I have a really good EHR  
19 and a fantastic staff, then I can do very well on  
20 those measures, and you will actually know  
21 nothing about me and it will be irrelevant.

22 Unless that changes, I really think

1 this is a fool's errand. And one can talk about  
2 all the ways in which that could be made to  
3 change, but I just don't see a fix.

4 The thing I am curious to know is  
5 whether there is any interest in using the non-  
6 MIPS measures, the QCDR measures as a way to  
7 either pilot some things or to help us get out of  
8 the silos of care, because I can see that as an  
9 opportunity in post-acute care.

10 I keep waiting to get kicked off this  
11 panel, and they didn't do it after the last  
12 meeting and that really surprised me.

13 (Laughter.)

14 I'm pretty sure that I didn't get  
15 kicked off this one. But the reason is that I'm  
16 not really a post-acute expert.

17 But, when I think about the way in  
18 which quality is focused in these sites of care,  
19 it's focused on the facility and not really the  
20 doc in the facility. And I don't mean to -- I  
21 realize that nurse practitioners and other  
22 practitioners are there, but it just feels that

1       there is no window on this other really important  
2       individual who has a lot to do with what happens  
3       to that patient. And that just worsens the  
4       siloiing of care, which we already realize is a  
5       problem.

6               And somehow that concept that our way  
7       of looking at quality is where your body is, and  
8       not who you are or what the matter is with you,  
9       just there's something that, I just rebel at the  
10      idea that that's what quality is.

11             If I have had a stroke, then why are  
12      you measuring something different when I'm in the  
13      hospital than when I'm in rehab, or when the home  
14      nurse comes to see me once I get home? I mean, I  
15      still just had a stroke. But they're completely  
16      unrelated things that people are looking at. It  
17      just doesn't make sense to me. I'm a simple  
18      girl. I get that.

19             So, it seems to me the only way to get  
20      out of that might be non-MIPS measures that are  
21      focused on the provider and the care that he or  
22      she is giving. It is just a silly idea, but it

1 might work.

2           And the other advantage of that is  
3 that you can pilot some things because you have  
4 more flexibility. Because of the things that  
5 seems apparent to me in looking at the process we  
6 go through is that it is really long and really  
7 challenging. In some cases, by the time we get  
8 something all the way through to the end, it's  
9 already obsolete and you have to start over  
10 again, which was one of the impetuses for the  
11 QCDR.

12           The other question that I have has to  
13 do with barriers, which always gets back to  
14 technology. So, I was kind of wanting to ask Liz  
15 about this later. But, you know, we're looking  
16 at smart apps using buyer technology, and that  
17 could break down so many silos. It's been on my  
18 mind all day long. So, I don't know if that is  
19 another area.

20           I mean, we know that we have high  
21 hopes for that, although, given the data blocking  
22 that we've been coping with all along, I know

1       that it's just going to be another head-banging  
2       thing; I know. I just need to get a Prozac salt  
3       lick out and just keep using it, because it's  
4       going to be horrible, just like it has always  
5       been. But maybe something wonderful will happen  
6       and technology can help us get past that. So, I  
7       hope that will be an opportunity, too.

8               And then, virtual groups, I don't know  
9       what your thoughts are or whether that offers  
10      another opportunity for us to better target  
11      measures at who you want to look at.

12             MR. LONG: Yes, those are all, I  
13      think, great points. And there's two, at least  
14      two, sort of foundational questions that you're  
15      sort of alluding to there. If everyone is okay  
16      with those, I was hoping I could actually ask you  
17      maybe for a few more of your thoughts on two of  
18      these things.

19             One is the tension between allowing  
20      clinicians to pick what they feel is most  
21      important to the care that they deliver, with the  
22      tradeoff there being that they might pick based



1 on other criteria that they may have as well.  
2 And that's one of the questions I had for you, if  
3 you have any thoughts about how to get around  
4 that, maybe specifically with respect to the  
5 post-acute care and long-term care setting.

6 Then, the other foundational, I think,  
7 issue is facility-based scoring, you are saying a  
8 few words about that. Now that would not give  
9 clinicians the same choice. It was be a yes/no.  
10 So, that is a little different than the issues  
11 that you brought up with the choice of a variety  
12 of measures.

13 But I was wondering if you could  
14 comment maybe on that sort of interplay between  
15 choice, options there to ensure we're getting  
16 where we all want to go, which is the most  
17 important areas for the patients, and how that  
18 might pertain to facility-based scoring.

19 MEMBER FIFE: So, I hope this is going  
20 to answer your question. One of the barriers  
21 that we currently have is we have a lot of  
22 physicians who go -- and my nurse practitioner

1 and her colleagues are always frustrated when I  
2 say "physicians," but I don't denigrate them. I  
3 elevate them.

4 But we have a lot of advanced  
5 practitioners who go multiple places. What  
6 happens is, if your amount of practice is less  
7 than 51 percent at any one particular place, you  
8 end up not reporting anywhere, because of the  
9 weirdness of the math. So, you end up being  
10 exempt from all quality reporting because your  
11 care is fragmented, and that seems like the very  
12 person you should be capturing.

13 So, it seems to me that the answer  
14 should be you report quality wherever you are and  
15 stop worrying about whether we have the sum total  
16 or whether it's more than 51 percent. So, I  
17 think that's a problem. We just have to say,  
18 we'll take it wherever you give it, and that it  
19 will be appropriate to the site of care. And  
20 then, we figure out what's appropriate.

21 I don't do long-term care. So, I  
22 probably shouldn't speak to that. But, if there

1 is a measure that we feel is both relevant to the  
2 physician and the facility, terrific; we'll take  
3 that. If, then, you're in the hospital setting,  
4 and it doesn't work that way in the hospital,  
5 then we take what's relevant to you there. Maybe  
6 that's just pain management. And then, when  
7 you're in your office, maybe it's something  
8 different. Maybe it's still pain management;  
9 maybe it has to do with use of high-risk  
10 medications in the elderly.

11 But whatever is fair for that site or  
12 that patient population should be fair in that  
13 setting. I just don't see why that is so hard,  
14 because there is a different mechanisms of  
15 submission unless we figure out, through  
16 technology, something that is more simple.

17 So, I don't know if that answered your  
18 question, but it just seems like it is always  
19 appropriate to your environment because we adjust  
20 to the purpose of our being there when we walk  
21 through the door.

22 MR. LONG: Yes. No, it gets back to

1 the fundamental point that we want to capture  
2 what's most important to the patient in different  
3 settings, but the patient is the same patient  
4 across settings.

5 It's obviously a challenge for us from  
6 a measurement standpoint, but I think it is a  
7 very worthy thing to raise and something we think  
8 a lot about, too. So, that is a very well-taken  
9 point.

10 MEMBER FIFE: I tax ID number isn't  
11 changing. So, it's a problem if you're from a  
12 group, and that is another issue that is really  
13 challenging in academics.

14 MR. LONG: Right.

15 MEMBER FIFE: Because when the  
16 university decides they're going to report  
17 everybody at the entire medical school under one  
18 tax ID number, then, you know, they're going to  
19 use BMI, smoking cessation, and blood pressure  
20 measurement. And you know the orthopedic  
21 surgeons are totally focused on blood pressure  
22 measurement, just saying.

1 CO-CHAIR LAMB: Okay. So, we've got  
2 three more folks. What we would ask is, please  
3 make your comment. And, then, Ted, if we could  
4 make the comments first and, then, kind of deal  
5 with it as a group, so that we can kind of have a  
6 round robin going on?

7 Pam, I think you were next.

8 MEMBER ROBERTS: I mean, I totally  
9 agree with Heather. I'm starting to look at, for  
10 therapies, PT, OT, and speech, being able to have  
11 individual measures at the PAC providers and,  
12 also, being able to carry those measures, because  
13 many times therapists work in multiple settings,  
14 and not just one setting. And then, kind of  
15 tying this back into the IMPACT Act discussion  
16 that we just had, where those are much more  
17 global measures.

18 But, if you really want to understand  
19 how do you improve quality at the facility level,  
20 if you could at, maybe via MIPS -- and this is  
21 just throwing it out -- what are some of the  
22 inputs that go in there? Then, the facility

1 could actually figure out where there is quality.  
2 But, right now, it is granular, which is the  
3 first step of being able to go across settings,  
4 but the next step would be able to get into like  
5 where the variety is. What is driving care and  
6 what is improving it? Maybe by having MIPS at  
7 the individual provider levels in post-acute care  
8 would help.

9 CO-CHAIR LAMB: Deb?

10 MEMBER SALIBA: Yes, I think during  
11 this initial transition period, I am comfortable,  
12 and in fact, think that it's a good idea, to  
13 allow providers to have some choice of the  
14 measures that they're being measured by, with the  
15 goal to perhaps move to your more ideal state of  
16 some of the more universal measures.

17 But I think we have a lot to learn  
18 about how these are going to work and how they're  
19 going to roll out. And having that opportunity  
20 to see which measures are being selected, how  
21 they perform, and getting provider buy-in, which  
22 particularly for smaller practices is going to be

1 an issue. I think in the larger practices where  
2 they've got smart people doing the analytics and  
3 picking out the measures, less of an issue.  
4 Still an issue. So, I'm comfortable with letting  
5 there be some selection process.

6 The other is I am uncomfortable with  
7 sort of the forced distribution measures. The  
8 fact that there have to be defined winners and  
9 losers on every measure, no matter how close they  
10 are to each other in performance, I know it's  
11 difficult, but it might be nice to come up with  
12 some kind of established benchmarks or  
13 performance levels that we consider, as we're  
14 looking at these measures, based on data for what  
15 can be achieved in best practice, to help with  
16 that. So that we're not deciding between people,  
17 ranking one person high and one person low with  
18 our organization with only a two-percentage-point  
19 difference, you know, between them.

20 CO-CHAIR LAMB: I'm not able to see  
21 the name tag down there. Frederick? Is it  
22 Frederick? Please.

1                   MEMBER ISASI: So, just a couple of  
2 thoughts, and these are global, I think beyond  
3 the questions you're asking here. I just want to  
4 contribute a little bit to this, and really  
5 associate myself with, I think it was Caroline's  
6 comments earlier.

7                   I come from doing a lot of work around  
8 post-acute care and long-term care for the  
9 governors at the National Governors Association  
10 and with a lot of their state leaders. And I was  
11 really struck by the measures that we were trying  
12 to develop that really had an impact, which often  
13 around behavioral health integration. It was  
14 often about social determinants, including things  
15 like transportation and housing and stability,  
16 things like that.

17                  Now it's for a subset of vulnerable  
18 populations, but the outcomes that these types of  
19 needs drive are pretty astronomical. They  
20 usually represent the top 5 percent of spend  
21 within a governor's state Medicaid program,  
22 something like that. So, they're associated with



1 very, very high spend.

2 And then, the third point I was going  
3 to make was on data exchange. One of the biggest  
4 obstacles for clinicians, just being these kinds  
5 of measures, is data blocking and the inability  
6 to really get data flowing. I think if we aren't  
7 a lot more deliberate about trying to understand  
8 and quantify the amount of data and the quality  
9 of data being exchanged by the providers, we're  
10 missing the opportunity to try to have providers  
11 solve the problem with us.

12 And then, the last thing I was going  
13 to say was, this notion that clinicians get to  
14 choose their measures is pretty crazy. If the  
15 idea is you want to allow clinicians to select  
16 measures they think that have the greatest impact  
17 on the quality of care that they're providing, it  
18 seems like you're just taking a cookie jar and  
19 just opening it up and saying, "Take whatever you  
20 want." Versus, you know, here's the set of  
21 measures that would be most responsive within  
22 your specialty or within your focus area; pick

1 five of seven, or whatever. It's giving them a  
2 menu. Or the diagnosis you're treating, yes.

3 But, if your end game here is to allow  
4 clinicians to be able to help guide the measures  
5 that are being emphasized, it seems like it's the  
6 tail wagging the dog if you're just saying, "Pick  
7 whatever you want." Right?

8 CO-CHAIR LAMB: Raj?

9 MEMBER MAHAJAN: Thank you.

10 And most of the people have heard me  
11 talk about this for several years now, and I am  
12 so happy that you came here and, as the  
13 practitioners in post-acute/long-term care for  
14 several years, we have said that current  
15 measures, although 50, 49 of them from the MIPS  
16 set apply to place of service and nursing homes,  
17 but when you break it down, really none of them  
18 are as meaningful as they should be.

19 So, we do have a quality measurement  
20 or Quality Measures Subcommittee as part of the  
21 big policy committee AMDA that has been looking  
22 at, okay, you're complaining all the time it

1 doesn't make sense. Then, what do you think  
2 makes sense? So, we do have a good 20 areas that  
3 we have identified that could be possibly good  
4 areas to develop measures.

5 And I just want to just comment that  
6 earlier this week I had my two fellows at the  
7 nursing home look at assessment plans and care  
8 plans, physician notes, assessment plans, and  
9 care plans from the MDS. And 80 percent of  
10 assessment plans and the physician notes had  
11 nothing in common with care plan at the nursing  
12 home. These are over 10 charts at a real  
13 institution just a couple of days ago.

14 And so, that is the problem. The  
15 facility has its own plan, and the physicians are  
16 thinking they're doing care, but they have their  
17 own plan on CHF management and all that. That  
18 might not really be that important for either the  
19 short-term or the long-term care plan.

20 Then, in the end, I will say that,  
21 while our group has looked at what things are out  
22 there, very strikingly, the measures that are

1 being looked at under IMPACT, most of them have a  
2 very high physician impact on their involvement.  
3 I think it should be looked at as an add-on to  
4 the work that is being done under IMPACT or  
5 additional work that the measures -- so, you're  
6 aligning all post-acute levels, but you can also  
7 align physicians' network in there. And they  
8 could all commonly report on these measures.

9 And so, as I said, most of the  
10 measures, as we looked last in IMPACT, are  
11 physician attributable. And if that is not a  
12 possibility, where just like hospitals, facility  
13 measures being used by docs -- I know there are a  
14 lot of logistical nightmares to where you live,  
15 what facility you use. And can people only use  
16 the good facilities and not bad? So, all those  
17 things are there.

18 But I think it is definitely worth  
19 officially looking at whether this can work. And  
20 I strongly think it can work. If it is not going  
21 to be facilities measures as in use MDS to  
22 report, those measures could be looked at,

1 validity, within the physician space and long-  
2 term care.

3 CO-CHAIR MULHAUSEN: So, one of the  
4 areas of confusion that -- I actually don't know  
5 the truth here -- that I have encountered in my  
6 own work with colleagues has been whether or not  
7 in the domain of practice improvement, whether  
8 improvement activities that one is engaged with  
9 in long-term care could apply to the practice  
10 improvement category.

11 So, the one that we've had a special  
12 interest in, because in part of my work I promote  
13 antimicrobial stewardship -- it's required by the  
14 SNFs. A lot of physician involvement is what  
15 we're promoting. And we've always struggled with  
16 the answer to the question, well, if I  
17 participate in the long-term care antimicrobial  
18 stewardship initiatives, can I count that? And  
19 at the level of asking CMS, it just ends up being  
20 confusing.

21 MR. LONG: Okay. So, I'll be very  
22 brief here, but I just want to say again thank

1       you, everybody, for your comments. I want to  
2       highlight a few summary notes that I was taking  
3       here from what people were saying, just to make  
4       sure I'm taking the right things away. And then,  
5       I'll answer your questions.

6               Pam, to your point, we need to look at  
7       PT and OT and their inclusion in the MIPS  
8       program. Definitely hear that and it's well-  
9       taken.

10              Deb, to your point, we have thought  
11       about the role of achievement points in the MIPS  
12       program, in addition to how we do benchmarking.  
13       But your emphasis on it here is very helpful to  
14       hear. So, thank you.

15              Frederick, we hear you on information  
16       block -- and everybody -- information blocking.  
17       We recognize it's definitely a problem.

18              Also, Frederick, one of the points you  
19       made which is interesting to me, and maybe if we  
20       get more feedback on this moving forward, is the  
21       idea of putting measures together in sets. So,  
22       it's a challenge with post-acute and long-term

1 care because it's a setting that we're talking  
2 about here. Whereas, for different specialties,  
3 we have created sets.

4 If you want to take a look at our  
5 website to see how this might work for the post-  
6 acute care and long-term care setting? For  
7 example, orthopedic surgery is a set. So, if  
8 you're an orthopedic surgeon, you go to your set  
9 and you see which measures apply to the type of  
10 surgery you do. So, if you're an orthopedic hand  
11 surgeon, the spine measures will not apply.  
12 That's where the choice comes in. It's in terms  
13 of designating really what's within the scope of  
14 your clinical practice.

15 I think it is a challenge to translate  
16 that to the post-acute care and long-term care  
17 setting, but I think we would be interested to  
18 explore that further. So, your point is well-  
19 taken on that, too.

20 Raj, looking at how the IMPACT  
21 measures could be taken over to the MIPS program,  
22 the concept behind that, with the attribution

1 currently to finish this, is very well-taken.

2 It's time we talk about it. No, I agree with

3 that. That's very important.

4 And, Paul, the improvement activity,  
5 so the answer is, absolutely, yes, the  
6 improvement activities do apply. Now the caveat  
7 to that is the improvement activities in the  
8 description of them sometimes have requirements  
9 that require the action to be done in a certain  
10 way or with a certain protocol.

11 I could tell you that antimicrobial  
12 stewardship not only has -- there is one, at  
13 least one improvement activity that is specific  
14 to that, but there's others that actually apply  
15 under that as well. So, the activity you're  
16 doing, the Act should have been met in a couple  
17 of different ways.

18 I found it's easiest to take it  
19 offline, and I would be happy to share my email  
20 with you and to answer that more specifically for  
21 you.

22 CO-CHAIR MULHAUSEN: It's very useful



1 to know, though, that improvement activities and  
2 long-term care can be applied in the practice  
3 improvement.

4 MR. LONG: Yes.

5 DR. YONG: Can I ask you why there's  
6 that? I mean, why would you think of getting it?

7 CO-CHAIR MULHAUSEN: Well, simply  
8 because everything has, to date, seemed very  
9 focused on ambulatory care. And I think many  
10 clinicians who are dedicated to long-term care  
11 have felt left out.

12 So, just a reflection on feeling left  
13 out. Before Telligen became the call center for  
14 QPP, so I'll confess to that, but this happened  
15 before.

16 (Laughter.)

17 I don't know what would happen if I  
18 called now. But, when I called the call center  
19 and said, you know, "So, if I'm in a nursing home  
20 and my practice is in a nursing home...", and the  
21 answer I kept getting back was, "No, nursing home  
22 work doesn't apply because the site-of-care

1 sub -- whatever -- code. Right? And at the  
2 time, I could have told you that more  
3 articulately.

4 And that message came over and over  
5 and over again. I even said to them once, I  
6 said, "That makes no sense to me. Are you sure  
7 that's correct?" But their argument was, well,  
8 it's not Part B. And I go, "Well, to my  
9 knowledge, everything I did over the course of my  
10 career in non-post-acute care settings was all  
11 Part B." And so, that created the confusion for  
12 me. Does that make sense?

13 MEMBER FIFE: Sorry. The other  
14 clarification was that most of this data is being  
15 collected from a specific type of, usually, EHR.  
16 And so, the entity that did the reporting had to  
17 attest that you had at least 51 percent of the  
18 data of that provider, if you were going to do  
19 their reporting for them.

20 So, if you were a PQRI, PQRS, or a  
21 MIPS-reporting registry, and you couldn't say,  
22 "Yes, I have 51 percent of their data," then it

1 wasn't applicable. And since most of us are  
2 attesting for their IAs as well as their MIPS on  
3 quality reporting, then you wouldn't attest to  
4 any IA activity that didn't happen in their  
5 office, where their EHR was. And so, if they  
6 were doing that in some other site of care, we  
7 wouldn't be attesting.

8 MEMBER MAHAJAN: And just to add onto  
9 that is a lot of times, for example, two of the  
10 big items right now that are high impact are  
11 either anticoagulation management or glycemic  
12 control. So, if there is a QAPI put together by  
13 the facility, it is an IA for the facility. It  
14 is housed in the facility EHR. And it is done  
15 for everybody that practices there.

16 So, although it makes sense if your  
17 patients are there and you are using that  
18 protocol for either anticoagulation or for  
19 glycemic management, and, yes, you are, but, I  
20 mean, you can attest to that. But I know a lot  
21 of people who attested to the incentive money and  
22 got their payment back after it was audited and

1 found out that it wasn't appropriate.

2 So, there is that fear that, if you  
3 use a protocol developed by the facility to  
4 attest to a physician-level intervention, it  
5 might not fly at an audit.

6 MR. LONG: Yes, I will add, this  
7 actually is really helpful feedback for us to  
8 hear because these are things we can really help  
9 to clarify.

10 If there are questions, we do have a  
11 way to answer, through our current service  
12 center, questions about which type of activities  
13 would qualify for improvement activities for  
14 clinicians as well. So, I would encourage you,  
15 and we can share that information, too. So, we  
16 do want this to be as clear as possible, and it  
17 sounds like there are ways for that.

18 CO-CHAIR LAMB: Thank you.

19 And in our ensuing discussions today,  
20 we're going to be talking about gap areas. So,  
21 we're hoping that we can also share that with you  
22 in terms of what may be relevant for looking at

1 MIPS in the post-acute/long-term care.

2 So, thank you so much for coming.

3 MR. LONG: Thank you all very much.

4 MEMBER FIFE: Do you dare leave your  
5 contact information?

6 (Laughter.)

7 Or do you want to like get out fast?

8 (Laughter.)

9 MR. LONG: It's alan.levitt -- no, I'm  
10 just kidding.

11 (Laughter.)

12 No, actually, I will be happy to be in  
13 touch. It's theodore, T-H-E-O-D-O-R-E, dot,  
14 long, L-O-N-G, @cms.hhs.gov. And we can share  
15 that, too. But I would be very happy to be in  
16 touch.

17 MEMBER FIFE: Okay. You'll be sorry.

18 (Laughter.)

19 MEMBER LEVITT: If I can just make a  
20 comment on the alan.levitt -- (laughter) -- no.  
21 No, it actually is true. Because last year we  
22 were sitting next to each other, Raj, Ash, and I.

1 We were talking about this. And when I left the  
2 meeting, I gave each other an email, so they  
3 could start talking about this and working.

4 And much like the feedback loop where  
5 you would tell the message back to us at CMS, it  
6 was we want to hear more about these measures.  
7 We have issues and questions about them. Please,  
8 when you can have some answers to them, bring  
9 them back. So, what you talk about here, we're  
10 listening too, and please continue to do that.

11 Alan.levitt@cms.hhs.gov.

12 (Laughter.)

13 CO-CHAIR LAMB: Thank you, Alan.

14 We're going to move into pre-  
15 rulemaking now, and Jean-Luc is going to lead us  
16 through that.

17 MR. TILLY: Great. Thanks, Gerri.

18 So, as many of you know who have been  
19 returning to this for a few different years, we  
20 have a three-step approach to pre-rulemaking.  
21 So, we'll start with a kind of program overview,  
22 so you'll hear about each of the different

1 programs in turn. We'll review the current  
2 measures in that program. And then, we'll take  
3 some time to look, in our case this year, at the  
4 one measure under consideration, kind of talk  
5 about how that would add to the program measure  
6 set, review the staff preliminary analysis, and  
7 then, vote on that measure. For the programs  
8 where we don't have a measure, we'll just kind  
9 of concentrate on that gaps discussion.

10 To evaluate a measure under  
11 consideration, essentially, we do have to reach a  
12 decision on every measure, which feels pretty  
13 attainable this round. The decision categories  
14 are standardized for consistency across the  
15 Workgroups. So, we're all kind of voting on the  
16 same things and giving CMS the same standardized  
17 feedback.

18 In addition to the vote that you take,  
19 we will be summarizing the conversation as a kind  
20 of statement of the Workgroup's rationale. That  
21 can help CMS understand the context that  
22 surrounds the voting decision.

1                   In previous years you'll remember we  
2                   used a kind of consent calendar voting process  
3                   where we looked at the staff's full analysis,  
4                   gave the Workgroup members a chance to pull  
5                   measures off the consent calendar and discuss  
6                   those. Given our unique situation, this round I  
7                   think we'll just pull the measure and give  
8                   everyone a chance to talk about it. You know, we  
9                   haven't assigned any lead discussants. So, we'll  
10                  just kind of open the floor for conversation  
11                  there and allow the Co-Chairs to summarize that  
12                  conversation, advance a motion, and then, vote on  
13                  that motion.

14                 When you're taking a look at the  
15                 preliminary analysis today, hopefully, not for  
16                 the first time, but we will see that, basically,  
17                 our goal is to give a kind of succinct profile of  
18                 the measure we're talking about, and this goes to  
19                 the core queue for the SNF therapy.

20                 We've given it a verdict and a little  
21                 bit of justification around that verdict. We've  
22                 walked through the criteria. So, you will have a



1 chance to kind of see our reasoning there, ask us  
2 questions about that, and discuss.

3 So, the MAP measure selection  
4 criteria, there are seven. They have to do with  
5 a kind of logical sequencing from looking at, you  
6 know, how well does the measure fit into the  
7 program set? How responsive is it to our  
8 standards for scientific acceptability? Does it  
9 help the measure set have the right set of  
10 measure types? Is it responsive to some of these  
11 more emerging demands? And does it reflect our  
12 emphasis on person- and family-centered care?  
13 And does the program measure set promote  
14 parsimony and alignment?

15 So, we'll talk, then, just really  
16 quickly about the four decision categories you'll  
17 be choosing from today for that one measure under  
18 consideration.

19 Support is pretty simple. That's just  
20 that the measure meets all of the criteria in the  
21 algorithm. If the measure is in use, it's that  
22 there haven't been any kind of unintended

1 consequences identified.

2 Conditional support is close. So, the  
3 measure meets most of the criteria, but maybe  
4 there are one or two things that should be either  
5 tweaked or in some other way revisited.

6 Typically, that means submitting the measure for  
7 NQF endorsement, to have that kind of deeper dive  
8 on the scientific acceptabilities on the  
9 different properties.

10 Refine it and resubmit it is a little  
11 bit more complicated. In a second, I'll turn it  
12 over to Erin to go into exactly what that means.  
13 But that's like a conditional support for  
14 rulemaking, but what we're thinking there is, are  
15 there really more substantial modifications that  
16 need to be made? And ideally, the measure would  
17 come back to the PAC/LTC Workgroup to have a kind  
18 of second crack at evaluating that measure and  
19 offering a decision.

20 Do not support means that, broadly  
21 speaking, the measure really doesn't meet the  
22 measure selection criteria that the MAP has

1       agreed on.

2                   And so, with that, I think I'll just  
3       turn it over to Erin to talk through the refine  
4       and resubmit.

5                   MS. O'ROURKE: Absolutely, and I don't  
6       want to belabor this because I know we're short  
7       on time, and our one measure is fully developed  
8       and NQF-endorsed.

9                   But, in the interest of being  
10       consistent across the Workgroup, and because this  
11       concern was raised during your fall web meeting,  
12       we just wanted to follow up with some guidance on  
13       the refine and resubmit category.

14                   The Coordinating Committee created  
15       this category, as Jean-Luc was saying, with the  
16       intent that a MUC that received this designation  
17       would be brought back to MAP before it was  
18       implemented. However, the Secretary of HHS does  
19       have statutory authority to propose a measure  
20       after considering MAP's recommendations.

21                   This year we implemented the feedback-  
22       loop process that you heard during your fall web

1 meeting as a way to bring you that feedback,  
2 perhaps not through the formal pre-rulemaking  
3 process, but to keep you all in the loop about  
4 how measure stewards and developers had acted on  
5 some of the Workgroup's input on prior MUC lists.

6 However, given some of the concerns  
7 we've heard from this Workgroup, as well as the  
8 similar theme arose at the Clinician and Hospital  
9 Workgroups' meeting, we are going to ask the  
10 Coordinating Committee to review this decision at  
11 their January meeting.

12 Next slide.

13 So, we did start to discuss this issue  
14 during the November 30th meeting of the  
15 Coordinating Committee. They reiterated their  
16 intent was to support a concept of a measure, but  
17 recognized there may be a potentially significant  
18 issue that should be addressed before  
19 implementation. Ultimately, they suggested for  
20 this year using this category judiciously,  
21 recommended that you use this decision when a  
22 measure may need a substantive change.

1                   The Committee also reiterated if  
2                   Workgroups could please clarify any suggested  
3                   refinements. This is feedback we've heard from  
4                   the measure stewards and developers that it's  
5                   challenging to make your changes when it's not  
6                   clear what they are.

7                   I also just wanted to talk a little  
8                   bit about how the Clinician Group used this  
9                   yesterday. They actually really saw the  
10                  conditional support as a way to address some of  
11                  the potential fuzziness with this category, and  
12                  they identified a few measures that they would  
13                  tweaked before they're implemented. So, they  
14                  named some very specific conditions, provided  
15                  that guidance to CMS, also to the NQF standing  
16                  committees when a measure was not endorsed on  
17                  specific areas where they wanted the standing  
18                  committee to weigh-in and perhaps evaluate the  
19                  evidence or some of the underlying scientific  
20                  merits of the measure.

21                  NQF does capture all of MAP's feedback  
22                  on unendorsed measures and bring that to the

1 standing committee when they come in for their  
2 endorsement reviews. So, we do try to be the  
3 conduit of information and make sure that the  
4 standing committee knows any concerns the MAP  
5 committees may have raised with a measure and  
6 give them that guidance on where you all would  
7 like them to look and some areas of focus.

8 You also do have the option of doing  
9 this refine and resubmit, but I did just want to  
10 caveat that there is no requirement for the  
11 measure to come back before you on the MUC list.  
12 So, that is a distinction we do want to note to  
13 you all.

14 So, I think, with that, I did just  
15 want to ask Pierre if you wanted to share  
16 anything about how CMS operationalizes this or  
17 any thoughts.

18 DR. YONG: Yes, thank you, Erin.

19 And I think we certainly value all the  
20 input. And a lot of what the value is, is  
21 captured not just on the actual recommendation,  
22 like whether it's support, conditional support,

1 refine and resubmit, or do not support, but a lot  
2 of the sort of contextual comments that you  
3 provide as part of that discussion to arrive at  
4 that decision, which is captured in the reports  
5 that NQF puts forward from the MAP.

6 And so, we all are here for a  
7 particular reason all day, right? This is really  
8 to listen intently about the comments and  
9 thoughts that you have about the particular  
10 measures.

11 I did want to also echo Erin's  
12 comments that I think what worked really well at  
13 the Hospital, at the Clinician Workgroup --  
14 excuse me -- yesterday was this sort of tweak  
15 about how they use the refine and resubmit. They  
16 did use it very sparingly, and they saw a way to  
17 use the conditional support to really incorporate  
18 some of the sort of concerns or issues that they  
19 raise as a way to sort of minimize the use of  
20 refine and resubmit in their voting process.

21 MS. O'ROURKE: And we did open this  
22 for conversation yesterday for input on this

1 category. In the interest of time, and that  
2 we're rapidly falling farther behind schedule, if  
3 you have feedback, or for those of you that have  
4 served on years past, please email me or give me  
5 a call offline and I'd be happy to hear it. We  
6 are collecting input from the Workgroups to bring  
7 this to the Coordinating Committee in January. I  
8 don't want to stand between you and your flights  
9 home, and we do still have some work to do. But,  
10 please, reach out if you have concerns or any  
11 feedback you want to share.

12 And I think, with that, I am actually  
13 back on to just walk you through the voting  
14 process.

15 Miranda, if you could skip forward a  
16 bit?

17 I'm going to try to go through these  
18 quickly, so we can get to the main event, if you  
19 will.

20 Just a few key voting principles to  
21 remind everyone. You've defined consensus as a  
22 60-percent threshold. So, we need greater than



1       60 percent of participants.

2               Every measure under consideration will  
3 receive a decision, either individually or as  
4 part of a slate of measures. We do ask that the  
5 Workgroup comes to a decision on every measure  
6 under consideration. In the past, we had what we  
7 called split decisions where we couldn't get to  
8 consensus at the Workgroup level and the decision  
9 was left to the Coordinating Committee. They  
10 pushed back that they don't have the depth of  
11 expertise in the subject matter area that the  
12 Workgroups have. So, they asked that you push  
13 forward and try to send them a decision on every  
14 measure.

15               Next slide.

16               So, we will provide an overview of the  
17 process to establish consensus through voting.  
18 We'll go over some introductory presentations on  
19 the program and how it works. We do have a  
20 discussion guide for you all. It's the  
21 electronic file. You'll see the preliminary  
22 analysis as well as the early public comments

1 received. We also have a brief, little snippet  
2 explaining the program for your reference.

3 We've put every measure under  
4 consideration, our one that was a lift this year,  
5 through this preliminary analysis, based on the  
6 algorithm approved by the Coordinating Committee.  
7 And that serves as how we got to this initial  
8 decision about support, do not support, so on and  
9 so forth.

10 Next slide.

11 So, the first step, we'll present you  
12 a consent calendar. You'll have a group of one  
13 this year. So, a bit of a formality. We can  
14 move on.

15 Our next slide.

16 The process still is a consent  
17 calendar. Right now, the measure received a  
18 decision of support.

19 Jim, I believe you sent some early  
20 comments. I don't know if you wanted that to act  
21 as a formal poll. But, if anyone wants to have  
22 conversation on this measure, we ask that you

1 pull it off the consent calendar and open the  
2 floor for discussion. You could potentially  
3 disagree with our preliminary analysis or have  
4 some new information. You might also want to ask  
5 some clarifying questions of either CMS or the  
6 measure developer.

7 So, once we know which measures we  
8 want to pull off the consent calendar, the Co-  
9 Chairs will ask if there's any objection to  
10 accepting the preliminary analysis and  
11 recommendation of anything that remains on the  
12 consent calendar. If you do not remove the  
13 measure from the consent calendar, the associated  
14 recommendation will be accepted without a  
15 discussion.

16 Next slide.

17 So, if a measure is pulled, we open  
18 for discussion. There's a lot of words on this  
19 slide to go through the process. We don't  
20 perhaps need to be quite as formal, since you  
21 only have one measure and we didn't assign anyone  
22 to serve as our lead discussant, because we

1 really wanted everyone to feel free to jump in.  
2 So, if you would like to make a motion, we will  
3 open for discussion.

4 Next slide.

5 After that, I will tally the votes.  
6 We're looking for greater than 60 percent of a  
7 vote to get to consensus. Just to clarify, we  
8 are doing hand voting, right? We're having a  
9 little technical difficulty with the clickers  
10 that we've used in the past. So, the Chairs will  
11 ask you to just raise your hands. Folks on the  
12 phone, please just speak up with your vote.

13 We do discourage abstentions. But, if  
14 you do abstain, you will not be counted in the  
15 denominator.

16 Next slide.

17 We will open for public comment before  
18 we start committee discussion. We've also  
19 incorporated input that the public provided prior  
20 to your meeting into your discussion guide for  
21 your review. We'll also have a global public  
22 comment at the end of the day, as well as a

1 public comment period on the Workgroup  
2 recommendations prior to the recommendations  
3 being reviewed and finalized by the Coordinating  
4 Committee.

5 Next slide.

6 So, I'll go through this at the end,  
7 because I know we're short on time.

8 Next slide.

9 With that, why don't we jump into it?  
10 Our one measure under consideration is for the  
11 Skilled Nursing Facility Quality Reporting  
12 Program.

13 Dr. Gifford, if you wouldn't mind  
14 coming to the table as well?

15 MEMBER LEVITT: And the measure  
16 developers step forward.

17 MS. O'ROURKE: Sorry, while we're all  
18 getting to the table, John just let me know we  
19 have another new member who has joined us on the  
20 phone.

21 Amy, could you introduce yourself and  
22 let us know if you have any disclosures of

1 interest?

2 MEMBER GOTWALS: Hi. Amy Gotwals,  
3 standing in for Sandy Markwood, with the National  
4 Association of Area Agencies on Aging.

5 And, no, I have no conflicts to  
6 disclose.

7 MS. O'ROURKE: Excellent.

8 So, just a quick overview of the  
9 program. We did go through this in November.  
10 This is the SNF Quality Reporting Program. It  
11 involves a penalty for failure to report.

12 Facilities that submit data under the  
13 SNF PPS are required to participate in this  
14 program, excluding units that are affiliated with  
15 critical access hospitals.

16 Data sources include Medicare fee-for-  
17 service claims as well as the minimum dataset  
18 assessment data.

19 Next slide.

20 This is another slide from the fall  
21 meeting just highlighting what's currently in the  
22 program. You have this information in your

1 meeting materials in case you want to reference.

2 Next slide.

3 Again, here it shows some of the high-  
4 priority domains that CMS has put forward in  
5 previous years and how they've addressed it. In  
6 particular, highlighting the need for measures of  
7 functional status, they added some measures  
8 through the rulemaking process this year to  
9 address that domain.

10 Making care safer, in particular, a  
11 measure modifying the current pressure ulcer  
12 measure. Again, another change that was  
13 implemented through this year's rulemaking.

14 And then, an outstanding potential  
15 high-priority need of measures assessing timely  
16 transfer of information.

17 Next slide.

18 Some previous gaps that the Workgroup  
19 has identified include experience of care, the  
20 efficacy of transfers as well as transfer of  
21 information between clinicians.

22 Next slide.

1                   With that, why don't we open for  
2 public comment on the SNF QPR and the measure  
3 under consideration?

4                   OPERATOR: Okay. If you would like to  
5 make specific comments, please press \*, then the  
6 number 1.

7                   (Pause.)

8                   And there are no public comments at  
9 this time.

10                  MS. O'ROURKE: And it looks like no  
11 one in the room.

12                  So, with that, we can move on to our  
13 consent calendar. So, we have one measure under  
14 consideration for this SNF QRP. It's MUC17-258,  
15 the CoreQ short-stay discharge measure.

16                  If you see your discussion guide, the  
17 current preliminary analysis decision is a  
18 support for rulemaking.

19                  So, we can open it up for the  
20 committee if you want to pull the measure for  
21 discussion or pass on the consent calendar.

22                  CO-CHAIR MULHAUSEN: Jim, did you want



1 to make a motion?

2 MEMBER LETT: Yes. I'd like to pull  
3 it. Just have a few process questions.

4 CO-CHAIR MULHAUSEN: All right. So,  
5 we're going to review MUC17-258, CoreQ, short-  
6 stay discharge measure. And we're open for  
7 discussion and questions.

8 Jim, go ahead.

9 MEMBER LETT: Oh, thank you. Thanks  
10 for being here, Giff.

11 I wasn't clear as to who bore the  
12 resource responsibility for sending out the  
13 survey, collecting it, collating it,  
14 distributing, who gets the results, who  
15 guarantees the quality of the data, and who's the  
16 repository and safekeeper of it.

17 DR. GIFFORD: Well, I can tell you how  
18 it is currently being used in the general public  
19 domain and everything. I cannot answer how this  
20 would be proposed in rulemaking because I don't  
21 work at CMS.

22 (Laughter.)

1                   And I don't know if they can comment  
2                   on how it's going to be in rulemaking because, if  
3                   it's in the midst of rulemaking, they can't  
4                   comment. If it's not, I mean, my understanding  
5                   of the MUC list is that these would be available  
6                   for future recommendations.

7                   I can tell you how we would recommend  
8                   they use it and help that through, but,  
9                   generally, you're approving -- because I'm on the  
10                  MAP -- as Erin has pointed out, you're approving  
11                  or recommending to the MAP whether measures  
12                  should be considered for future rulemaking. It's  
13                  hard to make that recommendation when you don't  
14                  know they would.

15                  Taking off my measure development hat  
16                  for a moment, I will say, representing AHCA, we  
17                  have recommended and would like to see this  
18                  incorporated into public reporting, and that we  
19                  would support them putting it in rulemaking to  
20                  make it a SNF QRP measure for either inclusion  
21                  under Compare or in Five Star. How those details  
22                  would be done would clearly need to be done.

1                   There's, clearly, a lot of questions  
2                   that need to be rolled out and answered on that.  
3                   I will say that -- now putting my measure  
4                   developer hat on -- when we designed CoreQ, we  
5                   tried to learn and use the way CAHPS is used in  
6                   different provider settings. And so, we designed  
7                   it to be incorporated for existing vendors to  
8                   deliver it. So, in all the other settings,  
9                   private vendors, providers contract with private  
10                  vendors, and they administer the CAHPS Survey  
11                  following standard protocol.

12                 We, in developing the measures and our  
13                 submission to NQF, we try to be very explicit in  
14                 that. We also wanted to start using it before  
15                 that, just for quality improvement purposes. And  
16                 so, we brought all the major satisfaction vendors  
17                 together and agreed on a bunch of standards about  
18                 how to collect the data and everything else, so  
19                 that it would be consistent. So, pretty much all  
20                 the major vendors have now incorporated it into  
21                 their existing instruments. And at no additional  
22                 charge, it just added questions to existing

1 instruments they're administering out there.

2 If providers out there don't have a  
3 contract with an existing vendor and want to use  
4 it, some of the different vendors will administer  
5 it separately. Or we also contracted with -- or  
6 we didn't contract -- we arranged with Nick  
7 Castle, who helped develop it and was one of the  
8 CAHPS developers at the University of Pittsburgh,  
9 he will now administer that survey to collect the  
10 data.

11 So, I can talk about the data  
12 administrator. How it would be transmitted to  
13 CMS, used in public reporting, I would assume it  
14 would be very similar to the way they do the  
15 CAHPS in the other settings.

16 As far as a burden onto the providers,  
17 it would only be an added burden, an added cost,  
18 if you currently don't collect satisfaction. If  
19 you currently do, there's really no added cost to  
20 that, unless you collect it and administer it  
21 yourself.

22 What we have found, that those are

1 highly homegrown instruments. How they're  
2 administered, how they calculate stuff is just  
3 all over the map. So, what we try to do is bring  
4 consistency to the table on that.

5 We also designed this to be added into  
6 existing survey instruments because many  
7 providers out there have historical data and did  
8 not want to switch vendors or have to switch to  
9 anything out there.

10 And so, we also took some lessons and  
11 challenges from the way CAHPS was rolled out in  
12 all the other settings to accommodate that as  
13 well.

14 And Lindsay Graham is the phone. I  
15 don't know the number. And Nick Castle is, too,  
16 to help answer.

17 Lindsay, how many vendors now do we  
18 have? And actually, since it's on the MUC list,  
19 a few vendors we didn't even know exist out there  
20 have now called us to add it in because they've  
21 gotten attention to it.

22 The vendors, we have regular calls

1 with them. They're very appreciative of trying  
2 to do this in a standardized way and it doesn't  
3 sort of disrupt their workflow, either.

4 Lindsay, how many vendors do we have  
5 it on now? Do you know?

6 MS. GRAHAM: Sure. Giff, can you hear  
7 me?

8 DR. GIFFORD: Yes.

9 MS. GRAHAM: Okay, great.

10 We have 15 vendors, and that continues  
11 to grow.

12 DR. GIFFORD: Yes. Does that answer  
13 it, Jim?

14 Thanks.

15 CO-CHAIR LAMB: Alan, did you want to  
16 add, too?

17 MEMBER LEVITT: Well, yes. Well,  
18 first of all, were there any measure-specific  
19 questions before we kind of get into the  
20 operationalization of the measure? Was there  
21 anything specific?

22 CO-CHAIR LAMB: We have a couple of

1 others up. So, why don't we go through them?

2 MEMBER LEVITT: Yes, if you want to  
3 do --

4 CO-CHAIR LAMB: And then, we'll do  
5 that first.

6 MEMBER LEVITT: Maybe we could do  
7 those, yes. Then, we can kind of talk about  
8 them. Okay.

9 DR. GIFFORD: Yes, that's fine.

10 CO-CHAIR LAMB: Okay.

11 MS. SCHLAIFER: As Erin mentioned  
12 earlier this morning, I co-chair the MAP Medicaid  
13 Adult Core Set Task Force. And in sitting in on  
14 the meeting, partly we listen to all the  
15 discussions that go on and all the measures  
16 discussed across the three Workgroups to help  
17 give us ideas to think about on the Medicaid side  
18 as we develop the Medicaid adult core and child  
19 core sets.

20 This is one measure that we identified  
21 that we think would be useful on the Medicaid  
22 side. And I realize that's not the reason for

1 the meeting today. But I think, from a MAP  
2 Coordinating Committee point of view, which I  
3 also sit on, always looking for the potential for  
4 harmonization across the various CMS programs.  
5 That's one thing CMS has asked the Medicaid  
6 Workgroup Chairs, to look at all measures and  
7 identify some that would be especially helpful in  
8 harmonizing across the Medicare and Medicaid  
9 programs, and this is one of the measures that we  
10 have identified as doing so.

11 So, I just want to, even though I'm a  
12 non-voting, not a voting member of this group,  
13 just put a plug in for it that reason.

14 CO-CHAIR LAMB: Thanks for sharing  
15 that.

16 Sean, is your card up?

17 DR. GIFFORD: Could I just comment on  
18 that?

19 We actually have an NQF-endorsed CoreQ  
20 for long-stay Medicaid beneficiaries as well as  
21 family members. And we're in the process of  
22 submitting one for assisted living for residents



1 and family. And the items and everything are  
2 consistent across there. That's why we call it  
3 CoreQ.

4 MEMBER MULDOON: Could you remind me  
5 about the timing as it relates to the 100-day  
6 window and when that starts, and what, if any,  
7 internal biases you've discovered or anticipate  
8 related to whether the survey is answered  
9 promptly or at the last minute?

10 DR. GIFFORD: So, I assume, by the  
11 100-day window, you mean we define -- since this  
12 is for short stay and the SNF QRP is for short-  
13 stay individuals, this would be individuals who  
14 are admitted and, then, discharged within 100  
15 days. So, if they're not discharged within 100  
16 days, we consider them long stay.

17 MEMBER MULDOON: Okay. That's what --  
18 that's right.

19 DR. GIFFORD: That's what that 100  
20 days is for.

21 CO-CHAIR LAMB: Sean, did you get what  
22 you needed?

1 MEMBER MULDOON: Yes.

2 CO-CHAIR LAMB: Okay. Kurt, is your  
3 card up?

4 Oh, it's Robyn. Robyn, can you put  
5 your microphone on?

6 MEMBER GRANT: I apologize for that.

7 So, I just want to start with a broad  
8 comment, which is, while I do not doubt the  
9 quality of AHCA's work, I guess I find it a bit  
10 -- I question the appropriateness of having an  
11 association that represents SNF providers  
12 actually be the developer of a SNF measure. So,  
13 I just kind of want to go on the record saying  
14 that. That troubles me.

15 But, in terms of my specific comments  
16 related to the measure, I think that in just a  
17 very general way, the name of the measure I found  
18 to be kind of misleading. I'm thinking, as a  
19 consumer, when I hear "short-stay discharge," my  
20 thought was, oh, this is a discharge measure.  
21 And then, I go and, you know, I looked at it, and  
22 most of the questions were about patient

1 experience and satisfaction during the stay. So,  
2 I guess I would recommend, if it's possible, to  
3 change something, so that it's more reflective  
4 about what it is actually discussing.

5 Second, I think that measuring the  
6 patient experience is really, really important.  
7 I think throwing the discharge measure question  
8 in kind of muddles it a bit. And it strikes me  
9 that discharge is so important, has been  
10 identified as a priority, that it really deserves  
11 its own measure in terms of patient experience  
12 because there's so much that goes into a good  
13 discharge experience for a resident. So, I was  
14 struggling with some of that.

15 The question about were your discharge  
16 needs met, I think as a consumer it's sort of  
17 hard to answer that because I don't think most  
18 consumers really have an idea of all that's  
19 entailed in a good discharge. I mean, all they  
20 really can judge is their own experience. I  
21 mean, we all know there's so much. Was the  
22 individual involved? Were they given choices?

1 Were they given information? Was their input  
2 listened to? And I don't think that a lot of  
3 folks realize that those elements contribute to a  
4 good discharge experience. So that I was  
5 wondering about that question.

6 And then, just lastly, I'm a little  
7 bit concerned about the exclusions as they relate  
8 to people with dementia. I'm just worried that  
9 their experiences will be underrepresented if  
10 we're excluding individuals with dementia with a  
11 certain EM score. And then, only allowing legal  
12 guardians to complete the form, that leaves out a  
13 lot of family members who are actually  
14 representing the interest of their loved ones,  
15 but who would not be permitted to complete the  
16 form.

17 So, I just wanted to raise those  
18 concerns.

19 DR. GIFFORD: So, with regard to the  
20 questions, Nick Castle helped develop these. In  
21 a couple of different places, we brought together  
22 both family members and residents of long-term

1 care, short-stay facilities as well as assisted  
2 living; did a number of different focus group  
3 meetings to identify what were the issues and  
4 concerns, rank those. And then, we did a number  
5 of rounds of cognitive testing, really worked to  
6 get the reading level down to a sixth grade  
7 reading level for that, and based on the items on  
8 those feedbacks.

9 So, we had different wording and  
10 different suggestions because we thought we knew  
11 better. And so, we really based it off of the  
12 focus groups with them out there.

13 With regard to the exclusions, we  
14 approached the exclusions with sort of three  
15 principles in mind. One, just pragmatic. So, if  
16 you're looking at a discharge and someone gets  
17 discharged to the hospital and is in the  
18 hospital, how do you mail a survey to a hospital?  
19 And most of those come back. Unfortunately, some  
20 don't. And that's a different group. So, there  
21 is just a pragmatic issue of how do you  
22 administer to certain people.

1           We really relied on the literature and  
2           satisfaction in all settings that clearly  
3           demonstrated that having a proxy fill out the  
4           information is not accurate to reflect there.  
5           It's a good measure; it just is a different  
6           measure.

7           So, that's why we have a family  
8           version of sort of all of these. You're seeing  
9           just the resident version here. In that sense,  
10          we thought a legal guardian, a court-appointed  
11          legal guardian shouldn't fill it out. If there's  
12          a DPA, durable power of attorney, or a living  
13          will, someone making decisions for them, they can  
14          assist filling it out, but they can't fill it out  
15          as a proxy.

16          So, we actually ask a question. One  
17          of the questions that we ask is, did you have  
18          someone help fill it out or not? And if they  
19          helped you, like they're blind or they don't  
20          understand, or anything, that's fine, we accept  
21          it. But, if they filled it on behalf of the  
22          person, we exclude the data because we don't

1 believe it's reflective of the person's  
2 experience and what they are out there. So, that  
3 was sort of the rationale we had behind these.

4 On the rest of the exclusions, we also  
5 were trying to be consistent with sort of  
6 industry standards. As we've said, we pulled all  
7 the people together. We didn't want to propose  
8 something that, all of a sudden, all of the  
9 vendors across the country had to change  
10 everything they were doing.

11 The other was we looked at what were  
12 the exclusions that were used in the CAHPS survey  
13 and other settings to try to be consistent where  
14 we could in that. I know a number of questions  
15 have come up and a lot of them are there.

16 And it was actually a very interesting  
17 experience to look at what all the exclusions  
18 were in all the different CAHPS, because they  
19 vary from some that say, do whatever you want, to  
20 very explicit out there as well.

21 The other thing we tried to be very  
22 explicit in our exclusions, which is not done in

1 a lot of the surveys, is a lot of surveys will  
2 says, we're going to sample women. Well,  
3 inherent in that is you exclude men. So, we had  
4 actually put down that we excluded men. Whereas,  
5 if you look at a lot of the surveys, they just  
6 say what they're sampling and they don't say --  
7 they say they have no exclusions. Well, you have  
8 exclusions if you're not doing a full sample.  
9 And so, again, we tried to be very explicit about  
10 that because we really wanted to make it really  
11 clear what was going on out there.

12 And then, the other issue, and the  
13 main one on the dementia one -- and we're very  
14 open to allowing it in there -- is we set a  
15 minimum response rate and a minimum number of  
16 respondents that you had to have the data in.  
17 Otherwise, the data we didn't think would be  
18 reflective. And the variability you would get  
19 from a small sample size would far exceed any  
20 variability you were seeing related to quality.  
21 That's why NQF sets usually -- and CMS follows --  
22 a minimum standard of 20.



1                   So, given the fact that a large number  
2                   of nursing homes have less than 100 beds, and 20  
3                   of those -- you're only talking about 20, and 20  
4                   are short stay, and you're trying to do the  
5                   turnover. If we included a lot of dementia, most  
6                   of those don't respond or they usually have  
7                   family members, and that's been the experience.  
8                   A few would be capable of doing it, but by not  
9                   excluding them, you drive down the response rate,  
10                  and you suddenly make a lot of facilities not be  
11                  able to have usable data, even though they have a  
12                  minimum number of respondents and they've gotten  
13                  all the data out there. These we wanted a more  
14                  representative sample. So, that was the driving  
15                  behind it.

16                 That said, most of these exclusions  
17                 don't affect the result, whether you include them  
18                 or not. We are happy to modify or come back to  
19                 them or talk to CMS about modifying them in some  
20                 areas in the dementia.

21                 And frankly, of all the exclusions,  
22                 this one has actually been somewhat problematic

1       for some facilities. Even though they all have  
2       MDS data, they haven't been able to always  
3       calculate it for some. And so, some actually  
4       just include it and send it out to everyone,  
5       which we're fine with. It just drives their  
6       response rate down. And we do have a problem  
7       with some response rates in the small facilities.

8               MEMBER SCHMIDT: So, I'm glad you  
9       brought up exclusions because my concern is about  
10       exclusions.

11              DR. GIFFORD: Okay.

12              MEMBER SCHMIDT: So, in the  
13       denominator you say, regardless of payer source  
14       and discharged within 100 days. And then, for  
15       the exclusions you mentioned one of them is  
16       patients discharged on hospice. So, I just  
17       wanted to clarify if that is discharged from the  
18       SNF on hospice as opposed to discharged to the  
19       Medicare hospice benefit while remaining in the  
20       SNF.

21              DR. GIFFORD: Well, if they're not  
22       discharged -- technically, if they convert over

1 to hospice during the SNF, they would not be  
2 discharged from the facility.

3 MEMBER SCHMIDT: From the SNF itself,  
4 yes.

5 DR. GIFFORD: So, they wouldn't get  
6 included in the sample. You only get included in  
7 the sample once you've been discharged.

8 MEMBER SCHMIDT: So, potentially, in  
9 the rare circumstance where a resident received  
10 hospice while in the SNF, but were discharged  
11 from hospice prior to going home and, then, went  
12 home with no hospice, they would be included in  
13 the SNF?

14 DR. GIFFORD: Correct.

15 MEMBER SCHMIDT: Great. Thank you.

16 DR. GIFFORD: And if they go to  
17 hospice from the facility, they would be  
18 excluded, and that's actually one of the things  
19 that's consistent right across the board for most  
20 of the CAHPS surveys.

21 MEMBER SCHMIDT: Yes, I think that the  
22 confusion was coming from the language.

1 DR. GIFFORD: Okay. Yes.

2 MEMBER SCHMIDT: Yes. Thank you.

3 CO-CHAIR LAMB: Kurt?

4 MEMBER MERKELZ: Yes, thank you. Just  
5 a general comment.

6 Even as we've been speaking here, and  
7 even in the preliminary analysis, it states that  
8 it gets to a core concept of patient experience.  
9 And we've been using experience and satisfaction  
10 interchangeably, and they're really different.  
11 They're really different concepts. Experience  
12 really has requirements that need to be met, as  
13 opposed to just perceptions that are being made  
14 by individual patients or family members. So, I  
15 would say really it doesn't really get to  
16 experience. It focuses on satisfaction.

17 I would also echo what Robyn stated  
18 regarding how well do you feel your discharge  
19 needs were met. I think it puts a lot of  
20 responsibility on the individual patients, family  
21 members who aren't aware of what discharge needs  
22 really need to be, what they should look like.

1                   We should actually be focusing on  
2                   potentially tailoring our care from the time of  
3                   admission towards making sure they're meeting  
4                   those discharge needs, getting medications  
5                   reconciled, making sure that the patient has  
6                   access to the medications, making sure that  
7                   they're safe upon discharge, making sure they're  
8                   functional, mobility needs are being met at the  
9                   time of discharge. And I think setting up  
10                  measures that are more geared toward the patient  
11                  succeeding after discharge is certainly something  
12                  I think CMS would benefit from looking at.

13                 Finally, just a comment regarding the  
14                 sicker patient and the facilities. Certainly,  
15                 from my past experience in long-term care and  
16                 post-acute care work, there is certainly a  
17                 difference in types of facilities. And there are  
18                 those facilities who tend to take the sicker  
19                 patient. So, I think, just by default, that type  
20                 of facility is likely going to be challenged more  
21                 with their satisfaction return surveys, and it  
22                 doesn't really get to the quality of the care

1       that was received in the facility, based on the  
2       perception that was received.

3               While I have a facility across the  
4       street that might be beautiful and they only do  
5       hips, that's all they're taking as part of their  
6       post-acute care. They have a beautiful facility  
7       with brand-new TV monitors. So, satisfaction  
8       scores are extremely high, but it really doesn't  
9       get anything to the quality of the care that they  
10      received while they were at the facility. While  
11      an older building that doesn't meet any of those  
12      nice bells and whistles can provide excellent  
13      care, but it may not be recognized in the  
14      satisfaction survey based on the nature of the  
15      patients.

16             DR. GIFFORD: We would completely  
17      agree that experience and satisfaction are  
18      conceptually different measures. Whether they  
19      actually end up achieving that, I think it  
20      depends on a lot of the wording and everything.  
21      And we would completely with the recommending to  
22      CMS that they explore developing experience

1 measures in the areas you talked about with  
2 transitions of care, because it's really  
3 important. That's not what this measure does, as  
4 you aptly point out.

5 CO-CHAIR LAMB: Paul?

6 CO-CHAIR MULHAUSEN: So, I was  
7 intrigued -- and maybe this gets at the  
8 operational part of it -- but the six months'  
9 sampling window and how that would, I guess, be  
10 operationalized. So, maybe it's an operational  
11 question. But the six-month sampling window  
12 strikes me as a challenge in programs that are  
13 doing ongoing measurement.

14 DR. GIFFORD: So, I will tell you it's  
15 always fun to do any project like this across the  
16 country and everything and what you discover. If  
17 nothing else, we brought some standardization to  
18 sampling and administering of surveys in the  
19 industry out there. And that is a technical  
20 question we get a fair amount with.

21 So, we picked the six-month window  
22 because we did a lot of modeling with the volume

1 of admissions and discharges from SNFs across the  
2 country. And we wanted to figure out, doing some  
3 sensitivity analysis based on different response  
4 rates, what would you need to get the minimum  
5 response of 20. Based on our piloting, we  
6 knew some range of that and how many surveys that  
7 would come back you would have to exclude because  
8 they were not filled out correctly.

9 And so, we looked at different  
10 numbers, and we picked six months, but you end up  
11 losing still a fair number of facilities with  
12 that. But we felt if you went beyond six months,  
13 you just had too large of a time window.

14 The other thing was we recommended  
15 that the survey be mailed out -- Lindsay, correct  
16 me if I'm wrong -- it's within two weeks of  
17 discharge, right, Lindsay?

18 MS. GRAHAM: Correct.

19 DR. GIFFORD: Yes, and that was all  
20 over the map in the industry. Now you can do it  
21 faster, and we recommend you do a faster, but we  
22 set a minimum time window.



1                   We also -- I think to some other  
2                   comment -- we set a window as to when they had to  
3                   have responses back by. If you didn't have  
4                   responses back within, I think, three months, you  
5                   were -- two months, yes -- we just said, no, it  
6                   doesn't matter. Now some come back and they  
7                   calculate it, and the vendors give the data. But  
8                   we said, from a measure standpoint, it wouldn't  
9                   be in there. So, that was sort of the whole  
10                  thought process that went behind that six-month  
11                  window.

12                  We also are really diligent about  
13                  emphasizing that it has to be in sequence of  
14                  getting the responses back. Because we do allow  
15                  you to stop, because there's about 15-20 percent  
16                  of facilities that are doing huge numbers of  
17                  post-acute care. And it just did not make sense  
18                  to force them to survey all the way, because once  
19                  you get past -- Nick, correct me if I'm wrong --  
20                  is it like 120 or 150, you don't need any more in  
21                  your sample? It just doesn't gather, right?

22                  DR. CASTLE: I think we said 125, yes.

1 DR. GIFFORD: Yes. And so, we make  
2 them do it in sequence. Very few meet that. And  
3 pretty much everyone is surveying all the time  
4 anyway, but we said you could stop it sooner.  
5 But we say you have to have it in sequence.

6 I'll tell you, the vendors have been  
7 really good because they've been sort of trained  
8 by CMS for CAHPS surveys in the hospitals. They  
9 are always calling us and they're telling  
10 providers they can't do certain things. And  
11 people were cherry-picking, and it was all over  
12 the map.

13 So, I think one reason we've tried to  
14 be so explicit, when you were asking these  
15 questions, is we anticipated this and we wanted  
16 to be really explicit, because we thought  
17 standardization was the most important aspect to  
18 get here. And that's why I say, if you think  
19 that we should drop an exclusion, we'll drop an  
20 exclusion, but we just wanted standardization.

21 MEMBER LETT: Oh, thank you.

22 I fully support this measure. It

1 fills an identified gap that we showed earlier.  
2 I like the questions because they are clear and  
3 they speak to not the need for expertise or  
4 clinical abilities on the part of the person who  
5 has experienced that care; just, what did you  
6 think? How did you feel?

7 And I would take respectful exception  
8 to -- I think it's great that a SNF provider is  
9 developing such a measure because it tells me  
10 that they want to learn how they can give a  
11 better experience in their facilities. So, for  
12 that, I applaud this move.

13 Just one exclusion question. A lot of  
14 times, particularly with post-acute patients,  
15 they're going to have multiple BIMS getting down  
16 with multiple MDSes getting done. And we all  
17 know that, with delirium or with sepsis, people  
18 can come in with the very low BIMS and, then, it  
19 rises. Do you have anything in the measure about  
20 which one do you choose of the BIMS results in  
21 order to take it?

22 DR. GIFFORD: No, we did not specify

1       that level. I would think that this issue about  
2       whether BIMS should be -- if CMS adopts this in a  
3       rule, and they probably won't even get this level  
4       in rule, but if in the specs they give out -- I  
5       mean, none of the rules specify any exclusions  
6       for any of the CAHPS surveys anyway.

7               But I think we would, as CMS develops  
8       this in a rule, and there's sub-regulatory rules  
9       out of it, I think this feedback they get from  
10      this group and others, and the public comments  
11      they would have if they put it in rulemaking,  
12      should be considered about that. Right now, we  
13      don't clarify it because this is actually the  
14      hardest thing of the data for any of them, to use  
15      to figure out how to do the exclusions.

16              And it really was just done -- this  
17      was one mainly for response rate. And the other  
18      was you get, if you include this, you get a lot  
19      of responses where the families fill it out. And  
20      so, that was the main reason we included the BIMS  
21      in there. I mean, there's other people out there  
22      that have other issues, and some vendors do

1       exclude and some don't. So, this is the one  
2       we're not a big stickler on because it just  
3       drives your response rate down.

4               CO-CHAIR LAMB: Along those lines,  
5       just to cover the public comments -- because  
6       you're probably aware there were seen or so  
7       public comments?

8               DR. GIFFORD: Yes.

9               CO-CHAIR LAMB: And I think we've  
10       covered most of them related to the clarity of  
11       that statement related to hospice, and that there  
12       seemed to be some confusion about how to  
13       interpret that.

14               On the BIMS, a question came up in  
15       terms of the cut-point. And what you were just  
16       saying, is that the answer to it? It is that the  
17       cut-point is more of a sampling issue rather than  
18       that the seven should be the cut-point?

19               DR. GIFFORD: No, what I was saying is  
20       whether you want to exclude dementia patients or  
21       not. The seven -- I forgot why we picked the  
22       seven. Don't you guys use seven for something

1       else somewhere else? Or maybe -- Nick, do you  
2       remember? Or, Lindsay? I can't remember why we  
3       picked seven. It's because it was used in other  
4       measures in other areas.

5               Deb, do you use seven in any of the  
6       QMs that you guys put together? I know BIMS 7 is  
7       a common cut-point for severe dementia. In the  
8       risk adjustment models, I can't remember why. We  
9       picked it because it's, "Oh, they use that." And  
10      if you want to pick six or five, I don't care;  
11      pick six or five.

12             (Laughter.)

13             Pick 5.5. I don't care.

14             CO-CHAIR LAMB: The last question I  
15      had from the public comments is part of the  
16      justification of moving, you know, recommending  
17      this measure, is the opportunity for improvement.  
18      Just interest is, have you seen any of the  
19      facilities that are using this, experimenting  
20      with it, that they actually are implementing it  
21      in their QI programs?

22             DR. GIFFORD: So, yes, and so, we've

1       made it our core of AHCA sort of quality  
2       initiative, which we're trying to get people to  
3       focus on it, to move it. Where we see it most  
4       being used is in post-acute care providers who  
5       are trying to partner with their hospitals in  
6       DDCI or ACOs, or other models, because the  
7       hospitals are recognizing that their satisfaction  
8       scores that are tied into the new payment systems  
9       for Medicare are linked to the satisfaction that  
10      gets completed. And SNF stays are clearly in  
11      that in individuals. So, we see a number of  
12      people asking for that and trying to focus on  
13      that satisfaction side of it.

14               I'm always sort of amazed by this,  
15      because sort of you say you want to do something,  
16      how many people start and say, "Okay, we'll go do  
17      it." A number of our state affiliates have now  
18      incorporated this into their training, about how  
19      to improve your satisfaction out there.

20               The vendors are realizing that this  
21      might lead to something going on the MUC list.  
22      And since it's been on the MUC list, we've been

1 getting a lot of calls about that improvement.

2 So, we are really optimistic that,  
3 with raising the vision, the visibility of this,  
4 you will see that. And then, as far as an  
5 opportunity goes in improvement, yes, actually,  
6 when we created this measure, we had a little  
7 trouble internally because the average scores  
8 went down from what many of them were seeing in  
9 their other measures, not by a lot, but a little,  
10 just enough that we had just some internal  
11 membership management issues.

12 CO-CHAIR LAMB: Gene? And then, if  
13 there aren't any more, then we're going to come  
14 back to Alan.

15 MEMBER NUCCIO: A quick question along  
16 the same lines in terms of how they measure and  
17 information will be used. The reporting to the  
18 nursing homes is done how? And would you believe  
19 that this measure is worthy of inclusion on a  
20 value-based purchasing as it is in home health?

21 DR. GIFFORD: Well, we recommend that  
22 the measure itself be reported, not the response



1 on the individual questions, because, then,  
2 you're making individual questions measures. And  
3 individual questions are not as good reliability  
4 and validity of the measure. That said, we think  
5 individual questions might help you in quality  
6 improvement. But, actually, if you're really  
7 trying for quality improvement, you need a lot  
8 more questions. And so, that's why we  
9 recommended it to be added into -- let vendors  
10 use it in their existing questionnaires, so they  
11 can explore and get a lot more additional  
12 information.

13 As far as whether I would recommend  
14 it, put it in a value-based purchasing, if you  
15 look at the sequence of public reporting, public  
16 reporting with rating, Five Star, and then, tie  
17 into payment, I don't think it's ready for  
18 payment because it just hasn't been used wide  
19 enough to understand it all yet. I think it's  
20 ready to begin to be ruled out for public  
21 reporting purposes. Whether there's enough data  
22 to support it being used in a Five Star, I don't

1 know. We're recommending that they use it in  
2 Five Star. But, if you ask me the data on it, I  
3 don't know, but I think moving that direction,  
4 it's helpful because it gets adoption and people  
5 using it.

6 But, for payment, I think in the  
7 future it should be used for payment once you get  
8 more experience. And I'm optimistic it would be  
9 good enough. I mean, if you use the metric of  
10 what's being used in other settings for payment,  
11 this is just as good. So, then, it should be  
12 used, but it just hasn't had that experience yet.

13 MEMBER NUCCIO: And your comparator  
14 group, is it national values, if you were doing  
15 public reporting? Or is it just simply this  
16 agency has a score of "X" and a rate of "X"? The  
17 other one has "Y"?

18 DR. GIFFORD: Oh, yes, that --

19 MEMBER NUCCIO: What does that mean?

20 DR. GIFFORD: That's a really good  
21 question. We're actually looking at that now,  
22 and I don't have an answer. I mean, we have

1       several thousand to answer the sort of question,  
2       but whether you get the whole nation on there --  
3       I would assume that CMS most likely, if they're  
4       going to do it in a Five Star rating system,  
5       would use a similar methodology for determining  
6       cut-points and values, which has essentially been  
7       quintiles. I personally don't like quintiles. I  
8       would recommend something else.

9               And I think this is a measure that  
10       would lend itself, as we gain more experience,  
11       where you actually could established  
12       predetermined cut-points ahead of time for that.  
13       What those exactly would be I couldn't tell you  
14       today, but I would not do it on a forced  
15       distribution.

16              I shared Deb's view of forced  
17       distributions in rating systems. Deb's probably  
18       going to comment right now on how, give a  
19       recommendation to CMS on how to do this.

20              CO-CHAIR LAMB: Do you want to comment  
21       on that?

22              DR. GIFFORD: But I think we're

1 putting the cart before the horse because CMS  
2 hasn't decided how they're going to do this yet.

3 MEMBER SALIBA: I'm not specifically  
4 commenting on that, Gerri and Giff, as much as  
5 I'm -- and I've raised this concern before about  
6 the measure. It's about the distribution of the  
7 measure which is related to this idea of a forced  
8 distribution. And the distribution that's  
9 reported in the metrics for this measure is that  
10 the median score is 82.5, which is, you know, it  
11 says that that's a gap between 82.5 and 100, but  
12 it's not a very big gap really, and that that's  
13 the median. The 75th percentile performance is  
14 at 88.6, which tells me -- and it says here,  
15 "Performance is largely clustered around the  
16 median." So, there's not a big distribution on  
17 this measure.

18 And it sounded, Giff, by your last  
19 comments, or the comments before the last  
20 comments, anyway recent comments, that you're  
21 suggesting it needs further testing before -- so,  
22 I'm not really sure what we're being asked to do

1       today in terms of the -- I'm getting a nod from  
2       Paul.

3                     Paul, do you want to help me here?

4                     DR. GIFFORD: No, it doesn't need  
5       further testing. I'm saying if you're going to  
6       use it in a value-based purchasing program, I  
7       couldn't tell you what the cut-points I would do  
8       at the moment are. I mean, if you ask me  
9       recommendations, we have enough data now we could  
10      make a recommendation, but I don't know how CMS  
11      is going to propose to use it.

12                    We have set as a target for our  
13      members that they should be over 90 percent. And  
14      I think as we gain more experience, we may  
15      actually raise that higher.

16                    And for the very reason you just  
17      talked about, I would not use a quintile-type  
18      distribution in any sort of scoring system out  
19      there. I'm just relaying what -- I'm guessing  
20      the way CMS and other stuff might use that  
21      process. And you're asking me how they're going  
22      to use something that I don't know how they're

1 going to use. I could tell you how I would  
2 recommend using it, but that's not what I think  
3 is before the committee.

4 I mean, you have an NQF-endorsed  
5 measure. Its distribution looks similar to CAHPS  
6 in other settings and everything else that are  
7 being used everywhere else. Now we may not like  
8 how they're being used everywhere else, but at  
9 least we're trying to follow that process on  
10 there.

11 CO-CHAIR LAMB: Yes?

12 CO-CHAIR MULHAUSEN: So, I, too, was  
13 impressed by how high the median was and the  
14 narrowness of the distribution. As I understand,  
15 what we really have on the table at this point is  
16 a motion to support for rulemaking. And yet,  
17 part of the conversation I'm hearing is we don't  
18 think it's quite ready for this. We don't think  
19 it's quite ready for this.

20 And the kinds of things that we're  
21 talking about are, in my mind, the kinds of  
22 things that I could see CMS actually using it.

1       So, then, I think to myself, well, if we don't  
2       really know how the reporting programs would use  
3       this particular measure, and it needs additional  
4       clarity in terms of its application, is there a  
5       reasonable argument against the motion to support  
6       for rulemaking and, rather, move it into a motion  
7       to support for conditional? So, it would be  
8       conditional based on, well, if you want to use  
9       this, could you bring it back and tell us how  
10      it's going to be used, or something like that?

11               MEMBER SALIBA: To follow up for one  
12      second, I mean, I want to applaud you all for all  
13      the work that you've done on this measure. It's  
14      great work, and I'm really supportive of the idea  
15      of getting consumer voice in terms of the quality  
16      of their experience into this instrument. It  
17      sounds to me like it would be really useful for a  
18      large organization such as CMS to adopt, you  
19      know, to embrace this for further testing and  
20      trying to understand its performance outside of  
21      your volunteer group possibly.

22               But I think the work you've done so

1 far has really moved this very far forward and  
2 has been really well-done. So, I'm not trying to  
3 be negative about the measure as much as I'm not  
4 sure that it's ready for this endorsement step.

5 DR. GIFFORD: So, I'll just take off  
6 my developer AHCA hat and put on my MAP hat.  
7 And, Paul, I think this is a question we struggle  
8 with at the MAP all the time, which is a number  
9 of measures come -- particularly when measures  
10 aren't even NQF-endorsed. So, often, measures  
11 are coming through this committee and up to us in  
12 the MAP Coordinating Committee that haven't even  
13 been endorsed, and they're asking us to endorse  
14 them for future rulemaking. And I think at least  
15 what CMS and Kate has relayed to the MAP is that  
16 they would at least bring back recommendations on  
17 that.

18 The reason I'm a little on the fence  
19 is I don't know how CMS is going to use it. I  
20 mean, I know how I would recommend they use, but  
21 they've sometimes used measures the way the MAP  
22 and the NQF haven't recommended stuff. And I



1 think if you set the standard that we have to  
2 wait until they issue a rule to know how the  
3 measure is going to be used -- the only time we  
4 ever have some sense about how the measure is  
5 going to be used is when it's being proposed  
6 under some sort of statutory guidance.

7 But, even then, once the MAP has put  
8 recommendations forth to the Secretary, he or she  
9 can use it in any way they want. I mean, that's  
10 just the risk that we have to take with that, and  
11 we have to decide whether we take CMS on faith  
12 value. And I've been very vocal at the MAP level  
13 on this very point of not always taking them on  
14 face value. I think Kate has recommended that  
15 they would bring stuff back for that.

16 So, I think it's a very reasonable  
17 recommendation. I think maybe I misportrayed it.  
18 This measure is as good as any other measure  
19 that's out there used for public reporting in  
20 other settings, and being used for payment and  
21 everything else.

22 How you use it, the devil's in the

1 details, and we will not know that until CMS  
2 makes the recommendation. And there is a public  
3 comment period of that.

4 I do think that this measure, stepping  
5 back, looking at this -- now I'm sort of wearing  
6 all hats at once -- looking back, meets the level  
7 that everywhere else is. I mean, then, this is a  
8 new standard that I would say is worthy of  
9 raising as a broad issue across the board and  
10 bringing up to the MAP that we should talk about  
11 as to what's the standard for recommending  
12 measures that we don't know what's going to be  
13 used in rulemaking. And that has caused a lot of  
14 angst at the MAP level, and I can appreciate it  
15 causing here.

16 And maybe I misportrayed it, but we're  
17 actively asking CMS right now to add this into  
18 Nursing Home Compare. And so, we, the provider  
19 community feels it's ready for that level. I  
20 mean, not all of our members do, but most of them  
21 do.

22 CO-CHAIR LAMB: Thank you for that

1 input.

2 Alan, would you like to --

3 MEMBER LEVITT: Yes, yes. Thank you.

4 First of all, sitting next to me, for  
5 those who don't know, is Mary Pratt. Mary, as  
6 you know, has been a leader in quality at CMS and  
7 for many years, as many years as I've been  
8 involved in post-acute care.

9 But, anyhow, Mary has also taken the  
10 hat now of being the Program Coordinator for the  
11 SNF QRP to help lead this program. So, thank  
12 you.

13 I also wanted to thank Dr. Gifford and  
14 AHCA for bringing this measure forward for us.  
15 I'll talk about the measure just in a second.

16 But, first, let's step back for a  
17 second, take a deep breath here. The SNF DDP is  
18 a statutorily-mandated program. It's one  
19 measure, readmission measure. Certainly, we  
20 could discuss other potential measures, but the  
21 discussion will probably have to be with Congress  
22 first, if we were going to be changing that.

1                   Regarding Five Star, the public  
2                   reporting that is done in the SNF Quality  
3                   Reporting Program, a plan you've done of the  
4                   measures in the program, the Five Star program is  
5                   different. It's not part of this. And so, in  
6                   the future could possibly things be incorporated?  
7                   Maybe.

8                   But, again, what we have done here is  
9                   what we have done before. We have brought  
10                  measures that were not developed by CMS to the  
11                  MAP to be submitted for the endorsement for a  
12                  particular Quality Reporting Program. That's  
13                  been done before in the other programs.

14                 And this is an NQF-endorsed measure.  
15                 It's been endorsed with all the specifications  
16                 that we've been discussing here. Certainly of  
17                 interest to CMS in terms of this discussion, or  
18                 coming out of this discussion, if the MAP  
19                 Workgroup came with recommendations of changing  
20                 specifications to the measure, for example,  
21                 exclusions, and CMS in the future was going to  
22                 propose such a measure, I would assume we would,

1       then, be proposing an application of the NQF-  
2       endorsed measure. So, it does start getting a  
3       little bit more complicated here.

4               But I do think we need to understand  
5       that this is an endorsed measure that's being  
6       used right now by a stakeholder and is being used  
7       voluntarily by a stakeholder. It's not  
8       mandatorily required, which would be what would  
9       be happening in the SNF Quality Reporting  
10      Program, which kind of in the end is what we're  
11      very interested in, because this is an NQF-  
12      endorsed measure already.

13              And we really do appreciate it. You  
14      know, this is a "we" here. Remember,  
15      public/private partnership. We appreciate  
16      measures that are being used successfully in the  
17      post-acute care community to be brought towards  
18      us. And when we feel that these measures should  
19      come as a measure under consideration, we want to  
20      bring them here. I mean, that's part of our  
21      mission here.

22              Giff led off with the devil in the

1 details, and the devil is in the details,  
2 obviously. I can tell you, if you're interested  
3 about how things are done in the CAHPS program,  
4 for example, if you're interested. But, again,  
5 similarly in the CAHPS program, there are  
6 vendors, those CMS-approved vendors, and the data  
7 is stored internally really within CMS. There  
8 certainly is going to be burden for those SNFs  
9 that are currently not using a vendor for the  
10 measure because it will become mandatory.

11 Estimates vary. I mean, I asked  
12 estimates last year and tried to confirm again,  
13 because when we brought the hospice CAHPS  
14 measure, I was trying to get an idea as to what  
15 the burden was. And the estimate was about  
16 \$3,000 to \$4,000, but it depends on a lot of  
17 things, the mode of how the survey is done, the  
18 number of surveys that are done, things like that  
19 which would affect the cost.

20 There is other burden, too. I mean,  
21 obviously, there's burden still to the hospices  
22 to submit the names, not the hospices -- excuse

1 me -- the SNFs, the names to the vendor.

2 I love working with the CAS people  
3 because, even in the rule this year, the hospice,  
4 if you noticed, they actually looked at the  
5 burden to the people who are filling out the  
6 survey. So, they actually put a burden assigned  
7 to that, a maximum amount of burden. So, there  
8 is burden that would be, then, mandatory burden  
9 unless the SNFs would accept the penalty or be  
10 non-compliant with doing this.

11 Depending on the decision of the MAP  
12 and recommendations from that, then we would take  
13 the next step to look at the details. And we  
14 talk about MIPS and how measures that we think  
15 should be working suddenly don't work. So,  
16 obviously, there are a lot of operational issues  
17 and consequences that come that we need to work  
18 out and work together to help to try to figure  
19 out whether or not we can fill this gap area,  
20 which it is a gap area, with an NQF-endorsed  
21 measure that is being used successfully in the  
22 community, whether or not that such measure

1       should be brought into our program for mandatory  
2       use.

3               Then, we would have to figure out  
4       those details as to how data that's being  
5       collected out there could be operationalized, so  
6       that it could work within our program, because  
7       that would be absolutely necessary. And that's  
8       something we would work with together.

9               I'm not sure if there are any other  
10       questions related to what I just said.

11              CO-CHAIR LAMB: Any further questions?

12              I think we've moved from the  
13       discussion of the measure attributes now into how  
14       it would actually appear in the MIPS program, how  
15       it would be administered from it.

16              MEMBER LEVITT: Yes, QRP. I'm sorry.  
17       Yes, the SNF QRP.

18              CO-CHAIR LAMB: Oh, excuse me, the  
19       QRP.

20              MEMBER LEVITT: The SNF QRP, yes.  
21       See, I've led you down the wrong path.

22              (Laughter.)



1 CO-CHAIR LAMB: Sorry. You did, Alan.

2 MEMBER LEVITT: Yes.

3 CO-CHAIR LAMB: You did.

4 MEMBER LEVITT: Yes.

5 CO-CHAIR LAMB: All right. Does  
6 anybody have any other questions relevant to  
7 MUC17-258 for moving into a vote?

8 Theresa, did you have a comment?

9 MEMBER SCHMIDT: Just a quick comment  
10 about the operationalization. I think referring  
11 back to the hospice CAHPS was really good. And  
12 one thing that I like about that program is that  
13 they have, I believe, a telephonic requirement as  
14 well, and potentially some consideration for  
15 different languages. So, to be sure we are  
16 capturing patient experiences beyond just the  
17 people who can read at the sixth grade level in  
18 English.

19 MEMBER LEVITT: In fact, they assign  
20 different burden in the rule to the Spanish  
21 version versus the English version, yes.

22 MS. O'ROURKE: So, seeing no further

1 cards, our Chairs are asking me to move this into  
2 the voting.

3 I do, first, want to double-check that  
4 everyone -- does anyone have an objection to  
5 doing a hand vote? I know, historically, MAP has  
6 been anonymous voting. So, is everyone okay?

7 And the second, procedurally, Jim, you  
8 pulled the measure from the consent calendar.  
9 So, it's your prerogative to put forward a motion  
10 for a vote.

11 For support or conditional support?  
12 Okay.

13 MEMBER LETT: Right. So, just to make  
14 sure everybody knows what they're voting on,  
15 there's a motion on the table to support  
16 MUC17-258, CoreQ, short-stay discharge measure.

17 Did I get it right?

18 (Laughter.)

19 For rulemaking in the skilled nursing  
20 facility, Skilled Nursing Quality Reporting  
21 Program. So, you're voting to support.

22 MS. KUWAHARA: Great. So, today you

1 will have two options on voting. Your first  
2 option is yes, meaning you support this measure  
3 for rulemaking, and your second option is no, you  
4 do not support this measure for rulemaking.

5 So, I believe at last count we had 22  
6 voting members, 20 in the room here and, then, 2  
7 remotely. Those participating remotely, please  
8 submit your answers via the chat function on the  
9 bottom righthand corner of your screen.

10 So, we'll begin. We are voting to  
11 support MUC17-258. This is CoreQ, short-stay  
12 discharge measure.

13 Those in favor of voting for option  
14 No. 1, yes, please raise your hand.

15 (Show of hands.)

16 And those who vote for option No. 2,  
17 no, please raise your hand.

18 (Show of hands.)

19 Thank you.

20 And we're still waiting for our remote  
21 participants.

22 MEMBER GOTWALS: May we do that

1 verbally if we're having computer problems?

2 MS. KUWAHARA: Sure, go for it.

3 MEMBER GOTWALS: All right. This is  
4 Amy Gotwals, NAAAA. We'll vote in favor. So,  
5 option 1, yes.

6 MEMBER DEBARDELEBEN: This is Mary  
7 Ellen Debardeleben, and we'll vote in favor.

8 MS. KUWAHARA: So, we have 19 in favor  
9 of supporting this measure for rulemaking and 1  
10 not in favor. So, it looks like we have 20  
11 voting members. But we did achieve the 60  
12 percent threshold. So, this measure will be  
13 supported for rulemaking.

14 CO-CHAIR LAMB: Thank you, everybody,  
15 and thanks for a robust conversation and lots of  
16 discussion about the issues.

17 So now, we will move forward. Thank  
18 you, Dr. Gifford, for coming, and thank you for  
19 the discussion.

20 MEMBER LEVITT: Yes, we really do  
21 appreciate it. Thank you very much for the  
22 discussion that we will be taking into

1 consideration now for our next steps.

2 MS. O'ROURKE: So, I think we had one  
3 outstanding item on the SNF QRP. We just wanted  
4 to touch back with you about gaps. I know we  
5 started this conversation in November.

6 So, just to refresh everyone on some  
7 of the themes of our previous conversation,  
8 overall, you recommended CMS continue to find  
9 ways to address gaps in patient, family, and  
10 resident engagement across the PAC/LTC programs,  
11 the results of needing more measures addressing  
12 the bidirectional transfer of information; in  
13 particular, assessing issues like, was the  
14 information actually received by the receiving  
15 site and did that site have any followup  
16 questions?

17 For the SNF program specifically,  
18 there were suggestions, a need for a measure,  
19 again, around the appropriate transfer of  
20 information, ensuring it's timely and in an  
21 accessible fashion; a measure of advanced  
22 directives, as well as starting to think about

1 the issue of getting to the correct medication,  
2 going beyond just medication reconciliation, but  
3 thinking about the appropriateness and do we have  
4 a list of what that patient is on, and is it the  
5 correct medication.

6 So, with that, I do want to open it up  
7 and see if these still resonate with the group,  
8 or any additional gaps to suggest?

9 CO-CHAIR LAMB: Heather?

10 MEMBER SMITH: I know we discussed  
11 this today already, but I just wanted to go on  
12 the record saying that I think those settings  
13 could benefit from a patient-reported outcome  
14 quality measure. And I won't bother saying that  
15 again, but I would say that for all the post-  
16 acute care settings today.

17 CO-CHAIR LAMB: Heather, if you feel  
18 that across, you just keep saying it.

19 So, patient experience, other gaps in  
20 there? I think earlier we had -- and I don't  
21 know if these are specific to skilled nursing  
22 facilities. So, let me throw them out.

1                   We had a couple of gaps that we talked  
2                   about earlier in the startup discussions related  
3                   to -- hang on here -- emotional health, mental  
4                   health service, and access to care, as well as I  
5                   think, Jim, you were talking about the med rec  
6                   needed to be relooked at. So, do those go for  
7                   SNF as well? Because these were the gaps we  
8                   identified last year: patient experience,  
9                   transfers to SNF, and then, transfer of info. Do  
10                  you want to add those to the gap areas?

11                 These were the gaps that we identified  
12                 last time we got together. What we are asking  
13                 now is, are there additional gaps that you would  
14                 like added to the list for future consideration?  
15                 That's part of the discussion we've had this  
16                 morning, is we are having this conversation in  
17                 the context of a lot of change going on related  
18                 to Meaningful Measures, MIPS, as well as PROMIS.  
19                 So, there is renewed opportunity to look at gaps  
20                 and to put them forward.

21                 These are the ones from last year. Do  
22                 we want to add anything? And that's going to be

1 the same question as we go through hospice and  
2 the other settings. So, this is sort of the  
3 leadoff for here is your chance to rethink, do we  
4 have the right gaps? Are these the priorities?  
5 Where do we want to be going, especially as we  
6 have the opportunity to put input into the  
7 playout of IMPACT, MIPS, and everything else  
8 we've talked about this morning? Clear? This is  
9 a chance to put new gaps on the table or to  
10 reaffirm that the gaps that we said last year are  
11 really the important ones and those are the  
12 priority areas for the future.

13 Kurt? I'm sorry. Raj, go ahead.

14 MEMBER MAHAJAN: So, there's transfer  
15 of information between clinicians and, then,  
16 there's efficacy of transfer from acute care to  
17 SNFs. But it does not officially talk about  
18 information transfer between facilities. So, I  
19 don't want to assume that it exists in between  
20 one -- two and three. So, I would like to have  
21 that as -- because that's where all the data  
22 blocking talk comes. And so, it's information



1 coming to the nursing home from the hospitals.

2 And then, based on the conversations  
3 we had today, aligning physician and facilities  
4 and their measures and their workflows as one of  
5 the areas of work.

6 CO-CHAIR LAMB: Raj, could you clarify  
7 that last one?

8 MEMBER MAHAJAN: Aligning physicians  
9 or practitioners and the facilities and their  
10 workflows and their measures. I'm not sure how  
11 to phrase that, but go ahead please help me, yes.  
12 I said aligning physician and facility workflows  
13 and quality measures.

14 CO-CHAIR LAMB: Okay, Kurt?

15 MEMBER HOPPE: A question about  
16 efficacy of transfers. What does that mean?  
17 What do you mean by that? I didn't have the  
18 benefit of hearing that discussion last fall  
19 because I wasn't here. So, I'm not sure what  
20 exactly, what dimensions you're looking at.

21 CO-CHAIR LAMB: Jean-Luc, can you help  
22 us?

1 MR. TILLY: Sure. So, certainly,  
2 comparing to that would be the transfer of  
3 information, but I think there is also a kind of  
4 quality of whether those transfers were  
5 burdensome from our patient experience kind of  
6 perspective. But I think now would be a great  
7 time to elaborate that, you know, get an idea of  
8 how we should characterize that.

9 MEMBER HOPPE: I think there's a lot  
10 to unload there, and I would suggest that that  
11 may be a discussion for another time, if that's  
12 not available right now for your time  
13 constraints.

14 I was thinking more of  
15 appropriateness. I was thinking of the transfer  
16 did actually occur. Was there an intervening  
17 event? I'm not sure what to make of that.  
18 Certainly, transfer of information is important.

19 CO-CHAIR LAMB: So, Kurt, just to  
20 clarify, you are confirming keep transfer of  
21 information up there as a priority, but you would  
22 like to see a deeper dive into the nature of the

1 transfers? And you've mentioned appropriateness  
2 of the transfer. Any other attributes of the  
3 transfer that you would like to at least throw  
4 out for consideration?

5 MEMBER HOPPE: I think Jean-Luc spoke  
6 about the patient experience of the transfer, if  
7 it's burdensome not only to providers, but to  
8 patients, and I would add families as well.  
9 Whether it was an appropriate transfer, whether  
10 there were aspects of the transfer of information  
11 that were not appropriately managed.

12 CO-CHAIR LAMB: Okay. Okay. I have  
13 no idea who was next. So, help me out here.

14 Jim, do you want to go?

15 MEMBER LETT: Thank you.

16 I'm kind of with Kurt here in terms of  
17 we might need to unbundle some of these rather  
18 generic statements. I mean, the transfer of  
19 information between clinicians, someone mentioned  
20 it's not just between clinicians; it also  
21 includes facilities and families.

22 Also, about unbundling the transfer of

1 information, I would love to call out -- I don't  
2 know how granular you want to get -- a couple of  
3 really significant things. One is the presence  
4 of dementia, because AMDA just put out a white  
5 paper on dementia and care transitions, and it is  
6 a massive impact.

7 The second is specific advance  
8 directives.

9 CO-CHAIR LAMB: Advance directives.  
10 Say a little bit more. What about advance  
11 directives?

12 MEMBER LETT: Simply we've gotten in  
13 the habit of writing down "DNR," do not  
14 resuscitate, which has essentially no meaning in  
15 terms of in-of-life care. So, discussions as to  
16 what interventions you want. Do you want to  
17 transfer back to the hospital? Do you want to  
18 ever be on antibiotics? Do you want artificial  
19 nutrition and hydration? Those types of really  
20 important issues that, No. 1, follow patient  
21 preferences, which is patient-centered care, and,  
22 No. 2, not incidentally, reduce transitions and

1 improve the quality of care in folks at the end  
2 of life.

3 CO-CHAIR LAMB: Okay. Thank you.

4 Kurt?

5 MEMBER MERKELZ: I just wanted to get  
6 clarification regarding what was commented  
7 regarding Raj stating expanding to make sure  
8 we're capturing the alignment between what the  
9 clinician is doing and the care plan. What was  
10 captured as the gap that needs to be identified?  
11 Because I think I get a sense of what Raj is  
12 asking for. I am just wondering if that was what  
13 the committee has picked up, and is that what's  
14 been recognized as a gap? That there is  
15 considerable disconnect between what's being  
16 performed by the clinician and the post-acute  
17 care, and the plan of care that's being document  
18 in the long-term care facility?

19 MEMBER LEVITT: Can I just make a  
20 comment? I mean, again, the gaps we're really  
21 trying to identify here are for this SNF QRP.  
22 There may also be operational gaps that are just

1 in general that are occurring, like we discussed  
2 before. I would assume that we're looking more  
3 for the program-specific. Yes? Okay.

4 MEMBER MAHAJAN: I think what I'm  
5 hearing is several people have commented on No. 2  
6 as that is way too generic and broad, and if we  
7 could get a little granular on that. And so, I  
8 think everybody agrees with No. 3 and No. 1, and  
9 I have added aligning physician and the facility  
10 workflows, in QMs, as an additional. But I think  
11 everybody else wants to see if we can get a  
12 little more granular this year on No. 2, as what  
13 does No. 2 mean?

14 CO-CHAIR LAMB: Okay, Sean.

15 MEMBER MULDOON: So, my card keeps  
16 going up and down. So, I'm going to leave it up.

17 I'm very much in line with what Alan  
18 said. I want this list to be things that this  
19 committee needs to work on, not what operators  
20 need to work on. And smoothing out the  
21 transition of care is certainly one of those  
22 things that needs to be improved upon. But the

1 reason it's on the gap list is for five years we  
2 haven't been able to find a way to create a  
3 measure that captures some or all of all those  
4 things that create risk at the time of  
5 transition.

6 So, we've got to fix this, but I don't  
7 know, and I would like to have a discussion, if  
8 it's this committee's job to fix it by hanging  
9 measures on it that would promote that.

10 CO-CHAIR LAMB: Anybody want to  
11 respond, reflect on that? It's a great question,  
12 Sean.

13 CO-CHAIR MULHAUSEN: So, I want to  
14 reflect on it. I don't know how helpful my  
15 reflections are.

16 First of all, it strikes me as  
17 backward, as I look at that. So, if I'm holding  
18 myself as a post-acute care provider accountable  
19 to some measurement and standard, it would be  
20 more about what do I do as I'm transferring  
21 someone from me to you, although I admit there is  
22 an element of reception that probably has best

1 practices built around it.

2 And then, the other is, so this  
3 literally was a conversation I was having on  
4 Monday in a community in Iowa where we're trying  
5 to organize this community of healthcare  
6 providers to help them reduce readmission rates.  
7 And the fundamental root problem, as they see it,  
8 is a challenge with transfers. Now I'm not smart  
9 enough to answer my own question, which was,  
10 aren't there lots of best practices in transfers,  
11 in the process? I mean, there certainly are tons  
12 of models. There's the Project Red model.  
13 There's the Transitions-of-Care Model. There  
14 must be a series of best practices that could be  
15 developed into a measurement tool that can help  
16 SNF providers understand the best practice and  
17 apply it in the spirit of improving the  
18 effectiveness of their transfer process.

19 CO-CHAIR LAMB: I'd like to weigh-in  
20 from the care coordination standpoint because I  
21 think that the issue that Sean has raised is one  
22 that we have been grappling on for almost a



1 decade in that area, and don't see a lot of new  
2 measures in that. And so, we really do need to  
3 have the dialog about what are Meaningful  
4 Measures in care coordination and transitional  
5 care.

6 And I see this particularly since when  
7 Pierre did the Meaningful Measures, and  
8 coordination and communication is one of the  
9 priority areas. It's about time we take a look  
10 at what reflects a good transition, and from the  
11 patient's standpoint and the providers'  
12 standpoint. Because at the care coordination  
13 level, what we have is what Don Casey frequently  
14 referred to as the one-handed handshake. Did the  
15 information go across? Not what was done with  
16 it. Did the patient have a good transfer or not?  
17 And what does that mean?

18 So, I think your question resonates  
19 for me, Sean, which is we haven't had a good  
20 answer to that. But the stars are aligning.  
21 It's in Meaningful Measures. It's in the  
22 National Quality Strategy as one of the six

1 pillars of the national quality. It's in all the  
2 IOM reports.

3 So, MAP might be looking at that in  
4 terms of what is a Meaningful Measure.  
5 Certainly, the Care Coordination Standing  
6 Committee now has been merged with Patient  
7 Experience and Function. So, I guess I would  
8 like to see this committee, if I had my  
9 druthers -- and I'll have my other hat on that I  
10 co-chair, I'll own I co-chair Patient Experience  
11 and Function. It is to make a recommendation  
12 that this is a priority area and that we really  
13 do need to encourage focused work.

14 The other thing is we do have  
15 preferred practices going back 10 years in care  
16 coordination that we have not done anything with.  
17 And so, can we bring those forward in the current  
18 context and move the needle on this? And is it  
19 timely to do that? So, I would like to see this  
20 committee say, yes, it is timely. But that's up  
21 to all of you. So, I'll take off my other hat  
22 that I wear related to the committees.

1                   MEMBER MULDOON: I would have no  
2 challenge to any of that. What we found when we  
3 have tried to do this in Louisville and Kentucky  
4 was that the sloppiest transfer was from the  
5 short-term hospital to the post-acute center.  
6 And much of that burden lies with the acute care  
7 hospital. And so, when it becomes a post-acute  
8 measure, our performance on that measure becomes  
9 highly dependent on a partner that has a  
10 different set of incentives around that.

11                   So, it's easier for the post-acute  
12 measure to say, did you send them from you with a  
13 leading practice? That's a lower, more workable  
14 measure because it is more attributable to the  
15 provider in question.

16                   MEMBER SMITH: Well, it kind of  
17 depends on how you look at, because, also, when  
18 you're looking at the continuity of services,  
19 you're looking at, if you're coming from acute to  
20 post-acute care, were the tests followed up on,  
21 were the results followed up on? So, there are  
22 process measures that can get at what would be

1       attributable to post-acute care, but I think it's  
2       very important to think about what does post-  
3       acute care have control over, not just what  
4       you're getting that's sloppy.

5               But, if there was a test done right  
6       the day before they left, you somehow have to get  
7       the results to figure out what you're going to do  
8       at the next level. And that's definitely a gap  
9       in care coordination.

10              And also, when you're thinking about  
11       transferring patients from different levels, also  
12       don't forget about the patient in that; what are  
13       their expectations? And how are those  
14       expectations addressed and changed? And I don't  
15       know the perfect measure for that, but that's a  
16       piece that I think is really important.

17              And then, on the transfer of  
18       information between clinicians, there's lots of  
19       way nowadays to be able to do electronic  
20       transfer, but what's the timeliness of that? And  
21       if you're getting it three hours after they're  
22       already there, and then, something happens in the

1 first three hours, you're in trouble. And so, a  
2 lot of your electronic records you can transfer  
3 electronically, but there's an issue on  
4 timeliness. And I think that that is an  
5 important piece on the care continuity and the  
6 care transitions to think about.

7 MEMBER HALL: Yes, I would just say  
8 the transition-of-care area is something we've  
9 been looking at for many years at ONC,  
10 particularly between acute and the various PAC  
11 settings. There's, obviously, various HHS  
12 policies around various requirements for  
13 different provider types. Obviously, for the  
14 meaningful use providers, what they have to send  
15 to other providers of care and, then, what is  
16 being, therefore, received by a SNF provider, for  
17 example. We hear very routinely that they are  
18 either getting too much information, there's gaps  
19 in information, and again, the timeliness of that  
20 information.

21 And then, you know, of course, there's  
22 also requirements on the long-term care side. We

1 have participation, obviously, in long-term care.  
2 And although it's not required to electronically  
3 share that information, the data is what -- you  
4 know, there's data requirements around what  
5 should be followed, of course, on a discharge or  
6 a transfer.

7 So, there are some existing policies  
8 around this. Yet, obviously, there continues to  
9 be this challenge.

10 At ONC we're also just looking, you  
11 know, starting to track the EHR adoption levels  
12 and interoperability across a number of these PAC  
13 settings. And so, one of the first data briefs  
14 that we've published this year was around the EHR  
15 adoption levels for SNF settings. So, we  
16 reported, are able to publish this year that SNFs  
17 nationally now are about 64 percent of national  
18 EHR adoption rate. So, this is an area where we  
19 are seeing increased levels of adoption.

20 So, looking at that electronic  
21 exchange will become of increased importance, and  
22 we will be looking at other settings in the PAC

1 settings to track their EHR adoption and  
2 interoperability levels as well. But we'll  
3 continue to work with providers around improving  
4 the way that information can be exchanged  
5 electronically. So, just that consideration.

6 CO-CHAIR LAMB: Thank you.

7 Connie?

8 MEMBER DAHLIN: So, just a couple of  
9 things to think about in terms of gaps. One is  
10 that I worry a little bit about CMS thinking  
11 about end-of-life care only because, when you  
12 think about palliative care and advance care  
13 planning, advance care planning really gives you  
14 the right goals of care; sets for many chronic  
15 diseases for these patients who are not going to  
16 be on hospice and not be on home health for a  
17 long time of not wanting aggressive measures.  
18 And so, it's more than an advance directive.  
19 It's more than a DNR/DNI. And so, I think this  
20 advance care planning for chronic diseases which  
21 happens so much in post-acute care and long-term  
22 care.

1 I will just address my second part to  
2 the comments of I recently experienced two close  
3 deaths of family members who were in their  
4 eighties, chronically ill. And although I'm an  
5 expert in hospice and palliative care, it was a  
6 disaster from start to finish. Every interaction  
7 that I had with a home health agency and a  
8 hospice agency (a) did not treat me well as a  
9 family member trying to coordinate this care; (b)  
10 wouldn't give me information, for instance, when  
11 a patient -- when one of the patients was  
12 discharged from a long-term care setting, I was  
13 told they couldn't give me recommendations for  
14 post-acute care organizations because it was a  
15 HIPAA violation and conflict. Now, for me, it  
16 was fine because I gained five more days in the  
17 city, a facility, because I spent getting 10  
18 rejections day by day of who wouldn't take them.

19 So, I think that there is a lot in  
20 this patient and family experience that we really  
21 forget, that it's not just about the patient.  
22 And for these patients that have cognitive



1       impairment or have older adult spouses or  
2       partners, or don't, and then, you have other  
3       people stepping in, there's a huge gap in which  
4       this whole part of what does long-term care mean;  
5       what does post-acute care mean; what is really  
6       available? And somehow, we're going to have to  
7       measure when it's -- you mentioned going from the  
8       acute care facility to that. What is our  
9       planning that really happens to really set that  
10      in place? Is that done?

11               But, then, in terms of when that next  
12      transfer happens, that's also when it gets lost,  
13      when they're going home with a home care agency  
14      or a hospice agency or private duty. And so, I  
15      think that there's got to be something that we  
16      measure because that's very costly care, because  
17      the alternative is, then, they start all over  
18      again and go back to the hospital, and we wait  
19      for them to go through.

20               CO-CHAIR LAMB:   Robyn?

21               MEMBER GRANT:    So, I'm sort of  
22      changing topics here and just wondered about a

1 possible gap being infections. I'm just really  
2 stunned by the percentages I've seen, about  
3 380,000 residents who are dying of infections in  
4 a year, and 1 to 3 million getting infections. I  
5 just wondered if that might be something we might  
6 think should be added.

7 MEMBER LETT: All you asked, are there  
8 not a set of principles of good transitions? And  
9 I would be remiss, as representative of the  
10 National Transitions of Care Coalition, if I  
11 didn't say that we've done that. We've looked at  
12 all the validated programs out there that reduce  
13 30-day hospital readmissions, and we have found  
14 seven essential characteristics that all those  
15 plans have. I'll be happy to share with you.

16 The second thing, Gerri, it's time, I  
17 agree with you. It's time, Sean. It's time.  
18 The hard part is the doing it. And getting into  
19 the gap piece of it is you can't expect a SNF or  
20 a hospital to do well on transitions if they're  
21 not both responsible for it. I mean, you become  
22 a one-armed paperhanger if you're a SNF trying to

1 do a good job or a hospital trying to do a good  
2 job and your partner at the other end of the  
3 ambulance is Bagon.

4 So, I'm back to my old drumbeat about  
5 bidirectional measures, that I give them to you.  
6 You're responsible for reading the information,  
7 for God's sakes. Calling me and saying, "Hey, I  
8 got the information, but I've got a few questions  
9 that we need to clarify." So, bidirectional  
10 measures.

11 And there is a program, there is a  
12 standard for that CMS has put together. And I  
13 sit on their TEP for this, infections in  
14 transitions of care. And they are now jointly  
15 surveying both the hospital and the skilled  
16 nursing facility through a transition to see what  
17 went on. Did everybody do their job? And if  
18 not, what are the gaps? And now, there's no  
19 penalties to it at this point in time, but they  
20 can, then, present a program back to both the  
21 hospital and the SNF and say, "Here's where  
22 things fell down, guys. Go to it."

1                   So, end of sermon. Thank you.

2                   CO-CHAIR LAMB: Let's take a moment  
3 here because we are now through the SNF quality  
4 reporting.

5                   Alan, you have yours. Did you want to  
6 say anything before we move to another area?

7                   MEMBER LEVITT: Okay, yes. I could  
8 say a lot of things, but I will try to be brief.

9                   In terms of the gaps identified in the  
10 program, I guess what is important information  
11 for us and for other people who are reading this  
12 document and may be submitting measures under  
13 consideration to us outside, you know, non-CMS  
14 measure developers, is to really get a clear idea  
15 as to a consensus of gaps that a particular  
16 program has. This isn't just for CMS; this is  
17 for all measure developers who are out there who  
18 may submit measures like we just saw before.

19                   And there are a lot of great ideas  
20 here. There are a lot of things we could do.

21                   Connie, I'm so sorry, you know, your  
22 terrible experience. It's, unfortunately, not

1 uncommon experience. And I think that's why  
2 we're all here today, because we know that and we  
3 know that we can do better and make things better  
4 here.

5 The devil is in the details for every  
6 measure. I keep looking at Tara, Dr. McMullen,  
7 back there. Hopefully, she's back there again.

8 Because, you know, being able to take  
9 these ideas, best practices, and trying to put  
10 them into a quality measure that is as least  
11 burdensome as possible, that can show performance  
12 differences, that can be meaningful, is a  
13 challenge. And that doesn't mean we shouldn't  
14 try to look at those challenges, because in post-  
15 acute care we all know that's what we do.

16 But understand that there are such  
17 challenges to things that you would think would  
18 be intuitively obvious. Because if they weren't  
19 -- if they were obvious, they would have been  
20 done already.

21 But, please, keep giving us this  
22 information. Please give us consensus gaps,

1 well-defined gaps, not just for us, but for other  
2 measure developers, as we keep going through all  
3 these programs.

4 MS. PRATT: And I would like to add,  
5 if there are best practices out there, there must  
6 be metrics associated with those to determine  
7 that they are the best. And we continue to  
8 invite measure developers to the table. Clearly,  
9 AHCA has been working steadily for a number of  
10 years, and so have other developers, but we do  
11 need more.

12 I don't want to say that misery loves  
13 company, but, you know, we've been in this  
14 business for a long time and we would really  
15 appreciate more, especially as these more complex  
16 concepts come to light, because these are really  
17 the heart of much of the care that occurs for  
18 people.

19 And also, just to say I'm the youngest  
20 of seven. All my siblings are Medicare  
21 beneficiaries now and retired. So, please help  
22 me out here.

1 (Laughter.)

2 Oh, yes, as my Medical Officer.

3 (Laughter.)

4 So, thank you all.

5 CO-CHAIR LAMB: Let's take a moment  
6 and just kind of see where we're at and make some  
7 decisions here. So, Paul and I and Erin and  
8 Jean-Luc and Miranda are going to throw out some  
9 choices. So, bear with us for a moment.

10 So, here we are at three o'clock. And  
11 on our schedule we are at 1:30.

12 (Laughter.)

13 And that's not to say -- this has been  
14 what we wanted to accomplish together.

15 So, here's the suggestion. Does  
16 Pierre have a hard stop or are we good?

17 MS. KUWAHARA: No.

18 CO-CHAIR LAMB: Okay. So, where's the  
19 suggestion. All right? It is to take the other  
20 areas, hospice, long-term, IRF, and so forth,  
21 home care, and we'll go through them. But,  
22 rather than do generic gaps, okay, we've talked

1 now about the patient experience being very  
2 important. We've talked about the attributes of  
3 the transfers being important, that we do need to  
4 do work in those areas related to  
5 appropriateness, timeliness, the type of  
6 information.

7 So, rather than kind of repeat general  
8 things that are true across all of post-  
9 acute/long-term care, would you all be  
10 comfortable in looking at what are the gaps we  
11 identified last year? And, then, speaking  
12 specifically to that setting, we will just take  
13 the experience of care and the transfers as a  
14 need, a priority across all settings. But, if we  
15 could heighten any unique issues to those  
16 settings in the next time together, would that be  
17 okay with everybody to do that? Okay. And then,  
18 we can add to it. It sounds like that's okay.

19 Now we do need to do input on measure  
20 removal, and Pierre is with us. So, after we do  
21 the kind of let's go through the settings, see if  
22 there are unique things -- because you are



1 experts in these unique settings and you may have  
2 measures that you really want to bubble up, and  
3 you've thought that we need to add measures.  
4 Let's do that.

5 Then, we'll have Pierre talk about the  
6 measure removal criteria. Now the two topics at  
7 3:30 and 4:00, NQF attribution work and guidance  
8 on attribution challenges in PAC/long-term care  
9 and equity, were for our information. They were  
10 not actual essential topics. They were more to  
11 keep us informed. So, we could either do them  
12 more briefly or we can take them off the agenda.  
13 What's your pleasure on that?

14 We must do the measure removal. We  
15 must do public comments. And, of course, I mean,  
16 what would this day be if Paul and I didn't  
17 summarize?

18 (Laughter.)

19 CO-CHAIR MULHAUSEN: Completely lost.

20 (Laughter.)

21 MEMBER DAHLIN: Gerri, are there  
22 materials for some of the ones that we would

1 possibly take of the agenda that we could still  
2 review and get the information?

3 CO-CHAIR LAMB: Go ahead.

4 MS. O'ROURKE: Yes, so the materials  
5 are in your slide deck. So, if you want to  
6 review, I think the main thing would be the  
7 attribution session was really Taroon, Jean-Luc,  
8 and I looking for some help with our homework on  
9 another project. We have another paper NQF is  
10 developing about patient attribution, and CMS has  
11 asked us to think a little bit about complex  
12 patients and, in particular, the home health  
13 setting. So, we wanted to tap this group's  
14 collective input. If we don't get to that today,  
15 the deck has everything we were going to share,  
16 and we would welcome your input via email or, if  
17 you would want to talk to us offline, we would be  
18 most appreciative. So, that was really our  
19 intent there, was to get input for that project.

20 MEMBER MAHAJAN: Or, alternatively, we  
21 can have a phone call in a week or two weeks and  
22 just get that done.

1 CO-CHAIR LAMB: We've got a couple of  
2 options. We can read stuff and we can have a  
3 phone call. Also, we have another, say, hour and  
4 45 minutes scheduled for this meeting. I don't  
5 know -- typically, folks will be leaving to catch  
6 planes.

7 We could, if there is interest in  
8 doing either and/or attribution and equity,  
9 dedicate like 45 minutes to gaps, have Pierre  
10 walk us through the measurement removal, and  
11 then, spend the last 15 minutes just knowing what  
12 the issues are in attribution or equity. Any or  
13 all. Do you want to do that? Spend about 45  
14 minutes, have Pierre talk, see where we're at,  
15 see if we want an update on attribution and  
16 equity? Or we will do a phone call, so that we  
17 don't lose our opportunity to have some into the  
18 process. Is that good?

19 Thanks for bearing with us. Was that  
20 a yea? Oh, good. Okay. Thank you. As past  
21 Chair, we value you.

22 With that, we're going to move into --

1 oh, I'm sorry, Alan, go.

2 MEMBER LEVITT: No, I'm sorry to  
3 interrupt.

4 But just you did a really nice paper  
5 on attribution in the NQF, and I would certainly  
6 recommend everybody, if you haven't seen it, to  
7 take a look. It is a challenge. It's really a  
8 challenge.

9 I know you were looking at it.  
10 Actually, post-acute care I think was the bad guy  
11 in some of the attribution.

12 (Laughter.)

13 But it is an issue that we have to  
14 deal with, obviously, as well in post-acute care  
15 in terms of trying to make sure that we are  
16 developing measures that the outcome -- you know,  
17 that we are appropriate in terms of outcome  
18 determinations.

19 But, if we don't discuss it, please  
20 just look at the paper.

21 CO-CHAIR LAMB: I don't know about the  
22 rest of you, but you just whet my appetite and

1 now I need to read the paper. And I would like  
2 to have a discussion together. So, we will come  
3 back to that attribution issue.

4 Okay. So, with that, then -- thank  
5 you for kind of putting that on the table, Alan.

6 Where are we? We are moving into  
7 hospice, and let's focus-in on the unique  
8 aspects.

9 Erin, are you -- no, it's hospice.  
10 Jean-Luc, it is you. Would you kick us off here?

11 MR. TILLY: Of course. So, the  
12 hospice program, as you're probably familiar  
13 with, is just a penalty-for-failure-to-report  
14 program. So, the data sources there are the  
15 hospice item set and the hospice CAHPS.

16 So, here are just the measures that  
17 are currently in the program. You will see there  
18 are a lot of things that kind of are lumped into  
19 this idea of a comprehensive assessment at  
20 admission. So, just treatment screening, pain  
21 assessment screening, capturing treatment  
22 preferences, the CHAPS hospice survey, and then,

1 a process measure around hospice visits when  
2 death is imminent. So, two different kinds of  
3 measures that are related to the timing.

4 And here are how the measures fit into  
5 the hospice high-priority areas for measurement.  
6 So, those are high-priority areas that this  
7 Workgroup had identified in the past. And here,  
8 you know how those measures are fitting into that  
9 currently. You can see a couple of gaps there.  
10 So, access to the healthcare team on a 24-hour  
11 basis and avoiding unnecessary admissions are  
12 both areas the Workgroup had identified in the  
13 past that haven't been addressed as yet.

14 Here are the few gaps that CMS had  
15 identified. So, symptom management outcome  
16 measures, timeliness and responsiveness of care,  
17 care coordination, and being responsive to  
18 patient and family care preferences. These have  
19 all been addressed, those measures recently added  
20 to the set.

21 And so, here you have the previous  
22 gaps that this Workgroup identified this past

1 session. So, medication management at the end of  
2 life, provision of bereavement services, and  
3 then, the kind of more general patient care  
4 preferences that we've discussed in other  
5 settings.

6 So, with that, I think I'll turn it  
7 back over to Gerri and Paul.

8 CO-CHAIR LAMB: Paul, do you want to  
9 pick up?

10 CO-CHAIR MULHAUSEN: So, we can see  
11 here the gaps that we've talked about in the  
12 past. And I guess at this point we're curious  
13 about your reflections on those gaps, especially  
14 whether or not, as you consider the program,  
15 whether there are additional gaps you identify  
16 and want to share, as well as the exercise we  
17 just went through, which is, is this granular  
18 enough, can it be filled out more and in a way  
19 that could be operationalized?

20 Do you like these gaps? Do you still  
21 see them as gaps? Can we eliminate one of them?

22 MEMBER MAHAJAN: Wasn't No. 3 already

1 addressed in the set we saw?

2 CO-CHAIR MULHAUSEN: Can we go back a  
3 slide? Yes.

4 MR. TILLY: Right. So, I think the  
5 care preferences there were a little bit  
6 different than what's captured in the CAHPS  
7 hospice survey. So, rather than patient  
8 experience or patient satisfaction, we're talking  
9 more about care preferences and, also, kind of  
10 different for the beliefs and values addressed  
11 piece.

12 CO-CHAIR MULHAUSEN: Theresa, I've  
13 been staring at the screen instead of looking to  
14 my right. So, please, we welcome your input.

15 MEMBER SCHMIDT: Of course I have  
16 something to say about this.

17 (Laughter.)

18 Do you mind putting it back on the  
19 gaps slide? Thank you.

20 First of all, provision of robust  
21 bereavement services is something we definitely  
22 advocate for, both in terms of thinking about



1        what makes and how do we define robust  
2        bereavement services, but, also, are the services  
3        themselves having the needed impact on the  
4        families and caregivers, which was behind my  
5        question about the PROMIS measure in part  
6        earlier? So, that's definitely an area that I  
7        think that there's a gap.

8                Also, included in the Medicare hospice  
9        benefit is the need to use volunteers, but there  
10       really aren't any quality measures related to  
11       volunteer utilization.

12               These are both measures that kind of  
13       have process components to them, but the  
14       statement that more outcomes, and specifically  
15       clinical outcomes measures, are needed is  
16       definitely at the top of our mind as well. All  
17       of the measures in the Hospice Quality Reporting  
18       Program today, based on the hospice item set, are  
19       process measures.

20               And the CAHPS measures are based on  
21       surrogate reports. So, as Dr. Gifford mentioned  
22       earlier, research has shown that surrogates often

1 don't provide an accurate view of the patient  
2 experience. So, it's important that the voice of  
3 the patients themselves be elevated as part of  
4 this program.

5 Finally -- well, not finally; I have  
6 two more -- psychosocial and spiritual care is an  
7 area where I think we've identified gaps before.  
8 Hospice provides emotional support, spiritual  
9 support, psychosocial, psychological support as  
10 well. And to ensure that those needs of the  
11 patients and of their families are being met is  
12 an important concept for us.

13 Definitely agree with the burdensome  
14 transitions of care for patients and families and  
15 the need to recognize and improve that.

16 And now, I'm almost at the end. I  
17 think it's important that measures support a  
18 diversity of diagnoses. So, not just outcomes  
19 that are important for elderly terminal cancer  
20 patients, but also outcomes for more of the  
21 Alzheimer's and dementia populations, two groups  
22 that have grown in hospice care.

1                   So, thank you.

2                   CO-CHAIR MULHAUSEN:  Connie?

3                   MEMBER DAHLIN:  Yes.  So, I think the  
4                   other gaps that I'm kind of worried about that  
5                   we're going to need to monitor is whatever  
6                   happens with health care, this whole part with  
7                   pediatric hospice and pediatric palliative care.  
8                   We're going to need to look at it to make sure  
9                   that some of those measures we're able to still  
10                  monitor and think about what happens with a child  
11                  experience, with their long-term care and some of  
12                  their post-acute care issues.

13                  And then, I think the other part, that  
14                  I will back Theresa in terms of thinking about  
15                  this whole interdisciplinary team part, that we  
16                  don't really measure that.  That's really what  
17                  makes hospice special.  And I would even push it  
18                  farther beyond the required disciplines of  
19                  medicine, nursing, social work, and chaplaincy,  
20                  but rehab is really important.  Nutrition is  
21                  really important, particularly if we're going to  
22                  keep these people safe at home.

1                   And then, last, of this other gap that  
2                   we haven't really measured, but I think makes a  
3                   big difference as we, again, think about wherever  
4                   our health care is land. This 24-hour, quote,  
5                   "accessibility," you know, that usually is a  
6                   phone call. But, for these families when they're  
7                   in crisis, they can just feel so alone and so  
8                   without anything. And so, I don't know what that  
9                   really means right now. So, I can't help CMS in  
10                  that. But I think that's going to be an area  
11                  that we mean, what does 24-hour access mean and  
12                  does that need to be more robust?

13                 Thanks.

14                 CO-CHAIR MULHAUSEN: Carol?

15                 MEMBER SPENCE: I thank you.

16                 I want to start with one of the  
17                 identified gaps, which is the medication  
18                 management. I'm not too sure what the concept  
19                 was behind that. But I would say that that is  
20                 already rolled into a lot of the symptom  
21                 management, which should be a combination of  
22                 medication and other things.

1                   And it also could be part of something  
2                   I'm about to mention as a gap, which has not been  
3                   addressed in hospice at all, which is safety.  
4                   There's been very little mention of that in  
5                   hospice. It is different in hospice in that so  
6                   much of the vast majority of hospice care does  
7                   take place in the home. Patient autonomy is a  
8                   huge piece of that. So, the whole concept of  
9                   safety in the hospice setting is quite different,  
10                  and I think it deserves its own look.

11                  Just transferring or borrowing  
12                  measures from other providers is not really going  
13                  to do justice to the concept in hospice, and I  
14                  think it should be identified as a gap and, then,  
15                  looked at for its unique properties there.

16                  So, I would say that medication piece,  
17                  if you were going to take something off, I would  
18                  take that off and just recognize how integral  
19                  that is to so many of the other areas of hospice  
20                  care.

21                  Adding, or enhancing I guess, or  
22                  changing a bit what Theresa said, I can't

1 emphasize enough the role of the family caregiver  
2 in hospice. Hospice is unique, also, in that we  
3 recognize the family and the patient as the unit  
4 of care.

5 The CAHPS hospice is not just a set of  
6 surrogate measures, however. It does, in part at  
7 least, recognize that the family member is a unit  
8 of care, because there are questions on that that  
9 do relate just to the family caregiver.

10 The one big focus on there, however,  
11 is on instruction, is on education of the  
12 caregiver, preparing them to provide the care.  
13 However, what that leaves out is the difference  
14 between simply instructing someone and actually  
15 enabling them to provide the care, making them  
16 feel that they are confident that they can do it,  
17 but also that hospice is there.

18 And it goes back to that 24-hour  
19 access that Connie was just talking about. That  
20 caregiver should feel like hospice has got their  
21 back, that they are there, that they are not  
22 alone in this. And that is not captured on the

1 CAHPS, and I think that is a significant gap that  
2 could be worked on and added to the CAHPS,  
3 because the CAHPS is the vehicle for getting the  
4 caregiver's perception of the care that they  
5 received as well as the patient.

6 CO-CHAIR MULHAUSEN: Alan?

7 MEMBER LEVITT: Well, thank you all  
8 again. Great, great ideas for us.

9 I want to first introduce Carol  
10 Schwartz who is the measure lead for hospice and  
11 for home health. So, I wanted to welcome Carol  
12 to the table to listen to this.

13 As you probably know from the rule  
14 this year in the future measures section, we are  
15 asking for comments on some of the claims-based  
16 measures that are under development. We agree  
17 that we need to continue measure development and  
18 are interested in filling these gaps as well.

19 Talking up the hard instrument again,  
20 but just the idea that, with good assessment  
21 instruments, with items that mean a lot for  
22 patients, also comes development of quality

1 measures off those items. So, we are looking  
2 forward to being able to continue to develop more  
3 and more Meaningful Measures for this program.

4 CO-CHAIR MULHAUSEN: Kurt?

5 MEMBER MERKELZ: Thank you.

6 I certainly want to echo certainly  
7 everything that's been stated. Certainly, trying  
8 to achieve safety, making sure that we're  
9 addressing the spiritual/psychosocial needs of  
10 individuals represents significant gaps that  
11 aren't accounted for in hospice extremely well.

12 I think further clarification on my  
13 end of what we're actually getting to regarding  
14 medication management at the end of life,  
15 actually trying to achieve specific outcomes, I  
16 think is certainly lacking. We're able to assess  
17 at the front end. And really, the hospice item  
18 set, you know, our current measurements and the  
19 Hospice Quality Reporting Program, the hospice  
20 item set, everything is captured at the initial  
21 visit, everything. So, it's not reported out  
22 until the patient dies. But further qualitative



1 data of what took place after that initial  
2 assessment isn't captured at all in the hospice  
3 item set data.

4 So, certainly having patient-reported  
5 outcome data and a focus to outcome data, but,  
6 also, specifically quality-of-life outcome data,  
7 having identified patient prioritized, quality-  
8 of-life domains represented and captured is  
9 certainly an area that needs to be identified.

10 We often address quality of life as  
11 the reduction of negative attributes, but when we  
12 really get to the value-add that hospice is  
13 bringing to the end-of-life care experience, we  
14 need to make sure we're doing things and  
15 promoting things that make the end of life more  
16 meaningful for the individual patient, making  
17 sure we're capturing components of who they are,  
18 being, belonging, becoming. And I think putting  
19 positive attributes and making sure we have a way  
20 of capturing the positive attributes that we do  
21 for individuals at this time of life is  
22 important, and not just reduction of the

1 negatives.

2 CO-CHAIR MULHAUSEN: Kurt?

3 MEMBER HOPPE: As Carol said before,  
4 I didn't have the ability to understand what was  
5 discussed before, but she talked about the  
6 medical management. I came off thinking that  
7 that gap was something else. And mine was the  
8 physician accountability for medication  
9 management.

10 It's nice that the facility has  
11 something. And I'm also thinking about our MIPS  
12 discussion. It's been a long time since I've  
13 been a hospice physician, but I do remember that  
14 getting certain physicians, and other providers  
15 now, that can prescribe narcotics and other  
16 medications to actively wanting to be engaged,  
17 either clinically or culturally, with hospice was  
18 sometimes a problem.

19 So, right there when it said medical  
20 management, that was my thought, the physician,  
21 nurse practitioner, or PA responsibility in  
22 actively helping the hospice with a patient that

1 was undergoing increased pain or was undergoing  
2 or having some of the symptoms that we associated  
3 with certain times of dying. I'm not sure if  
4 that was addressed previously.

5 CO-CHAIR MULHAUSEN: No, that's very  
6 helpful.

7 Carol, you've been going up and down.

8 MEMBER SPENCE: Yes. Sorry. So, I'll  
9 just go up.

10 I just wanted to say one thing about  
11 patient PROs and hospice and acknowledge the  
12 challenges in getting patient-reported measures.  
13 Over a third of hospice patients die within seven  
14 days. Back when the HQRP was first instituted  
15 there was a patient-reported outcome measure  
16 regarding pain. It sounds like the absolute  
17 perfect measure, and CMS withdrew it after just  
18 putting it in place for half-a-year, only a  
19 quarter's worth of data collection, in addition  
20 to the piloting that they did of it. And it was  
21 for multiple reasons.

22 But, now that HQRP has been in place,

1 HIS data collection has been in place, I really  
2 would like to see that measure, or a permutation  
3 of it, revisited because hospices are much more  
4 used to that. That was the first out of the box.  
5 It's a tough place to start for a whole set of  
6 providers that have never done any quality  
7 reporting, many of whom still don't know what a  
8 numerator/denominator is. You know, they thought  
9 monitoring something was doing quality  
10 measurement.

11 And I also appreciated back when Karen  
12 was reporting about rural, about easing into it.  
13 Hospice didn't get eased into it and they should  
14 have been. So, I think perhaps that's been a  
15 lesson learned, and I heartily endorse that  
16 easing into it.

17 But, again, this is a real challenge  
18 in hospice. I think it can be done. And again,  
19 I think that measure should be revisited with  
20 perhaps also at the same time testing of that  
21 caregiver response, so you know what that gap is.  
22 So, as that patient does get sicker, you could

1 over time pull in that caregiver's report and  
2 understand and actually statistically be able to,  
3 then, know what that caregiver's response is in  
4 relation to the patient. So, you could also  
5 perhaps use the caregiver as a surrogate on some  
6 of these symptom management outcome measures,  
7 which we dearly need.

8 CO-CHAIR MULHAUSEN: Any other  
9 comments regarding the gaps for the Hospice  
10 Quality Reporting Program?

11 (No response.)

12 Okay. Let's move to the next one.

13 CO-CHAIR LAMB: Long-term care  
14 hospital. Miranda, are you doing that one?

15 MS. KUWAHARA: I am.

16 So, like the other QRPs, this is a  
17 penalty for failure to report program. It was  
18 established under the ACA. And since federal  
19 fiscal year 2014, LTCHs that failed to submit  
20 data are subject to a two-percentage-point  
21 reduction of the applicable annual payment  
22 update.

1                   Three measures were finalized in the  
2                   fiscal year 2018 IPPS Final Rule. They include  
3                   compliance with spontaneous breathing trial by  
4                   day two of the LTCH stay, ventilator liberation  
5                   rate, and changes in skin integrity post-acute  
6                   care pressure ulcer/injury. And this will  
7                   replace NQF No. 0678, percent of residents or  
8                   patients with pressure ulcers that are new or  
9                   worsened, short stay.

10                  CMS identified the following domains  
11                  as high priority for future measure  
12                  consideration: effective prevention and  
13                  treatment, which was addressed through  
14                  ventilator-related measures; making care safer,  
15                  which is addressed through modifications to  
16                  existing pressure ulcer measures, and then,  
17                  communication and care coordination, addressed  
18                  through transitions and rehospitalizations as  
19                  well as medication reconciliation.

20                  Last year MAP identified gaps in the  
21                  LTCH QRP measure set. These include the need for  
22                  measures addressing the transfer of information

1 between attending clinicians, rather than being  
2 limited to transfers of information between  
3 settings. MAP also recommended adding measures  
4 addressing nutritional status. And then, MAP  
5 recommended adding an LTCH-specific CAHPS survey  
6 to assess patient experience of care.

7 And then, during our most recent web  
8 meeting in November, the Workgroup noted special  
9 considerations for LTCH transfers, specifically  
10 measures assessing the acute-to-acute transfer  
11 between hospitals and LTCHs.

12 CO-CHAIR LAMB: Okay. Gaps?  
13 Additional things? Confirming previous gaps?  
14 Adding gaps?

15 Sean?

16 MEMBER MULDOON: So, these are all  
17 getting at the right things. I think the TAPS is  
18 going to take care of itself because that's in  
19 the pipeline.

20 Everything that we talked about around  
21 transfer of information and that transition-of-  
22 care coming into a SNF I think applies to coming

1       into a long-term care hospital, as well as on the  
2       transfer out side, because, you know, probably a  
3       third to almost 40-percent of LTCH discharges end  
4       up going to another institutional entity in the  
5       post-acute care segment.

6               So, I think that list looks pretty  
7       good to me. I've got in the back of my mind this  
8       mental health/behavioral component that overlays  
9       your ability to get well. And that one is still  
10      out there. It was mentioned on the previous  
11      slide. So, I would have no objection to adding  
12      something related to that, either assessment or  
13      outcome, with the understanding that many of  
14      these are going -- many of the psychiatric  
15      diagnoses will be not chronic, because we already  
16      know about the chronic ones. But I've got no  
17      objection to those being added as a reminder of a  
18      gap.

19               CO-CHAIR LAMB: Caroline?

20               MEMBER FIFE: Even though this falls,  
21      again, under the fact that I can't pass up the  
22      opportunity to tilt a windmill and it's



1       pointless, but last year I mentioned that you  
2       would probably regret going through with the  
3       pressure injury terminology change. So, I just  
4       have to go on record as saying, I think you will  
5       regret that. It's still not clear that you will  
6       be able to code that under ICD-11. That's not a  
7       done deal. I realize they're working on it, but  
8       if it doesn't have an ICD-11 code, it's going to  
9       be interesting.

10               Also, it's possible under ICD-11 that  
11       all pressure ulcers will now have become wounds,  
12       because injuries are wounds. If so, they have to  
13       be secondarily coded by the thing that caused the  
14       wound. On top of that, this terminology now  
15       includes device-related pressure injury, which  
16       very specifically means that the device caused  
17       the thing. The manufacturers can get ready for  
18       this. It's going to be expensive for them.

19               This will also make it more difficult  
20       to defend pressure ulcer litigation against  
21       facilities. If you are an LTCH, call your law  
22       firm because you will pay for this monetarily,

1 and so will the providers who work there. It's  
2 going to be ugly, and I will enjoy telling you, I  
3 told you so.

4 CO-CHAIR LAMB: Kim?

5 MEMBER ELLIOTT: I just want to  
6 support what Sean said about the mental health or  
7 behavioral health. I think that's really  
8 critical to get these people ready to get out of  
9 that facility. So, we do need to manage the  
10 depression and things like that, which come along  
11 with those types of care and services.

12 CO-CHAIR LAMB: Other suggestions,  
13 confirmations of the gaps?

14 (No response.)

15 Okay. The next one is -- what are up  
16 to here?

17 CO-CHAIR MULHAUSEN: IRF.

18 CO-CHAIR LAMB: IRF.

19 CO-CHAIR MULHAUSEN: Miranda.

20 MS. KUWAHARA: It's me again.

21 All right. So, again, we're looking  
22 at another penalty for failure to report program.

1 Under this program, this applies to all IRF  
2 facilities that receive the IRF PPS. So, that  
3 includes IRF hospitals, IRF units that are  
4 affiliated with acute care facilities, and IRF  
5 units affiliated with the critical access  
6 hospitals.

7 Data sources for the IRF QRP measures  
8 include Medicare fee-for-service claims, the  
9 CDC's National Health Safety Network data  
10 submissions, and IRF patient assessment  
11 instrument records.

12 One measure was finalized in the  
13 fiscal year 2018 IRF PPS Final Rule. This  
14 measure is titled, "Changes in Skin Integrity  
15 Post-Acute Care: Pressure Ulcers/Injury," which  
16 will replace NQF No. 0678.

17 CMS identified the following domains  
18 as high priority for future measure  
19 consideration: making care safer, which is  
20 addressed through modifications to a current  
21 pressure ulcer measure, and then, communication  
22 and care coordination, which is addressed through

1 discharge to the community, potentially  
2 preventable readmissions, and med rec.

3 And here, we have the MAP's  
4 recommendations for gaps identified last year.  
5 We have experience-of-care measures related to  
6 patient and family engagement. Additionally,  
7 during the November 13th web meeting, Workgroup  
8 members cited refinements to infection measures,  
9 given low incidence, as an additional gap.

10 CO-CHAIR MULHAUSEN: Okay. So, again,  
11 the exercise is a reflection on gaps. Anything  
12 that you think needs to be amplified from  
13 previous lists of gaps and anything you think  
14 ought to be added at this point.

15 Sorry, I'm slowing down at 3:30.

16 (Laughter.)

17 Yes. No, no, I need some caffeine  
18 probably.

19 (Laughter.)

20 So, anyway, the same exercise. Any  
21 gaps that you perceive.

22 Caroline, I'm assuming your

1 reflections from our last conversation apply here  
2 as well?

3 MEMBER FIFE: They do.

4 CO-CHAIR MULHAUSEN: Yes, very good.

5 Sean, you have the floor.

6 MEMBER MULDOON: Yes, I'm a little  
7 curious if the experience with information  
8 transfer around the arrival into an IRF or in an  
9 acute rehab unit -- you know, given the more and  
10 more medical comorbidities that I'm told about  
11 somehow matters less or is better handled under  
12 an IRF setting, because it's conspicuous in its  
13 absence.

14 CO-CHAIR MULHAUSEN: Gene, I think you  
15 came up first.

16 MEMBER NUCCIO: I don't know exactly  
17 how to frame my comment. I was just sort of  
18 reflecting -- I mean, we are talking about  
19 quality measures. And I was thinking about, what  
20 do I see in the newspapers about these sorts of  
21 settings, whether they're nursing homes or long-  
22 term care facilities? And you see things about

1 abuse and you see things about just general poor  
2 quality care or lack of care to the patients.  
3 And I'm thinking specifically of the news in  
4 Florida, okay, where the patients lost power and  
5 they were in the 100-plus-degree temperature.

6 I don't know whether this is part of  
7 this. I don't know whether there are agencies at  
8 the state level that do checking of conditions of  
9 participation and whether the facilities are  
10 compliant. I was wondering if there's any value  
11 of trying to engage the folks that do survey and  
12 certification in this whole effort to integrate  
13 what they're finding with these patients. And it  
14 sort of could be applied to many of these  
15 institutional types of settings.

16 Again, I don't know how to frame my  
17 comment.

18 CO-CHAIR MULHAUSEN: Kurt?

19 MEMBER HOPPE: I just wanted to  
20 respond to Sean. I think one of the reasons why  
21 in IRFs some of the discussions and some of the  
22 transfer of information is a little less clunky

1 is because we have a big, mandated pre-admission  
2 screening procedure. As much as we may not like  
3 it sometimes, and it can be very time-consuming,  
4 but it does require us to do a second check and a  
5 double-check of everything we have. And it does  
6 require us, especially ones that are certified,  
7 to be able to go talk to patients and make sure  
8 that we are giving patients and family a lot of  
9 information. So, that kind of tool is in place,  
10 and it enforces a lot of discussion.

11 It sort of reminds me when MDS came in  
12 for SNFs, that that did promote quality and some  
13 discussions that were previously not available.  
14 So, I think that's the reason why IRFs, it feels  
15 like there's more engagement.

16 CO-CHAIR MULHAUSEN: Jim?

17 MEMBER LETT: Since I think IRFs could  
18 loosely be defined as skilled nursing facilities  
19 on steroids, I think the same thing around  
20 transitions, about information passage,  
21 medication, correct medication list, et cetera,  
22 might be worthwhile to enter here as well.

1       There's a lot of transitions from that, far more  
2       than LTCH.

3                   CO-CHAIR MULHAUSEN:   Yes, and what  
4       we've done is taken notes on Sean's reflections  
5       and your comments.   So, I think it will probably  
6       be there next year.

7                   Raj?

8                   MEMBER MAHAJAN:   So, just thinking  
9       about the Meaningful Measures, that whole circle  
10      and the big slide, I think it applies to IRF, but  
11      probably all settings is something on opioid use.  
12      I think with everything going on nationally with  
13      the epidemic, and everything, I think that,  
14      again, is another issue where you will have a  
15      physician and the facility be responsible for  
16      coming up with something, where if somebody  
17      prescribes an opioid, can you have some criteria  
18      that have to be met to use that, something around  
19      that?   And it can go for all four levels.

20                  CO-CHAIR MULHAUSEN:   All right.   Any  
21      other reflections, comments, additions?

22                  Dr. Levitt?



1                   MEMBER LEVITT: Well, thank you all  
2                   for the comments.

3                   Again, certainly elder abuse is  
4                   something that we are all concerned about,  
5                   particularly in the long-term care and nursing  
6                   home setting.

7                   And, Dr. McMullen, once again, is  
8                   interested in looking at measures associated with  
9                   that.

10                  Those measures or that sort of measure  
11                  wouldn't really fit into this program, which is  
12                  the IRF Rehab Quality Reporting Program.

13                  But, no, we are, obviously, interested  
14                  in continued measure development, identification  
15                  of gaps, making more and more Meaningful  
16                  Measures. So, please continue to think about  
17                  programs. We don't mind seeing bullets up there  
18                  for us all to be thinking about.

19                  CO-CHAIR MULHAUSEN: Okay. If no  
20                  other comments, then I think we'll move on to the  
21                  Home Health Quality Reporting Program. And Erin  
22                  is going to lead us in that discussion.

1 MS. O'ROURKE: Thank you.

2 So, again, another failure for penalty  
3 to report program.

4 Data from this program are reported on  
5 the Home Health Compare website.

6 Potential information sources include:  
7 the OASIS instrument, the CAHPS survey, and  
8 Medicare fee-for-service claims.

9 I know we're short on time. So, I  
10 will not read you all the measures in the  
11 program, but in your reference material, in case  
12 you need it.

13 And, yes, everything can thank the CMS  
14 team for their great work to remove measures  
15 here.

16 So here, you can see a lot of progress  
17 has been made addressing some of the high-  
18 priority domains that had previously been  
19 identified.

20 And then, the gaps that the Workgroup  
21 had identified last year were measures to adopt  
22 care plans for congestive heart failure. We also

1 started talking in November about a potential gap  
2 around opioid use and balancing that with pain  
3 management. So, I did want to bring that back to  
4 you, if you want to continue that conversation as  
5 we continue to refine this list.

6 CO-CHAIR LAMB: Additional gaps that  
7 you want to mention, bring forward?

8 (No response.)

9 I have to say I have the same reaction  
10 to this one that Sean had to one of the last  
11 ones, which is, wow, that's all we came up with  
12 last year?

13 Anything else?

14 Gene, go for it.

15 MEMBER NUCCIO: Sorry, I would  
16 disappoint Alan if I didn't speak.

17 (Laughter.)

18 We have many gaps.

19 I guess, again, my methodologist side  
20 is coming out to me. But one of the things that  
21 we hear consistently from home health agency  
22 representatives has to do with maintenance

1 measures. That is, keeping patients out of more  
2 expensive and intensive settings once they get  
3 them.

4 And so, from a methodological  
5 perspective, I think one of the things that home  
6 health agencies would like to see is some type of  
7 measure. Perhaps it's a utilization kind of  
8 measure. You could measure it with claims or you  
9 could measure it with OASIS, but that looked at  
10 the length of time that we keep patients from  
11 returning to more intensive care settings.

12 This, by the way, hospitals would love  
13 this because their 30-day rehospitalization rate  
14 in many cases is highly dependent on the quality  
15 of the home health agency. And so, collaborative  
16 efforts between acute care settings and home  
17 health, and nursing home kinds of settings, would  
18 be of value. So, I mean, it's a different kind  
19 of thing than we've been talking about because  
20 it's a type of measure.

21 We certainly would like to hear, have  
22 more in the way of the patient -- another type of

1       measure would be the patient voice in all this.  
2       So, as you heard earlier from Tara and Stace, the  
3       PROMIS work is promising.

4                       (Laughter.)

5                       At the same time, we've actually been  
6       thinking about this whole issue of the provider  
7       assessment of change in the patient's status  
8       versus the patient's perception of the change in  
9       the patient's own status, versus the caregiver's  
10      perception of that change.

11                      And so, we have sort of a diagram --  
12      and I will disappoint Alan that I won't draw it  
13      today -- that it's sort of overlapping Venn  
14      diagrams where the three perspectives of  
15      provider, patient, and caregiver overlap, and at  
16      that point of overlap is what is really happening  
17      with the patient. And so, I mean, that's sort of  
18      the conceptual model that we have begun to play  
19      with out at the University of Colorado in terms  
20      of how to make this happen.

21                      CO-CHAIR LAMB: Gene, can I just ask  
22      for just a little more here? On that issue of

1       how long somebody stays in home care or stays out  
2       of the hospital or more expensive -- right now,  
3       we are looking at readmission rates, hospital  
4       readmission. Is the gist of this measure, then,  
5       to flip it and to say the length of time somebody  
6       stays in the community?

7                   MEMBER NUCCIO: That is one way of  
8       measuring it. And again, we've done some  
9       preliminary work. In home health, as all of us,  
10      in terms of claims, it's a 60-day kind of window.  
11      However, every 60 days a patient is on care, we  
12      do a recertification of that patient's status on  
13      both functional and some clinical issues,  
14      clinical characteristics.

15                   And so, one of the things we're  
16      looking at is the number of periods of time where  
17      the patient remains out of the hospital and  
18      either is maintaining that level of performance  
19      or perhaps increasing that level of performance  
20      even. So, we're investigating that.

21                   Now we are quite well aware of  
22      unintended consequences of measures. That is, if

1       you're incentivizing people to maintain a person  
2       from going back to the hospital, then you're  
3       incentivizing the person, the agency to keep the  
4       patients on care for a long period of time, which  
5       is going to cost CMS more money.

6               So, trying to balance that sort of  
7       perverse incentive with the idea that truly  
8       keeping patients out of more expensive and  
9       intensive care is a meaningful and good goal for  
10      many home health agencies needs to be respected.

11             CO-CHAIR LAMB: Thank you.

12             Liz?

13             MEMBER HALL: Yes, so just to respond  
14      to this, I just wondered -- and I guess it's a  
15      question just for the group. You know, a lot of  
16      what we are hearing, I think, more and more at  
17      ONC is around the importance of not only sharing  
18      clinical information, but having a better  
19      understanding of a person's social determinants  
20      of health and being able to share that  
21      information and support a person's needs around  
22      that. So, I know that later on in the agenda you

1       were going to talk about health equity and SDOH.  
2       But I just wondered in terms, particularly around  
3       home health and as people go back in the  
4       community, about people's thoughts about measures  
5       that might support SDOH needs.

6                   CO-CHAIR LAMB:   Anybody have any  
7       thoughts for Liz?

8                   (No response.)

9                   MEMBER FIFE:   In one of our QCDR  
10       measures, we had included in our patient-reported  
11       nutritional screening the two-question survey on  
12       food insecurity, which I had to actually cry on  
13       the phone to get CMS not to reject yesterday.  
14       So, we say we care, but it's hard.

15                   CO-CHAIR LAMB:   We're not going to  
16       make you cry with this comment on this one.

17                   MEMBER FIFE:   Gene may have solved one  
18       of my really tormented problems, which is I see  
19       the world through the lens of people with chronic  
20       wounds, and they go through all of these sites of  
21       care that we're talking about.

22                   And I mentioned the analysis we did of



1 cost, which is \$96 billion, most of which is  
2 subacute care. And I haven't mentioned wounds in  
3 any of our gaps because it doesn't, after we have  
4 stated framework as this sort of high-level  
5 thing, somehow that seems too disease-specific.  
6 So, amazingly, I can be intimidated into not  
7 saying anything.

8 (Laughter.)

9 But, nevertheless, one of the issues  
10 around people with chronic wounds is trying not  
11 to have them end up being hospitalized for acute  
12 episodes. However, we just realized that the  
13 vast majority of their spend is subacute care. I  
14 don't know whether that's a good thing or a bad  
15 thing. But, nevertheless, it never occurred to  
16 me that we might try to craft measures that  
17 really are specifically looking at the success we  
18 have in keeping them out of acute care episodes.  
19 Maybe that's the win for us that I hadn't really  
20 grabbed onto.

21 It's kind of an exciting way to  
22 actually get a better look at those people as

1 they transition through all of these different  
2 care sites, because these are people who we  
3 really realize chronic wounds, it's not that  
4 we're going to heal them. We're never going to  
5 heal them. Their heal rate is like 30 percent.  
6 They're always going to have this thing. It's  
7 like diabetes. So, it's an interesting idea. I  
8 really like that idea.

9 CO-CHAIR LAMB: Alan?

10 MEMBER LEVITT: Just a couple of  
11 comments, again, that Carol, Gene, and I think  
12 about gaps all the time in home health.  
13 Maintenance measures is a really important topic  
14 for us. Over half I think, 60 percent of home  
15 health referrals, first of all, come from the  
16 community. They're not from a hospital. So,  
17 they're not readmissions. They're essentially  
18 hospitalizations if they go into the hospital  
19 from home health. And so, that's an outcome to  
20 look at.

21 But the existing stabilization  
22 measures that were around for a long time in home

1 health, since OASIS first came out, are all  
2 topped-out. They're topped-out measures that  
3 really could no longer be used to measure quality  
4 for our providers.

5 And so, the hope is, with better  
6 assessment items comes better new measures. And  
7 so, that, hopefully, as the assessment items that  
8 are coming forward in the IMPACT Act becomes  
9 parts of our program, we can start looking at  
10 saying, well, how can we build stabilization-type  
11 measures that would be applicable in home health,  
12 would be applicable in the long-term care setting  
13 as well?

14 So, these are identified gaps, and I  
15 assume they're Workgroup gaps as well. And we'll  
16 continue to be working on this.

17 CO-CHAIR LAMB: Okay. We're going to  
18 move now into -- we have Pierre Yong coming back  
19 to talk about measure removal criteria for our  
20 input.

21 How about if we aim for about -- oh,  
22 do we need to do public comment right now?

1 MS. O'ROURKE: Yes. So, I was going  
2 to propose if we could open for public comment.

3 If during the public comment, if  
4 everyone wants to stand and take a stretch break  
5 while we queue up the phone lines? I know we've  
6 had you all sitting for a while and perhaps  
7 everyone could use a little time out of your  
8 seat. But we are short on time.

9 So, Operator, could you the lines for  
10 comment?

11 OPERATOR: Yes, ma'am.

12 At this time if you would like to make  
13 a comment, please press \* and, then, the No. 1.

14 (Pause.)

15 And there are no public comments at  
16 this time.

17 MS. O'ROURKE: Shall we get through  
18 Pierre and, then, maybe a five-minute stretch?

19 CO-CHAIR MULHAUSEN: I think a five-  
20 minute stretch.

21 MS. O'ROURKE: Okay. Why don't we?  
22 the Chairs have asked for a five-minute stretch

1 and, then, we'll reconvene.

2 All right. Thank you.

3 (Whereupon, the above-entitled matter  
4 went off the record at 3:50 p.m. and went back on  
5 the record at 3:57 p.m.)

6 CO-CHAIR LAMB: Here's the plan for  
7 our last hour together. Okay. We're going to  
8 spend about 30 minutes talking with Pierre about  
9 measure removal criteria and offering input.

10 We'll get a brief update on  
11 attribution and the paper we heard about. And  
12 we'll figure out what next steps might be. And  
13 then we are going to bring the meeting to a  
14 close. We will be done by 5:00. So Pierre.  
15 Thank you.

16 DR. YONG: So great. So this is I  
17 thought a nice way to sort of close the circle at  
18 least on sort of the measures discussions.

19 Continuing on from earlier in the day,  
20 I mentioned when we were talking about Meaningful  
21 Measures that we are also internally starting to  
22 look at the actual measure sets for each of our

1 17 programs that we work on.

2 So wanted to take the opportunity  
3 while we had you here to really pick your brains  
4 and get some feedback and reactions about the  
5 criteria we should be thinking about when we do  
6 this evaluation. And we're doing this, just so  
7 you know, across the workgroups. And we'll be  
8 discussing it at the coordinating committee as  
9 well.

10 So we pulled together some sort of  
11 framing questions as well as some draft criteria  
12 for you to react to. But we'll keep this fairly  
13 short in order to maximize the time for our  
14 discussion. So if you move to the next slide,  
15 please.

16 So these are some considerations that  
17 we pulled together. So, again, they're drafts,  
18 so feel free to react to them. If there is  
19 anything missing or there's things that you think  
20 are important to note, we welcome that feedback.

21 First, that the measures that we want  
22 to keep are meaningful to patients and providers,

1 that they're patient-centered, that they're  
2 current with clinical guidelines. And as you  
3 know, you know, and you're intimately familiar,  
4 there are sometimes and often are specific  
5 statutory requirements a la IMPACT for the PAC  
6 programs that we need to meet and that's why we  
7 have certain measures in the programs.

8 Measure types, outcome measures are  
9 things that we've talked about as having a  
10 preference for. We certainly recognize that  
11 often times there are not outcome measures.  
12 There certainly is space for process measures,  
13 particularly process measures that are approximal  
14 to outcomes of interest, and so, but generally  
15 prefer outcome measures.

16 Variation and performance, looking for  
17 measures where there's continued variation in  
18 performance so that we are continuing to drive  
19 quality improvement.

20 Performance trends, so looking at how  
21 the, if a measure has been in a program for  
22 several years, looking at how the performance on

1       that measure has been, whether it's improving or  
2       whether's it's static or actually getting worse.

3               And so thinking then more broadly, if  
4       it's not heading in the direction that we are  
5       hoping they should head in, like whether, one,  
6       it's a useful measure or whether there needs to  
7       more like quality improvement efforts directed  
8       towards that particular quality issue. But those  
9       are considerations that I think we can take into  
10      account. If you move into the next slide.

11             Burden is something we've talked about  
12      today. But certainly the amount of burden  
13      associated with the measure is another key  
14      consideration.

15             Unintended consequences is something  
16      that has come up in some of our discussions, but  
17      is another key consideration.

18             Operational issues, we had a lot of  
19      discussion around operational issues with the  
20      CoreQ measure today. So that's certainly another  
21      key consideration.

22             And the final element that we put on



1 was alignment, in particular, within and across  
2 CMS programs, but also with private pairs to  
3 minimize unnecessary duplication, harmonization  
4 of measures to the extent that we can do that.  
5 So we can move to the next slide.

6 This is just the framing question.  
7 But are there criteria? You know, we showed you  
8 some draft ideas that we had that we should  
9 consider as we review the measure sets for our  
10 quality reporting and accountability program.

11 So I'll stop there and turn this back  
12 to Gerri and Paul.

13 CO-CHAIR LAMB: Thank you, Pierre.  
14 Can we go back two slides so that you can look at  
15 the criteria and offer suggestions? So these are  
16 the criteria that are being considered right now.

17 Pierre, how do these relate to the  
18 ones that when we do measure maintenance, they,  
19 you know, that we go through in terms of  
20 continuing them as endorsed or recommending  
21 endorsement?

22 DR. YONG: On the endorsement side,

1        maybe Erin can sort of comment on that. But I  
2        think they align pretty closely. But --

3                    MS. O'ROURKE: Sure. Apologies.  
4        Could you repeat the question?

5                    CO-CHAIR LAMB: I was just wondering,  
6        the criteria that Pierre just put forward for  
7        measure removal, how do they relate to what we go  
8        through when we look at measure maintenance?

9                    MS. O'ROURKE: Sure. So I think, as  
10       Pierre was saying, these are questions that we  
11       ask the standing committees to think about.

12                   Obviously, the endorsement process is  
13       more about the scientific merits of a measure  
14       rather than whether it's in or out of a specific  
15       program. But at least, you know, I haven't done  
16       the one-to-one mapping, but I see burden very  
17       much tied to the feasibility criteria that we ask  
18       our standing committees to take a look at.

19                   Similarly, we are always asking for  
20       input on potential unintended consequences,  
21       something we do think about in the endorsement  
22       review process. We also have, you know, a

1       separate process if anyone determines there is an  
2       unintended consequence. So we like, we even  
3       review it faster.

4               Again, operational issues I think tie  
5       back to both our feasibility and use and  
6       usability criteria where we want input on is this  
7       measure possible. Does it give you information  
8       you can work from and actually improve?

9               Alignment, not necessarily an NQF  
10       criteria, but we do ask our developers to under  
11       the use and usability criteria provide any  
12       information about where else the measure is being  
13       used. And we do expect that NQF endorsed  
14       measures are in use.

15               Oops, let me go back to the previous  
16       slide to just --

17               DR. YONG: And as it relates to that  
18       particular point as well, there is the related  
19       and competing measures process.

20               MS. O'ROURKE: Oh, that's a good  
21       point, yes.

22               DR. YONG: You know, that's not

1 necessarily in the context of a program as it's  
2 being used here. But conceptually it's very  
3 similar.

4 MS. O'ROURKE: And then I think here  
5 under, these three at least all to me really  
6 align with our importance to measure criteria.  
7 We want to ensure that endorsed measures are  
8 meaningful.

9 NQF has obviously noted a role for  
10 process measures. But we've continually  
11 emphasized a need for more high value measures.  
12 We only endorse measures that have a variation in  
13 performance. If a measure is determined to be  
14 topped out, it would go into our, what we call  
15 reserve status.

16 And then performance trend, we do ask  
17 developers to demonstrate that there is a quality  
18 gap and any information they can tell us about  
19 performance over time.

20 Is there anything I missed there?

21 DR. YONG: Yes, the only other thing  
22 I would emphasize as part of measure type is

1 that, you know, this is where we would look at  
2 the evidence.

3 If we're looking at process measures,  
4 really looking at the quality, quantity, and  
5 consistency of the evidence of the process as it  
6 relates to the outcome of interest. So while  
7 outcome measures are preferred, we would be  
8 looking a little bit more broadly in terms of  
9 that piece.

10 But overall, the criteria aligned very  
11 closely. It appears to be more focused on the  
12 measure set in the context of a particular  
13 program.

14 CO-CHAIR LAMB: Reactions,  
15 suggestions?

16 (Off mic comments.)

17 MEMBER DEBARDELEBEN: Hey, this is  
18 Mary Ellen Debardeleben. And I wanted to bring  
19 up some considerations that we've had within our  
20 IRF quality reporting program. Can you hear me?

21 CO-CHAIR LAMB: Keep going, Mary  
22 Ellen.

1                   MEMBER DEBARDELEBEN:   Okay.   Thanks.  
2   I just wanted to make sure.

3                   So I'm not sure whether these would  
4   fall within performance trending or  
5   meaningfulness or perhaps both or maybe even a  
6   separate bullet.   But in relation to our  
7   infections, we have spent the past several years  
8   since 2012 reporting on CAUTI and since 2015 on  
9   MRSA and C. diff.

10                  We actually just got, our IRF compare  
11   site was updated yesterday.   So I went in and  
12   looked for MRSA.   We have 1,199 IRFs on the IRF  
13   compare site.   And of the 1,199 IRFs, only one  
14   IRF actually had a data score for MRSA.   The  
15   other 1,198 IRFs had a NA because the incident  
16   rate was so low.

17                  There is a cost and time resource  
18   utilization to report that data.   Even though  
19   there aren't infections, there are required data  
20   elements that have to be put into the NHSN.   And  
21   so it's frustrating for providers that spend the  
22   time and resources away from patients to report

1 this data to not get anything back from the  
2 system.

3 So there's only one IRF that's  
4 actually going to get a score. And the score is  
5 actually same as the national average.

6 We've also seen a trend in CAUTI  
7 infections. So of the -- and this is updated as  
8 of yesterday. Of the 1,199 IRFs, 811 of them,  
9 which is almost 70 percent now, have an NA.

10 And so that, within the IRF industry,  
11 CMS's burden estimate is about \$1.5 million to  
12 report CAUTIs on an annual basis. And we've done  
13 that for the past five years, so, you know, \$7-  
14 plus million.

15 So 70 percent of IRFs in the system  
16 are getting an NA. So that's not helpful for the  
17 providers. It's not helpful for the public.

18 And for that rating for CAUTIs, it  
19 does continue to go up with the number of  
20 hospitals that have that NA continuing to  
21 increase. It's at 68 percent today. But last  
22 quarter it was at 53 percent.

1           So at what point does there actually  
2     have to be data, you know, for there to be  
3     calculated data for those measures to continue in  
4     the program, because we're not getting data back?  
5     But it does take a lot of time and money to put  
6     that data into the system.

7           I also wanted to note that the on  
8     assessment items, there are multiple items that  
9     can be duplicated on assessment tools. And we  
10    can be documenting the same item, whether it's  
11    functional items or comorbidities, in some way to  
12    streamline different measures to ensure that  
13    there isn't redundancy for providers in reporting  
14    measures.

15           And then the last point was, I know  
16    underneath -- well, there are some calls that  
17    have happened in the past few months. And  
18    there's actually one scheduled for tomorrow about  
19    the proposed removal of flu vaccination for  
20    healthcare personnel from the home health  
21    program. And that's at the CMS, the QRP level  
22    for that program. But there haven't been similar



1 discussions in other provider programs.

2 And so when we determine that a  
3 measure is not effective or reliable in one  
4 aspect of post-acute care, at what point do we  
5 need to reevaluate it in other levels of care?  
6 Thank you.

7 CO-CHAIR LAMB: Thanks, Mary Ellen.  
8 Alan, did you want to respond to any of that  
9 before we move on to other comments?

10 MEMBER LEVITT: Thank you, Mary Ellen.  
11 It's Alan. Well, first of all, the call tomorrow  
12 is regarding the use of the flu vaccination  
13 measure in the home health quality of patient  
14 care star rating. It's not in the home health  
15 quality reporting program. That's not what the  
16 call will be about.

17 I invite everybody to listen in  
18 tomorrow. I will be part of that call if you  
19 want to listen.

20 Obviously, we are looking at all of  
21 our measures in all of our programs in Meaningful  
22 Measures.

1 I do want to point out certainly when  
2 it comes to CAUTI that when you, when we look at  
3 the NHSN reports back ten years ago when it first  
4 came out, and again, it was voluntary reporting.  
5 And I think probably only 100 or so IRFs were  
6 there. The rate that was seen in the IRFs was  
7 actually highest. It was the highest rate that  
8 they had. It was done differently than the SIRs  
9 are currently done. And so there certainly was a  
10 need for looking at a CAUTI measure as part of  
11 the program as it, as part of that study.

12 If you look at the OIG report that  
13 looks at adverse events going on in inpatient  
14 rehab facilities that came out, it's an  
15 interesting report, and look at harm events going  
16 on, they looked at all different events. They  
17 were -- infections was not the highest on the  
18 list. The highest was actually medication  
19 delirium, probably a need for some sort of drug  
20 regimen review measure if that outcome is what we  
21 see.

22 But the rate of infections that was

1       seen in that report was a little over five  
2       percent there. And even in our potentially  
3       preventable within stay IRF measure that we have,  
4       it's now part of the quality reporting program.  
5       When we're looking at measure development in  
6       terms of what types of patients get transferred  
7       to acute care, about one and a half percent of  
8       the IRF patients get transferred out due to  
9       infections.

10               And so definitely there appears to be  
11       infections going on, impact settings, and  
12       certainly in IRFs. And we're looking at the  
13       measures that we have finalized regarding those  
14       infections and, you know, have the same  
15       observations that you have.

16               I don't know, Pierre, if you wanted to  
17       add anything. No. Okay. But thank you. Thank  
18       you for your comments.

19               CO-CHAIR LAMB: Thank you. Gene.

20               MEMBER NUCCIO: Just many of the items  
21       on the list, Pierre, the eight items get to  
22       general psychometric characteristics of the

1 measure. And as most of you know, NQF has  
2 started the scientific methods group to look at  
3 complex measures and certainly around the issue  
4 of reliability and validity. And I presume that  
5 that's sort of part of this, captured in your  
6 criteria.

7 The other thing that's not  
8 specifically out there that I'd like to suggest  
9 is looking at the risk adjustment capability or  
10 the quality of the risk adjustment in prediction  
11 models that are done especially with the outcome  
12 measures, that when you're looking at competing  
13 measures and one has a C-statistic of .6 and the  
14 other has a .75, there really is no question as  
15 to which one you should be looking at.

16 And the third point I just wanted to  
17 quickly make was that I would caution -- and I  
18 didn't really see it up here. But I caution CMS  
19 to ensure that measures that capture unique  
20 characteristics about individual post-acute care  
21 settings are not tossed away because they appear  
22 only in that setting.

1                   So I think just because a set of  
2                   measures might be unique to that setting, it  
3                   might be something that defines the true  
4                   character of that setting. And so I would  
5                   caution against removing measures that would do  
6                   that.

7                   CO-CHAIR LAMB: Other comments, other  
8                   suggestions? Sean.

9                   MEMBER MULDOON: So would there ever  
10                  be a situation where you've measured it, it's an  
11                  okay measure, but you just don't know how to  
12                  interpret it because it's not a unidirectional,  
13                  you know, high is good, bad is low or the  
14                  opposite?

15                  We run into that with our internal  
16                  readmission rate where there is a probably a U-  
17                  shaped curve where quality is sitting at the  
18                  bottom of the curve and not at the absolutely  
19                  lowest readmission rate or necessarily horrible  
20                  care at the absolute highest one because of all  
21                  these things that you either don't measure or  
22                  don't understand. Or is the assumption here that

1       these are all unidirectional?

2                   MEMBER LEVITT: Thank you, Sean, for  
3       the question. Every measure that is in  
4       development or measures that we propose have a  
5       purpose. And so, you know, we're -- if they no  
6       longer demonstrate meaningfulness in terms of the  
7       results going out, those would be measures that  
8       we'd want to consider for removal, replacement,  
9       changing specifications, et cetera, et cetera.

10                   When it comes to the one example you  
11       gave of the readmission measure, certainly the  
12       expectation of CMS is not there are no  
13       readmissions that occur. But the expectation is  
14       that with appropriate measure development and  
15       risk adjustment that, you know, we can look at  
16       the attribution that an LTCH would have in terms  
17       of the, any contribution to either an increased  
18       or a decreased readmission rate.

19                   MEMBER MULDOON: So the removal  
20       consideration is, would be either lost its  
21       usefulness or --

22                   MEMBER LEVITT: Well, multiple things,

1 again. There could be a better measure that  
2 we've developed. I mean, my hope is, as I've  
3 told everyone here before, is 20 years from now  
4 we have better measures than we have right now.  
5 And as we build those better measures with the  
6 better ideas that we all have and our next  
7 generation has, we will be removing the old  
8 measures.

9 CO-CHAIR LAMB: Thank you. Just one  
10 final thought from me is in the measure type.  
11 And I realize that these are truncated, and  
12 they're more for discussion. Is I would feel  
13 better if the caveats about process measures were  
14 down there as well, because there are some  
15 situations that the process measures are  
16 important. And not to have those there makes me  
17 a bit uncomfortable.

18 I understand they're preferred. But  
19 in certain situations, and I can think of several  
20 in care coordination, those process measures are  
21 really critical to understanding impact.

22 Comments before we move to

1 attribution? Okay. Thank you, Pierre.

2 DR. YONG: Thank you. That was  
3 helpful.

4 CO-CHAIR LAMB: In our final time  
5 here, we're going to talk about attribution. And  
6 Erin is going to fill us in on the paper and what  
7 some of the issues are. And then we'll figure  
8 out where we want to go from here.

9 MS. O'ROURKE: That sounds good.  
10 Actually, Taroon and I are going to do this  
11 together since there's a few slides, and we know  
12 you've been sitting a long time. So, Taroon, do  
13 you want to start and then I'll finish up?

14 MR. AMIN: Absolutely. So just to  
15 give everyone context, this project has been done  
16 in two phases. We've completed the first phase,  
17 which resulted in the report that Alan just  
18 described earlier. And then we are beginning our  
19 second phase of work.

20 So just to give, make sure we're all  
21 on the same page, the purpose of this attribution  
22 work is that with various different pieces of



1       legislation, IMPACT and MACRA, we're obviously  
2       moving and focused on the conversation around  
3       value-based purchasing.

4               And there's, as we move toward outcome  
5       measures, cost and resource use measures, the  
6       question of who is responsible is a question that  
7       comes up often.

8               Attribution generally can be defined,  
9       I want to make sure we're all on the same page on  
10      the definition, as the methodology used to assign  
11      patients and their quality or resource use  
12      outcomes to providers or clinicians.

13              And attribution models help us to  
14      identify the patient relationship that could be  
15      used to establish accountability for those costs  
16      and quality.

17              As we think about, again, as we think  
18      about moving away from fee-for-service to  
19      alternative payment models the question of shared  
20      accountability comes up often and over and over  
21      again.

22              So we embarked on an environmental

1 scan, if we could move to the next slide. We  
2 embarked on an environmental scan working with  
3 our colleagues at the University of Michigan,  
4 Andrew Ryan, who specifically led the  
5 environmental scan, to actually just categorize  
6 what's out there in terms of the attribution  
7 models and what the elements of an attribution  
8 model would entail.

9 I think we noticed through the various  
10 endorsement and selection processes that really  
11 what we're even describing as an attribution  
12 model wasn't clear.

13 And so one of the activities of this  
14 work was really just to define from the  
15 environmental scan what an attribution model  
16 would entail. 163 models were evaluated that  
17 were in use or proposed for use. 17 were  
18 currently in use. 89 used the retrospective  
19 attribution approach, 89 percent of them. And 77  
20 percent of them attributed to a single provider,  
21 mainly to a physician.

22 The commissioned paper findings noted

1 a few pretty important elements. First, that  
2 best practices to defining an attribution model  
3 were not determined. And existing models are  
4 largely built off of previously used approaches.

5 And the trade-offs, quite frankly,  
6 were not very clear in terms of when the measure  
7 developer or program implementer, the trade-offs  
8 weren't necessarily clear to the users.

9 There was no standard definition of an  
10 attribution model in the field. And the lack of  
11 standardization across the models made it very  
12 difficult to evaluate.

13 And again, noting the importance of  
14 the attribution model to a program score, again,  
15 making at least the transparency made it  
16 incredibly important. So if we move to the next  
17 slide.

18 Some of the challenges that we  
19 identified through this work is that, you know,  
20 greater standardization among attribution models  
21 was really needed to be able to compare between  
22 models and then really to allow best practices to

1 emerge.

2           There is little consistency across the  
3 models. But there was very good evidence that  
4 changing the attribution rules had a significant  
5 impact on results and, therefore, on provider  
6 scores in these various programs.

7           The lack of transparency, how the  
8 results were attributed and allowed no way really  
9 to appeal the results of the attribution model  
10 when there potentially might be wrongly assigned  
11 responsibility.

12           To address these challenges as a piece  
13 of foundational work, we decided to at least  
14 begin by developing a set of guiding principles  
15 in the development and use of attribution models,  
16 making recommendations relating to those guiding  
17 principles, and then, as a first step again for  
18 the field, to create an Attribution Model  
19 Selection Guide as a first step to potential  
20 evaluation of these models going forward.

21           These models allow for, these products  
22 we believed, or at least the committee believed

1 and based on the feedback that we received, would  
2 help with greater standardization, transparency,  
3 and stakeholder buy-in in terms of the use of  
4 these models, particularly for payment purposes.  
5 And so, you know, I can just move on from there.

6           There was, again, as we think about  
7 the guiding principles, some of the preamble  
8 statements that were made by the committee in the  
9 work was really to acknowledge the complex,  
10 multidimensional challenges to implementing  
11 attribution models, really being guided by the  
12 purpose and the data available, grounding any  
13 approach in the National Quality Strategy as the  
14 attribution plays a critical role in advancing  
15 those goals, and recognizing attribution can both  
16 be referring to the attribution of patients for  
17 accountability purposes and then also attribution  
18 of results of a performance measure.

19           They also highlighted that the absence  
20 of any gold standard for designing or selecting  
21 attribution model, that you must really  
22 understand the goals of each use case. And

1 again, the application of this and the purposes  
2 of the MAP work in which we're convened to  
3 discuss is incredibly relevant.

4 And then the key criteria for  
5 selecting an attribution model are the  
6 actionability, accuracy, and fairness, again,  
7 which two concepts but not really clear how they  
8 would be applied, and transparency as a first  
9 step.

10 So, with that, maybe I'll turn it over  
11 to Erin to walk us through some of the guiding  
12 principles and the elements of the measure, the  
13 Attribution Model Selection Guide.

14 MS. O'ROURKE: Absolutely. So I don't  
15 want to belabor this so that we can get to the  
16 conversation. But on this side you see the  
17 guiding principles the committee laid out for  
18 attribution.

19 They felt a model needs to fairly and  
20 accurately assign accountability. They've  
21 reemphasized that attribution is an essential  
22 part of measure development, implementation, as

1 well as policy and program designed.

2 The considered choices among the  
3 available data are fundamental to the design of  
4 an attribution model. The committee noted that  
5 models should be regularly reviewed and updated.  
6 They emphasized that models should be  
7 transparent, as well as consistently applied, and  
8 that the attribution model should align with the  
9 stated goals and purpose of the program.

10 So to start to reconcile this tension  
11 between the desire for clarity about an  
12 attribution model's fit for purpose and the  
13 current state of the science that left no real  
14 evidence about what are best practices and what  
15 we should be doing, the committee also noted  
16 there's a desire for a set of rules to clarify  
17 about which models should be used in a given  
18 circumstance. But they did not have enough  
19 evidence to support the development of such  
20 rules.

21 So to try to move beyond this and to  
22 advance the field, they developed what they

1       called an Attribution Model Selection Guide. It  
2       was a tool designed to aid measure developers,  
3       measure evaluation committees, and program  
4       implementers on what are the necessary elements  
5       of an attribution model. This was intended to  
6       represent the minimum elements that should be  
7       shared with an accountable entity.

8               So I apologize. This slide is hard to  
9       read. But we can also send around the paper that  
10      has this in case anyone's interested.

11             It's a series of questions asking,  
12      say, a measure developer or someone designing a  
13      pay-for-reporting or value-based purchasing  
14      program, to ask about what's the context and the  
15      goal and then, you know, what outcome are they  
16      trying to achieve.

17             What's the evidence base for this? Is  
18      this the current state, or are you trying to  
19      drive a change? What is the accountability  
20      mechanism? Is it reporting, payment, quality  
21      improvement? Then finally, which entities  
22      participate in this program?



1           Next it asks you think about how the  
2 measures relate to the context they're being  
3 used, thinking about things like the inclusion  
4 and exclusion criteria. And do you have an  
5 adequate sample size to draw fair conclusions?

6           Next, the guide asks you to think  
7 about who are the entities receiving attribution.  
8 Which units are eligible for the attribution  
9 model? Can the accountable unit meaningfully  
10 influence the outcome? Do the entities have a  
11 sufficient sample size to meaningfully aggregate  
12 measure results? And are there multiple units to  
13 which the attribution model could be applied?

14           And then, finally, how is the  
15 attribution performed? What are the data that  
16 are used? Does everyone have access to the data?  
17 What service do you use to drive assignment?  
18 Does the use of those services assign  
19 responsibility to the correct accountable unit?

20           What are the details of the algorithm  
21 that you're using to assign responsibility? Has  
22 the reliability of the model been tested using

1 multiple methodologies? Then what's the timing  
2 of the attribution computation?

3 MR. AMIN: Erin, before we move on, if  
4 we can go back to that slide for a second. So,  
5 and we may just want to sort of fast forward to  
6 the Phase 2 of this work.

7 MS. O'ROURKE: Yes.

8 MR. AMIN: But before we move on from  
9 this slide, I just wanted to highlight a few  
10 things.

11 First, since there was no standard  
12 definition of what an attribution model meant,  
13 what you can see from this guide is it basically  
14 outlined the elements of an attribution model.  
15 So that was number one.

16 Second is to have all these elements  
17 be transparent in the decisions that were made  
18 and then to describe the trade-offs that were  
19 made since there is no gold standard.

20 So the selection guide is intended to  
21 allow for that structure and transparency to, for  
22 the purposes of actually developing either

1 measures or for the purposes of programs.

2 MS. O'ROURKE: Excellent. Thank you.

3 So then I'll go through this very quickly and  
4 skip a few slides.

5 The final product out of this paper  
6 was a series of recommendations that built on the  
7 principles and the selection guide. Essentially,  
8 the committee recommended that measure developers  
9 and program implementers use the Attribution  
10 Model Selection Guide to evaluate the factors  
11 that go into the choice of an attribution model.

12 They recommended that models be  
13 tested, that models be subject to a multi-  
14 stakeholder review, that attribution models  
15 should attribute care to an entity that can  
16 actually influence the care and the outcomes, and  
17 that attribution models used in mandatory  
18 reporting or payment program should meet some  
19 minimum criteria.

20 And again, that's all detailed in the  
21 paper we'll send around. But we want to get to  
22 the conversation and where we're going from here.

1                   So we are working with CMS under  
2                   contract to develop a follow-on paper to provide  
3                   some continued guidance and to tackle some of the  
4                   issues that came out of this first paper that we  
5                   weren't really able to take on, to tackle really.

6                   So thinking about things like  
7                   unintended consequences, issues around data  
8                   integrity and data collection, attributing  
9                   complex patients, special populations, in  
10                  particular, we wanted to bring this to you all  
11                  because we were asked to think about home care  
12                  and how that attribution, that may be a  
13                  particular attribution challenge.

14                 Thinking about attribution as we move  
15                 to more team-based care and a lot of these  
16                 models, as you may have briefly seen on one of  
17                 those slides Taroon went to, assign  
18                 accountability to a single primary care  
19                 physician. But everyone knows there was a team  
20                 involved in that care. And how do we reconcile  
21                 where we are with where we're going to, you know,  
22                 more global payments and team-based care?

1                   Thinking about some questions around  
2                   testing attribution models and how we could start  
3                   to do this. And then finally, asking if there's  
4                   ways we could improve the Attribution Model  
5                   Selection Guide so that we're, you know,  
6                   continuing to enhance its usefulness as a tool  
7                   for the field.

8                   So, again, I'll just briefly -- we are  
9                   developing a second white paper. We're hoping to  
10                  get some input into this from you all today.

11                  And with that, I want to just see if  
12                  you have any guidance for the team here on how we  
13                  should consider attribution issues in post-acute  
14                  and long-term care and in particular, any special  
15                  challenges in home health, and to finally follow  
16                  up on Alan's point that perhaps the first paper  
17                  framed PAC/LTC as a bit of a bad guy.

18                  One of the issues we kept hearing from  
19                  the hospital contingency was that a lot of the  
20                  current readmission measures --

21                  MEMBER LEVITT: Right, the MSPB  
22                  measure.

1 MS. O'ROURKE: Yes. And --

2 MEMBER LEVITT: Right, right. The  
3 hospital-based outcome measures that go for 30  
4 days after that the question with the attribution  
5 of the PAC.

6 MS. O'ROURKE: For the spending  
7 measure, they felt a lot of the remaining  
8 variability is from your PAC costs rather than  
9 the hospital billing with readmission. That once  
10 the patient is out of the hospital and into the  
11 post-acute provider's care, where is the  
12 responsibility?

13 So I think with that we could open for  
14 --

15 CO-CHAIR LAMB: Caroline.

16 MEMBER FIFE: So 15 percent of  
17 Medicare beneficiaries have a chronic wound. And  
18 one of the problems that we have when we are  
19 trying to partner on the care that's provided by  
20 home nursing agencies is that they will not  
21 divide up the -- what's the name of the form that  
22 you sign for the home nursing, the skilled

1 nursing care at home? I'm sorry. I'm blocking  
2 on the name of the form. It has numbers.

3 They will only allow one doc to sign  
4 for that. And these patients have an average of  
5 12, 10 different medications that they take.

6 So, if I write the wound care orders,  
7 they want me to sign the form that transfers the  
8 responsibility for all of their medications to me  
9 as the person who's just writing their wound care  
10 orders. So I'm not going to do that.

11 So I have to send the wound care  
12 orders to their primary care doc, otherwise I  
13 have to be responsible for everything that they  
14 take. And many wound care docs have been sued  
15 over signing that form.

16 So it's just a huge problem. And I'm  
17 not aware of a statutory reason why they can't do  
18 that. They just won't. So that doesn't help  
19 your problem. I'm just pointing out the layers  
20 of complexity involved in that.

21 The other problem with one of the  
22 models had to do with looking at the plurality of

1 services provided. So, when somebody has a  
2 horrible wound, and they're seeing somebody for  
3 wound care. And I realize this is a unique  
4 thing. I'm just hoping this example is useful.

5 What happens is that the doc who may  
6 be seeing them for that kind of service is seeing  
7 them more often than their primary care doc. But  
8 because there's no specialty involved, I ended up  
9 being held accountable for all the readmissions  
10 of all of those patients who had congestive heart  
11 failure and all the other primary conditions that  
12 CMS was tracking for readmission.

13 I got dinged on that on my QRUR. And  
14 I had no way of saying, wait a minute, that  
15 wasn't my responsibility. I was seeing them for  
16 this other thing. But I did provide the  
17 plurality of their E&M services that year. And  
18 so it was fairly devastating. And fortunately it  
19 didn't adjust my payment too much. But it was a  
20 pretty interesting example of how you can be hurt  
21 by that.

22 CO-CHAIR LAMB: I'm delighted to have



1       this topic on the table. It's been on the table  
2       and off the table primarily I think because of  
3       the concerns about unintended consequences. And  
4       it's really complex. And the connect to payment  
5       makes it even more complex.

6               So the question that I have is the  
7       commitment to see this through, because if I just  
8       take the example of team-based care and we've  
9       been talking all day about the fact that diverse  
10      team members are involved. And as we deal with  
11      that, not all team members are qualified  
12      providers and eligible to participate in  
13      programs. We heard that with MIPS. You know, we  
14      see that with using the care coordination payment  
15      codes is it gets into some very sticky ground.

16             So it's essential to measurement.  
17      But, you know, I guess the bigger question, and I  
18      don't know that you can answer it, is when it  
19      gets into that sticky place that has very  
20      significant cost implications, what are we going  
21      to do with it, because I've been on committees  
22      that have really tap danced towards this and then

1 dropped it because of those issues. Jim, and  
2 then Alan.

3 MEMBER LETT: This one's going to be  
4 real easy I can tell you. What I will do is give  
5 you a model of what we did. I served -- funny  
6 you should mention, Alan, the OIG report on post-  
7 acute harm and readmissions back to the hosp.  
8 But I served on the physician workgroup that  
9 evaluated the charts. And we got into  
10 attribution, obviously, when somebody goes from  
11 acute to post-acute, whose fault is it,  
12 particular around *Clostridium difficile*  
13 infection. That was a 12-rounder.

14 And the only way that we found that  
15 things could get decided was you had to basically  
16 set criteria, whether people liked them or not,  
17 and get those criteria from basically an  
18 infallible source, that you may disagree with it,  
19 but you respected it. And it was applied evenly  
20 to every case of CDI.

21 And we ended up going to CDC and  
22 having a phone conference with them about, okay,

1 tell us about the disease, tell us about how long  
2 before symptoms show up and diarrhea begins in  
3 post-acute care, after which it is post-acute  
4 care's attribution, before which it is the acute  
5 side.

6 So, looking at that model, I don't see  
7 a simple way, other than setting up some,  
8 probably some TEPs with people from -- if you're  
9 thinking about readmissions from SNF, with  
10 skilled nursing facility people, hospital side  
11 people, and hospital and SNF personnel, because,  
12 boy, it takes a village in both those places to -  
13 - I can write the best order set in the world,  
14 but if the orders aren't taken off or the nurse  
15 doesn't turn the patient or, or, or, or.

16 So I think you're going to have to,  
17 along the model I'm talking about, get some  
18 infallible sources that everybody will agree,  
19 okay, I may disagree with the decision, but I  
20 respect the source of it, and apply them for what  
21 it's worth.

22 (Off mic comments.)

1                   MEMBER LEVITT: This is Alan. Another  
2 thing that keeps me up at night is attribution.  
3 I wish I had the report, because the beginning of  
4 the report I remember talked about the fact that,  
5 you know, we seem to live in the world of siloed  
6 care and that, you know, the idea of attribution  
7 is that, as in quality, whenever we do root cause  
8 analysis, anything like that, that's a system  
9 approach that's really, you know, that there are  
10 pieces of it that likely are including those who  
11 are taking care of the patient.

12                   Anyone who says that they're, you  
13 know, I have no attribution to something in terms  
14 of a bad outcome, likely it doesn't have  
15 attribution to a good outcome, too. And so, you  
16 know, if they're not really, you know, involved  
17 in either good or bad, why are they involved in  
18 the first place?

19                   The problem is really the model not  
20 the attribution. It's trying to develop the  
21 model that is, can best show this and demonstrate  
22 this fairly. And there is no easy answer to try

1 to figure this out.

2 But I think we all have to accept the  
3 fact as a community that, you know, attribution  
4 does exist and that we need to figure out better  
5 ways of being able to define that and to measure  
6 that so that we can, you know, fairly measure  
7 performance based on, you know, these sorts of  
8 outcomes.

9 (Off mic comments.)

10 CO-CHAIR MULHAUSEN: Can I respond to  
11 that, because I think, Caroline, you're on to  
12 something here? But I have a very different --

13 (Off mic comments.)

14 CO-CHAIR MULHAUSEN: I am a primary  
15 care provider, geriatrician. And what I see out  
16 of that experience, which I admit was very  
17 painful for you, is an incentive program asking  
18 you can you do this differently. Can you and I  
19 become a team? And, of course, we can't because  
20 you're in Houston. But can you and I become a  
21 team where I, we start to co-manage people  
22 together? Then I'm very happy to take sort of

1 the --

2 (Off mic comments.)

3 MEMBER LEVITT: Right. I just would  
4 also remind you in this discussion that, you  
5 know, the attribution we're talking about is not,  
6 you know, provider specific attribution that you  
7 were talking about, that it's really program, you  
8 know, in terms of a provider who is a setting-  
9 specific.

10 CO-CHAIR LAMB: Heather, and then Raj.

11 MEMBER SMITH: I'll try to keep my  
12 comments brief. I do think this is a complex  
13 topic. I don't have solutions. I do think that  
14 in trying to solve this, though, we should  
15 strongly think about piloting so that we can  
16 better examine potential unintended consequences.  
17 I mean, I've certainly heard radical things, like  
18 if you touch the patient, you get the attribution  
19 for the measure. And then everyone has skin in  
20 the game. So, you know, that brings attention to  
21 it.

22 I don't know that that type of thought

1 process is the right way to go about it. But I  
2 do know that there are definitely providers like  
3 physical therapists who are, don't have any cost  
4 measures, you know, anything that uses an E&M  
5 code for an attribution methodology were left  
6 complete out of.

7 And I don't think that that's right,  
8 because our providers, then, lack feedback and  
9 don't see the full picture of what's going on and  
10 some of the pressures that their colleagues are  
11 under.

12 And so, you know, I do think this is  
13 complex. I recognize when you tie it to payment  
14 it takes, you know, it goes to a different level.  
15 But ultimately, these measures are here so that  
16 we can improve the quality of care to the  
17 patients that we serve. And, you know, getting  
18 that information to providers is what helps to  
19 make that change. And so it's important for that  
20 reason as well.

21 And so, again, I think of things like,  
22 you know, is there someplace that's doing this

1 well or has ideas and could that be pilot tested  
2 so that we can get some better answers to these  
3 questions.

4 MEMBER MAHAJAN: Thank you. So I do  
5 want to talk about physician attribution into the  
6 MIPS program or before that. And so we all know  
7 that the value modifier and what happened to the  
8 physician. And I am always embarrassed to show  
9 my QRUR, because I am top at quality but the cost  
10 is high because I'm 80 percent post-acute long-  
11 term care practice.

12 So, and we were all kind of relieved  
13 a little bit when site 31, which is short-term,  
14 was out from attribution. But 32, which is long-  
15 term care, still stays in.

16 And we have big groups that have lost  
17 of millions of dollars because of the value  
18 modifier adjustment. And we thought, you know,  
19 with MIPS, since cost was out, it will be good  
20 and we'll eventually figure something out.

21 And then, you know, boom, comes 2018  
22 final rule and cost comes back. And methodology



1 is still not the new one, but it's the old  
2 methodology, which is the value modifier on  
3 methodology.

4 So, for us, we still are responsible  
5 for the cost of taking care of these vulnerable  
6 patients.

7 So there is a hope somewhere. I  
8 don't, I am not, and the devil is in the detail  
9 about how do you get compensated additional for  
10 complex care management, which is there in the  
11 2018 rule. But, you know, how do you calculate  
12 that for nursing home docs?

13 And then, so, yes, we are at -- that's  
14 a double-whammy. Not only you're taking care of  
15 this vulnerable population, but you're getting  
16 punished for doing that because of the way the  
17 cost is attributed to you.

18 And then on the suggestion side is I  
19 think 31 level of care is right to be an APM, and  
20 so whoever wants to look at it and help people  
21 develop something. And I think based on either  
22 utilization numbers or peer quality numbers or a

1 combination of that, it could be a very -- but  
2 folks that practice in that site do not have an  
3 association that is, you know, just loaded with  
4 resources to do all that kind of work.

5 So, but you're talking about folks  
6 that take care of this vulnerable population in  
7 the setting that is fairly expensive to CMS.

8 CO-CHAIR LAMB: We have two more folks  
9 with their signs up. So let's give the last  
10 comments to Deb and Theresa. And then we're  
11 going to wrap it up.

12 MEMBER SALIBA: So this expands a  
13 little bit on the last comment and simply to say  
14 that we tend to take an approach with these  
15 measures of looking at single conditions like  
16 heart failure or COPD. And we really need to be  
17 thinking about the complexity of a lot of these  
18 patients, not just in SNF but in hospital and in  
19 outpatient and across care settings.

20 And I know I'm making it even more  
21 complicated to do the measurement. But it's  
22 going to be really important for really

1 understanding the outcomes in this population.

2 MEMBER SCHMIDT: I agree with that.

3 And I also wanted to kind of build on Raj's  
4 comments about alternative payment models. As we  
5 move toward more of the population health  
6 initiatives, more and more it will be shared  
7 accountability. And it's kind of yours, mine,  
8 and but now we're in the territory of ours,  
9 right, so with shared savings and approaches.

10 Even taking off my hospice hat,  
11 putting on my post-acute hat, I remember when  
12 hospital readmissions started being measured, I  
13 was working with a lot of nursing homes. And we  
14 were trying to do everything we could to reduce  
15 readmission rates of their patients so they could  
16 be what we were calling providers of choice in  
17 their communities.

18 So, even though the hospitals were  
19 being held accountable and the patients  
20 attributed to them, at that time we were already  
21 looking ahead to taking responsibility for moving  
22 those rates.

1 CO-CHAIR LAMB: So, Erin, you're going  
2 to send out that paper to all of us. And what  
3 are our options for continuing to think together?

4 MS. O'ROURKE: Yes, this is excellent.  
5 And thank you for these thoughts. This has been  
6 great as we start to develop the second paper.

7 So we'll get you all the second paper  
8 and maybe send these questions via email. If  
9 you've got some extra time and want to give the  
10 paper a read and send us some input, we would  
11 greatly appreciate it.

12 I think we'll look into what's  
13 feasible as far as maybe scheduling an optional  
14 call if anyone wants to join. But I do need to  
15 check that we have resources available. But, at  
16 the minimum, we'll the paper and would love your  
17 thoughts via email if you are willing to  
18 generously donate more of your time to NQF.

19 Yes, so I think that is our, is it for  
20 what we needed to get through for the day.

21 (Off mic comments.)

22 MS. O'ROURKE: Let's do one more

1 public comment and then let Paul and Gerri  
2 summarize. And we'll go through the next step.  
3 Operator, is there anyone on the phone who wants  
4 to make a public comment?

5 OPERATOR: Ladies and gentlemen, if  
6 you'd like to make a public comment, press star 1  
7 on your telephone keypad, again, star 1 for a  
8 public comment.

9 MS. O'ROURKE: Anyone in the room?

10 (Off mic comments.)

11 MS. O'ROURKE: I appreciate you  
12 keeping me honest on the comment period, Alan.  
13 So I think with that, let's turn it to our co-  
14 chairs for their thoughts on the day.

15 OPERATOR: Apparently, no public  
16 comments.

17 CO-CHAIR MULHAUSEN: This has been a  
18 wonderful day, excellent discussion. We managed  
19 to accomplish our one action item. And we  
20 managed to think strategically about how we can  
21 help CMS move forward and improve measurement of  
22 quality in the setting that we're expert in and

1       that we love so dearly.

2                   I want to thank Gerri for helping me  
3       through the whole thing. Apologize for my  
4       absence seizure somewhere around 3:30 this  
5       afternoon. I've recovered with a little Diet  
6       Coke. Anyway, and it's been a pleasure to work  
7       with you today. So thank you.

8                   CO-CHAIR LAMB: Let me add thanks to  
9       all of you for hanging in and the folks that  
10      couldn't. It's been a really excellent day. The  
11      range of topics that we've covered are truly  
12      amazing.

13                  I also want to thank the NQF staff for  
14      arranging all of the dialogue opportunities that  
15      we've had. You were wonderful. Thank you to  
16      CMS. Thank you, Alan. Thank you, Pierre. Thank  
17      you, Liz. Thank you, all the folks who came in  
18      to talk to us.

19                  I'd just like to return, as Paul has.  
20      We had two goals. We accomplished both. One was  
21      to give our advice on MUC, which we did. Two was  
22      to think strategically together and look to the

1 future.

2 So thank you for a very, very  
3 productive day. And I'm going to look forward to  
4 continuing this discussion and really looking at  
5 the gaps in how we can move the field forward.  
6 So thank you.

7 (Applause.)

8 MS. O'ROURKE: Pierre, did you have a  
9 comment?

10 DR. YONG: Yes, yes, sure. I just  
11 wanted to add my thanks and pile on.

12 But in particular, I want to thank all  
13 of you for volunteering and taking time out of  
14 your very busy schedules to spend time with us  
15 not just today but across the webinars and other  
16 feedback that you put in, the time you put in.  
17 So thank you very much. We really do appreciate  
18 it. And we really do consider it seriously as we  
19 go through our internal process.

20 Also I do want to thank Gerri and Paul  
21 for their efforts in facilitating the entire  
22 effort for this workgroup this year. Wanted to

1       thank NQF staff, Erin, Taroon, Jean-Luc, and  
2       Miranda.

3               And then you've met a number of CMS  
4       staff today. But there's a literal army. And I  
5       do want to thank them, because without them this,  
6       all the work that you saw and sort of, would not  
7       have been possible.

8               But so I just want to thank them,  
9       including Stace Mandl, Mary Pratt, Alan Levitt,  
10      Tara McMullen, Chris Gross -- I told you it was  
11      an army -- Lorraine Wickiser, Kelly Miles, Cindy  
12      Massuda, Carol Schwartz, Joan Proctor, Maria  
13      Durham, Michelle Geppi, Helen Dollar-Maples,  
14      Brendan Loughran, Nidhi Singh-Shah, and Sophia  
15      Chan.

16              But without all of them, they all  
17      touch different pieces of the MAP process. So  
18      they were all critical to making this a success.  
19      So thank you all.

20              (Off mic comments.)

21              (Laughter.)

22              MS. O'ROURKE: It all goes to Pierre.



1       So just to add our thanks. I don't want to  
2       belabor it and keep you all from missing your  
3       flights. But thank you all again. We depend on  
4       you every year to generously give of your time  
5       and come here and provide us with this excellent  
6       input. So thank you very much.

7               And thank you especially to Paul and  
8       Gerri for expertly leading us through that  
9       meeting. We very much appreciate your continued  
10      efforts and all the work you did with us to get  
11      to today. So thank you very much.

12              (Whereupon, the above-entitled matter  
13      went off the record at 4:53 p.m.)

A			
<p><b>a.m</b> 1:10 5:2 103:3,4  <b>abilities</b> 115:2 148:8  162:7 251:4  <b>ability</b> 108:2 118:10  129:11 134:17 322:4  328:9  <b>able</b> 14:10 72:7,21  111:13 132:10,12,12  137:6,20 144:2,3  145:7 147:6 148:13  156:4 160:19 162:1  165:5,7,7,18 166:4  169:11,13 178:16,21  189:10,12 190:3,4  191:20 194:4 241:11  242:2 287:2 292:19  294:16 301:8 315:9  320:2,16 325:2 329:6  335:7 343:20 371:21  380:5 389:5  <b>above-entitled</b> 103:2  170:22 349:3 401:12  <b>absence</b> 333:13 373:19  398:4  <b>absolute</b> 323:16 365:20  <b>absolutely</b> 7:4 100:21  200:5 211:5 272:7  365:18 368:14 374:14  <b>abstain</b> 220:14  <b>abstentions</b> 220:13  <b>Abt</b> 150:22 157:4 160:4  <b>abuse</b> 334:1 337:3  <b>ACA</b> 325:18  <b>academic</b> 82:14 97:5  <b>academics</b> 188:13  <b>Academy</b> 1:17 13:2  42:7  <b>accept</b> 238:20 271:9  389:2  <b>acceptabilities</b> 210:8  <b>acceptability</b> 209:8  <b>accepted</b> 219:14  <b>accepting</b> 219:10  <b>access</b> 31:22 58:19  78:1 80:16 81:5 84:9  84:14 85:4 86:12  88:20 89:4,15,18 91:8  92:14 94:16 95:5  98:19 101:18,19  133:12 222:15 245:6  279:4 310:10 316:11  318:19 331:5 377:16  <b>accessibility</b> 316:5  <b>accessible</b> 277:21  <b>accessing</b> 88:8  <b>accident</b> 114:22  <b>accommodate</b> 229:12</p>	<p><b>accomplish</b> 303:14  397:19  <b>accomplished</b> 398:20  <b>account</b> 22:4 352:10  <b>accountability</b> 26:10  84:11 322:8 353:10  369:15,20 373:17  374:20 376:19 380:18  395:7  <b>accountable</b> 287:18  376:7 377:9,19 384:9  395:19  <b>accounted</b> 320:11  <b>accuracy</b> 374:6  <b>accurate</b> 238:4 314:1  <b>accurately</b> 153:16  374:20  <b>achieve</b> 150:10 276:11  320:8,15 376:16  <b>achieved</b> 159:3 191:15  <b>achievement</b> 198:11  <b>achieving</b> 31:21 246:19  <b>ACHPN</b> 2:7  <b>acknowledge</b> 171:16  323:11 373:9  <b>ACO</b> 93:12  <b>ACOs</b> 92:18 255:6  <b>act</b> 4:16 5:18,19 19:20  21:8 105:5,19 106:4  106:12,19,21 107:17  108:16 109:12,22  110:4 111:1,21 112:1  113:19 117:13,14,15  120:6 123:18 130:11  132:18 133:14 145:2  145:4 163:15 189:15  200:16 218:20 347:8  <b>acted</b> 212:4  <b>acting</b> 2:17 9:8 96:1  <b>action</b> 23:4 30:15 41:22  200:9 397:19  <b>actionability</b> 374:6  <b>actively</b> 266:17 322:16  322:22  <b>activities</b> 14:6 36:20  120:3,4 134:15  172:18 176:19 197:8  200:6,7 201:1 204:12  204:13 370:13  <b>activity</b> 8:17 200:4,13  200:15 203:4  <b>actual</b> 28:3,5 31:10  35:5 66:8 75:4 162:7  180:17 214:21 305:10  349:22  <b>acuity</b> 116:21  <b>acute</b> 1:20 50:13  106:22 107:7,8 110:8</p>	<p>140:6 165:17 199:6  278:16 280:16 291:6  291:19 292:3 293:10  297:8 301:15 331:4  333:9 340:16 345:11  345:18 363:7 386:7  386:11 387:4  <b>acute-to-acute</b> 327:10  <b>acute/long-term</b> 304:9  <b>add</b> 49:19 55:7 89:14  144:2 147:16 149:3  165:10 203:8 204:6  207:5 229:20 230:16  266:17 279:10,22  283:8 302:4 304:18  305:3 363:17 398:8  399:11 401:1  <b>add-on</b> 196:3  <b>added</b> 166:8 178:14  223:7 227:22 228:17  228:17,19 229:5  257:9 279:14 286:9  298:6 310:19 319:2  328:17 332:14  <b>adding</b> 40:21 143:4  317:21 327:3,5,14  328:11  <b>addition</b> 88:22 101:18  165:2 198:12 207:18  323:19  <b>additional</b> 14:18 49:19  84:2 124:15 125:17  158:18 162:21 196:5  227:21 257:11 263:3  278:8 279:13 286:10  311:15 327:13 332:9  339:6 393:9  <b>Additionally</b> 332:6  <b>additions</b> 336:21  <b>address</b> 27:21 29:20  35:19 52:10 58:5 70:5  100:12 111:19,22  213:10 223:9 277:9  296:1 321:10 372:12  <b>addressed</b> 212:18  223:5 292:14 310:13  310:19 312:1,10  317:3 323:4 326:13  326:15,17 331:20,22  <b>addresses</b> 59:9 172:19  <b>addressing</b> 75:11 77:11  277:11 320:9 326:22  327:4 338:17  <b>adequate</b> 377:5  <b>ADJOURN</b> 4:22  <b>adjust</b> 187:19 384:19  <b>adjusted</b> 35:13  <b>adjuster</b> 102:9</p>	<p><b>adjustment</b> 6:8 72:4  102:6 117:6 254:8  364:9,10 366:15  392:18  <b>adjustments</b> 101:21  <b>administer</b> 227:10  228:4,9,20 237:22  <b>administered</b> 229:2  272:15  <b>administering</b> 228:1  247:18  <b>Administration</b> 89:6  <b>administrator</b> 25:13  228:12  <b>admission</b> 33:15  129:21 130:5 245:3  309:20  <b>admissions</b> 33:16  248:1 310:11  <b>admit</b> 287:21 389:16  <b>admitted</b> 233:14  <b>admittedly</b> 49:1  <b>adopt</b> 124:3 263:18  338:21  <b>adopting</b> 125:3  <b>adoption</b> 160:21 258:4  294:11,15,18,19  295:1  <b>adopts</b> 252:2  <b>adult</b> 2:14,15 231:13,18  297:1  <b>adults</b> 87:21 120:12  <b>advance</b> 25:5 100:12  208:12 284:7,9,10  295:12,13,18,20  375:22  <b>advanced</b> 68:5,6,8  79:20 88:1 94:18  172:10 186:4 277:21  <b>advancing</b> 47:1 68:7  172:18 373:14  <b>advantage</b> 6:3 25:1  183:2  <b>adverse</b> 362:13  <b>advice</b> 78:15,22 398:21  <b>advise</b> 73:14  <b>advisor</b> 121:10  <b>advisors</b> 121:12  <b>Advisory</b> 2:5 12:21  15:7  <b>advocate</b> 312:22  <b>affect</b> 241:17 270:19  <b>affiliated</b> 222:14 331:4  331:5  <b>affiliates</b> 255:17  <b>affordable</b> 5:19 35:10  <b>afraid</b> 93:7  <b>African-American</b></p>

96:20  
**afternoon** 171:16 398:5  
**agencies** 1:15 13:12  
 87:6 90:3 107:1,11  
 110:9 113:6 121:14  
 128:22 129:1,9,13  
 131:5 142:20 144:6  
 151:2 156:21 157:18  
 222:4 334:7 340:6  
 343:10 382:20  
**agency** 129:7 132:14  
 138:22 143:15 157:5  
 157:15 179:15 258:16  
 296:7,8 297:13,14  
 339:21 340:15 343:3  
**agenda** 7:10 8:10 18:17  
 18:19 19:13 22:12,19  
 23:5,12 37:18 47:4  
 146:5 149:20 150:4  
 150:14 171:6,9  
 305:12 306:1 343:22  
**agent** 135:2  
**aggregate** 86:16 377:11  
**aggressive** 295:17  
**Aging** 1:15 13:12 222:4  
**ago** 5:12 54:2 69:20  
 73:20 75:2 76:15 77:5  
 82:19 87:10 118:13  
 138:11 143:13 157:11  
 195:13 362:3  
**agree** 52:14 58:7 65:16  
 92:13 166:6 169:19  
 189:9 200:2 246:17  
 298:17 314:13 319:16  
 387:18 395:2  
**agreed** 87:11 154:20  
 211:1 227:17  
**agreement** 154:18  
 167:22  
**agreements** 93:1 177:7  
**agrees** 124:18 286:8  
**AGS** 66:16  
**AHCA** 226:16 255:1  
 264:6 267:14 302:9  
**AHCA's** 234:9  
**ahead** 82:5 160:13  
 225:8 259:12 280:13  
 281:11 306:3 395:21  
**aid** 376:2  
**aim** 347:21  
**Alan** 2:11 16:22 49:18  
 79:2 89:10 93:15  
 100:5,21 151:19  
 169:22 206:13 230:15  
 256:14 267:2 273:1  
 286:17 300:5 308:1  
 309:5 319:6 339:16  
 341:12 346:9 361:8

361:11 368:17 386:2  
 386:6 388:1 397:12  
 398:16 400:9  
**Alan's** 381:16  
**alan.levitt** 205:9,20  
**Alan.levitt@cms.hhs...**  
 206:11  
**algorithm** 209:21 218:6  
 377:20  
**align** 53:2 67:16 132:17  
 196:7 354:2 356:6  
 375:8  
**aligned** 33:6 357:10  
**aligning** 168:14 196:6  
 281:3,8,12 286:9  
 289:20  
**alignment** 21:9 30:1  
 75:9 92:6 166:19  
 168:19 209:14 285:8  
 353:1 355:9  
**Allen** 10:13  
**allow** 108:2 109:21  
 179:2 190:13 193:15  
 194:3 208:11 249:14  
 371:22 372:21 378:21  
 383:3  
**allowable** 112:22  
**allowed** 173:4 372:8  
**allowing** 184:19 236:11  
 240:14  
**allows** 107:20,21  
**alluding** 184:15  
**Alpha** 119:1,1 125:11  
 125:11 134:3,3  
**alphabet** 68:11  
**altered** 135:11  
**alternate** 93:4  
**alternative** 29:22  
 172:10 297:17 369:19  
 395:4  
**alternatively** 306:20  
**Alzheimer's** 314:21  
**amazed** 255:14  
**amazing** 398:12  
**amazingly** 345:6  
**ambulance** 299:3  
**ambulatory** 201:9  
**AMDA** 10:17 66:17  
 194:21 284:4  
**American** 1:17,22 2:1,2  
 2:5 3:2 11:8,17,20  
 13:2,19 160:15  
**Amin** 2:19 18:13,14  
 368:14 378:3,8  
**amount** 186:6 193:8  
 247:20 271:7 352:12  
**amounts** 95:5  
**amplified** 332:12

**Amy** 1:15 221:21 222:2  
 276:4  
**analysis** 87:17 207:6  
 208:3,15 217:22  
 218:5 219:3,10  
 224:17 244:7 248:3  
 344:22 388:8  
**Analyst** 2:20 18:12  
**analytically** 145:7  
**analytics** 191:2  
**and/or** 307:8  
**Andrew** 370:4  
**Anecdotaly** 92:13  
**anesthetists** 172:22  
**Angeles** 11:9  
**angst** 266:14  
**announced** 130:19  
**announcement** 177:5  
**annual** 325:21 359:12  
**anonymous** 274:6  
**ANP-BC** 2:7  
**Anschutz** 10:21  
**answer** 32:9 82:4 93:8  
 102:5 135:14 185:20  
 186:13 197:16 198:5  
 200:5,20 201:21  
 204:11 225:19 229:16  
 230:12 235:17 253:16  
 258:22 259:1 288:9  
 289:20 385:18 388:22  
**answered** 187:17 227:2  
 233:8  
**answering** 82:10  
**answers** 92:10 149:2  
 170:10 206:8 275:8  
 392:2  
**antibiotics** 284:18  
**anticipate** 233:7  
**anticipated** 250:15  
**anticoagulation** 203:11  
 203:18  
**antimicrobial** 197:13  
 197:17 200:11  
**anxiety** 134:11 152:15  
 153:5,9,19 155:11,17  
 156:14 167:20  
**anybody** 68:3 273:6  
 287:10 344:6  
**anyone's** 376:10  
**anyway** 15:20 56:14  
 62:10 250:4 252:6  
 260:20 332:20 398:6  
**APM** 393:19  
**apologies** 19:4 354:3  
**apologize** 25:5 234:6  
 376:8 398:3  
**apparent** 183:5  
**Apparently** 397:15

**appeal** 372:9  
**appear** 38:7 272:14  
 364:21  
**appears** 357:11 363:10  
**appetite** 308:22  
**applaud** 83:17 164:19  
 251:12 263:12  
**applauding** 97:3  
**Applause** 399:7  
**apples** 137:20,20  
**appliance** 134:19  
**applicability** 163:9,19  
**applicable** 50:12,17  
 203:1 325:21 347:11  
 347:12  
**application** 20:2 37:2  
 263:4 269:1 374:1  
**applications** 1:3 73:13  
 84:18  
**applied** 36:21 38:13  
 87:13 165:14,21  
 201:2 334:14 374:8  
 375:7 377:13 386:19  
**applies** 327:22 331:1  
 336:10  
**apply** 36:19 37:13  
 38:22 46:1 71:17  
 81:16 110:16 178:21  
 194:16 197:9 199:9  
 199:11 200:6,14  
 201:22 288:17 333:1  
 387:20  
**appreciate** 9:6 49:15  
 58:3 86:5 137:14  
 145:22,22 266:14  
 269:13,15 276:21  
 302:15 396:11 397:11  
 399:17 401:9  
**appreciated** 158:5  
 324:11  
**appreciative** 8:7 230:1  
 306:18  
**approach** 17:19,20  
 20:19 35:4 73:5  
 118:17 131:2 134:2  
 175:12 176:11 206:20  
 370:19 373:13 388:9  
 394:14  
**approached** 237:14  
**approaches** 133:2  
 134:21 371:4 395:9  
**appropriate** 35:11  
 186:19,20 187:19  
 204:1 277:19 283:9  
 308:17 366:14  
**appropriately** 283:11  
**appropriateness**  
 234:10 278:3 282:15

283:1 304:5  
**approved** 218:6  
**approving** 226:9,10  
**approximal** 351:13  
**apps** 183:16  
**aptly** 247:4  
**arbitrary** 112:13  
**area** 1:15 13:12 28:16  
 31:19 32:16 33:1,13  
 48:22 49:1 52:7 57:9  
 79:7 86:14,18 88:14  
 90:18 93:5,19 101:14  
 163:5 179:10 183:19  
 193:22 217:11 222:4  
 271:19,20 289:1  
 290:12 293:8 294:18  
 300:6 313:6 314:7  
 316:10 321:9  
**areas** 27:11,12,14,17  
 27:21 28:1,4,4 31:8,9  
 32:4 33:5,21 35:7  
 38:12 43:10 58:22  
 59:18,19 65:16 71:22  
 77:16 79:9 80:7,19  
 81:2 83:8 84:22 86:11  
 92:14,18 96:15 98:12  
 101:5 111:4,19,21  
 128:10 137:10 141:3  
 154:20 155:3 169:7  
 173:17 174:1,9  
 176:12 185:17 195:2  
 195:4 197:4 204:20  
 213:17 214:7 241:20  
 247:1 254:4 279:10  
 280:12 281:5 289:9  
 303:20 304:4 310:5,6  
 310:12 317:19  
**argue** 55:18  
**argues** 55:17  
**argument** 202:7 263:5  
**Arizona** 16:4  
**army** 400:4,11  
**arose** 212:8  
**arranged** 228:6  
**arrangements** 14:12  
**arranging** 398:14  
**arrival** 333:8  
**arrive** 215:3  
**Art** 12:19  
**ARTHUR** 2:4  
**articulately** 202:3  
**artificial** 284:18  
**Ash** 12:6 205:22  
**ASHISH** 2:9  
**asked** 35:22 87:9  
 136:11 154:10,14  
 155:21 156:3,5,17  
 167:10,17 217:12

232:5 260:22 270:11  
 298:7 306:11 348:22  
 380:11  
**asking** 51:1 83:18  
 99:16 192:3 197:19  
 250:14 255:12 261:21  
 264:13 266:17 274:1  
 279:12 285:12 319:15  
 354:19 376:11 381:3  
 389:17  
**asks** 377:1,6  
**aspect** 116:6 250:17  
 361:4  
**aspects** 283:10 309:8  
**assess** 118:14 159:6  
 168:8 320:16 327:6  
**assessed** 123:4 153:3  
 167:17 168:9  
**assessing** 34:22  
 122:14 129:22 130:18  
 148:1 155:1,7,18  
 223:15 277:13 327:10  
**assessment** 106:1,6  
 107:3,3,14,18 108:13  
 108:18,19 109:7,17  
 109:18,20 110:1,6,17  
 111:11 112:2,15,20  
 113:3,11 114:11,15  
 114:17 115:1,12,21  
 117:12,16 126:22  
 127:5,11 129:22  
 132:17 133:19 134:9  
 134:12,16 135:13  
 136:14 138:2 140:3  
 141:3,9,17,19,22  
 142:20 144:12,16  
 146:15,16 148:17,20  
 148:21 156:8,15  
 195:7,8,10 222:18  
 309:19,21 319:20  
 321:2 328:12 331:10  
 341:7 347:6,7 360:8,9  
**assessments** 126:20  
 129:10,16 132:5,7  
 141:14 155:19 168:15  
**assessor** 112:17  
**assessors** 131:16  
**assign** 219:21 273:19  
 369:10 374:20 377:18  
 377:21 380:17  
**assigned** 208:9 271:6  
 372:10  
**assignment** 377:17  
**assist** 238:14  
**assistants** 172:20  
**assisted** 232:22 237:1  
**associate** 192:5  
**associated** 28:20 32:15

32:18 107:17 192:22  
 219:13 302:6 323:2  
 337:8 352:13  
**associates** 142:18  
 150:22  
**association** 1:15,22 2:3  
 3:3 11:9,18 13:12  
 15:11 76:11,11  
 160:16 192:9 222:4  
 234:11 394:3  
**associations** 145:8  
 169:18  
**assume** 228:13 233:10  
 259:3 268:22 280:19  
 286:2 347:15  
**assuming** 332:22  
**assumption** 365:22  
**assumptions** 97:6  
**astronomical** 192:19  
**atomistic** 30:18  
**attainable** 207:13  
**attempt** 67:2 167:1  
**attempting** 148:5  
**attend** 132:1  
**attendants** 97:20  
**attended** 45:7  
**attending** 327:1  
**attention** 229:21 390:20  
**attest** 202:17 203:3,20  
 204:4  
**attested** 203:21  
**attesting** 203:2,7  
**attorney** 238:12  
**attributable** 196:11  
 291:14 292:1  
**attribute** 379:15  
**attributed** 370:20 372:8  
 393:17 395:20  
**attributes** 272:13 283:2  
 304:2 321:11,19,20  
**attributing** 380:8  
**attribution** 4:17,18 6:8  
 22:1 175:10 199:22  
 305:7,8 306:7,10  
 307:8,12,15 308:5,11  
 309:3 349:11 366:16  
 368:1,5,21 369:8,13  
 370:6,7,11,15,19  
 371:2,10,14,20 372:4  
 372:9,15,18 373:11  
 373:14,15,16,17,21  
 374:5,13,18,21 375:4  
 375:8,12 376:1,5  
 377:7,8,13,15 378:2  
 378:12,14 379:9,11  
 379:14,17 380:12,13  
 380:14 381:2,4,13  
 382:4 386:10 387:4

388:2,6,13,15,20  
 389:3 390:5,6,18  
 391:5 392:5,14  
**audible** 17:14 18:2  
**audit** 204:5  
**audited** 203:22  
**August** 75:22  
**authority** 211:19  
**autonomy** 317:7  
**available** 28:15 75:7  
 80:18 226:5 282:12  
 297:6 335:13 373:12  
 375:3 396:15  
**avenue** 100:9  
**average** 256:7 359:5  
 383:4  
**avoiding** 310:11  
**aware** 106:3 107:10  
 108:11 109:1 110:5  
 115:22 149:14 172:4  
 244:21 253:6 342:21  
 383:17

---

**B**


---

**b** 173:4 176:9 178:13,18  
 178:19 202:8,11  
 296:9  
**back** 5:21 7:17 41:11,15  
 41:16 43:9 46:20,22  
 47:4 59:17,18 65:13  
 84:22 100:3 101:15  
 102:15 104:20 116:3  
 125:4 126:16 132:11  
 136:15 139:8 142:13  
 150:1 151:17 158:20  
 167:13 173:8 176:3  
 183:13 187:22 189:15  
 201:21 203:22 206:5  
 206:9 210:17 211:17  
 214:11 216:13 217:10  
 237:19 241:18 248:7  
 249:3,4,6,14 256:14  
 263:9 264:16 265:15  
 266:5,6 267:16  
 273:11 277:4 284:17  
 290:15 297:18 299:4  
 299:20 301:7,7 309:3  
 311:7 312:2,18  
 315:14 318:18,21  
 323:14 324:11 328:7  
 339:3 343:2 344:3  
 347:18 349:4 353:11  
 353:14 355:5,15  
 359:1 360:4 362:3  
 378:4 386:7 392:22  
**background** 69:14,18  
 105:1 106:9 112:10  
 149:9 151:22 152:19

**backs** 132:6  
**backward** 287:17  
**bad** 196:16 308:10  
     345:14 365:13 381:17  
     388:14,17  
**Bagon** 299:3  
**balance** 162:2 343:6  
**balances** 145:12  
**balancing** 339:2  
**ball** 137:1  
**bank** 138:21 154:17  
**bar** 65:5  
**barriers** 183:13 185:20  
**base** 77:7 376:17  
**based** 14:5 20:3 29:16  
     34:22 35:2 50:22  
     63:18 109:3 135:8,11  
     135:12 139:6,11  
     143:20 145:10 170:12  
     184:22 191:14 218:5  
     237:7,11 246:1,14  
     248:3,5 263:8 281:2  
     313:18,20 373:1  
     389:7 393:21  
**basic** 97:6 119:11 141:6  
     142:6  
**basically** 119:12 125:14  
     208:16 378:13 386:15  
     386:17  
**basis** 70:12 310:11  
     359:12  
**bear** 88:3 303:9  
**bearing** 307:19  
**beautiful** 246:4,6  
**becoming** 321:18  
**beds** 79:14 92:21 241:2  
**bedside** 66:4,8  
**began** 141:5,5  
**beginning** 69:1 84:19  
     141:2,18 368:18  
     388:3  
**begins** 128:4 387:2  
**begun** 171:13 341:18  
**behalf** 238:21  
**behavior** 92:13  
**behavioral** 57:12 58:6  
     134:8 192:13 330:7  
**belabor** 173:20 211:6  
     374:15 401:2  
**beliefs** 312:10  
**believe** 128:2 149:7  
     151:18 154:12 167:14  
     167:21 168:22 179:2  
     218:19 239:1 256:18  
     273:13 275:5  
**believed** 372:22,22  
**bells** 246:12  
**belonging** 321:18

**benchmarking** 198:12  
**benchmarks** 191:12  
**beneficiaries** 110:19  
     232:20 302:21 382:17  
**beneficiary** 109:14  
**benefit** 81:22 242:19  
     245:12 278:13 281:18  
     313:9  
**bereavement** 311:2  
     312:21 313:2  
**best** 34:7 45:4 75:6,6  
     120:9,10 126:18  
     180:14 191:15 287:22  
     288:10,14,16 301:9  
     302:5,7 371:2,22  
     375:14 387:13 388:21  
**beta** 128:3,4 131:15  
     132:16 133:10,15  
     138:15 154:17 155:4  
     157:9 169:11  
**better** 23:10 55:17,18  
     58:12 65:8,10 85:16  
     137:7 184:10 237:11  
     251:11 301:3,3  
     333:11 343:18 345:22  
     347:5,6 367:1,4,5,6  
     367:13 389:4 390:16  
     392:2  
**beyond** 118:11 121:3  
     123:7,18 129:11  
     132:19 137:9 192:2  
     248:12 273:16 278:2  
     315:18 375:21  
**biases** 233:7  
**bidirectional** 277:12  
     299:5,9  
**big** 31:2 38:8 55:4 92:3  
     97:18 194:21 203:10  
     253:2 260:12,16  
     316:3 318:10 335:1  
     336:10 392:16  
**bigger** 24:19 385:17  
**biggest** 26:21 193:3  
**bill** 135:19 178:11,12,17  
**billing** 173:3 382:9  
**billion** 64:21 345:1  
**BIMS** 251:15,18,20  
     252:2,20 253:14  
     254:6  
**bins** 134:7  
**bio-break** 150:1  
**bit** 5:20 11:10 21:3  
     25:13 28:19 32:7  
     34:14 48:14 51:4,16  
     51:18 69:7,13 75:11  
     75:19 78:2 79:21 83:3  
     84:17 86:10 87:16  
     106:9,10 111:19

    123:12 132:18 149:3  
     173:9 192:4 208:21  
     210:11 213:8 216:16  
     218:13 234:9 235:8  
     236:7 269:3 284:10  
     295:10 306:11 312:5  
     317:22 357:8 367:17  
     381:17 392:13 394:13  
**bizarre** 61:9  
**bless** 76:2  
**blind** 238:19  
**block** 198:16  
**blocking** 183:21 193:5  
     198:16 280:22 383:1  
**blood** 188:19,21  
**bloodstream** 32:19  
**blow** 91:22  
**blue** 65:20  
**BMI** 60:8 188:19  
**board** 12:17 125:5  
     126:16 243:19 266:9  
**bodies** 41:18,20 42:12  
     103:19  
**body** 182:7  
**boom** 392:21  
**bore** 225:11  
**borrowing** 317:11  
**bother** 278:14  
**bottom** 30:19 275:9  
     365:18  
**box** 146:8 324:4  
**boy** 81:12 387:12  
**brains** 350:3  
**brand** 85:9  
**brand-new** 246:7  
**break** 22:15 99:13  
     100:17 105:10 119:13  
     149:22 183:17 194:17  
     348:4  
**breath** 267:17  
**breathing** 326:3  
**Brendan** 400:14  
**bridging** 175:7  
**brief** 172:4 173:19  
     197:22 218:1 300:8  
     349:10 390:12  
**briefly** 19:14 171:20  
     305:12 380:16 381:8  
**briefs** 294:13  
**bring** 8:20 10:2 44:3  
     58:3 69:2 82:11,15  
     100:19 102:15 152:9  
     171:4 206:8 212:1  
     213:22 216:6 229:3  
     263:9 264:16 265:15  
     269:20 290:17 339:3  
     339:7 349:13 357:18  
     380:10

**bringing** 8:10 49:21  
     68:3 92:5 163:17  
     164:1 266:10 267:14  
     321:13  
**brings** 74:17 390:20  
**broad** 50:21 176:13  
     234:7 266:9 286:6  
**broadband** 98:22 99:3  
**broader** 35:7 47:3  
     52:13  
**broadly** 34:14 79:22  
     210:20 352:3 357:8  
**broken** 67:10  
**brought** 22:20 72:14  
     87:12,19 91:15 94:13  
     116:18 143:8 164:12  
     185:11 211:17 227:16  
     236:21 242:9 247:17  
     268:9 269:17 270:13  
     272:1  
**BSN** 3:4  
**BSW** 3:4  
**bubble** 305:2  
**build** 124:19 170:8  
     347:10 367:5 395:3  
**building** 146:21,22  
     148:16 151:17 246:11  
**built** 5:20 117:10  
     148:21 160:5 288:1  
     371:4 379:6  
**bullet** 73:12 124:11  
     358:6  
**bullets** 337:17  
**bunch** 227:17  
**bundle** 92:18  
**burden** 25:22 28:18,20  
     32:1 36:14 39:9 46:13  
     47:18 48:6 50:7,8  
     60:12,18 83:22 97:13  
     97:13,13 98:5 137:3  
     140:2,9,14 141:7  
     153:14,14 155:1  
     162:22 228:16,17  
     270:8,15,20,21 271:5  
     271:6,7,8,8 273:20  
     291:6 352:11,12  
     354:16 359:11  
**burdensome** 40:22  
     126:10 127:2 282:5  
     283:7 301:11 314:13  
**business** 302:14  
**busy** 32:8 399:14  
**button** 19:2  
**buy** 82:2  
**buy-in** 190:21 373:3  
**buyer** 183:16

---

**C**


---

- C** 358:9  
**C-O-N-T-E-N-T-S** 4:1  
**C-statistic** 364:13  
**caffeine** 332:17  
**CAHPS** 227:5,10 228:8  
 228:15 229:11 239:12  
 239:18 243:20 250:8  
 252:6 262:5 270:3,5  
 270:13 273:11 309:15  
 312:6 313:20 318:5  
 319:1,2,3 327:5 338:7  
**calculate** 113:22 229:2  
 242:3 249:7 393:11  
**calculated** 360:3  
**calculation** 108:14  
 113:17 114:9  
**calendar** 123:16 208:2  
 208:5 218:12,17  
 219:1,8,12,13 224:13  
 224:21 274:8  
**California** 11:9  
**call** 19:8 55:21 58:22  
 76:17 101:13,15  
 131:20 140:11 201:13  
 201:18 216:5 233:2  
 284:1 306:21 307:3  
 307:16 316:6 329:21  
 356:14 361:11,16,18  
 396:14  
**called** 15:17 25:16 59:5  
 59:6 119:1 144:13  
 175:16 201:18,18  
 217:7 229:20 376:1  
**calling** 131:9 132:3  
 250:9 299:7 395:16  
**calls** 229:22 256:1  
 360:16  
**CAM** 134:8  
**Campus** 10:21  
**cancer** 134:20 314:19  
**candidate** 118:14 120:9  
 121:1,19 126:19  
**capability** 71:4 364:9  
**capable** 241:8  
**capture** 18:22 146:10  
 165:7 188:1 213:21  
 364:19  
**captured** 115:7 166:5  
 214:21 215:4 285:10  
 312:6 318:22 320:20  
 321:2,8 364:5  
**captures** 287:3  
**capturing** 115:1 164:16  
 186:12 273:16 285:8  
 309:21 321:17,20  
**card** 19:7 59:20 232:16  
 234:3 286:15  
**cardiologist** 64:7,9
- cards** 274:1  
**care's** 387:4  
**CARE/LONG-TERM** 1:5  
**career** 202:10  
**caregiver** 164:12 318:1  
 318:9,12,20 324:21  
 325:5 341:15  
**caregiver's** 319:4 325:1  
 325:3 341:9  
**caregivers** 66:8,18  
 124:5 131:3 148:2  
 163:10,17,21 164:17  
 174:19 313:4  
**Carol** 2:3 3:7 11:22  
 316:14 319:9,11  
 322:3 323:7 346:11  
 400:12  
**Caroline** 2:8 15:14 40:8  
 40:9 59:22 62:19 67:5  
 180:1,2 328:19  
 332:22 382:15 389:11  
**Caroline's** 192:5  
**carried** 5:17 136:4  
 178:15  
**carriers** 76:10,11  
**carry** 136:5 189:12  
**carrying** 137:1  
**cart** 260:1  
**carve-out** 81:22  
**carving** 82:9  
**CAS** 271:2  
**case** 73:6 77:11 81:18  
 93:13 117:4 122:7  
 207:3 223:1 338:11  
 373:22 376:10 386:20  
**cases** 183:7 340:14  
**Casey** 289:13  
**Castle** 3:2 228:7 229:15  
 236:20 249:22  
**catch** 307:5  
**categories** 112:4,8,12  
 113:10 114:18 117:17  
 120:5 172:17 207:13  
 209:16  
**categorize** 370:5  
**category** 47:2 197:10  
 211:13,15 212:20  
 213:11 216:1  
**cause** 388:7  
**caused** 266:13 329:13  
 329:16  
**causing** 266:15  
**CAUTI** 358:8 359:6  
 362:2,10  
**caution** 364:17,18  
 365:5  
**CAUTIs** 359:12,18  
**caveat** 200:6 214:10
- caveats** 155:14 367:13  
**CDC** 386:21  
**CDC's** 331:9  
**CDI** 386:20  
**cell** 101:11  
**center** 16:4 44:11 82:14  
 110:13 201:13,18  
 204:12 291:5  
**centered** 65:20  
**centers** 2:11 3:3,4,5,6,7  
 3:8 70:11 143:18  
**central** 32:19 142:4  
**centrally** 46:19  
**certain** 65:7 72:9 78:17  
 106:5 117:7 125:15  
 143:17 178:6 200:9  
 200:10 236:11 237:22  
 250:10 322:14 323:3  
 351:7 367:19  
**certainly** 8:14 42:16  
 53:19 55:19 57:13,17  
 81:18 83:13 90:15  
 141:16 162:2 179:7  
 179:14 214:19 245:11  
 245:14,16 267:19  
 268:16 270:8 282:1  
 282:18 286:21 288:11  
 290:5 308:5 320:6,6,7  
 320:16 321:4,9 337:3  
 340:21 351:10,12  
 352:12,20 362:1,9  
 363:12 364:3 366:11  
 390:17  
**certificate** 84:7  
**certification** 143:17  
 334:12  
**certified** 172:21 335:6  
**cessation** 188:19  
**cetera** 335:21 366:9,9  
**chafing** 83:22  
**chain** 66:19  
**Chair** 2:15 307:21  
**chairs** 1:11 219:9  
 220:10 232:6 274:1  
 348:22 397:14  
**challenge** 20:13 47:12  
 71:18 96:4 99:1  
 101:12 188:5 198:22  
 199:15 247:12 288:8  
 291:2 294:9 301:13  
 308:7,8 324:17  
 380:13  
**challenged** 245:20  
**challenges** 4:18 20:11  
 20:15 21:13,16 62:22  
 69:22 70:3,5,19 72:10  
 80:8 100:22 101:17  
 171:22 180:3,5
- 229:11 301:14,17  
 305:8 323:12 371:18  
 372:12 373:10 381:15  
**challenging** 72:3 183:7  
 188:13 213:5  
**Chan** 400:15  
**chance** 208:4,8 209:1  
 280:3,9  
**change** 41:10 165:19  
 165:20 173:1 181:3  
 212:22 223:12 235:3  
 239:9 279:17 329:3  
 341:7,8,10 376:19  
 391:19  
**changed** 87:15 292:14  
**changes** 5:13,18 39:11  
 45:16 63:6 67:1 84:13  
 169:6 180:22 213:5  
 326:5 331:14  
**changing** 84:6 139:16  
 188:11 267:22 268:19  
 297:22 317:22 366:9  
 372:4  
**chaplaincy** 315:19  
**chaplains** 95:22  
**CHAPS** 309:22  
**character** 365:4  
**characteristic** 116:21  
 117:1 127:15  
**characteristics** 298:14  
 342:14 363:22 364:20  
**characterize** 282:8  
**Charbonneau** 104:14  
**charge** 142:12 227:22  
**charged** 19:19 20:9  
**charges** 173:4  
**charts** 195:12 386:9  
**chat** 149:12 275:8  
**check** 335:4 396:15  
**checking** 97:21 334:8  
**checklist** 145:18  
**checklists** 29:9  
**checks** 172:9  
**chemotherapy** 118:3  
**cherry-picking** 250:11  
**CHF** 195:17  
**Chicago** 10:17  
**Chief** 16:11 104:15  
**child** 231:18 315:10  
**chilly** 11:10  
**choice** 44:5 63:11 91:2  
 91:8 185:9,11,15  
 190:13 199:12 379:11  
 395:16  
**choices** 235:22 303:9  
 375:2  
**choose** 193:14 251:20  
**choosing** 121:21

209:17  
**chose** 123:20 124:2  
 125:2  
**chosen** 122:20  
**Chris** 400:10  
**chronic** 33:19 34:1 59:3  
 64:14 87:2,4 88:1  
 111:9 158:14 295:14  
 295:20 328:15,16  
 344:19 345:10 346:3  
 382:17  
**chronically** 296:4  
**Cindy** 400:11  
**circle** 336:9 349:17  
**circumstance** 243:9  
 375:18  
**cited** 332:8  
**city** 81:12 82:3,14  
 296:17  
**CLABSI** 32:18  
**claims** 109:4 222:17  
 331:8 338:8 340:8  
 342:10  
**claims-based** 63:19  
 319:15  
**clarification** 202:14  
 285:6 320:12  
**clarifications** 39:21  
**clarify** 204:9 213:2  
 220:7 242:17 252:13  
 281:6 282:20 299:9  
 375:16  
**clarifying** 219:5  
**clarity** 253:10 263:4  
 375:11  
**class** 62:17 120:10  
 126:18  
**classic** 112:11  
**clear** 56:10 60:13 116:1  
 164:14 204:16 213:6  
 225:11 240:11 251:2  
 280:8 300:14 329:5  
 370:12 371:6,8 374:7  
**clearer** 58:12  
**clearly** 56:18 226:22  
 227:1 238:2 255:10  
 302:8  
**clickers** 220:9  
**clinical** 15:17 25:19  
 26:2 60:4 94:22 95:17  
 95:21 96:1 111:16  
 113:9 115:11,13  
 116:22 121:10,11  
 127:11,14 141:7,13  
 142:6 144:18 172:20  
 199:14 251:4 313:15  
 342:13,14 343:18  
 351:2

**clinically** 322:17  
**clinician** 20:8 29:8  
 36:14 37:16 50:6  
 141:21 162:15 173:11  
 174:21 175:10,20  
 212:8 213:8 215:13  
 285:9,16  
**clinicians** 20:11 40:11  
 61:11 146:19 158:5  
 159:7,13,16,19 173:3  
 174:19 184:20 185:9  
 193:4,13,15 194:4  
 201:10 204:14 223:21  
 280:15 283:19,20  
 292:18 327:1 369:12  
**clock** 102:21  
**clock-wise** 10:10  
**clockwise** 15:4  
**close** 114:3 191:9 210:2  
 296:2 349:14,17  
**closely** 38:15,22 110:13  
 354:2 357:11  
**clunky** 334:22  
**clustered** 260:15  
**CMD** 1:18,19  
**CMS's** 359:11  
**CMS-approved** 270:6  
**cms.hhs.gov** 205:14  
**CNAs** 66:4 94:19  
**co-** 1:11 219:8 397:13  
**co-chairing** 7:5  
**co-chairs** 6:20 15:21  
 17:19 19:7 20:5  
 208:11  
**co-manage** 389:21  
**Coalition** 1:19 12:17  
 15:12 298:10  
**code** 111:3 202:1 329:6  
 329:8 391:5  
**coded** 329:13  
**coders** 97:19  
**codes** 112:17,21  
 385:15  
**coding** 165:12  
**cognition** 123:9 153:17  
**cognitive** 112:5 114:21  
 115:2 117:19 123:1  
 123:21 132:21 135:12  
 152:14 153:5,8  
 155:22 165:4 168:11  
 237:5 296:22  
**cognitively** 159:4  
**Coke** 398:6  
**cold** 5:5 11:10  
**collaborate** 177:6  
**collaboration** 124:20  
 152:1  
**collaborative** 30:7

42:10 53:2 125:1  
 340:15  
**collating** 225:13  
**colleague** 109:8  
**colleagues** 18:1 38:16  
 39:3 46:10 51:22 86:6  
 100:20 118:12 151:21  
 155:7 157:8,12 160:3  
 160:5 186:1 197:6  
 370:3 391:10  
**collect** 126:3 132:12,12  
 146:19 158:4 227:18  
 228:9,18,20  
**collected** 156:10,12,16  
 202:15 272:5  
**collecting** 28:21 126:22  
 127:1 129:13 133:9  
 135:9 147:12 152:12  
 169:14 216:6 225:13  
**collection** 80:9 129:17  
 130:17 133:21 146:17  
 152:8 153:14 165:12  
 323:19 324:1 380:8  
**collective** 306:14  
**collectively** 22:21  
**Colorado** 10:21 341:19  
**column** 139:10 148:9  
**combination** 316:21  
 394:1  
**combine** 9:14  
**combined** 172:12  
**come** 5:18 35:19 42:18  
 54:16 59:17 76:1  
 77:17,21 78:1 79:19  
 90:2 98:10,14 100:3  
 101:9 132:9 137:13  
 140:12 150:1 151:21  
 173:15 191:11 192:7  
 210:17 214:1,11  
 237:19 239:15 241:18  
 248:7 249:6 251:18  
 256:13 264:9 269:19  
 271:17 302:16 309:2  
 330:10 346:15 352:16  
 401:5  
**comes** 47:9 90:22  
 92:19,20 182:14  
 199:12 217:5 280:22  
 319:22 347:6 362:2  
 366:10 369:7,20  
 392:21,22  
**comfortable** 190:11  
 191:4 304:10  
**comical** 68:5  
**coming** 83:6 205:2  
 221:14 243:22 264:11  
 268:18 276:18 281:1  
 291:19 327:22,22

336:16 339:20 347:8  
 347:18  
**comment** 4:9,20 39:13  
 51:16 57:22 68:18  
 81:8 84:15 86:21 93:6  
 93:17 98:17 119:18  
 132:8 145:15 151:9  
 152:22 154:14 176:17  
 185:14 189:3 195:5  
 205:20 220:17,22  
 221:1 224:2 226:1,4  
 232:17 234:8 244:5  
 245:13 249:2 259:18  
 259:20 266:3 273:8,9  
 285:20 333:17 334:17  
 344:16 347:22 348:2  
 348:3,10,13 354:1  
 394:13 397:1,4,6,8,12  
 399:9  
**commented** 285:6  
 286:5  
**commenting** 69:1  
 260:4  
**comments** 18:18 23:16  
 40:7 49:16 53:8 58:3  
 68:14,17 86:6 99:15  
 100:20 116:1 123:6  
 136:11 155:2 164:22  
 169:21 175:14 176:3  
 178:10 179:17,20  
 189:4 192:6 198:1  
 215:2,8,12 217:22  
 218:20 224:5,8  
 234:15 252:10 253:5  
 253:7 254:15 260:19  
 260:19,20,20 296:2  
 305:15 319:15 325:9  
 336:5,21 337:2,20  
 346:11 348:15 357:16  
 361:9 363:18 365:7  
 367:22 387:22 389:9  
 389:13 390:2,12  
 394:10 395:4 396:21  
 397:10,16 400:20  
**commercial** 30:6  
**commissioned** 370:22  
**commitment** 385:7  
**committee** 17:2 18:15  
 20:10 75:19 76:1  
 104:15 173:12 194:21  
 211:14 212:10,15  
 213:1,18 214:1,4  
 216:7 217:9 218:6  
 220:18 221:4 224:20  
 232:2 262:3 264:11  
 264:12 285:13 286:19  
 290:6,8,20 350:8  
 372:22 373:8 374:17

375:4,15 379:8  
**committee's** 73:16  
 287:8  
**committees** 75:16  
 100:7 164:7 213:16  
 214:5 290:22 354:11  
 354:18 376:3 385:21  
**common** 35:18 109:10  
 195:11 254:7  
**commonly** 67:11 196:8  
**communicate** 130:3,8  
**communication** 33:14  
 108:1 111:7 165:4  
 289:8 326:17 331:21  
**communications**  
 115:15  
**communicative** 130:1,6  
 165:14  
**communities** 31:22  
 34:7 58:19 83:21  
 84:12 87:18,21 88:10  
 88:19 94:22 98:21  
 101:13 395:17  
**community** 34:9 44:1  
 47:6 57:16 58:15  
 80:22 91:6 95:21 97:4  
 101:9 109:1 125:8  
 131:4 136:9 266:19  
 269:17 271:22 288:4  
 288:5 332:1 342:6  
 344:4 346:16 389:3  
**community-based**  
 79:22 110:15 165:17  
**community-integrated**  
 83:20  
**comorbidities** 112:8  
 118:5 333:10 360:11  
**company** 302:13  
**comparability** 109:21  
**comparator** 258:13  
**compare** 137:20 226:21  
 266:18 338:5 358:10  
 358:13 371:21  
**comparing** 35:1 282:2  
**comparison** 158:9  
**comparisons** 108:3  
**Compassus** 1:20 12:13  
**compensated** 393:9  
**competing** 355:19  
 364:12  
**complain** 46:11  
**complaining** 194:22  
**complete** 14:8 63:11  
 236:12,15 391:6  
**completed** 157:20  
 255:10 368:16  
**completely** 43:2 52:14  
 77:13 92:12 182:15

246:16,21 305:19  
**completing** 159:21  
**complex** 44:10 45:1  
 111:3 143:5 302:15  
 306:11 364:3 373:9  
 380:9 385:4,5 390:12  
 391:13 393:10  
**complexity** 127:15  
 383:20 394:17  
**compliance** 326:3  
**compliant** 334:10  
**complicated** 210:11  
 269:3 394:21  
**complications** 87:4  
**component** 44:6 96:5  
 146:8 162:22 328:8  
**components** 313:13  
 321:17  
**comprehensive** 151:14  
 309:19  
**comprised** 172:16  
**computation** 378:2  
**computer** 276:1  
**computers** 133:13  
**concentrate** 207:9  
**concept** 42:5 64:11  
 145:19 156:2 157:8  
 175:16 182:6 199:22  
 212:16 244:8 314:12  
 316:18 317:8,13  
**concepts** 21:20 92:6  
 244:11 302:16 374:7  
**conceptual** 341:18  
**conceptualized** 30:17  
**conceptually** 246:18  
 356:2  
**concern** 86:14 140:10  
 211:11 242:9 260:5  
**concerned** 41:12 47:2  
 153:13,15 236:7  
 337:4  
**concerning** 78:16  
**concerns** 153:22 178:8  
 212:6 214:4 215:18  
 216:10 236:18 237:4  
 385:3  
**concluding** 159:8  
**conclusions** 377:5  
**concrete** 46:1  
**concur** 166:13  
**condition-** 99:20 100:8  
**conditional** 210:2,13  
 213:10 214:22 215:17  
 263:7,8 274:11  
**conditions** 34:1 78:18  
 112:7 118:5 158:14  
 213:14 334:8 384:11  
 394:15

**conduct** 132:5 157:13  
**conducted** 118:18  
 121:7,7 157:17  
**conducting** 129:2  
 131:18  
**conduit** 214:3  
**conference** 1:10 131:20  
 131:22 386:22  
**conferences** 131:7  
**confess** 201:14  
**confident** 318:16  
**confirm** 270:12  
**confirmations** 330:13  
**confirming** 282:20  
 327:13  
**conflict** 14:20 15:19  
 16:15 17:17 296:15  
**conflicts** 11:1 16:9  
 104:3,16 222:5  
**confuse** 68:7  
**confusing** 68:11 159:10  
 159:15 197:20  
**confusion** 197:4 202:11  
 243:22 253:12  
**congestive** 338:22  
 384:10  
**Congress** 106:15  
 136:11,16 267:21  
**connect** 385:4  
**connections** 81:1  
**Connie** 15:9 94:10  
 295:7 300:21 315:2  
 318:19  
**conscientious** 48:15  
**consensus** 95:15 116:5  
 119:17 124:20 130:21  
 148:4,5 149:5 166:16  
 216:21 217:8,17  
 220:7 300:15 301:22  
**consent** 208:2,5 218:12  
 218:16 219:1,8,12,13  
 224:13,21 274:8  
**consequence** 355:2  
**consequences** 53:12  
 53:14 210:1 271:17  
 342:22 352:15 354:20  
 380:7 385:3 390:16  
**consider** 27:19 31:17  
 65:18 81:11 84:10  
 86:3 99:5 101:21  
 174:4 191:13 233:16  
 311:14 353:9 366:8  
 381:13 399:18  
**considerable** 88:7  
 285:15  
**consideration** 5:7 20:6  
 21:1 22:16 30:2 55:12  
 57:15,20 98:19

133:10 159:2 179:17  
 207:4,11 209:18  
 217:2,6 218:4 221:10  
 224:3,14 269:19  
 273:14 277:1 279:14  
 283:4 295:5 300:13  
 326:12 331:19 352:14  
 352:17,21 366:20  
**considerations** 22:3  
 31:16 327:9 350:16  
 352:9 357:19  
**considered** 226:12  
 252:12 353:16 375:2  
**considering** 22:9 29:1  
 56:9 63:10 73:6 84:8  
 211:20  
**consistencies** 168:6  
**consistency** 207:14  
 229:4 357:5 372:2  
**consistent** 142:8  
 167:15 168:10 211:10  
 227:19 233:2 239:5  
 239:13 243:19  
**consistently** 339:21  
 375:7  
**consolidated** 48:4  
**conspicuous** 333:12  
**CONSTANCE** 2:7  
**constraints** 282:13  
**construct** 51:3  
**constructed** 51:4  
**constructive** 46:9  
**constructs** 96:2  
**consultant** 18:14  
**consulted** 121:13  
**consulting** 14:11  
**consumer** 1:16 12:10  
 90:21 103:17 234:19  
 235:16 263:15  
**consumers** 103:22  
 154:10,11 166:22  
 167:5,10 235:18  
**contact** 205:5  
**content** 57:9 96:22  
**context** 7:13 51:16  
 207:21 279:17 290:18  
 356:1 357:12 368:15  
 376:14 377:2  
**contextual** 215:2  
**continence** 123:10  
 134:18,19  
**contingency** 381:19  
**continually** 356:10  
**continue** 21:9 38:1  
 52:22 53:21 90:13,14  
 105:1,7 121:11 136:5  
 144:8 170:4 171:14  
 171:18 206:10 277:8



295:3 302:7 319:17  
 320:2 337:16 339:4,5  
 347:16 359:19 360:3  
**continued** 337:14  
 351:17 380:3 401:9  
**continues** 98:22 230:10  
 294:8  
**continuing** 24:9 349:19  
 351:18 353:20 359:20  
 381:6 396:3 399:4  
**continuity** 115:15  
 291:18 293:5  
**continuum** 137:21  
 138:3 160:20 161:11  
 164:21 179:7  
**contract** 227:9 228:3,6  
 380:2  
**contracted** 228:5  
**contractor** 2:19 114:6  
 150:22  
**contractors** 139:2  
 142:18  
**contribute** 192:4 236:3  
**contribution** 366:17  
**control** 203:12 292:3  
**convened** 374:2  
**convening** 5:11  
**conversation** 7:7,21  
 8:1 20:2 104:21  
 171:19,21 174:3,6  
 207:19 208:10,12  
 215:22 218:22 262:17  
 276:15 277:5,7  
 279:16 288:3 333:1  
 339:4 369:2 374:16  
 379:22  
**conversations** 6:7  
 28:12 52:1 171:15  
 281:2  
**convert** 242:22  
**cookie** 193:18  
**cooperative** 177:7  
**coordinate** 296:9  
**coordinated** 108:8  
**coordinating** 18:15  
 20:10 75:19,22  
 173:12 211:14 212:10  
 212:15 216:7 217:9  
 218:6 221:3 232:2  
 264:12 350:8  
**coordination** 5:16  
 21:21 33:14 80:19  
 89:4 94:21 100:10  
 109:13 111:7 121:15  
 169:6 288:20 289:4,8  
 289:12 290:5,16  
 292:9 310:17 326:17  
 331:22 367:20 385:14

**Coordinator** 2:12 12:5  
 267:10  
**COPD** 394:16  
**coping** 183:22  
**core** 2:14,15 30:7 42:8  
 42:9 53:1 74:2,5 75:5  
 76:21 94:5 110:5  
 140:18 208:19 231:13  
 231:18,19 244:8  
 255:1  
**CoreQ** 224:15 225:5  
 227:4 232:19 233:3  
 274:16 275:11 352:20  
**corner** 275:9  
**Corporation** 1:14  
 118:13 120:16  
**correct** 145:19 202:7  
 243:14 248:15,18  
 249:19 278:1,5  
 335:21 377:19  
**correctly** 248:8  
**cost** 31:21 35:13 60:18  
 172:17 228:17,19  
 270:19 343:5 345:1  
 358:17 369:5 385:20  
 391:3 392:9,19,22  
 393:5,17  
**costly** 95:10 297:16  
**costs** 60:9 369:15  
 382:8  
**count** 76:6 197:18  
 275:5  
**counted** 220:14  
**country** 25:20 96:14  
 98:8 103:16 239:9  
 247:16 248:2  
**couple** 7:3 14:9,17  
 34:11 35:18 41:15,16  
 46:7 69:20 73:20,22  
 76:14 77:5,16,21  
 79:11 82:18 94:11  
 100:19 115:20 118:13  
 133:5,8 137:17 138:8  
 149:19 161:9 179:16  
 192:1 195:13 200:16  
 230:22 236:21 279:1  
 284:2 295:8 307:1  
 310:9 346:10  
**course** 30:12 62:1 63:9  
 74:14 202:9 293:21  
 294:5 305:15 309:11  
 312:15 389:19  
**court-appointed**  
 238:10  
**cover** 19:13,18 20:18  
 253:5  
**covered** 149:16 253:10  
 398:11

**CPH** 2:8  
**CPHQ** 1:21  
**CR** 24:10  
**crack** 111:3 210:18  
**craft** 345:16  
**crafted** 7:11  
**crazy** 76:22 193:14  
**create** 48:7 49:8 66:9  
 73:12 178:4 179:1  
 287:2,4 372:18  
**created** 172:6 199:3  
 202:11 211:14 256:6  
**creating** 55:21 60:21  
**credibility** 162:12  
**credit** 98:7  
**crisis** 316:7  
**criteria** 4:15 22:9 37:22  
 54:6 75:1,5 77:8  
 91:17,17 185:1  
 208:22 209:4,20  
 210:3,22 305:6  
 336:17 347:19 349:9  
 350:5,11 353:7,15,16  
 354:6,17 355:6,10,11  
 356:6 357:10 364:6  
 374:4 377:4 379:19  
 386:16,17  
**critical** 83:18 222:15  
 330:8 331:5 367:21  
 373:14 400:18  
**critical-access** 70:11  
**critically** 160:20 161:4  
 161:7 168:19  
**cross** 77:12 163:3  
**cross-** 31:15 85:3  
**cross-cutting** 22:13  
 58:16,18 78:17 85:4  
**crunched** 102:4  
**cry** 344:12,16  
**culturally** 322:17  
**curious** 176:7,7 181:4  
 311:12 333:7  
**current** 7:17 58:9 69:3  
 101:22 126:13 139:6  
 140:3,5 151:16  
 194:14 204:11 207:1  
 223:11 224:17 290:17  
 320:18 331:20 351:2  
 375:13 376:18 381:20  
**currently** 127:21 138:4  
 174:20 177:18,21  
 185:21 200:1 222:21  
 225:18 228:18,19  
 270:9 309:17 310:9  
 362:9 370:18  
**curve** 365:17,18  
**customer** 65:20  
**customers** 66:3

**cut** 77:10 142:21  
 143:10  
**cut-point** 253:15,17,18  
 254:7  
**cut-points** 259:6,12  
 261:7  
**cutting** 31:16 77:12  
**CWS** 2:8  
**cycle** 39:12,14,16  
 176:20  
**cynical** 41:2

---

**D**


---

**D.C** 1:10 5:6  
**Dahlin** 2:7 15:9,10  
 94:11 295:8 305:21  
 315:3  
**daily** 119:10  
**damnable** 65:10  
**danced** 385:22  
**dare** 205:4  
**dataset** 140:18 222:17  
**date** 76:4 201:8  
**dates** 112:3  
**DAVID** 3:2  
**day** 4:21 9:7 13:14 22:8  
 25:1 40:1 133:19  
 136:1 137:9 156:13  
 183:18 215:7 220:22  
 292:6 296:18,18  
 305:16 326:4 349:19  
 385:9 396:20 397:14  
 397:18 398:10 399:3  
**days** 5:14 156:10,17  
 195:13 233:15,16,20  
 242:14 296:16 323:14  
 342:11 382:4  
**DDCI** 255:6  
**DDP** 267:17  
**de** 119:20 123:3 138:16  
**de-MUC** 55:22 56:4  
 91:13  
**deal** 86:20 175:9 189:4  
 308:14 329:7 385:10  
**dealing** 57:11 84:6  
 99:19  
**dealt** 141:1  
**dearly** 325:7 398:1  
**dearth** 57:18  
**death** 310:2  
**deaths** 296:3  
**Deb** 2:1 11:19 87:7  
 89:14 121:8 147:2  
 190:9 198:10 254:5  
 394:10  
**Deb's** 259:16,17  
**Debardeleben** 1:14  
 104:7,8 276:6,7

357:17,18 358:1  
**decade** 289:1  
**December** 1:7 153:7  
**decide** 79:8 91:17  
 265:11  
**decided** 65:1 75:13  
 136:16 260:2 372:13  
 386:15  
**decides** 188:16  
**deciding** 54:18 191:16  
**decile** 62:8  
**decision** 111:16 113:9  
 113:15 115:13 207:12  
 207:13,22 209:16  
 210:19 212:10,21  
 215:4 217:3,5,8,13  
 218:8,18 224:17  
 271:11 387:19  
**decisionmaking** 135:1  
 148:12  
**decisions** 217:7 238:13  
 303:7 378:17  
**deck** 306:5,15  
**declare** 12:18  
**decrease** 140:7,8  
**decreased** 366:18  
**dedicate** 307:9  
**dedicated** 23:10 201:10  
**deep** 267:17  
**deeper** 210:7 282:22  
**deeply** 8:7 103:20  
**default** 245:19  
**defend** 329:20  
**defer** 59:15  
**define** 233:11 313:1  
 370:14 389:5  
**defined** 61:7 191:8  
 216:21 335:18 369:8  
**defines** 365:3  
**defining** 371:2  
**definitely** 71:18 77:21  
 85:13 87:11 92:22  
 102:6 161:18 163:22  
 196:18 198:8,17  
 292:8 312:21 313:6  
 313:16 314:13 363:10  
 391:2  
**definition** 369:10 371:9  
 378:12  
**definitions** 109:11  
**definitively** 77:17  
**degree** 82:9 92:16  
**deliberate** 193:7  
**delighted** 7:5 57:22  
 384:22  
**delineate** 119:15  
**delineated** 117:17  
 124:3 145:1

**delirium** 251:17 362:19  
**deliver** 184:21 227:8  
**demand** 57:10 114:2  
**demands** 209:11  
**dementia** 117:22 236:8  
 236:10 240:13 241:5  
 241:20 253:20 254:7  
 284:4,5 314:21  
**demonstrate** 72:21  
 356:17 366:6 388:21  
**demonstrated** 238:3  
**Demonstration** 116:13  
 122:15 147:1  
**denigrate** 186:2  
**Dennis** 38:18  
**denominator** 220:15  
 242:13  
**depend** 401:3  
**dependent** 168:5 291:9  
 340:14  
**Depending** 271:11  
**depends** 139:7 246:20  
 270:16 291:17  
**depression** 117:21  
 134:11 152:17 155:11  
 155:16 156:14 330:10  
**depth** 122:11 217:10  
**describe** 116:8 378:18  
**described** 368:18  
**describing** 122:7  
 370:11  
**description** 200:8  
**deserve** 17:2  
**deserves** 235:10  
 317:10  
**design** 375:3  
**designated** 135:2  
**designating** 199:13  
**designation** 211:16  
**designed** 62:5,11 227:4  
 227:6 229:5 375:1  
 376:2  
**designing** 373:20  
 376:12  
**desire** 375:11,16  
**detail** 84:17 127:14  
 138:13 167:9 393:8  
**detailed** 139:9 179:13  
 379:20  
**details** 32:8 33:9 41:15  
 54:12 226:21 266:1  
 270:1,1 271:13 272:4  
 301:5 377:20  
**determinants** 192:14  
 343:19  
**determinations** 308:18  
**determine** 29:16 302:6  
 361:2

**determined** 356:13  
 371:3  
**determines** 355:1  
**determining** 259:5  
**devastating** 384:18  
**develop** 31:7 42:17  
 53:21 54:7 74:22  
 114:6 117:15 153:4  
 192:12 195:4 228:7  
 231:18 236:20 320:2  
 380:2 388:20 393:21  
 396:6  
**developed** 26:8 41:6  
 67:16 95:16 121:19  
 138:22 139:1 159:1  
 204:3 211:7 268:10  
 288:15 367:2 375:22  
**developer** 21:18 219:6  
 227:4 234:12 264:6  
 371:7 376:12  
**developers** 21:19 212:4  
 213:4 221:16 228:8  
 300:14,17 302:2,8,10  
 355:10 356:17 376:2  
 379:8  
**developing** 21:17 30:11  
 119:20 120:17 144:16  
 164:8 227:12 246:22  
 251:9 306:10 308:16  
 372:14 378:22 381:9  
**development** 38:10  
 39:7 138:17 139:11  
 147:19 153:1 164:4  
 166:15,16 177:8  
 226:15 319:16,17,22  
 337:14 363:5 366:4  
 366:14 372:15 374:22  
 375:19  
**develops** 252:7  
**device** 329:16  
**device-related** 329:15  
**devil** 54:11 269:22  
 270:1 301:5 393:8  
**devil's** 265:22  
**DHEERAJ** 1:19  
**diabetes** 77:18 118:7  
 346:7  
**diagnoses** 314:18  
 328:15  
**diagnosis** 194:2  
**diagram** 42:1 110:12  
 341:11  
**diagrams** 341:14  
**dialog** 177:16 289:3  
**dialogue** 7:11 9:1 43:17  
 44:3 100:4 105:8  
 130:13 398:14  
**diarrhea** 387:2

**dictate** 146:18  
**die** 96:7 323:13  
**dies** 320:22  
**diet** 134:22 398:5  
**diff** 358:9  
**difference** 168:21,22  
 169:8 191:19 245:17  
 316:3 318:13  
**differences** 96:18  
 149:13 167:4 301:12  
**different** 34:11 41:20  
 42:12 50:16 55:10  
 56:6 59:19 63:1 64:10  
 67:16,17 80:17 81:17  
 82:12,19,21 84:14  
 86:11 92:1 95:4 96:16  
 130:4 133:20,22  
 134:1,1 135:9 147:14  
 166:1 168:14 175:11  
 182:12 185:10 187:8  
 187:14 188:2 199:2  
 200:17 206:19,22  
 210:9 227:6 228:4  
 236:21 237:2,9,10,20  
 238:5 239:18 244:10  
 244:11 246:18 248:3  
 248:9 268:5 273:15  
 273:20 291:10 292:11  
 293:13 310:2 312:6  
 312:10 317:5,9  
 340:18 346:1 360:12  
 362:16 368:22 383:5  
 389:12 391:14 400:17  
**differentiate** 29:18  
**differently** 59:10 70:13  
 145:10 362:8 389:18  
**difficile** 386:12  
**difficult** 83:3 111:19  
 159:9 191:11 329:19  
 371:12  
**difficulty** 88:8 153:15  
 159:16,20 167:18  
 220:9  
**diligent** 249:12  
**dimensions** 281:20  
**dinged** 384:13  
**direct** 16:4 85:21  
**directed** 352:7  
**direction** 103:21 163:22  
 174:8 258:3 352:4  
**directions** 7:14 52:5  
**directive** 295:18  
**directives** 277:22 284:8  
 284:9,11  
**Director** 2:18,19 15:16  
 18:6 23:22 103:14  
 104:9 180:4  
**directors** 12:18 69:11

**disadvantaged** 72:1  
**disagree** 90:16 219:3  
 386:18 387:19  
**disagreement** 150:2  
**disappoint** 339:16  
 341:12  
**disaster** 296:6  
**discern** 66:22  
**discharge** 108:6 109:1  
 129:22 130:5 224:15  
 225:6 234:19,20  
 235:7,9,13,15,19  
 236:4 237:16 244:18  
 244:21 245:4,7,9,11  
 248:17 274:16 275:12  
 294:5 332:1  
**discharged** 233:14,15  
 237:17 242:14,16,17  
 242:18,22 243:2,7,10  
 296:12  
**discharges** 248:1 328:3  
**discipline** 49:3  
**disciplines** 315:18  
**disclose** 10:12 12:22  
 13:4,8,20 14:10,19  
 15:8,13 17:1 103:12  
 104:4,17 222:6  
**disclosed** 13:22 15:2  
**disclosure** 15:5  
**disclosures** 4:2 9:10,14  
 10:19 11:11,18 12:2,8  
 12:11,14 14:1 17:11  
 103:8 221:22  
**disconnect** 285:15  
**discourage** 220:13  
**discover** 247:16  
**discovered** 233:7  
**discuss** 120:4,18 134:4  
 135:4 149:18 150:11  
 179:15 208:5 209:2  
 212:13 267:20 308:19  
 374:3  
**discussant** 219:22  
**discussants** 208:9  
**discussed** 151:5 155:5  
 163:20 179:4 180:5  
 231:16 278:10 286:1  
 311:4 322:5  
**discussing** 45:15 51:2  
 85:14 176:22 235:4  
 268:16 350:8  
**discussion** 7:12 20:5  
 24:7 29:7 33:11 36:18  
 37:19 38:8 40:6 42:14  
 65:19 69:17 78:3,7  
 82:8 119:4 150:8  
 153:12,12 161:3  
 170:2 177:11 189:15

207:9 215:3 217:20  
 219:2,15,18 220:3,18  
 220:20 224:16,21  
 225:7 267:21 268:17  
 268:18 272:13 276:16  
 276:19,22 279:15  
 281:18 282:11 287:7  
 309:2 322:12 335:10  
 337:22 350:14 352:19  
 367:12 390:4 397:18  
 399:4  
**discussion's** 157:3  
**discussions** 10:3 28:11  
 42:13 150:21 179:14  
 204:19 231:15 279:2  
 284:15 334:21 335:13  
 349:18 352:16 361:1  
**disease** 33:20 111:9  
 387:1  
**disease-specific** 345:5  
**diseases** 87:3,5 295:15  
 295:20  
**disorders** 34:4 59:7  
**disparities** 31:20  
**disrupt** 230:3  
**dissatisfaction** 66:18  
**distance** 102:7,8  
**distinction** 214:12  
**distinguishing** 159:17  
**distress** 134:16  
**distributing** 225:14  
**distribution** 191:7  
 259:15 260:6,8,8,16  
 261:18 262:5,14  
**distributions** 259:17  
**disturbance** 152:16  
 153:10  
**dive** 210:7 282:22  
**divergence** 168:17  
**diverse** 43:22 94:15  
 385:9  
**diversity** 96:16 314:18  
**divide** 382:21  
**divided** 159:7  
**Dlostridium** 386:12  
**DNR** 284:13  
**DNR/DNI** 295:19  
**doc** 181:20 383:3,12  
 384:5,7  
**docs** 61:17 196:13  
 383:14 393:12  
**doctor** 67:12 97:14  
**doctoral** 160:10  
**doctors'** 136:19  
**document** 285:17  
 300:12  
**documentation** 84:2  
**documenting** 360:10

**documents** 142:9  
**dog** 194:6  
**doing** 9:15 19:19 25:11  
 29:10 30:6 35:14 42:4  
 45:4,9 48:22 53:18,20  
 56:13,14 65:7 71:12  
 88:9 90:11 91:21 98:5  
 98:13 101:21 105:7  
 116:15 133:21 146:13  
 146:14 150:20 157:1  
 159:5 170:6,7,10,11  
 191:2 192:7 195:16  
 200:16 203:6 214:8  
 220:8 232:10 239:10  
 240:8 241:8 247:13  
 248:2 249:16 258:14  
 271:10 274:5 285:9  
 298:18 307:8 321:14  
 324:9 325:14 350:6  
 375:15 391:22 393:16  
**Dollar-Maples** 400:13  
**dollars** 392:17  
**domain** 31:18 32:3 33:3  
 33:18,22 34:6 35:10  
 59:2 121:12 197:7  
 223:9 225:19  
**domains** 31:14 43:5  
 47:7 106:5,20 123:18  
 123:19,21 132:15,17  
 132:21 152:12,14  
 161:3 223:4 321:8  
 326:10 331:17 338:18  
**dominant** 88:5  
**Don** 289:13  
**donate** 396:18  
**door** 130:20 187:21  
**dot** 205:13  
**dots** 30:22,22 31:2,2  
 32:11  
**double-check** 274:3  
 335:5  
**double-whammy**  
 393:14  
**doubt** 234:8  
**downside** 83:4  
**DPA** 238:12  
**Dr** 16:20 23:18 40:2  
 41:13 44:16 49:15  
 58:2 62:19,21 63:7,9  
 63:14,18 104:14  
 116:10 121:8 138:9  
 142:16,17 144:20  
 146:17 150:17 163:11  
 165:9 166:6 167:8  
 169:10 173:6 201:5  
 214:18 221:13 225:17  
 230:8,12 231:9  
 232:17 233:10,19

236:19 242:11,21  
 243:5,14,16 244:1  
 246:16 247:14 248:19  
 249:22 250:1 251:22  
 253:8,19 254:22  
 256:21 258:18,20  
 259:22 261:4 264:5  
 267:13 276:18 301:6  
 313:21 336:22 337:7  
 349:16 353:22 355:17  
 355:22 356:21 368:2  
 399:10  
**draft** 45:11 350:11  
 353:8  
**drafts** 350:17  
**draw** 341:12 377:5  
**drawing** 125:5 126:16  
**draws** 42:21  
**drew** 30:10 42:8,17  
**drive** 27:1 29:13 63:5  
 101:8 102:19 114:16  
 115:17 192:19 241:9  
 351:18 376:19 377:17  
**driven** 46:18  
**drives** 242:5 253:3  
**driving** 51:14 190:5  
 241:14  
**drop** 250:19,19  
**dropout** 166:10  
**dropouts** 129:4  
**dropped** 386:1  
**drug** 362:19  
**drumbeat** 299:4  
**druthers** 290:9  
**dual-** 87:1  
**dual-eligibles** 35:3  
**due** 363:8  
**uplicated** 360:9  
**duplication** 353:3  
**durable** 238:12  
**Durham** 400:13  
**duty** 297:14  
**dying** 298:3 323:3  
**dynamic** 7:7

---

**E**


---

**E&M** 384:17 391:4  
**earlier** 24:16 28:19  
 118:4 127:7 192:6  
 195:6 231:12 251:1  
 278:20 279:2 313:6  
 313:22 341:2 349:19  
 368:18  
**early** 5:14 129:4 217:22  
 218:19  
**eased** 324:13  
**easier** 291:11  
**easiest** 200:18

<b>easily</b> 81:2 108:1	125:12,16 127:4,12	<b>endorse</b> 264:13 324:15	25:8,9 68:15 69:4
<b>easing</b> 324:12,16	132:20 134:6 137:19	356:12	171:9 210:12 211:3
<b>easy</b> 54:15 61:2 179:5	137:22 140:3,7 236:3	<b>endorsed</b> 213:16	214:18 226:10 231:11
386:4 388:22	358:20 370:7 371:1	264:13 268:15 269:2	303:7 309:9 337:21
<b>echo</b> 7:3 67:4 98:17	374:12 376:4,6	269:5,12 353:20	354:1 368:6 374:11
164:21 168:13 215:11	378:14,16	355:13 356:7	378:3 396:1 400:1
244:17 320:6	<b>elevate</b> 186:3	<b>endorsement</b> 77:8,9	<b>Erin's</b> 215:11
<b>edit</b> 95:18	<b>elevated</b> 314:3	78:17 210:7 214:2	<b>errand</b> 181:1
<b>Edition</b> 95:18	<b>elevator</b> 19:11	264:4 268:11 353:21	<b>especially</b> 5:6 92:13
<b>educating</b> 128:6	<b>eligible</b> 87:2 128:16	353:22 354:12,21	165:3 232:7 280:5
<b>education</b> 44:12 318:11	172:15 377:8 385:12	370:10	302:15 311:13 335:6
<b>effect</b> 134:14	<b>eliminate</b> 311:21	<b>ends</b> 197:19	364:11 401:7
<b>effective</b> 33:13,19	<b>elimination</b> 31:19	<b>energy</b> 8:20	<b>essential</b> 298:14
56:11 59:3 111:7,8	<b>Elisa</b> 2:17 9:7 16:5	<b>enforces</b> 335:10	305:10 374:21 385:16
127:2 326:12 361:3	103:8	<b>engage</b> 146:4 334:11	<b>essentially</b> 81:22
<b>effectively</b> 8:19 57:14	<b>ELIZABETH</b> 2:12	<b>engaged</b> 44:15 67:2	178:16 207:11 259:6
137:8 180:16	<b>Ellen</b> 1:14 3:6 57:13	197:8 322:16	284:14 346:17 379:7
<b>effectiveness</b> 288:18	103:9 104:6,8 276:7	<b>engagement</b> 21:21 33:4	<b>establish</b> 82:1 217:17
<b>efficacy</b> 223:20 280:16	357:18,22 361:7,10	34:9 111:6 277:10	369:15
281:16	<b>Elliott</b> 2:8 11:2 15:6,6	332:6 335:15	<b>established</b> 191:12
<b>efficiency</b> 155:10	80:14 330:5	<b>English</b> 273:18,21	259:11 325:18
<b>effort</b> 91:10 114:13	<b>EM</b> 236:11	<b>enhance</b> 381:6	<b>estimate</b> 270:15 359:11
125:1 130:11 148:13	<b>email</b> 200:19 206:2	<b>enhancing</b> 317:21	<b>estimates</b> 270:11,12
149:17 334:12 399:22	216:4 306:16 396:8	<b>enjoy</b> 330:2	<b>et</b> 335:21 366:9,9
<b>efforts</b> 27:1 80:9 100:14	396:17	<b>enormous</b> 98:6	<b>ethnic</b> 98:11
122:14 131:14 137:14	<b>embark</b> 150:5	<b>enrolled</b> 157:19	<b>Eugene</b> 2:9 15:4
151:3 340:16 352:7	<b>embarked</b> 119:17	<b>enrollee</b> 98:8	<b>evaluate</b> 38:1 207:10
399:21 401:10	369:22 370:2	<b>ensuing</b> 204:19	213:18 371:12 379:10
<b>EHR</b> 172:14 180:18	<b>embarking</b> 152:2	<b>ensure</b> 107:15 124:21	<b>evaluated</b> 64:19 85:1
202:15 203:5,14	<b>embarrassed</b> 392:8	185:15 314:10 356:7	370:16 386:9
294:11,14,18 295:1	<b>embrace</b> 54:21 100:2	360:12 364:19	<b>evaluating</b> 168:20
<b>eight</b> 25:10 363:21	263:19	<b>ensuring</b> 103:20 127:1	210:18
<b>eighties</b> 296:4	<b>emerge</b> 372:1	277:20	<b>evaluation</b> 350:6
<b>either</b> 36:14 55:15	<b>emerging</b> 209:11	<b>entail</b> 370:8,16	372:20 376:3
81:10 162:14 169:1	<b>emotional</b> 279:3 314:8	<b>entailed</b> 235:19	<b>evenly</b> 159:7 386:19
181:7 195:18 203:11	<b>emphasis</b> 56:15 88:18	<b>enter</b> 101:13 335:22	<b>event</b> 216:18 282:17
203:18 210:4 217:3	198:13 209:12	<b>entered</b> 26:4	<b>events</b> 134:20 362:13
219:5 226:20 230:3	<b>emphasize</b> 318:1	<b>enthusiasm</b> 105:22	362:15,16
293:18 305:11 307:8	356:22	<b>entire</b> 127:16,18 188:17	<b>eventually</b> 392:20
322:17 328:12 342:18	<b>emphasized</b> 194:5	399:21	<b>everybody</b> 29:4,10,17
365:21 366:17,20	356:11 375:6	<b>entirely</b> 62:5	56:13 61:4 64:3 66:10
378:22 388:17 393:21	<b>emphasizing</b> 249:13	<b>entities</b> 376:21 377:7	66:11,19 67:2 150:13
<b>elaborate</b> 282:7	<b>employee</b> 11:13	377:10	171:4 173:14 188:17
<b>elder</b> 337:3	<b>enable</b> 108:7 109:9	<b>entity</b> 202:16 328:4	198:1,16 203:15
<b>elderly</b> 187:10 314:19	111:2 124:12	376:7 379:15	274:14 276:14 286:8
<b>electronic</b> 107:22	<b>enabled</b> 99:2	<b>environment</b> 8:21 69:3	286:11 299:17 304:17
217:21 292:19 293:2	<b>enabling</b> 318:15	121:1 187:19	308:6 361:17 387:18
294:20	<b>encompassed</b> 122:16	<b>environmental</b> 123:5	<b>everybody's</b> 68:16
<b>electronically</b> 129:14	123:3	369:22 370:2,5,15	<b>everyone's</b> 148:4 172:4
293:3 294:2 295:5	<b>encountered</b> 197:5	<b>epidemic</b> 336:13	<b>evidence</b> 41:7 77:7
<b>element</b> 107:20 116:16	<b>encourage</b> 66:20 100:2	<b>episode</b> 35:12	213:19 357:2,5 372:3
116:19 117:12 127:18	145:15 178:20 204:14	<b>episodes</b> 345:12,18	375:14,19 376:17
133:7 159:11 287:22	290:13	<b>equity</b> 4:19 22:7 34:8	<b>evidence-based</b> 77:2
352:22	<b>encouraged</b> 30:22	34:10,12,13 35:6	<b>evolution</b> 106:19
<b>elements</b> 27:18 106:2,7	<b>encouraging</b> 160:17	59:12 305:9 307:8,12	<b>ex</b> 12:4
110:6 112:4 115:21	<b>end-of-life</b> 33:7 295:11	307:16 344:1	<b>exactly</b> 50:15 85:8
117:16 118:21 119:22	321:13	<b>Erin</b> 2:18 7:3,9,16 8:8	110:1 125:18 179:21
121:20 122:13 125:11	<b>ended</b> 384:8 386:21	9:11 18:6 22:19 23:18	210:12 259:13 281:20

333:16  
**examine** 390:16  
**example** 30:3,5 32:17  
 34:17 36:21 38:17,20  
 39:4 45:2 46:13 50:20  
 53:22 84:19 110:8  
 117:18,19 118:2,6  
 131:12 138:19 141:9  
 143:12 167:15 175:22  
 199:7 203:9 268:20  
 270:4 293:17 366:10  
 384:4,20 385:8  
**examples** 48:1  
**exceed** 240:19  
**excellent** 23:14 69:5  
 104:5,18 141:8  
 171:11 222:7 246:12  
 379:2 396:4 397:18  
 398:10 401:5  
**exception** 251:7  
**excess** 10:7  
**exchange** 109:9,15  
 193:3 294:21  
**exchangeability** 108:7  
**exchangeable** 110:20  
**exchanged** 193:9 295:4  
**excited** 5:8,9 6:2,18  
 22:12 23:12 24:14  
 67:14 69:11 73:15  
 74:19 76:7 102:14  
 106:13,13,14 173:15  
 173:19 177:15  
**exciting** 8:13 9:1  
 345:21  
**exclude** 238:22 240:3  
 248:7 253:1,20  
**excluded** 83:9 240:4  
 243:18  
**excluding** 222:14  
 236:10 241:9  
**exclusion** 250:19,20  
 251:13 377:4  
**exclusions** 236:7  
 237:13,14 239:4,12  
 239:17,22 240:7,8  
 241:16,21 242:9,10  
 242:15 252:5,15  
 268:21  
**excuse** 31:2 215:14  
 270:22 272:18  
**executive** 15:16 103:14  
 123:10 180:4  
**exempt** 16:1 186:10  
**exercise** 311:16 332:11  
 332:20  
**exist** 50:9 162:8 229:19  
 389:4  
**existence** 113:11

**existing** 37:13 42:21  
 51:11 138:2 139:15  
 162:19 227:7,21,22  
 228:3 229:6 257:10  
 294:7 326:16 346:21  
 371:3  
**exists** 98:20 113:20  
 280:19  
**expand** 137:9 139:21  
 140:4  
**expanded** 65:21  
**expanding** 285:7  
**expands** 394:12  
**expect** 10:2 298:19  
 355:13  
**expectation** 366:12,13  
**expectations** 292:13,14  
**expensive** 56:22 60:12  
 329:18 340:2 342:2  
 343:8 394:7  
**experience** 14:6 20:13  
 33:8 223:19 235:1,6  
 235:11,13,20 236:4  
 239:2,17 241:7 244:8  
 244:9,11,16 245:15  
 246:17,22 251:11  
 258:8,12 259:10  
 261:14 263:16 278:19  
 279:8 282:5 283:6  
 290:7,10 296:20  
 300:22 301:1 304:1  
 304:13 312:8 314:2  
 315:11 321:13 327:6  
 333:7 389:16  
**experience-of-care**  
 332:5  
**experienced** 251:5  
 296:2  
**experiences** 87:14  
 236:9 273:16  
**experimenting** 254:19  
**expert** 119:18 121:8,10  
 121:12 146:13 151:8  
 152:21 153:2 154:4  
 181:16 296:5 397:22  
**expertise** 6:3 43:14  
 217:11 251:3  
**expertly** 401:8  
**experts** 2:7 9:20 11:3  
 14:2 15:3 147:19  
 305:1  
**explain** 155:15  
**explaining** 218:2  
**explicit** 227:13 239:20  
 239:22 240:9 250:14  
 250:16  
**exploration** 118:16  
**explore** 164:1 199:18

246:22 257:11  
**express** 178:9  
**expressing** 117:20  
**expression** 134:6  
**extensive** 56:21  
**extent** 47:3 49:5 83:9  
 91:16 113:12 353:4  
**extra** 89:17 396:9  
**extraordinary** 136:6  
**extreme** 63:10,20  
**extremely** 67:14 73:15  
 89:15 90:17 246:8  
 320:11  
**eye** 6:15

---

**F**


---

**FAAN** 2:7  
**fabulous** 64:6  
**face** 171:22 265:14  
**faced** 47:13 88:7  
**faces** 23:20,21  
**facets** 126:19  
**facilitate** 7:6 109:12  
**facilitating** 399:21  
**facilities** 51:8 52:2 99:4  
 107:1,2,9,12 113:6  
 115:8 128:22 129:1  
 129:13 131:4 141:10  
 156:20 175:11 196:16  
 196:21 222:12 237:1  
 241:10 242:1,7  
 245:14,17,18 248:11  
 249:16 251:11 254:19  
 278:22 280:18 281:3  
 281:9 283:21 329:21  
 331:2,4 333:22 334:9  
 335:18 362:14  
**facility** 4:12 21:2 36:15  
 50:13 114:9 115:8  
 129:7 132:14 175:18  
 178:13,19,22 181:19  
 181:20 187:2 189:19  
 189:22 195:15 196:12  
 196:15 203:13,13,14  
 204:3 221:11 243:2  
 243:17 245:20 246:1  
 246:3,6,10 274:20  
 281:12 285:18 286:9  
 296:17 297:8 299:16  
 322:10 330:9 336:15  
 387:10  
**facility-based** 175:16  
 175:17 185:7,18  
**facing** 6:1 66:13  
**fact** 120:16 121:21  
 137:19 178:17 180:10  
 190:12 191:8 241:1  
 273:19 328:21 385:9

388:4 389:3  
**factor** 28:22 90:10  
**factors** 54:17 81:3  
 379:10  
**failed** 325:19  
**failure** 118:8 222:11  
 325:17 330:22 338:2  
 338:22 384:11 394:16  
**fair** 72:5 187:11,12  
 247:20 248:11 377:5  
**fairly** 350:12 374:19  
 384:18 388:22 389:6  
 394:7  
**fairness** 374:6  
**faith** 265:11  
**fall** 46:4 211:11,22  
 222:20 281:18 358:4  
**falling** 216:2  
**falls** 158:12 328:20  
**familiar** 23:20 30:14  
 34:18 112:14 113:4  
 141:2,4 309:12 351:3  
**families** 1:18 103:10,15  
 163:10,18 164:17  
 252:19 283:8,21  
 313:4 314:11,14  
 316:6  
**family** 33:4 111:5 131:3  
 163:21 164:11 169:2  
 174:18 232:21 233:1  
 236:13,22 238:7  
 241:7 244:14,20  
 277:9 296:3,9,20  
 310:18 318:1,3,7,9  
 332:6 335:8  
**family-centered** 209:12  
**fantastic** 180:19  
**FAOTA** 1:21  
**far** 9:6 114:16 228:16  
 240:19 256:4 257:13  
 264:1,1 336:1 396:13  
**farther** 216:2 315:18  
**fashion** 162:9 277:21  
**fast** 76:16 106:17 116:2  
 205:7 378:5  
**faster** 248:21,21 355:3  
**fatigue** 152:16 153:9  
**fault** 386:11  
**favor** 275:13 276:4,7,8  
 276:10  
**favorites** 134:10 135:5  
**FCC** 99:2  
**FDA** 152:1  
**fear** 204:2  
**feasibility** 122:5,17  
 123:8 129:17 152:8  
 159:6,8 164:8 354:17  
 355:5

<b>feasible</b> 108:1 125:17 127:3 147:7 157:14 158:3 396:13	252:15 271:18 272:3 292:7 349:12 368:7 389:1,4 392:20	368:16 371:1 372:17 372:19 374:8 378:11 380:4 381:16 388:18	394:8 398:9,17
<b>feature</b> 146:7	<b>figured</b> 177:19	<b>fiscal</b> 123:15 325:19 326:2 331:13	<b>follow</b> 211:12 262:9 263:11 284:20 381:15
<b>federal</b> 2:10 16:17 17:5 76:6 88:16 325:18	<b>figuring</b> 144:1	<b>fit</b> 48:9 126:21 132:21 209:6 310:4 337:11 375:12	<b>follow-on</b> 380:2
<b>fee-for-</b> 222:16	<b>file</b> 217:21	<b>fitting</b> 310:8	<b>follow-up</b> 60:8 64:19 131:18
<b>fee-for-service</b> 331:8 338:8 369:18	<b>fill</b> 166:12 238:3,11,14 238:18 252:19 271:19 368:6	<b>five</b> 79:3 81:21 112:4 133:18 194:1 226:21 254:10,11 257:16,22 258:2 259:4 268:1,4 287:1 296:16 359:13 363:1	<b>followed</b> 291:20,21 294:5
<b>feedback</b> 27:4,13 33:11 35:17 37:20 39:20 41:6,6 44:21 58:11 125:21 131:17 153:8 154:6 168:3 173:10 173:18 174:2 176:16 177:14 179:21 198:20 204:7 206:4 207:17 212:1 213:3,21 216:3 216:11 252:9 350:4 350:20 373:1 391:8 399:16	<b>filled</b> 238:21 248:8 311:18	<b>five-minute</b> 348:18,22	<b>following</b> 97:20 112:4 119:7 123:21 152:11 152:14 227:11 326:10 331:17
<b>feedbacks</b> 237:8	<b>filling</b> 238:14 271:5 319:18	<b>five-percent</b> 64:20	<b>follows</b> 240:21
<b>feeding</b> 115:5 134:22	<b>fills</b> 251:1	<b>fix</b> 82:4,5 181:3 287:6,8	<b>followup</b> 277:15
<b>feeds</b> 38:10	<b>final</b> 45:11,13 100:16 326:2 331:13 352:22 367:10 368:4 379:5 392:22	<b>flavor</b> 79:13	<b>food</b> 150:1 170:17 344:12
<b>feel</b> 47:16 66:11 72:20 77:2 88:12 105:14 136:9 174:3 176:14 184:20 187:1 220:1 244:18 251:6 269:18 278:17 316:7 318:16 318:20 350:18 367:12	<b>finalize</b> 39:14 123:20 125:2	<b>flexibility</b> 183:4	<b>fool's</b> 181:1
<b>feeling</b> 201:12	<b>finalized</b> 128:20 156:13 221:3 326:1 331:12 363:13	<b>flights</b> 216:8 401:3	<b>foray</b> 76:22
<b>feels</b> 47:17 168:18 181:22 207:12 266:19 335:14	<b>finally</b> 22:8 52:14 57:8 70:15 72:5 75:10,21 77:14 78:22 175:13 245:13 314:5,5 376:21 377:14 381:3 381:15	<b>flip</b> 342:5	<b>force</b> 2:14,15 231:13 249:18
<b>fell</b> 299:22	<b>financial</b> 84:3	<b>floated</b> 79:8,9,20 80:6	<b>forced</b> 74:11 191:7 259:14,16 260:7
<b>fellows</b> 195:6	<b>find</b> 57:9 98:12 140:2 154:8 159:9 234:9 277:8 287:2	<b>floor</b> 1:10 208:10 219:2 333:5	<b>forecast</b> 177:4
<b>felt</b> 68:18 83:1 87:11 167:19 201:11 248:12 374:19 382:7	<b>finding</b> 57:9 120:16 121:21 131:21 158:16 159:10 166:11 334:13	<b>Florida</b> 334:4	<b>forefront</b> 81:4
<b>fence</b> 264:18	<b>findings</b> 150:20 151:7 160:2 370:22	<b>flowing</b> 193:6	<b>forget</b> 74:14 95:8 97:4 130:6 292:12 296:21
<b>fewer</b> 71:11	<b>fine</b> 231:9 238:20 242:5 296:16	<b>flu</b> 360:19 361:12	<b>forgot</b> 253:21
<b>field</b> 105:13 116:4 119:10 128:7,8 131:17,22 160:6,12 169:14 371:10 372:18 375:22 381:7 399:5	<b>finish</b> 200:1 296:6 368:13	<b>fly</b> 204:5	<b>form</b> 10:13 14:3 236:12 236:16 382:21 383:2 383:7,15
<b>Fife</b> 2:8 15:14,14 40:9,9 60:1 63:4,8,13,17,22 67:19 180:2,2 185:19 188:10,15 202:13 205:4,17 328:20 333:3 344:9,17 382:16	<b>firm</b> 16:12 329:22	<b>focus</b> 21:19 26:12 27:5 31:9 37:8 43:13 51:11 80:4 83:12 119:4,19 121:6 125:22 131:7 148:2,15,19 152:4 155:2 164:2 193:22 214:7 237:2,12 255:3 255:12 318:10 321:5	<b>formal</b> 212:2 218:21 219:20
<b>fifth</b> 17:2	<b>first</b> 7:4 8:4 9:17 17:8 26:4 32:3,4,17 55:6 70:7,19 76:14,22 77:9 83:16 89:14 90:6 95:16 106:18 118:19 120:7 135:17 136:17 138:7 153:2 173:13 174:10 189:4 190:3 208:16 218:11 230:18 231:5 267:4,16,22 274:3 275:1 287:16 293:1 294:13 312:20 319:9 323:14 324:4 333:15 346:15 347:1 350:21 361:11 362:3	<b>focus-in</b> 309:7	<b>formality</b> 218:13
<b>figure</b> 168:1 186:20 187:15 190:1 248:2		<b>focused</b> 23:9 122:1 123:9 181:18,19 182:21 188:21 201:9 290:13 357:11 369:2	<b>formed</b> 73:17
		<b>focuses</b> 44:5 244:16	<b>former</b> 86:21
		<b>focusing</b> 26:21 78:10 84:9 116:10 127:4 132:16 133:3 148:12 245:1	<b>forth</b> 25:15 111:17 142:14 218:9 265:8 303:20
		<b>fold</b> 72:15	<b>fortunate</b> 7:19 175:13
		<b>folks</b> 7:20 19:1 32:10 34:18 35:21 36:1 39:15,21 45:1,5,18 52:19 70:4 73:3 76:8 76:9 77:4 85:11 123:6 129:15 131:16 165:14 166:8 167:17 189:2 220:11 236:3 285:1 307:5 334:11 394:2,5	<b>fortunately</b> 384:18
			<b>forum</b> 1:1,10 42:4 130:20 131:20,22
			<b>forward</b> 8:1 9:1 34:21 40:7 45:20 58:22 63:5 70:4 78:20 85:9 115:22 123:15 124:22 125:3 126:7 161:14 169:20 176:15 177:10 178:3 179:17 198:20 215:5 216:15 217:13 221:16 223:4 264:1 267:14 274:9 276:17 279:20 290:17 320:2 339:7 347:8 354:6 372:20 378:5 397:21 399:3,5
			<b>foster</b> 21:9
			<b>found</b> 64:20 124:8

135:11 147:4 151:2,8  
 152:19 154:18 155:22  
 158:2 159:11,14,22  
 168:4 200:18 204:1  
 228:22 234:17 291:2  
 298:13 386:14  
**foundation** 40:5  
**foundational** 40:17  
 184:14 185:6 372:13  
**foundationally** 43:8  
**four** 67:6 131:1 140:17  
 140:19 145:1 165:10  
 165:15,16 172:12,16  
 209:16 336:19  
**fourth** 59:6  
**FPCN** 2:7  
**FQHCs** 70:13  
**fragmented** 186:11  
**frame** 40:7 333:17  
 334:16  
**framed** 381:17  
**framework** 4:4 19:16  
 23:17 26:7,8 27:3,10  
 30:11 31:7 37:3 38:4  
 39:1 42:20 44:4,8,19  
 45:18,19 46:1 47:20  
 48:6 50:1 52:12 57:2  
 57:8 58:9 91:12,16  
 120:18,21 345:4  
**framing** 350:11 353:6  
**frankly** 241:21 371:5  
**Fred** 103:14  
**Frederick** 1:18 103:10  
 191:21,22 198:15,18  
**free** 220:1 350:18  
**frequency** 134:19  
**frequently** 289:13  
**front** 10:8 320:17  
**frontier** 95:14  
**frustrated** 186:1  
**frustrating** 65:10  
 358:21  
**FUHM** 2:8  
**full** 22:11 44:8 154:17  
 163:1,4 178:4 208:3  
 240:8 391:9  
**full-time** 11:13  
**fully** 211:7 250:22  
**fun** 247:15  
**function** 112:5 117:18  
 117:19 123:1,21  
 149:8 152:15,15  
 153:5,8,9,17 160:19  
 162:3 179:5,11 275:8  
 290:7,11  
**functional** 33:8 89:16  
 112:5,16,19 114:21  
 115:2 123:19 139:18

148:7 158:14 223:7  
 245:8 342:13 360:11  
**functioning** 123:10  
 152:17  
**fundamental** 88:8  
 188:1 288:7 375:3  
**fundamentally** 81:19  
**funded** 69:21 74:18,20  
**funding** 177:4  
**funny** 386:5  
**further** 13:4 75:4 113:8  
 165:6 199:18 260:21  
 261:5 263:19 272:11  
 273:22 320:12,22  
**future** 8:2 22:22 74:21  
 78:13 85:17,19  
 103:20 105:13 131:14  
 147:12 161:8 163:22  
 164:10 177:7 226:6  
 226:12 258:7 264:14  
 268:6,21 279:14  
 280:12 319:14 326:11  
 331:18 399:1  
**fuzziness** 213:11

## G

**gain** 148:5 259:10  
 261:14  
**gained** 296:16  
**game** 61:1 194:3  
 390:20  
**gamut** 123:17 147:22  
**gap** 61:19,20 65:19  
 166:5 204:20 251:1  
 260:11,12 271:19,20  
 279:10 285:10,14  
 287:1 292:8 297:3  
 298:1,19 313:7 316:1  
 317:2,14 319:1 322:7  
 324:21 328:18 332:9  
 339:1 356:18  
**gaps** 20:16 21:4,10,15  
 27:14 38:7 75:9  
 121:17,18 139:22  
 173:10 207:9 223:18  
 277:4,9 278:8,19  
 279:1,7,11,13,19  
 280:4,9,10 285:20,22  
 293:18 295:9 299:18  
 300:9,15 301:22  
 302:1 303:22 304:10  
 307:9 310:9,14,22  
 311:11,13,15,20,21  
 312:19 314:7 315:4  
 316:17 319:18 320:10  
 325:9 326:20 327:12  
 327:13,14 330:13  
 332:4,11,13,21

337:15 338:20 339:6  
 339:18 345:3 346:12  
 347:14,15 399:5  
**gateway** 134:10  
**gather** 24:18 69:1 119:5  
 138:6 249:21  
**gathering** 118:19  
**geared** 245:10  
**Gene** 10:20 55:2 58:2  
 90:8 146:3 158:10,11  
 256:12 333:14 339:14  
 341:21 344:17 346:11  
 363:19  
**general** 71:21 100:9  
 119:12 153:6 225:18  
 234:17 244:5 286:1  
 304:7 311:3 334:1  
 363:22  
**generalized** 129:11  
**generally** 226:9 351:14  
 369:8  
**generate** 114:7  
**generated** 48:20  
**generation** 48:18 367:7  
**generations** 21:14  
**generic** 283:18 286:6  
 303:22  
**generously** 396:18  
 401:4  
**gentlemen** 397:5  
**geographic** 71:1 82:22  
 128:10  
**Geppi** 400:13  
**geriatric** 2:1,5 11:20  
 96:8  
**geriatrician** 389:15  
**geriatricians** 147:20  
**geriatrics** 13:19 66:14  
**Gerri** 1:11,13 6:20 8:3,4  
 16:3 22:20 23:19  
 24:15 44:16 99:11,13  
 104:20 206:17 260:4  
 298:16 305:21 311:7  
 353:12 397:1 398:2  
 399:20 401:8  
**getting** 8:12 26:2 37:21  
 68:12 92:3 161:11  
 185:15 190:21 201:6  
 201:21 221:18 245:4  
 249:14 251:15,16  
 256:1 261:1 263:15  
 269:2 278:1 292:4,21  
 293:18 296:17 298:4  
 298:18 319:3 320:13  
 322:14 323:12 327:17  
 352:2 359:16 360:4  
 391:17 393:15  
**GG** 148:7

**Giff** 225:10 230:6 260:4  
 260:18 269:22  
**Gifford** 3:2 221:13  
 225:17 230:8,12  
 231:9 232:17 233:10  
 233:19 236:19 242:11  
 242:21 243:5,14,16  
 244:1 246:16 247:14  
 248:19 250:1 251:22  
 253:8,19 254:22  
 256:21 258:18,20  
 259:22 261:4 264:5  
 267:13 276:18 313:21  
**gift** 113:18  
**girl** 182:18  
**gist** 342:4  
**give** 14:9 49:17 53:21  
 58:10 60:7,13 75:18  
 76:12 78:15 79:1  
 81:21 100:16 105:6  
 106:8 119:5 133:8  
 150:19 151:22 152:18  
 167:18 169:8 170:10  
 175:3,22 185:8  
 186:18 208:7,17  
 214:6 216:4 231:17  
 249:7 251:10 252:4  
 259:18 296:10,13  
 299:5 301:22 355:7  
 368:15,20 386:4  
 394:9 396:9 398:21  
 401:4  
**given** 5:6 33:21 163:8  
 163:12 183:21 208:6  
 208:20 212:6 235:22  
 236:1 241:1 332:9  
 333:9 375:17  
**gives** 40:6 77:1 295:13  
**giving** 69:14 182:22  
 194:1 207:16 301:21  
 335:8  
**glad** 7:2 40:11,14 242:8  
**gleaned** 125:15  
**global** 135:3 151:1  
 155:10,16,20 156:9  
 156:12 157:14,19  
 159:15,21 160:6  
 189:17 192:2 220:21  
 380:22  
**glycemic** 203:11,19  
**go-** 17:8  
**goal** 50:1 54:14 128:22  
 146:8,8 156:21  
 190:15 208:17 343:9  
 376:15  
**goals** 6:21 27:8 33:7  
 47:18 148:6,8,9,18,19  
 148:21 295:14 373:15

373:22 375:9 398:20  
**God's** 299:7  
**gold** 124:16,17 126:3  
 128:6 129:14 132:3  
 146:13 147:5 373:20  
 378:19  
**gotten** 44:18 51:18  
 229:21 241:12 284:12  
**Gotwals** 1:15 222:2,2  
 275:22 276:3,4  
**GOVERNMENT** 2:10  
**governor's** 192:21  
**governors** 192:9,9  
**grabbed** 345:20  
**grade** 237:6 273:17  
**Graham** 229:14 230:6,9  
 248:18  
**Grant** 1:16 12:9,9 90:20  
 234:6 297:21  
**grants** 14:11  
**granular** 47:22 190:2  
 284:2 286:7,12  
 311:17  
**granularity** 41:5  
**graphic** 30:13 65:15  
 119:11 128:12  
**grappling** 288:22  
**grateful** 104:14  
**greater** 116:19 124:12  
 216:22 220:6 371:20  
 373:2  
**greatest** 193:16  
**greatly** 396:11  
**Gross** 400:10  
**ground** 385:15  
**grounding** 373:12  
**group** 5:11,15,17 15:7  
 17:12 19:18,19 20:7  
 20:10,14,17,21 21:15  
 21:18 22:2,10 24:2  
 50:6 61:7,10 72:11  
 79:2 85:12 88:22 89:9  
 100:2 175:20 180:13  
 188:12 189:5 195:21  
 213:8 218:12 232:12  
 237:2,20 252:10  
 258:14 263:21 278:7  
 343:15 364:2  
**group's** 306:13  
**grouped** 31:14  
**groups** 84:18 96:16  
 97:15,18,19 119:19  
 121:6 125:22 131:7  
 143:17 166:18,19  
 179:2 184:8 237:12  
 314:21 392:16  
**grow** 53:21 230:11  
**growing** 57:10

**grown** 314:22  
**guarantee** 164:10  
**guarantees** 225:15  
**guardian** 238:10,11  
**guardians** 236:12  
**guess** 44:7 53:10 93:10  
 115:20 153:12 234:9  
 235:2 247:9 290:7  
 300:10 311:12 317:21  
 339:19 343:14 385:17  
**guessing** 261:19  
**guidance** 4:17 20:14  
 76:17 78:16 211:12  
 213:15 214:6 265:6  
 305:7 380:3 381:12  
**guide** 194:4 217:20  
 220:20 224:16 372:19  
 374:13 376:1 377:6  
 378:13,20 379:7,10  
 381:5  
**guided** 121:20 373:11  
**guidelines** 95:17 351:2  
**guiding** 73:21,22 75:2  
 141:12 154:3 372:14  
 372:16 373:7 374:11  
 374:17

## H

**habit** 284:13  
**hair** 67:19  
**half** 133:21 156:8,11,15  
 156:17 157:1,11  
 346:14 363:7  
**half-a-year** 323:18  
**Hall** 2:12 12:3,4 17:7,8  
 98:16 109:8 293:7  
 343:13  
**hand** 20:19 39:2,2  
 58:18 80:11 199:10  
 220:8 274:5 275:14  
 275:17  
**hand-in-hand** 162:19  
**hand-offs** 77:22  
**handheld** 129:15  
**handled** 333:11  
**hands** 220:11 275:15  
 275:18  
**handshake** 289:14  
**hang** 279:3  
**hanging** 287:8 398:9  
**happen** 24:8,12 81:1  
 85:3 94:21 143:3  
 184:5 201:17 203:4  
 341:20  
**happened** 54:2 201:14  
 360:17 392:7  
**happening** 7:14,15  
 25:20 162:14 269:9

341:16  
**happens** 182:2 186:6  
 292:22 295:21 297:9  
 297:12 315:6,10  
 384:5  
**happy** 24:5 32:9 120:19  
 134:4 135:14 179:13  
 194:12 200:19 205:12  
 205:15 216:5 241:18  
 298:15 389:22  
**hard** 26:19 49:7 51:5  
 57:9 187:13 226:13  
 235:17 298:18 303:16  
 319:19 344:14 376:8  
**harder** 29:18  
**hardest** 252:14  
**harm** 32:6 362:15 386:7  
**harmonization** 49:10  
 52:15 232:4 353:3  
**harmonize** 161:2  
**harmonizing** 232:8  
**hat** 226:15 227:4 264:6  
 264:6 267:10 290:9  
 290:21 395:10,11  
**hate** 162:20 163:13  
**hats** 266:6  
**head** 38:19 46:18 53:11  
 92:5 352:5  
**head-banging** 184:1  
**heading** 6:12 352:4  
**heal** 346:4,5,5  
**health-** 50:21  
**health/behavioral**  
 328:8  
**healthcare** 1:21 8:18  
 10:22 11:14 26:4 32:6  
 35:11 43:21 44:2,9,22  
 66:10 86:12 103:17  
 112:12 135:2 288:5  
 310:10 360:20  
**healthcare-** 32:17  
**healthcare-acquired**  
 47:14,22 48:2  
**healthcare-associated**  
 32:5  
**HealthSouth** 1:14  
 103:10 104:9  
**healthy** 34:7  
**hear** 22:18 45:12 52:16  
 54:20 55:6 58:1 91:1  
 101:15 105:3 118:10  
 131:11 133:7 134:17  
 170:3 173:18,20  
 174:6 179:22 198:8  
 198:14,15 204:8  
 206:6,22 216:5 230:6  
 234:19 293:17 339:21  
 340:21 357:20

**heard** 17:11 23:11 25:6  
 25:9,12 26:13 28:10  
 43:19 56:19 57:3 67:6  
 108:9 116:1 118:4,6  
 127:6 132:8,9 194:10  
 211:22 212:7 213:3  
 341:2 349:11 385:13  
 390:17  
**hearing** 41:4 80:14  
 140:2 148:4 176:15  
 262:17 281:18 286:5  
 343:16 381:18  
**heart** 118:8 126:10  
 144:14 302:17 338:22  
 384:10 394:16  
**heartily** 324:15  
**Heather** 2:2 11:16  
 160:13 168:13 177:17  
 189:9 278:9,17  
 390:10  
**Heather's** 164:22  
**heave** 67:15  
**heavily** 91:7 168:2  
**heighten** 304:15  
**held** 138:22 152:21  
 153:3 384:9 395:19  
**Helen** 400:13  
**Hello** 11:16,19 12:3  
 13:5,15,17,18 15:9  
 16:20 18:13  
**help** 6:3 14:7 22:13  
 26:8 29:21 69:21  
 78:20 91:16 96:14  
 100:11 115:17 127:9  
 142:7 181:7 184:6  
 190:8 191:15 194:4  
 204:8 207:21 209:9  
 226:8 229:16 231:16  
 238:18 257:5 261:3  
 267:11 271:18 281:11  
 281:21 283:13 288:6  
 288:15 302:21 306:8  
 316:9 369:13 373:2  
 383:18 393:20 397:21  
**helped** 31:6 95:18  
 158:1 228:7 236:20  
 238:19  
**helpful** 26:17 31:6  
 35:18 49:13 51:13  
 53:5 161:7,13,16  
 198:13 204:7 232:7  
 258:4 287:14 323:6  
 359:16,17 368:3  
**helping** 8:9 322:22  
 398:2  
**helps** 51:15 62:9  
 111:22 391:18  
**hesitant** 161:20



**heterogeneity** 71:19  
 93:20  
**hey** 79:16 86:1 101:14  
 124:6 299:7 357:17  
**HHS** 121:13 164:7  
 211:18 293:11  
**Hi** 12:6 103:13 138:9  
 222:2  
**high** 46:13 60:12,20  
 61:16 87:21 183:20  
 191:17 193:1 196:2  
 203:10 246:8 262:13  
 326:11 331:18 356:11  
 365:13 392:10  
**high-** 223:3 338:17  
**high-impact** 27:21  
**high-level** 75:21 345:4  
**high-priority** 223:15  
 310:5,6  
**high-risk** 187:9  
**higher** 86:13 261:15  
**highest** 60:7 175:5  
 362:7,7,17,18 365:20  
**highest-scoring** 180:9  
**highlight** 173:10 198:2  
 378:9  
**highlighted** 373:19  
**highlighting** 222:21  
 223:6  
**highlights** 148:9  
**highly** 229:1 291:9  
 340:14  
**HIPAA** 296:15  
**hips** 246:5  
**historical** 229:7  
**historically** 105:20  
 274:5  
**hit** 83:5 120:2  
**hold** 59:17  
**holding** 131:7,20  
 287:17  
**home** 4:14 10:22 21:5  
 54:2,4 56:19 66:4  
 67:12 74:15 90:1,2,9  
 91:3,4,5,6 96:7,10  
 101:1,2 104:11 107:1  
 107:10 110:8 113:5  
 129:9 142:20 143:12  
 143:19 144:8 145:4  
 151:1 157:5,12,15,18  
 158:4,13,15,18,20  
 160:4 165:16 182:13  
 182:14 195:7,12  
 201:19,20,21 216:9  
 243:11,12 256:20  
 266:18 281:1 295:16  
 296:7 297:13,13  
 303:21 306:12 315:22

317:7 319:11 337:6  
 337:21 338:5 339:21  
 340:5,15,16,17 342:1  
 342:9 343:10 344:3  
 346:12,14,19,22  
 347:11 360:20 361:13  
 361:14 380:11 381:15  
 382:20,22 383:1  
 393:12  
**home-based** 95:13  
 101:1  
**homegrown** 229:1  
**homes** 97:17 110:22  
 194:16 241:2 256:18  
 333:21 395:13  
**homework** 306:8  
**honest** 397:12  
**honestly** 46:8 102:2  
**hope** 7:10,18 45:12,18  
 49:12 74:20 92:10  
 132:1 149:2 151:13  
 177:21 184:7 185:19  
 347:5 367:2 393:7  
**hopefully** 36:1 39:8  
 42:19 51:15 53:4 58:8  
 69:22 75:22 78:13  
 85:16 113:8 137:9  
 208:15 301:7 347:7  
**hopes** 183:21  
**hoping** 37:19 184:16  
 204:21 352:5 381:9  
 384:4  
**Hoppe** 1:17 13:1,2 86:5  
 281:15 282:9 283:5  
 322:3 334:19  
**horrible** 184:4 365:19  
 384:2  
**horse** 260:1  
**hosp** 386:7  
**hospice** 2:2,3 4:10 12:1  
 12:13 13:7 15:10,12  
 21:4 83:19 90:2 96:9  
 96:10 101:1,7 102:19  
 144:11,13 145:3  
 242:16,18,19 243:1  
 243:10,11,12,17  
 253:11 270:13 271:3  
 273:11 280:1 295:16  
 296:5,8 297:14  
 303:20 309:7,9,12,15  
 309:15,22 310:1,5  
 312:7 313:8,17,18  
 314:8,22 315:7,17  
 317:3,5,5,6,9,13,19  
 318:2,2,5,17,20  
 319:10 320:11,17,19  
 320:19 321:2,12  
 322:13,17,22 323:11

323:13 324:13,18  
 325:9 395:10  
**hospices** 101:4 270:21  
 270:22 324:3  
**hospital** 4:11 34:19  
 37:16 50:14 70:17  
 74:9 81:20 82:3 95:4  
 98:4 141:11 176:2  
 182:13 187:3,4 212:8  
 215:13 237:17,18,18  
 284:17 291:5,7  
 297:18 298:13,20  
 299:1,15,21 325:14  
 328:1 342:2,3,17  
 343:2 346:16,18  
 381:19 382:9,10  
 387:10,11 394:18  
 395:12  
**hospital-based** 382:3  
**hospitalizations** 346:18  
**hospitalized** 345:11  
**hospitals** 33:16 35:2,2  
 70:11 97:16 104:10  
 106:22 107:7 110:8  
 136:19,20 196:12  
 222:15 250:8 255:5,7  
 281:1 327:11 331:3,6  
 340:12 359:20 395:18  
**hour** 149:17 307:3  
 349:7  
**hours** 101:4,8 102:19  
 144:4,6 292:21 293:1  
**housed** 203:14  
**housekeeping** 18:18  
**houses** 101:11  
**housing** 192:15  
**Houston** 15:15 389:20  
**HQRP** 323:14,22  
**HRSA** 69:21  
**huge** 61:19 66:13 70:21  
 88:18 92:14 96:12  
 168:22 169:3 249:16  
 297:3 317:8 383:16  
**hundreds** 160:7  
**hungry** 88:10  
**hurry** 106:18  
**hurt** 384:20  
**hydration** 284:19

---

**I**


---

**IA** 203:4,13  
**IAs** 203:2  
**ICD-11** 329:6,8,10  
**ICU** 74:10,12  
**ID** 188:10,18  
**idea** 46:18 47:15,19  
 54:1,10 57:4 72:18  
 74:5 79:22 80:6 81:14

87:5 93:3 94:4 121:15  
 144:15 153:3 175:3  
 182:10,22 190:12  
 193:15 198:21 235:18  
 260:7 263:14 270:14  
 282:7 283:13 300:14  
 309:19 319:20 343:7  
 346:7,8 388:6  
**ideal** 126:17 190:15  
**ideally** 210:16  
**ideas** 117:20 167:15  
 170:3 176:22 231:17  
 300:19 301:9 319:8  
 353:8 367:6 392:1  
**identification** 337:14  
**identified** 166:22 195:3  
 210:1 213:12 223:19  
 231:20 232:10 235:10  
 251:1 279:8,11  
 285:10 300:9 304:11  
 310:7,12,15,22 314:7  
 316:17 317:14 321:7  
 321:9 326:10,20  
 331:17 332:4 338:19  
 338:21 347:14 371:19  
**identifies** 30:9  
**identify** 74:2 75:5 84:20  
 132:6 232:7 237:3  
 285:21 311:15 369:14  
**IHS** 89:5  
**II** 1:18  
**ill** 296:4  
**illness** 88:1 116:21  
**illnesses** 59:4  
**illuminate** 148:13  
**imagine** 169:10  
**immigrant** 98:11  
**imminent** 310:2  
**impact** 4:16 5:18,20  
 19:20 21:8 30:3 66:11  
 70:21 71:2 84:13 86:3  
 105:5,19 106:3,19,21  
 107:17 110:4 111:1  
 111:21 112:1 113:19  
 117:13,14 120:6  
 123:18 130:10 132:18  
 133:14 145:2,3  
 152:14 163:15 189:15  
 192:12 193:16 196:1  
 196:2,4,10 199:20  
 203:10 280:7 284:6  
 313:3 347:8 351:5  
 363:11 367:21 369:1  
 372:5  
**impaired** 159:4  
**impairment** 89:17  
 297:1  
**impairments** 112:8

114:21 118:9 122:21 122:22 124:1 132:22 <b>impetuses</b> 183:10 <b>implement</b> 172:7 <b>implementation</b> 4:16 19:20 80:9 212:19 374:22 <b>implemented</b> 211:18,21 213:13 223:13 <b>implementer</b> 371:7 <b>implementers</b> 376:4 379:9 <b>implementing</b> 254:20 373:10 <b>implications</b> 39:9 385:20 <b>implicit</b> 56:16 <b>importance</b> 137:7 168:14 294:21 343:17 356:6 371:13 <b>important</b> 14:18 26:20 29:6 31:17 49:9 56:20 58:7 77:2,7 81:3 86:22 88:3,14 89:12 89:13,15 90:17 92:22 93:19 97:3 116:6 122:2,8 137:5,11 138:14 141:14 142:3 148:6 153:20 159:10 160:20 161:4 164:3 166:22 167:5 168:19 169:1,17 174:8,18 175:5 177:1,2 179:20 182:1 184:21 185:17 188:2 195:18 200:3 235:6,9 247:3 250:17 280:11 282:18 284:20 292:2,16 293:5 300:10 304:2,3 314:2 314:12,17,19 315:20 315:21 321:22 346:13 350:20 367:16 371:1 371:16 391:19 394:22 <b>impose</b> 36:5 <b>impressed</b> 262:13 <b>impressions</b> 167:3 <b>improve</b> 26:5,22 45:17 89:4,7 107:16 108:6 136:12 189:19 255:19 285:1 314:15 355:8 381:4 391:16 397:21 <b>improved</b> 58:19 65:20 126:1 286:22 <b>improvement</b> 27:1,2 29:3,12 36:5,10 38:17 38:19 51:14 56:18 77:6 109:13 113:16 114:8,13,16 172:17	197:7,8,10 200:4,6,7 200:13 201:1,3 204:13 227:15 254:17 256:1,5 257:6,7 351:19 352:7 376:21 <b>improving</b> 6:10,17 31:22 106:11 122:2 190:6 288:17 295:3 352:1 <b>in-home</b> 102:19 <b>in-of-life</b> 284:15 <b>in-patient</b> 78:11 80:4 84:19 <b>inability</b> 193:5 <b>incentive</b> 20:3 60:22 93:5 172:2,7,15 203:21 343:7 389:17 <b>incentives</b> 24:1 291:10 <b>incentivized</b> 180:8 <b>incentivizing</b> 343:1,3 <b>incidence</b> 332:9 <b>incident</b> 358:15 <b>incidentally</b> 284:22 <b>include</b> 26:12 37:10,10 66:3 87:5 94:6 109:19 112:3 176:22 179:3 222:16 223:19 241:17 242:4 252:18 326:2 326:21 331:8 338:6 <b>included</b> 26:16 30:12 66:10 70:8 72:9,15 149:8 177:22 241:5 243:6,6,12 252:20 313:8 344:10 <b>includes</b> 129:19,21 173:2 283:21 329:15 331:3 <b>including</b> 29:6 32:21 33:5 76:10 89:6 93:22 108:15 124:21 133:1 146:16 192:14 388:10 400:9 <b>inclusion</b> 55:16 85:1 198:7 226:20 256:19 377:3 <b>incorporate</b> 57:7 161:12 215:17 <b>incorporated</b> 220:19 226:18 227:7,20 255:18 268:6 <b>increase</b> 98:18 359:21 <b>increased</b> 294:19,21 323:1 366:17 <b>increasing</b> 99:5 342:19 <b>incredibly</b> 371:16 374:3 <b>independent</b> 179:10 <b>independently</b> 178:11 178:12,17	<b>Indian</b> 89:1 96:19 <b>Indiana</b> 13:20 <b>indicate</b> 154:11 <b>individual</b> 10:6 30:20 33:1 50:17 51:6,6 97:14 114:20 115:18 169:1 174:21 182:2 189:11 190:7 235:22 244:14,20 257:1,2,3,5 321:16 364:20 <b>individual's</b> 112:18 <b>individually</b> 217:3 <b>individuals</b> 120:11 143:5,6 147:14 148:3 153:18 154:7 156:22 157:20 158:15 165:4 169:15 233:13,13 236:10 255:11 320:10 321:21 <b>indulgence</b> 145:21 <b>industry</b> 239:6 247:19 248:20 359:10 <b>infallible</b> 386:18 387:18 <b>infection</b> 32:20 54:10 332:8 386:13 <b>infections</b> 32:5,18 47:14,22 48:2 298:1,3 298:4 299:13 358:7 358:19 359:7 362:17 362:22 363:9,11,14 <b>influence</b> 105:13 377:10 379:16 <b>info</b> 279:9 <b>infographics</b> 46:5 <b>inform</b> 43:10 85:19 108:10 115:17 158:1 <b>information</b> 2:13 33:17 47:1 52:9 68:8 69:2 109:10,16 110:19 113:4 118:19 121:4 126:9 132:13 139:14 142:12 160:15 163:16 166:3 172:18 198:15 198:16 204:15 205:5 214:3 219:4 222:22 223:16,21 236:1 238:4 256:17 257:12 277:12,14,20 280:15 280:18,22 282:3,18 282:21 283:10,19 284:1 289:15 292:18 293:18,19,20 294:3 295:4 296:10 299:6,8 300:10 301:22 304:6 305:9 306:2 326:22 327:2,21 333:7 334:22 335:9,20 338:6 343:18,21	355:7,12 356:18 391:18 <b>information's</b> 142:2 <b>informed</b> 305:11 <b>informing</b> 111:16 <b>infrastructure</b> 98:20 99:6 <b>inherent</b> 240:3 <b>initial</b> 27:10 28:1 30:11 31:12 44:5 45:11,13 49:18 76:17 78:16 176:4 190:11 218:7 320:20 321:1 <b>initially</b> 136:12 <b>initiative</b> 25:16 48:18 49:7 102:20 126:11 255:2 <b>initiatives</b> 16:14 52:21 99:3 197:18 395:6 <b>injuries</b> 329:12 <b>injury</b> 123:19 329:3,15 <b>inner-</b> 82:2,13 <b>inner-city</b> 81:20 95:3 <b>Innovation</b> 2:2 13:7 83:20 <b>inpatient</b> 4:12 104:10 107:1,11 362:13 <b>input</b> 4:15 6:9 20:7,17 21:18 22:2,10 36:17 45:3,10,15 75:14,19 75:21 85:14 102:15 119:6 121:10,11 131:13 154:5 167:18 212:5 214:20 215:22 216:6 220:19 236:1 267:1 280:6 304:19 306:14,16,19 312:14 347:20 349:9 354:20 355:6 381:10 396:10 401:6 <b>inputs</b> 189:22 <b>inquiry</b> 81:9 <b>insecurity</b> 344:12 <b>insider</b> 175:2 <b>insight</b> 173:18 <b>insightful</b> 25:3 <b>insights</b> 169:3,9 <b>instance</b> 162:5 296:10 <b>instituted</b> 323:14 <b>institution</b> 195:13 <b>institutional</b> 328:4 334:15 <b>instructing</b> 318:14 <b>instruction</b> 318:11 <b>instructions</b> 126:1 145:6 <b>instrument</b> 110:1 115:1 140:5 142:20 143:22
---	---	---	---

144:13 148:20 263:16  
319:19 331:11 338:7  
**instruments** 107:3  
109:17,19 110:6  
112:2,15 113:11  
114:15 138:2,5,6  
140:4,8,17,17 141:18  
141:22 148:17 152:6  
227:21 228:1 229:1,6  
319:21  
**intact** 158:4  
**integral** 317:18  
**integrate** 94:6 334:12  
**integrated** 159:4  
**integrates** 99:17  
**integration** 192:13  
**integrity** 326:5 331:14  
380:8  
**intended** 376:5 378:20  
**intensity** 117:2  
**intensive** 340:2,11  
343:9  
**intent** 44:8 48:3 122:6  
145:13 148:19 149:1  
165:10 211:16 212:16  
306:19  
**intently** 215:8  
**inter-rater** 126:6  
**inter-related** 71:1  
**interact** 84:17  
**interaction** 75:15 80:3  
85:22 296:6  
**interchangeably**  
244:10  
**interdisciplinary** 96:5  
315:15  
**interest** 4:2 9:10,15  
14:20 33:10 57:10  
85:5 181:5 197:12  
211:9 216:1 222:1  
236:14 254:18 268:17  
307:7 351:14 357:6  
**interested** 76:13 103:20  
104:12 139:13 164:5  
199:17 269:11 270:2  
270:4 319:18 337:8  
337:13 376:10  
**interesting** 8:14 79:16  
98:13 198:19 239:16  
329:9 346:7 362:15  
384:20  
**interests** 10:1,2,7 14:2  
103:17,22  
**interference** 134:14  
**interfering** 26:2  
**intermittently** 13:13  
**internal** 233:7 256:10  
365:15 399:19

**internally** 45:16 256:7  
270:7 349:21  
**internet** 133:12  
**internists** 147:20  
**interoperability** 121:15  
294:12 295:2  
**interoperable** 109:7  
142:3  
**interplay** 185:14  
**interpret** 253:13 365:12  
**Interprofessional** 16:4  
44:11  
**interrupt** 308:3  
**intersection** 167:2  
**intersections** 167:7  
**intervening** 282:16  
**intervention** 204:4  
**interventions** 112:7  
115:3 118:2 123:1  
124:1 133:1 141:20  
284:16  
**interview** 134:13  
135:12  
**interviews** 125:22  
129:20 131:18 155:22  
**intimately** 351:3  
**intimidated** 345:6  
**intrigued** 247:7  
**introduce** 9:7 18:5  
103:11 150:3 173:6  
221:21 319:9  
**introduced** 17:8  
**introducing** 75:17  
**INTRODUCTION** 4:5  
**introductions** 9:9,14  
**introductory** 217:18  
**intuitively** 301:18  
**investigating** 342:20  
**invite** 68:17 302:8  
361:17  
**invited** 6:11 128:17  
**inviting** 177:13  
**involve** 149:5  
**involved** 48:17 54:18  
86:22 89:18 163:13  
163:15 180:18 235:22  
267:8 380:20 383:20  
384:8 385:10 388:16  
388:17  
**involvement** 196:2  
197:14  
**involves** 222:11  
**IOM** 290:2  
**Iowa** 288:4  
**Iowan** 102:18  
**IPPS** 326:2  
**IRF** 21:5 50:13 303:20  
330:17,18 331:1,2,3,3

331:4,7,10,13 333:8  
333:12 336:10 337:12  
357:20 358:10,12,14  
359:3,10 363:3,8  
**IRF-PAI** 107:12  
**IRFs** 129:8 145:4  
334:21 335:14,17  
358:12,13,15 359:8  
359:15 362:5,6  
363:12  
**irrelevant** 62:12 180:21  
**Isasi** 1:18 103:13,14  
104:3 192:1  
**islands** 86:20,20  
**isolated** 71:6,8 88:12  
**isolation** 71:1 82:22  
**issue** 49:20 57:7,19  
58:6 59:12,13 66:14  
89:15 92:14 185:7  
188:12 191:1,3,4  
212:13,18 237:21  
240:12 252:1 253:17  
265:2 266:9 278:1  
288:21 293:3 308:13  
309:3 336:14 341:6  
341:22 352:8 364:3  
**issues** 5:22 6:6 22:14  
46:22 47:7 57:13  
58:14,18 70:1,18 78:8  
89:18 94:13 99:6,18  
99:19,22 100:3 175:9  
185:10 206:7 215:18  
237:3 252:22 256:11  
271:16 276:16 277:13  
284:20 304:15 307:12  
315:12 342:13 345:9  
352:18,19 355:4  
368:7 380:4,7 381:13  
381:18 386:1  
**item** 23:5 122:4,5,7  
126:2,4,7 127:1 133:3  
135:9,10 138:21  
139:7,11,17 143:22  
143:22 144:21 145:5  
145:9,13,18 147:18  
147:19 148:1 150:14  
152:7 153:14 154:17  
156:2,3 167:16 171:6  
171:9 277:3 309:15  
313:18 320:17,20  
321:3 360:10 397:19  
**item's** 117:4 122:1  
139:15,16,16  
**items** 56:4 117:7 118:3  
118:14 120:9 121:1,4  
121:14,21 122:16,19  
122:21 123:4,5,9,14  
123:17,20 124:7,9,15

124:16 125:6 126:1,9  
126:19,21 127:8,9,10  
127:10,16,21,22  
129:21 130:17 131:17  
133:4,17,18,20 134:1  
134:9,13 135:10  
138:16,17,18,19,20  
139:3,4,5 144:2,16,22  
146:8,11,18,19 148:5  
148:11,13,18,21  
152:8 153:4,17,20  
154:1,3,10,12,12,17  
155:21 156:1 159:17  
161:13 164:21 167:11  
203:10 233:1 237:7  
319:21 320:1 347:6,7  
360:8,8,11 363:20,21

**IV** 134:21

**Iwugo** 38:18

## J

**JAMES** 1:18

**January** 153:3 212:11  
216:7

**jar** 193:18

**JD** 1:18

**Jean-Luc** 2:20 8:8 18:8  
206:15 211:15 281:21  
283:5 303:8 306:7  
309:10 400:1

**Jeneen** 38:18

**Jim** 12:15 65:11 97:8  
137:15 218:19 224:22  
225:8 230:13 274:7  
279:5 283:14 335:16  
386:1

**jive** 91:11

**Joan** 400:12

**job** 60:17 65:8 72:20  
142:19 287:8 299:1,2  
299:17

**John** 221:18

**Johnson** 2:19 6:11 69:9  
69:10 82:17 85:7  
91:14 93:7 102:5,14

**join** 5:8 9:2 22:12  
396:14

**joined** 103:7 105:20  
109:8 221:19

**joining** 6:19

**joint** 114:13

**jointly** 299:14

**joy** 103:18

**judge** 235:20

**judiciously** 212:20

**jump** 140:22 220:1  
221:9

**justice** 317:13

**justification** 208:21  
254:16

# K

**Karen** 2:19 6:11 69:6,10  
80:13 89:12 102:11  
324:11

**Kate** 264:15 265:14

**Kathleen** 2:5 13:15,17

**keep** 41:16,18 43:9 48:3

56:20 59:1,21,22 78:9

80:17 81:4 90:21

100:9,18 137:5 143:4

147:2 150:1,8 181:10

184:3 212:3 278:18

282:20 301:6,21

302:2 305:11 315:22

340:10 343:3 350:12

350:22 357:21 390:11

401:2

**keeping** 6:15 51:12

68:16 340:1 343:8

345:18 397:12

**keeps** 90:4 100:6

140:13 286:15 388:2

**Kelly** 400:11

**Kentucky** 291:3

**kept** 82:19 201:21

381:18

**key** 30:1,10 38:12 59:18

78:8 127:5 155:3

169:7 173:17 174:1

216:20 352:13,17,21

374:4

**keypad** 397:7

**kick** 309:10

**kicked** 181:10,15

**kicking** 128:14

**kidding** 205:10

**Kim** 2:8 15:6 80:13 99:7

330:4

**Kim's** 101:6

**Kindred** 1:21 11:13

**kinds** 57:12 71:5 73:3

92:7 115:6 193:4

262:20,21 310:2

340:17

**knew** 166:7 237:10

248:6

**knowing** 130:6 142:12

147:8 307:11

**knowledge** 117:10

202:9

**knowledgeable** 116:12

**knows** 57:13 90:8 91:22

214:4 274:14 380:19

**Kurt** 1:17,20 12:13 13:1

89:14 234:2 244:3

280:13 281:14 282:19  
283:16 285:4 320:4

322:2 334:18

**Kuwahara** 2:20 18:10

18:11 274:22 276:2,8

303:17 325:15 330:20

# L

**L-O-N-G** 205:14

**la** 351:5

**labeled** 130:7

**lack** 91:2 95:2 334:2

371:10 372:7 391:8

**lacking** 320:16

**Ladies** 397:5

**lagging** 169:6,9

**laid** 175:22 374:17

**LAN** 30:14 50:19

**land** 85:18 316:4

**landed** 102:17

**language** 47:9,10

243:22

**languages** 273:15

**large** 33:20 65:13 241:1

248:13 263:18

**largely** 260:15 371:4

**larger** 27:7 31:4 33:22

35:8 87:20 191:1

**lastly** 236:6

**latest** 169:4

**laughingly** 140:11

**laughter** 16:2 17:4 56:1

62:18,20 68:1 177:12

181:13 201:16 205:6

205:8,11,18,20

206:12 225:22 254:12

272:22 274:18 303:1

303:3,12 305:18,20

308:12 312:17 332:16

332:19 339:17 341:4

345:8 400:21

**launch** 7:22 171:8

**law** 106:16 107:13

109:5,18 329:21

**lay** 44:2 173:22 177:6

**layers** 383:19

**LCDS** 107:8

**lead** 9:9 86:19 171:10

206:15 208:9 219:22

255:21 267:11 319:10

337:22

**leader** 267:6

**leaders** 192:10

**leadership** 9:6 41:10

52:3,4

**leading** 291:13 401:8

**leadoff** 280:3

**leads** 78:3

**learn** 93:10 190:17

227:5 251:10

**learned** 125:14 324:15

**Learning** 30:14 41:22

**leave** 17:21 151:18

205:4 286:16

**leaves** 236:12 318:13

**leaving** 307:5

**led** 269:22 272:21 370:4

**left** 6:16 10:15 15:4

72:18 112:22 138:13

201:11,12 206:1

217:9 292:6 375:13

391:5

**left-58:17**

**legacy** 172:12

**legal** 236:11 238:10,11

**legislation** 369:1

**lend** 162:12 259:10

**length** 340:10 342:5

**lengthier** 11:5 14:3

**lens** 344:19

**lesson** 324:15

**lessons** 229:10

**let's** 48:10 59:17 76:22

78:7 102:22 105:7,15

114:22 115:3 125:4,5

125:7 152:9,10 154:6

155:2 157:14 267:16

300:2 303:5 304:21

305:4 309:7 325:12

394:9 396:22 397:13

**Lett** 1:18 12:15,16

65:12 97:10 137:16

140:1 142:15 145:14

225:2,9 250:21

274:13 283:15 284:12

298:7 335:17 386:3

**letting** 191:4

**level** 26:9 28:20 31:2,3

43:13,16 48:7,7 55:16

55:17,19 56:9 84:11

89:17 114:10,10

129:10 139:17 174:22

189:19 197:19 217:8

237:6,7 252:1,3

265:12 266:6,14,19

273:17 289:13 292:8

334:8 342:18,19

360:21 391:14 393:19

**level-one** 31:1,9

**level-three** 30:22 32:10

**level-two** 31:2,9

**levels** 87:21 190:7

191:13 196:6 292:11

294:11,15,19 295:2

336:19 361:5

**levers** 34:17

**Levitt** 2:11 16:22,22

53:6 89:11 93:17

135:16 143:11 170:1

205:19 221:15 230:17

231:2,6 267:3 272:16

272:20 273:2,4,19

276:20 285:19 300:7

308:2 319:7 336:22

337:1 346:10 361:10

366:2,22 381:21

382:2 388:1 390:3

400:9

**Levitt's** 142:17

**liaison** 2:14 85:10

**liaisons** 76:6

**liberation** 326:4

**library** 127:19

**licensed** 146:20

**lick** 184:3

**lies** 291:6

**life** 136:10 153:6 285:2

311:2 320:14 321:10

321:15,21

**lift** 19:6 218:4

**light** 114:18 302:16

**liked** 386:16

**limit** 151:10

**limitations** 161:18

166:8

**limited** 57:16 147:11

174:4 327:2

**Lindsay** 229:14,17

230:4 248:15,17

254:2

**line** 104:6 134:2 142:5

158:12 162:6 165:6

286:17

**line-associated** 32:19

**lines** 253:4 256:16

348:5,9

**link** 118:7 168:16

**linked** 65:6 255:9

**linking** 161:10

**links** 169:12,13

**list** 20:6 36:21 37:1,3,5

37:11 48:8 55:22 56:3

56:5 75:20 81:15

83:13 85:15 91:13

92:3 121:19 145:20

154:10 214:11 226:5

229:18 255:21,22

278:4 279:14 286:18

287:1 328:6 335:21

339:5 362:18 363:21

**listed** 73:9 130:7

**listen** 215:8 231:14

319:12 361:17,19

**listened** 46:11 236:2

**listening** 99:15 206:10  
**lists** 81:21 212:5 332:13  
**literal** 400:4  
**literally** 48:19 136:1  
 288:3  
**literature** 121:2 238:1  
**litigation** 329:20  
**little** 5:20 25:13 28:19  
 30:21 32:7 34:14 41:2  
 41:12 48:14 51:4,16  
 51:18 66:1 75:4,11,19  
 79:10,21 83:3 84:17  
 86:10 106:9,14  
 111:18 132:18 149:3  
 149:9 173:9 185:10  
 192:4 208:20 210:10  
 213:7 218:1 220:9  
 236:6 256:6,9 264:18  
 269:3 284:10 286:7  
 286:12 295:10 306:11  
 312:5 317:4 333:6  
 334:22 341:22 348:7  
 357:8 363:1 372:2  
 392:13 394:13 398:5  
**live** 71:21 82:5 196:14  
 388:5  
**lively** 7:7  
**lives** 83:7  
**living** 34:8 232:22  
 237:2 238:12  
**Liz** 12:3 17:7 98:15  
 109:8 183:14 343:12  
 344:7 398:17  
**loaded** 394:3  
**local** 113:15  
**locations** 104:11  
**log-in** 19:10  
**logical** 209:5  
**logistical** 196:14  
**long** 3:3 28:9 107:21  
 170:16 173:7,13  
 179:19 180:13 183:6  
 183:18 184:12 187:22  
 188:14 197:21 201:4  
 204:6 205:3,9,14  
 233:16 295:17 302:14  
 322:12 342:1 343:4  
 346:22 368:12 387:1  
**long-** 69:2 106:21 107:7  
 197:1 333:21 392:10  
 392:14  
**long-stay** 232:20  
**long-term** 1:16,20 4:11  
 5:13,22 7:13 10:18  
 12:10 20:4,12 22:4  
 23:1,9,11 43:7,16  
 67:9 87:22 91:1 92:16  
 100:13 103:21 107:7

110:8,16 111:13,14  
 140:11 174:12,17  
 175:6 176:5 185:5  
 186:21 192:8 195:19  
 197:9,17 198:22  
 199:6,16 201:2,10  
 236:22 245:15 285:18  
 293:22 294:1 295:21  
 296:12 297:4 303:20  
 315:11 325:13 328:1  
 337:5 347:12 381:14  
**longer** 139:18 347:3  
 366:6  
**longer-facing** 22:14  
**longitudinal** 109:16  
**look** 17:15 29:2 30:16  
 37:13 43:5,10,15 46:5  
 46:15 47:21 48:8  
 50:19 53:16 54:22  
 58:17 59:4 65:14,15  
 70:16 76:1 77:1,8  
 79:14,17 81:14 88:2  
 90:10,13 92:8,10 98:8  
 109:16 111:12,14  
 112:15 115:9 117:1,4  
 127:15 129:15 132:6  
 132:11 133:9 137:3  
 141:4,6,7 143:9,14  
 146:7 155:18 156:7  
 160:19 164:20 165:13  
 167:2 168:1 175:8  
 176:5 179:11 184:11  
 189:9 195:7 198:6  
 199:4 207:3 208:14  
 214:7 232:6 239:17  
 240:5 244:22 257:15  
 271:13 279:19 287:17  
 289:9 291:17 301:14  
 308:7,20 315:8  
 317:10 345:22 346:20  
 349:22 353:14 354:8  
 354:18 357:1 362:2  
 362:12,15 364:2  
 366:15 393:20 396:12  
 398:22 399:3  
**look-back** 133:19  
**looked** 40:20 95:15  
 141:16 142:10 155:21  
 157:17,19 195:21  
 196:1,3,10,22 208:3  
 234:21 239:11 248:9  
 271:4 298:11 317:15  
 340:9 358:12 362:16  
**looks** 41:8 224:10  
 262:5 276:10 328:6  
 362:13  
**loop** 206:4 211:22  
 212:3

**looping** 43:9  
**loosely** 335:18  
**Lorraine** 400:11  
**Los** 11:9  
**lose** 62:1 67:19 307:17  
**losers** 191:9  
**losing** 248:11  
**lost** 61:21 297:12  
 305:19 334:4 366:20  
 392:16  
**lots** 44:10 144:6 276:15  
 288:10 292:18  
**loud** 116:1  
**Loughran** 400:14  
**Louisville** 291:3  
**love** 47:15,19 66:5  
 79:17 133:7 137:19  
 145:3 148:10 173:18  
 174:1,6 175:2 179:22  
 271:2 284:1 340:12  
 396:16 398:1  
**loved** 236:14  
**loves** 302:12  
**low** 46:13 73:6 77:11  
 82:3 93:21 191:17  
 251:18 332:9 358:16  
 365:13  
**low-case** 72:6  
**low-volume** 173:1  
**lower** 58:17 60:18  
 291:13  
**lowest** 96:21 365:19  
**LTACHs** 129:8 145:4  
**LTACs** 108:12  
**LTCH** 21:5 326:4,21  
 327:9 328:3 329:21  
 336:2 366:16  
**LTCH-specific** 327:5  
**LTCHs** 129:8 325:19  
 327:11  
**luckily** 24:10  
**lumped** 309:18  
**lunch** 149:21 170:15  
 171:4

---

**M**


---

**ma'am** 348:11  
**MACRA** 172:6 369:1  
**macro** 57:19 58:14  
 59:13  
**Mahajan** 1:19 10:16,16  
 40:16 43:1 67:4,21  
 68:2 92:12 194:9  
 203:8 280:14 281:8  
 286:4 306:20 311:22  
 336:8 392:4  
**mail** 76:10,11 237:18  
**mailed** 248:15

**main** 20:19 148:8  
 216:18 240:13 252:20  
 306:6  
**maintain** 122:3 343:1  
**maintaining** 342:18  
**maintenance** 56:20  
 57:1 339:22 346:13  
 353:18 354:8  
**major** 124:13 227:16,20  
**majority** 317:6 345:13  
**making** 5:4 35:10 40:22  
 93:21 152:13 223:10  
 238:13 245:3,5,6,7  
 257:2 318:15 320:8  
 321:16,19 326:14  
 331:19 337:15 371:15  
 372:16 394:20 400:18  
**malnutrition** 118:7  
 127:6  
**manage** 137:8 330:9  
**managed** 283:11  
 397:18,20  
**management** 16:12  
 33:15 34:1,2 146:5  
 149:18 187:6,8  
 195:17 203:11,19  
 256:11 310:15 311:1  
 316:18,21 320:14  
 322:6,9,20 325:6  
 339:3 393:10  
**Manager** 2:20 18:9  
**mandated** 70:14 335:1  
**mandates** 117:15  
**mandatorily** 269:8  
**mandatory** 72:16 73:1  
 270:10 271:8 272:1  
 379:17  
**Mandl** 3:4 105:5,18  
 140:21,21 149:4  
 400:9  
**manner** 145:5  
**manufacturers** 329:17  
**map** 2:14 4:5 6:13  
 18:15 19:18 24:8  
 28:11 42:14 45:2  
 69:12 75:7 99:18  
 104:15 106:18 209:3  
 210:22 211:17 214:4  
 215:5 226:10,11  
 229:3 231:12 232:1  
 248:20 250:12 264:6  
 264:8,12,15,21 265:7  
 265:12 266:10,14  
 268:11,18 271:11  
 274:5 290:3 326:20  
 327:3,4 374:2 400:17  
**MAP's** 211:20 213:21  
 332:3

**mapping** 354:16  
**MAPs** 26:14 99:18,20  
**Maria** 400:12  
**Marissa** 2:15 6:13  
**marked** 165:20  
**markets** 129:3,12  
**Markwood** 222:3  
**Mary** 1:14 3:6 103:9  
     104:6,8 267:5,5,9  
     276:6 357:18,21  
     361:7,10 400:9  
**massive** 64:12 284:6  
**Massuda** 400:12  
**material** 41:5 42:16,16  
     338:11  
**materials** 223:1 305:22  
     306:4  
**maternity** 151:18  
**math** 186:9  
**matter** 2:7 9:19 11:3  
     14:2 15:3 103:2  
     147:19 170:22 182:8  
     191:9 217:11 249:6  
     349:3 401:12  
**matters** 92:7 333:11  
**maximize** 33:11 105:15  
     350:13  
**maximum** 140:12 271:7  
**MBA** 1:14 2:12  
**McGann** 38:19  
**McMullen** 3:5 105:5  
     116:10 138:9 142:16  
     144:20 146:17 150:17  
     163:11 165:9 166:6  
     167:8 169:10 301:6  
     337:7 400:10  
**MD** 1:13,17,18,19,20,21  
     2:1,4,5,8,11 3:2,3,8  
**MDS** 107:10 141:2,18  
     147:2 195:9 196:21  
     242:2 335:11  
**MDSes** 251:16  
**mean** 14:20 28:12 37:5  
     37:17 41:3 44:17  
     45:11 54:7 66:1 67:21  
     76:21 77:3 96:12  
     143:8 144:3 148:15  
     149:1 161:17 164:5  
     169:13 181:20 182:14  
     183:20 189:8 201:6  
     203:20 226:4 233:11  
     235:19,21 252:5,21  
     258:9,19,22 261:8  
     262:4 263:12 264:20  
     265:9 266:7,20  
     269:20 270:11,20  
     281:16,17 283:18  
     285:20 286:13 288:11

    289:17 297:4,5  
     298:21 301:13 305:15  
     316:11,11 319:21  
     333:18 340:18 341:17  
     367:2 390:17  
**meaning** 46:13 275:2  
     284:14  
**meaningful** 4:3 7:22  
     19:16 23:17 26:7,12  
     27:3,11 28:1,7 31:8  
     31:19 32:4,16 33:1,5  
     33:21 35:7 37:9 40:6  
     40:21 43:11,15 46:12  
     46:16 47:6 48:16 49:3  
     50:3 51:17,19,22 52:5  
     52:7,13 54:8,9,10  
     55:6,8,9,10,11 58:21  
     65:13,16 66:6,9 67:1  
     67:7,15 68:5 91:11  
     93:18,21 105:2  
     126:11 127:10 142:13  
     179:11 194:18 279:18  
     289:3,7,21 290:4  
     293:14 301:12 320:3  
     321:16 336:9 337:15  
     343:9 349:20 350:22  
     356:8 361:21  
**meaningfully** 377:9,11  
**meaningfulness** 358:5  
     366:6  
**means** 28:14,16 37:14  
     60:8 61:18 62:3 97:17  
     126:2,5 134:1 140:4  
     210:6,12,20 316:9  
     329:16  
**meant** 378:12  
**measurable** 31:20  
**measure-specific**  
     230:18  
**measured** 90:6 190:14  
     316:2 365:10 395:12  
**measurement** 6:1,5  
     7:15 8:19 20:16 23:1  
     24:1 30:16 36:10 52:7  
     70:1,3,19,22 71:2  
     72:2,7 75:12 79:6,10  
     81:19 92:6 95:8  
     104:13 126:12 127:14  
     188:6,20,22 194:19  
     247:13 287:19 288:15  
     307:10 310:5 324:10  
     385:16 394:21 397:21  
**measurements** 320:18  
**measuring** 90:5 182:12  
     235:5 342:8  
**mechanism** 376:20  
**mechanisms** 187:14  
**med** 145:18 279:5

    332:2  
**median** 260:10,13,16  
     262:13  
**Medicaid** 2:11,14,15  
     3:4,5,6,7,8,9 6:14  
     30:5 39:3 85:10 86:22  
     110:14 192:21 231:12  
     231:17,18,21 232:5,8  
     232:20  
**medical** 10:21 16:11  
     74:15 82:14 88:1  
     104:15 112:7 115:13  
     118:5 188:17 303:2  
     322:6,19 333:10  
**Medicare** 2:11 3:3,5,5,6  
     3:7,8 64:20 98:8  
     106:11 109:13 143:18  
     172:14 173:4,5  
     178:13 222:16 232:8  
     242:19 255:9 302:20  
     313:8 331:8 338:8  
     382:17  
**Medicare-certified**  
     157:18  
**medication** 33:15  
     123:11 127:8 133:4  
     135:5 138:18 145:16  
     145:20 278:1,2,5  
     311:1 316:17,22  
     317:16 320:14 322:8  
     326:19 335:21,21  
     362:18  
**medications** 187:10  
     245:4,6 322:16 383:5  
     383:8  
**medicine** 1:17,20 10:19  
     13:3 42:7 315:19  
**MedPAC** 63:10  
**meet** 96:4 101:8 210:21  
     246:11 250:2 351:6  
     379:18  
**meeting** 4:2 5:9 8:6,10  
     8:12 52:3 76:14  
     104:16 181:12 206:2  
     211:11 212:1,9,11,14  
     220:20 222:21 223:1  
     231:14 232:1 245:3  
     307:4 327:8 332:7  
     349:13 401:9  
**meetings** 42:15 105:11  
     237:3  
**meets** 50:5 209:20  
     210:3 266:6  
**members** 1:12 2:10  
     9:16,18,19,21 16:17  
     16:18 17:6 76:5 83:19  
     103:7 131:3 174:18  
     208:4 232:21 236:13

    236:22 241:7 244:14  
     244:21 261:13 266:20  
     275:6 276:11 296:3  
     332:8 385:10,11  
**membership** 256:11  
**men** 240:3,4  
**mental** 34:2 57:12 59:5  
     112:5 117:20,22  
     123:1,22 132:21  
     134:9 158:9 279:3  
     328:8 330:6  
**mention** 57:2 79:12  
     98:19 144:10 317:2,4  
     339:7 386:6  
**mentioned** 31:10,13  
     58:13 83:1 88:12  
     146:13 231:11 242:15  
     283:1,19 297:7  
     313:21 328:10 329:1  
     344:22 345:2 349:20  
**mentor** 8:5  
**menu** 74:3 194:2  
**merged** 290:6  
**Merit-** 20:2  
**Merit-Based** 172:1  
**merits** 213:20 354:13  
**Merkelz** 1:20 12:12,13  
     244:4 285:5 320:5  
**message** 136:14 178:2  
     202:4 206:5  
**met** 1:9 157:10 200:16  
     235:16 244:12,19  
     245:8 314:11 336:18  
     400:3  
**method** 147:6,8  
**methodological** 340:4  
**methodologies** 378:1  
**methodologist** 339:19  
**methodology** 130:16  
     146:22 259:5 369:10  
     391:5 392:22 393:2,3  
**methods** 364:2  
**metric** 163:19 258:9  
**metrics** 42:8 260:9  
     302:6  
**metropolitan** 128:10  
**MHA** 2:5  
**MHS** 1:13 3:3  
**mic** 357:16 387:22  
     389:9,13 390:2  
     396:21 397:10 400:20  
**Michelle** 400:13  
**Michigan** 370:3  
**microphone** 18:21 19:5  
     234:5  
**middle** 139:9  
**midst** 226:3  
**Miles** 400:11

**milestone** 177:1,2  
**milestones** 176:19  
**million** 144:4 298:4  
 359:11,14  
**millions** 392:17  
**mind** 43:6 46:21 54:1  
 78:9 80:17 88:3 90:21  
 183:18 221:13 237:15  
 262:21 312:18 313:16  
 328:7 337:17  
**mindset** 86:10  
**mine** 322:7 395:7  
**minimal** 50:7,8  
**minimize** 25:21 215:19  
 353:3  
**minimum** 94:1 140:11  
 222:17 240:15,15,22  
 241:12 248:4,22  
 376:6 379:19 396:16  
**minute** 162:5 233:9  
 348:20 384:14  
**minutes** 102:21 150:9  
 150:18 160:9 170:16  
 173:14 307:4,9,11,14  
 349:8  
**MIPS** 40:10 47:2 60:2  
 60:20,21 61:5,8 62:16  
 62:22 63:1 67:10  
 172:9,12,16 173:16  
 174:10,13 175:1,7,15  
 175:16,18,20 180:6  
 181:6 189:20 190:6  
 194:15 198:7,11  
 199:21 203:2 205:1  
 271:14 272:14 279:18  
 280:7 322:11 385:13  
 392:6,19  
**MIPS-eligible** 173:2  
 177:19  
**MIPS-reporting** 202:21  
**MIPS-specific** 173:9  
**Miranda** 2:20 8:8 18:11  
 216:15 303:8 325:14  
 330:19 400:2  
**MIS** 2:12  
**misery** 302:12  
**misleading** 234:18  
**misportrayed** 265:17  
 266:16  
**missed** 356:20  
**missing** 23:7 55:14  
 193:10 350:19 401:2  
**mission** 120:17 121:21  
 269:21  
**misunderstanding**  
 110:2  
**mix** 117:4 122:8 139:20  
 163:13

**mixed** 139:4 153:12  
 154:6  
**mixture** 138:15  
**mobility** 112:19 117:18  
 152:15 153:9 245:8  
**mode** 130:17 134:6,12  
 270:17  
**model** 35:1 93:4 117:6  
 144:8 145:11,11  
 288:12,13 341:18  
 370:8,12,15 371:2,10  
 371:14 372:9,18  
 373:21 374:5,13,19  
 375:4,8 376:1,5 377:9  
 377:13,22 378:12,14  
 379:10,11 381:4  
 386:5 387:6,17  
 388:19,21  
**model's** 375:12  
**modeling** 122:9 247:22  
**models** 29:22 74:15  
 92:17 108:10 172:11  
 254:8 255:6 288:12  
 364:11 369:13,19  
 370:7,16 371:3,11,20  
 371:22 372:3,15,20  
 372:21 373:4,11  
 375:5,6,17 379:12,13  
 379:14,17 380:16  
 381:2 383:22 395:4  
**modes** 129:18  
**modifications** 210:15  
 326:15 331:20  
**modified** 109:18,19  
 112:3 156:11  
**modifier** 172:14 392:7  
 392:18 393:2  
**modify** 241:18  
**modifying** 223:11  
 241:19  
**mom** 97:16  
**moment** 226:16 261:8  
 300:2 303:5,9  
**Monday** 288:4  
**monetarily** 180:8  
 329:22  
**money** 60:9 95:5  
 203:21 343:5 360:5  
**monitor** 315:5,10  
**monitored** 95:16  
**monitoring** 324:9  
**monitors** 246:7  
**months** 179:16 248:10  
 248:12 249:4,5  
 360:17  
**months'** 247:8  
**mood** 156:18  
**morning** 12:12,15,19

13:1 18:10 69:9  
 166:17 171:13 180:6  
 231:12 279:16 280:8  
**mortality** 34:4  
**motion** 208:12,13 220:2  
 225:1 262:16 263:5,6  
 274:9,15  
**motor** 114:22  
**move** 18:17 26:6 27:9  
 29:21 30:7,13 31:1,11  
 32:2 33:2,12,17 34:5  
 35:9,13 39:17 40:7  
 43:20 44:8 45:20  
 46:20 50:21 56:9  
 58:22 59:11 68:21  
 69:4 100:8 105:4  
 124:22 126:7 145:16  
 161:14 171:6 190:15  
 206:14 218:14 224:12  
 251:12 255:3 263:6  
 274:1 276:17 290:18  
 300:6 307:22 325:12  
 337:20 347:18 350:14  
 352:10 353:5 361:9  
 367:22 369:4 370:1  
 371:16 373:5 375:21  
 378:3,8 380:14 395:5  
 397:21 399:5  
**moved** 54:3 118:13,15  
 264:1 272:12  
**moves** 68:20  
**moving** 29:14 34:21  
 59:22,22 63:12 76:16  
 95:19 118:11 125:3  
 150:2 152:20 169:20  
 178:3 179:8 198:20  
 254:16 258:3 273:7  
 309:6 369:2,18  
 395:21  
**MPH** 1:14,18 2:1,2,17  
 3:2,5,8  
**MRSA** 358:9,12,14  
**MSBP** 109:3  
**MSN** 2:7  
**MSPB** 381:21  
**MSW** 1:16  
**MUC** 36:21 37:1,3,5,10  
 75:20 85:14 211:16  
 212:5 214:11 226:5  
 229:18 255:21,22  
 398:21  
**MUC17-258** 224:14  
 225:5 273:7 274:16  
 275:11  
**muddles** 235:8  
**Muldoon** 1:21 11:12,13  
 81:8 233:4,17 234:1  
 286:15 291:1 327:16

333:6 365:9 366:19  
**Mulhausen** 1:11,13 8:3  
 16:10,11 22:18 46:2  
 93:15 94:10 97:8  
 98:15 99:7 100:15  
 102:11,18 137:15  
 146:2 149:15 170:18  
 171:3 197:3 200:22  
 201:7 224:22 225:4  
 247:6 262:12 287:13  
 305:19 311:10 312:2  
 312:12 315:2 316:14  
 319:6 320:4 322:2  
 323:5 325:8 330:17  
 330:19 332:10 333:4  
 333:14 334:18 335:16  
 336:3,20 337:19  
 348:19 389:10,14  
 397:17  
**multi-** 379:13  
**multidimensional**  
 373:10  
**multiple** 100:1 129:18  
 163:3 166:17 175:11  
 186:5 189:13 251:15  
 251:16 323:21 360:8  
 366:22 377:12 378:1  
**multitudes** 169:14  
**Munthali** 2:17 9:8,11  
 11:4 13:9,17,21 15:21  
 16:7,16 17:5,10,15  
 18:3  
**must-have** 77:15

---

**N**

---

**N** 129:1 157:19  
**N.W** 1:10  
**NAAAA** 276:4  
**name** 11:12 13:5 18:11  
 21:11 23:22 69:10  
 99:8 104:8 138:11  
 147:21 191:21 234:17  
 382:21 383:2  
**name's** 103:13  
**named** 21:15,22 213:14  
**names** 270:22 271:1  
**narcotics** 322:15  
**narrowness** 262:14  
**nation** 259:2  
**national** 1:1,9,15,16,18  
 2:1,3,4,12 12:1,5,10  
 12:16,20 13:6,12 42:3  
 42:6 44:11 45:5 46:6  
 82:1,12,15 83:19  
 119:3 125:6,13  
 126:14,15 128:3,4  
 133:15 151:4,17  
 155:4 156:8,9 157:9

158:2,20 169:5 192:9  
 222:3 258:14 289:22  
 290:1 294:17 298:10  
 331:9 359:5 373:13  
**nationally** 294:17  
 336:12  
**natural** 180:10  
**nature** 246:14 282:22  
**NCP** 95:17  
**necessarily** 23:9  
 136:21 355:9 356:1  
 365:19 371:8  
**necessary** 110:7 272:7  
 376:4  
**neck** 101:6  
**need** 16:6 51:8,8 53:16  
 54:22 68:18 73:5  
 80:17 84:8 95:11  
 96:11 118:2 121:16  
 121:16 124:10,11,14  
 124:19 125:16,22  
 135:16,17 136:13  
 137:8 142:1,21  
 146:19 170:3,8,18  
 184:2 198:6 210:16  
 212:22 216:22 219:20  
 223:6,15 226:22  
 227:2 244:12,22  
 248:4 249:20 251:3  
 257:7 261:4 269:4  
 271:17 277:18 283:17  
 286:20 289:2 290:13  
 299:9 302:11 304:3  
 304:14,19 305:3  
 309:1 313:9 314:15  
 315:5,8 316:12  
 319:17 321:14 325:7  
 326:21 330:9 332:17  
 338:12 347:22 351:6  
 356:11 361:5 362:10  
 362:19 389:4 394:16  
 396:14  
**needed** 101:22 139:22  
 158:19 233:22 279:6  
 313:3,15 371:21  
 396:20  
**needing** 277:11  
**needle** 290:18  
**needs** 29:20 50:5,11,17  
 57:3,20 60:14 66:11  
 73:4 87:22 96:12  
 110:9 142:12 143:18  
 143:21 144:17 148:22  
 192:19 235:16 244:19  
 244:21 245:4,8  
 260:21 263:3 285:10  
 286:19,22 314:10  
 320:9 321:9 332:12

343:10,21 344:5  
 352:6 374:19  
**negative** 264:3 321:11  
**negatives** 322:1  
**nested** 117:22  
**nets** 83:21  
**network** 30:15 41:22  
 196:7 331:9  
**never** 73:3 324:6  
 345:15 346:4  
**nevertheless** 345:9,15  
**new** 6:12,13 19:15,17  
 22:7 23:21 35:22 36:6  
 36:6 42:19 45:8 55:15  
 69:7,12 74:19 79:1  
 81:12 85:9 103:7  
 122:16 123:3 126:11  
 138:18 139:16 151:22  
 175:16 219:4 221:19  
 255:8 266:8 280:9  
 289:1 326:8 347:6  
 393:1  
**news** 334:3  
**newspapers** 333:20  
**NHSN** 358:20 362:3  
**nice** 23:20 142:19  
 191:11 246:12 308:4  
 322:10 349:17  
**nicely** 30:18  
**NICHOLAS** 3:2  
**Nick** 228:6 229:15  
 236:20 249:19 254:1  
**Nidhi** 400:14  
**night** 90:4 100:6 140:13  
 388:2  
**nightmares** 196:14  
**NIH** 138:22 139:2  
 151:21 152:1 156:13  
 157:10  
**nine** 25:10  
**Nineteen** 90:2  
**ninth** 41:3  
**nod** 261:1  
**nodding** 80:2  
**nominate** 25:8  
**non** 165:14  
**non-** 177:18 181:5  
**non-CMS** 300:13  
**non-communicative**  
 166:1  
**non-compliant** 271:10  
**non-healing** 64:13,21  
**non-MIPS** 182:20  
**non-post-acute** 202:10  
**non-reporters** 61:19  
**non-therapy** 134:15  
**non-voting** 2:10 16:18  
 232:12

**normal** 39:12  
**normative** 162:16  
**Northwest** 97:1  
**note** 127:20 214:12  
 350:20 360:7  
**noted** 327:8 356:9  
 370:22 375:4,15  
**notes** 68:16 195:8,10  
 198:2 336:4  
**notice** 73:12  
**noticed** 7:10 36:22  
 59:20 95:14 122:12  
 271:4 370:9  
**noting** 371:13  
**notion** 193:13  
**Novartis** 12:7  
**November** 76:17 153:7  
 212:14 222:9 277:5  
 327:8 332:7 339:1  
**novo** 119:20 123:3  
 138:16  
**nowadays** 292:19  
**NPs** 66:5  
**NQF** 2:17,19 8:8 17:20  
 18:5,14 21:17 23:19  
 30:12 68:15 69:11  
 77:8 78:17 95:16  
 210:7 213:15,21  
 215:5 227:13 240:21  
 264:22 305:7 306:9  
 308:5 326:7 331:16  
 355:9,13 356:9 364:1  
 396:18 398:13 400:1  
**NQF's** 4:17 22:1,7  
**NQF-** 269:1,11  
**NQF-endorsed** 77:1  
 211:8 232:19 262:4  
 264:10 268:14 271:20  
**Nuccio** 2:9 10:20,20  
 55:3 56:2 59:15 146:6  
 149:11 256:15 258:13  
 258:19 333:16 339:15  
 342:7 363:20  
**nuggets** 79:3  
**number** 16:13 24:21  
 33:20 35:15 41:17  
 87:1 94:1 129:6 178:1  
 188:10,18 224:6  
 229:15 237:2,4  
 239:14 240:15 241:1  
 241:12 248:11 255:11  
 255:17 264:8 270:18  
 294:12 302:9 342:16  
 359:19 378:15 400:3  
**numbers** 97:14 102:3  
 248:10 249:16 383:2  
 393:22,22  
**numerator/denomina...**

324:8  
**nurse** 97:15,21 112:10  
 126:3 147:9 172:20  
 172:20,21 181:21  
 182:14 185:22 322:21  
 387:14  
**nurse/nurse** 146:14  
**nurses** 15:11 66:4  
 128:6 129:14 132:4,4  
 146:14 147:6 180:15  
**nursing** 4:7 21:2 66:4  
 67:12 91:3,4,5,6  
 97:17 99:4 106:22  
 107:9 112:11 113:6  
 141:10 194:16 195:7  
 195:11 201:19,20,21  
 221:11 241:2 256:18  
 266:18 274:19,20  
 278:21 281:1 299:16  
 315:19 333:21 335:18  
 337:5 340:17 382:20  
 382:22 383:1 387:10  
 393:12 395:13  
**nutrition** 64:22 118:4  
 284:19 315:20  
**nutritional** 64:18 65:2  
 118:3 127:7 133:2  
 134:21 327:4 344:11  
**nutshell** 175:17

## O

**o'clock** 303:10  
**O'Rourke** 2:18 5:3 9:4  
 18:4,6,16 23:14 69:5  
 103:5 104:2,5,18  
 171:11 211:5 215:21  
 221:17 222:7 224:10  
 273:22 277:2 306:4  
 338:1 348:1,17,21  
 354:3,9 355:20 356:4  
 368:9 374:14 378:7  
 379:2 382:1,6 396:4  
 396:22 397:9,11  
 399:8 400:22  
**OASIS** 107:11 142:17  
 143:14,16 157:6  
 338:7 340:9 347:1  
**objection** 219:9 274:4  
 328:11,17  
**OBJECTIVES** 4:2  
**observation** 129:20  
**observational** 134:12  
**observations** 49:12  
 102:12 363:15  
**obsolete** 183:9  
**obstacles** 193:4  
**obstetrician** 64:8  
**obvious** 70:20 301:18



301:19  
**obviously** 20:22 21:17  
 24:7 38:7 57:5 102:7  
 148:7 161:18 168:16  
 177:22 179:4 188:5  
 270:2,21 271:16  
 293:11,13 294:1,8  
 308:14 337:13 354:12  
 356:9 361:20 369:1  
 386:10  
**occasionally** 90:16  
**Occupational** 1:22 11:8  
**occur** 282:16 366:13  
**occurred** 165:20  
 345:15  
**occurring** 125:9 286:1  
**occurs** 302:17  
**ocean** 148:14  
**October** 106:16 131:19  
**odd** 112:13  
**of-life** 321:8  
**offer** 353:15  
**offered** 71:16  
**offering** 210:19 349:9  
**offers** 184:9  
**office** 2:12 12:4 88:17  
 98:3 187:7 203:5  
**Officer** 16:11 104:15  
 303:2  
**offices** 136:19  
**officially** 196:19 280:17  
**officio** 12:4  
**offline** 150:12 200:19  
 216:5 306:17  
**offset** 129:4  
**oftentimes** 83:22  
 174:20  
**OIG** 362:12 386:6  
**old** 60:21 178:15 299:4  
 367:7 393:1  
**older** 71:21 87:20  
 120:12 246:11 297:1  
**oldest** 103:15  
**onboard** 124:22  
**ONC** 17:6 52:4 109:9  
 293:9 294:10 343:17  
**once** 19:2 92:8 170:6  
 182:14 202:5 219:7  
 243:7 249:18 258:7  
 265:7 266:6 337:7  
 340:2 382:9  
**one's** 386:3  
**one-armed** 298:22  
**one-handed** 289:14  
**one-to-one** 354:16  
**ones** 61:20,21,22 62:1  
 73:9,10 74:8 77:16,21  
 88:7 136:22 236:14

279:21 280:11 305:22  
 328:16 335:6 339:11  
 353:18  
**ongoing** 247:13  
**online** 128:15 130:7  
 133:11,13 139:14  
 156:6  
**Oops** 355:15  
**open** 130:20 131:22  
 208:10 215:21 219:1  
 219:17 220:3,17  
 224:1,19 225:6  
 240:14 278:6 348:2  
 382:13  
**open-ended** 176:13  
**opening** 4:3 19:15  
 193:19  
**openness** 14:22  
**operational** 247:8,10  
 271:16 285:22 352:18  
 352:19 355:4  
**operationalization**  
 230:20 273:10  
**operationalized** 247:10  
 272:5 311:19  
**operationalizes** 214:16  
**Operator** 224:4 348:9  
 348:11 397:3,5,15  
**operators** 286:19  
**opinion** 8:13,14  
**opioid** 34:3 59:7 336:11  
 336:17 339:2  
**opportunities** 26:22  
 29:2 80:18,21,22 99:2  
 99:5 179:1 398:14  
**opportunity** 22:21 23:6  
 23:13 24:17 29:11  
 35:15 49:13 52:15,22  
 67:15,22 77:6 98:18  
 105:3,10,15 113:20  
 143:14 150:11 171:18  
 177:5,6 181:9 184:7  
 184:10 190:19 193:10  
 254:17 256:5 279:19  
 280:6 307:17 328:22  
 350:2  
**opposed** 35:5 49:11  
 162:14 242:18 244:13  
**opposite** 365:14  
**optically** 46:20  
**optimal** 132:6,11,11  
**optimistic** 256:2 258:8  
**option** 214:8 275:2,3,13  
 275:16 276:5  
**optional** 74:3,8 94:5  
 396:13  
**options** 185:15 275:1  
 307:2 396:3

**orally** 10:12  
**order** 42:17 60:16 62:12  
 138:6 251:21 350:13  
 387:13  
**orders** 383:6,10,12  
 387:14  
**organization** 2:4 10:1  
 12:2 14:5 40:12  
 191:18 263:18  
**organizational** 9:17,18  
 9:21 10:4 13:10  
 120:18  
**organizations** 13:22  
 97:5 103:16 131:13  
 296:14  
**organize** 167:11 288:5  
**orient** 107:6  
**originally** 159:1  
**orthopedic** 64:10  
 188:20 199:7,8,10  
**orthopod** 64:7  
**OT** 189:10 198:7  
**OTR/L** 1:21  
**OTs** 147:18 149:9  
**ought** 332:14  
**out-patient** 70:17 78:11  
 80:4 84:20  
**outcome** 28:9,15,17  
 62:9 115:17 169:11  
 278:13 308:16,17  
 310:15 321:5,5,6  
 323:15 325:6 328:13  
 346:19 351:8,11,15  
 357:6,7 362:20  
 364:11 369:4 376:15  
 377:10 382:3 388:14  
 388:15  
**outcomes** 31:20 33:8  
 56:15 62:2 107:16  
 109:14,17 111:13,14  
 115:17 129:11 158:3  
 164:16 168:8,17  
 169:3 192:18 313:14  
 313:15 314:18,20  
 320:15 351:14 369:12  
 379:16 389:8 395:1  
**outlined** 120:6 378:14  
**outpatient** 179:9  
 394:19  
**outside** 40:14 89:5  
 130:13 138:5 140:3  
 263:20 300:13  
**outstanding** 6:5 223:14  
 277:3  
**overall** 127:5 149:1  
 153:11 154:15 155:8  
 158:2,7,9 159:17  
 160:2 168:4,6 176:14

277:8 357:10  
**overarching** 36:3,8  
 64:12 72:12 73:8  
**overcome** 20:11,15  
 21:13  
**overlap** 42:22 341:15  
 341:16  
**overlapping** 77:13  
 341:13  
**overlays** 328:8  
**overly** 126:10  
**overview** 19:17 22:1,7  
 22:8 105:6 172:4  
 206:21 217:16 222:8  
**oxygen** 115:6 142:5

---

**P**


---

**P-R-O-C-E-E-D-I-N-G-S**  
 5:1  
**p.m** 171:1,2 349:4,5  
 401:13  
**P4P** 70:8  
**PA** 322:21  
**PAC** 24:20 30:3 32:21  
 37:15 43:7,16 69:2  
 94:6 100:12 109:17  
 121:2,3 122:5,21  
 124:14 125:7,20  
 136:21 142:18 145:1  
 153:21 154:13 165:16  
 189:11 293:10 294:12  
 294:22 351:5 382:5,8  
**PAC-LTC** 78:8  
**PAC-PRD** 116:14,14,18  
 117:8 119:22 122:16  
 122:18 123:14 149:7  
**PAC/Long-Term** 7:18  
 8:2 305:8  
**PAC/LTC** 4:18 5:15  
 210:17 277:10 381:17  
**packed** 105:11  
**page** 130:11 133:14  
 172:3 368:21 369:9  
**paid** 14:14,16 65:7  
 70:13  
**pain** 123:10 132:22  
 134:13,13,16 139:4,5  
 152:17 187:6,8  
 309:20 323:1,16  
 339:2  
**painful** 389:17  
**paint** 163:1  
**pair** 52:18  
**pairs** 52:15,20 53:4  
 67:17 353:2  
**Palena** 2:12 12:3 17:7  
 109:8  
**palliative** 2:4 12:1

15:10,12 79:22 95:12  
 95:13 96:21 101:2  
 295:12 296:5 315:7  
**Pam** 11:7 164:18 189:7  
 198:6  
**PAMELA** 1:21  
**panel** 2:5 12:21 22:3  
 77:5 119:18 121:8  
 151:8 152:21 153:2  
 154:4 181:11  
**paper** 30:15,16 42:2  
 50:20 98:7 284:5  
 306:9 308:4,20 309:1  
 349:11 368:6 370:22  
 376:9 379:5,21 380:2  
 380:4 381:9,16 396:2  
 396:6,7,10,16  
**paperhanger** 298:22  
**paperwork** 25:16 57:4  
 126:13  
**paradigm** 116:14  
 120:22 121:20  
**paramount** 101:3  
**parsimonious** 50:3  
**parsimony** 209:14  
**part** 7:20 47:3 73:19  
 79:11 82:18 83:11  
 94:20 95:11 96:13  
 98:1 114:19 136:10  
 157:3 158:11 167:22  
 173:4 177:21 178:13  
 178:18,19 194:20  
 197:12 202:8,11  
 215:3 217:4 246:5  
 247:8 251:4 254:15  
 262:17 268:5 269:20  
 279:15 296:1 297:4  
 298:18 313:5 314:3  
 315:6,13,15 317:1  
 318:6 334:6 356:22  
 361:18 362:10,11  
 363:4 364:5 374:22  
**participant** 177:19  
**participants** 217:1  
 275:21  
**participate** 70:10,14  
 72:8 128:17 172:1  
 178:16 179:1 197:17  
 222:13 376:22 385:12  
**participated** 73:3  
 180:17  
**participating** 20:13  
 275:7  
**participation** 72:16  
 73:2 128:17 159:3  
 172:9 294:1 334:9  
**particular** 10:1 20:16  
 21:6 25:9,15 28:15

29:14 32:15 34:12,16  
 35:16 44:6 50:4,5,12  
 54:8 58:4,13 59:1,5,6  
 86:14 90:1 112:3  
 146:3 173:16 186:7  
 215:7,9 223:6,10  
 263:3 268:12 277:13  
 300:15 306:12 352:8  
 353:1 355:18 357:12  
 380:10,13 381:14  
 386:12 399:12  
**particularly** 28:19  
 29:12 35:17 45:21  
 72:3 77:19 83:2 90:22  
 98:21 99:3 100:10  
 113:5 136:19 190:22  
 251:14 264:9 289:6  
 293:10 315:21 337:5  
 344:2 351:13 373:4  
**parties** 124:21  
**partly** 231:14  
**partner** 255:5 291:9  
 299:2 382:19  
**partners** 88:16 89:5,5  
 110:14 111:6 143:15  
 297:2  
**partnership** 1:3 2:1  
 13:7 38:20 73:13  
 83:19 137:2 170:13  
 269:15  
**partnerships** 84:18  
**parts** 9:15 347:9  
**PAs** 66:5 97:16  
**pass** 62:6 173:11  
 224:21 328:21  
**passage** 335:20  
**passed** 24:11 106:15  
 110:4 135:20  
**passing** 61:15  
**passwords** 19:10  
**path** 272:21  
**patient** 21:21 26:5  
 50:16 57:3 66:20  
 71:20 89:16 106:1,6  
 107:2 108:17,18  
 109:6,20 114:10  
 115:10 127:15 129:19  
 129:20 146:11 158:6  
 160:19 161:19 162:6  
 162:15 164:11 168:18  
 182:3 187:12 188:2,3  
 188:3 234:22 235:6  
 235:11 244:8 245:5  
 245:10,14,19 273:16  
 277:9 278:4,19 279:8  
 282:5 283:6 284:20  
 289:16 290:6,10  
 292:12 296:11,20,21

304:1 306:10 310:18  
 311:3 312:7,8 314:1  
 317:7 318:3 319:5  
 320:22 321:7,16  
 322:22 323:11 324:22  
 325:4 327:6 331:10  
 332:6 340:22 341:1  
 341:15,17 342:11,17  
 361:13 369:14 382:10  
 387:15 388:11 390:18  
**patient's** 33:6,8 162:13  
 289:11 341:7,8,9  
 342:12  
**patient-centered** 28:6  
 154:2 284:21 351:1  
**patient-focused** 35:12  
**patient-reported** 158:3  
 168:8 278:13 321:4  
 323:12,15 344:10  
**patient/resident** 134:18  
**patients** 25:16 28:7  
 38:21 55:9 56:21 57:4  
 60:15 65:22,22 74:7  
 74:15 86:8,15,17 87:1  
 94:1 96:6,8 101:4,9  
 101:18 126:12 129:6  
 130:1,2 132:5 136:18  
 153:16 158:4,8,13  
 159:4,8,13,16,20  
 160:7 161:4,10 163:4  
 163:18,21 167:5  
 173:5 174:18 175:11  
 179:9,12 185:17  
 203:17 242:16 244:14  
 244:20 246:15 251:14  
 253:20 283:8 292:11  
 295:15 296:11,22  
 306:12 314:3,11,14  
 314:20 319:22 323:13  
 326:8 334:2,4,13  
 335:7,8 340:1,10  
 343:4,8 350:22  
 358:22 363:6,8  
 369:11 373:16 380:9  
 383:4 384:10 391:17  
 393:6 394:18 395:15  
 395:19  
**Paul** 1:11,13 6:20 7:5  
 8:2 16:10 23:19 24:15  
 38:18 49:16 104:20  
 105:14 170:16 200:4  
 247:5 261:2,3 264:7  
 303:7 305:16 311:7,8  
 353:12 397:1 398:19  
 399:20 401:7  
**pause** 5:21 34:9 69:8  
 224:7 348:14  
**pay** 329:22

**pay-for-reporting**  
 376:13  
**payer** 242:13  
**payers** 30:6 49:11 55:9  
**payment** 20:3 29:22,22  
 35:5 41:22 44:6 93:4  
 108:10,15 116:13  
 122:9,15 143:19  
 147:1,1 172:2,7,8,11  
 172:14 203:22 255:8  
 257:17,18 258:6,7,10  
 265:20 325:21 369:19  
 373:4 376:20 379:18  
 384:19 385:4,14  
 391:13 395:4  
**payments** 29:16 83:10  
 92:18 113:17 380:22  
**pediatric** 131:12 315:7  
 315:7  
**peer** 393:22  
**pejorative** 66:1  
**penalties** 299:19  
**penalty** 222:11 271:9  
 325:17 330:22 338:2  
**penalty-for-failure-to...**  
 309:13  
**penetrated** 92:17  
**people** 36:7 44:19 45:6  
 51:20 52:17 53:10,15  
 53:16 54:22 62:5  
 64:13 66:21 68:7 71:7  
 71:8,21,22 77:3 81:2  
 91:7,18 93:1,3 96:7  
 100:1 124:5 131:3,4  
 143:1 153:13,15,22  
 154:20 166:3 182:16  
 191:2,16 194:10  
 196:15 198:3 203:21  
 236:8 237:22 239:7  
 250:11 251:17 252:21  
 255:2,12,16 258:4  
 271:2,5 273:17 286:5  
 297:3 300:11 302:18  
 315:22 330:8 343:1  
 344:3,19 345:10,22  
 346:2 386:16 387:8  
 387:10,11 389:21  
 393:20  
**people's** 177:9 344:4  
**perceive** 332:21  
**perceived** 134:18  
**percent** 29:5 83:7 90:2  
 125:18,20 130:11  
 186:7,16 192:20  
 195:9 202:17,22  
 217:1 220:6 249:15  
 261:13 276:12 294:17  
 326:7 346:5,14 359:9

359:15,21,22 363:2,7  
 370:19,20 382:16  
 392:10  
**percentages** 298:2  
**percentile** 260:13  
**perception** 162:13  
 246:2 319:4 341:8,10  
**perceptions** 244:13  
**perfect** 180:13 292:15  
 323:17  
**perform** 190:21  
**performance** 7:15  
 29:16,19 30:18 31:4  
 34:22 70:1 112:18  
 162:4 163:2 165:1  
 172:16 191:10,13  
 260:13,15 263:20  
 291:8 301:11 342:18  
 342:19 351:16,18,20  
 351:22 356:13,16,19  
 358:4 373:18 389:7  
**performed** 125:16  
 285:16 377:15  
**performing** 29:4,17  
**period** 152:22 190:11  
 221:1 266:3 343:4  
 397:12  
**periods** 151:9 342:16  
**permitted** 236:15  
**permutation** 324:2  
**person** 33:4 98:4 111:5  
 117:1 127:6 132:13  
 147:9 148:22 156:4  
 165:21 186:12 191:17  
 191:17 238:22 251:4  
 343:1,3 383:9  
**person's** 164:2 239:1  
 343:19,21  
**person-** 209:12  
**person-centered** 154:2  
**person-centeredness**  
 122:3  
**personalized** 33:6  
**personally** 259:7  
**personnel** 95:7 360:20  
 387:11  
**perspective** 87:16  
 90:22 282:6 340:5  
**perspectives** 43:22,22  
 341:14  
**pertain** 108:21 185:18  
**pertaining** 159:7  
**perverse** 343:7  
**Pharm.D** 2:9  
**Pharmaceuticals** 12:7  
**phase** 118:19 119:2  
 120:7,7 129:2 368:16  
 368:19 378:6

**phased** 73:5 118:16  
**phases** 368:16  
**PhD** 1:13,21 2:3,8,9 3:2  
 3:5  
**philosophically** 64:1  
**PHN** 3:4  
**phone** 13:11,13,16 17:6  
 19:1 24:22 101:11  
 220:12 221:20 229:14  
 306:21 307:3,16  
 316:6 344:13 348:5  
 386:22 397:3  
**PhQ** 141:8  
**PHQ-2** 134:10  
**PHQ-9** 134:10,11  
**phrase** 281:11  
**physical** 1:17 2:2 11:17  
 13:3 149:8 152:15  
 153:9 158:9 159:18  
 160:16 177:20 178:11  
 391:3  
**physician** 15:15 44:6,7  
 46:10 48:17 66:5  
 141:10 172:19 187:2  
 195:8,10 196:2,11  
 197:1,14 281:3,12  
 286:9 322:8,13,20  
 336:15 370:21 380:19  
 386:8 392:5,8  
**physician-level** 204:4  
**physicians** 60:2,6 93:4  
 94:17 97:20 143:7  
 172:19 180:7 185:22  
 186:2 195:15 281:8  
 322:14  
**physicians'** 196:7  
**pick** 60:2,6 95:1 180:7,9  
 180:13 184:20,22  
 193:22 194:6 254:10  
 254:11,13 311:9  
 350:3  
**picked** 247:21 248:10  
 253:21 254:3,9  
 285:13  
**picking** 191:3  
**picture** 24:19 163:1,4  
 178:4 391:9  
**piece** 292:16 293:5  
 298:19 312:11 317:8  
 317:16 357:9 372:12  
**pieces** 151:6 368:22  
 388:10 400:17  
**Pierre** 3:8 16:19,20  
 19:14 21:6 23:15,22  
 39:22 40:1 43:12,19  
 44:13 46:3 53:7 55:20  
 214:15 289:7 303:16  
 304:20 305:5 307:9

307:14 347:18 348:18  
 349:8,14 353:13,17  
 354:6,10 363:16,21  
 368:1 398:16 399:8  
 400:22  
**pile** 399:11  
**pillars** 290:1  
**pilot** 122:11 125:12,15  
 151:1 157:13,17  
 158:1 181:7 183:3  
 392:1  
**piloted** 118:20  
**piloting** 119:1,20 248:5  
 323:20 390:15  
**pin** 17:3  
**pipeline** 327:19  
**Pittsburgh** 3:2 228:8  
**place** 8:18 26:4 39:10  
 102:1 129:4 161:11  
 174:5 186:7 194:16  
 297:10 317:7 321:1  
 323:18,22 324:1,5  
 335:9 385:19 388:18  
**places** 98:10 186:5  
 236:21 387:12  
**plan** 176:1 195:11,15  
 195:17,19 268:3  
 285:9,17 349:6  
**planes** 307:6  
**planning** 68:6,8 79:20  
 108:6 111:17 113:7  
 113:15 115:14 137:9  
 295:13,13,20 297:9  
**plans** 195:7,8,8,9,10  
 298:15 338:22  
**play** 42:6 341:18  
**play-out** 43:11  
**played** 167:6  
**players** 44:10  
**playout** 280:7  
**plays** 373:14  
**please** 17:18 18:20 19:6  
 27:9 30:8 33:12 62:17  
 65:14 68:20 170:9  
 176:13 189:2 191:22  
 206:7,10 213:2 216:4  
 216:10 220:12 224:5  
 275:7,14,17 281:11  
 301:21,22 302:21  
 308:19 312:14 337:16  
 348:13 350:15  
**pleasure** 305:13 398:6  
**plug** 232:13  
**plurality** 383:22 384:17  
**plus** 164:4 359:14  
**pockets** 96:15  
**point** 25:10 29:5 35:8  
 38:8 44:21 58:8 59:11

66:13 85:11 99:1  
 102:16 110:21 120:2  
 120:8 126:16 128:20  
 132:10 149:20 152:18  
 159:14 165:18 169:18  
 173:21 178:1,8 188:1  
 188:9 193:2 198:6,10  
 199:18 232:2 247:4  
 262:15 265:13 299:19  
 311:12 332:14 341:16  
 355:18,21 360:1,15  
 361:4 362:1 364:16  
 381:16  
**pointed** 97:15 226:10  
**pointing** 59:9 147:2  
 383:19  
**pointless** 329:1  
**points** 58:4 69:17 78:4  
 171:17 179:20 184:13  
 198:11,18  
**policies** 293:12 294:7  
**policy** 34:16 84:13  
 194:21 375:1  
**poll** 218:21  
**poor** 64:22 86:21 334:1  
**poorly** 61:17  
**pop** 97:16  
**population** 30:15 42:2  
 50:21 63:18 83:7  
 87:18 89:16 96:12,19  
 96:20 142:22 158:10  
 187:12 393:15 394:6  
 395:1,5  
**population-based**  
 29:21 99:21  
**populations** 6:16 50:16  
 71:20 88:4,6 98:11  
 131:9,10 143:1  
 153:21 192:18 314:21  
 380:9  
**positive** 321:19,20  
**possibility** 71:15  
 196:12  
**possible** 204:16 235:2  
 298:1 301:11 329:10  
 355:7 400:7  
**possibly** 88:21 195:3  
 263:21 268:6 306:1  
**post-** 1:19 140:5 199:5  
 278:15 292:2 301:14  
 304:8 386:6  
**post-acute** 1:5 5:13  
 7:12 8:21 10:18 11:14  
 20:3,12 22:4 23:1,9  
 23:11 57:11 66:14  
 67:8 78:12 80:7 90:1  
 92:15 98:4 104:13  
 106:11 108:4 113:21

116:13 136:9,12 137:21 138:3,21 143:3 146:22 152:4,6 155:12 164:6 170:7 171:22 174:11,16 175:6 176:5 178:10 178:18 179:8 181:9 181:16 185:5 190:7 192:8 196:6 198:22 199:16 245:16 246:6 249:17 251:14 255:4 267:8 269:17 285:16 287:18 291:5,7,11,20 292:1 295:21 296:14 297:5 308:10,14 315:12 326:5 328:5 331:15 361:4 364:20 381:13 382:11 386:11 387:3,3 392:10 395:11	<b>practitioner</b> 47:5 185:22 322:21 <b>practitioners</b> 67:8 97:15,21 172:20 181:21,22 186:5 194:13 281:9 <b>pragmatic</b> 237:15,21 <b>Pratt</b> 3:6 267:5 302:4 400:9 <b>pre-</b> 206:14 <b>pre-admission</b> 335:1 <b>pre-rulemaking</b> 20:18 206:20 212:2 <b>preamble</b> 373:7 <b>preceding</b> 157:4 <b>predetermined</b> 259:12 <b>prediction</b> 364:10 <b>prefer</b> 351:15 <b>preference</b> 28:18 146:11 148:11 351:10 <b>preferences</b> 33:7 123:11 133:2 135:1,2 148:14 284:21 309:22 310:18 311:4 312:5,9 <b>preferred</b> 28:9 167:16 167:19 290:15 357:7 367:18 <b>preliminary</b> 207:6 208:15 217:21 218:5 219:3,10 224:17 244:7 342:9 <b>preparing</b> 8:6 128:5 318:12 <b>prerogative</b> 274:9 <b>prescribe</b> 322:15 <b>prescribes</b> 336:17 <b>presence</b> 25:2 134:14 284:3 <b>present</b> 1:12 3:1,12 69:12 100:22 105:19 106:1 151:11 171:5 218:11 299:20 <b>presentation</b> 4:5 25:7,9 39:19 41:4 45:8 57:17 68:22 133:6 150:10 <b>presentations</b> 35:15 217:18 <b>presented</b> 56:7 <b>presenting</b> 160:15 <b>president</b> 2:18 9:8 11:20 12:17 <b>presiding</b> 1:11 <b>press</b> 224:5 348:13 397:6 <b>pressure</b> 2:4 12:20 118:6,7 123:19 188:19,21 223:11 326:6,8,16 329:3,11	329:15,20 331:15,21 <b>pressures</b> 391:10 <b>presume</b> 364:4 <b>pretty</b> 5:9 22:11 42:22 44:10 83:8 85:15 86:7 86:19 176:13,13 181:14 192:19 193:14 207:12 209:19 227:19 250:3 328:6 354:2 371:1 384:20 <b>prevent</b> 82:10 <b>preventable</b> 32:6 109:2 332:2 363:3 <b>prevention</b> 33:19 34:1 34:3 59:3 111:8 326:12 <b>preventive</b> 33:22 <b>previous</b> 208:1 223:5 223:18 277:7 310:21 327:13 328:10 332:13 355:15 <b>previously</b> 21:22 122:19 323:4 335:13 338:18 371:4 <b>primarily</b> 20:9 385:2 <b>primary</b> 24:2 55:13 70:16 380:18 383:12 384:7,11 389:14 <b>principles</b> 73:21 74:1 75:2 141:6,12 216:20 237:15 298:8 372:14 372:17 373:7 374:12 374:17 379:7 <b>prior</b> 26:14 98:17 122:14 212:5 220:19 221:2 243:11 <b>priorities</b> 25:14 280:4 <b>prioritization</b> 92:7 <b>prioritize</b> 99:10 <b>prioritized</b> 321:7 <b>priority</b> 48:10 169:7 175:3,5 176:3 223:4 235:10 280:12 282:21 289:9 290:12 304:14 326:11 331:18 338:18 <b>private</b> 52:20 178:11 227:9,9 297:14 353:2 <b>privilege</b> 9:2 48:17 88:9 <b>proactively</b> 179:15 <b>probably</b> 25:10 28:17 40:11 51:19 63:20 76:19 77:15 79:3 83:11 85:20 86:12 91:21 92:2 106:3 107:9 108:11,22 111:2 144:4 164:11 171:7 186:22 252:3 253:6 259:17 267:21	287:22 309:12 319:13 328:2 329:2 332:18 336:5,11 362:5,19 365:16 387:8 <b>problem</b> 60:1 65:5,7 71:14 81:19 150:5 182:5 186:17 188:11 193:11 195:14 198:17 242:6 288:7 322:18 383:16,19,21 388:19 <b>problematic</b> 126:9 241:22 <b>problems</b> 47:5 71:3,6 83:1 93:20 134:18 137:18 165:5 276:1 344:18 382:18 <b>procedurally</b> 274:7 <b>procedure</b> 335:2 <b>process</b> 11:5 28:13 56:10 62:2 64:15,17 68:21 119:17 130:21 137:17 145:16 146:16 166:21 183:5 191:5 208:2 211:22 212:3 215:20 216:14 217:17 218:16 219:19 223:8 225:3 232:21 249:10 261:21 262:9 288:11 288:18 291:22 307:18 310:1 313:13,19 351:12,13 354:12,22 355:1,19 356:10 357:3,5 367:13,15,20 391:1 399:19 400:17 <b>processes</b> 119:19 133:22 370:10 <b>Proctor</b> 400:12 <b>produce</b> 48:15 <b>product</b> 379:5 <b>productive</b> 399:3 <b>products</b> 372:21 <b>professional</b> 168:20 <b>professionals</b> 44:1 172:15 <b>professions</b> 147:14,17 <b>profile</b> 153:6 208:17 <b>profiles</b> 153:19 <b>profound</b> 86:19 <b>program-specific</b> 286:3 <b>programs</b> 20:20 21:5 23:8 24:3,20 26:11,13 29:12,15 30:3,4,21 32:14,21,21 37:10,14 37:15,16,17,17 38:15 50:2 51:4,6 53:4,17 53:17 54:10 55:1 70:8 70:10,15 72:9,15,17 73:4,22 78:8 84:21
--	--	--	--

85:2 89:21 94:6 95:6  
96:14 144:9 152:3  
161:16 162:10 172:12  
207:1,7 232:4,9  
247:12 254:21 263:2  
268:13 277:10 298:12  
302:3 337:17 350:1  
351:6,7 353:2 361:1  
361:21 372:6 379:1  
385:13  
**progress** 76:4 338:16  
**project** 2:20,20 18:9,11  
69:21 70:6 76:16  
79:10 95:15 119:16  
247:15 288:12 306:9  
306:19 368:15  
**projects** 89:2  
**proliferation** 26:15  
**PROM-** 153:4  
**PROM-QM** 164:4,8  
**PROM-QMs** 152:13  
**PROMIS** 4:6 19:21  
133:3,3 134:11,11  
135:3,3 138:19 150:4  
150:9,15,20 151:1,4  
151:16 152:2,9,13  
153:1,4,5 154:7,10,12  
154:17,20 155:3,10  
155:10,11,16,16  
157:20 158:21,22  
163:10,20 164:21  
165:3 166:21 168:4  
169:20 279:18 313:5  
341:3  
**promise** 57:5 60:9  
**promising** 341:3  
**promote** 34:7 197:12  
209:13 287:9 335:12  
**promoting** 33:13,18  
111:6,8 197:15  
321:15  
**promotion** 59:2  
**promptly** 233:9  
**PROMs** 152:12,13  
153:4  
**pronged** 131:1  
**proof** 157:7  
**properties** 210:9  
317:15  
**proportion** 87:20  
**proportions** 35:2  
**proposal** 118:22 123:15  
125:3,10  
**proposals** 39:15 115:22  
124:3  
**propose** 149:20 150:8  
211:19 239:7 261:11  
268:22 348:2 366:4

**proposed** 39:13 123:16  
125:4 175:14 176:1  
225:20 265:5 360:19  
370:17  
**proposing** 269:1  
**PROs** 158:3 164:22  
323:11  
**protocol** 129:19 130:2  
146:7,12 165:13  
166:7 200:10 203:18  
204:3 227:11  
**protocols** 129:22 130:4  
130:9 133:11,16  
153:19 154:7 155:11  
155:17 156:6,9,15  
165:10 167:11 168:9  
**proud** 72:19  
**prove** 124:17  
**proven** 117:8 122:20  
**provide** 20:8 21:22 22:6  
45:3 51:15 73:20  
88:19 101:2 111:15  
114:1 116:8 119:11  
154:14 215:3 217:16  
246:12 314:1 318:12  
318:15 355:11 380:2  
384:16 401:5  
**provided** 48:1 113:22  
213:14 220:19 382:19  
384:1  
**provider** 11:14 50:5  
57:15 84:14 108:5  
110:7 111:12 113:1  
115:10 182:21 190:7  
190:21 202:18 227:6  
251:8 266:18 287:18  
291:15 293:13,16  
341:6,15 361:1  
370:20 372:5 389:15  
390:6,8  
**provider's** 382:11  
**providers** 28:7 29:19  
39:8 52:1 55:11 70:2  
70:9 72:14,19 74:4,7  
83:2,20 86:15,18  
88:10 89:22 93:22  
94:7,15,19,22 95:1,20  
98:2 99:22 100:22  
101:18 107:14 108:12  
114:2 124:12 128:16  
142:13 154:9,11  
160:17,22 167:6  
171:22 178:3,6,10,22  
179:3 189:11 190:13  
193:9,10 227:9 228:2  
228:16 229:7 234:11  
250:10 255:4 283:7  
288:6,16 293:14,15

295:3 317:12 322:14  
324:6 330:1 347:4  
350:22 358:21 359:17  
360:13 369:12 385:12  
391:2,8,18 395:16  
**providers'** 289:11  
**provides** 314:8  
**providing** 19:17 173:4  
193:17  
**provision** 311:2 312:20  
**proxies** 148:3  
**proxy** 164:11,15 238:3  
238:15  
**Prozac** 184:2  
**psychiatric** 328:14  
**psychological** 57:12  
58:6 314:9  
**psychometric** 363:22  
**psychosocial** 314:6,9  
**PT** 2:2 189:10 198:7  
**PTs** 146:16 147:18  
149:9  
**public** 4:9,20 27:22  
31:21 39:13 110:15  
116:1 119:18 123:6  
132:8 151:9 152:21  
175:14 217:22 220:17  
220:19,21 221:1  
224:2,8 225:18  
226:18 228:13 252:10  
253:5,7 254:15  
257:15,15,20 258:15  
265:19 266:2 268:1  
305:15 347:22 348:2  
348:3,15 359:17  
397:1,4,6,8,15  
**public/private** 269:15  
**publically** 94:8  
**publicly** 135:17  
**publish** 294:16  
**published** 294:14  
**pull** 133:15 138:2 208:4  
208:7 219:1,8 224:20  
225:2 325:1  
**pulled** 219:17 239:6  
274:8 350:10,17  
**punished** 393:16  
**purchasing** 29:15  
143:20 256:20 257:14  
261:6 369:3 376:13  
**purpose** 187:20 366:5  
368:21 373:12 375:9  
375:12  
**purposes** 107:15  
108:14 117:5 118:15  
127:22 152:8 227:15  
257:21 373:4,17  
374:1 378:22 379:1

**pursing** 161:5  
**pursuing** 176:9  
**push** 19:1,2 46:20,22  
217:12 315:17  
**pushed** 217:10  
**put** 5:15,19 8:9 14:5  
23:6 42:7 55:4 70:4  
83:13 92:4 98:7  
123:14 128:13 177:3  
177:3,3,8 179:17  
203:12 218:3 223:4  
232:13 234:4 240:4  
252:11 254:6 257:14  
264:6 265:7 271:6  
274:9 279:20 280:6,9  
284:4 299:12 301:9  
352:22 354:6 358:20  
360:5 399:16,16  
**puts** 215:5 244:19  
**putting** 86:4 95:7 177:4  
198:21 226:19 227:3  
260:1 309:5 312:18  
321:18 323:18 395:11

---

**Q**


---

**QAPI** 203:12  
**QCDR** 40:13 60:10  
61:10 62:4 67:20  
180:4 181:6 183:11  
344:9  
**QI** 71:13 80:9 254:21  
**QIN-QIO** 38:20  
**QMs** 153:5 254:6  
286:10  
**QPP** 201:14  
**QPR** 224:2  
**QRP** 224:14 226:20  
233:12 267:11 272:16  
272:17,19,20 277:3  
285:21 326:21 331:7  
360:21  
**QRPs** 325:16  
**QRUR** 384:13 392:9  
**qualified** 15:17 60:4  
90:3 385:11  
**qualify** 96:9,10 204:13  
**qualitative** 125:21  
133:8 320:22  
**quality-** 321:7  
**quality-of-life** 321:6  
**quality-related** 36:20  
**quantify** 193:8  
**quantity** 357:4  
**quarter** 37:6 359:22  
**quarter's** 323:19  
**question** 10:5 36:11  
40:17 41:12 43:6,18  
44:17 82:10 83:4

84:16 85:21 87:10  
 89:21 91:10,15 92:11  
 92:15 93:6,8 102:6  
 112:16 137:22 138:7  
 138:10,13 140:1  
 144:21 163:8,12  
 166:15,18 183:12  
 185:20 187:18 197:16  
 234:10 235:7,15  
 236:5 238:16 247:11  
 247:20 251:13 253:14  
 254:14 256:15 258:21  
 259:1 264:7 280:1  
 281:15 287:11 288:9  
 289:18 291:15 313:5  
 343:15 353:6 354:4  
 364:14 366:3 369:6,6  
 369:19 382:4 385:6  
 385:17  
**questionnaires** 257:10  
**questions** 17:12 32:9  
 35:17,18 36:12,16  
 39:21 68:14 78:4,6  
 83:17 98:14 112:20  
 120:19 135:14 137:17  
 138:4 140:10,16,16  
 140:19 141:1,3,19  
 150:12 151:11 159:22  
 184:14 185:2 192:3  
 198:5 204:10,12  
 206:7 209:2 219:5  
 225:3,7 227:1,22  
 230:19 234:22 236:20  
 238:17 239:14 250:15  
 251:2 257:1,2,3,5,8  
 272:10,11 273:6  
 277:16 299:8 318:8  
 350:11 354:10 376:11  
 381:1 392:3 396:8  
**queue** 19:8 208:19  
 348:5  
**quick** 100:18 106:17  
 146:6 163:7 222:8  
 256:15 273:9  
**quickly** 27:12 31:13  
 35:20 69:15 82:18  
 142:7 152:20 153:13  
 209:16 216:18 364:17  
 379:3  
**quiet** 177:11  
**quintile-type** 261:17  
**quintiles** 259:7,7  
**quite** 21:15 56:10 69:13  
 69:13 72:12 78:1  
 102:8 219:20 262:18  
 262:19 317:9 342:21  
 371:5  
**quorum** 171:7

**quote** 316:4

---

**R**

---

**radar** 177:9  
**radical** 390:17  
**raise** 65:5 140:22 188:7  
 215:19 220:11 236:17  
 261:15 275:14,17  
**raised** 153:22 211:11  
 214:5 260:5 288:21  
**raising** 41:12 256:3  
 266:9  
**Raj** 10:15,16 40:15  
 41:13 194:8 199:20  
 205:22 280:13 281:6  
 285:7,11 336:7  
 390:10  
**Raj's** 395:3  
**ramble** 57:21  
**RAND** 118:13 120:16  
 121:7 147:17 151:5  
 151:16 155:7 157:8  
 159:12 167:14  
**randomly** 128:11  
**range** 248:6 398:11  
**rank** 237:4  
**ranking** 191:17  
**ranks** 86:12  
**rapidly** 216:2  
**rare** 243:9  
**rate** 61:15 240:15 241:9  
 242:6 252:17 253:3  
 258:16 294:18 326:5  
 340:13 346:5 358:16  
 362:6,7,22 365:16,19  
 366:18  
**rates** 242:7 248:4 288:6  
 342:3 395:15,22  
**rating** 257:16 259:4,17  
 359:18 361:14  
**ratings** 90:9  
**rational** 207:20 239:3  
**re-** 33:15  
**reach** 45:4 88:19  
 129:10 207:11 216:10  
**reaching** 131:2  
**react** 46:8 47:11 48:14  
 350:12,18  
**reacting** 51:20  
**reaction** 46:9,16,17,17  
 47:8 51:18 81:13  
 339:9  
**reactions** 49:18 350:4  
 357:14  
**read** 124:5 273:17  
 307:2 309:1 338:10  
 376:9 396:10  
**reading** 237:6,7 299:6

300:11  
**readmission** 109:2  
 267:19 288:6 342:3,4  
 365:16,19 366:11,18  
 381:20 382:9 384:12  
 395:15  
**readmissions** 34:19  
 298:13 332:2 346:17  
 366:13 384:9 386:7  
 387:9 395:12  
**ready** 5:4 7:6 170:15  
 257:17,20 262:18,19  
 264:4 266:19 329:17  
 330:8  
**reaffirm** 280:10  
**real** 17:18 52:22 71:14  
 124:5 131:3,4 146:6  
 195:12 324:17 375:13  
 386:4  
**reality** 152:9  
**realization** 73:2  
**realize** 52:18 78:9 88:5  
 181:21 182:4 231:22  
 236:3 329:7 346:3  
 367:11 384:3  
**realized** 345:12  
**realizing** 255:20  
**realtime** 111:15 113:1,3  
 114:3,4  
**reason** 14:3 61:4 62:4  
 87:12 124:2 144:18  
 147:15 170:2 181:15  
 215:7 231:22 232:13  
 250:13 252:20 261:16  
 264:18 287:1 335:14  
 383:17 391:20  
**reasonable** 77:9 92:4  
 263:5 265:16  
**reasoning** 209:1  
**reasons** 144:19 152:5  
 178:1 323:21 334:20  
**rebel** 182:9  
**rec** 145:18 279:5 332:2  
**receive** 217:3 331:2  
**received** 14:3 123:6  
 125:21 176:2 211:16  
 218:1,17 243:9 246:1  
 246:2,10 277:14  
 293:16 319:5 373:1  
**receiving** 115:4 158:15  
 277:14 377:7  
**reception** 287:22  
**recertification** 342:12  
**recipients** 55:13  
**recognize** 162:21  
 198:17 314:15 317:18  
 318:3,7 351:10  
 391:13

**recognized** 212:17  
 246:13 285:14  
**recognizing** 255:7  
 373:15  
**recommend** 226:7  
 235:2 248:21 256:21  
 257:13 259:8 262:2  
 264:20 308:6  
**recommendation** 72:13  
 73:9,16 214:21  
 219:11,14 226:13  
 259:19 261:10 265:17  
 266:2 290:11  
**recommendations** 40:8  
 70:1,4 73:7,11,20  
 75:9 105:8 169:22  
 211:20 221:2,2 226:6  
 261:9 264:16 265:8  
 268:19 271:12 296:13  
 332:4 372:16 379:6  
**recommended** 212:21  
 226:17 248:14 257:9  
 264:22 265:14 277:8  
 327:3,5 379:8,12  
**recommending** 226:11  
 246:21 254:16 258:1  
 266:11 353:20  
**reconcile** 375:10  
 380:20  
**reconciled** 245:5  
**reconciliation** 123:11  
 127:9 133:4 135:5  
 138:18 145:17 278:2  
 326:19  
**reconvene** 102:22  
 150:1 349:1  
**record** 103:3 115:13  
 129:20 171:1 234:13  
 278:12 329:4 349:4,5  
 401:13  
**recorded** 11:6  
**records** 293:2 331:11  
**recovered** 398:5  
**recovery** 124:12  
**recruit** 128:22  
**recruited** 128:21  
 156:20  
**recruitment** 129:3  
**red** 19:2 288:12  
**redefining** 49:11  
**reduce** 36:13 47:18  
 154:16 284:22 288:6  
 298:12 395:14  
**reducing** 32:1 48:5  
**reduction** 34:19 321:11  
 321:22 325:21  
**redundancy** 154:1  
 360:13

**reemphasized** 374:21  
**reevaluate** 361:5  
**reference** 158:10 218:2  
 223:1 338:11  
**referenced** 42:1  
**referrals** 346:15  
**referred** 172:8 289:14  
**referring** 164:15,16  
 273:10 373:16  
**refine** 210:10 211:3,13  
 214:9 215:1,15,20  
 339:5  
**refinements** 213:3  
 332:8  
**reflect** 7:17 47:8 49:14  
 71:4 93:16 209:11  
 238:4 287:11,14  
**reflecting** 105:9 333:18  
**reflection** 146:3 201:12  
 332:11  
**reflections** 6:21 102:12  
 287:15 311:13 333:1  
 336:4,21  
**reflective** 235:3 239:1  
 240:18  
**reflects** 43:21 289:10  
**Reform** 116:13 122:15  
 147:1  
**reformat** 156:1  
**refresh** 277:6  
**regard** 236:19 237:13  
**regarding** 70:18 244:18  
 245:13 268:1 285:6,7  
 320:13 323:16 325:9  
 361:12 363:13  
**regardless** 31:17 91:4  
 242:13  
**regimen** 362:20  
**registered** 172:21  
**registry** 15:17,18 60:4,5  
 202:21  
**regret** 329:2,5  
**regroup** 170:21,21  
**regular** 229:22  
**regularly** 375:5  
**regulations** 84:7  
**regulatory** 84:1  
**rehab** 94:19 107:2,12  
 182:13 315:20 333:9  
 337:12 362:14  
**rehabilitation** 1:17 4:12  
 13:3 104:10  
**rehospitalization**  
 340:13  
**rehospitalizations**  
 326:18  
**reinforces** 22:19 87:3  
**reiterated** 212:15 213:1

**reject** 65:1 344:13  
**rejections** 296:18  
**rejects** 61:14  
**rejoin** 103:6  
**relate** 236:7 318:9  
 353:17 354:7 377:2  
**related** 10:8 14:6 36:12  
 36:15 59:13 64:22  
 99:20,22 112:18  
 134:15,16 141:19  
 233:8 234:16 240:20  
 253:10,11 260:7  
 272:10 279:2,17  
 290:22 304:4 310:3  
 313:10 328:12 332:5  
 355:18  
**relates** 25:17 233:5  
 355:17 357:6  
**relating** 39:16 372:16  
**relation** 102:1 325:4  
 358:6  
**relationship** 369:14  
**relative** 24:20  
**relatively** 49:8  
**relayed** 264:15  
**relaying** 261:19  
**release** 124:13  
**releases** 124:13  
**relevance** 43:7 61:2  
 62:14 66:7 141:7,13  
**relevant** 14:12,13 28:8  
 40:12 45:3 60:14 68:9  
 75:8,12 77:20 81:14  
 142:1 180:10 187:1,5  
 204:22 273:6 374:3  
**reliability** 72:6 122:4  
 126:6 133:21 147:5  
 155:8 157:2 257:3  
 364:4 377:22  
**reliable** 117:8 122:20  
 124:7 125:19 132:13  
 147:6 158:17 361:3  
**relied** 168:10 238:1  
**relieved** 392:12  
**relooked** 279:6  
**remaining** 242:19 382:7  
**remains** 219:11 342:17  
**remarkable** 98:11  
**remarks** 4:3 19:15  
**remember** 14:19 17:17  
 54:1 94:14 135:19  
 151:20 208:1 254:2,2  
 254:8 269:14 322:13  
 388:4 395:11  
**remind** 9:22 17:16 19:4  
 156:19 216:21 233:4  
 390:4  
**reminder** 328:17

**reminders** 14:10,18  
 15:1  
**reminds** 335:11  
**remiss** 298:9  
**remote** 275:20  
**remotely** 275:7,7  
**removal** 4:15 22:10  
 84:7 85:2 304:20  
 305:6,14 307:10  
 347:19 349:9 354:7  
 360:19 366:8,19  
**removals** 38:1  
**remove** 144:1 219:12  
 338:14  
**removed** 143:13 144:4  
**removing** 365:5 367:7  
**renewed** 279:19  
**repeat** 132:5 304:7  
 354:4  
**replace** 326:7 331:16  
**replacement** 366:8  
**report** 36:7 42:8 51:9  
 60:3,8,10 61:8,12,18  
 61:21,22 62:7 108:17  
 161:20 169:5 186:14  
 188:16 196:8,22  
 222:11 325:1,17  
 330:22 338:3 358:18  
 358:22 359:12 362:12  
 362:15 363:1 368:17  
 386:6 388:3,4  
**reported** 94:2,9 158:8  
 159:13,16,20 256:22  
 260:9 294:16 320:21  
 338:4  
**reporting** 4:8,10,11,13  
 4:14 16:14 21:2 26:10  
 28:21 35:22 36:2,6  
 38:14 46:13 47:18  
 48:6,9,18 52:17,19,20  
 53:3 54:5 61:1,13  
 63:15,15 71:12,13  
 98:5 140:9 152:3  
 161:15 162:10 186:8  
 186:10 202:16,19  
 203:3 221:11 222:10  
 226:18 228:13 256:17  
 257:15,16,21 258:15  
 263:2 265:19 268:2,3  
 268:12 269:9 274:20  
 300:4 313:17 320:19  
 324:7,12 325:10  
 337:12,21 353:10  
 357:20 358:8 360:13  
 361:15 362:4 363:4  
 376:20 379:18  
**reports** 114:1,8 215:4  
 290:2 313:21 362:3

**repository** 138:20  
 225:16  
**represent** 9:21,22 11:8  
 11:17 12:1,13,16 13:2  
 13:6 86:7 192:20  
 376:6  
**representative** 10:4  
 12:20 241:14 298:9  
**representatives** 13:10  
 131:12 339:22  
**represented** 45:2 321:8  
**representing** 6:13  
 10:17 14:4 15:11 44:9  
 59:18 103:17 104:14  
 226:16 236:14  
**represents** 234:11  
 320:10  
**reprieve** 24:11  
**reproduced** 140:20  
**requests** 44:18 84:3  
**require** 107:4 109:22  
 200:9 335:4,6  
**required** 106:4 112:9  
 142:10 172:7 197:13  
 222:13 269:8 294:2  
 315:18 358:19  
**requirement** 214:10  
 273:13  
**requirements** 36:6  
 39:11 46:14 52:19  
 84:1 114:6 200:8  
 244:12 293:12,22  
 294:4 351:5  
**requires** 106:5,21  
 107:13 108:16 109:5  
 109:18 112:2  
**requiring** 56:21 115:5  
**research** 132:4 313:22  
**reservation** 101:8,10  
**reserve** 356:15  
**resident** 147:10 235:13  
 238:9 243:9 277:10  
**residents** 72:22 75:13  
 77:20 130:1,2 160:7  
 232:22 236:22 298:3  
 326:7  
**resolution** 24:10  
**resonate** 27:15 278:7  
**resonates** 289:18  
**resonating** 99:16  
**resource** 88:21 108:21  
 117:2 137:7 225:12  
 358:17 369:5,11  
**resources** 57:17 58:15  
 71:11 95:2,6 97:18,22  
 136:20 358:22 394:4  
 396:15  
**respecifying** 175:4

**respect** 185:4 387:20  
**respected** 343:10  
 386:19  
**respectful** 251:7  
**respiratory** 134:21  
**respond** 82:17 241:6  
 287:11 334:20 343:13  
 361:8 389:10  
**respondence** 248:5  
**respondents** 240:16  
 241:12  
**response** 17:14 18:2  
 46:16 112:17,21  
 159:14,15 168:10  
 240:15 241:9 242:6,7  
 248:3 252:17 253:3  
 256:22 324:21 325:3  
 325:11 330:14 339:8  
 344:8  
**responses** 249:3,4,14  
 252:19  
**responsibility** 24:2  
 225:12 244:20 322:21  
 372:11 377:19,21  
 382:12 383:8 384:15  
 395:21  
**responsible** 298:21  
 299:6 336:15 369:6  
 383:13 393:4  
**responsive** 193:21  
 209:7,10 310:17  
**responsiveness** 310:16  
**rest** 23:19 62:15 115:12  
 239:4 308:22  
**restricted** 176:14  
**restrooms** 19:11  
**restructured** 34:21  
**resubmit** 210:10 211:4  
 211:13 214:9 215:1  
 215:15,20  
**result** 61:1 180:12  
 241:17  
**resulted** 368:17  
**results** 131:21 147:7  
 152:19 154:6,16  
 225:14 251:20 277:11  
 291:21 292:7 366:7  
 372:5,8,9 373:18  
 377:12  
**resumed** 103:3 171:1  
**resumption** 157:21  
**resuscitate** 284:14  
**rethink** 280:3  
**retired** 302:21  
**retrieve** 147:7  
**retrospective** 370:18  
**return** 245:21 398:19  
**returning** 206:19

340:11  
**reused** 127:17  
**review** 4:2,3,17 19:15  
 22:19 23:12,16 31:14  
 37:3 39:6 121:2  
 129:21 207:1,6  
 212:10 220:21 225:5  
 306:2,6 353:9 354:22  
 355:3 362:20 379:14  
**reviewed** 42:15 54:3  
 123:4 221:3 375:5  
**reviewing** 20:9,21  
 22:15 28:21 105:12  
**reviews** 214:2  
**revised** 139:5 158:21  
**revisited** 210:5 324:3  
 324:19  
**rewarding** 56:13  
**rich** 7:11  
**ridiculous** 61:11  
**right-hand** 112:21  
**righthand** 275:9  
**ring** 64:3 78:18  
**rises** 251:19  
**risk** 6:7 72:4 101:21  
 102:6,9 117:5 254:8  
 265:10 287:4 364:9  
 364:10 366:15  
**risk-** 35:12  
**risk-adjusted** 34:4  
**risk-based** 92:17  
**RN** 1:13 2:3,12 3:4  
 146:13  
**road** 91:12,13 130:15  
 161:6  
**Roberts** 1:21 11:7,7  
 164:19 165:22 189:8  
**robin** 189:6  
**robust** 7:22 82:8 119:17  
 130:21 157:22 276:15  
 312:20 313:1 316:12  
**Robyn** 1:16 12:9 59:20  
 90:19 234:4,4 244:17  
 297:20  
**role** 9:5 28:13 29:8,9  
 47:4 152:16 198:11  
 318:1 356:9 373:14  
**roll** 48:4 49:22 190:19  
**rolled** 227:2 229:11  
 316:20  
**rolling** 47:15  
**room** 1:10 10:11 15:2  
 19:6 24:18,22 43:15  
 68:19 123:7 224:11  
 275:6 397:9  
**root** 288:7 388:7  
**root-based** 63:14  
**roster** 76:13

**round** 189:6 207:13  
 208:6  
**rounds** 237:5  
**routinely** 293:17  
**Rph** 2:15  
**rule** 39:14,16 64:4  
 118:22 123:15 124:5  
 175:15 252:3,4,8  
 265:2 271:3 273:20  
 319:13 326:2 331:13  
 392:22 393:11  
**ruled** 257:20  
**rulemaking** 39:12 45:21  
 176:20 206:15 210:14  
 223:8,13 224:18  
 225:20 226:2,3,12,19  
 252:11 262:16 263:6  
 264:14 266:13 274:19  
 275:3,4 276:9,13  
**rules** 123:16 252:5,8  
 372:4 375:16,20  
**run** 62:4 65:13 114:2,7  
 123:17 147:22 365:15  
**running** 40:13 60:3  
 149:17  
**rural** 4:5 6:12 19:18  
 31:22 57:18 58:19  
 69:7,12,19 70:2,9,10  
 71:21 72:14,19 73:17  
 74:3 75:8,12 76:11  
 77:20 80:7,18 81:2,5  
 81:14 82:9,20,21 83:2  
 83:8,12 84:9 85:14  
 86:7,8,11,15 87:12,18  
 88:10,18,19 89:22  
 90:3,12 92:14,17  
 93:12,18,22 96:15  
 98:12,21 101:5 102:1  
 105:3 324:12  
**Ryan** 370:4

---

## S

---

**safe** 29:9 245:7 315:22  
**safeguard** 27:22  
**safeguarding** 31:21  
**safekeeper** 225:16  
**safer** 223:10 326:14  
 331:19  
**safety** 32:3 83:21 317:3  
 317:9 320:8 331:9  
**sake** 127:21  
**sakes** 299:7  
**Saliba** 2:1 11:19,19  
 87:8 121:9 147:2  
 190:10 260:3 263:11  
 394:12  
**salient** 83:2  
**salt** 184:2

**sample** 112:16 156:8  
 156:15 157:9 158:8  
 240:2,8,19 241:14  
 243:6,7 249:21 377:5  
 377:11  
**sampling** 128:9 240:6  
 247:9,11,18 253:17  
**sand** 45:14  
**Sandy** 222:3  
**satisfaction** 65:21  
 66:21 227:16 228:18  
 235:1 238:2 244:9,16  
 245:21 246:7,14,17  
 255:7,9,13,19 312:8  
**satisfied** 66:22 106:5  
**satisfy** 106:19  
**savings** 31:22 395:9  
**saw** 5:16 20:6 113:9  
 213:9 215:16 300:18  
 312:1 400:6  
**saying** 7:9,16 24:15,16  
 43:12 81:12 87:9  
 100:6 124:6 125:22  
 135:22 142:21 168:13  
 169:2 185:7 188:22  
 193:19 194:6 198:3  
 211:15 234:13 253:16  
 253:19 261:5 278:12  
 278:14,18 299:7  
 329:4 345:7 347:10  
 354:10 384:14  
**says** 65:20 102:22  
 240:2 260:11,14  
 388:12  
**scale** 159:14,15  
**scan** 121:2 123:5 370:1  
 370:2,5,15  
**scars** 40:13  
**SCFES** 1:21  
**schedule** 216:2 303:11  
**scheduled** 307:4  
 360:18  
**schedules** 399:14  
**scheduling** 396:13  
**scheme** 48:10  
**SCHLAIFER** 231:11  
**SCHLEIFER** 2:15  
**Schmidt** 2:1 13:5,6  
 83:16 100:18 163:7  
 164:14 242:8,12  
 243:3,8,15,21 244:2  
 273:9 312:15 395:2  
**school** 188:17  
**Schwartz** 3:7 319:10  
 400:12  
**science** 6:6 79:10  
 375:13  
**scientific** 209:8 210:8



213:19 354:13 364:2  
**scope** 33:21 199:13  
**scoped** 70:16  
**score** 60:7,19,20 62:8  
 67:13 153:6 175:16  
 175:19,20 236:11  
 258:16 260:10 358:14  
 359:4,4 371:14  
**scored** 180:14  
**scores** 246:8 255:8  
 256:7 372:6  
**scoring** 90:7 175:17  
 178:22 185:7,18  
 261:18  
**scratch** 138:17 139:2  
**screen** 275:9 312:13  
**screening** 64:18 65:2  
 309:20,21 335:2  
 344:11  
**scrutiny** 84:3  
**SDOH** 344:1,5  
**se** 35:8 42:20 52:13  
**seamless** 33:16 52:8  
**Sean** 1:21 11:12 81:7  
 87:11 90:16 232:16  
 233:21 286:14 287:12  
 288:21 289:19 298:17  
 327:15 330:6 333:5  
 334:20 339:10 365:8  
 366:2  
**Sean's** 336:4  
**seat** 348:8  
**seated** 76:4  
**second** 9:19 32:5 34:10  
 47:12 84:15 95:18  
 116:11 120:7 135:4  
 146:12 157:3 167:19  
 174:16 210:11,18  
 235:5 263:12 267:15  
 267:17 274:7 275:3  
 284:7 296:1 298:16  
 335:4 368:19 378:4  
 378:16 381:9 396:6,7  
**secondarily** 329:13  
**secondly** 90:7  
**Secretary** 112:9 211:18  
 265:8  
**section** 117:15 120:6  
 148:7,9 179:4 319:14  
**seeing** 32:14 65:17  
 100:1 238:8 240:20  
 256:8 273:22 294:19  
 337:17 384:2,6,6,15  
**seek** 39:13 66:21  
**seeking** 137:18  
**Seema** 25:13  
**seen** 5:12 11:2 154:1  
 160:21 253:6 254:18

298:2 308:6 359:6  
 362:6 363:1 380:16  
**sees** 175:10  
**segment** 328:5  
**seizure** 398:4  
**select** 180:8,15 193:15  
**selected** 128:11 190:20  
**selecting** 55:15 73:21  
 75:1 121:1 373:20  
 374:5  
**selection** 68:10 73:11  
 73:14 75:3 91:17  
 118:16 191:5 209:3  
 210:22 370:10 372:19  
 374:13 376:1 378:20  
 379:7,10 381:5  
**self-** 161:19  
**self-care** 117:18  
**self-report** 153:16  
 162:6,15  
**self-reporting** 158:6  
**send** 19:9 101:16  
 217:13 242:4 291:12  
 293:14 376:9 379:21  
 383:11 396:2,8,10  
**sending** 225:12  
**sends** 178:2  
**senior** 2:17,18,19,20  
 9:8 18:6,9 69:10  
**sense** 46:7 105:12  
 182:17 195:1,2 202:6  
 202:12 203:16 238:9  
 249:17 265:4 285:11  
**sensitivity** 248:3  
**sensory** 118:11 122:21  
**sent** 154:9 218:19  
**separate** 144:14 355:1  
 358:6  
**separately** 144:12  
 228:5  
**sepsis** 251:17  
**September** 106:15  
**sequence** 249:13 250:2  
 250:5 257:15  
**sequencing** 209:5  
**series** 89:2 288:14  
 376:11 379:6  
**seriously** 399:18  
**sermon** 300:1  
**serve** 9:16 219:22  
 391:17  
**served** 216:4 386:5,8  
**serves** 101:7 218:7  
**service** 2:11 89:2  
 101:14 134:20 194:16  
 204:11 222:17 279:4  
 377:17 384:6  
**services** 3:4,5,6,7,8,9

11:15 15:7 71:16  
 86:16 87:22 88:8,20  
 110:15,16 112:6  
 115:10 118:1 120:13  
 122:22 123:22 132:22  
 165:20 291:18 311:2  
 312:21 313:2,2  
 330:11 377:18 384:1  
 384:17  
**serving** 79:1 103:21  
**SES** 82:3  
**session** 306:7 311:1  
**set** 2:14,15 25:14 27:10  
 31:12 50:4 54:3 55:9  
 55:10,11 64:20 75:1  
 76:21 107:8 120:21  
 133:3 140:11,13,16  
 174:2 193:20 194:16  
 199:7,8 207:6 209:7,9  
 209:9,13 231:13  
 240:14 248:22 249:2  
 261:12 265:1 291:10  
 297:9 298:8 309:15  
 310:20 312:1 313:18  
 318:5 320:18,20  
 321:3 324:5 326:21  
 357:12 365:1 372:14  
 375:16 386:16 387:13  
**sets** 38:2,7 39:6 50:11  
 51:11 74:2,5 75:6  
 143:2 198:21 199:3  
 231:19 240:21 295:14  
 349:22 353:9  
**setting** 6:1 85:4 120:13  
 120:13 157:1,5,12,15  
 165:6 174:12,17  
 175:6 185:5 187:3,13  
 189:14 199:1,6,17  
 245:9 296:12 304:12  
 306:13 317:9 333:12  
 337:6 347:12 364:22  
 365:2,4 387:7 394:7  
 397:22  
**setting-** 390:8  
**settings** 21:9,11 22:5  
 26:14 71:20 78:11,12  
 108:4 117:3 121:3,3  
 122:5,21 124:14  
 125:7,20 132:14  
 136:21 137:10 145:1  
 154:13 155:13 158:5  
 160:18 163:3 164:9  
 165:11,16 174:19  
 178:13,18,19 179:8  
 188:3,4 189:13 190:3  
 202:10 227:6,8  
 228:15 229:12 238:2  
 239:13 258:10 262:6

265:20 278:12,16  
 280:2 293:11 294:13  
 294:15,22 295:1  
 304:14,16,21 305:1  
 311:5 327:3 333:21  
 334:15 336:11 340:2  
 340:11,16,17 363:11  
 364:21 394:19  
**settled** 77:18  
**setup** 67:17  
**seven** 5:12 133:19  
 156:13,17 159:14  
 194:1 209:4 253:18  
 253:21,22,22 254:3,5  
 298:14 302:20 323:13  
**severe** 114:21 254:7  
**severity** 116:21 134:14  
**shaped** 365:17  
**share** 16:5 19:15 20:17  
 21:7,7 23:2 69:7 79:4  
 87:16 200:19 204:15  
 204:21 205:14 214:15  
 216:11 294:3 298:15  
 306:15 311:16 343:20  
**shared** 7:3 259:16  
 369:19 376:7 395:6,9  
**sharing** 161:14 232:14  
 343:17  
**shifted** 87:15  
**shining** 114:18  
**shooting** 139:20  
**short** 149:22 211:6  
 221:7 233:12 241:4  
 326:9 338:9 348:8  
 350:13  
**short-** 225:5 233:12  
**short-stay** 224:15  
 234:19 237:1 274:16  
 275:11  
**short-term** 195:19  
 291:5 392:13  
**shortage** 71:4 94:16  
 143:8  
**shout-out** 64:14  
**show** 40:14 60:16 76:9  
 128:13 137:7 275:15  
 275:18 301:11 387:2  
 388:21 392:8  
**showed** 251:1 353:7  
**showing** 120:1  
**shown** 139:17 313:22  
**shows** 47:14 120:15  
 128:12 132:15 223:3  
**shutdown** 24:8  
**shy** 68:19  
**siblings** 302:20  
**sick** 96:8  
**sicker** 245:14,18

324:22  
**side** 10:14 30:17 32:7  
 35:5 58:18 82:8 85:3  
 92:16 112:21 176:2,6  
 231:17,22 255:13  
 293:22 328:2 339:19  
 353:22 374:16 387:5  
 387:10 393:18  
**sign** 382:22 383:3,7  
**signed** 106:16  
**significant** 87:20  
 166:11 212:17 284:3  
 319:1 320:10 372:4  
 385:20  
**signing** 383:15  
**signs** 42:8 134:8 394:9  
**silly** 182:22  
**siloed** 100:14 388:5  
**siloing** 182:4  
**silos** 181:8 183:17  
**similar** 42:5 140:16  
 212:8 228:14 259:5  
 262:5 356:3 360:22  
**similarly** 270:5 354:19  
**simple** 182:17 187:16  
 209:19 387:7  
**simply** 201:7 258:15  
 284:12 318:14 394:13  
**Simultaneous** 63:3,21  
**Singh-Shah** 400:14  
**single** 23:4 49:22  
 172:13 370:20 380:18  
 394:15  
**sinusitis** 67:12  
**SIRs** 362:8  
**sister** 121:13 138:22  
**sit** 14:4 232:3 299:13  
**site** 140:5 186:19  
 187:11 203:6 277:15  
 277:15 358:11,13  
 392:13 394:2  
**site-of-care** 201:22  
**sites** 61:6 98:2 140:20  
 181:18 344:20 346:2  
**sits** 110:12  
**sitting** 85:12 89:19  
 205:22 231:13 267:4  
 348:6 365:17 368:12  
**situate** 7:12  
**situation** 208:6 365:10  
**situations** 367:15,19  
**six** 31:14 43:5 54:4 60:2  
 60:6 162:5 247:8  
 248:10,12 254:10,11  
 289:22  
**six-month** 247:11,21  
 249:10  
**sixth** 237:6 273:17

**size** 71:18 240:19 377:5  
 377:11  
**skilled** 4:7 21:1 96:11  
 99:4 106:22 107:9  
 221:11 274:19,20  
 278:21 299:15 335:18  
 382:22 387:10  
**skin** 326:5 331:14  
 390:19  
**skip** 216:15 379:4  
**skipped** 139:9  
**slate** 217:4  
**sleep** 134:14 152:16  
 153:10  
**sleeping** 167:19  
**slide** 18:17 26:6 27:6,9  
 30:8,13,19 31:11 32:2  
 32:7 33:2,10,12,18  
 34:5 35:9,14 39:17  
 47:13 55:4 56:6 58:17  
 59:11 65:14 73:10  
 87:19 111:2 116:11  
 116:17 119:13 120:15  
 128:19 129:5 132:15  
 152:20 212:12 217:15  
 218:10,15 219:16,19  
 220:4,16 221:5,8  
 222:19,20 223:2,17  
 223:22 306:5 312:3  
 312:19 328:11 336:10  
 350:14 352:10 353:5  
 355:16 370:1 371:17  
 376:8 378:4,9  
**slides** 41:16 56:17  
 69:13 119:8,12 133:5  
 133:8 172:4 353:14  
 368:11 379:4 380:17  
**sloppiest** 291:4  
**sloppy** 292:4  
**slowing** 332:15  
**small** 71:7,8,10,18  
 81:18 97:11,12,14,16  
 157:17 240:19 242:7  
**smaller** 95:5 190:22  
**smart** 66:15 183:16  
 191:2 288:8  
**SME** 10:22  
**Smith** 2:2 11:16,16  
 160:14 177:18 278:10  
 291:16 390:11  
**smoking** 188:19  
**smoothing** 286:20  
**SNF** 208:19 222:10,13  
 224:2,14 226:20  
 233:12 234:11,12  
 242:18,20 243:1,3,10  
 243:13 251:8 255:10  
 267:11,17 268:2

269:9 272:17,20  
 277:3,17 279:7,9  
 285:21 288:16 293:16  
 294:15 298:19,22  
 299:21 300:3 327:22  
 387:9,11 394:18  
**SNFs** 145:4 197:14  
 248:1 270:8 271:1,9  
 280:17 294:16 335:12  
**snippet** 218:1  
**social** 94:22 96:1  
 152:16 192:14 315:19  
 343:19  
**socially** 72:1  
**society** 1:19 2:1,6  
 10:18 11:21 13:19  
 48:21  
**solicit** 154:6  
**solicited** 121:6 153:8  
**solidified** 160:5  
**solution** 114:19  
**solutions** 390:13  
**solve** 193:11 390:14  
**solved** 344:17  
**somebody** 101:16  
 336:16 342:1,5 384:1  
 384:2 386:10  
**someplace** 391:22  
**somewhat** 241:22  
**soon** 124:6 177:5  
**sooner** 250:4  
**Sophia** 400:14  
**sorry** 13:19 57:20 84:11  
 119:7 128:11 129:5  
 138:13 139:8 202:13  
 205:17 221:17 272:16  
 273:1 280:13 300:21  
 308:1,2 323:8 332:15  
 339:15 383:1  
**sorts** 81:5 119:9 333:20  
 389:7  
**sounded** 260:18  
**sounds** 66:1 69:16  
 144:5 176:8 204:17  
 263:17 304:18 323:16  
 368:9  
**soup** 68:11  
**source** 242:13 386:18  
 387:20  
**sources** 30:10,10 42:18  
 42:21 108:20 222:16  
 309:14 331:7 338:6  
 387:18  
**south** 96:20  
**southeast** 96:21  
**space** 38:14,17 39:3  
 104:13 115:20 197:1  
 351:12

**spaces** 179:9  
**Spanish** 273:20  
**sparingly** 215:16  
**speak** 17:18 18:21 19:2  
 19:6 67:6 120:20  
 139:12 147:17 186:22  
 220:12 251:3 339:16  
**speaking** 14:11 63:3,21  
 131:6 210:21 244:6  
 304:11  
**speaks** 72:6  
**special** 22:2 112:6  
 118:1 122:22 123:22  
 130:20 131:9 132:22  
 197:11 315:17 327:8  
 380:9 381:14  
**specialists** 172:21  
**specialties** 149:6 199:2  
**specialty** 48:21,22 49:1  
 60:11 61:13 193:22  
 384:8  
**specific** 10:5 31:18  
 58:10 60:11 61:12  
 65:6,9 79:14 99:21  
 100:9 110:7,9 114:18  
 131:8 155:18 171:21  
 200:13 202:15 213:14  
 213:17 224:5 230:21  
 234:15 278:21 284:7  
 320:15 351:4 354:14  
 390:6,9  
**specifically** 73:10  
 79:12 108:19 109:6  
 109:11 112:1 117:14  
 148:19 155:20 163:15  
 185:4 200:20 260:3  
 277:17 304:12 313:14  
 321:6 327:9 329:16  
 334:3 345:17 364:8  
 370:4  
**specifications** 54:13  
 268:15,20 366:9  
**specified** 50:12 174:21  
**specify** 251:22 252:5  
**specs** 50:15 252:4  
**speech** 189:10  
**spell** 109:15  
**spelled** 109:12  
**Spence** 2:3 11:22,22  
 316:15 323:8  
**spend** 21:3 46:9 75:11  
 192:20 193:1 307:11  
 307:13 345:13 349:8  
 358:21 399:14  
**spending** 382:6  
**spent** 64:21 110:3  
 296:17 358:7  
**spine** 199:11

<b>spirit</b> 14:21 68:20 288:17	136:14 162:9 207:14 207:16 230:2	<b>statistical</b> 158:22	<b>strikes</b> 44:3 46:19 56:5 235:8 247:12 287:16
<b>spiritual</b> 314:6,8	<b>standardizing</b> 144:16	<b>statistically</b> 325:2	<b>strikingly</b> 195:22
<b>spiritual/psychosocial</b> 320:9	<b>standards</b> 82:2 109:10 162:17 209:8 227:17 239:6	<b>status</b> 10:3 112:5,6,16 117:21 123:2,19,22 125:9 127:7 132:21 132:22 134:9 158:6 158:14 223:7 327:4 341:7,9 342:12 356:15	<b>stroke</b> 182:11,15
<b>split</b> 133:20,21 157:1 217:7	<b>standing</b> 213:15,17 214:1,4 222:3 290:5 354:11,18	<b>statutorily-mandated</b> 267:18	<b>strong</b> 77:6 160:21
<b>spoke</b> 283:5	<b>standpoint</b> 54:20 162:3 188:6 249:8 288:20 289:11,12	<b>statutory</b> 144:17 211:19 265:6 351:5 383:17	<b>strongly</b> 105:15 160:17 178:20 196:20 390:15
<b>spoken</b> 99:12 138:1	<b>star</b> 90:9 226:21 257:16 257:22 258:2 259:4 268:1,4 361:14 397:6 397:7	<b>stay</b> 92:20 225:6 233:12 233:13,16 235:1 241:4 326:4,9 363:3	<b>struck</b> 98:9 169:4 192:11
<b>spontaneous</b> 326:3	<b>staring</b> 312:13	<b>stays</b> 255:10 342:1,1,6 392:15	<b>structure</b> 378:21
<b>spouses</b> 297:1	<b>stars</b> 160:11 289:20	<b>steadily</b> 302:9	<b>structured</b> 63:1
<b>spring</b> 176:21	<b>start</b> 9:20 10:10,13,14 15:4 16:19 18:19 45:22 68:15 69:18 72:3 81:11 87:8 92:5 93:3 119:16 136:3 137:11 151:15 157:21 161:12 174:5 176:20 177:20 179:6 183:9 206:3,21 212:13 220:18 227:14 234:7 255:16 269:2 296:6 297:17 316:16 324:5 347:9 368:13 375:10 381:2 389:21 396:6	<b>stemming</b> 134:3	<b>struggle</b> 264:7
<b>stability</b> 192:15	<b>started</b> 5:4,11 36:18 37:12 53:1 120:17 152:4 277:5 339:1 364:2 395:12	<b>step</b> 5:21 7:17 113:8 126:14 170:5 190:3,4 218:11 221:16 264:4 267:16 271:13 372:17 372:19 374:9 397:2	<b>struggled</b> 57:14 197:15
<b>stabilization</b> 346:21	<b>starting</b> 32:11 46:4 136:2 161:6 162:11 164:20 189:9 277:22 294:11 349:21	<b>stepping</b> 266:4 297:3	<b>struggles</b> 67:9
<b>stabilization-type</b> 347:10	<b>starts</b> 233:6	<b>steps</b> 277:1 349:12	<b>struggling</b> 100:8 235:14
<b>stable</b> 158:21	<b>startup</b> 279:2	<b>steroids</b> 335:19	<b>student</b> 160:10
<b>stable's</b> 158:22	<b>state</b> 7:17 16:5 97:11 126:13,18 151:16 164:3 190:15 192:10 192:21 255:17 334:8 375:13 376:18	<b>stewards</b> 212:4 213:4	<b>study</b> 362:11
<b>Stace</b> 3:4 21:7 89:19 105:5,16 117:17 124:3 135:18 140:21 149:2 150:15 341:2 400:9	<b>state-mandated</b> 142:9	<b>stewardship</b> 197:13,18 200:12	<b>stuff</b> 58:15 75:7 229:2 261:20 264:22 265:15 307:2
<b>staff</b> 2:17 8:8 17:20 23:19 24:21 71:5 134:9,12,16 180:19 207:6 398:13 400:1,4	<b>stated</b> 244:17 320:7 345:4 375:9	<b>stickler</b> 253:2	<b>stunned</b> 298:2
<b>staff's</b> 208:3	<b>statement</b> 207:20 253:11 313:14	<b>sticky</b> 385:15,19	<b>sub</b> 202:1
<b>stage</b> 174:3	<b>statements</b> 283:18 373:8	<b>stoked</b> 70:6	<b>sub-regulatory</b> 252:8
<b>stake</b> 45:14	<b>states</b> 52:21 84:8,12 104:11 244:7	<b>Stone</b> 2:4 12:19,19	<b>subacute</b> 345:2,13
<b>stakeholder</b> 36:17 125:8 155:2 166:18 269:6,7 373:3 379:14	<b>static</b> 352:2	<b>stop</b> 39:19 80:11 136:18 147:21 186:15 249:15 250:4 303:16 353:11	<b>Subcommittee</b> 194:20
<b>stakeholders</b> 123:7 124:4 130:14 131:2 154:19 167:1,10	<b>stating</b> 285:7	<b>store</b> 101:9	<b>subgroup</b> 82:11
<b>stand</b> 67:10 216:8 348:4		<b>stored</b> 270:7	<b>subject</b> 2:7 9:19 11:3 14:2 15:3 147:19 217:11 325:20 379:13
<b>standard</b> 82:12,16 124:16,17 126:3,6 128:6 129:14 132:4 146:14 147:5 227:11 240:22 265:1 266:8 266:11 287:19 299:12 371:9 373:20 378:11 378:19		<b>strategic</b> 7:14 23:2,3,13 24:19 26:9 42:4 69:3	<b>submission</b> 187:15 227:13
<b>standardization</b> 106:6 116:16 118:15 122:6 127:13,22 155:12 159:11 247:17 250:17 250:20 371:11,20 373:2		<b>strategically</b> 22:22 397:20 398:22	<b>submissions</b> 37:7 331:10
<b>standardized</b> 106:1 107:2,14,18 108:13 108:17,18 109:6,20 110:12,17 111:11 113:12,14 114:17 115:12,21 117:12,16		<b>strategy</b> 5:16 36:3,8,9 46:6 49:12 53:19 169:5 289:22 373:13	<b>submit</b> 107:2,4,7,10,11 107:12,14 108:12 222:12 270:22 275:8 300:18 325:19

**sued** 383:14  
**suffer** 87:2  
**sufficient** 377:11  
**suggest** 78:19 162:20  
 278:8 282:10 364:8  
**suggested** 20:4 212:19  
 213:2  
**suggesting** 260:21  
**suggestion** 174:14  
 303:15,19 393:18  
**suggestions** 42:3  
 237:10 277:18 330:12  
 353:15 357:15 365:8  
**suitable** 153:21 154:13  
 154:13  
**sum** 186:15  
**summarize** 208:11  
 305:17 397:2  
**summarizing** 207:19  
**summary** 4:21 198:2  
**supersedes** 145:11  
**support** 26:1 49:6  
 57:16,18 73:8 90:14  
 98:17 110:16 111:16  
 113:9,15,15,19 114:5  
 115:14 209:19 210:2  
 210:13,20 212:16  
 213:10 214:22,22  
 215:1,17 218:8,8,18  
 224:18 226:19 250:22  
 257:22 262:16 263:5  
 263:7 274:11,11,15  
 274:21 275:2,4,11  
 314:8,9,9,17 330:6  
 343:21 344:5 375:19  
**supported** 31:15  
 276:13  
**supporting** 18:7,9,14  
 73:7 276:9  
**supportive** 25:18,20  
 263:14  
**supports** 16:13 46:6  
 87:22  
**supposed** 29:13 65:3  
 142:3  
**surgeon** 199:8,11  
**surgeons** 188:21  
**surgery** 29:9 199:7,10  
**surprised** 181:12  
**surprising** 72:12  
**surrogate** 164:15  
 313:21 318:6 325:5  
**surrogates** 313:22  
**surrounds** 207:22  
**survey** 143:17 152:22  
 157:20 159:9,21  
 225:13 227:10 228:9  
 229:6 233:8 237:18

239:12 246:14 248:15  
 249:18 270:17 271:6  
 309:22 312:7 327:5  
 334:11 338:7 344:11  
**surveying** 250:3 299:15  
**surveys** 152:7 240:1,1  
 240:5 243:20 245:21  
 247:18 248:6 250:8  
 252:6 270:18  
**suspects** 76:7  
**swallow** 118:10 134:17  
**swing** 79:14 92:21  
**switch** 229:8,8  
**symptom** 310:15  
 316:20 325:6  
**symptoms** 134:8 323:2  
 387:2  
**system** 20:3 43:21 44:9  
 44:22 61:1,10 62:4  
 66:10,12,12 67:2,17  
 172:2 259:4 261:18  
 359:2,15 360:6 388:8  
**systemic** 84:12  
**systems** 86:9 124:10  
 255:8 259:17

## T

### T-H-E-O-D-O-R-E

205:13  
**tab** 133:14  
**table** 10:2 22:20 23:21  
 40:3 76:8 85:12 88:17  
 89:8 100:20 103:6  
 171:4,5,8 221:14,18  
 229:4 262:15 274:15  
 280:9 302:8 309:5  
 319:12 385:1,1,2  
**tables** 76:10 85:13  
**tablets** 129:15  
**tackle** 6:4 380:3,5  
**tag** 99:8 191:21  
**tail** 194:6  
**tailoring** 245:2  
**taken** 57:20 73:16  
 115:16 123:5,13  
 142:11 198:9 199:19  
 199:21 267:9 336:4  
 387:14  
**takes** 387:12 391:14  
**talk** 25:13 38:9 44:19  
 51:21 52:4 69:16 70:2  
 80:15 86:8 89:20 96:2  
 105:1 131:21 139:15  
 151:7 160:11 165:16  
 167:16 173:14,16  
 181:1 194:11 200:2  
 206:9 207:4 208:8  
 209:15 211:3 213:7

228:11 231:7 241:19  
 266:10 267:15 271:14  
 280:17,22 305:5  
 306:17 307:14 335:7  
 344:1 347:19 368:5  
 392:5 398:18  
**talked** 28:18 42:2 168:5  
 247:1 261:17 279:1  
 280:8 303:22 304:2  
 311:11 322:5 327:20  
 351:9 352:11 388:4  
**talking** 7:7 24:3 57:6  
 67:7 73:18 97:13  
 122:9 131:15 150:15  
 163:18 164:7 166:16  
 166:17 199:1 204:20  
 206:1,3 208:18 241:3  
 262:21 279:5 312:8  
 318:19 319:19 333:18  
 339:1 340:19 344:21  
 349:8,20 385:9  
 387:17 390:5,7 394:5  
**tally** 220:5  
**tap** 306:13 385:22  
**TAPS** 327:17  
**Tara** 3:5 21:7 105:5,16  
 116:8 135:18 138:12  
 141:4 143:11 150:15  
 166:14 301:6 341:2  
 400:10  
**target** 26:22 28:2 65:9  
 121:16 129:6 156:22  
 184:10 261:12  
**targeted** 129:9 131:8  
**Taroon** 2:19 18:13  
 306:7 368:10,12  
 380:17 400:1  
**task** 2:14,15 8:22 20:19  
 231:13  
**tasked** 20:21  
**tax** 188:10,18  
**team** 18:5 23:5 68:15  
 142:17 150:12 160:4  
 160:4 167:14 178:5  
 310:10 315:15 338:14  
 380:19 381:12 385:10  
 385:11 389:19,21  
**team-based** 380:15,22  
 385:8  
**teams** 100:1  
**technical** 98:20 114:6  
 119:18 121:7 151:8  
 152:21 153:2 154:4  
 220:9 247:19  
**technically** 242:22  
**technology** 2:13 101:12  
 183:14,16 184:6  
 187:16

**Ted** 173:7 189:3  
**teed** 6:7  
**teleconference** 3:12  
**telehealth** 98:18  
**telemedicine** 80:21  
**telephone** 397:7  
**telephonic** 273:13  
**tell** 10:11 26:19 40:11  
 64:6 78:21 81:10  
 112:11 116:20 127:10  
 127:16 142:7 200:11  
 206:5 225:17 226:7  
 247:14 250:6 259:13  
 261:7 262:1 263:9  
 270:2 356:18 386:4  
 387:1,1  
**Telligen** 16:12 201:13  
**telling** 250:9 330:2  
**tells** 251:9 260:14  
**temperature** 334:5  
**ten** 102:21,22 150:19  
 170:16 362:3  
**ten-minute** 100:17  
**tend** 6:16 84:4 245:18  
 394:14  
**tends** 82:14  
**tension** 184:19 375:10  
**tent** 19:7  
**TEP** 299:13  
**TEPs** 387:8  
**term** 51:19 55:6 69:3  
 106:22 107:8 197:2  
 333:22 392:11,15  
**termed** 30:21  
**terminal** 314:19  
**terminology** 68:10  
 329:3,14  
**terms** 8:9 39:1,18 51:10  
 54:12,15 55:15 58:5  
 59:18 80:8 83:4 85:18  
 91:8 95:19 99:17  
 130:16 168:22 176:18  
 199:12 204:22 234:15  
 235:11 253:15 256:16  
 261:1 263:4,15  
 268:17 283:16 284:15  
 290:4 295:9 297:11  
 300:9 308:15,17  
 312:22 315:14 341:19  
 342:10 344:2 353:19  
 357:8 363:6 366:6,16  
 370:6 371:6 373:3  
 388:13 390:8  
**terrible** 67:20 178:2  
 300:22  
**terrific** 8:5,9 66:16  
 102:20 149:16 150:14  
 187:2

**territory** 395:8  
**test** 93:13 121:22  
 125:12,13,15 126:14  
 126:15 128:4,4  
 132:10 133:10 138:15  
 147:12 151:4,17  
 155:4 157:2 158:2,20  
 158:21 160:8 162:5  
 292:5  
**tested** 117:7 122:14,20  
 377:22 379:13 392:1  
**testing** 116:5 117:10  
 119:3,19 122:11,17  
 123:8 124:15 125:6  
 125:17 127:21 129:21  
 130:12,16 131:14,16  
 133:15,16,22 134:3  
 139:1,17 144:22,22  
 145:5 147:4 149:7  
 151:9 154:17 156:9  
 158:18 160:6 168:11  
 169:11 237:5 260:21  
 261:5 263:19 324:20  
 381:2  
**tests** 162:17 291:20  
**thank-yous** 8:4  
**thanks** 8:3,22 9:11  
 39:22 44:16 49:15  
 58:2 65:11 68:13  
 80:13 85:7 103:22  
 145:21 146:6 149:11  
 206:17 225:9 230:14  
 232:14 276:15 307:19  
 316:13 358:1 361:7  
 398:8 399:11 401:1  
**theme** 212:8  
**themes** 171:14 277:7  
**theodore** 3:3 205:13  
**therapies** 189:10  
**therapists** 177:20  
 178:11 189:13 391:3  
**therapy** 1:22 2:3 11:8  
 11:17 134:15 149:8  
 160:16 208:19  
**Theresa** 2:1 13:6 80:2  
 83:15 99:11,16  
 100:16 163:6 169:2  
 273:8 312:12 315:14  
 317:22 394:10  
**third** 33:13 38:5 46:3  
 48:13 55:11 59:4  
 95:18 193:2 323:13  
 328:3 364:16  
**thorny** 6:5 99:19 100:2  
 175:9  
**thorough** 15:16  
**thought** 22:19 31:5,5  
 43:4 44:13 50:19 58:9

58:20 59:18 76:12  
 77:9 79:12 126:17  
 135:20 145:16 158:16  
 163:8,12 167:5  
 198:10 234:20 237:10  
 238:10 249:10 250:16  
 305:3 322:20 324:8  
 349:17 367:10 390:22  
 392:18  
**thoughts** 24:18 25:3  
 37:21 49:17,19 133:7  
 154:15 161:9 175:2  
 176:4,10,15 184:9,17  
 185:3 192:2 214:17  
 215:9 344:4,7 396:5  
 396:17 397:14  
**thousand** 259:1  
**three** 19:3 26:18 40:17  
 48:7 55:13 62:7 98:5  
 101:8 111:3 130:4  
 131:1 133:18 135:18  
 136:4 156:10 173:22  
 174:4,9 176:12 189:2  
 231:16 237:14 249:4  
 280:20 292:21 293:1  
 303:10 326:1 341:14  
 356:5  
**three-day** 92:20 156:16  
**three-step** 206:20  
**threshold** 173:2 216:22  
 276:12  
**throw** 78:6 278:22  
 283:3 303:8  
**throwing** 189:21 235:7  
**tic-box** 64:16  
**tide** 114:12  
**tie** 257:16 355:4 391:13  
**tied** 51:21 255:8 354:17  
**Tilly** 2:20 18:8,8 206:17  
 282:1 309:11 312:4  
**tilt** 328:22  
**time-consuming** 335:3  
**timeframe** 156:13,16  
**timeline** 119:13  
**timelines** 176:19  
**timeliness** 292:20  
 293:4,19 304:5  
 310:16  
**timely** 223:15 277:20  
 290:19,20  
**times** 25:10 28:14  
 94:18 127:17 136:21  
 160:11 189:13 203:9  
 251:14 323:3 351:11  
**timing** 126:20,21  
 129:16 132:7 133:19  
 135:13 155:19 233:5  
 310:3 378:1

**tired** 106:14  
**titled** 331:14  
**today** 6:22 8:22 9:13  
 11:10 24:4,14,17  
 36:18 38:9 52:2 73:18  
 75:16 76:15 104:16  
 105:16,22 108:9  
 119:5 120:19 128:21  
 151:14 156:20 173:15  
 174:3 176:16 177:1  
 177:15 204:19 208:15  
 209:17 232:1 259:14  
 261:1 274:22 278:11  
 278:16 281:3 301:2  
 306:14 313:18 341:13  
 352:12,20 359:21  
 381:10 398:7 399:15  
 400:4 401:11  
**told** 202:2 296:13 330:3  
 333:10 367:3 400:10  
**tomorrow** 25:7 360:18  
 361:11,18  
**tone** 143:2  
**tons** 288:11  
**tool** 4:6 19:22 117:9  
 150:4,9,16 160:18  
 161:2 163:10 288:15  
 335:9 376:2 381:6  
**tools** 161:19 360:9  
**top** 65:19 66:19 192:20  
 313:16 329:14 392:9  
**topic** 75:12,13 77:16  
 79:6,9 89:13,14 90:17  
 146:4 346:13 385:1  
 390:13  
**topical** 27:11,17 28:4  
**topics** 25:4 26:20  
 297:22 305:6,10  
 398:11  
**topped** 29:3 56:12  
 61:16 139:17 356:14  
**topped-out** 60:21 347:2  
 347:2  
**tormented** 344:18  
**tossed** 364:21  
**total** 35:13 37:6,17 54:3  
 157:19 186:15  
**totally** 63:2 82:21  
 188:21 189:8  
**touch** 118:21 123:12  
 205:13,16 277:4  
 390:18 400:17  
**touched** 64:2 141:4  
**touches** 66:20  
**touching** 171:13  
**tough** 324:5  
**town** 91:3,4 97:12  
**traced** 37:2

**track** 32:15 33:1 48:3  
 117:2 122:13,16,18  
 123:3,12 125:9  
 294:11 295:1  
**tracked** 31:20  
**tracking** 384:12  
**tracks** 122:12  
**traction** 49:10  
**trade-offs** 371:5,7  
 378:18  
**tradeoff** 184:22  
**traditional** 179:9  
**trained** 250:7  
**training** 88:11,13 126:1  
 128:5 255:18  
**trainings** 88:9  
**trajectory** 117:3 139:10  
**transcribing** 138:12  
**transcriptionist** 18:22  
**transfer** 33:16 52:8,9  
 163:16 223:16,20  
 277:12,19 279:9  
 280:14,16,18 282:2  
 282:15,18,20 283:2,3  
 283:6,9,10,18,22  
 284:17 288:18 289:16  
 291:4 292:17,20  
 293:2 294:6 297:12  
 326:22 327:10,21  
 328:2 333:8 334:22  
**transferred** 363:6,8  
**transferring** 287:20  
 292:11 317:11  
**transfers** 223:20 279:9  
 281:16 282:4 283:1  
 288:8,10 304:3,13  
 327:2,9 383:7  
**Transformation** 106:12  
**transition** 137:4 190:11  
 286:21 287:5 289:10  
 299:16 346:1  
**transition-of-** 327:21  
**transition-of-care**  
 293:8  
**transitional** 289:4  
**transitions** 1:18 12:16  
 77:22 80:20 100:11  
 108:8 113:19 142:1,9  
 142:14 247:2 284:5  
 284:22 293:6 298:8  
 298:10,20 299:14  
 314:14 326:18 335:20  
 336:1  
**Transitions-of-Care**  
 288:13  
**translate** 175:19 199:15  
**transmission** 108:3  
**transmitted** 228:12

**transparency** 14:21  
 371:15 372:7 373:2  
 374:8 378:21  
**transparent** 130:12  
 375:7 378:17  
**transportation** 71:3  
 86:16,17,18 101:3  
 192:15  
**travel** 101:4  
**treat** 296:8  
**treating** 194:2  
**treatment** 33:19 34:2,3  
 59:3 111:8 309:20,21  
 326:13  
**treatments** 112:6 115:3  
 118:1 122:22 123:22  
 133:1 134:20 141:20  
**tremendous** 24:17 65:4  
**trend** 356:16 359:6  
**trending** 358:4  
**trends** 351:20  
**trial** 326:3  
**tried** 37:8 227:5 239:21  
 240:9 250:13 270:12  
 291:3  
**trip** 5:5  
**Trivedi** 2:9 12:6,6  
**trouble** 256:7 293:1  
**troubles** 64:1 234:14  
**true** 37:4 78:18 205:21  
 304:8 365:3  
**truly** 64:10 162:13  
 343:7 398:11  
**truncated** 367:11  
**truth** 197:5  
**try** 49:8 66:22 69:14  
 89:6 90:10 161:22  
 193:10 214:2 216:17  
 217:13 227:13 229:3  
 239:13 271:18 300:8  
 301:14 345:16 375:21  
 388:22 390:11  
**trying** 25:21 29:15  
 36:16 45:10 48:15  
 51:11 53:2 54:7 55:14  
 65:5 82:1,19 86:16  
 88:18 89:4 96:4  
 119:15 135:20 137:4  
 147:22 163:1,3 170:6  
 172:1 192:11 193:7  
 230:1 239:5 241:4  
 255:2,5,12 257:7  
 262:9 263:20 264:2  
 270:14 285:21 288:4  
 296:9 298:22 299:1  
 301:9 308:15 320:7  
 320:15 334:11 343:6  
 345:10 376:16,18

382:19 388:20 390:14  
 395:14  
**tube** 115:5 134:22  
**turn** 6:19 18:21 19:3,5  
 19:14 23:15 69:6  
 104:20 116:7 173:8  
 176:17 207:1 210:11  
 211:3 311:6 353:11  
 374:10 387:15 397:13  
**turned** 54:15 157:11  
**turning** 114:12  
**turnover** 241:5  
**turns** 82:20  
**TV** 246:7  
**tweak** 45:17 215:14  
**tweaked** 210:5 213:13  
**two** 9:15,16 26:17 31:3  
 32:4 36:11,13 43:14  
 43:16 44:20 48:7 54:2  
 55:7,16,19 56:9 58:22  
 75:2 85:11 122:12  
 124:14 133:20 138:11  
 143:13 144:4 150:21  
 155:17 157:11 172:9  
 184:13,14,17 195:6  
 203:9 210:4 248:16  
 249:5 275:1 280:20  
 296:2 305:6 306:21  
 310:2 314:6,21 326:4  
 353:14 368:16 374:7  
 394:8 398:20,21  
**two-percentage-point**  
 191:18 325:20  
**two-question** 344:11  
**two-week** 24:11  
**tying** 189:15  
**type** 70:8 88:11 136:13  
 165:11 179:21 199:9  
 202:15 204:12 245:19  
 304:5 340:6,20,22  
 356:22 367:10 390:22  
**types** 9:16 56:8 84:14  
 108:5 110:7 111:12  
 112:12 114:18 148:3  
 192:18 209:10 245:17  
 284:19 293:13 330:11  
 334:15 351:8 363:6  
**typically** 210:6 307:5

---

**U**


---

**U-** 365:16  
**U.S** 15:17 158:10  
**ugly** 330:2  
**ulcer** 2:4 12:21 123:20  
 223:11 326:16 329:20  
 331:21  
**ulcer/injury** 326:6  
**ulcers** 118:6,7 326:8

329:11  
**Ulcers/Injury** 331:15  
**ultimately** 110:11,21  
 143:9 169:16 212:19  
 391:15  
**umbrella** 36:8  
**unable** 130:3,8  
**unbundle** 283:17  
**unbundling** 283:22  
**uncomfortable** 191:6  
 367:17  
**uncommon** 301:1  
**undergoing** 323:1,1  
**underlying** 213:19  
**underneath** 360:16  
**underperform** 82:15  
**underpinning** 27:16  
**underrepresented**  
 236:9  
**underserved** 96:17  
**understand** 36:1 40:18  
 43:3 44:20 81:16  
 86:10 95:20 116:2  
 156:4 166:9,13  
 168:18 189:18 193:7  
 207:21 238:20 257:19  
 262:14 263:20 269:4  
 288:16 301:16 322:4  
 325:2 365:22 367:18  
 373:22  
**understanding** 43:12  
 116:19 117:20 134:7  
 165:22 166:20 169:8  
 226:4 328:13 343:19  
 367:21 395:1  
**understood** 91:19  
 108:2  
**unendorsed** 213:22  
**unexpected** 98:10  
**unfortunately** 93:9  
 237:19 300:22  
**unidirectional** 365:12  
 366:1  
**uniform** 110:21 115:7  
**uniformity** 107:20  
**unintended** 53:12,13  
 209:22 342:22 352:15  
 354:20 355:2 380:7  
 385:3 390:16  
**unique** 23:6 62:22  
 100:22 111:18 113:20  
 208:6 304:15,22  
 305:1 309:7 317:15  
 318:2 364:19 365:2  
 384:3  
**unit** 318:3,7 333:9  
 377:9,19  
**units** 222:14 331:3,5

377:8,12  
**universal** 128:1 136:13  
 167:21 190:16  
**universality** 121:4  
**university** 3:2 10:21  
 16:5 188:16 228:8  
 341:19 370:3  
**unload** 282:10  
**unnecessary** 310:11  
 353:3  
**unrelated** 182:16  
**Unroe** 2:5 13:15,16,18  
**unseasonably** 5:5  
**unwilling** 130:3,8 166:9  
**upcoming** 176:18  
**update** 4:6,16,19 19:20  
 21:8 106:9,10 116:8  
 119:5 150:4,9 307:15  
 325:22 349:10  
**updated** 128:19 129:6  
 139:5 358:11 359:7  
 375:5  
**updates** 19:21 105:20  
 119:9,10  
**urban** 90:12 95:3 97:4  
**USA** 1:18 103:10,15  
**usability** 129:16 355:6  
 355:11  
**usable** 110:20 111:15  
 147:7 241:11  
**useful** 117:5,7 121:14  
 125:7 127:11,13  
 142:22 143:10 148:14  
 154:3,21 160:1  
 167:12 200:22 231:21  
 263:17 352:6 384:4  
**usefulness** 155:8,9  
 156:3 366:21 381:6  
**useless** 47:15  
**users** 67:11 371:8  
**uses** 55:9,10,11 137:8  
 391:4  
**usual** 76:7,9 112:18  
**usually** 105:11 192:20  
 202:15 240:21 241:6  
 316:5  
**utility** 45:19 122:7  
**utilization** 66:7 313:11  
 340:7 358:18 393:22  
**utilize** 74:1

---

**V**


---

**VA** 88:17  
**vaccination** 360:19  
 361:12  
**vacuum** 78:14  
**valid** 117:8 122:21  
 124:8 125:19,20

**validated** 298:12  
**validity** 72:7 122:3  
 155:8 197:1 257:4  
 364:4  
**Valley** 101:7  
**valuable** 47:16,17  
 127:3  
**value** 8:16 49:9 158:6  
 178:3 214:19,20  
 265:12,14 307:21  
 334:10 340:18 356:11  
 392:7,17 393:2  
**value-** 143:19  
**value-add** 321:12  
**value-based** 24:1 29:14  
 172:13 256:20 257:14  
 261:6 369:3 376:13  
**values** 258:14 259:6  
 312:10  
**variability** 240:18,20  
 382:8  
**variation** 165:11,19  
 351:16,17 356:12  
**varied** 154:19  
**variety** 25:3 185:11  
 190:5  
**various** 36:20 42:14  
 107:15 149:6 232:4  
 293:10,11,12 368:22  
 370:9 372:6  
**vary** 120:13 239:19  
 270:11  
**vast** 317:6 345:13  
**vehicle** 114:22 319:3  
**vendor** 228:3 270:9  
 271:1  
**vendors** 227:7,9,10,16  
 227:20 228:4 229:8  
 229:17,19,22 230:4  
 230:10 239:9 249:7  
 250:6 252:22 255:20  
 257:9 270:6,6  
**Venn** 110:12 341:13  
**vent** 142:2  
**ventilator** 115:4 118:3  
 326:4  
**ventilator-related**  
 326:14  
**verbal** 107:22  
**verbally** 276:1  
**verdict** 208:20,21  
**Verma** 25:13  
**version** 156:11,12  
 238:8,9 273:21,21  
**versions** 155:17  
**versus** 51:12 90:12  
 96:19,22 193:20  
 273:21 341:8,9

**Veterans** 89:6  
**vetting** 119:18 130:21  
**Vice** 2:17 9:8  
**view** 8:5 46:20 49:6  
 232:2 259:16 314:1  
**village** 387:12  
**violation** 296:15  
**virtual** 184:8  
**virtually** 56:12  
**visibility** 256:3  
**vision** 146:9 256:3  
**visit** 101:4 320:21  
**visits** 102:19 310:1  
**Vital** 42:7  
**vocal** 265:12  
**voice** 1:16 12:10 57:3  
 135:21 164:2,12,15  
 263:15 314:2 341:1  
**voices** 44:14  
**volume** 72:6 73:6 77:11  
 81:18 93:21 247:22  
**voluntarily** 269:7  
**voluntary** 70:12 128:18  
 362:4  
**volunteer** 263:21  
 313:11  
**volunteered** 14:15  
**volunteering** 399:13  
**volunteers** 313:9  
**vote** 135:20 207:7,18  
 208:12 220:7,12  
 273:7 274:5,10  
 275:16 276:4,7  
**votes** 220:5  
**voting** 2:7 207:15,22  
 208:2 215:20 216:13  
 216:20 217:17 220:8  
 232:12 274:2,6,14,21  
 275:1,6,10,13 276:11  
**vulnerable** 6:11 192:17  
 393:5,15 394:6

# W

**wagging** 194:6  
**Wagner** 38:18  
**wait** 265:2 297:18  
 384:14  
**waiting** 181:10 275:20  
**waivers** 92:20  
**walk** 162:5 187:20  
 216:13 307:10 374:11  
**walked** 208:22  
**walking** 130:20 162:7  
**wanted** 9:12,22 14:9  
 17:16 34:9 35:19  
 55:20 70:2 98:16,19  
 100:19 173:22 177:8  
 179:16 211:12 213:7

213:17 214:15 218:20  
 220:1 227:14 236:17  
 240:10 241:13 242:17  
 248:2 250:15,20  
 267:13 277:3 278:11  
 285:5 303:14 306:13  
 319:11 323:10 334:19  
 350:2 357:18 358:2  
 360:7 363:16 364:16  
 378:9 380:10 395:3  
 399:11,22  
**wanting** 183:14 295:17  
 322:16  
**wants** 46:22 64:3  
 148:22 149:3 218:21  
 286:11 348:4 393:20  
 396:14 397:3  
**warranted** 158:19  
**Washington** 1:10 5:5  
**wasn't** 82:21 164:15  
 168:6,10 203:1 204:1  
 225:11 281:19 311:22  
 370:12 384:15  
**watched** 135:19  
**watching** 135:19  
**way** 25:21 26:2 27:4  
 32:12 38:3 48:19 49:2  
 51:3 58:20 63:1 64:8  
 65:8 66:2,18 67:9  
 83:9 91:16,20,20 92:1  
 92:10 101:11 115:7  
 117:7 127:2,3 139:18  
 145:6 181:6,17 182:6  
 182:19 183:8 187:4  
 200:10 204:11 210:5  
 212:1 213:10 215:16  
 215:19 227:5 228:14  
 229:11 230:2 234:17  
 249:18 261:20 264:21  
 265:9 286:6 287:2  
 292:19 295:4 311:18  
 321:19 340:12,22  
 342:7 345:21 349:17  
 360:11 372:8 384:14  
 386:14 387:7 391:1  
 393:16  
**ways** 34:11 46:1 58:11  
 59:10 70:7 71:2,9  
 81:17 181:2 200:17  
 204:17 277:9 381:4  
 389:5  
**wear** 290:22  
**wearing** 266:5  
**weave** 171:14  
**web** 130:11 133:14  
 211:11,22 327:7  
 332:7  
**webinar** 45:5,6 132:2

**webinars** 43:20 131:7  
 399:15  
**website** 130:10 199:5  
 338:5  
**WEDNESDAY** 1:7  
**week** 24:6 114:4 119:8  
 128:20 195:6 306:21  
**weeks** 76:15 248:16  
 306:21  
**weigh-in** 213:18 288:19  
**weighed** 168:2  
**weighs** 91:7  
**weird** 81:13  
**weirdness** 186:9  
**welcome** 4:2 6:20 7:1  
 27:13 36:17 39:20  
 43:3 104:19 147:13  
 306:16 312:14 319:11  
 350:20  
**welcoming** 23:16  
**well-** 198:8 199:18  
**well-defined** 302:1  
**well-done** 264:2  
**well-resourced** 97:5  
**well-taken** 188:8 200:1  
**went** 41:6 103:3 115:22  
 120:16 126:16 138:5  
 147:8 171:1 243:11  
 248:12 249:10 256:8  
 299:17 311:17 349:4  
 349:4 358:11 380:17  
 401:13  
**weren't** 24:6 167:7  
 168:6 301:18 371:8  
 380:5  
**whatsoever** 61:3 62:14  
**wheel** 55:4 65:20  
**wheelhouse** 141:17  
**whet** 308:22  
**whether's** 352:2  
**whistles** 246:12  
**white** 30:15,16 42:2  
 50:19 284:4 381:9  
**wholly** 110:1  
**Wickiser** 400:11  
**wide** 257:18  
**wifi** 19:9  
**willing** 396:17  
**win** 345:19  
**windmill** 328:22  
**window** 60:13 182:1  
 233:6,11 247:9,11,21  
 248:13,22 249:2,11  
 342:10  
**winners** 191:8  
**winnow** 47:20 48:11  
**wish** 24:13 60:3 180:7  
 388:3

**withdrew** 323:17  
**withheld** 178:6  
**women** 240:2  
**wonder** 84:10 101:19  
**wondered** 297:22 298:5  
 343:14 344:2  
**wonderful** 40:5 65:15  
 105:10 160:3 184:5  
 397:18 398:15  
**wondering** 146:9 169:7  
 185:13 236:5 285:12  
 334:10 354:5  
**woods** 101:6  
**word** 56:17,18,19 68:10  
 100:16  
**wording** 237:9 246:20  
**words** 40:18 44:5 55:7  
 173:7 185:8 219:18  
**workable** 291:13  
**worked** 103:18 215:12  
 237:5 319:2  
**worker** 80:22  
**workers** 44:2,2 96:1  
**workflow** 26:1 230:3  
**workflows** 281:4,10,12  
 286:10  
**workforce** 66:14 94:16  
 143:8  
**workgroup** 1:5,9,11  
 6:12,14 9:13,17 16:18  
 18:7,9 20:8 21:10  
 29:8 42:14 73:13,17  
 74:19 76:5,18 77:4  
 79:1 81:10 84:16  
 91:11 103:7 173:8,11  
 208:4 210:17 211:10  
 212:7 215:13 217:5,8  
 221:1 223:18 232:6  
 268:19 310:7,12,22  
 327:8 332:7 338:20  
 347:15 386:8 399:22  
**Workgroup's** 207:20  
 212:5  
**workgroups** 25:11 37:5  
 37:21 75:18 85:1  
 207:15 213:2 216:6  
 217:12 231:16 350:7  
**Workgroups'** 212:9  
**working** 27:8 34:6  
 37:18 38:11,15,21  
 39:3 40:21 49:7 62:16  
 74:21 93:3 94:4 96:18  
 110:13 116:4,4  
 149:21 206:3 271:2  
 271:15 302:9 329:7  
 347:16 370:2 380:1  
 395:13  
**works** 48:5,12 66:12

217:19  
**world** 5:14 8:18 49:6  
 56:19 57:11 69:19  
 127:18 130:14 135:7  
 344:19 387:13 388:5  
**worried** 167:20 236:8  
 315:4  
**worry** 140:12 295:10  
**worrying** 186:15  
**worse** 158:8,14 352:2  
**worsened** 326:9  
**worsens** 182:3  
**worth** 51:2 144:5  
 196:18 323:19 387:21  
**worthwhile** 335:22  
**worthy** 188:7 256:19  
 266:8  
**wouldn't** 166:2 203:3,7  
 221:13 243:5 249:8  
 296:10,18 337:11  
**wound** 15:18 329:14  
 382:17 383:6,9,11,14  
 384:2,3  
**wounds** 64:14,21  
 329:11,12 344:20  
 345:2,10 346:3  
**wow** 339:11  
**wrap** 394:11  
**wring** 248:16  
**write** 383:6 387:13  
**writing** 284:13 383:9  
**written** 107:22 154:14  
**wrong** 249:19 272:21  
**wrongly** 372:10

---

**X**


---

X 258:16,16

---

**Y**


---

**Y** 258:17  
**yea** 135:22 307:20  
**year** 5:7,21 7:5 17:2  
 34:20 37:7 42:7 45:22  
 56:3 61:14 65:1 74:20  
 74:21 75:21 85:15  
 87:9 93:11 123:15,16  
 151:18,19 157:10  
 173:3,5 175:15  
 205:21 207:3 211:21  
 212:20 218:4,13  
 223:8 270:12 271:3  
 279:8,21 280:10  
 286:12 294:14,16  
 298:4 304:11 319:14  
 325:19 326:2,20  
 329:1 331:13 332:4  
 336:6 338:21 339:12  
 384:17 399:22 401:4

**year's** 39:16 78:10  
 223:13  
**years** 5:12 21:16 46:11  
 54:2 62:8 67:7 69:20  
 73:20 74:21 75:2 77:5  
 79:3 82:18 87:10,15  
 89:3 110:3 115:20  
 118:13 124:14 132:9  
 135:18 136:4 138:11  
 143:13 157:11 194:11  
 194:14 206:19 208:1  
 216:4 223:5 267:7,7  
 287:1 290:15 293:9  
 302:10 351:22 358:7  
 359:13 362:3 367:3  
**yes/no** 185:9  
**yesterday** 29:7 130:19  
 213:9 215:14,22  
 344:13 358:11 359:8  
**Yong** 3:8 16:20,20  
 23:18,22 40:2 41:13  
 44:16 49:15 58:2  
 62:19,21 63:7,9,14,18  
 201:5 214:18 347:18  
 349:16 353:22 355:17  
 355:22 356:21 368:2  
 399:10  
**youngest** 302:19

---

**Z**


---

**zero** 60:22  
**zeroed** 126:19  
**Zolof** 68:3

---

**0**


---

**0678** 326:7 331:16

---

**1**


---

**1,198** 358:15  
**1,199** 358:12,13 359:8  
**1,200** 76:19,21  
**1.5** 359:11  
**1:00** 76:15  
**1:30** 303:11  
**10** 135:3 151:1 155:10  
 155:16,20 156:10,12  
 157:14,19 158:22,22  
 159:15,21 160:6  
 195:12 290:15 296:17  
 383:5  
**10,000** 10:7 16:6,7  
**10:56** 103:3  
**100** 29:4 125:18,19  
 130:11 233:14,15,19  
 241:2 242:14 260:11  
 362:5  
**100-day** 233:5,11  
**100-plus-degree** 334:5

**1030** 1:10  
**11** 160:9  
**11:00** 102:22  
**11:08** 103:4  
**12** 157:17 383:5  
**12-rounder** 386:13  
**12:18** 171:1  
**12:35** 170:21  
**12:40** 171:2  
**120** 249:20  
**125** 249:22  
**128** 104:9  
**13** 1:7  
**13th** 332:7  
**14** 128:9  
**15** 150:19 170:16,19,20  
 230:10 307:11 382:16  
**15-20** 249:15  
**150** 4:6 249:20  
**15th** 1:10  
**163** 370:16  
**17** 37:17 350:1 370:17  
**172** 128:21 156:20  
**18** 27:10 28:1,3 31:13  
**19** 4:4 276:8

---

**2**


---

**2** 119:1 122:16 123:3  
 124:11 125:9,9,11  
 134:3 275:6,16  
 284:22 286:5,12,13  
 378:6  
**20** 83:7 156:22 195:2  
 240:22 241:2,3,3  
 248:5 275:6 276:10  
 367:3  
**200** 104:11 173:5  
**2008** 60:6  
**2012** 358:8  
**2014** 64:21 106:12,15  
 106:16 325:19  
**2015** 118:20 172:6  
 358:8  
**2016** 118:20 153:8  
**2017** 1:7 153:3  
**2018** 75:22 120:2  
 123:16 128:9 130:22  
 131:19 155:6 172:17  
 173:2 326:2 331:13  
 392:21 393:11  
**2019** 177:22  
**210** 129:1,1 156:21  
**213** 157:19  
**22** 275:5  
**221** 4:8  
**22nd** 24:12  
**24-hour** 310:10 316:4  
 316:11 318:18



248 4:9  
 25 76:5 129:8,9  
 28 76:6  
 285 154:9  
 29th 76:17  
 2A 117:15 120:6

---

**3**

---

3 286:8 298:4 311:22  
 3,000 270:16  
 3.0 147:2  
 3:30 305:7 332:15 398:4  
 3:50 349:4  
 3:57 349:5  
 30 56:3 104:10 129:7,8  
     129:8 150:9,17  
     156:22 346:5 349:8  
     382:3  
 30-day 298:13 340:13  
 309 4:10  
 30th 212:14  
 31 392:13 393:19  
 32 392:14  
 325 4:11  
 337 4:14  
 34 54:3  
 347 4:15  
 349 4:16  
 379 4:18  
 380,000 298:3  
 397 4:20,21

---

**4**

---

4,000 45:6 270:16  
 4:00 305:7  
 4:53 401:13  
 40 56:4  
 40-percent 328:3  
 401 4:22  
 45 307:4,9,13  
 49 194:15

---

**5**

---

5 4:2 192:20  
 5.5 254:13  
 5:00 349:14  
 50 194:15  
 51 186:7,16 202:17,22  
 53 359:22  
 56 157:20

---

**6**

---

6 364:13  
 60 217:1 220:6 276:11  
     342:11 346:14  
 60-day 342:10  
 60-percent 216:22  
 61 154:9

64 294:17  
 68 359:21  
 69 4:5

---

**7**

---

7 254:6  
 7- 359:13  
 70 359:9,15  
 75 364:14  
 75th 260:13  
 77 370:19

---

**8**

---

80 195:9 392:10  
 811 359:8  
 82.5 260:10,11  
 88.6 260:14  
 89 370:18,19

---

**9**

---

9:00 1:10  
 9:12 5:2  
 90 261:13  
 90,000 173:3  
 96 64:21 345:1  
 9th 1:10

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 Wkshp  
Measure Applications Partnership

Before: NQF

Date: 12-13-17

Place: Washington, DC

was duly recorded and accurately transcribed under  
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