THE NATIONAL QUALITY FORUM

+ + + + +

PEDIATRIC CARDIAC SURGERY STEERING COMMITTEE

NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR

PEDIATRIC CARDIAC SURGERY

EXECUTIVE SESSION

+ + + + +

WEDNESDAY
OCTOBER 21, 2009

+ + + + +

The Pediatric Cardiac Surgery Steering Committee met in Congressional A in the Hyatt Regency Washington Hotel, 400 New Jersey Avenue, N.W., Washington, D.C., at 9:30 a.m., Howard Jeffries and Lisa Kohr, Co-Chairs, presiding.

STEERING COMMITTEE MEMBERS PRESENT:

HOWARD JEFFRIES, MD, MPH, MBA, Co-Chair
LISA M. KOHR, MS, MPH, RN, CPNP, Co-Chair
SCHONAY BARNETT-JONES, MBA
PATRICIA A. GALVIN, RN, BSN, CNOR
NANCY GHANAYEM, MD

DARRYL GRAY, MD, ScD
ALLEN J. HINKLE, MD
MARK HOYER, MD
SYLVIA LOPEZ, MD
CONSTANTINE MAVROUDIS, MD
JOHN E. MAYER, MD
LISA NUGENT, MFA

NQF STAFF PRESENT:

HELEN BURSTIN

SARAH FANTA

TINA GRANNIS

LISA HINES

CHRISTINA TSIATIS

ASHLIE WILBON

ALSO PRESENT:

DR. KATHY JENKINS

DR. KIMBERLEE GAUVREAU

DR. MARSHALL JACOBS

DR. JEFFREY JACOBS

1 P-R-O-C-E-E-D-I-N-G-S
2 9:34 a.m.
3 MS. GRANNIS: Good morning,
4 everybody. I'd like to welcome you to the
5 National Voluntary Consensus Standards for
6 Pediatric Cardiac Surgery, the Steering
7 Committee Meeting.
8 I am Tina Grannis, and this is
9 another Project Manager, Ashlie Wilbon. We
10 wanted to let you know the purpose of the
11 Steering Committee is to evaluate and
12 recommend measures for pediatric cardiac
13 surgery for public reporting and quality
14 improvement related to pediatric cardiac
15 surgery process, structure and patient
16 outcomes.
17 This is our executive session.
18 It's a closed session right now. And just
19 kind of wanted to go through the flow of the
20 day and just kind of what to expect out of
21 this meeting. And I'll be referencing the
22 revised agenda that Sarah Fanta handed out to

1 us.

2 Around ten o'clock we're going to

3 open the session up. So, it will be - the

4 public can come and join us in the audience.

5 There may be people who will be participating,

6 dialing in and calling in.

7 At that time, Dr. Jeffries, Howard

8 Jeffries, and Lisa Kohr, who are co-chairs,

9 will be going around the room. We'll welcome,

10 we'll do introductions, we will also have

11 disclosures of interest.

12 And since this is such a

13 specialized topic, we have a lot of experts

14 here at our table. And these are experts in

15 the field of pediatric cardiac surgery, so we

16 may need - if you happen to work for a

17 particular organization that submitted a

18 measure - and for example, I spoke with Patty

19 this morning.

20 She works for Children's Hospital

21 of Boston. They submitted a measure, but she

22 had no part of developing the measure. So,

1 she is going to disclose that she works for
2 Children's Hospital of Boston and has not
3 developed any measures.
4 So, we just want to make sure that
5 we go on record disclosing any potential
6 conflicts of interest.
7 After that, Ashlie Wilbon will be
8 giving a project overview. And we also have
9 Helen Burstin who is our Senior Vice-President
10 of the Performance Measures Department at the
11 National Quality Forum, and she'll be giving
12 just a brief overview as well.
13 Around 10:40 we're going to have
14 measure developers give general comments. And
15 this is a chance for measure developers just
16 to kind of give the Steering Committee any
17 special instructions or any type of general
18 comments at that time.
19 If you have questions for the
20 measure developers, we just ask that you just
21 hold off until we reconvene as the Steering
22 Committee and actually go into the measure

1 review.

2 We're going to break up into

3 workgroups after that. By now, everyone knows

4 that we're broken up into Workgroup A and

5 Workgroup B. And Workgroup A will be looking

6 at the process and structural measures, and

7 Workgroup B will be looking at the outcome

8 measures.

9 You have also been assigned as

10 primary and secondary reviewers. And when we

11 break up into the workgroups, Lisa Kohr will

12 be with Group A, and Howard Jeffries will be

13 with Group B. They'll be facilitating the

14 discussion.

15 You'll be kind of going over -- as

16 a primary/secondary reviewer, you'll be going

17 over the measure that you were assigned with

18 your group just kind of opening dialog and

19 discussion within your workgroup. We will

20 also have you fill out the evaluation form at

21 that time.

22 Also when we break into workgroup,

1 we're going to ask that there is somebody who
2 actually takes notes during this time.
3 And, Sarah, do you have the slide
4 for the -
5 (Off the record comments.)
6 MS. GRANNIS: And we're just going
7 to bring this up on screen. And in the past
8 in other steering committees, how we've done
9 this is sometimes it may be one person who
10 decides that they would like to take notes,
11 other times it was the secondary reviewer who
12 would be taking notes while the primary
13 reviewer is just presenting it in their
14 workgroup.
15 And then when we reconvene as a
16 steering committee, we are going to be able to
17 look at the notes from your workgroup
18 discussion and to just kind of serve as like
19 just kind of jogging our memory in everything.
20 Okay. And Sarah is just going to bring this
21 up so we can just go over it.
22 Everything is recorded. We have

1 someone who transcribes to our right behind
2 us, and the transcription is actually used for
3 our records, for NQF records. And sometimes
4 it's just when we're kind of trying to
5 remember how a discussion goes, we'll use the
6 transcripts.
7 It is recorded as well overhead
8 via the phone, and that will be posted online
9 on the NQF website. So, if you needed to go
10 back and listen to any discussion, you'll be
11 able to listen over the two days through the
12 website.
13 So, this is where you're going to
14 be taking notes. And during the workgroup
15 discussion, you're going to be evaluating
16 scientific acceptability, importance,
17 usability, feasibility.
18 And under each - I believe - hold
19 on a second.
20 So, you're able to see all the
21 categories underneath there and you'll be able
22 to just take your notes accordingly.

1 And again, it's up to the
2 workgroup to decide whether they want to
3 assign somebody to take the notes or whether
4 you just wanted to assign the secondary
5 reviewer to take the notes, and we can go over
6 this more in depth when we break into the
7 workgroups.
8 And Ashlie and I will be available
9 during the workgroup breakout sessions, to
10 help guide you in any questions that you may
11 have.
12 After the workgroup discussions,
13 we're going to reconvene. And I believe that
14 is around three o'clock. We're going to
15 reconvene and we will discuss - we'll start
16 with the outcome measures.
17 We have one outcome measure from
18 the Children's Hospital in Boston. And we're
19 going to review that first. And then we'll go
20 into the STS measures after that.
21 And then after the outcome
22 measures, we will review the process and

1 structure measures, and we have that slated
2 for Day 2.
3 And everyone also received the
4 thumb drives, and it has all the meeting
5 materials that was either e-mailed to you and
6 some of the meeting materials we revised. And
7 that would just be the agenda.
8 We also have a PowerPoint
9 presentation that Ashlie will be giving a
10 general overview, and that is on the thumb
11 drive as well.
12 Anything else?
13 So, when the Steering Committee
14 reconvenes and they're going to review, we'll
15 start the discussion and we'll have the
16 primary reviewer from the workgroup and from
17 the groups that you were assigned, to present
18 to the Steering Committee.
19 And after that, we'll have a
20 secondary reviewer add any additional input
21 that they may have.
22 Lisa and Howard will open it up

1 for Steering Committee discussion at that
2 time, and that is also the time to have any
3 type of clarification that you may need from
4 the measure developers.
5 The measure developers will come
6 and they'll stand by the microphone, and
7 you'll be able to ask them for any type of
8 clarification that you may need.
9 We will be voting after that, and
10 the co-chairs are responsible for kind of
11 facilitating and monitoring discussion. So
12 once they feel that the discussion has ended
13 that there's really no more issues, they can
14 call for a vote at that time.
15 There's also another way that -
16 they can call for a straw vote if for some
17 reason the discussion seems to be going
18 towards one way and they can't really get a
19 feel. Maybe half of the group seems to be
20 leaning towards yes, half the group seems to
21 be leaning towards no. They can call for a
22 straw vote at that time just to see, really,

1 how the group is leaning and if we need any
2 more discussion.
3 The voting options that we have
4 today are we could recommend the measures for
5 endorsement, and that's if they meet the
6 majority of the criteria, or you could not
7 recommend them. And it's consensus that it
8 goes on either for recommendation or not to
9 recommend.
10 So, we will be asking when you
11 vote, to raise your hand. When one of the co-
12 chairs says how are we going to vote, are we
13 going to recommend for endorsement, we would
14 need you to raise the hand because we need to
15 count how many people for and how many people
16 against.
17 Any questions at this time?
18 DR. GRAY: I just had a question
19 about the straw vote so that the purpose of
20 that is to - when you sort of said get a sense
21 that there is a divergence of opinion, to then
22 have more discussion to clarify whatever the

1 issues are such that at the point we actually
2 have the more official vote that there is
3 going to be more of a preponderance in one
4 direction or the other, is that the point of
5 the straw vote?
6 MS. GRANNIS: Correct. Yes. And
7 it will - sometimes what ends up happening is
8 there might be somebody in the crowd who wants
9 to play devil's advocate, get all the issues
10 out, but they may want to actually vote "Yes"
11 for the actual measure.
12 So, really what the straw vote
13 would be showing was if really we do need more
14 discussion on this issue or whether the issue
15 has been resolved and we can move to a final
16 vote.
17 DR. GRAY: Okay. And the other
18 thing is that the recommendation of I guess it
19 was presumably yes, as is or a yes, with
20 conditions as an option.
21 So, it's not really just yes or
22 no, right?

1 MS. GRANNIS: Right. During your
2 discussion, you'll be clarifying with the
3 measure developer if there's any type - and,
4 for example, I'll just bring up the example of
5 what we discussed on the orientation call
6 which was - I think it was seven and eight,
7 Measure 7 and 8 where they had two similar
8 titled -
9 DR. GRAY: Right, right.
10 MS. GRANNIS: So, that might be the
11 time where you would say we would want one of
12 them, the title changed to reflect more of the
13 measure depending on which one you want
14 changed.
15 And then the measure developer
16 would say yes, we can agree to that condition.
17 And then that's how we would go ahead and
18 vote.
19 DR. GRAY: So once the "with
20 conditions" is actually presumably addressed,
21 the measure developer is given the opportunity
22 during this meeting to - or the

1 representatives of the measure developers to
2 decide whether or not they accept the
3 conditions. And so that ends up getting
4 codified in terms of the--the recommendation
5 yes, but with the following conditions which
6 the measure developer has agreed to?
7 MS. GRANNIS: Correct. Yes. And
8 that will also be captured in the note taking
9 that you'll be doing in your groups, too. If
10 you find that there's something that you want
11 to clarify with the measure developer, you can
12 add that under the "comment" section that you
13 want this condition met.
14 And then when we reconvene as a
15 steering committee and the measure is actually
16 presented by the primary or secondary
17 reviewer, at that time you can ask the measure
18 developer if they're able to meet that
19 condition.
20 Does that answer your question?
21 DR. GRAY: Yes.
22 MS. GRANNIS: Okay.

1 DR. GRAY: And all these are being
2 accepted with a time - I guess it's -
3 MS. GRANNIS: Time-limited
4 endorsement, yes.
5 DR. GRAY: Okay.
6 MS. GRANNIS: Exactly. Okay.
7 Great.
8 MS. WILBON: Any other questions
9 before - I guess we can keep it moving. We
10 left 30 minutes for the executive session.
11 But if there aren't any more questions or
12 anything else to discuss, we can just go ahead
13 and move forward to the open part of the
14 meeting and keep the day rolling. We'll let
15 Dr. Jeffries and Lisa share any comments they
16 might have before we - or how they, you know,
17 the goal of the day or any goals you might
18 have for the meeting or what have you.
19 CO-CHAIR JEFFRIES: Okay. I wasn't
20 prepared for this.
21 MS. GRANNIS: Sorry to put you on
22 the spot.

1 CO-CHAIR JEFFRIES: That's okay.
2 I'll figure it out.
3 Well, first I just want to thank
4 the NQF for getting this together and asking
5 me to be a part of it. And I won't speak for
6 Lisa. I'll let her speak for herself, but I
7 look forward to the work today.
8 I think these measures are very
9 interesting and are a great thing for us to
10 look through.
11 So, my background is in critical
12 care, and we have worked on some measures in
13 critical care in the past, and have found
14 those to be very helpful as we try to improve
15 our practice in ICU. And I think these
16 measures will allow for the same thing within
17 pediatric cardiac surgery.
18 So, I look forward to the work
19 today and in working with all of you to work
20 on this.
21 CO-CHAIR KOHR: I also want to
22 thank you for being invited to participate in

1 this. I think it's extremely important for us
2 to push this forward and I look forward to the
3 dialog that we're going to have about these
4 measures.
5 MS. GRANNIS: Okay. So, any more
6 questions from anybody?
7 DR. HOYER: No, but I can make a
8 comment. I can fill time if you want to.
9 MS. GRANNIS: Sure.
10 DR. HOYER: Just as I'm thinking
11 about this, and, again, this is a new thing
12 for me as a pediatric cardiologist to be
13 sitting on this committee, but I see a lot of
14 applicability of what will happen today to
15 subsequent submissions.
16 I'm part of something called the
17 Congenital Cardiac Interventional Study
18 Consortium, CCISC, if I can get that right,
19 and we're 50 plus centers that are trying to
20 kind of answer some questions at least so far.
21 There's also the ACC's PCI data
22 registry which has been pretty well

1 established, and there's our attempts to try
2 to make something similar happen in the
3 pediatric cardiology or pediatric
4 interventional world coming up.
5 And it's been kind of coming on
6 several fronts. And where that's ultimately
7 going to kind of, you know, basically ferret
8 out and whether it will be ACC sponsored,
9 whether it will be something else is not
10 certain yet, but I can see this as being
11 something that will be the next submission or
12 one of the next submissions in the next few
13 years, possibly.
14 So, I am very interested and
15 excited about what we're going to be studying
16 and talking about because I think we'll all
17 learn something about how we will deal with
18 these things in the future.
19 MS. NUGENT: Could you talk a
20 little bit about what happens after the
21 endorsement, where these things go, any
22 examples that you could provide?

1 DR. BURSTIN: Yes, let me give you
2 a little bit of background. So, one of the
3 main goals of NQF is endorsing consensus
4 standards. And the logic for doing that is
5 actually something called the National
6 Technology Transfer and Advancement Act. That
7 specifically designates NQF as the standard
8 setting organization.
9 Some of you know the IT world,
10 know HITSP or any other standard setting
11 organizations. We are that organization for
12 healthcare quality.
13 So, the key and important piece of
14 this is that it obligates the federal
15 government to use NQF-endorsed standards
16 whenever available whenever they're seeking
17 standards.
18 So, for example, if you go to
19 hospital compare, if you go to nursing home
20 compare, all of those measures are NQF-
21 endorsed and are required to be. So, that's
22 part of the reason that there's a significant

1 emphasis on getting these measures NQF
2 endorsed.
3 The pediatric side is a little
4 different because traditionally much of this
5 work to date as most pediatricians know, and
6 other folks know very well, has been heavily
7 emphasized on the Medicare side. And Sylvia
8 certainly know this at the federal level at
9 least, less so Medicaid.
10 But I think there is increasingly
11 a push to start thinking about how some of
12 these pediatric measures, especially in the
13 age of the new CHIPRA legislation that went
14 through and the requirement to have pediatric
15 quality measures available will follow.
16 I also think we've also seen
17 significant uptake of these kinds of measures
18 at the state level, the health plan level as
19 well. So, having the imprimatur of being NQF
20 endorsed is a powerful incentive to having the
21 measures be used.
22 That being said, we don't control

1 the implementation of those measures, and it's
2 really important to remember that. Although
3 we say this is a really good measure and this
4 goes forward, it's still up to the ultimate
5 implementer to say this is a measure we want
6 to use as part of whatever the program, maybe
7 publicly reporting or pay for performance or
8 however they choose to play it.
9 As long as we're still in
10 executive session, I just want to also mention
11 some of you may have heard of a lot of
12 discussions recently around the STS adult
13 measures and the fact that we had some
14 competing measures submitted that didn't have
15 perhaps that same rigor or risk adjustment,
16 clinical risk adjustment, that our board is
17 actually still grappling with.
18 We have deferred the decision on
19 those other measures for now, but part of the
20 issue here really was about the fact that to
21 date at least, the STS measures are not
22 publically reported. And really, one of the

1 ideas of NQF endorsement is that those
2 measures are appropriate for both public
3 reporting and quality improvement, but really
4 the public reporting piece is pretty
5 paramount.
6 So, the board just reaffirmed the
7 fact that yes, we really do expect that
8 perhaps not at submission, you couldn't expect
9 measures at submission to NQF to be publically
10 reported, but by the time of the three-year
11 maintenance review which we do for all of our
12 measures, there should at least be
13 demonstration of how far along the path
14 towards public reporting, meaning reporting to
15 the public at large, is available.
16 So, as you think about this set of
17 measures, how soon can it be before a parent
18 is able to go online and find out some of the
19 outcomes of pediatric cardiac surgery before
20 they begin picking a site of care.
21 That's our ultimate goal and our
22 expectation should be. And in discussions

1 with STS and ACC and others, that's clearly
2 a move, the direction in which they're going,
3 but I think that that will be something we're
4 really hoping to see, some of these registry-
5 based measures increasingly see the light of
6 day beyond - I mean they've been powerful
7 forces for benchmarking and quality
8 improvement, seen dramatic improvements on the
9 adult side with outcomes related to cardiac
10 surgery, but I think there's also as we'll go
11 over with the NQF criteria, one of them
12 specifically is usability.
13 And the idea there is that that
14 information can be used by consumers or those
15 who purchase care on their behalf to make
16 better decisions.
17 And so, I think that's ultimately
18 where we want to see these measures go.
19 Questions?
20 DR. HOYER: I do have a question
21 about that. It's Helen, right?
22 DR. BURSTIN: Yes.

1 DR. HOYER: Yes. Thank you. Many
2 different societies and organizations have
3 also been endorsing -
4 DR. BURSTIN: Yes.
5 DR. HOYER: - quality measures.
6 And I guess the question I had was with NQF
7 being somewhat of a federal charge to some
8 degree, who else competes with NQF maybe in
9 the private sector for creating those kind of
10 endorsement standards?
11 DR. BURSTIN: It's been an
12 interesting time, actually. And over the last
13 couple of years there was partly driven by the
14 need to have rapid approval of a set of
15 measures for the Physician Quality Reporting
16 Initiative, PQRI, the AQA, formerly known as
17 the Ambulatory Care Quality Alliance, did
18 approval of measures.
19 That is now defunct and at this
20 point there is no other group that's actually
21 endorsing measures besides NQF. And part of
22 that has been our, you know, we've rapidly -

1 we have tried to make the process move as
2 quickly as it could.
3 There was issues in the past that
4 NQF was too slow, not responsive. So as much
5 as possible, we've been trying to move things
6 quickly.
7 The other piece of this that's
8 important to know is part of the reason we can
9 make this happen and hire almost, you know,
10 half the staff up here are brand new in the
11 last year or so, is that we've also gotten a
12 significant federal appropriation through the
13 Medicare law last year.
14 So, we have up to $10 million a
15 year over the next four years to focus on
16 setting national priorities and goals,
17 endorsing consensus standards.
18 And actually the big piece we're
19 doing right now is trying to think about how
20 these measures migrate to an electronic
21 platform.
22 So these measures are great, but

1 how many of them could actually - how much
2 could these clinical registries become
3 interoperable with electronic health records,
4 pull the key data elements you need out of
5 EHRs, add in the data elements you could only
6 get through a clinical registry and piece that
7 together.
8 So, we now have the resources.
9 We're significantly expanding to be able to do
10 that so we can work faster, we can pick up
11 more projects, which is both a blessing and a
12 curse.
13 Which means I think I'm at a
14 steering committee almost every day through
15 the end of the month because we've got so many
16 projects now revving up including some very
17 exciting work.
18 The Outcomes Across 20 Conditions
19 has just started. That actually includes a
20 pediatric outcomes component as well that is
21 going to kick up shortly.
22 And so, this project will feed

1 into part of that, but it's an exciting time
2 to actually have, I think, a real impact of
3 picking the measures and putting forward
4 measures that we think people will use and
5 want to use for both QI and public reporting.
6 DR. GHANAYEM: Hi. I'm Nancy
7 Ghanayem from Wisconsin, Children's Hospital
8 of Wisconsin.
9 To be a little bit of a devil's
10 advocate, the adult STS measures are largely
11 based on outcome data because there's been far
12 more - I suspect far more contribution to the
13 adult database, adult STS database, which is
14 somewhat different with the pediatric measures
15 that are proposed. For many of them there are
16 no outcome data linked to them.
17 How does that play into our
18 ability to vote on these measures when there's
19 lots of outcome data that's actually not
20 available?
21 DR. BURSTIN: That's a good
22 question. You've got to start somewhere.

1 And, in fact, I just did this analysis last
2 night looking at all the specialty
3 designations for all of our 500 measures. It
4 wasn't fun, but somebody had to do it.
5 We actually if you look through
6 the cardiac surgery database, the cardiac
7 surgery measures we've endorsed, there
8 actually are a blend of process and outcomes.
9 They're not all outcomes.
10 And I think the outcomes have
11 somewhat come in the latter part of bringing
12 those measure through, so there are a whole
13 set of measures about appropriate use of beta
14 blockade, anti-platelet agents, things like
15 that in addition to over time and the risk-
16 adjusted mortality, risk-adjusted
17 complications.
18 And actually, they've just
19 submitted to us as part of our large
20 cardiovascular outcomes project, their
21 composite measure on the adult cardiac surgery
22 side which we're very excited to review

1 shortly.
2 So, I think we're making progress.
3 But I think as we think about the vision of
4 where we think we need to go as you
5 ultimately, I think, want a package of
6 measures, that you want to have outcome
7 measures, you want to have some process
8 measures that clearly have some link to
9 outcome measures so that they're useful for
10 quality improvement.
11 And I think you also want to be
12 able to pull in some of the other key kinds of
13 measures like cost and resource use, patient
14 experience of care, really, to get a broad
15 view of where I think we want to get a full
16 view of what's happening in a given area.
17 DR. MAYER: Maybe, Nancy, I can
18 just respond a little bit to - I've sort of
19 been involved in this whole database thing for
20 a number of years because of my roles in the
21 STS.
22 DR. GHANAYEM: Sure.

1 DR. MAYER: The congenital database
2 at least is at an earlier point in its
3 evolution than the adult cardiac database.
4 The adult cardiac database has been around
5 since 1989. It's got 3.6 million patients,
6 you know. It's got a huge denominator, as
7 they say.
8 And I think what we are now is
9 we're on the sort of rapid uptake of adoption
10 by congenital heart surgery centers in the
11 United States. I think the last count is
12 we're at almost 70 congenital heart surgery
13 centers out of what we guess is 120 some odd
14 in the country.
15 The adult database now has just
16 enrolled its one-thousandth participating
17 institution, and we think that that represents
18 90 percent of the, as best you can guess,
19 adult cardiac centers in the country. So, I
20 think we're just at a different phase.
21 When we, STS, put the adult
22 cardiac surgery measures through the NQF

1 process, even at that point we had two-and-a-
2 half million or two million patients. So, the
3 database was much more mature, if you will,
4 than where we are.
5 But I think, and Jeff and Marshall
6 will tell you, I mean I think that this has
7 gotten support all up and down the STS
8 organizational structure. That even though we
9 know we're not as far along as the adult
10 database is, that this is something we clearly
11 think is important.
12 We think it's much better that we
13 figure out what the measures ought to be, we
14 the STS, rather than having them imposed from
15 outside.
16 And I think we're getting close to
17 the point now where we can get the expert
18 opinion part out of the database and
19 understanding outcomes, and get it entirely
20 data driven.
21 So, we don't have a denominator
22 nearly so large as three-and-a-half million,

1 but I think we're getting close.
2 MS. GRANNIS: Thank you. It is now
3 ten o'clock, so we're going to start the
4 meeting. We're going to open it up to our
5 open session, and we're out of our executive
6 session now.
7 DR. GRAY: Sorry. Just had one
8 other question. We had talked about trying to
9 get the books that Jeff Jacobs sent.
10 Do we know where they are?
11 MS. GRANNIS: I think we're still
12 trying to look into that.
13 MS. WILBON: So, the measure
14 developers are here. I think Lisa is just
15 making sure everyone gets in the room who was
16 signed up to attend the meeting in the
17 audience.
18 So, we'll let them get settled
19 briefly, and then we'll go ahead and get
20 started.
21 (Whereupon, the meeting went into
22 Open Session.)

A

ability 28:18
able 7:16 8:11,20 8:21 11:7 15:18 23:18 27:9 30:12
ACC 19:8 24:1
accept 15:2
acceptability 8:16
accepted 16:2
ACC's 18:21
Act 20:6
actual 13:11
add 10:20 15:12 27:5
addition 29:15
additional 10:20
addressed 14:20
adjusted 29:16
adjustment 22:15 22:16
adoption 31:9
adult 22:12 24:9 28:10,13,13 29:21 31:3,4,15,19,21 32:9
Advancement 20:6
advocate 13:9 28:10
age 21:13
agenda 3:22 10:7
agents 29:14
agree 14:16
agreed 15:6
ahead 14:17 16:12 33:19
ALLEN 1:21
Alliance 25:17
allow 17:16
Ambulatory 25:17
analysis 29:1
answer 15:20 18:20
anti-platelet 29:14
anybody 18:6
applicability 18:14
appropriate 23:2 29:13
appropriation 26:12
approval 25:14,18
AQA 25:16
area 30:16
Ashlie 2:13 3:9 5:7 9:8 10:9
asking 12:10 17:4
assign 9:3,4
assigned 6:9,17 10:17
attempts 19:1
attend 33:16
audience 4:4 33:17
available 9:8 20:16 21:15 23:15 28:20
Avenue 1:13
a.m 1:14 3:2

B

B 6:5,7,13
back 8:10
background 17:11 20:2
BARNETT-JON... 1:18
based 24:5 28:11
basically 19:7
behalf 24:15
believe 8:18 9:13
benchmarking 24:7
best 31:18
beta 29:13
better 24:16 32:12
beyond 24:6
big 26:18
bit 19:20 20:2 28:9 30:18
blend 29:8
blessing 27:11
blockade 29:14
board 22:16 23:6
books 33:9
Boston 4:21 5:2 9:18
brand 26:10
break 6:2,11,22 9:6
breakout 9:9
brief 5:12
briefly 33:19
bring 7:7,20 14:4
bringing 29:11
broad 30:14
broken 6:4
BSN 1:19
Burstin 2:7 5:9 20:1 24:22 25:4 25:11 28:21

C

call 11:14,16,21 14:5
called 18:16 20:5
calling 4:6
captured 15:8
cardiac 1:3,5,12 3:6,12,14 4:15 17:17 18:17 23:19 24:9 29:6,6,21 31:3,4,19,22
cardiologist 18:12
cardiology 19:3
cardiovascular 29:20
care 17:12,13 23:20 24:15 25:17 30:14
categories 8:21
CCISC 18:18
centers 18:19 31:10 31:13,19
certain 19:10
certainly 21:8
chairs 1:14 12:12
chance 5:15
changed 14:12,14
charge 25:7
Children's 4:20 5:2 9:18 28:7
CHIPRA 21:13
choose 22:8
CHRISTINA 2:12
clarification 11:3,8
clarify 12:22 15:11
clarifying 14:2
clearly 24:1 30:8 32:10
clinical 22:16 27:2 27:6
close 32:16 33:1
closed 3:18
CNOR 1:19
codified 15:4
come 4:4 11:5 29:11
coming 19:4,5
comment 15:12 18:8
comments 5:14,18 7:5 16:15
committee 1:3,12 1:16 3:7,11 5:16 5:22 7:16 10:13 10:18 11:1 15:15 18:13 27:14
committees 7:8
compare 20:19,20
competes 25:8
competing 22:14
complications 29:17
component 27:20
composite 29:21
condition 14:16 15:13,19
conditions 13:20 14:20 15:3,5 27:18
conflicts 5:6
congenital 18:17 31:1,10,12
Congressional 1:12
consensus 1:4 3:5 12:7 20:3 26:17
Consortium 18:18
CONSTANTINE 1:22
consumers 24:14
contribution 28:12
control 21:22
Correct 13:6 15:7
cost 30:13
count 12:15 31:11
country 31:14,19
couple 25:13
Co-Chair 1:17,18 16:19 17:1,21
co-chairs 4:8 11:10
CPNP 1:18
creating 25:9
criteria 12:6 24:11
critical 17:11,13
crowd 13:8
curse 27:12

D

DARRYL 1:20
data 18:21 27:4,5 28:11,16,19 32:20
database 28:13,13 29:6 30:19 31:1,3 31:4,15 32:3,10 32:18
date 21:5 22:21
day 3:20 10:2 16:14 16:17 24:6 27:14
days 8:11
deal 19:17
decide 9:2 15:2
decides 7:10
decision 22:18
decisions 24:16
deferred 22:18
defunct 25:19
degree 25:8
demonstration 23:13
denominator 31:6 32:21
Department 5:10
depending 14:13
depth 9:6
designates 20:7
designations 29:3
developed 5:3
developer 14:3,15 14:21 15:6,11,18
developers 5:14,15 5:20 11:4,5 15:1

33:14
developing 4:22
devil's 13:9 28:9
dialing 4:6
dialog 6:18 18:3
different 21:4 25:2 28:14 31:20
direction 13:4 24:2
disclose 5:1
disclosing 5:5
disclosures 4:11
discuss 9:15 16:12
discussed 14:5
discussion 6:14,19 7:18 8:5,10,15 10:15 11:1,11,12 11:17 12:2,22 13:14 14:2
discussions 9:12 22:12 23:22
divergence 12:21
doing 15:9 20:4 26:19
Dr 2:19,20,21,22 4:7 12:18 13:17 14:9,19 15:21 16:1,5,15 18:7,10 20:1 24:20,22 25:1,4,5,11 28:6 28:21 30:17,22 31:1 33:7
dramatic 24:8
drive 10:11
driven 25:13 32:20
drives 10:4
D.C 1:13

E

E 1:23
earlier 31:2
EHRs 27:5
eight 14:6
either 10:5 12:8
electronic 26:20 27:3
elements 27:4,5
emphasis 21:1
emphasized 21:7
ended 11:12
endorsed 20:21 21:2,20 29:7
endorsement 12:5 12:13 16:4 19:21 23:1 25:10
endorsing 20:3 25:3,21 26:17
ends 13:7 15:3
enrolled 31:16
entirely 32:19
especially 21:12
established 19:1
evaluate 3:11
evaluating 8:15
evaluation 6:20
everybody 3:4
evolution 31:3
Exactly 16:6
example 4:18 14:4 14:4 20:18
examples 19:22
excited 19:15 29:22
exciting 27:17 28:1
executive 1:6 3:17 16:10 22:10 33:5
expanding 27:9
expect 3:20 23:7,8
expectation 23:22
experience 30:14
expert 32:17
experts 4:13,14
extremely 18:1
e-mailed 10:5

F

facilitating 6:13 11:11
fact 22:13,20 23:7 29:1
Fanta 2:8 3:22
far 18:20 23:13 28:11,12 32:9
faster 27:10
feasibility 8:17
federal 20:14 21:8
25:7 26:12
feed 27:22
feel 11:12,19
ferret 19:7
field 4:15
figure 17:2 32:13
fill 6:20 18:8
final 13:15
find 15:10 23:18
first 9:19 17:3
flow 3:19
focus 26:15
folks 21:6
follow 21:15
following 15:5
forces 24:7
form 6:20
formerly 25:16
Forum 1:1 5:11
forward 16:13 17:7 17:18 18:2,2 22:4 28:3
found 17:13
four 26:15
fronts 19:6
full 30:15
fun 29:4
future 19:18

G

GALVIN 1:19
GAUVREAU 2:20
general 5:14,17 10:10
getting 15:3 17:4 21:1 32:16 33:1
Ghanayem 1:19 28:6,7 30:22
give 5:14,16 20:1
given 14:21 30:16
giving 5:8,11 10:9
go 3:19 5:5,22 7:21 8:9 9:5,19 14:17 16:12 19:21 20:18 20:19 23:18 24:10 24:18 30:4 33:19
goal 16:17 23:21
goals 16:17 20:3 26:16
goes 8:5 12:8 22:4
going 4:2,9 5:1,13 6:2,15,16 7:1,6,16 7:20 8:13,15 9:13 9:14,19 10:14 11:17 12:12,13 13:3 18:3 19:7,15 24:2 27:21 33:3,4
good 3:3 22:3 28:21
gotten 26:11 32:7
government 20:15
Grannis 2:9 3:3,8 7:6 13:6 14:1,10 15:7,22 16:3,6,21 18:5,9 33:2,11
grappling 22:17
GRAY 1:20 12:18 13:17 14:9,19 15:21 16:1,5 33:7
great 16:7 17:9 26:22
group 6:12,13,18 11:19,20 12:1 25:20
groups 10:17 15:9
guess 13:18 16:2,9 25:6 31:13,18
guide 9:10

H

half 11:19,20 26:10 32:2
hand 12:11,14
handed 3:22
happen 4:16 18:14 19:2 26:9
happening 13:7 30:16
happens 19:20
health 21:18 27:3
healthcare 20:12
heard 22:11
heart 31:10,12
heavily 21:6
Helen 2:7 5:9 24:21
help 9:10
helpful 17:14
Hi 28:6
HINES 2:11
HINKLE 1:21
hire 26:9
HITSP 20:10
hold 5:21 8:18
home 20:19
hoping 24:4
hospital 4:20 5:2 9:18 20:19 28:7
Hotel 1:13
Howard 1:14,17 4:7 6:12 10:22
HOYER 1:21 18:7 18:10 24:20 25:1 25:5
huge 31:6
Hyatt 1:13

I

ICU 17:15
idea 24:13
ideas 23:1
impact 28:2
implementation 22:1
implementer 22:5
importance 8:16
important 18:1 20:13 22:2 26:8 32:11
imposed 32:14
imprimatur 21:19
improve 17:14
improvement 3:14 23:3 24:8 30:10
improvements 24:8
incentive 21:20
includes 27:19
including 27:16
increasingly 21:10 24:5
information 24:14
Initiative 25:16
input 10:20

institution 31:17
instructions 5:17
interest 4:11 5:6
interested 19:14
interesting 17:9 25:12
interoperable 27:3
interventional 18:17 19:4
introductions 4:10
invited 17:22
involved 30:19
issue 13:14,14 22:20
issues 11:13 13:1,9 26:3

J

J 1:21
Jacobs 2:21,22 33:9
Jeff 32:5 33:9
JEFFREY 2:22
Jeffries 1:14,17 4:7 4:8 6:12 16:15,19 17:1
JENKINS 2:19
Jersey 1:13
jogging 7:19
JOHN 1:23
join 4:4

K

KATHY 2:19
keep 16:9,14
key 20:13 27:4 30:12
kick 27:21
KIMBERLEE 2:20
kind 3:19,20 5:16 6:15,18 7:18,19 8:4 11:10 18:20 19:5,7 25:9
kinds 21:17 30:12
know 3:10 16:16 19:7 20:9,10 21:5 21:6,8 25:22 26:8 26:9 31:6 32:9 33:10
known 25:16
knows 6:3
Kohr 1:14,18 4:8 6:11 17:21

L

large 23:15 29:19 32:22
largely 28:10
law 26:13
leaning 11:20,21 12:1
learn 19:17
left 16:10
legislation 21:13
level 21:8,18,18
light 24:5
link 30:8
linked 28:16
Lisa 1:14,18,23 2:11 4:8 6:11 10:22 16:15 17:6 33:14
listen 8:10,11
little 19:20 20:2 21:3 28:9 30:18
logic 20:4
long 22:9
look 7:17 17:7,10 17:18 18:2 29:5 33:12
looking 6:5,7 29:2
LOPEZ 1:22
lot 4:13 18:13 22:11
lots 28:19

M

M 1:18
main 20:3
maintenance 23:11
majority 12:6
making 30:2 33:15
Manager 3:9
MARK 1:21
Marshall 2:21 32:5
materials 10:5,6
mature 32:3
MAVROUDIS 1:22
MAYER 1:23 30:17 31:1
MBA 1:17,18
MD 1:17,19,20,21 1:21,22,22,23
mean 24:6 32:6
meaning 23:14
means 27:13
measure 4:18,21,22 5:14,15,20,22 6:17 9:17 11:4,5 13:11 14:3,7,13 14:15,21 15:1,6 15:11,15,17 22:3 22:5 29:12,21 33:13
measures 3:12 5:3 5:10 6:6,8 9:16,20 9:22 10:1 12:4 17:8,12,16 18:4 20:20 21:1,12,15 21:17,21 22:1,13 22:14,19,21 23:2 23:9,12,17 24:5 24:18 25:5,15,18 25:21 26:20,22 28:3,4,10,14,18 29:3,7,13 30:6,7,8 30:9,13 31:22 32:13
Medicaid 21:9
Medicare 21:7 26:13
meet 12:5 15:18
meeting 3:7,21 10:4,6 14:22 16:14,18 33:4,16 33:21
MEMBERS 1:16
memory 7:19
mention 22:10
met 1:12 15:13
MFA 1:23
microphone 11:6
migrate 26:20
million 26:14 31:5 32:2,2,22
minutes 16:10
monitoring 11:11
month 27:15
morning 3:3 4:19
mortality 29:16
move 13:15 16:13 24:2 26:1,5
moving 16:9
MPH 1:17,18

N

Nancy 1:19 28:6 30:17
national 1:1,4 3:5 5:11 20:5 26:16
nearly 32:22
need 4:16 11:3,8 12:1,14,14 13:13 25:14 27:4 30:4
needed 8:9
new 1:13 18:11 21:13 26:10
night 29:2
note 15:8
notes 7:2,10,12,17 8:14,22 9:3,5
NQF 2:5 8:3,9 17:4 20:3,7,20 21:1,19 23:1,9 24:11 25:6 25:8,21 26:4 31:22
NQF-endorsed 20:15
NUGENT 1:23 19:19
number 30:20
nursing 20:19
N.W 1:13

O

obligates 20:14
OCTOBER 1:9
odd 31:13
official 13:2
okay 7:20 13:17 15:22 16:5,6,19 17:1 18:5
once 11:12 14:19
one-thousandth 31:16
online 8:8 23:18
open 4:3 10:22 16:13 33:4,5,22
opening 6:18
opinion 12:21 32:18
opportunity 14:21
option 13:20
options 12:3
organization 4:17 20:8,11
organizational 32:8
organizations 20:11 25:2
orientation 14:5
ought 32:13
outcome 6:7 9:16 9:17,21 28:11,16 28:19 30:6,9
outcomes 3:16 23:19 24:9 27:18 27:20 29:8,9,10 29:20 32:19
outside 32:15
overhead 8:7
overview 5:8,12 10:10
o'clock 4:2 9:14 33:3

P

package 30:5
paramount 23:5
parent 23:17
part 4:22 16:13 17:5 18:16 20:22 22:6,19 25:21 26:8 28:1 29:11 29:19 32:18
participate 17:22

participating 4:5 31:16
particular 4:17
partly 25:13
path 23:13
patient 3:15 30:13
patients 31:5 32:2
PATRICIA 1:19
Patty 4:18
pay 22:7
PCI 18:21
pediatric 1:3,5,12 3:6,12,14 4:15 17:17 18:12 19:3 19:3 21:3,12,14 23:19 27:20 28:14
pediatricians 21:5
people 4:5 12:15,15 28:4
percent 31:18
performance 5:10 22:7
person 7:9
phase 31:20
phone 8:8
Physician 25:15
pick 27:10
picking 23:20 28:3
piece 20:13 23:4 26:7,18 27:6
plan 21:18
platform 26:21
play 13:9 22:8 28:17
plus 18:19
point 13:1,4 25:20 31:2 32:1,17
possible 26:5
possibly 19:13
posted 8:8
potential 5:5
powerful 21:20 24:6
PowerPoint 10:8
PQRI 25:16
practice 17:15
prepared 16:20
preponderance 13:3
present 1:16 2:5,16 10:17
presentation 10:9
presented 15:16
presenting 7:13
presiding 1:14
presumably 13:19 14:20
pretty 18:22 23:4
primary 6:10 7:12 10:16 15:16
primary/seconda... 6:16
priorities 26:16
private 25:9
process 3:15 6:6 9:22 26:1 29:8 30:7 32:1
program 22:6
progress 30:2
project 3:9 5:8 27:22 29:20
projects 27:11,16
proposed 28:15
provide 19:22
public 3:13 4:4 23:2,4,14,15 28:5
publically 22:22 23:9
publicly 22:7
pull 27:4 30:12
purchase 24:15
purpose 3:10 12:19
push 18:2 21:11
put 16:21 31:21
putting 28:3
P-R-O-C-E-E-D-... 3:1

Q

QI 28:5
quality 1:1 3:13 5:11 20:12 21:15 23:3 24:7 25:5,15 25:17 30:10
question 12:18 15:20 24:20 25:6 28:22 33:8
questions 5:19 9:10 12:17 16:8,11 18:6,20 24:19
quickly 26:2,6

R

raise 12:11,14
rapid 25:14 31:9
rapidly 25:22
reaffirmed 23:6
real 28:2
really 11:13,18,22 13:12,13,21 22:2 22:3,20,22 23:3,7 24:4 30:14
reason 11:17 20:22 26:8
received 10:3
recommend 3:12 12:4,7,9,13
recommendation 12:8 13:18 15:4
reconvene 5:21 7:15 9:13,15 15:14
reconvenes 10:14
record 5:5 7:5
recorded 7:22 8:7
records 8:3,3 27:3
referencing 3:21
reflect 14:12
Regency 1:13
registries 27:2
registry 18:22 24:4 27:6
related 3:14 24:9
remember 8:5 22:2
reported 22:22 23:10
reporting 3:13 22:7 23:3,4,14,14 25:15 28:5
representatives 15:1
represents 31:17
required 20:21
requirement 21:14
resolved 13:15
resource 30:13
resources 27:8
respond 30:18
responsible 11:10
responsive 26:4
review 6:1 9:19,22 10:14 23:11 29:22
reviewer 6:16 7:11 7:13 9:5 10:16,20 15:17
reviewers 6:10
revised 3:22 10:6
revving 27:16
right 3:18 8:1 13:22 14:1,9,9 18:18 24:21 26:19
rigor 22:15
risk 22:15,16 29:15
risk-adjusted 29:16
RN 1:18,19
roles 30:20
rolling 16:14
room 4:9 33:15

S

Sarah 2:8 3:22 7:3 7:20
says 12:12
ScD 1:20
SCHONAY 1:18
scientific 8:16
screen 7:7
second 8:19
secondary 6:10 7:11 9:4 10:20 15:16
section 15:12
sector 25:9
see 8:20 11:22 18:13 19:10 24:4 24:5,18
seeking 20:16
seen 21:16 24:8
Senior 5:9
sense 12:20
sent 33:9
serve 7:18
session 1:6 3:17,18 4:3 16:10 22:10 33:5,6,22
sessions 9:9
set 23:16 25:14 29:13
setting 20:8,10 26:16
settled 33:18
seven 14:6
share 16:15
she'll 5:11
shortly 27:21 30:1
showing 13:13
side 21:3,7 24:9 29:22
signed 33:16
significant 20:22 21:17 26:12
significantly 27:9
similar 14:7 19:2
site 23:20
sitting 18:13
slated 10:1
slide 7:3
slow 26:4
societies 25:2
somebody 7:1 9:3 13:8 29:4
somewhat 25:7 28:14 29:11
soon 23:17
Sorry 16:21 33:7
sort 12:20 30:18 31:9
speak 17:5,6
special 5:17
specialized 4:13
specialty 29:2
specifically 20:7 24:12
spoke 4:18

sponsored 19:8
spot 16:22
staff 2:5 26:10
stand 11:6
standard 20:7,10
standards 1:4 3:5 20:4,15,17 25:10 26:17
start 9:15 10:15 21:11 28:22 33:3
started 27:19 33:20
state 21:18
States 31:11
steering 1:3,12,16 3:6,11 5:16,21 7:8 7:16 10:13,18 11:1 15:15 27:14
straw 11:16,22 12:19 13:5,12
structural 6:6
structure 3:15 10:1 32:8
STS 9:20 22:12,21 24:1 28:10,13 30:21 31:21 32:7 32:14
Study 18:17
studying 19:15
submission 19:11 23:8,9
submissions 18:15 19:12
submitted 4:17,21 22:14 29:19
subsequent 18:15
support 32:7
sure 5:4 18:9 30:22 33:15
surgery 1:3,5,12 3:6,13,15 4:15 17:17 23:19 24:10 29:6,7,21 31:10 31:12,22
suspect 28:12
Sylvia 1:22 21:7

T

table 4:14
take 7:10 8:22 9:3 9:5
takes 7:2
talk 19:19
talked 33:8
talking 19:16
Technology 20:6
tell 32:6
ten 4:2 33:3
terms 15:4
thank 17:3,22 25:1 33:2
thing 13:18 17:9,16 18:11 30:19
things 19:18,21 26:5 29:14
think 14:6 17:8,15 18:1 19:16 21:10 21:16 23:16 24:3 24:10,17 26:19 27:13 28:2,4 29:10 30:2,3,3,4,5 30:11,15 31:8,11 31:17,20 32:5,6 32:11,12,16 33:1 33:11,14
thinking 18:10 21:11
three 9:14
three-and-a-half 32:22
three-year 23:10
thumb 10:4,10
time 4:7 5:18 6:21 7:2 11:2,2,14,22 12:17 14:11 15:17 16:2 18:8 23:10 25:12 28:1 29:15
times 7:11
Time-limited 16:3
Tina 2:9 3:8
title 14:12
titled 14:8
today 12:4 17:7,19 18:14
topic 4:13
traditionally 21:4
transcribes 8:1
transcription 8:2
transcripts 8:6
Transfer 20:6
tried 26:1
try 17:14 19:1
trying 8:4 18:19 26:5,19 33:8,12
TSIATIS 2:12
two 8:11 14:7 32:2
two-and-a 32:1
type 5:17 11:3,7 14:3

U

ultimate 22:4 23:21
ultimately 19:6 24:17 30:5
underneath 8:21
understanding 32:19
United 31:11
uptake 21:17 31:9
usability 8:17 24:12
use 8:5 20:15 22:6 28:4,5 29:13 30:13
useful 30:9

V

Vice-President 5:9
view 30:15,16
vision 30:3
Voluntary 1:4 3:5
vote 11:14,16,22 12:11,12,19 13:2 13:5,10,12,16 14:18 28:18
voting 11:9 12:3

W

want 5:4 9:2 13:10 14:11,13 15:10,13 17:3,21 18:8 22:5 22:10 24:18 28:5 30:5,6,7,11,15
wanted 3:10,19 9:4
wants 13:8
Washington 1:13 1:13
wasn't 16:19 29:4
way 11:15,18
website 8:9,12
WEDNESDAY 1:9
welcome 3:4 4:9
went 21:13 33:21
we'll 4:9,10 8:5 9:15,19 10:14,15 10:19 16:14 19:16 24:10 33:18,19
we're 4:2 5:13 6:2 6:4 7:1,6 8:4 9:13 9:14,18 18:3,19 19:15 22:9 24:3 26:18 27:9 29:22 30:2 31:9,12,20 32:9,16 33:1,3,4,5 33:11
we've 7:8 21:16 25:22 26:5,11 27:15 29:7
Wilbon 2:13 3:9 5:7 16:8 33:13
Wisconsin 28:7,8
work 4:16 17:7,18 17:19 21:5 27:10 27:17
worked 17:12
workgroup 6:4,5,5 6:7,19,22 7:14,17 8:14 9:2,9,12 10:16
workgroups 6:3,11 9:7
working 17:19
works 4:20 5:1
world 19:4 20:9

Y

year 26:11,13,15
years 19:13 25:13 26:15 30:20

$

$10 26:14

1

10:40 5:13
120 31:13
1989 31:5

2

2 10:2
20 27:18
2009 1:9
21 1:9

3

3.6 31:5
30 16:10

4

400 1:13

5

50 18:19
500 29:3

7

7 14:7
70 31:12

8

8 14:7

9

9:30 1:13
9:34 3:2
90 31:18